THE EARLY WORKFORCE EXPERIENCES OF MIDWIVES WHO GRADUATED FROM TWO DIFFERENT EDUCATION COURSES IN AUSTRALIA

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Certificate of Original Authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of 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 preparation 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 Student:

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Date:

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Preface

As a novice midwife in the turbulent throes of midwifery education and preliminary clinical employment, I held a group of senior midwives in high esteem: Louise White, Janice Mullins and Rosie Nichols. These women materialised as subtle and off-the-record super heroes. Observing these women midwife labouring women was to see woman-centred midwifery care in action. Watching them attend to women in urgent clinical need was akin to watching a performance of a flawlessly choreographed ballet, where the possession of clinical proficiency, physical dexterity, intellect, advanced communication skills, compassion and kindness were key, all followed by a reassuring and encouraging chinwag. These women performed a providential and essential role in my successful adjustment and transition into being a new graduate midwife. I extend my gratitude towards them. I want all midwives to be able to develop into these un-caped wonders, to flourish as exemplary midwives in full fruition. A workplace environment that houses compassionate personnel, and is supportive of the comprehensive midwifery role is imperative.

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Abstract

Title The early workforce experiences of midwives who graduated from two different education courses in Australia

Background There are workforce shortages in the nursing and midwifery professions in Australia. Many factors have been associated with these shortages such as high workloads, an inadequate skill mix, low nurse/midwife-to-patient/woman ratios, and heightened acuity, all of which can lead to professional burnout for staff. Connected to these shortages are perceptions of inadequate remuneration, experiences of bullying and work-related stresses, the lack of managerial action to tackle these issues and a perceived lack of opportunities for career diversity and progression. Much of this is well known in the nursing discipline, however it is unclear how these factors are similarly impacting midwifery and therefore, research into the workforce experiences of Australian midwives is timely.

Objective / Purpose To explore early workforce participation trends, experiences and choices of midwives who graduated from one Australian university (graduating years 2007 and 2008). Participants were educated either in Bachelor of Midwifery or Graduate Diploma of Midwifery programs (*n* = 113). Further objectives of the study were to identify work environment and personal factors that may influence workforce experiences, and to compare any workforce trends by midwifery course.

Methods A sequential explanatory mixed methods design was conducted. Phase 1 survey collected mainly quantitative demographic and workforce participation data. Three validated instruments were also used: Maslach Burnout Inventory (MBI); Practice Environment Scale of the Nursing Work Index (PES-NWI); and Perceptions of Empowerment in Midwifery scale (PEMS). Due to sample size restrictions, analysis was restricted to non-parametric measures including frequency distribution and simple correlations ($p \leq 0.01$). Phase 2 was a qualitative study using semi-structured interviews with qualitative content and contextual analysis.

Results In Phase 1, the survey response rate was 66 percent (*n* = 75). Fifty-nine were working as midwives, half of them in full-time employment. Personal factors contributing to workforce choices were only a cause of concern for a small number of midwives. The

main reason for having exited from the profession was child rearing. There was a low degree of burnout and high levels of empowerment. Inadequate clinical resources and ineffective managerial support in the workplace were also identified. Bachelor of Midwifery participants were older than the Graduate Diploma midwives but no other relationship between the midwifery course and any of workforce measure existed. In Phase 2, 28 participants were interviewed. Three themes, each comprising of subthemes, were generated: (i) 'sinking and swimming'; (ii) 'needing a helping hand'; and (iii) 'being a midwife… but'. The initial transition into midwifery was overwhelming for most participants, particularly when providing intrapartum care. Coping within the experience was dependent upon support. Job satisfaction was strongly related to the midwife-woman relationship and working to the full scope of practice ability, both which encouraged midwives to remain in midwifery. Dissatisfaction stemmed from poor remuneration, inflexibility of rostering, high workloads and poor managerial approaches. Experiences of bullying were ubiquitous. Factors inducing midwives to stay in the midwifery profession were not the absence of those that caused dissatisfaction. The midwife-woman relationship sustained their practice despite those factors that generated job dissatisfaction.

Conclusion Elements of the early workforce experiences of these midwives paralleled many of those evident in the Australian nursing profession and similar workforce factors contributing to job satisfaction and dissatisfaction were identified. The midwife-woman relationship was a source of job satisfaction and inspired these midwives to remain in midwifery. Exiting the profession- temporarily or permanently- was mainly due to child rearing.

Implications for practice Any vacuum created by eliminating factors of job dissatisfaction will require an amplified investment of factors that bring job satisfaction in order to have genuine content in midwives. Strategies that deliver transitional support, rostering flexibility, leadership training and address workplace bullying, will be ameliorative in the face of staffing shortages. Employment models that enhance relational aspects of midwifery are integral for job satisfaction in midwives. Health systems and services have a duty to support the continued professional development and accessibility of career progression for midwives, to allow individuals to cultivate their midwifery skills and work to their potential.

Organisation of Dissertation

Chapter One: Describes the aim of the study, the context and background for which it was undertaken, the purposes and aims of the larger project that this study is a part of, and the philosophical background of this thesis.

Chapter Two: Is an appraisal of the literature and research surrounding the research topic, thus placing this study within the research canon, as well as providing grounds for the undertaking of the study.

Chapter Three: The methodology chapter describes the overarching design of the study and its ethical considerations.

Chapter Four: This chapter is comprised of the specific methods of the study: the tactic of having it organised in two phases as well as the study's setting, participants, the recruitment and data collection methods.

Chapter Five: This chapter presents the measures used for data analysis of both Phase 1 and Phase 2 of the study

Chapter Six: The first of the survey results chapters relays the demographic findings from Phase 1 of the study, in text and table form.

Chapter Seven: The second of the survey results chapters provides the results from three instruments used to collect data on burnout, the practice environment and perceptions of midwifery empowerment.

Chapter Eight: The interview results chapter presents the findings of the interview data, which constitutes Phase 2 of the study.

Chapter Nine: The discussion chapter interprets and integrates the results derived from both methods of the study, firstly by grouping the integrated analysis as to the research objectives and secondly, by placing this in context with existent research and philosophical literature. In conclusion, this chapter synthesises the findings obtained from the process of analytic synthesis. Limitations of the study will be discussed as well as indicating the significance of the findings for midwifery practice and future research.

Appendixes: The Appendixes provide a copy of the ethics approval letter, the coversheet to the Phase 1 survey and the survey itself. A recruitment information sheet is also included. These supplement the main body of the thesis document.

References: A reference list is supplied in alphabetical order.

List of Abbreviations

ABS Australian Bureau of Statistics

AHPRA Australian Health Practitioner Regulation Agency

ATSI Aboriginal or Torres Strait Islander

AIHW Australian Institute of Health and Welfare

Australian States and Territories

- **ACT** Australian Capital Territory
- **NSW** New South Wales
- **NT** Northern Territory
- **QLD** Queensland
- **SA** South Australia
- **TAS** Tasmania
- **VIC** Victoria
- **WA** Western Australia

BM Bachelor of Midwifery

FTE Full-time equivalent

GD Graduate Diploma of Midwifery

GRAMMS Good Reporting of A Mixed Methods Study

HCCC Health Care Complaints Commission

HW2025 Health Workforce 2025 Doctors, Nurses and Midwives

MBI Maslach Burnout Inventory

MGP Midwifery Group Practice/s

MIDTREC Midwifery Transitions Retention Experiences and Choices - the MidTREC study

MMR Mixed methods research

NRAS National Registration and Accreditation Scheme

NMBA Nursing and Midwifery Board of Australia

PEMS Perceptions of Empowerment in Midwifery Scale

PES-NWI Practice Environment Scale of the Nursing Work Index

QUAL Qualitative research

QUAN Quantitative research

SPSS Statistical Package for the Social Sciences

UTS University of Technology Sydney

WHO World Health Organization

WML 'Why midwives leave?' study

WRS Work Readiness Scale

Chapter 1: Introduction

The health of women and their babies is reliant upon a professional, competent, and efficacious midwifery workforce. The strength of the midwifery profession is contingent upon individuals flourishing within their profession as well as their collaboration together. Each individual midwife is both an asset to their profession and a resource to their community. The strength and sustainability of the midwifery workforce therefore rests on each individual succeeding in their professional capacity. The early career period has been identified as significantly pivotal for midwives, with distinctive demands and support needs. The period of translation from a student midwife into a midwife in the midwifery workforce can be confronting and overwhelming. Equipping midwifery work environments with the apparatus needed for successful transitions and proficient workforces require knowledge of what the requirements are for flourishing as a new midwife. These considerations are of great consequence when taking into account the current and predicted shortages of the Australian health workforce.

Understanding the elements that constitute the work experiences of Australian midwives can therefore be readily understood as critical. As a researcher who is part of a larger University of Technology Sydney research program entitled **Mid**wifery **T**ransitions **R**etention **E**xperiences and **C**hoices- the MidTREC study, I was interested in gaining an understanding of what Australian work experiences in the early career period of a midwife were. The MidTREC study is a longitudinal study of midwifery students from the graduating years 2008 to 2012. The aim of MidTREC is to analyse and track workforce participation trends in Australian midwifery graduates over a five year period and identify personal and organisational factors that influence the workforce participation of these graduates (Centre for Midwifery Child and Family Health 2015).

The aims of my study were to examine the workforce experiences of newly graduated midwives in Australia, the trends of modes of working, the choices made within the early career period, and perceptions of the profession following commencement of midwifery practice. Any discernible distinction between participants from two of the education routes into the midwifery profession, namely the relatively new Bachelor of Midwifery program and the more traditional Graduate Diploma of Midwifery, were also explored.

Underpinning these aims is the need to understand the experiences within the midwifery workforce in view of its present and forecasted workforce shortages.

As an introduction, this chapter presents the first component of the research process, comprising the interrelated tasks of choosing and refining the research question and then positioning it within a context or background to the question. The research aim is given, as is a personal justification for undertaking the study. The context and background to the study is then provided.

1.1 Aim

The study aimed to provide information about the early workforce participation trends of newly graduated midwives in Australia. The research question was:

> *What is the early workforce experiences of midwives who graduated from two different education courses in Australia?*

The objectives the study sought to address pertained to 113 midwifery graduates from one Australian university from two graduating years (2007 and 2008). These were, to:

1. Identify workforce participation trends, workforce experiences and career choices;
2. Identify organisation and work environment factors that may influence workforce participation trends;
3. Identify personal factors and stressors that influence workforce participation trends; and
4. Identify and compare workforce participation trends by program (Bachelor of Midwifery or Graduate Diploma of Midwifery).

1.2 Justification for the study

An epistemological starting point for research rests in personal reasons for undertaking the research, because:

> *"the purpose for a … research study is rooted in the unique conceptualisation in the researcher's thinking about the study"* (Newman et al. 2003, p. 173).

Being a registered and practising midwife emanating from undergraduate direct entry Bachelor of Midwifery education, I am conscious that I would have had no access to this less traditional education route if it were not for the labours of countless supporters of direct entry in Australia, many of whom were midwives. Years of dedication, researching and advice to government to garner support, had at its core commitment to maternity safety and choice and midwifery professionalisation. Taking note of the prolonged challenges necessary for political agitation in the implementation of the Bachelor of Midwifery in Australia, and the impact this education will have upon maternal and infant health, it is vital that the translation of students into graduates and practising midwives occurs. This means developing a profession where midwives, from all education paths, remain, and are content to do so.

When as a student and now as a midwife, I admire and hold in high esteem senior midwives with extensive years of service and practice. The knowledge they bestow upon their junior colleagues and their capacity to provide safe maternity care fascinates me. Witnessing experienced midwives tend to a woman with a post-partum haemorrhage for example, is like observing a precisely choreographed ballet. From these observations I developed an interest in midwifery job satisfaction and workforce sustainability. Research has the potential to contribute to these, as well as enrich women's experiences and enhance maternal and infant safety through a joint enterprise of research and practice.

Any project embarking upon enhancing workforce sustainability in the midwifery profession involves retention of new graduates. Understanding what the profession is like for new midwives can generate information which may add to strategies which boost midwifery workforce retention.

Once a purpose for conducting an investigation into a phenomenon of interest has been ascertained, the questions that will drive the project need to be articulated, starting with the context within which the research sits.

1.3 Context

Similar to other countries across the globe (World Health Organization 2006), the midwifery and nursing professions in Australia are experiencing challenges relating to shortages of their health workforces (Productivity Commission 2005). Straightforwardly expressed, workforce shortages can arise from insufficient numbers of practitioners being educated to enter the workforce, causing the supply to fall short of demand. Shortages can also be due to staff turnover, both voluntarily and involuntarily, and also the inability to retain staff once in the workforce. A pithy definition of staff turnover is the rate at which an employer gains and loses employees (Price & Mueller 1981).

Skill shortages occur when employers are unable to fill or have considerable trouble filling vacancies for an occupation at current levels of remuneration and conditions of employment, and in reasonably accessible locations (Australian Government Department of Employment 2015b). The most recent data from the Australian Government Department of Employment shows midwifery shortages currently across all of New South Wales and Northern Territory and in regional South Australia. Recruitment difficulties transpire when some employers have difficulty filling vacancies for an occupation. There may be an adequate supply of workers but some employers are unable to attract and recruit sufficient, suitable workers for various reasons (Australian Government Department of Employment 2015b). Presently, there is recruitment difficulty across all of Tasmania, in regional Queensland, and in metropolitan Victoria (Australian Government Department of Employment 2015c). Research has not identified any significant difficulty filling vacancies in Western Australia or the Australian Capital Territory (Australian Government Department of Employment 2015c).

Understanding health workforce shortages is difficult, principally due to the variations of demand and the multiplicity of factors contributing to the phenomenon. For instance, the labour market ratings shift between rating periods. The previous labour market ratings for each of the states may be dissimilar from the current rating period, for example, the South Australian 2013 to 2014 labour market rating period showed no shortage of midwives. However, a regional shortage of midwives occurred in that state in the 2014 to 2015 period (Australian Government Department of Employment 2015c).

State-to-state fluctuations of labour ratings result in employers not readily filling midwifery vacancies, leaving positions unfilled. An example of this is in Sydney and regional New

South Wales, whereby a staggering 60 percent of midwifery vacancies remained unfilled in the 2014 to 2015 period (Australian Government Department of Employment 2015a). This is due to a range of reasons. Variations of applicant numbers contribute to applicant deficits or insufficiencies. Another issue is the suitability of applicants, candidates not possessing relevant qualifications, or holding appropriate skills or experience. Applicants may possess insufficient work experience for working independently in small regional and rural hospitals. In some cases, the positions are hard to fill when employers receive no applications due to the challenging nature of the role. Furthermore, some applicants are unwilling to relocate if positions offered are not secure full-time permanent positions. High accommodation, living and relocation costs also act as disincentives to prospective employees. Key reasons cited by employers for the unsuitability of applicants for midwifery positions in rural areas were being unsuitably qualified, not being a registered nurse, or lacking the required experience (Australian Government Department of Employment 2015a).

Another issue for the midwifery profession in Australia is the decline in the number of individuals holding dual registration as both registered midwife and registered nurse. For example, in NSW numbers of dual registrants fell from 10,300 to 8,830, whilst the number of individuals registered exclusively as a midwife increased from 379 to 802, over the three years to March 2015[1]. This is problematic for many small-sized regional hospitals where preferences are to recruit individuals with dual registration due to the need to cover shifts in other general wards (Australian Government Department of Employment 2015a). Subsequently, debate exists within the nursing and midwifery professions regarding the most appropriate midwifery training pathway and education standards. Whether direct entry education in a Bachelor of Midwifery program, post-graduate education after a nursing degree for a Graduate Diploma of Midwifery qualification, or a dual degree of both nursing and midwifery is more suitable (Commonwealth of Australia 2009).

Thorough understanding of the factors leading to staff turnover is important if shortages can be adequately addressed for health professions (Segal & Bolton 2009). Complex interactions of demographic, geographic, socio-cultural, educational, political, clinical and

[1] The entry into this occupation is either through the completion of the more traditional Postgraduate Diploma in Midwifery or a Bachelor of Midwifery, the latter of which being a more recent course to endeavour, meaning the number of individuals registered through the undergraduate Bachelor of Midwifery route are vastly fewer in number than the Postgraduate cohort.

professional factors exert multiple influences upon the demand for health workforces employ, as well as the supply of health workers (Productivity Commission 2005). Reasons for midwifery workforce shortages, consequently, are many and varied and cannot be countered by single policy solutions alone (Segal & Bolton 2009). This means examining general drivers across all health professions, as well as those factors specific to each profession. In addition, understanding the many consequences of workforce shortages and staff turnover is also necessary.

When examining the midwifery profession, a consideration of the nursing sector of the health workforce is necessary. The majority of midwives in Australia come from a nursing background[2]. In Australia, there are forecasted nursing shortages (Health Workforce Australia 2012). These are being generated by an ageing Australian population who have longer life expectancies and experience more complex health and disability concerns (Health Workforce Australia 2012). The health dollar is overextended with mounting health costs, increasing complexity of technology and treatment, and inflated consumer expectations (Health Workforce Australia 2012).

In many countries, adequate numbers of midwives are needed to ensure women survive childbirth and that babies are born safely (World Health Organization 2013). Despite the good quality of Australian health systems (albeit not universally provided across Australian regions and peoples), nursing and midwifery shortages will still have adverse impacts on the population due to the reduction in the quality of care provided (ten Hoope-Bender et al. 2014). Shortages also detrimentally affect the existent workforce as depicted in

Figure 1 which represents a positive feedback loop where staff shortages decrease the quality of working circumstances for those staff remaining in the profession, which then further promotes employees leaving their profession.

Workforce turnover causes the strain of an amplified work load, absenteeism, illness and injury, a compulsion to work extended hours to meet rostering demand, and then an eschewing of leave entitlements. Evidence has shown contributing to overwhelming workloads[3] for hospital nurses are cost-cutting measures and reformed healthcare delivery systems which have replaced length of stay with increased patient acuity (Duchscher & Myrick 2008). Additionally, insecurities evoked from proposed restructuring and removal of

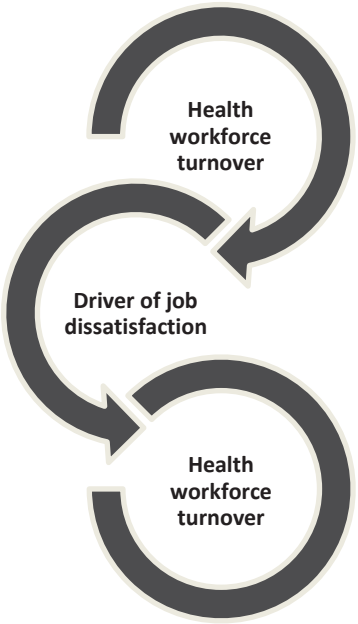
[2] See Footnote #1.
[3] Any incident where the individual had too much work to the point that it caused the participant to feel stressed.

national penalty rates are causing apprehension in the nursing and midwifery professions (McCarthy 2015).

Concomitant with workforce pressures is the lack of education and continuing professional development opportunities for staff. Professional development is necessary for rekindling motivation in individuals and for acquisition of contemporary skills and knowledge. Within the increasingly complex domain of maternity care, reduced access to experiences of professional development diminishes quality and safety for women and newborns. Altogether this leads to increasing stress, reduced quality of working life and dampened morale (Preston 2006).

Weakening community aspirations to join the profession ensue due to the perceived lack of appeal of working in health professions. For example, North American government reports from Canada and the US suggest that half of practising nurses would not recommend a career in nursing and one quarter would actively discourage others from a nursing career (Duchscher 2009). Recruitment and retention is challenging in the work place milieu borne from these complexities (DeJoy 2010; Preston 2006).

Figure 1 Turnover amplifying the rate of health workforce turnover



Also important to consider is the inclination of intent, either to remain in or to leave a profession. Both 'intent to leave' and the converse 'intent to stay' are terms used

throughout health workforce research literature. These refer to the perception of the estimated likelihood of continuing working within the profession (Price & Mueller 1981). In Australia and elsewhere, one troubling trend for many service occupations, such as policing, education, child care, and nursing (Gaynor et al. 2006), is that a high proportion of new graduates either are choosing not to practice, or are considering withdrawing from their professions, if not leaving after a few years of employment (Bowles & Candela 2005; Levett-Jones 2005; Productivity Commission 2005). The shrinking of the nursing workforce has relevance to the midwifery profession and is important to contemplate.

The loss of fledgling health professionals is a concern, not only due to the personal burdens for the individuals undergoing occupational vicissitude, but also for the nursing profession due to predicted health workforce shortages. Understandably, retaining new graduate nurses in their profession is crucial in moderating the potential significant nurse shortage dilemma. High turnover rates of recently registered nurses are disruptive to unit work stability and can diminish the quality of care owing to a lack of continuity. The loss of nurses from a clinical area just when they are developing competence and expertise is disruptive to clinical ward stability (Hungtington et al. 2012). A consideration of issues related with intent to stay is necessary because there is a great potential for administrative management, unit managers and staff to develop interventions and practices that may encourage intent to remain in nursing. This may subsequently prevent the costs associated with staff turnover (Nedd 2006).

What is clear is that integrated strategies will be required to address this acute dilemma. With no change to current policy approaches, Australia is predicted to encounter an "imminent acute nursing shortage" as per the first, long-term national workforce projections for doctors, nurses and midwives (Health Workforce Australia 2012). A national workforce projection study performed to help in future workforce planning, entitled *Health Workforce 2025 Doctors, Nurses and Midwives (HW2025)*, determined workforce retention and workplace productivity of nurses as critical factors in reducing the projected gap between supply and demand for nurses by 2025. Strategies implemented by *HW2025* were the *Clinical Training Funding Program 2011-13* provided to subsidise the cost of student placements, with the aim of increasing student numbers and clinical placements across Australia. Another strategy has been that of foreign nurses being granted temporary skilled

working visas in Australia to temporarily emigrate as skilled migrants[4]. The supply of midwives to Australia via immigration is a relatively minor source, however, it is probable that some midwives coming to Australia are also registered nurses (Australian Government Department of Employment 2015a).

The Productivity Commission (2005) recommendations of "a realignment of existing health workforce roles, or the creation of new roles, to make optimal use of skills and ensure best health outcomes" (Productivity Commission 2005, p. xxi) is integral to buttressing the various health workforces in Australia. The *Nursing Retention and Productivity Project* set up in response to the *HW2025* report has this aim, to encourage a more effective use of the national nursing workforce (Health Workforce Australia 2016). The aim has been to determine the urgent issues needing to be tackled for effective nationally-coordinated action, endeavouring to promote nursing retention and productivity. Forthcoming will be a report that will recommend concentrating on three major areas of change with the aim of mitigating risk factors of the forecasted nursing shortage (Health Workforce Australia 2016). One area, dedicated to improving nurse retention in the new graduate period, is a focus on early career preparation, support and provision of opportunities (Levett-Jones 2005). This area of focus is topical and pertinent to this research study.

The recent introduction of undergraduate direct entry midwifery courses without concurrent modifications to data collection capabilities of the National Registration and Accreditation Scheme (NRAS) impaired the reliability of workforce data collection (Australian Government Department of Health 2013a). Future modelling and planning process have been delayed as no separate categories for nursing and midwifery existed in the NRAS. In future, NRAS midwifery workforce data will be able to be gainfully separated from nursing workforce information (Australian Government Department of Health 2013a).

As such, policies and projects aimed at mitigating health workforce shortages commonly incorporate the midwifery workforce into that of nursing. This study however, centering upon midwives, rather than nurses, aimed to explore workforce issues in an Australian midwifery context. The workforce experiences and choices of Australian midwifery

[4] The Temporary Work (Skilled) subclass 457 visa is designed to allow employers to address labour shortages by bringing skilled workers into the country where they cannot find an appropriately skilled Australian. Occupations eligible under the subclass 457 visa programme are established by the Department of Immigration and Border Protection. Subclass visa 457 workers can work in Australia for a period of between one day and 4 years (Australian Government Department of Immigration and Border Protection 2015).

graduates may actually be similar to that of nursing, and new graduate midwifery turnover may be an issue for the midwifery profession. However, given the paucity of research examining the intentions of new midwifery graduates separate to those of nursing, the experiences and choices of midwives and trends of practising in the early stages of employment is largely unknown. As with all health professions, it is imperative in current and future workforce planning to understand the existing midwifery workforce (Health Workforce Australia 2012). This study aimed to yield information new graduate midwives in Australia.

This thesis now continues with the grounds for concern regarding new graduates leaving the health professions by examining nursing and midwifery workforce trends nationally and internationally.

1.4 Profile and issues of the Australian nursing and midwifery workforces

Prior to the literature review, which presents contemporary research on nursing and midwifery workforce issues in Chapter 2, this Section 1.4 addresses specific features of the midwifery workforce in the Australian setting.

1.4.1 Reflecting upon some workforce statistics

Grouped together, nurses and midwives are the largest professional group in the national healthcare system. In 2014, the total number of nurses and midwives registered in Australia was 352,838 (consisting of 256,794 registered nurses, 59,112 enrolled nurses and 3,204 registered midwives). This total number was a 6.7 percent increase from 2011 (330,680 nurses and midwives) (Australian Institute of Health and Welfare 2015b). The upsurge in the total number, however, obscures the large 20.1 percent decrease in the number of registered midwives between 2011 and 2014. In Australia, many registered nurses are also registered midwives. The decline of registered midwives is allied with the introduction of new midwifery registration standards, launched when the varying Australian state and territory registration bodies amalgamated into the national registration board, which stipulates meeting recency of practice criteria for the maintenance of registration (Australian Institute of Health and Welfare 2015b). Those midwives not actively participating in midwifery employment within the previous five years

fail to meet registration requirements (Nursing and Midwifery Board of Australia 2010). The most recent data reveals that there are 33,114 registered midwives with 29,281 individuals holding dual registration of nursing and midwifery. Therefore, individuals who are double registrants, holding both nursing and midwifery registration, who do not work sufficient hours in midwifery or meet the continuing professional education requirements of registration in midwifery, forfeit their midwifery registration and their right to practise as a midwife.

Not all registered nurses and midwives are in employment. In 2014, there were 300,979 nurses and midwives employed in Australia. The number of registered midwives who reported working some hours in either midwifery or nursing in the week prior to completing the national workforce survey was 28,756. This figure was slightly decreased from 29,831 in 2013. Of these, 23,862 reported having worked hours in midwifery (Australian Institute of Health and Welfare 2015a). Nine out of ten of those working in midwifery were employed in a clinical role (21,140 midwives). Clinicians worked the highest average weekly hours in midwifery (23.4 hours) as compared to midwives working as administrators or researchers (Australian Institute of Health and Welfare 2015d).

The work settings employing the most numbers of midwives were hospitals (46 FTE per 100,000 of population[5]). There were nearly triple the number of midwives working in the public sector as compared to those in the private sector (20,195 compared to 7,899). A similar trend is seen in nursing. Nearly all midwives hold a registration in nursing (99.9%). Most undertook their midwifery education in Australia (20,345; 85.3%) with England being the next most common country of initial qualification (1,743; 7.3%) (Australian Institute of Health and Welfare 2015d).

1.4.2 A uniquely Australian perspective

Recent data shows that there were 223 midwives employed in Australia who identified as an Aboriginal and/or Torres Strait Islander, thus representing 0.9% of all midwives who provided their Indigenous status (Australian Institute of Health and Welfare 2015c). This is less than the proportion of Indigenous people in Australia's population (3 percent) (Australian Bureau of Statistics 2013b). The under-representation of Indigenous midwives

[5] Full-time equivalent is a unit of measure that specifies the workload of an employed person so as to be able to compare across workloads. An FTE of 1.0 is equivalent to a full-time worker, while an FTE of 0.5 signals half of a full workload.

in the workforce indubitably does not support equity of access to services for Indigenous peoples (Lenthall et al. 2011).

Another indicator which limits the uniform access to health care in Australia is the inconsistencies of supply of the midwifery workforce across geographical areas. There is an imbalance in the supply of midwives between metropolitan, regional, rural and remote areas across Australia (Australian Government Department of Employment 2015a).

When considering that the health system's ability to attract, educate and retain a skilled midwifery workforce is vital to the health of a community, the provision of supported pathways for midwifery graduates into rural and regional settings, as recommended by *HW2025*, is essential. Furthermore, these workforce distribution issues especially affect Indigenous communities across Australia with 43% of Aboriginal and Torres Strait Islander people living in regional areas, and 25% in remote areas (Australian Bureau of Statistics 2013b; Productivity Commission 2005). In a submission to the Australian Government Maternity Services Review, the Rural Doctors declared that the maintenance of a rural maternity workforce requires adequate training and proper incentives, adequate remuneration and professional and personal support (Commonwealth of Australia 2009). Moreover, a recommendation to the same review process emphasised the need to train more Indigenous people as midwives (Commonwealth of Australia 2009).

1.4.3 University admissions as a measure of workforce stability

Realising a consistent and stable Australian midwifery workforce may well be unattainable given that the *HW2025* report indicates that demand for midwives will exceed supply by 2025 (Health Workforce Australia 2012). The report established that a doubling of current graduate annual completions would be required to correct the shortfalls (Health Workforce Australia 2012; Productivity Commission 2005). Even though the national supply of midwives has increased in the last few years, persistent shortages have been revealed for the Australian midwifery profession.

Furthermore, as the vast majority of midwives are drawn from the nursing profession via the route of postgraduate midwifery education, the deficit of nursing workforce numbers will impact upon those of the midwifery workforce. Since 2006 in Australia, increased numbers of university places for nursing have been instituted to embark upon workforce increases (Commonwealth of Australia 2009). Given the attrition of significant numbers of

nursing students from education (Sabin, Taylor & Tilley 2012), and moreover the numbers disappearing from the nursing profession (Gaynor et al. 2006), increasing the number of nursing student places alone will not address the nursing and midwifery shortage (Bowles & Candela 2005). The financial, staffing and administrative constraints on university education and clinical training capacities also preclude superfluity of new graduates. The grounds for exiting the nursing profession are as numerous as they are diverse (McLaughlin, Moutray & Muldoon 2008). Any response to these circumstances will have to match the complexity of the many and varied reasons.

1.4.4 Improving productivity via workforce reform

As mentioned previously, enhancing productivity supports the efficacy of healthcare delivery by an existent workforce. One way of tackling midwifery workforce shortages is to reshape the workforce and restructure the way midwives work, aiming for improved efficiency and sustainability. Outdated professional boundaries can reinforce conventional roles of health professionals, limit flexible responses to contemporary challenges and restrain the potential for transformation of health services (Commonwealth of Australia 2009). Productivity of the midwifery workforce has been enhanced in Australia by expanding the structure of midwifery employment via an increase in the variety of models of maternity care provided to women (Tracy et al. 2014). One response for expanding the midwifery workforce is the introduction of undergraduate Bachelor of Midwifery education programs in Australia, the first of which commenced in 2002 (Flinders University 2015). Bachelor of Midwifery programs, with their emphasis on working within a woman-centred philosophy with a focus on normalcy in childbirth, champion alternate and innovative midwifery models of care such as working in midwifery group practice (MGP). Enhancing productivity in this case means a re-thinking of the configuration of the standard shift work approach of staffing (Hartz et al. 2012).

Midwives employed in a midwifery group practice have an annual salary for the provisions of continuity of care for a caseload of women, in which women are looked after by the same midwife throughout pregnancy. Whereas standard care is when a midwife is employed to provide a rostered service and is rostered on wards or clinics. MGP models of care have been shown to achieve a significant cost reduction in the public health system (Tracy et al. 2014), thus generating efficiency within the midwifery workforce. MGP models have been linked with job satisfaction attributable to the provision of continuity of care and

the building of relationships with women and also through practising autonomously as a midwife (Sandall 1999). As will be discussed in Chapter 2, various studies have shown an association between job satisfaction and reduced intent to leave, thus generating sustainability in the midwifery workforce.

1.4.5 Deterrents to workforce sustainability

A variety of circumstances seem to work against the efficiency and sustainability of the midwifery workforce. Several key trends have been noted to be deleteriously influencing nursing and midwifery workforce participation. In line with the Australian population, the nursing and midwifery workforce is ageing, with large numbers due to retire (Health Workforce Australia 2012). Almost four out of ten nurses and midwives are aged 50 years or over and this number is increasing exponentially. Older workers tend to decrease their average working hours due to an increase of part-time work as compared to full-time work (Australian Institute of Health and Welfare 2007). This diminution of working hours is a contributing factor in the projected shortages anticipated for the future pools of nursing and midwifery labour (Health Workforce Australia 2012). Therefore, the midwifery profession needs, not only to replace retiring midwives, but as the numbers of ageing midwives continue to increase as a percentage of the workforce, it also needs to increase the number of midwives entering and staying in the workforce (Health Workforce Australia 2012).

It is clear that the proportion of the midwifery workforce approaching retirement age is increasing (Commonwealth of Australia 2009). At 48.9 years, the average age of a registered midwife in 2014 was older than the 44.2 years of registered nurses (Australian Institute of Health and Welfare 2015c). The number of people in Australia over the age of 50 years make up 30.5 percent of the total population (Australian Institute of Health and Welfare 2007) . The proportion of midwives over the age of 50 years was 57.1 percent in 2014 (Australian Institute of Health and Welfare 2015c). Workforce participation in Australia drops sharply between the age groups of 45–54 and 55–59 years. When examining employment trends for older Australians, the increasing trend towards part-time employment for this age cohort is also notable (Australian Institute of Health and Welfare 2007).

Public policy initiated by the Australian Government with the intention of inducing older workers to remain in paid employment for as long as possible is current workforce strategy (Australian Institute of Health and Welfare 2007). For example, there exists a government proposal to increase the national Age Pension eligibility age from 65 to 70 years by 2035. Midwifery work is both physically and emotionally taxing, possibly even more so for older workers (National Commission of Audit 2014). As such, health system policies will need to be designed to particularly address the issue of their ageing health workforces who undertake demanding physical and emotional work.

A recent government review highlighted the increase of mature age entrants who have chosen a career change to the health professions, entering into nursing and midwifery education programs (Australian Government Department of Health 2013b). Despite the potential of these entrants being in the midwifery workforce for fewer years than younger counterparts, these older entrants are more mature and hold qualifications and careers skills from other sectors. This cohort differs from school leavers, as by making this active choice at an older age they are presumed to be more likely to remain within the profession until retirement (Australian Government Department of Health 2013b).

Nearly all midwives in 2014 were female (98.4%) (Australian Institute of Health and Welfare 2015d). One discernible consequence of the female composition of the midwifery workforce is that more midwives are needed due to women working fewer weekly hours on average (Health Workforce Australia 2012). On average, midwives worked the aforementioned 23 hours per week in midwifery, almost ten hours less than the average Australian worker (Australian Bureau of Statistics 2013c). Escalating the predicted workforce shortages of 2025 is that a larger proportion of employed women aged 45 years and over work part-time, with three times more women than men working in this capacity (45%:15%). A sizeable number of midwives are electing to work part-time, with 47.7 percent working in this capacity in 2014 (Australian Institute of Health and Welfare 2015c). The predominantly female characteristic of health professions foreshadows the shape of their workforces, affecting hours spent at work and work patterns, lowering average working hours and increasing specialisation in a number of professions (Health Workforce Australia 2012; Productivity Commission 2005). Other health professions such as medicine and dentistry are now progressively being comprised of more women, rendering a feminisation of their workforces (Health Workforce Australia 2012). As the midwifery

profession is already a feminised workforce, these working patterns are currently shaping the female midwifery workforce.

1.4.6 Midwifery-specific occupational issues

Apart from the demographic profiling of Australian midwives affecting the state of its workforce, other factors have been identified to contribute to decisions to leave the workforce. Within Australia's positive population growth, one factor directly affecting midwifery that has been observed is the gradual, yet fluctuating, increasing fertility rate since 2001. In the year 2001, the lowest fertility rate was recorded at 1.74. In 2015, it was recorded at 1.93 (Australian Bureau of Statistics 2013a). This increase has resulted in an intensification of the work undertaken in a midwifery role, especially when the work derived from an increase in the number of births is augmented with increased complexity of care and patient expectations (Tracy et al. 2014). Various perceptions of working within the health system have been recognised for decades: Perceived poor remuneration, lengthening shifts, inflexible working conditions (Diamond 1998) and inadequate staffing levels and increased workloads have long been recognised to be present throughout health workforces (Chang 1995), with these whittling away at job satisfaction (Productivity Commission 2005). Participation in the midwifery workforce has also been impacted upon by changing models of care and service delivery, which require both the health dollar and labour for their restructuring (Health Workforce Australia 2012; Productivity Commission 2005).

Not surprisingly then, the focus of much policy attention aimed at enhancing workforce sustainability has been on increasing health workforce supply, improving the efficiency and effectiveness of the workforce, diminishing turnover and boosting workforce retention (Productivity Commission 2005). One strategy for addressing the shortages is to encourage those who are educated and trained for positions to commence practising in the professions for which they are trained, and continue to do so for their working lives.

Information about expected future workforce participation trends is necessary in workforce planning. To be able to plan for future challenges, it is crucial to understand the existing workforce, its size and characteristics (Leach, Segal & May 2010). Little information is available about the specific indicators of supply and demand of midwives. Presently the

information base is inconsistent, obtained from a variety of sources and subsumed within nursing workforce data.

More than a decade and a half ago, Tracy, Barclay and Brodie (2000) declared that an alarming feature for the *Australian Midwifery Action Project* was the deficiency of comprehensive data on the midwifery profession and inconsistencies in definitions across data sources. The lack of relevant information has constrained the capacity for clear comprehension of the national picture of the midwifery workforce (Tracy, Barclay & Brodie 2000a). Unfortunately, since then, the situation is largely unchanged.

As nurses and midwives comprise the largest proportion of the health workforce, their current and intensifying shortages have significant impacts on the delivery of effective healthcare across the nation. The recent *Health Workforce 2025* report stated that "strong concerns exist about the quality of midwifery-related data" (Health Workforce Australia 2012, p. 20). One issue highlighted by this report is that understanding workforce participation of graduates is flawed. As a profession, midwifery must embark upon definitive strategies "to recognize, understand, and ameliorate a climate that continues to abet the [predicament]" (Duchscher & Myrick 2008, p. 192) Therefore, this study aimed to provide some information, for recognition and understanding, of workforce participation of new midwifery graduates in Australia.

1.5 Conclusion

Nurses and midwives are the largest group of regulated professionals in the Australian healthcare workforce. The current and predicted staffing shortages in the nursing and midwifery workforces warrant attention due to their potential impact on the provision of safe and efficacious community healthcare. An understanding of these workforces is crucial for strategic planning, to ensure both positive outcomes for our nation as well sustain qualified nursing and midwifery professions. This is particularly germane given the long-term structural issues of an ageing nursing and midwifery workforce impeding effective health outcomes of an ageing population. Transformations to the face of healthcare resulting from increased complexity and acuity of presenting patients, technological advancements of medical treatment, and amplified patient demands add to the challenges the nursing and midwifery workforces are facing.

As an introduction, this chapter presented the aims of the research question and then positioned it within the Australian context of the nursing and midwifery workforces. The next chapter is the literature review.

Chapter 2: Literature review

2.1 Introduction

Formulation of research questions includes sourcing and reviewing literature and existing theory related to the topic. Evaluation of literature then further refines the research question, leading to the development of a conceptual framework. The framework encapsulates and summarises the concepts underlying the theory and research questions to be explored (Hennink, Hutter & Bailey 2011). For this study, it meant positioning it within the conceptual framework of health workforce retention and turnover research.

This section describes the research literature relevant to the study. The overall aim of Chapter 2 was to establish the significance of the general topic of the study, and also demonstrate the validity of having made a new contribution. Most of the chapter concentrates on the critical evaluation of nursing and midwifery workforce issues as well as the methodologies used in studies in this field. The goal of this was to work out which approach was most appropriate for investigating the research question.

2.2 Sourcing the literature

2.2.1 Why include nursing literature?

In the wake of Australian nursing education moving from hospital training in the 1980s to the university sector, midwifery education relocated into a postgraduate university setting (McLelland & McKenna 2008). Presently, various pathways to becoming a registered midwife exist: Post graduate studies following an undergraduate nursing degree and undergraduate direct entry midwifery education programs or combined nursing and midwifery degrees (known as a double degree). Undergraduate midwifery education is a relative newcomer in the Australian university domain (Flinders University 2015). For that reason, the overwhelming majority of midwives are currently drawn from the nursing workforce by means of post graduate midwifery programs. Consequently, the numbers of midwives and the issues impacting upon their demand and supply are inextricably linked to those that affect nurses (Australian Health Workforce Advisory Committee 2002). Therefore, the inclusion of both nursing and midwifery literature in the literature review

was justified. Additionally, inclusion of international studies was considered appropriate because even though they were conducted in different midwifery cultures, they identified parallel key indicators (Pallant et al. 2015a)

2.2.2 Clarifying some issues in nursing and midwifery workforce literature

In evaluating literature on midwifery workforce research, it was apparent that:

> *"Some studies have identified factors contributing to midwives leaving the profession, while others found retention improves when the same conditions are met"* (Pugh et al. 2013, p. 498).

Despite this observation, an issue manifested itself which influenced the progression of literature sourcing: The assumption that what triggers midwives to stay in their profession as being merely an absence of those triggers that impel them to leave, has not been established in the research about workforce participation in the fields of nursing and midwifery. Granted that a starting point of absence begets inquiry into what should be present, it cannot be said that in the absence of job dissatisfaction there is job satisfaction. Moreover, it is not wholly accurate to state that job satisfaction leads to workplace retention and job dissatisfaction leads to workplace turnover. What must be made clear is to consider what parameters lead to job satisfaction and also what parameters lead to job dissatisfaction.

Figure 2 represents the idea that sources of job satisfaction and job dissatisfaction are separate, yet related parameters of occupational intent in health. This clarity is necessary because there is a positive relationship between job satisfaction and intent to stay in nursing which is then a good predictor of turnover. When nurses no longer intend to stay in their job, this intention is likely to be followed by turnover behaviour (Nedd 2006). This suggests that a nurse's (and possibly a midwife's) intent to leave the profession is a good predictor of actual turnover (Alexander et al. 1998; Hayes et al. 2006).

Figure 2 Sources of job satisfaction and job dissatisfaction are separate, yet related parameters of occupational intent in nursing

Any vacuum created by the elimination of those factors that result in job dissatisfaction may well require an amplified investment of those factors that bring about job satisfaction in order to bring about genuine content within midwifery work. What became apparent in the literature was how the discrete matters of job satisfaction and job dissatisfaction intricately influence the intentions to remain in, or exit from, the midwifery profession.

Factors that influence job satisfaction and dissatisfaction, workforce retention and turnover were all regarded as distinct issues throughout the initial stages of the research process so that any predetermined relationship between these factors would not erroneously steer the research. The literature sources were related to factors which reflected the range of possible experiences that may transpire in a midwife's career in its early stages (Table 1). Various factors external to workforce conditions, such as family demographic and health status, which may also affect an individual's career intentions, were also sought in this review.

Table 1 Possible midwifery workforce participation trends and associated keywords

Graduated	**still practising as a midwife** health workforce retention, midwifery retention, nursing retention, job satisfaction
	practised midwifery for a period of time and then ceased midwifery practice to return to nursing or into another field of employment, health workforce turnover, midwifery turnover, nursing turnover, recency of practice, job dissatisfaction
	never practised as a midwife rejecting profession, not practising, work choices

Table 2 presents potential influencing factors for initial midwifery workforce choices and associated reasoning and keywords for these topics.

Table 2 Potential influencing factors for initial midwifery workforce choices and associated keywords

Factors influencing early midwifery workforce experiences	fitness to practice, confidence
	new graduate transition motivation for workforce entry, reality shock
	workforce entry support new graduate transition programs, mentoring, preceptorship

Search terminology utilised various combinations of 'nursing' and 'midwifery' with the various workforce-related keywords (Tables 1 and 2). The main databases used were CINAHL, Journals @ Ovid, MedLine, ProQuest, PsycINFO, Sciencedirect, the Cochrane Database of Systematic Reviews, and Biomed Central. The reference lists in the primary resources were checked for secondary resources, which were retrieved and utilised if relevant. National Government workforce reports related to the field of study were also included. To maintain accurate interpretation of literature, the search was limited to those written in the English language. Current literature from 2000 to the present was the primary focus; however some noteworthy prior literature was included. This next section about workforce participation trends in nursing commences with an examination of retention in the nursing and midwifery workforces.

2.3 Retention

Much of the literature surrounding nurse workforce retention considered parameters of job satisfaction. However, asserting that workforce retention is wholly related to job satisfaction is too simplified an approach. Furthermore, job satisfaction does not solely result from the absence of those factors that yield job dissatisfaction. That said, intention to stay and factors contributing to job satisfaction were connected in the literature. Increasing nurse job satisfaction can serve a central role in stemming the outward flow of nurses to other professions and occupations. This section presents research regarding the possible workforce participation trend of continued practice in the nursing and midwifery professions.

2.3.1 Graduated and still practising nursing and midwifery: Who stays?

Generally, in the study of staff retention in the health sector, it is workforce turnover, presented shortly, that is the main topic researched and analysed in order to understand outflow trends (Buchan 2010). However attention alone on turnover, and on those staff members who leave, is only one piece of the puzzle. The springboard for developing successful retention strategies is to understand why staff stay in their roles. Insights into workforce retention and how staying and workforce stability can be integral to the efficacy of health service delivery, controlling escalating costs, the provision of a constant staff workload, as well as the numerous aspects of organisational and staff performance is vital (Buchan 2010).

Although recounting only a fraction of the nursing evidence available in this field, this section of the literature review does present a comprehensive representation of issues common to nursing retention. Moreover, the studies were chosen for inclusion if they were representative of these issues and if methodology and methods were effectively explained.

2.3.2 Workforce retention in nursing

Nursing work behaviour and experiences are affected by personal characteristics, attitudes toward work, job opportunities, and workplace attributes (Kovner et al. 2009). To begin with though, an understanding of work readiness in new graduate nurses and how it may enhance retention and improve transition into the workplace is important (Walker et al. 2015). Work readiness, or preparedness, is a multi-dimensional concept for predicting graduate potential (Caballero & Walker 2010).

Work readiness is the extent to which graduates hold the skills, characteristics and qualities that prepare them for success in the workplace (Caballero & Walker 2010). Readiness is increasingly being recognised as being allied with a capacity for career advancement, satisfactory role functioning, and job success (Walker et al. 2015). Aspects of readiness include being competent in communication skills, qualities taught during education, yet also determined by individual personalities and aptitude for interpersonal rapport. For continuing workplace accomplishment, employers anticipate that graduates possess a varied array of skills and attributes that are not exclusively nursing competencies, such as problem solving, communication, teamwork, and innovation and enthusiasm (Walker et al.

2015). Four factors contributing to the construct of work readiness as per the authors of the Work Readiness Scale (WRS) are organisational acumen, social intelligence, personal work characteristics, and work competence (Caballero & Walker 2010).

The WRS has been used as a criterion for graduate recruitment and evaluation. In a sample of 96 new nurses graduated less than 12 months prior, and across two regional hospital sites in Australia, Walker and Campbell (2013) investigated the relationship between the readiness to practise and a number of variables that portray the work experiences of new graduate nurses throughout the first year in practice. The particular aim was to explore whether the dimensions of work readiness can predict job satisfaction, work engagement and intention to remain (Walker & Campbell 2013). Participants' clinical competence and organisational acumen were significantly and positively related to job satisfaction. Therefore, participants who perceived themselves clinically competent were more satisfied with their job. Furthermore, those participants who were more satisfied with their job perceived themselves as clinically competent. These clinically competent participants perceived themselves as less likely to leave. However, clinical competence and organisational acumen were not found to be associated with work engagement. Whilst social intelligence and effective communication skills predicted work engagement, possibly through the capacity for support-seeking behaviours, opposite to expected results, social intelligence was not found to be associated with job satisfaction. None of the work readiness dimensions were found to predict graduate nurses' intention to remain. Problems with these self-reporting instruments lie in social desirability bias whereby participants may perhaps want to accommodate the researchers' aims. Work readiness was also measured as per participant perception, rather than an independent perspective from a colleague or management (Walker & Campbell 2013). Nonetheless, new nurses who are confident in their skills and feel competent at the starting point of work may experience greater job satisfaction.

The Walker and Campbell (2013) research finding of an association between competence and job satisfaction is echoed in other research which portrays that those nurses who are empowered to provide care according to professional nursing standards experience greater job satisfaction and are more likely to remain in their post (Nedd 2006).Therefore, when nursing job satisfaction increases, job turnover decreases, thus reducing the need for recurrent cycles of recruitment (Roberts, Jones & Lynn 2004). Clearly then, one central factor in minimising the loss of nurses from their profession seems to be to encourage job

satisfaction (Aiken et al. 2002a). Sources of job satisfaction in nursing are widespread: Supervisory support and leadership, work group cohesion, skill development training, variety and diversity of positions, promotional opportunity, role autonomy, organisational constraint in place of over-reaching into clinical roles, promotional opportunities, involvement in decision making, role structuring so as not to overextend or overburden with workload, and having a work-life balance (Aiken, Smith & Lake 1994; Kovner et al. 2006; Kovner et al. 2009).

Specific to the early career period, one longitudinal study beginning in 1997 (Murrells, Robinson & Griffiths 2008), examined which components of the nursing role produced job satisfaction. Survey data were collected from newly qualified nurses in the United Kingdom at 6 months, 18 months and 3 years after qualification. Career histories and geographical movement were collected. The complexities of the results were indicative of the complicated subject matter, in which no single pattern emerged across time. Trends varied by nursing specialty and job satisfaction component. It was clear though, that nurses were least satisfied with pay. Migratory patterns of employment were found to be held by young nurses at the beginning of their career, and by those who wanted to pursue a more suitable work environment, which included improved pay and career promotion opportunities (Murrells, Robinson & Griffiths 2008).

Various studies demonstrate that turnover rates are higher in younger workers with these rates declining with age then beginning to increase again when nearer to retirement (McCarthy, Tyrrell & Cronin 2002). It is suggested that turnover rates are higher for those in the first year of employment and the shortest length of employment. Peak time for nurse turnover may be during the third year of employment. It has been suggested however that it is not the single variable of age that leads to turnover. Rather the characteristics frequently correlated with age, such as lack of experience and knowledge about role responsibilities, lower pay, mundane tasks, less contribution into decision making, and having fewer family/care responsibilities, lead to turnover (Price & Mueller 1981).

Another longitudinal study (Pelletier, Donoghue & Duffield 2005), this time in an Australian setting, examined workforce issues in five cohorts of graduate nursing students (University graduating years 1998-2002). Participants had either graduated with a graduate diploma or masters of nursing. They were surveyed at graduation and then at six years post-graduation (n=151). Recent career moves, motivations for relocation, and career intentions and influencing factors were examined. Roughly half of each cohort intended to remain in their

profession and varying percentages (20% to 30%) of each cohort were uncertain of their intentions. The greatest motivator for changing jobs was a desire for increased job satisfaction. Other factors were work-life balance and career advancement. The strongest facilitator or barriers to career advancement were personal situations. Fidelity to the perceived role of nursing was important, as the participants' ability to carry out their role appeared to be of greater importance than job satisfaction. One quarter of participants did report wanting to change their career (Pelletier, Donoghue & Duffield 2005). The time frames of data collection at six year's post-graduation as well as the comparative component of the analysis were features of the Pelletier, Donoghue and Duffield (2005) research that were important to consider in view of my study.

The particular implications of Pelletier et al.'s (2005) study is that workplace endeavours aimed at enhancing retention should focus on variables that can be changed, such as the health of the work environment and opportunities for advancement, rather than on individual variables that cannot be changed. A North American study, with a 42 percent response rate from a random sample of 500 nurses, examined which organisational factors, defined in this study as empowerment structures, would support them to remain in their profession (Nedd 2006). The nurses perceived greatest access to opportunity in their positions followed by support, information, and access to resources as factors keeping them as nurses. Opportunity referred to the development of knowledge and skills which enabled them to advance in their role and enhance role efficacy. Support involved guidance and feedback from subordinates, peers, and supervisors. Access to resources referred to necessary materials, supplies, finances, and personnel needed to meet institutional goals (Nedd 2006).

Perceptions of empowerment have been shown to be important in another survey study, this time performed in an inner-city private hospital in Australia (Joiner, Stanton & Bartram 2004). The researchers explored the impact social support and empowerment had upon nursing job satisfaction and job stress. Supervisory and collegial support was found to increase job satisfaction and decrease job stress. Additionally, a sense of empowerment and meaning of the role, perception of competence and self-determination, also increased job satisfaction and decreased job stress. The survey completed by 157 nurses included three instruments measuring supervisory and collegial social support; empowerment; and job satisfaction (26% response rate of 600 nurses; n = 157) (Joiner, Stanton & Bartram 2004). Nursing workplaces which offered high levels of support, as well as providing the

capacity for working within the nursing role with empowerment, a sense of meaning and self-determination, were associated with higher levels of job satisfaction and lower levels of occupational stress. The authors considered the utilisation of strategies that improved levels of social support and empowerment would result in coping with workplace stress and enhanced job satisfaction. The ability of the nursing manager to facilitate a teamwork environment, by taking advantage of the existent relationships and networks in the workplace, was shown in the study to be key in establishing collegial support. Other strategies, such as increasing nurse involvement in decision making to strengthen nurse empowerment and self-determination could possibly enhance organisational loyalty and commitment. It is clear from this study that there is an interconnectedness of all of these workplace issues (Joiner, Stanton & Bartram 2004).

A team ethic of mutual support was demonstrated to be a significant factor in nursing retention in a small phenomenological interview study of the early nursing career period of six acute care nurses in the Unites States of America (USA) (Zeller et al. 2011). The desire to help others and provide service was the motivation underlying why participants became nurses. Intent to remain in the profession was linked to this need to help and the emotional sustenance received from the role. The culture of mutual support borne of shared experiences was important in the early career period; a time characterised by much anxiety and role uncertainty. Individual personal traits such as emotional maturity, the propensity for perseverance, and the ability to utilise skills acquired in previous occupations emerged as influences of nursing retention. Finally, being prepared for the reality and difficulties of the nursing role was considered to be crucial for new nurses to stay in nursing. Increased access to firstly, occasions of clinical experience throughout the years of nursing education and secondly, the benefit derived from formal mentoring and education programs were recommended to neutralise the fear and anxiety of the new career period. These recommendations contributed to the intention to remain in the nursing profession by these participants (Zeller et al. 2011).

The intention to remain in nursing has also been shown to be encouraged by supportive styles of leadership by nurse managers. Recent Canadian research was an investigation of the effect of varying management leadership practices on 541 nurses who had spent five years or less in practice (Lavoie-Tremblay et al. 2015). In this study, transformational styles of leadership practices had the potential to generate high quality nursing care and a weak intention to resign. On the contrary, leadership practices recognised as abusive potentially

lead to poorer quality nursing care, and to strong intention to resign both from the healthcare facilities and those in the nursing profession. The studies highlight the need for better understanding of the factors that potentially influence the retention of nurses in the early stages of their career. Due to similarities of managerial role structure and function between nurses and midwives, these findings are of consequence to midwifery despite the nursing context of the studies.

The role of the nurse manager is challenging due to their duty of having to reconcile many competing interests and responsibilities of financial, human and strategic resource management, staff development and quality improvement (Courtney et al. 2001). The needs of the new graduate nurse may lose prominence within this inventory. However, nursing unit managers have a day-to-day responsibility of supporting and therefore retaining their staff. The significance of leadership practices of nursing managers upon clinical staff with regards to job satisfaction and intention to quit cannot be overstated insofar as one estimation proclaims that the manager is the chief retention officer in a hospital, and people do not leave institutions, they leave managers (Nursing Executive Center 2007).

These factors were explored in a study using a wide array of data (participant surveys, staffing data and patient data) in 80 medical and surgical units in Australian public hospitals from a 2004-2005 period (Duffield et al. 2009). Nurses more likely intended to remain in their job if they were satisfied in their role, were older and had dependents. Furthermore, they were also likely to benefit from good leadership with quality communication between management and nurse as well as positive nurse-doctor relationships, which may be representative of an ethic espousing a team approach. Satisfaction with the nursing profession was common amongst participants. However, satisfaction within their current role was less common. Having job satisfaction was statistically associated with nurse autonomy, control over practice and positive nursing leadership. This study demonstrates the enhanced capacity of analysis that can be undertaken from using multiple sources of data (Duffield et al. 2009).

It is timely when pointing out how participants held a general feeling of satisfaction with the nursing profession in the Duffield et al. (2009) study, despite feeling less positive about aspects of their profession, to consider what intrinsic factors initially drive individuals into the profession. The foremost reasons for motivating individuals into nursing in a mixed-methods study (Elay et al. 2012) exploring the relationship between personality traits of

nurses and their reasons for entering the profession were for an opportunity for caring, with nursing being a life-long vocation. Frequently observed personality traits of the participants were those that conveyed empathy and altruistic ideals. Another recurrent trait was being highly pragmatic. Strategies, such as models of care and adequate staffing levels, which support nurses to practice in a way that reaffirms the original impetus for entering the nursing profession, namely the desire to help and care for others, should be considered when attempting to address retention issues (Elay et al. 2012).

Taking advantage of the altruistic desire to help others within the nursing role as a means of aiding retention could be accomplished by measures which encourage ample access to the nurse-patient relationship. Staffing policies, which promote low patient to nurse ratios allowing nurses adequate time with patients, are important. This was shown to be an issue in a large study which surveyed 2,203 nurses from 11 countries. The results revealed that 92 percent of participants expressed facing time constraints in their work (DeCola & Riggins 2010). Also of concern was that those nurses who considered it to be very likely that they would be still practising nursing in five years only made up only 53 percent of the sample. Statistically significant parameters which influenced the likelihood of staying in nursing were having greater independence and control over their practice and greater involvement in decisions impacting work and patient care. Other considerations affecting participants' intentions to stay in nursing were having sufficient staff and an improved work-life balance. Having adequate staffing was pertinent for the reason that 46 percent of participants considered their workload to be worse than five years previously. When considering the results depicting a perception of insufficient staffing *and* an escalating workload, 96 percent believed that spending more time with individual patients would have significant impacts on patient health (DeCola & Riggins 2010).

It is evident when safety is defined as "the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare" (Vincent 2007, p. 51), how adequate nursing staff is essential for patient safety. Ninety- six percent of participants in the DeCola and Riggins (2010) study acknowledged the potential for improving patient health through nurses having adequate time assigned to patient care. This perception is well-founded. Other studies have shown that the employment of increased numbers of nurses in healthcare settings enhances patient quality of care and safety (Aiken et al. 2002a) and decreases the prevalence of medical errors (Cho, Ketefian & Barkaauskas 2003) .

One interventional study (Bullock, Groff Paris & Terhaar 2011), undertaken in a North American hospital, with the aim of maintaining numbers of employed nurses by targeting their early career period, measured the effectiveness of a staff orientation program as the nursing staffing intervention. A strategy for enhancing new graduate retention by recognising and neutralising issues inherent to the early career period is the development and enrichment of hospital orientation and role transition programs (Duchscher 2009). The study assessed the implementation of a newly established orientation program, designed by nursing staff to decrease turnover of nurses in their hospital in the first years after graduating (Bullock, Groff Paris & Terhaar 2011).

The multi-staged program was founded upon the principle that orientation of new graduate nurses was to be shared amongst all tiers of nursing (Bullock, Groff Paris & Terhaar 2011). New graduates were to be considered the collective responsibility of the entire nursing staff, including preceptors, managers, and clinical nursing staff. Other features of the program, which were identified as important by nurses designing the program, were the necessity of the provision of adequate resources and formal training and support for the program's leaders (Bullock, Groff Paris & Terhaar 2011).

Bullock et al.'s study demonstrated the imperative of having well thought out organisational strategies aimed at practical skill development, when aiming for improved retention of early career nurses. Rather than new nurses experiencing unplanned and unstructured beginnings, the strategical stages of the intervention hoped to facilitate a supported and simplified introduction to the profession. The stages were: preparation; welcome, engagement and assessment; intense support; increasing independence; increasing patient load; increasing acuity; independent with feedback; and lastly, continued access to mentor nurses. At the conclusion of the first year, decreased turnover, increased preceptor satisfaction, and substantial financial savings were documented. This indicates how important planned interventional strategies that foster enhanced transitional support can make a positive impact upon staffing. Peer-to-peer support was considered an aspect of the success of the program (Bullock, Groff Paris & Terhaar 2011).

Further research supports the establishment of transitional support programs, this time in Australia (Cubitt & Ryan 2011). One hospital in the Australian Capital Territory redeveloped an existing transitional program as a response to new graduate nurse feedback. It

incorporated specific strategies to meet the requirements of the newest Generation Y[6] cohort. An increase in nursing staff retention, as well as the mitigation of stress and anxiety, resulted from the comprehensive implementation of three levels of support, namely: frequent facilitated workshops, face-to-face ward education by educators, and hands-on clinical support by preceptors. Another significant finding was difficulties arising in the preceptor relationship, due to personality conflicts between the more experienced nurse and the novice. Rostering, patient allocation, poor skill mix, increased work load and increased patient acuity were considered detrimental to the presence of preceptors (Cubitt & Ryan 2011).

Other evaluations of interventional programs have shown either a stabilisation or decrease in turnover rates. Specifically to the new graduate period is one program aimed to develop nursing leadership and research skills that boost individual capacity to make contributions to, and influence, their practice environments (Dyess & Sherman 2011). This is timely when Finnish research has shown that many new graduate nurses feel powerless to change their unsatisfactory work environments (Flinkman & Salantera 2015). Although not exclusively relating to the transitional period, the implementation of a full-time nursing role specifically designed to assist and support experienced nurses as they make a career transition has stabilised turnover rates in a North American hospital (Creakbaum 2011)

Other organisational strategies, not only for new nurses, have been suggested as being supportive of nurse workforce retention and there appears to be a positive relationship between organisational commitment and intent to stay (Kovner et al. 2009). Strategies aimed at improving retention have been noted as the reward of good performance, the provision of employment options to deliver a suitable level of flexibility and variety to maintain interest, increasing professional development and training opportunities, and improving management and leadership practices through adequate engagement with nursing staff (Dawson et al. 2014).

2.3.3 Summary of workforce retention in nursing

In the context of the forecasted nursing shortage, retaining the new graduate, as well as experienced nurses in the workforce, is critical to ensure their sufficient numbers. This

[6] Generation Y are a demographic cohort with the birth years ranging from the early 1980s to the early 2000s.

section of the literature review presented the links between workplace readiness, job satisfaction and intentions to remain in the nursing workforce. Satisfaction within nursing can be obtained from autonomy and self-determination within the role, working in a position that the individual nurse feels is compatible with the nursing role, positive teamwork and collegial rapport, effective managerial and leadership practises, and access to continued professional development. It is important that the nurse in the early career period feels engaged and empowered within the healthcare setting. Satisfaction was noted to be generated by supportive transitional programs as well as quality leadership approaches of nurse managers. In view of intensifying nursing shortages, these characteristics of job satisfaction must be considered when developing effective policy strategies to retain nurses. In a top-down approach, a crucial role of administrative management is to show the way, to plan, design and implement systemic retention processes which guide and instruct unit managers upon ways of keeping their staff (Kaye & Jordan-Evans 2001). However, a bottom-up approach is also essential and keeping a nursing staff engaged and involved in decision-making processes is an ingredient of retention. These issues surrounding nurse retention and the mixed methodology of the studies were considered in the data collection process of this study.

Research related to workforce retention for the midwifery profession will now be presented.

2.3.4 Workforce retention in midwifery

Amidst national fears of inadequacies surrounding staffing levels in the future midwifery workforce, understanding what factors contribute to retention is imperative. However, research has shown that akin to nursing, retention in midwifery is a complex process to consider. One parameter that is essential to explore is how midwives perceive their jobs, so as to identify strategies that might enhance the quality of their working lives and improve retention (Skinner, Madison & Humphries 2012). This is due to an association between job satisfaction and intentions to remain in the midwifery profession.

Research which has investigated job satisfaction in the midwifery profession was undertaken by Sullivan, Homer and Lock (2011). For this sample, job satisfaction was strongly linked to the shared relationship between midwife and woman. Through focus groups and surveys, the researchers examined which factors contributed to the retention

of midwives. The top three reasons for staying in midwifery were *'I enjoy my job'*, *'I am proud to be a midwife'* and *'I get job satisfaction'*. Job satisfaction was attained when participants felt they had made a difference to women, had positive interactions with women in their care, and had observed women happy in their care. The motivation to keep going in the profession was achieved by a positive outlook; having job satisfaction, and having relationships with work colleagues provide a sense of belonging (Sullivan, Lock & Homer 2011). These altruistic motivations echo the similar drivers that initially steer individuals into nursing and then maintain interest in the profession (Elay et al. 2012).

Sullivan et al.'s (2011) replicated a study called *Why Midwives stay?* from the UK. The original research associated retention with an ability, firstly, to develop and have relationships with women and, secondly, make a difference to these women (Kirkham, Morgan & Davies 2006). Feeling supported and valued by colleagues and managers was also crucial, as was having adequate resources and sufficient staffing. Possessing a degree of autonomy within the professional role and determining an individualised personal role as a midwife was another factor. Having control and flexibility within their work was important, as illustrated by wanting work hours to meet personal circumstances (Kirkham, Morgan & Davies 2006).

The model of maternity care, whereby a woman is cared for by a primary midwife in her pregnancy, birth and initial postnatal period, was established to enhance a woman's encounter within the organisational context of the hospital and improve the likelihood that women and their infants will experience good outcomes (McLachlan et al. 2012; Sandall et al. 2015). This caseload model of midwifery continuity of care is often known as midwifery group practice. As well as being beneficial for women, the model is associated with enhanced job satisfaction for the midwife. Sandall's seminal work into models of midwifery care (1999) established that care which facilitated continuity of midwifery care was associated with high levels of job satisfaction. This potentially can encourage midwifery workforce retention by leading to a decreased desire to leave the profession. The high job satisfaction was suggested to be due to decreased burnout and emotional exhaustion (Sandall 1999). Location of practice also contributed, as those working in community-based settings reported higher job satisfaction and less burnout, compared with hospital-based midwives working in either caseload or standard midwifery positions. Job satisfaction was therefore associated with autonomy of practice and enriched relationships with women.

One Australian study in nurses and midwives (Skinner, Madison & Humphries 2012) defining job satisfaction as job enjoyment and self-perception of being suited to the particular type of work, examined factors contributing to nursing and midwifery job satisfaction. Findings revealed that just over half of the participants gave descriptions and experiences of stress, however the vast majority somewhat paradoxically were content with their work, and possessed job satisfaction (Skinner, Madison & Humphries 2012). It must be noted, however, in the measures of job dissatisfaction, frequent experiences of high level dissatisfaction were not apparent. Participant job satisfaction alone did not prevent them from considering seeking workplace change or exiting the profession entirely so that despite the majority (96% of the 562 nurse and midwifery participants; response rate = 41%) feeling moderately to highly satisfied with their work, a third of them considered leaving from time to time. Being younger was also associated with job dissatisfaction. This study suggests that even though a large number of nurses and midwives described experiencing stress, coping and managing mechanisms must be being utilised so that stress does not emerge as job dissatisfaction. In view of retention policies, this research indicates the importance of nurses and midwives to be employed in a role that they think they are suited to the work they (Skinner, Madison & Humphries 2012).

Various issues regarding Skinner et al.'s (2012) research exist. A recruitment bias is potentially apparent due to recruitment occurring at nursing and midwifery professional conferences therefore selecting more motivated professionals. Despite the professional development model where individual nurses and midwives must undertake continued skills training and education to guarantee their registration with the Australian Health Practitioner Regulation Agency, not all nurses and midwives attend professional conferences. High motivation and professional enthusiasm may be inherent in the individuals attending these events, thus enhancing the levels of job satisfaction in the findings. Another issue exists with this research due to the merging of nursing and midwifery data and the lack of comparison between the two groups.

One study that does provide some comparative measure, not between participant groups but between individual midwives' perceptions of job satisfaction after assuming a new role, is interesting to consider in view of midwifery retention (Collins et al. 2010). Australian researchers examined potential changes in midwives' attitudes to their professional role subsequent to the introduction of a midwifery group practice in their workplace. The findings showed positive outcomes for job satisfaction as satisfaction levels increased due

to the provision of continuity of care and the building of relationships with women and families. Other factors instrumental to increased job satisfaction were practising autonomously as a midwife, expanding midwifery skills, enhanced collegial relationships with other caseload midwives, and control of working hours (Collins et al. 2010).

Midwives in Collins et al.'s (2010) study felt that despite the challenge of managing being on call and the hours worked, high levels of professional satisfaction were present (Collins et al. 2010). Confirming the association of caseload practice with high levels of professional satisfaction is another Australian study which measured burnout in caseload midwives as compared to standard care midwives (Newton et al. 2014). Newton et al. (2014) compared satisfaction and burnout amongst caseload midwives and non-caseload midwives in 2008 and again in 2010. The surveys measured professional satisfaction, professional support, client interaction, personal burnout, work-related burnout and client-related burnout. The caseload and standard care midwives had similar characteristics in all measures at baseline, with exception to client-related burnout which was lower for caseload midwives. Two years later, the caseload midwives as compared with the midwives in standard care, had higher scores in professional satisfaction, professional support and client interaction and lower scores for personal burnout, work-related burnout and client-related burnout (Newton et al. 2014). Therefore, caseload midwifery was associated with lower burnout and higher professional satisfaction, yet again, an improved level of support of the midwife and enhanced interaction with women is noted in this model.

Specific to the Australian new graduate period is a recent study of the experience of midwives working in continuity of care models (Cummins, Denney-Wilson & Homer 2015). Data were collected using semi-structured interviews of new midwives in their first or second year of practice and employed in a continuity of care model. Participants positively regarded the trusting relationships with women and obtained satisfaction from providing continuity of care. The model enhanced the learning processes of skill acquisition and consolidation, vital for success in the new graduate period. They also gained satisfaction from support shared within the relationships with other midwives in the group practices (Cummins, Denney-Wilson & Homer 2015).

Participant numbers in the study was limited to 13 owing firstly to the qualitative methodology used and secondly, the unconventionality of being employed in a caseload model as a new midwife. Standard post registration employment is via a transitional support program in a rotational capacity that sees the midwife work in alternate midwifery

clinical roles as this has traditionally been considered the effective process for comprehensive skill consolidation. Contesting this mode of thinking are the results from Cummins et al.'s (2015) study which endorse the adoption of continuity of care models into the new graduate period.

Having the first employed role as a midwife in a caseload practice may be an innovative approach to reduce the apprehension commonly felt by new midwives. A grounded theory study which aimed for theory generation interviewed 11 recently graduated midwives. Results revealed the inherent challenges of the first six months of employment (Barry et al. 2013). Initial stages of acculturation into the profession involves the individual to affiliate their personal perception of what being a midwife means into the larger picture of the healthcare setting and women's lives. Loss of control over personal midwifery philosophies occur as does a loss of the locus of control in the way individuals care for women. Acculturation transpires when individuals evaluate their personal and employment situation within a context of their professional beliefs and values. Participants who successfully survived this challenging period attempted to align personal and professional expectations with the reality of encountered experiences. Professional satisfaction occurred when expectations were successfully met, achieved or realistically attainable. If, however, expectations were not met, or what the anticipated experience of being a midwife was unattainable, frustration occurred and doubts about their chosen profession ensue (Barry et al. 2013).

The stage of becoming accustomed to the professional role of a midwife in the Barry et al (2013) research was called 'transcending barriers'. This terminology reveals the confronting and difficult nature of the new graduate period. Hunter and Warren's (2014) qualitative investigation via participant interviews into key moments of a midwife's work when adversity might be experienced most keenly, and how resilience might be fostered to contribute to promoting career longevity is interesting to note here. Resilience has been perceived as learned, coping strategies such as accessing support and acquiring a protective self-awareness (Hunter & Warren 2014). Perceptions of resilience were undermined and the vulnerability inherent as a new midwife was amplified if working within a bullying culture or having experienced adverse incidents such as poor clinical outcomes (Hunter & Warren 2014). Resilience was also undermined from workplace conditions such as high workload, staff shortages and when quality of care was compromised.

Mutually supportive and reciprocally helpful relationships with colleagues were sources of support and facilitated resilience (Hunter & Warren 2014). Providing support for vulnerable peers emerged as particularly beneficial within collegial relationships as it encouraged positive midwife-to-midwife relationships through mentoring junior midwives and role modelling. Trust and safety within peer relationships reinforced a strong sense of personal and professional identity as a midwife. The vocational aspect of midwifery and the belonging to a professional group meant that being a midwife was something someone *was* as opposed to something someone *did*. This collective identity contributed to occupational resilience. The concept of building resilience is noteworthy as a strategy to enhance retention (Hunter & Warren 2014).

Access to positive leadership such as managers and educators has been shown to be valuable when grappling with the personally and professional demanding transition period (Clements, Fenwick & Davis 2012). Effective mentorship programs have been shown as beneficial, however the variability of these programs is extensive (van der Putten 2008). As well as formally instituted programs of support, Australian research identifies that an important source of support is from managers, educators, and those who do not hold traditional educational roles such as experienced clinical midwifery staff (Clements, Fenwick & Davis 2012).

Leadership remains important throughout all years of practice with midwifery managers central to employment experiences and intentions to remain in the profession (Price 2005). Managers are crucial in encouraging midwives to continue in their role especially if they actively engage their workforce in workplace and employment issues. A UK study of 42 'experienced' midwives indicated that the main factor important to their employment experience was one which could be influenced by management. Control over, and flexibility with, rostering and leave arrangements was imperative to these participants. Other important factors for remaining in the profession were career development and an appreciation of contribution with a sense of feeling valued. Managers were perceived to be obliged to engage midwives in these parameters. Managers were also considered to be able to positively influence midwifery engagement in practice and protocol decision-making via establishing key decision-making initiatives and forums. Supporting midwifery education activities and professional development through staff appraisals and maintaining an educational budget were also identified as important duties of midwifery managers (Price 2005).

Recent Dutch research exploring factors associated with satisfaction reiterates previous work in the field of midwifery job satisfaction (Warmelink et al. 2015). Factors positively associated with satisfaction was having direct contact with women in their care, supportive collegial relationships comprising cooperation and teamwork, innovation within midwifery practice and the experiences of autonomy, freedom, variety and opportunities within their work. Areas for improvement included improved relationships with other maternity health professions, as well as lessening the amount of activities not associated with contact with women such as paperwork and meetings to devote more time to women's needs. A reduction in work stress and a reduced load in their caseloads were also desired (Warmelink et al. 2015). These findings are reminiscent that dual attention to factors associated with satisfaction (augmented) and dissatisfaction (diminished) is needed in the combat against shortages of staff.

2.3.5 Summary of workforce retention midwifery

Some midwives remain in midwifery, not merely due to financial necessity, but because they want to do the job. Job satisfaction in midwifery and intentions to remain working as a midwife are clearly linked to the shared relationship with women, known as 'being with woman'. This relationship was perceived to be strengthened when working in a midwifery group practice where continuity of care is undertaken in a caseload model. Working in such a model was associated with increased job satisfaction, enhanced autonomy and decreased levels of burnout. Regardless of working within a caseload or standard model of care, autonomy within the professional role was considered important. Midwifery management was considered to be crucial in supporting role autonomy and professional development. Also important to midwives were a degree of flexibility in rostering and a sense of control over rostering and leave arrangements. Resilience may also contribute to midwives remaining in their profession.

2.3.6 Comparison of retention in nursing and midwifery

The canon of nursing research in retention strategies is more long-standing and weightier than that of midwifery, so that the variety of issues explored in nursing research is more extensive. Predominantly research from both professions reveals that job satisfaction enhances the intent to remain in their workforces. That said, differences appear to be

present between them. Nursing parameters contributing to satisfaction emanate mainly from aspects intrinsic to the nursing role as well as positive workplaces. Whereas the guiding beacon of job satisfaction in the midwifery profession is working in continuity of care models and having effective relationships with women.

Proceeding with the literature review, when put side-by-side with turnover research, it is clear that comparatively little is written on what encourages nurses and midwives to continue in employment. The considerable literature on the pressures and work-related problems facing nurse and midwives will now be presented, albeit in an abridged format, commencing with nursing research.

2.4 Turnover

Definitional problems for turnover can occur because turnover can be considered as any job move, leaving an organisation, or even exiting from an occupation or profession completely. Turnover is a process whereby staff leave or transfer within an occupational environment. This definition encompasses voluntary, where staff resign, or involuntary, where staff are requested to leave. Turnover can be internal, where staff move within an organisation, or external, where staff exit from an organisation (Hayes et al. 2006).

Asserting that workforce turnover is wholly related to job dissatisfaction is simplistic. However, intention to leave and factors that contribute to job dissatisfaction were connected in the literature. This section presents research regarding the workforce participation trend of ceasing practice in the nursing and midwifery professions.

2.4.1 Graduated and practiced nursing or midwifery for a period of time and then ceasing: Who leaves?

Adding fuel to the current and projected nursing shortage in Australia, and elsewhere, is the high attrition rate from the nursing profession in the first few years post graduation. Different sources of workforce statistics deliver varying rates firstly, of intention to leave and then, of new nurse turnover. Various studies and government data revealed different rates, ranging up to 55% of new nurses leaving the workforce in the first year of employment. The extent of the worrying trend is difficult to gauge. It may be that the elevated figures are only isolated occurrences, being particular exceptions to the new

graduate nursing workforce. However, the presence of multiple sources of new graduate turnover across the globe, whatsoever the rate, is cause for concern. Contributing to workforce shortages is the migration of new nurses between hospitals, with relocation being a widespread approach to employment in the new nurse population (Duchscher & Myrick 2008; Hungtington et al. 2012). Nurses voluntarily exchanging work status from full-time to part-time or casual also contribute. A further obstacle in the provision of a stable health workforce is that varying health settings across Australia possess different levels of turnover rates. Certain sectors appear to undergo higher than average rates of nursing turnover, such as rural and remote sectors (Hildingsson, Westlund & Wiklund 2013) and mental health nursing (Fenwick et al. 2012).

The prominence of nursing turnover, in the new graduate period and beyond, has negative bearings on the fiscal affairs of hospitals with turnover expenditure comprising productivity losses, absenteeism costs, illness and injury costs, temporary replacement costs, human resources tasks, advertising, recruitment and orientation (Buchan 2010). Specifications of financial costs of turnover differ amongst varying sources of workforce literature. This is because there are a several ways that the overall impact of staff turnover costs can be calculated (Buchan 2010). Nonetheless the expense to institutions is marked, with some estimations placed near $50,000 for each FTE (Duffield et al. 2014). Focusing on recruitment only for staff is paltry, institutions need to retain new graduate nurses to avoid the expense and disruption of turnover. Amidst shortages undermining budgetary strength, prudency suggests instituting measures for reducing turnover. On an individual level, the stress to each person encountering what may be needless occupational mobility is also of concern. Moreover, high turnover of nurses compromises patient care due to loss of expertise, staffing stability, and institutional collective knowledge.

This all begs the question: Is turnover in nursing, particularly in the new graduate period, avoidable and preventable? The literature illustrates a complex picture, one which incorporates the previous section and its presented influences of retention. To properly consider this question, the contributing factors of nursing turnover must be reflected upon.

2.4.2 Workforce turnover in nursing

The initial foray into nursing practice occurs for the majority of new nurses within the hospital environment. Over four decades of research has shown distinctive pressures which

take place most intensely during the first year of transition into hospital practice. To encounter employment as a new nurse is to be exposed to a range of physical, emotional, socio-developmental/cultural and intellectual changes (Duchscher 2009). Nurses with less work experience have been shown to experience greater stress than more experienced nurses (Hoffman & Scott 2003). The numerous deleterious stressors in the transition are likely to play a role in the exodus from nursing.

Transition shock, or reality shock (Kramer 1974), is the "most immediate, acute and dramatic stage in the process of professional role adaptation for the new graduate" (Duchscher 2009, p. 1104). Stress triggered from surprise of the "in-between-ness" (Duchscher 2009, p. 1104) of being accustomed to the student role then moving into the relatively less familiar role of professionally practising nurse, coupled with poor or absent transitional support, generates stress and anxiety in new nurses. Deployment into the nursing workforce has been shown to instigate feelings of frustration, uncertainty, disillusionment, vulnerability, loneliness and seclusion (Duchscher 2009). This is exacerbated by perceptions of unpreparedness for employment in respect to clinical skills and workplace socio-cultural mores as shown by work readiness research (Caballero & Walker 2010).

The rationale for providing well-thought-out support in the early career period is affirmed by an Australian study in which nurses were interviewed one and six month/s after initially commencing nursing (Kelly & Ahern 2008). Despite findings from a preliminary study collected towards the end of their nursing education that showed participants held positive views of their impending nursing roles, the data collected post commencement spoke of a different experience. The new nurses were unprepared for the hostile culture of nursing and experiences of nursing colleagues withholding support. The persistent feeling of being new to the staff due to rostering structures which saw new nurses rotate around the varying hospital wards was unsettling. Akin to the Bullock et al.'s (2011) interventional study which highlighted the importance of having a communal approach to new nurse orientation, Kelly and Ahern (2008) emphasise the crucial role that experienced nurses and management hold in the socialisation of new graduate nurses.

Recent Finnish research investigating reasons for leaving nursing employment is notable here (Flinkman & Salantera 2015). Interviews with 15 young nurses (less than 30 years of age) who had left employment from one hospital due to perceptions of poor work environments depict a troubling picture. These nurses, who were considering leaving the

profession altogether, experienced moral stress and ethical quandaries amidst a workplace where quality of care was jeopardised due to high workloads. Furthermore, powerlessness to change the work environment contributed to feelings of stress. The busy workload, burnout and anxiety regarding the mortal responsibilities they held as clinical practitioners added to stress. Lack of support from colleagues and managers, inadequate orientation and absent mentoring all contributed to the nurses leaving. A perception of limited capacity for professional development and role versatility in nursing was also evident, with some participants considering nursing a 'dead-end' job with little room for promotion. Finally, for some of the participants, nursing was a default career, one they 'stumbled' into, rather than being induced by vocational desire or career passion, deemed helpful in career longevity.

The Finnish researchers recognised that their study's limitations included participant awareness of the research aim. Knowing that the focus was nursing turnover and intention to leave, a heightening of negative responses may have occurred due to participants wanting to legitimate their decision of attrition (Flinkman & Salantera 2015). The Finnish results, did however, show a broad range of stress. The scope of the stress in the findings corresponds to those from an earlier systematic review, which identified that nurses commonly experience low work morale and low job satisfaction, and also consider that the remunerations and rewards for their skills are not commensurate with their labours (Lim, Bogossian & Ahern 2010). Most of the studies included by the authors showed that there were a variety of stressors in the work environment including excessive workloads, lack of support, role ambiguity and experiences of aggression and bullying. Seeking out social support was a common coping strategy used by nurses. Support seemed to be a kind of buffer to deal with work stress. In the absence of social support, nurses frequently perceive greater stress at work (Lim, Bogossian & Ahern 2010). Most of the included studies gave evidence of the negative effects on the physical and mental health of the nurses.

Nursing stress significantly correlated with diminished mental health in the studies of Lim, Bogossian and Ahern (2010). Other research shows that morbidity may contribute to nursing turnover with ill-health contributing to turnover. For example, the physical health of many female nurses and midwives is problematic as many have an unhealthy weight. Nursing shift work is associated with a higher risk of being overweight and obese (Zhao et al. 2011). One large longitudinal study of 1653 nurses indicated that full-time employment as well as an increased number of occupational injuries transpiring in full-time employees,

namely muscular sprains predominantly to the back, resulted in more turnover (Brewer et al. 2012).

Resuming attention to the common nurse experience of moral stress, as that found in the Finnish (2015) study, is other research supporting its prominence in the profession. Australian research by Bartram et al. (2012) examined ethical dilemmas experienced by nurses in the practice environment. Findings revealed that emotional labour is positively associated with both burnout and intention to leave nursing. Emotional labour arises when nurses undertake nursing practice activities and display behaviours the employing health setting requires of them that may conflict with their own emotional state (Bartram et al. 2012). These findings associate negative demands of emotional labour to burnout, because ultimately the nurses were inclined to leave the stressful employment situations.

Bartram et al. (2012) suggest that certain hospital workplace policies and practices may reduce the negative effects of emotional labour on nursing staff. Such practices are job security, selective hiring, extensive training, teams and decentralized decision-making, information sharing, transformational leadership, and high-quality work (Bartram et al. 2012). These practices may offset the negative features of hospital working life which have been revealed to contribute to decisions for leaving employment (Strachota et al. 2003) To find out why ex-employees terminated their employment, Strachota et al.'s (2003) recruited ex-employees of three hospitals within one health sector through its human resources division. Work scheduling issues were of major concern, whereby inflexible rostering of working long shifts, overtime, weekends, nights, and holidays prompted nurses to exit the workplace. High workload, inadequate staffing levels and poor managerial support were also cause to leave. Insufficient remuneration and problematic clinical resources emerged in the data as cause to be dissatisfied with previous employment.

Strachota et al.'s (2003) study was able to examine a wide variety of clinical specialties as the participants' clinical settings were diverse. Nurses in specialty areas, such as critical care, had the highest turnover rate. Important to note is that almost half of the 84 nurses interviewed were disturbed by the poor quality of care they were able to deliver due to low staffing and increased demands. Incidents of unsafe patient care practices were relayed in many of the interviews (Strachota et al. 2003). Other research indicates that staffing levels impact on quality of nursing care, with the delivery of low quality care being shown to be much more likely to be in hospitals with low staffing levels with rates of patient mortality increasing as nurse to patient ratio increases (Aiken et al. 2002a).

Adverse hospital environments impact on how nurses feel about the institutions employing them. Brewer et al. (2012) identified low job satisfaction and diminished organisational loyalty as parameters of turnover. Surpassing organisational indifference is disinterest in the identity of nursing. Another study, undertaken in Turkey, revealed that the intention to leave the nursing profession was greater among those nurses who possessed minimal professional identity, as well as low job satisfaction (Sabanciogullari & Dogan 2015).

Lacking a commitment to nursing and having poor organisational loyalty appears to be important in the findings of a study examining employee attitude and organisational culture in nursing (Cameron 2011). Organisational culture was defined as emotional climate, practice-related issues, and collaborative relations. Possessing a negative perception of organisational culture was commonly experienced by nurses in acute care settings in the Canadian study, as was low levels of trust, commitment and intent to stay. Almost three quarters of the 343 survey respondents were 'likely' or 'very likely' to leave their current employer. The authors recommended the development and implementation of policies and strategies aimed at creating more supportive work environments. Other research also has demonstrated that work environments characterized by positive inter-collegial relationships have a positive impact on nursing staff satisfaction and affective commitment and loyalty (Australian Government Department of Employment 2015c).

Clearly, nursing job satisfaction is influenced by workplace environment and relationships. However, efforts aimed at improving job satisfaction should not only be confined to the work setting due to the importance of work-to-family conflict to nurse turnover (Twigg & Pugh 2011). A supportive environment is crucial for job satisfaction when considering out-of-work responsibilities of nurses. Conflicts arising from familial responsibilities can contribute to diminished professional and organisational loyalty. Family commitment is a factor in leaving nursing (Duffield & Franks 2002).

Research has shown an association between work-to-family conflict and intentions to leave nursing (Hasselhorn et al. 2005). Different life stages contribute to the intention to leave due to family challenges, most pronounced at the beginning of a nursing career and then at ages 30 and 40 years (Simon et al. 2005). Nurses who place high value on work life/home life balance often practise nursing for a shorter time period (Duffield et al. 2004), while some have reported leaving because they found the demands of work incompatible with a fulfilling home life (Morrell 2005).

Having a sense of balance in the facets of work and home seems to be of critical significance for nurses, and is likely to be similar for midwives. The inflexibility of shift work, its night shifts and obligatory rotations, have been demonstrated to be cause of leaving nursing (Cartledge 2001). Stress, burnout, work-related exhaustion, excessive workload, and job strain have been demonstrated as being reasons for intending to leave. Cheung's (2004) study, which identified firstly, triggers to voluntarily leave the profession and secondly, processes of the leaving event, provided information from a wide range of workforce experiences.

Recruitment was from a range of clinical settings and varying metropolitan, regional and rural areas across four Australian states (Cheung 2004). The initial trigger generating the desire to exit the profession was a general dissatisfaction with working conditions. Stress arising from continual staff shortages and lack of support were found to be significant factors for decisions to change careers, as were the lack of career structure and opportunities (Cheung 2004). Finally, burnout and disillusionment with the nursing profession were commonly elicited reasons for attrition. Many participants in the study found the decision to leave difficult and was made over lengthy time periods of months or years.

The subject of turnover and reasons for considering leaving the nursing profession was also explored as part of a larger study of the practice environment and job satisfaction. Nurses' experiences and needs was ascertained by way of analysis of additional comments on the workforce study (Dawson et al. 2014). One strength of this research is that recruitment was broad, undertaken in 11 public hospitals across three states and territories. Findings linked the lack of autonomy in practice and lack of involvement in decision making to participant intentions of leaving the profession. Some participants considered a privation of professional autonomy diminished the nursing role and scope of nursing contributions to healthcare, insofar as feeling there was no reason to continuing practising (Dawson et al. 2014). Career opportunities were considered to be impeded, with shortages of opportunities and difficulties securing a job in the initial new graduate period influencing participants to contemplate other occupations. The range of employment options and the capacity for career progression were also doubted.

Another professional concern of nurses is physical and mental exhaustion, or burnout, brought about by the role. Burnout will be contemplated more thoroughly in the Chapter 4 when a data collection instrument that measures burnout in the health professions is

presented. Suffice to say, the specificity of the issue of burnout to my study of midwives in the newly graduated period is confirmed by recent research that indicates that burnout is not restricted to the long term practising nurse (Australian Government Department of Employment 2015a). A large, multi-site, longitudinal Swedish study exploring new graduate nurses' intentions to leave the profession and the shifting rates of these intentions revealed a troubling trend. One in five nurses strongly intended to leave the profession after five years of practice. The prevalence of intention to leave nursing doubled between the first and the fifth years after entering the workforce and this increase of intention to leave was associated concurrently to levels of burnout with those nurses who experienced burnout more likely to intend to leave the nursing profession. Another important finding was that disengagement from employment influenced an increase in intention to leave nursing in the latter of those five years. Rudman et al.'s (2014) research establishes the likelihood of there being multiple occasions in the new graduate nurse period where interventional strategies encouraging nurse retention can occur (Australian Government Department of Employment 2015a).

One last issue to illuminate, before moving onto midwifery turnover, linked to intention to leave nursing and nursing turnover, is the issue of occupational violence or horizontal bullying in the workplace. Workplace bullying is a term that signifies repeated behaviours by members of an employment setting or organisation that are offensive, intensify and worsen over time and have the intention of being harmful (Nursing and Midwifery Board of Australia 2008). Experiencing bullying leads to lower job satisfaction and higher intentions to leave the workplace (Curtis, Ball & Kirkham 2006c) for both those targeted by bullying and those who have witnessed it (Prowse 2015). The different hierarchical levels and power imbalances inherent within the organisational structure of the hospital has been considered to contribute to workplace bullying.

Workplace bullying compromises new graduates' transitions into their nursing role, their perceptions of a positive adjustment period, and their workplace health and wellbeing (Nursing and Midwifery Board of Australia 2006). In a period where successful movement from competence to confidence aids successful transition into the nursing role, being targeted by behaviours that diminish confidence is detrimental to the evolution of a new graduate nurse.

A New Zealand survey study receiving 551 completed surveys revealed that one-third of nurses in their first year post registration experienced verbal conflict, including statements

that were rude, abusive, humiliating or unjust criticism (McKenna et al. 2003). These experiences contributed to participant absenteeism from the workplace. Furthermore, a high proportion of those respondents targeted by bullying had thoughts of leaving the profession (McKenna et al. 2003). Adding to the unease of these results is that under-reporting of the bullying was evident in the study, with almost half of the events of bullying described not being reported within the workplace. Furthermore, only 12 percent of those who described a distressing incident were given formal debriefing, and the majority of respondents received no training to manage the behaviour (McKenna et al. 2003).

Other research into the phenomenon of bullying as perceived by nursing participants in Canadian nursing workplaces highlighted two organisational factors to be conducive to bullying (Blackstock et al. 2015). The first factor was those unofficial social and hierarchical networks that exist amongst the bullying perpetrators as informal social alliances that enable and protect the perpetrators of the bullying. The second factor allowing bullying to occur and flourish was when bullying was permitted to occur in flawed organisational decision making processes and when there was a failure to follow organisational procedures. These findings highlight the need to reduce the running of adverse informal alliances in hospitals, staff skills-based training in communication and conflict management, and support efforts of transparency and accountability within workplace practices. Another important factor is to provide adequate resources so as to firmly establish suitable policies and procedures for when decisions need to be made surrounding bullying incidents (Blackstock et al. 2015).

2.4.3 Summary of workforce turnover in nursing

The provision of best possible health care depends upon the quality of nursing work environments and, more than ever, the extent to which nurses are empowered to deliver high standard of care in the hospital environment. Nursing turnover has been shown to be influenced by many parameters such as trying work conditions engendered by increased workloads, poor skill-mixes, low nurse-to-patient ratios and heightened patient acuity, inadequate remuneration, professional burnout and work-related stresses. These factors are exacerbated by the lack of managerial action to tackle these issues and a perceived lack of opportunities for career diversity and progression. Decreased job satisfaction and a lack of autonomy, as well as workplace bullying are factors impacting nursing turnover. Although encountering these experiences are not restricted to the new graduate period,

the presence of these in the fledgling work of a new graduate shapes a hostile and adversarial workplace environment and compromises the development of confidence in a critical period. There are considerable consequences when work environments and collegial relationships inhibit the socialisation of new graduate nurses into their profession.

The literature for turnover in the midwifery profession will now be presented.

2.4.4 Workforce turnover in midwifery

Turnover in midwifery is a global problem and the merging of midwifery workforce data into nursing data occurs on an international scale. Therefore, an international and national approach to the literature review of intention to leave midwifery and midwifery turnover research has been undertaken.

At the outset, one study that must be recounted is Curtis, Ball and Kirkham's '*Why midwives leave?*' UK research, the aim of which was to explore decisions surrounding leaving the midwifery profession in a sample that had actually chosen to leave (Curtis, Ball & Kirkham 2006c). Midwives who had signalled to the national registration council (UK Nursing and Midwifery Council) that they were planning to practise midwifery in 1999, but not the following year (*n* =1,975) were included in the sample. The first stage included a postal survey of a random sample (*n* = 250) of midwifery leavers (response rate = 56%) followed by 28 semi-structured interviews. Secondly, an additional postal survey of the remainder of the leaver sample was undertaken, amended from the first survey, to strengthen data collection (response rate = 53%).

Dissatisfaction with various aspects of midwifery work emerged as a major reason for exodus from the midwifery profession with almost half of the participants ceasing practice due to dissatisfaction stemming from not being the midwife they wanted to be. Participants were dissatisfied both with the organisation of midwifery care and with their working roles (Curtis, Ball & Kirkham 2003; Curtis, Ball & Kirkham 2006b). Key worries raised by the participants were the absence of autonomy and flexibility in their work, a lack of support and limited sense of value surrounding their work. Also, stress from the workplace was a critical issue with 42 percent of participants revealing feeling extreme stress resulting from midwifery work. An important matter to highlight was that stress experienced by one third of participants was reported to be affecting their physical and/or mental health (35 per cent).

Decision making and deliberation regarding leaving midwifery was a prolonged and upsetting experience for most participants. The majority of participants in the '*Why midwives leave?*' study were mid-career, having had practised for some years since qualification. By this stage in a career, considerable clinical experience and consolidation of training has occurred. Of concern to the profession was that almost one half of the midwifery leavers were under 40 years of age, representing a significant loss of potential years of working life (42 percent had an 11.3 year mean length of employment; 35 percent were between 36 and 45 years of age). Participants who ceased practising because of dissatisfaction were well educated having a diploma, degree or higher degree (Curtis, Ball & Kirkham 2003; Curtis, Ball & Kirkham 2006b), suggesting that higher levels of education are associated with ease of career migration. This finding contradicts an earlier, and somewhat dated, descriptive survey of the employment practice of midwives in the UK which showed that better educated midwives were more likely to practice midwifery on a long term basis (Mander 1989).

As well as collecting data about discontinuing midwifery practice, the '*Why midwives leave?*' study sought to determine employment patterns post leaving. Phase 1 of the study indicated that 68 percent of the 28 midwifery participants who left midwifery continued in the labour market. This even was the case for some participants who left for family commitments or ill-health, suggesting current employers were better able to accommodate their needs than midwifery. Most moved into health related occupations, albeit outside of the hospital setting, such as community nursing or research/teaching. Many of the nurse-qualified midwives returned to previous areas of practice. Shift work was mostly abandoned. If they did work in such a capacity tailored fixed shifts meeting personal needs were the means of employment (Curtis, Ball, & Kirkham, 2006c).

Another UK analysis into midwifery turnover is Shen, Cox and McBride's (2004) review of literature on factors affecting the retention and turnover of hospital consultants and midwives in the National Health Service. Perceptions of not being appreciated and feelings of not being valued were key concerns influencing turnover for both occupations. Hours worked, workload and work schedules were common concerns to both groups. Career development, promotion and appreciation of contribution were important retention factors for midwives. The subject of bullying was also mentioned.

Most of the studies examined by Shen et al. (2004) examined decision-making surrounding workforce issues that *could* make current midwives leave, rather than participants who *had*

actually left midwifery of concerns that lead them to making the judgement (Shen, Cox & McBride 2004). Other testimony of intentions to leave midwifery were found in a study examining burnout in Swedish midwives (Hildingsson, Westlund & Wiklund 2013), where one in three of the 475 participants had considered leaving midwifery. In that study, 40 percent scored high levels of burnout on the Copenhagen Burnout Inventory. The strongest associations for burnout were firstly, the age of participants being less than 40 years and secondly, work experience being less than ten. A lack of staff and resources and a stressful work environment, conflict with colleagues and mangers, worries about the future and own health were also associated with burnout (Hildingsson, Westlund & Wiklund 2013).

Reaffirming the international reach of midwifery shortages is a Canadian study investigating the rising attrition rate in their early career period by determining why graduate midwives leave the profession (Cameron 2011). Similar to the duration of practice in my study, *early* was defined as less than six years post registration. Due to similarities with my study, this research will be discussed at some depth. Interviews conducted with nine participants who *had* left the midwifery profession provided data. All participants had worked in a full-time capacity until leaving. One participant left at six years post registration, whilst the other participants had worked for three. Ages ranged from 30 to 38 years. Like Curtis, Ball and Kirkham's (2003) research, these figures denote significant potential years of employment lost to the profession. The findings were structured into three categories: 1) Becoming, 2) Being, and 3) Loss of Self.

One of the notable findings in the Canadian research was the strong relationship between reasons for becoming a midwife and the reasons for leaving. When the expectations derived from the motivations for becoming a midwife were not met in employment, expectations inverted into a desire to leave. Participants had long-standing altruistic desires to be a midwife and very high expectations about what it would mean. Midwifery was considered as a vocation requiring dedication and devotion to perform the role. When expectations were not met in reality, midwives experienced significant disappointment (Cameron 2011).

In the Cameron (2011) study, participants were initially enthusiastic in the beginning of practice when the role of a midwife was being assimilated into their self-identity, whereby they belonged to a unique group where midwifery was a lifestyle and not merely a job. Soon, however, they encountered discordancy between perceived ideals and the reality of midwifery. Loss of control occurred in their personal lives due to midwifery work strongly

impinging upon work-to-life balance, spurring them to question their devotion to their relationships with women. Despite the important relationships with women being the cause of the most satisfaction as a midwife, participants decided to leave as they were unable to practise how they had hoped. This in a way, salvaged their sense of self-identity, lost within the practice of ways adverse to their expectations and the imbalance of work and life. Common to the participants were strong feelings of grief and remorse due to attrition from the profession (Cameron 2011). Exiting midwifery was considered a moral failing.

Other significant findings in Cameron's (2011) research were that participants considered midwifery as a superior model of care for women and different from the medically aligned traditional medical model of birth. As well, support was considered as crucial and the relationship the participants had with other midwives were housed in terms of how much support they received. For most, the level of support they received was insufficient to their needs. Another finding was that burnout and stress also contributed to the participants' decisions to leave the profession (Cameron 2011).

The author does not specify what specific sources in practise and employment contributed to reality being dissimilar from expectations. Cameron (2011) did assert that strong and overly ideal belief systems of midwifery were unrealistic. This heralds the need to ascertain and address unrealistic expectations at initial entry points into the profession (Cameron 2011).

Australian research also depicts the challenges that new graduate midwives encounter in the early career period (Fenwick et al. 2012). Sixteen participants from the UTS MidTREC study (Hammond et al. 2011) contributed to knowledge about the first 12 months of practice. Participants were asked in interviews to describe clinical practice experiences and environments of the transition period. Other data examined were factors which facilitated or constrained their development as a midwife during this period (Fenwick et al. 2012).

The importance of positive midwife-to-midwife relationships for new graduate midwives when transitioning from student to registered midwife was verified (Fenwick et al. 2012). Analysis drew forth how integral continuity with women and midwifery colleagues was for participants to flourish in their new role. Continuity enhanced confidence and emphasised their commitment to philosophies of normal birth. Some evidence emerged of midwives

struggling in the provision of woman-centred care and being challenged by the risk-averse culture of maternity care (Fenwick et al. 2012).

The authors used aquatic imagery to portray their findings (Fenwick et al. 2012). The hospital was a 'pond', being a multi-layered environment. This symbol encompassed the context and culture of hospital-based midwifery practice, which was both accommodating and uncooperative to midwifery practice. Other symbolism used was a 'life-raft', signifying midwife-to-midwife relationships supportive of new graduates in transition. These could be positive and facilitate new midwives to gain confidence and competence and 'swim', or they could cause her to 'sink', lose confidence and struggle both personally and professionally. The figurative language used by the authors in their thematic analysis of the qualitative interview data seemed to arise from the complexity of the phenomenon under examination, to compel readers to intuit the meaning of analysis. It also serves to make a broader point of the transition being a separate domain or realm of existence, unknown to only those midwives who experience it, thus reminding us of the necessity of research about the midwifery transition.

The Cameron (2011) and Fenwick et al (2012) studies comprised small numbers of participants. Another qualitative study (van der Putten 2008), this time Irish, also included a small sample size of six interviews. The researcher considered this size appropriate as the study was exploratory of understanding the complex human phenomenon of new midwives' experiences. Dominant themes were, that despite feeling theoretically well prepared for clinical practice, participants experienced reality shock, insecurity and stress within acute awareness of heightened responsibilities (van der Putten 2008). Having more clinical and practical preparation as students was suggested by half of the participants, as possibly being beneficial for adjustment to clinical practice. Access to support, mentorship and continued professional development was considered crucial in the transition period. As newly registered midwives, participants considered there to be a discrepancy between reality of practice and theory of education (van der Putten 2008).

A much larger, and local, study to report, one not confined to the new graduate midwife was a West Australian workforce survey undertaken to inform the Nursing and Midwifery Office and Department of Health Western Australia about workforce data (Twigg & Pugh 2011). The aim was to verify the suspected increasingly peripatetic nature of its midwifery workforce in order to guide development for medium and long-term planning for sustainability.

In the Western Australian study, almost one in five midwives (*n* = 712) were surveyed. Roughly half of the sample intended to move from their current job within five years, about one third within 1 to 5 years, and 14% within 12 months. The majority of midwives planning to move jobs were aged less than 35 years and worked in the public sector. The two most common reasons were family commitments and work conditions. Approximately half intended to permanently leave the midwifery profession: 18% within 1 to 5 years, and 12% in more than five years. Keeping in mind that the proportion of West Australian midwives over the age of 50 was higher than the national average, participants with both seniority of age and work experience were more likely to be planning to leave. Retirement, work-to-life balance and working conditions were the three main reasons for intending to leave. Constructively, the three parameters of work that would need to be addressed in order for the participants to remain in the midwifery profession were having more accommodating work arrangements, improved and more flexible staffing, increased access to caseload models which incorporate manageable and realistic workloads, and increased remuneration (Pugh et al. 2013; Twigg & Pugh 2011).

Patient safety is a matter of unease for midwives and can be a source of dissatisfaction. Qualitative research of 591 participants (midwives and obstetricians) examined maternity safety by identifying aspects of maternity care that were less safe than they should be (Smith, Dixon & Page 2009). Problems described included the increasing social and medical complexity of pregnant women, low staffing levels, inadequacy of skill mix, poor staff morale, inadequate training and education, medicalisation of birth, poor management, lack of resources and reconfiguration. Barriers to implementing change included stressed staff, resistance to practice changes, inadequate management, and poor staff management. Solutions similar to those proposed in the nursing field were suggested by participants. Increased numbers of staff, enhanced team work and better skill mix, improved training, more one-to-one care, additional caseload models, better management, more resources, improved guidelines, and learning from incidents were seen as solutions to safety issues (Smith, Dixon & Page 2009).

Described in Section 2.3 was seminal research of the interrelatedness of continuity of care, job satisfaction, dissatisfaction and burnout in a sample of 48 midwives employed in community-based continuity of care models. Sandall (1999) was concerned that once dedicated pioneers who forged the continuity model into reality retired, burnout would ensue in midwives subsequently employed in that model.

Three themes emerged for sustainable practice as to safeguard against burnout within the provision of woman-centred care: The first being the importance of occupational autonomy and having some control over individual working patterns (Sandall 1999). The findings provided a link between a control over organisation of work and burnout. Stress participants felt was related to the extent of control of self- organisation rather than the workload itself.

The second theme was developing meaningful relationships with women. The provision of continuity of care to women was critical to job satisfaction. The failure to develop meaningful relationships with women, brought about by fragmented contact, was a source of participant stress and reduced job satisfaction. Sandall's (1999) research illuminated the benefit of working with a reasonably sized personal caseload comprising of adequate sick leave and maternity cover, rather than working with to provide women continuity by a team of midwives. It must be noted that for some participants, there was an aspiration to practise within an idealised concept of continuity of care, unachievable in caseload structures. When midwives struggled to work with these unrealistic and unsustainable expectations, they became disillusioned and left the practice. This is similar to Cameron's (2011) findings whereby romanticised ideas of midwifery held by new graduates led to disillusionment and exits from the profession.

Sandall (1999) also established a link between collegial support and turnover. Those sites that were organised in a way that ensured collegial support between midwives experienced less burnout. Support in the form of regular meetings, case discussions and social interactions, diminished levels of stress and was a source of job satisfaction.

The recommendation of adequate maternity leave in the study is important as employer initiatives to promote family friendly, flexible working arrangements are highly sought. Midwifery managers are experiencing growing demands from midwives to work part-time and to improve flexible rostering (Curtis, Ball & Kirkham 2003). Factors contributing to shortages have been detailed as the inflexibility of employment, lack of work-life balance and difficulties of combining shift work with caring commitments (Curtis, Ball & Kirkham 2006c). Recent research reveals that the balancing act of meeting varying needs leads to piecemeal rostering and frequently full-time staff are in the position of filling the rostering gaps (Prowse 2015). This leads to antagonism, resentment and divisions between midwives (Curtis, Ball & Kirkham 2003).

Curtis et al. (2006) also referred to the lack of expertise in new midwives contributes to workloads of senior midwives, with the lack of experience being a source of 'otherness' in the clinical setting. Marginalisation and distinction of 'otherness' may contribute towards bullying in the hospital environment (Curtis, Ball & Kirkham 2006c), despite Australian professional standards for the profession clearly state that ill-treatment of a colleague is inappropriate. The *Code of Ethics for Midwives in Australia* asserts respectful interactions between colleagues, in tandem with fostering supportive, constructive and non-punitive relationships (Nursing and Midwifery Board of Australia 2008). Other professional expectations, as espoused by the Nursing and Midwifery Board of Australia, are to enhance the professional development of self and others. This requires the contribution to learning experiences and professional development of colleagues (Nursing and Midwifery Board of Australia 2006). Acting in ways contrary to this is counter to the professional standards of midwives in Australia.

Bullying of new graduates is of concern and can lead to midwives leaving their profession (Hastie 2006; Hogh, Hoel & Carneiro 2011). In the '*Why Midwives Leave?*' study a portion of participants reported being either a victim or witness to bullying in their workplaces (Curtis, Ball & Kirkham 2006a). One third of participants felt at times they had been bullied by managerial staff, whilst almost one quarter reported having experienced bullying as horizontal violence from colleagues. With such high proportions experiencing bullying from managers, it is comprehensible why such low proportions fail to report their experiences (Tehrani 2004). Prior experiences of bullying were associated with dissatisfaction with midwifery. To explicate this association, Curtis et al. (2006) explained that midwives dissatisfied in their work were uncomfortable with the type of midwifery care they were required to provide. These participants articulated practice philosophies that were often contrasting to the status quo thus inciting divisions between and a tendency to bullying from colleagues (Curtis, Ball & Kirkham 2006a). Specific to my study are Curtis, Ball and Kirkham's (2006a) findings that less experienced or younger midwives were more likely to report experiencing being bullied.

The physical body is shaped from midwifery work. Akin to nursing research depicting the affect musculoskeletal disorders have on the stability of its workforce (Brewer et al. 2012), research determining the prevalence of musculoskeletal symptoms in a group of Australian midwives reveals a similar incidence of the condition. Neck and upper back musculoskeletal symptoms were prevalent in the large sample. Nearly half of the 1,398 participants

reported musculoskeletal problems of the neck, whilst just over a quarter of participants reported upper back disorders (Long, Johnston & Bogossian 2013). One finding showed working in awkward postures was significantly associated with these musculoskeletal symptoms. In day-to-day work, midwives' bodies are constantly moving and being positioned in awkward ways, for example when monitoring fetal heart rates, caring for labouring women and postnatal women post caesarean. These ailments may include the exodus from the workforce, diminished work ability, and functional capacity outside of work (Long, Johnston & Bogossian 2013). The research finding of physical postures requiring unnatural body alignments and the frequent occurrence of musculoskeletal pain and discomfort, most notably of the spine, as experienced by midwives in their work has been identified in other research (Nowotny-Czupryna et al. 2012).

2.4.5. Summary of workforce turnover in midwifery

New graduates have been shown to exhibit strong intentions of entering the midwifery workforce and optimistic expectations of commencing. Previous research in NSW into the early career intentions of new graduate midwives revealed that 95 percent of the sample intended to enter the profession for which they were trained (Hammond et al. 2011). Intention to remain working as a midwife was related to job satisfaction, strong positive professional identity and perceptions of making a difference to women. Participants possessed a strong desire to practice using the full scope of their midwifery knowledge (Hammond et al. 2011). Despite this optimism, there is another side of the picture as it is clear that not all midwives remain in the profession once they graduate. Discrepancies between what graduates understand midwifery to be throughout their education, and what meets them in the real world of employment, contributes to attrition. Some reasons for leaving and intention to leave the profession were job dissatisfaction, family commitments, the disparity between unrealistic expectations and reality, poor work-life balance, stressful work conditions, and the experience of bullying.

Important points when considering midwifery turnover research is that some analysis centres upon reasons why midwives have left and some on what employment factors cause midwives to consider leaving. Speculation about negative aspects of work may occur easily when employment is secure. Also significant is that response rates for much of this research are relatively low. Therefore, it is necessary to consider the motivations

stimulating specific individuals to participate in the research as impartiality is impossible in qualitative research.

2.4.6 Comparison of nursing and midwifery research

Similarities exist between factors contributing to turnover in the professions of nursing and midwifery. Differences do however also occur between the two professions. This may be due to the potential of the relationship in midwifery care to comprise of the timespan of pregnancy, birth and postnatally, causing the relationship between a midwife and woman to be ultra-significant as sources of job satisfaction. In summary, Table 3 presents the multitude of factors potentially affecting individual decision making processes in the nursing and midwifery workforces. The quantity of factors confirms the sheer complexity of workforce research, reinforcing the need for qualitative, quantitative and mixed methods research in the field.

Table 3 Summary of factors associated with turnover and retention in nursing and midwifery

Factors associated with turnover
Age
Less work experience
Lack of permanent tenured positions
Family/care responsibilities
Higher levels of education
Inadequate professional development and education
Less promotional opportunity
Poor economic reward/pay
Rewards not related to performance input
Less positive work environment
Alternative employment opportunity
Robust job market
Low organisational and job commitment
Low job satisfaction
Low quality of work-life
Perceived lack of autonomy
Inflexible rostering
High levels of workload
Increasing level of demands
Work stress
Lack of participation in decision making
Inadequate levels of support
Obstructive workplace communication styles
Inadequate staffing and skill mix
Experiences of bullying
Poor managerial and supervisory style
Negatively perceived status within organisation Behavioural intention to leave

Table 3 cont… Summary of factors associated with turnover and retention in nursing and midwifery

Factors which could promote retention or prevent turnover
Enjoy work variety
Familiarity with routine, equipment and personnel
Repetition at work
Job satisfaction
Positively perceived status within organisation
High organisational and job commitment
Perception of job security
More positive work environment
Good resources
Quality of working life
Opportunities to use skills
Facilitation of professional development
Facilities provided by your employer to meet continuing professional development
Good promotional opportunities
Rewards related to performance input
Work related communication
Decision making capacity
Working on preferred rota/shift
Behavioural intention to stay
Contact with women and patient
Longer time employed with current employer
Soliciting input from staff on critical work issues
Building teamwork and co-worker support
Helping staff cope with work stress
Minimizing administrative time spent on non-patient care activities

Source: conceived from results of McCarthy, Tyrell and Cronin (2002).

2.5 What we do not know

It is now deemed important to examine how midwives feel about and experience their working lives, due to the understanding that satisfaction and dissatisfaction at work affect, amongst other things, turnover and retention. Research has considered this for midwives in general, for midwives in the first year or two of transition, and for student midwives on the verge of graduation. Research of new graduate participation in the midwifery workforce which provides ample reflection of the initial transition and then the movement into the next seven years is wanting in the research canon. My study is useful as it provides data on new midwives reflecting on their initial transition into the midwifery workforce and then evaluating how that experience shaped their current participation in employment.

Furthermore, this study provides evidence on the ways that new midwives in Australia are working. Despite evidence which highlights the critical period of the initial years of

midwifery practice, current Australian midwifery workforce data cannot provide a statistical representation of midwives in the first years of practice. My study provides a starting point for a methodology of expanded data collection on this issue.

2.6 Conclusion

The loss of both experienced and fledgling midwives is concerning. Skill losses affect students and new graduates alike, because experienced midwives educate and support the newer ones. As well, losses impact upon the safety and quality of maternity care occur (Tracy, Barclay & Brodie 2000b; World Health Organization 2006). This literature review demonstrated a complex interplay of competing factors influencing the maintenance of the midwifery work force supply in Australia and across the globe. Of interest to this study of midwifery workforce participation is the trend of nurses leaving the profession soon after graduation because most midwives are drawn from nursing. If this phenomenon occurs in nursing, it is feasible it is happening in midwifery as well. Studies have been presented which describe several influences, common to both professions, for workforce attrition and retention, including professional satisfaction, personal recognition and appreciation, resource availability, career progression, flexibility of working arrangements and the level of role autonomy. In order to implement possible remedial strategies aimed at enhancing workforce numbers, a well-defined picture of the midwifery workforce must be identified and described. National data for midwives does not parallel the quality of nursing. Furthermore, knowledge about midwifery graduates in general is a limited, yet growing field. More is needed to be known about Australian midwifery graduates, their early career intentions, participation rates and movements. This study aims to add to this field of data. The findings may be able to help inform strategies to address turnover and attrition in midwifery. Chapter 3 addresses the proposed research methodology and then Chapter 4 the specific strategies for undertaking the study.

Chapter 3: Methodology

The formulation of research objectives leads to the development of a conceptual framework that summarises the concepts and underlying theory to be explored in the study. Next, the selection of a global approach to data collection and analysis is necessary, to enable the researcher to suitably collect data so as to answer the specific research question. This process involves using existent literature and theory to deduce a conceptual framework, which is then used to guide data collection (Hennink, Hutter & Bailey 2011). This process is methodology, presented here in Chapter 3.

3.1 Introduction

Research methodology "help(s) us understand the process of scientific inquiry" (Maxcy 2003, p. 78). It refers to an "overall approach to inquiry regularly linked to particular theoretical frameworks" (Sandelowski 2003, p. 324). This differs from *methods* which are procedures, purposely chosen for the specific research question, the techniques or tasks and instruments employed to gather, analyse, and interpret data, then present the findings and conclusions (Maxcy 2003). Thus, the two terms are not one and the same. Yet, the research methodology incorporates values and assumptions about the social world that have a bearing upon how the project is designed, the research question is considered, and which specific research techniques will be used for gathering and analysing data (Burke Johnson, Onwuegbuzie & Turner 2007).

This chapter addresses the overall epistemological paradigm of the study.

3.2 Methodological design

The study's approach was mixed-methods, both for data collection (using survey and interviews) and analysis (using thematic analysis and philosophic interpretation). Broadly speaking, mixed methods research is an approach to knowledge, encompassing both theory and practice, which endeavours to consider multiple techniques, viewpoints and perspectives using both qualitative and quantitative methods (Burke Johnson,

Onwuegbuzie & Turner 2007). A visual model of the multi-stage format as a graphical representation of my study, to aid in comprehension of the sequence of its procedures, is provided in Table 4. The model depicts the sequence of the research activities in the study and is derived from a graphical representation of the mixed-methods sequential explanatory design procedures in Ivankova, Creswell and Stick (2006).

Table 4 Visual model of sequence and procedures in my study

Phase	Procedure	Product
Quantitative data collection	• Purposive non-randomised paper-based survey (*n* = 113) • Data screening • Text messages to encourage further responses	• Printed copies of surveys
Quantitative data analysis	• Survey RR 66% (*n* = 75) • IBM SPSS v. 22 • Frequency distributions • Non-parametric analysis • Cronbach α coefficient establishing internal consistency	• Descriptive statistics • Non-parametric correlations
Connecting quantitative and qualitative phases	• Elicitation materials: Developing interview guide	• 28 cases selected • Developing interview protocols
Qualitative data collection	• 40 participants self-selected to partake in Phase 2 interviews • Individual in-depth telephone interviews with 28 participants • Writing field notes	• Text data (interview transcripts and field notes)
Qualitative data analysis	• Verbatim transcription of interviews into text • Preparation of text into documents for coding • Coding and analysis • Cross-thematic analysis	• Codes • Themes and subthemes • Similar and different themes
Integration of quantitative and qualitative results	• Interpretation and explanation of the quantitative and qualitative results	• Discussion • Implications • Future research

Adapted from *Visual Model for Mixed-Methods Sequential Explanatory Design Procedures* (Ivankova, Creswell & Stick 2006, p. 16).

3.3 Why use a mixed methods design?

Notwithstanding that factors internal and external to the workforce would appear at first glance to be disconnected from workforce conditions and experiences, they do appear to interact with one another, for example the often discussed family-life and work-life balance, and also when work conditions impact upon workers' health. These many variables point towards the provision of a stable midwifery workforce being a complex subject. Research on the matter, therefore, would be well served by using a mixed methods research approach. Many of the studies identified in the literature review in Chapter 2 utilised such an approach.

Historically, the formerly unnamed mixed methods research approach was initially employed in the first half of the twentieth century in social science research by methodologists who considered both qualitative and quantitative viewpoints and methods useful for addressing research questions that required a broad scope of understanding (Ve´lez Ortiz, Sosulski & Sherwood 2012). The synthesis of quantitative and qualitative research, as found in mixed methods research, was an explicit strategy for knowledge production in response to the false polarisation (Kingdon 2004) amidst the theoretical void of the two constituents of the method, and to halt tensions between deductive and inductive approaches (Ve´lez Ortiz, Sosulski & Sherwood 2012).

Mixed methods research undoubtedly developed since its early stages, now enjoys widespread recognition. Much theoretical and empirical use of mixed methods research now influences the fields of information building in education, health, and evaluation (Bergman 2011).

Mixed methods research is now endorsed, not merely as a methodology, but as a research paradigm (Sommer Harrits 2011), sitting alongside quantitative and qualitative paradigms (Burke Johnson, Onwuegbuzie & Turner 2007). The value of combining qualitative and quantitative approaches is an overall tactic for knowledge generation, the combination of which is at all stages of the research process: design, data collection, and data analysis. Merging the two approaches is not limited to the methodic tasks and strategies, as the moniker *mixed methods research* implies (Burke Johnson, Onwuegbuzie & Turner 2007). The term *method within the name mixed methods research holds* various significances. *Methods* refers to the methods of data collection (such as an interview), as well as the

methods of research (such as ethnography), and at the same time research philosophy (such as the epistemology underpinning a study) (Greene 2006).

Mixed methods research commonly denotes the mixing of quantitative and qualitative research methods in a study. The stage within the research cycle mixing takes place is important as mixing can occur at any stage and in different ways (Burke Johnson, Onwuegbuzie & Turner 2007) and is dependent on the intentions of combining the two methods (Rossman & Wilson 1985).

Firstly, combining methods is useful for confirmation and corroboration of each approach through a process called triangulation. This is when two or more methods are combined in a study in order to check the results of one and the same subject to improve the accuracy of the data. This validates data sourced from two methods as a cross verification and estimation of the integrity of the research (Collins, Onwuegbuzie & Sutton 2006). Mixed methods research can be used as a tactic to avoid biases intrinsic to single-method approaches, so as to compensate for specific strengths and weaknesses within particular methods (Denscombe 2008). Demonstrated variances are more likely to be the result of the examined phenomenon and not due to the method (Rossman & Wilson 1985).

Secondly, the application of qualitative and quantitative methods can provide richer data and comprehensive examination of phenomenon, thus engendering a more complete picture by combining information from complementary kinds of data or sources (Denscombe 2008). Greene, Caracelli and Graham (1989) refer to this as aiming for complementarity, the elaboration and clarification of results from each method. Thirdly, mixed methods research can initiate new ways of thinking by exploring the paradoxes or contradictions that emerge from the two data sources (Rossman & Wilson 1985) initiating a reframing of the research question (Greene, Caracelli & Graham 1989).

Greene, Caracelli and Graham (1989) provide two further objectives for using mixed methods research, for *development* and *expansion* of results. The former refers to the application of results from one method to help inform the other method as a way of developing the analysis and building on initial findings using contrasting kinds of data or methods. The latter signifies the expansion of breadth, scope and range of inquiry by using different methods for different inquiry components (Greene, Caracelli & Graham 1989), for example using it as an aid in sampling with surveys being used to screen potential participants for inclusion in an interview phase (Denscombe 2008).

It is valuable to consider these objectives within the context of the study's aim with the intention of thinking through which research methods, in which order, can be used to most complement the elected objective along with the research aim. Research of complex social phenomenon, such as workforce issues, can benefit from a mixed methods approach. It helps to facilitate thickness and richness of data, enhance the interpretation and applicability of findings (Collins, Onwuegbuzie & Sutton 2006).

Nomenclature for classification of design structure of mixed methods research has arisen in methodological literature (Bergman 2011) to indicate the sequencing and priority that is given to the quantitative (QUAN) and qualitative (QUAL) elements of data collection and analysis. The terminology employing abbreviations is used to locate the point the study sits on a conceptual qualitative ↔ quantitative continuum to provide an explicit account of the manner in which the QUAN and QUAL aspects of the research relate to each other. The central point of the continuum is where equal prominence of both qualitative and quantitative research occurs within the same study. Research that is qualitative dominant is symbolised as QUAL + quan, the dominant approach given heightened emphasis as indicated by the use of capital letters (Denscombe 2008). At the other extremity, whereby quantitative research prevails, is symbolised as QUAN + qual (Burke Johnson, Onwuegbuzie & Turner 2007).

Notwithstanding the myriad of ideas championing the use of mixed methods research:

> *"for answering complex questions… it can take many forms…* [it] *takes time, expertise, and resources, however, and is not appropriate for every question"* (Sosulski & Lawrence 2008, p. 143).

Mixed methods research has its equal share of opponents insisting research must derive from either quantitative or a qualitative dominance and true synthesis and fusion of approaches is out of reach (Morse 2003; Ve´lez Ortiz, Sosulski & Sherwood 2012). In addition, the growing popularity of mixed methods research has led to the pluralistic development in how researchers execute and describe it (Sommer Harrits 2011). Variations of established terminology can lead to ambiguity and confusion (Bergman 2011).

Any alleged erroneousness of utilising a research methodology grounded in two interpretive frameworks, as occurs in a mixed methodology, is misleading. The philosophy underpinning mixed methodology rejects the unproductive dichotomies of qualitative versus quantitative (Greene & Caracelli 2003). The decontextualized generality of

methodological disagreements is incongruent with research approaches that concentrate on the particular, the concrete and the lowermost levels of abstraction (Moghaddam, Walker & Harré 2003). McLafferty and Onwuegbuzie (2006) accept the coexistence of quantitative and qualitative approaches and provide a *dimensional framework* as philosophical foundation for mixed methods research. Hereby the two approaches are no longer dichotomous and contradicting, but differing in various dimensions.

Mixed methods is a legitimate research choice, if within the dimensions of a study, the methodology is suitable for responding to the *what?* of the research question, the *why?* of the purpose of undertaking it, the *how?* or its process, and the potential *results?* (McLafferty & Onwuegbuzie 2006). Good mixed methods research must include an epistemology and ontology, a research question and theoretical framework, sampling strategies, and interpretations that are conducive to both qualitative and quantitative methods (Bergman 2011). Moreover, to dispel a lack of clarity clear specification of terminology, design, methods and purposes is vital (González Castro et al. 2010). Furthermore, the exponential use of mixed methods research in the health sciences (O'Cathain, Murphy & Nicholl 2007) indicates that many researchers have found practical value in the blending of both the research techniques and philosophical bases of knowledge generation. The incompatibility thesis asserting incommensurability of qualitative and quantitative approaches is unwarranted (Greene 2006; Greene & Caracelli 2003).

A judicial application of using the methodology is important. Inherent credibility, trustworthiness or validity of research depends upon its objectives along with the plausible application of data collection and analysis methods, not solely the data collection and analysis techniques themselves (Bergman 2011). The limitations of any theoretical approach regardless of the number of sources used and analyses employed, is that it cannot wholly resolve any question (Bergman 2011).

Nonetheless, questions in the field of the human sciences are multi-faceted with the phenomena of interest frequently highly complex. Researchers engaged with the human sciences are:

> *"often not only interested in what has happened (causal effects) but also in how or why it has happened (causal mechanisms)"* (Tashakkori & Teddlie 2010, p. 274).

The complexity of midwifery phenomena is one justification for using mixed methods research. For my study, one rationale is that it allows for an examination of multiple queries relating to workforce decisions, the drivers and influences of these decisions and workforce choices that may not be readily be fulfilled by either a qualitative or quantitative approach alone (Tashakkori & Teddlie 2010). A mixed methods approach was employed because I was concerned with both what is happening and how or why it is happening (Ve´lez Ortiz, Sosulski & Sherwood 2012).

3.4 Epistemological viewpoint

Research designs and analytical strategies must be appropriate to the questions at both a technical and philosophical level. The epistemological viewpoint of the researcher requires transparency giving context to the research and unveiling any theoretical lens. A viewpoint will influence how questions are conceptualised, how research is designed, implemented and translated into a thesis, all of which are contingent upon epistemology and modes of knowledge. The philosophy underpinning mixed methods research is pragmatism (Denscombe 2008).

As a brief synopsis, this section locates the methodology of mixed methods research within a philosophical discourse. It is not intended to be exhaustive philosophical commentary, rather, a reference to the foundations of the methodology used to validate the employment of the methodology.

An American philosophical tradition, pragmatism, broadly maintains the determination of the efficacy of methods generating truth and value is in the practical application of the knowledge generated (Honderich 2005). This theory of meaning and inquiry seeks a practical end to knowledge creation rather than it merely being a theoretic affair. Value and meaning of concepts lie in their practical application and the real life consequences of holding the concept to be true. The outcome of fusing the pragmatic tradition with experimental practice was that pragmatism became a strategy for selecting methods of inquiry.

The consummate method to be utilised in a pragmatic approach is that method which begets the outcome most effectively in practice. Methods of research are appropriate if they hold the most potential to accomplish the task and respond to its objectives

(Honderich 2005), thus advocating a practical starting point, rather than a theoretical foundation. Pragmatic research utilises what works, employing diverse approaches (Morgan 2007). Motivations lie in the real-world impetus for knowledge generation and practical requirements are key to the pragmatic mixed methods researcher (Maxcy 2003). The researcher uses the most appropriate tools that best work for the specific line of inquiry. For mixed methods research, the validity of the utilisation of both qualitative and quantitative practices is contingent upon the compatibility of the design to the question (Newman et al. 2003). The pragmatism characteristic of mixed methods research has parallels with everyday human problem solving as everyday problem solvers largely use multiple approaches concomitantly or in close succession to examine various sources of evidence in decision making (Tashakkori & Teddlie 2010). However, any association of the word pragmatism with expedient common-sense gives an impression of a certain absence of principles motivating a course of action. This is not the philosophical denotation of pragmatism and this meaning is not associated with mixed methods research (Denscombe 2008).

Research methods are not independent of the cultural context it dwells within, rather they are closely interlinked with cultural practices. Research methodologies are in themselves cultural practices which reflect the bias of a given cultural context and cultural assumptions operate within research (Moghaddam, Walker & Harré 2003).

The philosophy underpinning much of midwifery research is woman-centred care:

> *"Focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or professions…* [This type of care] *recognises the woman's right to self-determination in terms of choice, control and continuity of care"* (The Nursing and Midwifery Board of Australia 2006, p. 3).

Within this care framework, a woman has an integral voice bequeathing her agency. In this vein, the new graduate midwife also has agency. The aim of using a mixed methods approach in woman-centred research is to employ multiple perspectives of inquiry, to overtly encourage varied ways of thinking and knowing, and to discover any evident or consistent patterns within the vast possibilities of human complexity (Greene & Caracelli 2003). Mixed methods research gives emphasis to a humanistic conceptualisation within the research process (Tashakkori & Teddlie 2010). Practice disciplines in the health sciences are especially suitable fields for the use of mixed methods research. Nursing was one of the

first research fields to explicitly make reference to mixed methods research. The prevalence rate for use of mixed methods research design as described by studies in elite nursing journals was shown to be significant with the most common design being sequential (Alise & Teddlie 2010).

The concrete focus of mixed methods research (Moghaddam, Walker & Harré 2003), is valuable for midwifery research because of the complexity required for answering its questions, giving primacy to the importance of the research problem and question, and valuing both objective and subjective knowledge. Utilising mixed methods in an attempt to respond to "the complexities of human activities and the considerable challenges of endeavouring to understand these activities" (Greene & Caracelli 2003, p. 93) can be instrumental in the portrayal and contextualisation of participants' voices.

The confluence of ideas borne from the continuous exchange between research and practice, as found in the convention of evidence-based practice espoused within the midwifery profession (Rogers 2008), is useless if research findings are not translated back into midwifery practice. Within the eminent ranking of objectivist hierarchies of evidence, non-experimental research methodology is subordinated into a position of negligible credibility (Kingdon 2004). The validity of this ranking seems inappropriate for a research aim calling for depiction and understanding (Kingdon 2004) which requires multi-perspective, yet intimate data (Scott & Briggs 2009). A real-world approach to research, oriented to practice, has an underlying research philosophy of pragmatism and the linking of theory and practice, which was therefore ideal for my study.

3.5 Conclusion

Of late, the momentum for the employment of research on the new graduate experience of midwives in Australia is growing. Nevertheless, examination of experiences in the early career period is fairly new. As such this study aimed to generate knowledge and build theory as opposed to testing any known hypothesis. A flexible methodological approach was needed, warranting the use of mixed methods exploration rather than experimental design (Scott & Briggs 2009). Pragmatism granted the foundation for using mixed methods research as an option since it was decided neither quantitative nor qualitative research alone would provide ample findings for the piece of research.

The next chapter follows on from the first component of the study, the design cycle, and now presents the study's methods, those core tasks involved in the collection of data.

Chapter 4: Methods

4.1 Introduction

This chapter articulates the impetus for designing the core tasks of the study and gives a description of them. Methods are specific strategies for conducting research (Tashakkori & Teddlie 2010). A wide gamut of approaches, strategies and resources has been employed by researchers utilising mixed methods research with little consistency in reportage in the literature (Tashakkori & Teddlie 2010). Therefore, the requirement to clearly specify design and methods utilised undertaking this study with rationale given for employing the approach is acute in these instances. Clarity of how and why the methods were mixed is essential.

The manner of presentation of the methods of a study is important for assessing the credibility of a study. Although no definitive criteria for appraising the quality of mixed methods studies exists, judgements about these studies can be guided by a framework, not unlike a checklist, devised specifically for use in research in the field of the health services (O'Cathain, Murphy & Nicholl 2008). Along with the checklist, the authors created a guide, entitled *Good Reporting of A Mixed Methods Study* (*GRAMMS*) (Table 5), to act as a prompt for effectual articulation of the research process (O'Cathain, Murphy & Nicholl 2008).

Table 5 Guidelines for Good Reporting of A Mixed Methods Study (GRAMMS)

Good Reporting of A Mixed Methods Study (GRAMMS)
(1) Describe the justification for using a mixed methods approach to the research question
(2) Describe the design in terms of the purpose, priority and sequence of methods
(3) Describe each method in terms of sampling, data collection and analysis
(4) Describe where integration has occurred, how it has occurred and who has participated in it
(5) Describe any limitation of one method associated with the present of the other method
(6) Describe any insights gained from mixing or integrating methods

(O'Cathain, Murphy & Nicholl 2008, p. 97)

The *GRAMMS* checklist was referred to in my study, as a framework to guide research development and progression. It was used also in the authoring of this thesis, for the purposes of transparency of the methods and processes within the research.

Chapter 3 attended to the first *Item* in the *GRAMMS* framework by justifying the use of a mixed methods approach to the research question. *GRAMMS Item 2* will be addressed, by disclosing the specific strategies utilised whilst conducting the study, as well as the research purpose and sequence of methods. *GRAMMS Item 3* is then concentrated upon, as each method is discussed in terms of sampling information, recruitment processes, participant information, and research instrument design and data collection. *GRAMMS Items 4* four through to *6* concentrate upon what happens to the data once collected, and thus are attended to in later Chapters.

Firstly, in Chapter 4, the research question will be presented in memorandum.

4.2 Research question

The research question, as indicated in Chapter 1, was:

> *What is the early workforce experiences of midwives who graduated from two different education courses in Australia?*

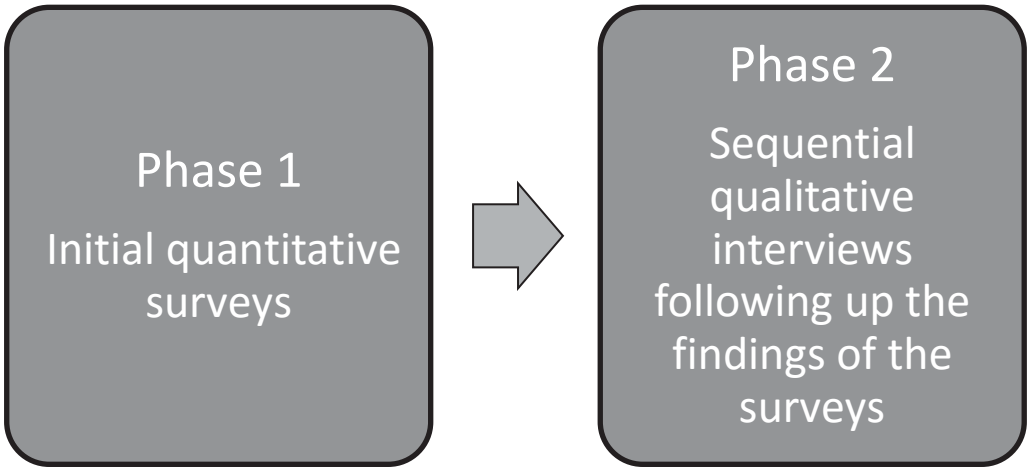
Broadly speaking, the study used descriptive methods for gathering and organising the data in an order which allowed for the depiction of events and the exposition of emergent patterns within the chosen sample, with the purpose of responding to the research question.

4.3 Methods design

The research project was a two-phased, mixed methods research survey study of a specific sample of Australian midwives consisting of the collection and analysis of both quantitative (primarily numerical information) and qualitative data (textual information). The study design was fixed, the methods being predetermined prior to its commencement, as there was a specific intention to mix quantitative with qualitative approaches at the start of the study.

A sequential explanatory design was utilised (QUAN+QUAL), entailing collecting and analysing first the baseline information from quantitative data (Phase 1) followed by qualitative data (Phase 2) in two consecutive phases within one study (Creswell et al. 2003). This allowed for further explanation of the quantitative analysis through the qualitative follow up. Consequently, the overall aim of the study was explanatory. The methods used are depicted in Figure 3.

Figure 3 Sequential explanatory design of this study



The qualitative data assisted with the interpretation, clarification, description, and validation of the quantitative results. Additionally, the first phase informed the latter phase for sampling purposes. In the analysis stage, an integrated data analysis approach was adopted as inferences were based upon analysis of both data sets (Tashakkori & Teddlie 2003).

4.4 Recruitment setting

At the time of data collection, participants were midwives graduated within the past 6 to 7 years from an Australian university. The recruitment setting was the university in which the graduates completed their midwifery course. University of Technology, Sydney (UTS) offers two educational pathways to midwifery qualification: postgraduate and undergraduate pathways. Despite the growing numbers of midwives graduating from undergraduate

midwifery courses, the most common route to qualification in Australia at the time of the initial recruitment to the cohort (2007-2008) was a postgraduate Diploma of Midwifery. This is commonly a 12 to 18 month course, which follows on from completion of an undergraduate nursing degree. The other pathway to midwifery qualification at UTS is the undergraduate three-year direct entry Bachelor of Midwifery degree. The university was chosen for recruitment due to the participation of the midwifery graduates as students in a previous MidTREC study (Hammond et al. 2011).

As UTS offers midwifery education paralleling that of a number of other Australian universities, the findings may be presumed to be credible within the Australian midwifery context. Claims of total generalisation however, will not be postulated. Although sampling was homogenous apropos the sampling site, heterogeneity was conveyed by inclusion of participants from two midwifery education streams. The prospect that participants were working in varying hospitals, models of care across Australia also introduced sample variance. It was also assumed that some participants were employed external to the midwifery profession, thus capable of providing specific workforce data.

4.5 Sampling

A particular population was needed to be accessed in this study therefore, sampling used non-random purposive techniques. This is defined here as selecting units, herein the institution, groups of individuals, and individuals, based on specific objectives associated with responding to the research questions (Teddlie & Yu 2007). In this study, a particular institution (university providing midwifery education), persons (midwifery graduates), and events (early career period) were deliberately chosen for sampling purposes.

As will be explained shortly, this study re-recruited participants already part of the MidTREC study in the years 2007 and 2008, as students in the final week of their course (Hammond et al. 2011), sampling strategies were not particular to this research, as the methods for recruitment were already set in place. Therefore, estimating a reasonable sample size for inclusion in the study was unwarranted as the participants had been already recruited. Sampling methods were one of convenience and adherence to a pre-existing project. However, this research would not have been conducted if there was poor decision making previously undertaken. Hammond et al.'s (2011) project sampled participants purposively to access information from those who possessed knowledge of the research

topic. Sampling techniques had aimed to achieve representativeness and comparability through the strategy of typical case sampling. Representativeness was addressed within the purposive sample by choosing a group typical or representative of a broader group of cases as closely as possible (Teddlie & Yu 2007). Sampling aimed to achieve comparability across different types of cases on the phenomenon of newly graduated midwives.

Hammond et al.'s (2011) participants were registered for inclusion in future data collection within the MidTREC project by consenting to remain on a UTS MidTREC database. The number of potential participants on the database for the 2007 graduating year was 42 Graduate Diploma midwives and 19 Bachelor of Midwifery midwives (*n* = 61) and 32 Graduate Diploma midwives and 20 Bachelor of Midwifery midwives in the 2008 graduating year (*n* = 52). This made a total of 113 potential participants. The sample size was slightly diminished due to database errors and the geographical mobility of participants, both in terms of place of address and employment site. A great deal of time and effort was exercised in tracking as many participants as possible.

The Phase 2 qualitative data aimed to build upon on data from quantitative Phase 1 in the same sample. Therefore, recruitment for Phase 2 had to occur within Phase 1 data collection. As a sequential explanatory design, the two phases were connected during selection of participants for the qualitative interview analysis based on quantitative results from the first phase (Creswell 2003). Particular cases were selected from the sample obtained in the quantitative phase. Recruitment to participate in Phase 2 interview data collection occurred by purposive non-random sampling.

4.6 Participants

The purposive group of participants were a cross-sectional sample of midwives, graduated and recruited in the 2007-2008 period. Inclusion criteria were derived from having been recruited for the UTS new midwifery graduate MidTREC study (Hammond et al. 2011). All students eligible to register as midwives on graduation were invited to participate. Recruitment occurred prior to course completion, in the final week of the course. The prior MiDTREC study had a recruitment rate of 99 percent of the potential population (Hammond et al. 2011). Data for my study were collected in 2013 and 2014, at either five to six years (graduation in 2008) or six or seven years (graduation in 2007) post graduation (Table 6).

The time period of five to seven years post graduation was chosen for a few reasons. The duration post graduation was a feasible interval to allow for a range of career trajectories such as relocation to another site of midwifery practice, career progression within the midwifery profession, return to nursing practice or changeover to a different profession altogether. Therefore inclusion criteria include participants who were or were not currently working as midwives.

Table 6 Year of graduation and time point of data collection

Graduating year	*Time point of recruitment to UTS MidTREC study (prior to course completion: pre-graduation)*	*Time post graduating at data collection (2013/14)*
2007	2007	6-7 years
2008	2008	5-6 years

Participants were chosen as being representative of midwives and newly graduated from an Australian university. The study consisted of 2 groups of midwives. Participant heterogeneity was present in the sample as education pathway to midwifery qualification varied amongst the participants.

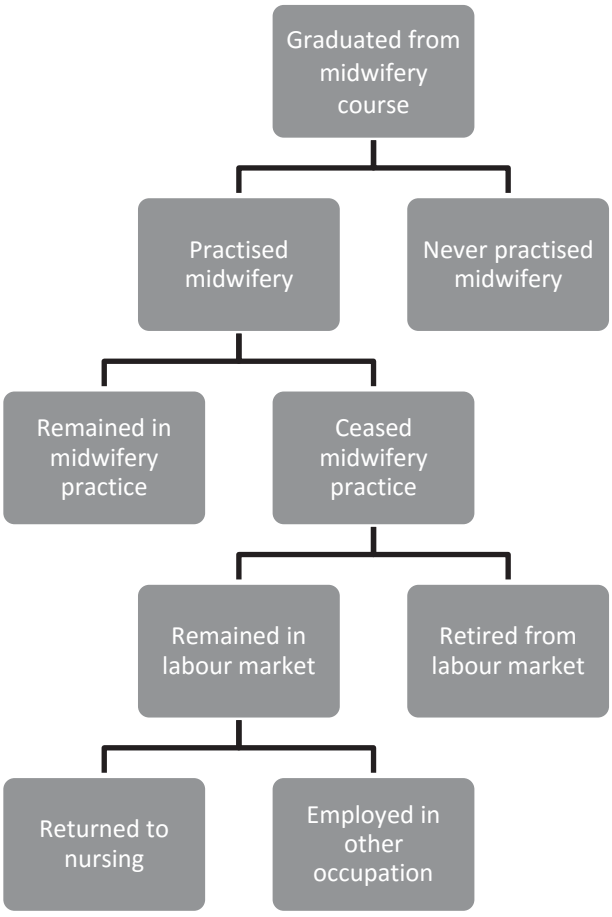
The first participatory group had graduated from a 12 month post-graduate Diploma of Midwifery and held the dual registration of nursing and midwifery. The timeframe of acquisition of nursing qualifications was variable. Participants could have been newly graduated and registered nurses, having undertaken midwifery education directly following nursing graduation so that they entered the nursing workforce for the first time as midwifery students. Another possibility for this participatory group was they were not new to the nursing profession and time had passed between their nursing and midwifery graduations. This kind of participant had previous employment in the nursing workforce. Participants in the latter group may have undertaken nursing studies at UTS, at another Australian or international university.

The second participatory group were graduated via the three year undergraduate degree of Bachelor of Midwifery program at UTS. This group were midwives and midwives only, although a few were enrolled nurses in the past. As the Bachelor of Midwifery is a recent program of study in Australia, the vast majority of midwives in Australia possess both nursing and midwifery qualifications. However, in order to be representational of the

current Australian workforce, it was crucial that both cohorts be included. Furthermore, it provided potential comparison for differential data analysis.

Participants were distributed amongst four midwifery workforce participation trends as shown in Figure 4.

Figure 4 Potential midwifery workforce participation trends



Distribution across trends was not anticipated to be even. Phase 1 quantitative data measured rates of these anticipated midwifery workforce trends. Particular cases were then drawn from the different trends for qualitative description for provision of an explanation of the observed midwifery workforce trends and patterns.

4.7 Phase 1

Phase 1 of the study was a survey of the participants. As part of mixed methods research, surveys are extensively used in health and workforce research (Alise & Teddlie 2010),

examples of which were detailed in the Chapter 2. This method allows for administration to an entire sample and focus on specific issues and questions. They enable the researcher to obtain data about practices, situations or views, at one point in time, and to analyse the data using quantitative analytical techniques.

The survey allowed for exploration of Objective 1 (track workforce participation trends such as retention, turnover, workforce experiences and career choices), and Objective 4 (identify and compare workforce participation trends by program (single degree undergraduate vs. postgraduate).

4.7.1 Data collection instrument for Phase 1: Survey

A survey was used to collect data (Appendix 3). The survey examined workforce participation experiences, corresponding with the research objectives. Various factors needed to be addressed when designing the survey. A preliminary issue was the selection of data collection instruments. Principal to this decision was prior clarification of well-defined concepts in connection to the phenomenon. This signposted the variables needing to be explored and directed to which units of measurement should be employed.

Ultimately the survey contained 79 questions divided into seven sections, which were:

1. Demographic information (22 questions);
2. Workforce information from participants not currently working in the capacity of a midwife (14 questions);
3. Workforce information from participants currently working in the capacity of a midwife (19 questions);
4. Burnout data collection instrument (1 instrument: 23 statements);
5. Practice environment data collection instrument (1 instrument: 31 statements);
6. Midwifery empowerment data collection instrument (1 instrument: 23 statements); and
7. Future employment plans (21 questions).

The survey development process will be discussed shortly.

The data collected in the survey were mainly quantitative. A few questions that could be responded to in an open-ended nature provided some qualitative data. The research objectives necessitated the collection of demographic and workforce data, essential for encapsulating individual participant variables. These included: demographics such as age,

gender, current place of residence (state or territory, metropolitan, regional, rural), marital status, number/s and age/s of children, educational level of self, perceptions of midwifery preparation, duration of career and midwifery experience, employment status , current level of appointment, shifts worked, hours worked per week, reasons for extra hours if undertaken, absences from work, model of current maternity position, place of work, health sector (Lennox, Jutel & Foureur 2012). Information provided variables to classify participants into the midwifery workforce participation trends. The section seeking information regarding the participants' future plans is derivative from previous Australian midwifery workforce research (Sullivan, Lock & Homer 2011), itself derivative from the '*Why Midwives Leave?*' UK research (Curtis, Ball & Kirkham 2006c).

Another section of the survey focused on the variables identified through the literature review to be instrumental in the experiences of midwives in the midwifery workforce. These were concepts, which will be soon presented, which contributed to experiences of nursing and midwifery workforce retention and turnover, along with experiences of workforce participation in these professions.

It was important to establish whether these concepts, having been persistently identified in existing research literature, contributed to workforce experiences of midwives. The selection of survey instruments allowed for measurement of these factors, including both measures of internal factors, such as individual participant traits, and also external factors, for example employment context and characteristics.

4.7.2 Instruments sourced from literature review

Many workforce studies have been undertaken using quantitative closed-ended self-report scales and the numbers of these instruments developed for assessing parameters of health workplaces are plentiful. Accordingly, careful analysis was required for appropriate selection (Skinner, Madison & Humphries 2012). The challenge was for clarity regarding relevant constructs. Three instruments were selected for my study for Phase 1 data collection (Table 7).

Table 7 Selected instrument and authorised abbreviation

Data collection instrument	Abbreviation	Reference
Maslach Burnout Inventory	MBI	(Maslach, Jackson & Leiter 1996)
Practice Environment Scale of the Nursing Work Index	PES-NWI	(Lake 2002)
Perceptions of Empowerment in Midwifery Scale	PEMS	(Matthews, Scott & Gallagher 2009a)

(Lake 2002; Maslach & Jackson 1981; Matthews, Scott & Gallagher 2009a)

Table 8 highlights tool selection in relation to the concepts sourced from literature review analysis. It also shows the PEMS and PES-NWI traversing more than one concept, thus allowing examination of the concepts from various viewpoints.

Table 8 Instruments selected for measurement of concepts contributing to workforce experiences as sourced from literature review analysis

Concept	Conceptual elements	Instrument selected
Burnout	Occupational stress Occupational burnout Disillusionment Reality shock Excessive workload Increased complexity of patient care Decreased length of hospital stay Organisational financial constraints Bullying Personnel shortages	MBI
Satisfaction	Occupational empowerment Motivation Vocational drive Job satisfaction Role satisfaction Organisational commitment Self-esteem in role Sense of being valued Allied health support Appreciation of contribution Variety/flexibility of work Organisational loyalty and commitment	PES-NWI
Readiness to practice	Fitness to practice Confidence to practice Clinical mentoring Workforce participation support Transitional program	PEMS
Leadership	Supervisor support Clinical leadership	PEMS PES-NWI
Work environment	Work group cohesion Work group support Staff morale Adequate resources Location of practice Working conditions	PES-NWI

Table 8 cont… Instruments selected for measurement of concepts contributing to workforce experiences as sourced from literature review analysis

Concept	Conceptual elements	Instrument selected
Personal professional progression	Autonomy of practice Professional development support Promotional capacity Challenged by role Career development	PEMS PES-NWI
Work and life balance	Working hours Workload Rostering and schedules Pay and remuneration	MBI
Woman centredness	Woman centred care Continuity of care Models of care Relationship with women Fidelity to the perceived role of midwifery	PEMS

Table 9 gives a brief description of the three instruments.

Table 9 Instrument description

Concept	Instrument	Explanation of instrument / data
Midwifery workforce	Perceptions of Empowerment in Midwifery Scale (PEMS)	Designed to measure conditions that facilitate empowerment in midwifery and perceptions of practice and practice environments. It contains three subscales: autonomous midwifery practice, effective management and woman centred practice. Validity and reliability has been established (Matthews, Scott & Gallagher 2009a).
	Practice Environment Scale of the Nursing Work Index (PES-NWI)	Developed from the Nursing Work Index and includes five subscales: leadership and support from managers, participation in hospital affairs, midwife-doctor relationships, the foundations for quality care, and staffing and resources. The PES-NWI has been used widely in nursing. Validity and reliability has been established (Lake 2002)
	Maslach Burnout Inventory (MBI)	Designed to measure the perception of burnout in the health services professions, and includes three subscales: emotional exhaustion, depersonalisation and reduced personal accomplishment. The MBI has been used widely in nursing with good validity and reliability (Maslach, Jackson & Leiter 1996).

Detailed information regarding each of these three data collection instruments will now be provided. This includes discussion on the application of the instruments and their relationship with each other.

4.7.3 Maslach Burnout Inventory (MBI)

Burnout as a concept has generated long-standing interest in scientific research. Many decades have elapsed since the inception of a thesis of burnout by Maslach and Jackson (1981). Burnout has been primarily observed within occupations that involve communication and direct service with others (Ahola & Hakanen 2007; Maslach 1982; Panagopoulou, Montgomery & Benos 2006; Papathanasiou 2007; Rupert & Kent 2007; Vahey et al. 2004). As a professional group, health care workers are affected by burnout (Alimoglu & Dönmez 2005; Mollao˜glu, Fertelli & Tuncay 2005; Wu et al. 2007). The primary reference to the terminology burnout was by Freudenberger (1974), when as a practising psychiatrist he observed emotional and physical symptoms of exhaustion in the context of his workplace, thus experiencing feelings of failure, despondency, and a sense of being worn out. This led to his dissemination in research literature the concept of burnout (Freudenburger 1974). Burnout arises when prolonged stress leads to a loss of energy and exhaustion (Jordan et al. 2013).

Following this, Maslach, a social psychology researcher interested in emotions elicited in the workplace, investigated cognitive strategies as coping methods to meet emotional demands in the health professions (Maslach & Jackson 1981; Maslach, Schaufeli & Leiter 2001). Fieldwork conducted by Maslach and Jackson, revealed that health professionals used strategies such as detached concern and dehumanisation in their working role to cope. Burnout was triggered within the specific emotional and demanding relationship between the human service provider and the recipient (Maslach & Jackson 1981), as occurs between healthcare professional and patient.

Burnout has been conceived as a psychological process occurring when human service professionals, enthusiastic at the outset, come to be overwhelmed with the unanticipated stress of the job preventing efforts of positive service for others. Maslach and Jackson defined burnout as:

> *"A psychological syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity. Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources. Depersonalisation refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service or care. Reduced*

personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work" (cited in Schaufeli, Enzmann & Girault 1993, pp. 20-1).

An abundance of inquiry into burnout has created many, varied definitions, an absence of a distinct operational definition and compromised terminology (Anagnostopoulos & Papadatou 1992; Waugh & Judd 2003). Table 10 portrays the many suggested effects burnout can have upon an individual.

Table 10 Signs and symptoms of burnout

Physical	Psychological	Work behaviour
• Fatigue • Sleep disturbances • Difficulty sleeping • Difficulty getting up • Stomach ailments • Tension headaches • Migraine headaches • Gastrointestinal problems • Frequent colds • Lingering colds • Frequent bouts of flu • Backaches • Nausea • Muscle tension • Shortness of breath • Malaise • Frequent injuries • Weight loss • Weight gain • Stooped shoulders • Weakness • Change of eating habit	• Anger • Frustration • Depression • Boredom • Discouragement • Disillusionment • Despair • Apathy • Guilt • Anxiety • Suspicion • Paranoia • Helplessness • Hopelessness • Pessimism • Immobility • Resentment • Moodiness • Attitudes: • Cynicism • Indifference • Resignation • Self-doubt • Loss of empathy • Difficulty concentrating • Difficulty attending • Low morale • Decreased sense of self-worth	• Dehumanisation of patients • Victimisation of patients • Fault finding • Blaming other • Defensiveness • Impersonal, stereotyped communication with patients • Applying derogatory labels to patients • Physical distancing from patients and others • Withdrawal • Isolation • Stereotyping patients • Postponing patient contact • Going by the book • Clock watching • Living for breaks • Absenteeism • Making little mistakes • Unnecessary risk taking • Use of drugs and alcohol • Marital and family conflict • Conflict with co-workers • Decreased job efficiency • Over or under commitment

Source: (Pines & Aronson 1988)

Such a wide-ranging array of somatic and psychological manifestations rendered the need for measurement and diagnosis and definitional clarity. Development of a standardised survey to assess burnout was essential to enable consistency of measurement of the phenomenon (Halbesleben & Buckley 2004). Following on from Maslach and Jackson's (1981) working definition, was their development of the Maslach Burnout Inventory (MBI). The MBI incorporates three surveys: Human Services Survey, General Survey (MBI-GS), and Educators Survey (MBI-ES). My study uses the Human Services Survey (MBI-HSS) developed for use with people working in the human services and health care (Maslach, Schaufeli & Leiter 2001). In this thesis, it will be referred to as the MBI.

The MBI consists of three subscales which are used as an operational theoretical framework reflective of the original conceptualisation of burnout, these are:

(i) **Emotional exhaustion** (9-items) measures feelings of being emotionally overextended and exhausted by one's work (for example: I feel like I am at the end of my rope); and

(ii) **Depersonalisation** (5-items) measures an unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction (for example: I don't really care what happens to some recipients); and

(iii) **Reduced personal accomplishment** (8-items) measures the lack of feelings of competence and successful achievement in one's work (for example: I deal very effectively with the problems of my recipients).

Although measures for assessing burnout have been developed by other researchers (Kristensena et al. 2005; Pines & Aronson 1988), the MBI is regarded as the 'gold standard' (Schutte et al. 2000) having been established over many decades of use. The MBI comprises three subscales measuring constructs of emotional exhaustion, depersonalisation, and reduced personal accomplishment. Translation into several languages and citation by more than 500 studies in the international domain across the northern and southern hemispheres have fashioned the most widely utilised burnout measure (Galanakis et al. 2009; Schutte et al. 2000). It has been used among nurses, doctors, medical assistants, clinical officers, enrolled nurses, psychologists, teachers, police forces and law enforcement. Evidence supports it as a useful instrument across a wide-array of languages, countries, and occupations (Hwang, Scherer & Ainina 2003). Pertinent to this study, the MBI has been previously used in both national and international nursing and midwifery

research (Alparslan & Doga 2009; Fenwick et al. 2012; Galanakis et al. 2009; Mollart et al. 2013; Thorson, Tharp & Meguid 2011).

Psychometric testing of the properties in the MBI was conducted by Maslach and Jackson (1981), establishing measures of validity, reliability, convergent validity, and discriminant validity. The detailed analyses of instrument performance showed that the MBI had good psychometric properties (Maslach & Jackson 1981; Poghosyan, Aiken & Sloane 2009). Reliability coefficients for the MBI were calculated in samples of nurses, teachers, social workers, probation officers, counsellors, mental health workers, and agency administrators (n = 420) (Maslach & Jackson 1981). Internal consistency was estimated by Cronbach alpha score (α) (Nunnally 1978), which yielded reliability coefficients for the MBI and its three subscales (discussed in Chapter 5) as being all above the preferred minimum level for reliability of 0.7 (Maslach & Jackson 1981). Data on test-retest reliability were obtained from a graduate student sample (n = 53). Test sessions were separated by a two to four week interval. Test-retest reliability coefficients for the subscales were in the main above 0.7 (Maslach & Jackson 1981). Convergent validity was examined by three sets of correlations which provided substantial evidence for the validity of the MBI (Maslach & Jackson 1981). Further evidence of the MBI instrument's credibility was obtained by distinguishing its measures from other psychological constructs presumed to be confounded with burnout. Discriminant validity was evaluated (n = 91) establishing that burnout did not exhibit high correlation with job dissatisfaction, thus suggesting that these two concepts are not the same thing (Maslach & Jackson 1981).

MBI validity and reliability has been substantiated in many studies, in many settings, occupations and cultural contexts. A Greek study examined psychometric properties and factorial structure of the MBI amongst a sample of 536 midwives and obstetricians. Findings exhibited satisfactory reliability coefficients above 0.7 for all three dimensions of the MBI, in congruence with those results from the other investigations (Poghosyan, Aiken & Sloane 2009).

The applicability of MBI use in international nursing research has been established. Confirmatory and exploratory factor analysis revealed (Poghosyan, Aiken & Sloane 2009) factorial structure and internal consistencies of the MBI among large representative samples of nurses from eight English and Non-English speaking countries. The study revealed that the 22-item MBI has a similar factor structure and, with minor adjustments,

performed similarly across countries thus providing evidence as to the utility of the MBI in international burnout research (Poghosyan, Aiken & Sloane 2009).

4.7.4 Burnout in the health professions

Research into burnout in the health workplace reveals that it disturbs health and decreases work productivity, thus resulting in absenteeism. Burnout has been linked with damaging workplace behaviours, for instance increases in sick leave, job dissatisfaction, early retirement via resignation, workplace accidents, interruptions in the provision of quality of service, low morale, and frequent employee migration. Alcohol abuse, increases in smoking and coffee consumption, familial, social, and economic problems result for the individual (Bakker et al. 2000; Demerouti et al. 2001; Leiter 2005; Leiter et al. 2007; Maslach, Schaufeli & Leiter 2001). These parameters are relevant to explore in my study.

4.7.5 Use of the MBI in midwifery research

It is important to conceptualise and integrate existing burnout literature with midwifery, a stressful profession which has intense and continuous face-to-face relationships with people (Hunter 2005), and explore previous use of the instrument within a midwifery context (Maslach, Schaufeli & Leiter 2001). The direct and intimate relationship is intrinsic to the role of the midwife. Midwives are critical to the health and development of mothers and children, so their wellbeing is paramount for effective provision of healthcare.

Australian midwives face complex and excessive workloads on a day-to-day basis which impinge upon quality of service delivery. Such work environments have the potential to result in substantial workforce burnout, lack of workplace involvement, impaired role performance, negative attitudes engendering a lack of workplace engagement and motivation and a sense of cynicism, work-related stress, illness, absenteeism, and turnover (Aiken et al. 2002a; Dickinson & Wright 2008; Jordan et al. 2013; Leiter & Maslach 2009; Wu et al. 2007). Studies of burnout and associated factors support the existence of stress and burnout in midwifery (Carlisle et al. 1994; Deery 2005; Kirkham & Stapleton 2000; Pallant et al. 2015a; Sandall 1999). Burnout has been linked to personal and work-related factors rather than with the caring relationship with women (Jordan et al. 2013). Caseload midwifery has been associated with lower burnout scores and higher professional

satisfaction (Newton et al. 2014). Younger and less experienced midwives have exhibited higher levels of work-related burnout (Jordan et al. 2013).

Some studies using the MBI have measured the level of burnout in the samples by comparing the mean burnout scores and the MBI test norms from USA data (Maslach & Jackson 1981). In some studies, correlation scores analysing relationships between the three subscales and independent variables were undertaken. For example, a cross-sectional study of 147 Turkish midwives used the MBI to investigate statistical relationships between socio-demographic and professional variables and burnout scores (Alparslan & Doga 2009). Variables were determined by the researchers as those factors which were perceived to contribute to midwifery burnout in Turkey. Personal characteristics, place of employment, work schedule, work hours per week, length of employment, school from which graduated, reasons for working as midwives, willingness for entering the profession, levels of satisfaction with midwifery, and frequency of complaining about midwifery were all measured (Alparslan & Doga 2009). Participants scored moderate levels of burnout. Age, marital status, number of children, work area and work schedule were not found to have an effect on the midwives' burnout. Those participants for whom midwifery was a default occupation, not willingly having chosen it, working for economic reasons, had higher mean scores for levels of emotional burnout and depersonalization and a lower mean score for personal accomplishment ($p < 0.05$). This was also the case for those participants who were not pleased with working in their profession.

Considering the sample and aims of my study, Alparslan and Doga (2009) stated that:

> *"Burnout decreases with age and job experience, for this reason the first years of an employment in a profession have the highest risk for burnout"* (Alparslan & Doga, 2009, p. 24).

As age and number of years of employment increased emotional burnout, depersonalisation and work-related stresses decrease and personal accomplishment and job satisfaction increase (Aslan, Aslan & Kesepara 1997; Maslach, Schaufeli & Leiter 2001; Mollao˜glu, Fertelli & Tuncay 2005; Öncel, Özer & Efe 2007; Patrick & Lavery 2007).

Similarly, one Australian study of 152 midwives working in two public hospital maternity units within NSW revealed midwives who had spent longer in the profession and undertook physical exercise scored low burnout levels (Mollart et al. 2013). This study examined incidences and level of work-related stress and burnout in midwives and demographic

factors that may influence those levels. Despite a low response rate of 37 percent (*n* = 56/152), reported levels of burnout were concerning. The authors suggested that if the sample is affected by burnout the response rate would be low due to the various adverse employment factors which lead to burnout.

Almost two thirds of midwives in Mollart et al.'s (2013) sample scored moderate to high levels of emotional exhaustion, a third high levels of reduced personal accomplishment, and a third scored high levels of depersonalisation, the three constructs related to burnout. Those midwives who had spent longer in the profession and exercised, scored low burnout levels.

Other factors besides duration of employment are thought to impact on burnout. Calling into question the sustainability of caseload midwifery on-call structures of employment was one UK study which investigated those work factors associated with levels of burnout in community-based midwives as compared with hospital midwives (Yoshida & Sandall 2013). Using the MBI for analysis of levels of burnout in 238 midwives (response rate of 54%, *n* = 128), the research showed that participants working in community-based midwifery practice had considerably higher levels of emotional exhaustion and depersonalisation than those who worked in a hospital only. However, community-based midwives had lower levels of reduced personal accomplishment compared to hospital group. Multiple regression analysis correlated lower levels of burnout with higher levels of perceived autonomy, which was more prevalent in the community-based midwives. Supportive strategies from the employer were protective against burnout. As an aside, bullying was also perceived to be more prevalent in the hospital setting (Yoshida & Sandall 2013).

Other evidence is suggestive of occupational autonomy having a relationship with burnout (Tracy & Hartz 2005). As part of a NSW Health quality review of a caseload midwifery practice, the MBI was administered to 15 midwives to explore their psychological wellbeing and the impact of the introduction of caseload midwifery. Unfortunately pre and post testing was not undertaken and no comparison could be made between levels of burnout before and after the implementation of the caseload model. Eight of the 13 caseload midwives had low levels and five had moderate levels of burnout. The authors suggested occupational autonomy, professional support and capacity to develop meaningful relationships with women leads to a strong level of work satisfaction, although the sample size was small (Tracey & Hartz, 2005).

A larger cross-sectional survey of 200 Dutch midwives also revealed that community midwifery seemed to be a protective factor in levels of burnout (Bakker et al. 1996). MBI survey data revealed equal emotional exhaustion levels that were similar to doctors in general practice. However, midwives had lower levels of depersonalisation and reduced personal accomplishment compared with general practitioners. The greater hours worked by a community midwife per week, the higher was the sense of personal accomplishment in comparison with the doctors. Interestingly, no relationship was found between working hours and emotional exhaustion. Yoshida and Sandall (2013) suggested caseload work was ameliorative against burnout and not a cause of it.

Comparison of varied participant groups was also conducted by Thorson, Tharp and Meguid (2011) in their study of 101 healthcare professionals employed by the Department of Obstetrics and Gynaecology and related units in a hospital in Malawi. An adapted version of the MBI revealed moderate and high levels of burnout amongst the participants (response rate 90%). Two third of respondents were enrolled nurses, a fact which may have artificially strengthened association between burnout symptoms and work environment, as respondents' perceptions of diminished competency may exist within that section of the sample (Thorson, Tharp & Meguid 2011). This functions as a cue to analyse findings within the universal context of the study design.

Research undertaken in Slovakia examined sources of occupational stress as measured by the Expanded Nursing Stress Scale (ENSS) and their association with burnout in midwives as measured by the MBI. The 100 respondents reported high levels of depersonalisation, average levels of emotional exhaustion and high levels of reduced personal accomplishment (n = 100; RR = 77%). A relationship was identified between conflict with doctors, supervisors and midwifery colleagues, and work overload with both emotional exhaustion and reduced personal accomplishment.

Finally in brief, a range of nursing research has utilised the MBI for various purposes, often correlating scores from different instruments. Links have been revealed between strategical work conditions augmenting nurse empowerment and new graduates' experiences of workplace bullying, with increased prevalence of burnout, especially the perception of higher levels of emotional exhaustion (Laschinger et al. 2010). Higher levels of burnout are associated with increased reporting of fair or poor quality of care, patient falls, medication errors, and infections (Nantsupawat et al. 2015).

4.7.6 Alterations made to MBI prior to survey administration

The MBI has the potential to be utilised by a wide variety of occupations. To incorporate this diversity, the term *recipient* is used to refer to individuals to whom service and care is provided. In my study, the word was changed to *women I care for* in favour of midwifery specificity and ease of comprehension to the reader.

4.7.7 MBI conclusion

The broad scope encompassing research into the relationship between workload pressures and nurses' and midwifery burnout levels was instrumental in the use of the MBI in my study and has showed burnout to be an important factor to explore. As an instrument it is valid and reliable and straightforward to administer.

4.7.8 Practice Environment Scale of the Nursing Work Index (PES-NWI)

The Practice Environment Scale-Nursing Work Index (PES-NWI) is a survey-based measure of the nursing practice environment generally used for measuring samples of staff registered nurses. A description of the PES-NWI will be provided here.

Work settings impact upon employees. Furthermore, a positive work environment is essential for the retention of nurses. Various studies, particularly in general nursing ward settings, have established elements within healthcare practice environments influence nurse and patient outcomes (Aiken et al. 2008; Rafferty et al. 2007). Associations between a positive work environment, nurse satisfaction and workforce retention have been demonstrated in several studies (Christmas 2008; Cohen, Stuenkel & Nguyen 2009). There is also a relationship between work environment and patient outcomes such as mortality, medication errors, falls, and other critical incidents (Aiken et al. 2008; Aiken, Smith & Lake 1994).

Amidst the severe staff shortages in the North American workforce of the 1980s, research identified environmental factors (Table 11) extant in certain hospitals of good repute due to high quality nursing care and proficient capacity for nursing staff recruitment retention (Lundmark 2008). These hospitals became known as *Magnet* Hospitals in reference to certification given to these hospitals by the *American Nurses' Credentialing Center*, an affiliate of the *American Nurses Association (American Nurses Credentialing Center 2015)*.

Magnet status is an award in which a hospital is found to provide nursing care that delivers excellent patient outcomes. Nurses in Magnet hospitals have high levels of job satisfaction and low rates of nurse turnover. Magnet status also indicates nursing engagement in decision-making processes of patient care delivery. Another element is having committed nursing leaders who are supportive of staff nurses. Strong career development through continuing education and promotion opportunities and effective communication channels between health professionals must be present to be conferred Magnet status. The provision of an adequate and flexible staff with an appropriate skill mix to attain the best patient outcomes and staff work environment is also a factor (American Nurses Credentialing Center 2015).

Table 11 Factors associated with success in attracting and retaining professional nurses in *Magnet* Hospitals

- adequate staffing levels
- flexible scheduling
- strong, supportive, and visible nurse leadership
- recognition for excellence in practice
- recognition of professional nurse autonomy
- participative management with open communication
- decentralisation of decision making to the level of the nursing unit
- good relationships with physicians
- salaried rather than hourly compensation for nurses
- professional development
- career advancement opportunities
- richer nursing skill mix
- reflecting a high priority on quality patient care

(Aiken & Patrician 2000; Lake 2002)

Due to the complexity of health settings, researchers need to measure the environmental factors in practice environments that endorse this professional nursing practice. Fostering nursing practice environments to bring about desired outcomes entails valid and reliable instruments for assessing practice environments (Warshawsky 2011). The Practice Environment Scale of the Nursing Work Index (PES-NWI) is the most widely employed instrument used to measure the state of nursing practice environments with mounting international use of the PES-NWI across multiple organisational and clinical contexts evident (Warshawsky 2011). It allows for assessing the presence of those characteristics which define a positive practice environment (Aiken & Patrician 2000).

The instrument used in this study was the PES-NWI, however, various versions of the Nursing Work Index (NWI) have been used by researchers (Aiken & Patrician 2000). The PES-NWI was developed as a psychometrically rigorous and diminutive version with

empirically derived domains. The PES-NWI proceeded from two former instruments previously conceived in the 1980s and 1990s, being the Nursing Work Index (NWI), developed to measure nursing job satisfaction and perception of quality of care (Aiken et al. 2002b; Aiken & Patrician 2000; Aiken, Smith & Lake 1994), and the Revised Nursing Work Index (NWI-R), originally constructed to describe the professional and organisational nurse work environment (Aiken & Patrician 2000).

Five subscales were identified in the PES-NWI, they are:

(i) **Nurse participation in hospital affairs** (9 items): Referring the opportunities for staff nurses to participate in hospital and nursing committees and hospital policy decisions;
(ii) **Nursing Foundations for Quality of Care** (10 items): Reflected by whether hospitals provide preceptor system, active in-service, and continuing education programs for nurse self-development;
(iii) **Nurse Manager, ability, leadership and support of nurses** (5 items): Referring whether the supervisory staff was supportive of the nurse practice;
(iv) **Staffing and resource adequacy** (4 items): Measuring whether hospitals have enough nursing staff to provide quality patient care; and
(v) **Collegial Nurse-Physician relations** (3 items): Regarding whether there are good working relationships between physicians and nurses.

Subscales (i) and (ii) address the practice environment from a facility-level, with the remaining three being unit/ward specific (Lake 2002). The NWI-PES has displayed good psychometric properties in large samples. All five scales exhibited good psychometric properties, with the construct validity of the scale being supported by statistically significant higher scores being recorded for nurses from hospitals anticipated to have better nurse practice environments (Lake 2002).

Since the seminal work with Magnet hospitals, countless studies have used the NWI-PES indicating the link between positive general nursing work environments and better outcomes for nursing job satisfaction and staff turnover, and patientcare. Nurses satisfied within their employment have been linked to better quality of care and satisfied patients (Aiken et al. 2008; Lake & Friese 2006). Internal consistency of the NWI-PES has been demonstrated as satisfactory with each of the subscales and the instrument as a whole possessing a Cronbach alpha score (α) in excess of 0.7 (Lake & Friese 2006; Nunnally 1978).

4.7.9 Use of PES-NWI in midwifery research

Outside of midwifery, the use of PES-NWI is well supported. The North American *National Quality Forum*, a key organisation which promotes quality healthcare delivery, has endorsed use of the PES-NWI as a patient safety and quality of nursing measure in hospitals and acute practice settings (National Quality Forum 2016). Numerous healthcare organisations and clinical contexts have used the PES-NWI. In their review, Warshawsky and Sullivan Havens (2011) demonstrated a large and efficacious international reach of the PES-NWI, with its use being reported in 27 research studies across a vast array of clinical practice settings with varying sample sizes ranging from 31 to 72,889 nurses (Warshawsky 2011). The majority of the publications reviewed concentrated on associations between PES-NWI scores and nurse outcomes. PES-NWI scores were repeatedly associated with assessments of nurse well-being as measured through a variety of scales: Job enjoyment, satisfaction, dissatisfaction, and burnout (Warshawsky 2011). The review also revealed that the PES-NWI was commonly modified for use in different practice settings, with revision of item wording of organisation-specific occupational role titles and unit/ward names to enhance relevancy to specific practice environments undertaken. Omission of various items also occurred in some studies (Laschinger & Leiter 2006).

Despite the target origin and origin of the PES being in nursing, many concepts underpinning nursing practice environments show relevancy to midwifery work settings. In consequence, a recent study assessed the psychometric properties of the PES-NWI on a large sample of 600 New Zealand midwives and adapted it for use for the midwifery profession (Pallant et al. 2015a). The authors concluded that the PES-WI was a potentially useful tool for assessing the work environment of midwives, however they considered a potential limitation as not including a measure of a sense of autonomy or empowerment, considered one of the leading factors to enhance job satisfaction in midwives. The authors advised using the PES-NWI with the PEMS. The study also aimed to explore the association between scores on the PES subscales and midwives' intention to leave the profession. Results indicated the subscale scores were found to be significantly associated with midwives' indication that they had considered leaving the profession in the past 6 months. The information regarding the correlational statistics was limited as the data was instituted for psychometric testing as opposed to the dissemination of inferential statistics. Hence, these published findings were limited. The authors abridged the PES by removing 11 items

to extricate items perceived as less applicable to the midwifery setting (PES:Midwives), a task my study did not do (Pallant et al. 2015a).

4.7.10 PES-NWI conclusion

Australian research has seen the utilisation of the PES-NWI in various, albeit not generally in maternity, clinical settings (Duffield et al. 2009; Gardner et al. 2009; Middleton et al. 2008). Australian psychometric testing with a large random sample of nurses working in both the public and private sectors established construct validity and reliability with internal consistency with a Cronbach alpha score (α) above 0.7 for the entire instrument as well as each of the five subscales (Nunnally 1978; Parker et al. 2010). The authors (Parker et al. 2010) concluded that the PES-NWI is a reliable survey instrument for a range of clinical settings. Although none of these Australian studies have been conducted for the midwifery practice environment setting, the breadth of scope of endorsement of the PES-NWI indicated that with terminology modifications, the PES-NWI could be suitable for the Australian midwifery setting.

4.7.11 Perceptions of Empowerment in Midwifery Scale (PEMS)

The third instrument used in my study was the PEMS. Inclusion of this instrument was key due to the dearth of existent midwifery-related measures. PEMS is specific for use within midwifery, purposely developed to measure a construct of empowerment, distinct within the profession. The process of tool development was multi-staged via analysis of prior research analysis, survey and focus groups. Data determined a sense of what constituted a midwifery-specific construct of empowerment, namely relationships with women, collegial support and autonomy of practice-based skills (Matthews, Scott & Gallagher 2009b). The development process of the PEMS will be presented here, beginning firstly with definitional discussion of empowerment.

4.7.12 Definitions and concepts of empowerment

Comparable to other substantially scrutinised ideas such as burnout, the concept of empowerment enjoys many lines of print. Typing the word empowerment into a research search engine inundates the reader with copious studies into the phenomenon in varying

international settings. Empowerment is considered both a process and a characteristic, and as a concept it is as elusive as is attractive. Although extensively debated, the concept is complex, multi-faceted, indefinite, and subjective in nature. Conceptual immeasurability is not considered a desirable quality in ideas intended for research and strategy making. The heterogeneity of instruments purporting to measure empowerment in a clinical setting prohibits evaluation of the efficacy of interventions and policies designed to empower patients in healthcare (Barr et al. 2015).

Various approaches exist that aim to clarify the term empowerment for the development of operational definitions. This section draws upon nursing literature to explore definitions and theoretical approaches of the concept of empowerment particular to the healthcare setting. After discussion of the construction of a conception of empowerment, attention will shift to empowerment at the level of healthcare provider and healthcare system, followed by the level of the healthcare recipient.

Health is situated within a social context, bestowing the individual an entitlement to participate in the planning and implementation of their own healthcare. In 1978, the Alma-Ata Declaration of the World Health Organization established social action as an element for public health (World Health Organization and UNICEF 1978). A conception of empowerment for the oppressed evolved, encouraging them to voice influence and control their health through engendering increased power and using the body of knowledge intrinsic to the individual. Empowerment constructs emerged as fundamental to community awareness of health promotion and education (Kuokkanen & Leino-Kilpi 2001; Scott, Matthews & Corbally 2003). The political context, legislation, health priorities and culture influences the individual's experience of empowerment by moderating healthcare delivery (Bravo et al. 2015).

Rodwell (1996) considered empowerment to mean an inter-relation of autonomy, responsibility, accountability, power, choice, advocacy, motivation and authority (Rodwell 1996). Lewis and Urmston (2000) regarded the concept to be better-defined by an absence of qualities, attributing powerlessness, helplessness, alienation, victimisation, subordination, oppression, paternalism, marginalisation, a loss of a sense of control over one's life, and dependency as the antithesis of empowerment (Lewis & Urmston 2000). Definitions which utilise the non-existence of a quality to draw attention to it when manifested as a positive quality, due to difficulty of conceptualisation, are unfeasible if wanting to employ the concept for measurement. It is difficult to make a compelling

argument that one form of practice is more or less empowering than another (Gilbert 1995).

Specific factors and health environments enable the development of an empowered individual or allows for employment of power in an individual (Kuokkanen & Leino-Kilpi 2001) contributing to the health status of the individual, their quality of life and well-being (Bravo et al. 2015). These have been identified as mutual trust and respect, education and support, participation and commitment. The upshot of empowerment is positive self-esteem, an ability to set and reach goals and change processes, a sense of both control over life and hope for the future (Rodwell 1996).

Akin to practice environment research demonstrating the importance of occupational context upon nursing outcomes, empowerment has been conceived in a similar way. In the *organisational* conception of empowerment the nurse environment is crucial for shaping an engaged and productive staff (Van Bogaert et al. 2015). Empowerment in nurses has been defined as:

> *"the ability to get things done, to mobilise resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet"* (Kanter 1977)

In this structural conception of empowerment, ready access to information, open communication practices, support, opportunity and resources, and staff learning and development play a key role in increased productivity and efficacy. Leadership and management strategies are pivotal, with the role performed by nurse managers in championing empowering work environments that bring about shared visions of knowledge transfer and joint decision-making in practice and quality care (Skytt et al. 2015). A relationship exists between organisational empowerment and psychological empowerment, where perceptions of organisational empowerment produce statistically significant changes in job satisfaction and psychological empowerment (Laschinger, Finegan & Shamian 2001a; Laschinger, Finegan & Shamian 2001b).

Nurse environments are considered key within a *psychological* interpretation whereby empowerment is considered within a process of personal growth and development. The context of the practice environment has the potential to lead nurses to experience a sense of role meaningfulness, competence, confidence, self-determination, and impact in their role. Empowered individuals have a sense of perceived capacity of influence over important outcomes within an organisational context. They display congruence with

institutional belief systems and values and can meet the requirements of their job (Spreitzer 1995).

Nursing research, and more recently midwifery, has examined the concept of empowerment within the context of professional development strategies (Fulton 1997; Kuokkanen & Leino-Kilpi 2001). A group of 30 Finnish nurses in a hospital career advancement project perceived an empowered nurse as one to uphold values that intersect with the humanistic moral principles of nursing such as equity, respect for people, and equality. An empowered nurse is professionally skilled and continually stimulating evolution in practice despite challenging environments. Empowered nurses have expanded decision-making capabilities and are supported in mentoring, education, networking, leadership, support, confidence and collaborative skills. Empowered progress within nursing is witnessed when these values are put into action and fulfilled in practice. Compulsory for empowerment to flourish was an environment of autonomy fostering mutual trust and respect (Kuokkanen, Leino-Kilpi & Katajisto 2003).

Other perspectives on the phenomenon were exhibited in focus group research of British nurses (*n* = 16). Empowerment was seen to occur when nurses possess freedom to make decisions, have choices and ensure their voices are heard. Autonomy was inhibited by unequal power relations with medical staff, triggering confidence and self-esteem deficits, restricting nurse freedom and hence empowerment (Fulton 1997). In other research, high workloads are believed to be a barrier in the realisation of enhanced empowerment in the nurse environment (Van Bogaert et al. 2015).

Some studies suggest that the more empowered nurses feel, the more professionally satisfied they will be (Cardoso Teixeira & Barbieri-Figueiredo 2015; Cicolini, Comparcini & Simonetti 2014). Contradictory results for a relationship between the perception of empowerment and age are apparent. Some research shows that younger nurses have been considered as more positive about empowerment than older nurses (Van Bogaert et al. 2015), whilst other research depicts higher levels of empowerment in older nurses (Cardoso Teixeira & Barbieri-Figueiredo 2015). Dutch research has revealed the relationship between structural empowerment and psychological empowerment in health care facilities. Psychological empowerment seems to be a mediator between structural empowerment and innovative behaviour, thus reiterating the need for institutional support of midwifery empowerment and autonomy that stimulate the development of innovative models of care that place the woman central to her care (Knol & van Linge 2009).

The principles of patient and woman-centred care in nursing and midwifery have shrunk the focus of an empowerment framework to that of the viewpoint of an individual, thus dissociating from paternalism towards equitable and collaborative models of healthcare delivery (Bravo et al. 2015). Several indicators of patient empowerment have been identified at the healthcare recipient level (Bravo et al. 2015). Examples of these are self-efficacy and self-determination, self-awareness to influence personal health behaviours, perceived power within the healthcare relationship, feeling respected, sense of coherence and meaning about their health condition, and health literacy (Bravo et al. 2015). These can be moderated by the socio-economic context, personal characteristics, illness-related circumstances, social support and personal values.

Within the healthcare recipient approach to empowerment an appropriation of c*ritical social* theory asserts empowerment as a social phenomenon, the presence or absence of which is situated in the politics of socio- economic and historical structures (Fulton 1997). Critical social theory concentrates upon the healthcare recipient as the foundation for empowerment, mirroring the move towards intensifying consumerism and individualism. As such, the culture of the healthcare institution is progressively moving away from paternalistic principles towards an ethic of empowering healthcare recipients to play an active role in their health status (Barr et al. 2015). The authoritarian concept of power observed in critical social theory also asserts that a deficiency of empowerment in the nursing and midwifery professions is linked to their oppressed status, stemming from gender and class. Empowerment, herein, is analogous to liberation (Gilbert 1995).

The use of the terminology *empowerment* is often bandied around within midwifery literature, often erroneously, used to signify one individual bequeathing another with power. However, the:

> *"concept of empowerment is a core community development principle. One person cannot empower another but an individual can be involved in facilitating situations that enable power to be taken up by another person. By its very nature, power is not given but taken. If we accept this notion, we should avoid talking and writing about midwives 'empowering women' and rather focus on the potential of midwives to facilitate situations where women can feel empowered" (Leap 2009, p. 14)*.

In my study, I conceive that the role of maternity service delivery relating to 'empowerment' of women comes about circuitously. Aside from the resources the woman herself possesses, promoting conditions in which woman can feel empowered arise through the prioritisation of education and skills apposite with competent provision of woman-centred care. The current cultural milieu of maternity service delivery demands an individual midwife with attributes of boldness and fearlessness in order to practise within a framework of woman-centredness due to the institutional pressures placed upon the midwife and woman. To surmount the challenges of a workplace that limits the capacity to work with the needs and requirements of the woman sitting in front of them, midwives must further hone their many-dimensional skills to create the conditions whereby they are competent, confident and courageous enough to undertake their roles and responsibilities. This then positions the midwife and woman within a healthcare context where women can feel empowered, thus linking woman-centred care to the specific practice activities of continued professional development of the midwife (Pope, Graham & Patel 2001).

The PEMS measures traits of perceived midwifery empowerment. Inspection of instrument items indicates that the act of midwifery empowerment is inseparable to being an advocate of the woman (Scott, Matthews & Corbally 2003). The unique tenets of the midwifery profession that place the woman at the centre of her care as well as locate the woman as fundamental to the success of the midwifery role, through role fulfilment and meaningfulness via the centrality of the midwife-woman relationship, demanded the development of a specialty-specific empowerment tool. This is the PEMS, and as such was included in my study.

4.7.13 Development of the PEMS as a measure of midwifery-specific empowerment

The Perception of Empowerment in Midwifery Scale (PEMS) is the first instrument that is specific to midwifery and is based on midwives' views on what constitutes empowerment for them (Matthews, Scott & Gallagher 2009b).

Specificity to a target population is crucial for sound research methodology. Authors of a recently published systematic review which assessed the properties of the available psychometric instruments, which purport to capture conditions of health-related empowerment, reported their awareness of 50 questionnaires available for use in

measuring this construct (Barr et al. 2015). Despite this abundance, the PEMS was justifiably omitted with the focus of the review being patients and the PEMS has a target population of the working midwife (Barr et al. 2015).

One important issue highlighted by Barr et al. (2015) was that the lack of definitional consistency has resulted in the development of large numbers of condition-specific and specialty-specific patient empowerment measures. A number of instruments measuring patient empowerment have been published, for example, in mental health, diabetic healthcare, cancer treatment and clinical genetics. Whether this variety stems from different constructs being important for different conditions or because development was isolated, and lacking a universal theoretical framework of patient empowerment amidst the vast international research community, is unknown (Barr et al. 2015).

Various instruments aim to measure employee empowerment using the frameworks of organisational and psychological empowerment. For the healthcare workforce, the instruments have been developed to measure employee empowerment, such as the Conditions for Work Effectiveness Questionnaires (Laschinger et al. 2001), the Psychological Empowerment Instrument (Knol & van Linge 2009), and the Psychological Empowerment Scale (Akey, Marquis & Ross 2000). Clarity of the construct of measuring is crucial. Research undertaken within an employee empowerment framework sometimes utilise instruments measuring constructs other than empowerment, such as job satisfaction (Wagner et al. 2010).

There is no universally accepted measure of patient empowerment that can be used to evaluate and compare patient empowerment initiatives. Existent measures have been developed independently across different healthcare services, with scale content informed by different theoretical frameworks. Agreement regarding the best way to demonstrate that patients have indeed been empowered is illusory. No single instrument exists that measures the construct of empowerment within a generic population of healthcare professionals. Furthermore, such a goal is neither feasible nor desirable (Barr et al. 2015), a view held by those who developed the PEMS.

The multi-stage development process of the multidimensional representation of empowerment involved analysis of healthcare professional empowerment literature and research, focus groups, survey data, and incorporation of aspects of other tools (Matthews et al. 2006). For example, domains were incorporated from the Conditions for Work

Effectiveness Questionnaire II (Laschinger et al. 2001) which measures information, support, information and resources in the workplace. However, additional areas were included which were of specific interest and importance to midwifery. These were midwifery relationships with women, collegial support and their level of practice-based skills (Matthews et al. 2006).

Like other psychometric scales which undergo various modifications through version development, the PEMS had an antecedent in the Understanding of Empowerment Scale (UES), also developed by the authors of the PEMS. The UES was developed succeeding the publication of a report of a new national health strategy in Ireland which called for the need to strengthen the contribution that nurses and midwives make in the management and provision of services for greater innovative use of existent resources in view of a recent constriction in the Irish health budget (Matthews et al. 2006).

As a response a *Steering Group on the Empowerment of Nurses and Midwives* was established in 2000, identifying key areas of innovation, one being empowerment. Investigating the perceptions and experiences of empowerment in focus group settings of midwives, which revealed that empowerment was not easily expressed (Scott, Matthews & Corbally 2003).

Another important finding from the midwifery data corresponded to Rodman's (1996) conception of empowerment being both a process and an outcome. Participants repeatedly used practice examples to illustrate their understanding of empowerment. A practical and real-world picture of empowerment evolved from the data. Stemming from the focus groups with Irish midwives, the UES was developed. This was later revised with an expanded national survey serving as a process or refinement and validation. Further revision of terminology and abridgement led to the current PEMS (Scott, Matthews & Corbally 2003). Factors perceived by participants of the national survey as contributing to empowerment were professional support and recognition, professional preparedness, role clarity and client advocacy and empowerment (Table 12).

Table 12 Factors relating to the understanding of empowerment

Factor 1: Professional support and recognition
• Having a supportive manager • Being recognised for my contribution to patient care by my manager • Having the back-up of my manager • Being valued by my manager • Having support from colleagues • Having effective communication with management • Being recognised for my contribution to patient care by the medical profession
Factor 2: Professional preparedness
• Having the skills to carry out my role • Being adequately educated to perform my role • Knowing what my scope of practice is • Being accountable for my practice • Being informed about changes in my organisation that will affect my practice
Factor 3: Role clarity
• Delegating non-nursing tasks to auxiliary staff • Performing tasks that were previously performed by doctors and other professionals • Being involved in nurse/midwife-led practice • Having autonomy in my practice • Being recognised as a professional by the medical profession • Having access to resources for staff education and training
Factor 4: Patient/client advocacy and empowerment
• Being an advocate for my patients/clients • Empowering my patients/clients • Having access to resources for patients/client

(Scott, Matthews & Corbally 2003, p. 36)

The selection of the title *Perceptions of Empowerment in Midwifery Scale* was chosen to illuminate that perceptions were being measured and that the instrument was specific to midwifery (Matthews, Scott & Gallagher 2009b). It is a 22 item instrument with the three PEMS subscales comprising of 18 items, with six in each sub-scale, these being:

(i) **Autonomous practice** (6 items): Measure factors relating to being recognised both as a professional and for one's contribution to the care of birthing women. It includes having recognition from fellow professionals and being listened to by other members of the multidisciplinary team, such as medical staff. Adequate access to resources is also contained within this factor, relating the condition of having resources with having control and autonomy;

(ii) **Effective management** (6 items): Includes items that relate to being recognised, supported and valued by midwifery managers. This includes being informed about changes that affect one's practice; and

(iii) **Women-centred[7] care** (6 items): This relates to midwifery perceptions that they empower birthing women, are involved in midwifery-led practices, and are advocates for birthing women. Possessing appropriate skills and collegial support is contained within this subscale as these assist in facilitating this care (Matthews, Scott & Gallagher 2009b).

As a 22 item instrument, four items included in the tool are not structured within the three subscales. Inclusion of the four items for utilisation in separate analysis was deemed appropriate by the developers of the instrument due to the applicability of the four items to the construct of midwifery empowerment (further described in Chapter 5).

Psychometric evaluation was undertaken which found the instrument to be internally reliable and theoretically coherent (Matthews, Scott & Gallagher 2009b). A validation process saw it administered to a sample of 900 practising nurses and midwives (*n* = 244 midwives). A variety of psychometric analyses was undertaken including descriptive and exploratory factor analyses to demonstrate that items related to factors which specifically measure conditions which contribute to empowerment and these items clustered together coherently in the subscales. In accordance with aims of internal consistency, each subscale demonstrated a Cronbach alpha score (α) of 0.7or more (Matthews, Scott & Gallagher 2009b).

4.7.14 Use of the PEMS in midwifery research

At time of publishing the papers, the PEMS was in its infancy. The authors recommended testing the PEMS on larger, more varied, samples to test the cross-national generalisability of the scale (Matthews, Scott & Gallagher 2009a). This task undertaken by a different group of researchers via an online survey of a sample of 600 practising midwives in New Zealand, a different cultural setting and maternity health system than place of origin (Pallant et al. 2015b). The structure of the scale was assessed for ease of interpretability through various

[7] This thesis follows the language used in Australia to describe the philosophical position regarding midwifery care as being *woman-centred*, focusing on the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professionals. The term *women-centred* care downgrades the important role of midwives in providing individualized care to *a* particular woman, *woman-centred* care aspires to work with each individual woman's specific needs and situation (Leap 2009). As such, this is the only time the subscale will be referred to using the PEMS terminology.

statistical methods, the results of which did not support the underlying structure of the PEMS.

The factor structure of the three subscales of the PEMS indicated that a four item structure was more easily interpretable for analysis and was modified into a four factor scale called the PEMS-Revised (PEMS-R). These were: (i) Autonomy/Empowerment; (ii) Manager Support; (iii) Professional Recognition; and (iv) Skills and Resources. Psychometric testing of the revised scale supported the structure of the revised PEMS with internal consistency being demonstrated by using both the Cronbach alpha coefficient (α) and the mean inter-item correlation value (Pallant et al. 2015b).

Comparisons were made of the results of the PEMS-R between midwives who had or had not considered leaving their profession in the last six months. Midwives who had considered leaving the profession scored lower on the four subscales, thus distinguishing between those midwives who had considered leaving the profession, and those that had not. Pallant et al.'s (2015) results correspond to other studies which show relationship between job satisfaction and the four factors as depicted by the four revised subscales (Pallant et al. 2015b)

Upon comparison of the two empowerment instruments, the PEMS-R appears to be a sound refinement of the original PEMS, with the slightly cluttered configuration of items in the three subscales warranting reorganisation of the instrument's items. However, the PEMS-R was not used in my study as its inception was still forthcoming. No further published use of the PEMS or PEMS-R was available in health research journals at the time of finishing the literature review of this thesis in February 2016.

4.7.15 Summary and relationships between the three instruments

This section of Chapter 4 presented the three participant outcome measures used in my study, namely burnout, impact of the practice environment, and perceptions of empowerment. Using that approach of Abbenbroek, Duffield and Elliott (2014) for assessing the selection of appropriate tools, it was decided firstly, the Maslach Burnout Inventory was to be used to capture individual emotional responses identifying experiences of emotional exhaustion, moral distress, anxiety and depersonalisation among the participants (Abbenbroek, Duffield & Elliott 2014). Secondly, the Practice Environment Scale of the Nursing Work Index was used to gauge the impact of conditions in the work

environment that can be assessed by employee outcome measures. And thirdly, the inclusion of the Perceptions of Empowerment in Midwifery Scale was important as it is the first midwifery-specific instrument that measures perceived empowerment. All three instruments have demonstrated acceptable levels of reliability, with the Cronbach alpha score (α) mean composite coefficient for all studies sitting above 0.7 (Nunnally 1978), the recommended minimum threshold for establishing reliability. Replicated testing studies establishing strong psychometric properties further supported selection of the three instruments (Abbenbroek, Duffield & Elliott 2014; Lake 2002; Maslach, Jackson & Leiter 1996; Matthews, Scott & Gallagher 2009b).

A workforce survey comprised of these three concepts was considered to be comprehensive and capable of providing many-sided data. All three instruments measure outcomes pertinent to the midwife. Various workload pressures have been demonstrated to impact midwifery burnout levels. The PES-NWI seeks to elicit information regarding the felt experience and perception of the quality of the practice environment, thus providing the ability to discriminate a positive work environment. The MBI focuses on interpersonal and psychosocial aspects, with some relevance to organisational factors but with a closer focus on individual perceptions and emotions (Abbenbroek, Duffield & Elliott 2014). The PEMS strengthens congruence of data, through capturing perceptions of empowerment, linked to autonomy and perceived professionalism, outcomes measures that are strongly coupled to the midwife-woman relationship and the ability to provide woman-centred care.

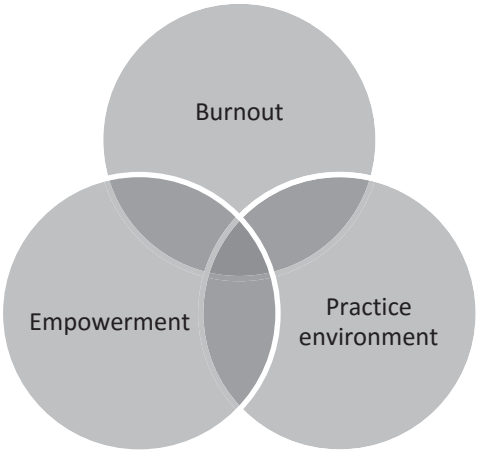
The Maslach Burnout Inventory, Practice Environment Scale of the Nursing Work Index and the Perceptions of Empowerment in Midwifery Scale measure distinct and definite concepts (burnout, practice environment, empowerment). The study of these concepts is complex and relationships between the three concepts and job satisfaction has been delineated in the research canon, whereby:

- practice environment ↔ burnout ↔ job satisfaction
- practice environment ↔ empowerment ↔ job satisfaction
- empowerment ↔ burnout ↔ job satisfaction

Not counting the negative impacts these factors can have upon patient outcomes, burnout, conditions of the practice environment and perceptions of empowerment coalesce and

influence the workforce experience, employee outcomes and intentions to remain in the workforce (Figure 5).

Figure 5 Interrelated influences of workplace conditions on job satisfaction



There is a significant amount of research that indicates that healthcare *practice environments* contribute to staff *burnout*. An association between negative working conditions and employee stress is well known (Laschinger & Leiter 2006). Work stress and burnout are also associated with negative work attitudes, poor work engagement and performance, diminished job satisfaction and reduced intentions to remain in the work setting (Cicolini, Comparcini & Simonetti 2014). On the flipside, the prevalence of *burnout* in an institution can then impact upon the *practice environment* through shortages borne from staff attrition. Attrition detrimentally impacts upon the remaining workforce decreasing the quality of working conditions for the staff that remain, contributing to swollen workloads, non-attendance at work, and illness and injury (Preston 2006). Inversely, those individuals with higher job satisfaction experience lower levels of *burnout* and have more positive perceptions of their *practice environment*.

The context of the *practice environment* has been demonstrated to enhance the sense of achievable *empowerment*. Structural determinants of empowerment are present when the practice environment exhibits low levels of incivility, collegial support, effective managers and leaders, adequate resources to achieve organisational objectives, opportunities for skills training and professional development. These conditions when present in the practice environment influence behaviour in an organisation and employees with sufficient empowerment are able to fulfil the tasks the organization requires of them (Knol & van

Linge 2009). In the reverse, *empowerment* can transform the *practice environment* through the initiation of pro-active innovative behaviour, such as the development of new models of care (Knol & van Linge 2009). The capacity for promoting new ideas at work and implementing and assessing plans, with a sense of future-orientedness and finding creative solutions for challenges are elements of empowered staff (Kuokkanen et al. 2014).

Numerous studies have linked empowerment directly and indirectly to job satisfaction and commitment. A relationship exists between access to work *empowerment* and nurse *burnout*. Work empowerment significantly promotes work efficiency and prevents burnout. It is critical that nursing work environments are structured in ways that ensure nurses feel engaged in their work and want to remain in their jobs. Nurses who perceived their *work environments* to be *empowering,* where a sense of autonomy, control over the practice environment and good nurse/physician relationships, report higher levels of job satisfaction and lower levels of *burnout*. This relationship suggests that there are consistencies between the causal variables of burnout and empowerment within the healthcare work environment. An empowered environment is less likely to lead to staff burnout. A perceived access to structural empowerment in the work environment had an impact upon psychological empowerment, and ultimately emotional exhaustion despite exposure to stressful working conditions (Laschinger et al. 2001).

Burnout can be accompanied by symptoms of low mood and intention to leave the profession, and may interfere with quality performance at work and perceptions of accomplishment (Gustavsson, Hallsten & Rudman 2010).

The relationship between *empowerment* and *burnout* may also lie in the inherent personality or hardiness of the individual (Garrosa et al. 2010). Individual characteristics impacting upon workforce experiences were further explored in Phase 2 interview data. The apathy and lack of confidence ensuing from burnout has the potential to affect the safety of care provided. Thus, the importance of developing healthy work environments, which discourage the conditions and factors which lead to burnout, is clear. The quality of the healthcare practice environment has been associated with recruitment and retention and quality patient outcomes (Aiken & Patrician 2000). Because of the present and predicted midwifery workforce shortage in Australia, together with the increased acuity of care required for delivery safe and efficacious outcomes, it is important that these interrelated concepts of burnout, work environment and empowerment be studied in the Australian midwifery setting.

This section presented the instruments used in my study and has presented accounts of their validation.

4.7.16 Survey piloting process

An important step in research that uses a survey method for data collection is the pre-test pilot of the survey. This allows for finalising of survey questions configuration and refinement of survey format. The goal of the piloting process is to assess the competency and quality of the questionnaire and to estimate the duration needed to conduct the survey (Iraossi 2006). The pilot indicates whether terminology and phrasing is clear, understandable and free from mistakes, and provides feedback on whether questions are understood in the same way by all. Piloting also demonstrates whether any important issues have been overlooked.

Aiming for a somewhat heterogeneous sample, the pilot setting was both a large tertiary referral unit and a small stand-alone maternity unit in two hospitals in the same health area in Sydney, New South Wales. Permission was granted by the divisional head of the sites and midwifery unit managers of the delivery suite and postnatal wards, as the locations of the pilot.

The hospital sites employ midwives of varying subgroups and demographic, as well as employ midwives educated by different midwifery education routes, in various roles, models of care and work patterns. Therefore, the sites were chosen to enhance representativeness. Twenty-five midwives participated in the pilot.

A cover sheet was adjoined to the front of the survey explaining reasons for the research project and the aim of the piloting process. Participants were thanked for undertaking the pilot and the UTS Human Research Ethics Committee reference number was provided. They were asked to make recommendations and to critique and comment on the pages of the survey. Three specific viewpoints were sought: How long it took to complete, the ease of filling in the survey, and suggestions for improving the survey.

The duration of pilot completion ranged from 10 to 30 minutes, with an average of 16 minutes. The final surveys were sent to residential addresses and were most likely completed in the domestic setting. However, the pilot was undertaken within a work shift. The distractions of work were considered similar to those of home life and it was presumed

that the time it took to complete the survey in real time would be similar, or even less, than that of the pilot. Therefore, it was determined that the survey was of satisfactory length and not too long.

All participants indicated that the survey could be completed with ease and the various sections were correctly answered by all participants. The follow-on prompts were understood, assuring the survey map was clear, implying that the respondents understood the objective of the survey. This was important as some sections of the survey were mandatory for all participants and some were specific to whether the participant was currently working as a midwife or not.

A few participants mentioned the repetitiveness of a few items. This duplication was amended in the revision process. Overall suggestions for improving the survey were some formatting advice (one participant), that the survey did not apply to agency staff (one participant), and the Likert scales for the three instruments used were not uniform (one participant). Specific attention was directed to certain questions that were considered amendable. Alteration to the Likert scale was not permitted due to the inclusion of three validated scales in the survey. Upon reflection, the variance in the Likert scales did not add undue complexity.

Every question was answered by all of the respondents, suggesting that they felt comfortable answering the questions and that they were not too hard to answer. There was enough diversity in the answers received, suggesting that appropriate questions were used to solicit adequate and varied responses moderating the likelihood of response bias. Encouragingly, participants considered the survey applicable to their work life except for one participant who felt it did not adequately address 'agency' midwives, that is, those midwives working for an agency rather than a health service or self-employed. This was despite *agency* being incorporated in the work status section. Her suggestion was addressed by incorporating agency as a possible response in other questions.

Survey questions using set time intervals were clear to the respondents and matched the time intervals of the participants' responses. Various remarks next to certain questions motivated some alterations to the survey, these mainly corresponded to terminology. Phrasing revision was done on items soliciting information about the entry route into the profession, current relationship status and time spent in current work/role. Other attention

was drawn, by two respondents, to the absence of 'on-call' as a possible answer in hours worked each week.

4.7.17 Survey administration process

Paper-based surveys were sent to all of the 113 recruited participants via mail with return-to-sender envelopes included. As participants had consented to being contacted via the phone numbers that they had provided at the point of initial recruitment, these numbers were then used. Firstly, a text message was sent to all participants informing them of the impending arrival of the survey envelopes. Following this, two further text messages were sent to politely remind them to complete and return the survey if they had not already done so. The response rate of the surveys and the results from Phase 1 will be discussed in Chapter 6.

The next section will discuss Phase 2 of the research project, the phase which collected data through interviews with participants.

4.8 Phase 2

Phase 2 of the study was qualitative in design, using interviews. Phase 2 interviews allowed for exploration of Objective 2 (identify organisation and work environment factors that influence workforce participation trends) and Objective 3 (identify personal factors and stressors that influence workforce participation trends).

Much of health workforce research has been performed using quantitative methodology, particularly by means of closed-ended self-report scales. These studies impart significant information about the experience of employment in these professions and provide information for statistical analyses of workforce-variable relationships (Mazzola et al. 2011). However, there are limitations in using only quantitative scales. Single methods like these can reflect what a researcher regards as important, their assumptions and biases construed in advance of conducting the research. A researcher can risk missing information about other aspects important to individual participants, not accurately displaying the complete range of workforce experiences present in a sample. This is particularly concerning in research of a population new to research, such as new graduate midwives. Relying only on closed-ended self-report scales may not sufficiently capture their

experiences. Complementing these measures with additional qualitative data gives participants the opportunity to report their experiences, without being confined within scale item responses (Mazzola et al. 2011).

4.8.1 Data collection instrument for Phase 2: Interviews

The interview method is commonly used for data collection in qualitative health care research (Britten 1999; Legard, Keegan & Ward 2003). The aims of research interviews are to explore views and experiences, beliefs and motivations of individual participants on specific topics (Gill 2008). This method may elicit substantial and detailed data of complex social phenomenon, adding to knowledge produced by quantitative methods, and is especially useful in the context of Australian new graduates of midwifery. Furthermore, interviews are an apt form of data collection for the study of sensitive issues where the participant may be reticent or embarrassed to disclose personal information. Midwifery is a role of working closely with women and families in a time of great transition. The role can be challenging and sensitive and as a consequence personal information can arise within midwifery research. Interviews can bestow privacy to the process of data collection, giving participants the confidence to talk openly about a research topic. A sense of privacy and confidence are enhanced by the guarantee of de-identification, which this research process ethically adhered to.

This research utilised a semi-structured method, a common approach in health care interviews (Hennink, Hutter & Bailey 2011). It involved engaging with strategic and open-ended questions to define and explore the research questions. This method gives guidance on the topics of discussion, but also lets the researcher and participant deviate and follow ideas or responses in detail. This permits for an unearthing or expansion of important information that participants may not have previously understood to be relevant or influential to the topic (Gill 2008). Discovery and elaboration occurs through following on from participant answers and gently probing noteworthy responses. If questioned in a predetermined and structured manner, these responses may not have arisen in the same way, if at all, making the semi-structured method very useful in research. Therefore, the semi-structured interview method was thought to be most relevant as a technique to uncover participant views on predetermined areas of interest, such as turnover, retention, and workforce experiences and choices, while still focussing on their essential experience. The participant was an active contributor to knowledge creation (Marshall & Rossman

2006) and the interview was a knowledge producing conversation in which the interviewer and interviewee co-create knowledge and meaning (Hennink, Hutter & Bailey 2011).

The development of the interview questions for the qualitative data collection was a phase-to-phase connecting point within the research. Development was grounded in the results of analysis in the first quantitative phase (Ivankova, Creswell & Stick 2006). As well as acting as a prompt to inform the participant the aim of the research and ethical considerations such as confidentiality and anonymity, the interview guide was formulated to provoke questions and lines of inquiry that originated from literature review findings. Common determinants of the topic and aims and objectives of the research question informed the guide (Gill 2008). In reality, the interview guide was not explicitly followed; rather exploratory questions were naturally formulated as the interview proceeded depending upon responses (Holloway & Wheeler 2002). Natural and comfortable discussions generated rich data. Opening questions steered conversation toward the research topic and built rapport, through targeted, easy questions about their present and past professional experiences. Open-ended questioning followed directing the focus to more complex and sensitive topics, central to the research question. Further questions at the close of the interview elicited broad discussion on elements participants considered pertinent to midwifery workforce experiences in the new career period (Hennink, Hutter & Bailey 2011).

4.8.2 Reflexivity

As a practising registered midwife, the interview process was one where I was interviewing participants who worked in, or had worked, in the profession within which I practice. There are advantages and disadvantages related to the shared language and norms associated to peer data collection. Communication usually occurs via shared conventions, and verbal expressions have a role in this. In the most fundamental way, language works by speakers uttering words which hearers then interpret. Communication is known to have taken place successfully when the hearer interprets the speaker's words and meaning correctly. At the commencement of the interview, I explained to the participant that I may ask for clarification of concepts or ideas that may seem obvious for me to readily understand as an insider to the profession. An explanation was given for this as to ensure data would be from their perspective and not from mine. Throughout the interviews I frequently asked

their intentions with language choices, what they were trying to convey with certain words, and paraphrased participant comments to make sure interpretation was as valid as can be.

These questions were intentional tactics because of the shared or habitual understanding of the research domain by the researcher. Midwives can share a common language and the intention of communication often is assumed and unsaid. As a researcher, I did not want to inadvertently guess or incorrectly interpret language intention. Linguistic meaning only occurs when both speaker and hearer agree to intended meanings. As a midwifery researcher, focusing on a workforce in which I partake, I could misinterpret that the research domain is opaquely knowable to me. To ignore the complexity of perspectives of knowledge and make overly rapid conclusions would be a form of epistemic imperialism and would speak for the participant rather than the participant to speak for themselves (Code 2007).

The shared knowledge of the midwifery profession was also constructive to the interview process. Certain skills necessary in the clinical setting can be employed in a research interview. These are interpersonal skills, such as questioning, conversing and listening. Differences also exist and it was apparent to the participant that the purpose of the interview was to collect data about the midwifery workforce and not undertake personal analysis or counselling therapy, or offer advice. At the commencement of the interview, the participants were advised that the fundamental aim was for me to be attentive to what the participants had to say, in order for me to acquire knowledge about the research topic.

4.8.3 Interview sampling and process

Participants were asked to self-select for Phase 2 participation in a one-off interview. A *self-selection to perform interview page* was included at the conclusion of the paper survey (Appendix 4). Forty participants agreed to undertake an interview and ultimately 28 individuals were interviewed. Phase 2 participants, and therefore the data collected from them, could not be matched to their Phase 1 survey data as the *self-selection to perform interview page* was detached from the completed survey, thus strengthening confidentiality.

Interview participants therefore were not chosen with prior knowledge to their career choices. Interviews occurred if and when the participants responded to my communications. Participants were contacted to establish a date and time for the

telephone interviews. The order of interview participation depended upon the participants responding to my telephone and mobile text messaging contact, their agreement to participate in the interviews, and mutual agreement for a time of interview. Not all survey participants who self-selected for the interview process remained faithful to that decision, with some participants relinquishing their previous decision.

The eventual number of 28 interview participants was a result of the unpremeditated process of timetabling the self-selected participants. Continuation of interviews occurred until interviews with participants from all of the potential midwifery workforce participation trends transpired. Twenty eight interviews led to saturation of data and the overlapping of participant experiences. Further interviews were considered surplus to the requirements of the data collection process.

Previous experience of interviewing within my Bachelor of Midwifery Honours research study provided me with familiarity with the process and valuable skill attainment (Sheehy et al. 2011). Further promoting fluency within the interview process was my undertaking of a pilot interview with one participant prior to actual data collection. These data were not included in the data analysis. The pilot allowed me to establish the clarity and comprehensibility of interview guide and whether it was capable of answering the research questions and providing rich data for analysis. Additional questions were added to the interview guide after this process. It also taught me to use field notes during and immediately after each interview. These observations were further lines of questioning to probe the participant for greater detail and clarity. These notes also helped in the data analysis process.

The interviews were via phone, where both researcher and participant were situated in a private room in their respective homes at a time which suited. This ensured they were free from major distractions. The phone was used, instead of the customary face-to-face method used frequently in qualitative research due to the geographical diversity of their homes, thus distance and time. The phone interviews were audio-taped into a digital audio format and downloaded onto a password protected computer file. Participants were advised of certain ethical concerns as part of the informed consent process: The privacy of the interview setting and anonymity of data. They were asked if having the phone on loud-speaker mode was permitted.

No participant was negatively concerned with this setting or method. The home setting seemed to imbue a calm and productive style and a good rapport was established with most of the participants. One recent inquiry (Ward, Gott & Hoare 2015) regarding the use of the telephone, undertaken by a group of nursing researchers utilising phone interviews in their grounded theory study, reported a positive experience of telephone interviewing. The participants of their study reflected upon the telephone interview process. Themes were identified of the participants' thoughts on phone interviewing, which resonated with my study. The themes centred upon participants feeling positive about the phone interview, feeling accustomed to the technology, and being able to concentrate completely on the interviewer's voice instead of being distracted by their face. The phone interviews lent towards an easy rapport and the participants did not feel judged or inhibited within the interview process (Ward, Gott & Hoare 2015).

As a natural flow of information progressed in each interview, my interview skills developed and 'loosened-up'. Length of the interviews varied from 40 to 75 minutes, with participants being notified that the duration averaged 60 minutes at the beginning in order to alert them as to what to expect. At the conclusion of the interview the participants were thanked and asked for further comments in case there was anything else they wanted to add.

The interviews generated lengthy data when the data were transcribed verbatim for analysis. I undertook the audio transcription, a process which was both laborious and beneficial to the data analysis process. The physical act of the transcription process entailed a 'reliving' of the interview experience, albeit with heightened focus. Interview transcription occurred concomitantly within the months I was conducting the interviews. This meant I was thinking about important methods of questioning and interview direction as I was still carrying them out.

My interview skills grew with each interview and interview transcription. Self-transcription also allowed for a general picture of common ideas and thoughts to emerge, which then could be supplied back to the participants if related concepts emerged in their interviews for clarification whether shared viewpoints existed for them. Transcribing them myself also permitted me, to hear the distinctive nuances of individual participant's speech. For example, when they used laughter, why they used laughter, when matters evoked deep concern or emotions in them, length of pauses and silence and pronunciation and word stresses. I found it an invaluable part of the data analysis process. Verbatim transcription

has been acknowledged to provide richer data than simply listening and writing field notes, or transcribing into point form (Holloway & Wheeler 2002). By transcribing the data, precious information was available to me that was used in data analysis.

4.9 Ethical considerations

This study is part of the University of Technology, Sydney Faculty of Health MidTREC study. The UTS MidTREC study was granted ethical approval by UTS (UTS Human Research Ethics Committee REF No is 2007-219A) (Appendix 1). As MidTREC research commenced prior to me joining the project, an amendment to this application was undertaken to enlist me as a researcher on the study. Yearly reports were provided to the UTS Human Research Ethics Committee with no further concern from that body.

All ethical considerations regarding the trustworthiness of the research project were adhered to. The process of obtaining informed consent from participants was explicit within the research process. Despite potential participants having previously indicated their willingness to participate at time of initial recruitment to the study, further information sheets (Appendix 1) and written consents were gained prior to inclusion of any participant in my study. Information that could identify participants needed to be collected in a quantitative survey so that participants could be contacted for a qualitative follow-up phase. This required a justification for requiring this identifiable information. Safeguards were put in place for protecting personal information. Furthermore, individuals were aware that participation in my study was completely voluntary and confidential.

As I was a UTS graduate from the Bachelor of Midwifery course in 2007, some of the potential participants were known to me. Awareness of the intricacies of researching a participant group in which some of the potential participants were known to the researcher is crucial. Having had previously undertaken research of midwifery colleagues (Sheehy et al. 2011), that also posed a similar issue of familiarity, I was aware of ethical considerations of undertaking research on known participants. I displayed competence in research methods and trustworthiness to adhere to the tenets of ethical research (Rogers 2008). I was, and am, respectful of the potential challenges in carrying out such a task. Being familiar with potential research participants can be commonplace when researching midwifery perspectives on workforce issues and midwifery practices due to the collective and co-operative spirit of the Australian midwifery community.

Mixed methods research allows a topic to be studied via different approaches. This variety of perspectives however, may place additional burden on participants, particularly pertinent for those, like midwives, who experience prohibitive levels of constraint on available time. Cognisant of not wanting to overly burden participants, information about the required multiple forms of data and estimated time frames for completion were clearly stated in participant communiqués.

Mindful that the interview process may be undertaken at an emotional cost to the participants, arousing feelings of distress from past critical incidents in practice, I was aware that the interviews explored potential sensitive topics (Rogers 2008). Aware of the power dynamics in play in research, I was careful to position the emotional state of the participant as key, and 'check-in' with the participant throughout the interview. No incident occurred which was distressing to the participants. On the contrary, the interview participants voiced their appreciation of taking part in workforce experience data collection as this topic was perceived as insignificant in their places of employment.

Lastly, adhering to normal conventions of research, I was cognisant that the gathering of personal information through audio-recordings could identify a participant. All data collected were de-identified to maintain the anonymity of the participants and stored on a password protected computer in a locked study.

4.10 Conclusion

Thus far in this thesis, using *GRAMMS* as a guide, the first four chapters have attended to the justification for using the mixed methods approach as a response to the research question, as well as give a description of the research design in terms of the purpose, priority and sequence of methods. Each method has been described as regards to sampling and data collection (O'Cathain, Murphy & Nicholl 2008), thus attending to the first three *GRAMMS Items*. Ethical requirements were also considered in Chapter 4.

Attention in Chapter 5 will now turn to the description and justification of the methods used for data analysis as well as how data was integrated and where it occurred. *GRAMMS* also presses firstly, for the description of any limitations of a method used when associated with the uses of the other method and secondly, the insights gained from mixing or integrating methods, of which both will be explored in Chapter 9. But presently, discussion moves to data analysis methods in Chapter 5.

Chapter 5: Data analysis

5.1 Introduction

This chapter explains how the numeric data from the quantitative surveys and the textual data from the qualitative interviews were analysed following well established methods and techniques. The core analytic strategies, tasks and overall process of data analysis are presented. This incorporates both the deductive process of data analysis for the quantitative data and the inductive elements of analysis for the qualitative interviews to identify and interpret the results of the study (Hennink, Hutter & Bailey 2011).

5.2 Analysis methods of survey data

As I conducted the survey, the survey data had to be translated into computer format. Numeric survey data were entered into the IBM SPSS Statistics 22 (SPSS) for analysis (SPSS Inc. 2013) and SPSS variable names were specified and data were cleaned and errors corrected. The small amounts of descriptive textual data were also entered into SPSS for evaluation. The numeric data were mainly statistically analysed by measuring the frequency distributions and means of single variables within the sample and for measuring relationships between variables for simple correlations descriptive analysis. The three instruments, developed and validated prior to this research, were analysed as per the authors' recommendations and will be discussed below.

Comparisons were conducted for the midwifery graduates from the two different education streams. The Bachelor of Midwifery education route is referred to in this chapter as BM, whilst the Graduate Diploma of Midwifery is GD. Means and standard deviations were calculated and statistical differences were computed at the 1% (0.01) significance level. This conservative confidence level was chosen for stringency due to the small sample size of 75 alongside a large number of comparisons examined. The risk of Type I error, where statistical association is the result of chance, increase when large numbers of comparisons are made. A one-way analysis of variance was used to investigate the relationship between the scales of the 3 tools used and selected clinical and demographic variables. Non-parametric testing was used in this study as various assumptions that apply

to parametric techniques were not satisfied, namely the sample was non-random, the population was not normally distributed for numerous variables, and the sample size was small (*n* = 75).

5.2.1 Analysis methods for Maslach Burnout Inventory data

The intention of the Maslach Burnout Inventory (MBI) is to investigate how individuals in the helping professions view their job and the people with whom they work as regards to chronic occupational stress. The instrument, a 22-item questionnaire, is used for assessment of burnout in individual participants. Participants rate each item on a seven-point Likert-type scale for how frequently they experience the condition being considered. It must be highlighted that each statement can be rated on two dimensions: Frequency and intensity. Due to the large quantity of measures included in the complete survey distributed to the participants in my study, the abbreviated MBI was used for purposes of brevity, as has been done in other health research (Alexander & Hegarty 2000) and midwifery research (Galanakis et al. 2009) in order to reduce test length. The abbreviation omits the intensity scale, including only the frequency scale. Data regarding the potency of feelings of participant burnout were collected during Phase 2 interviews. Another alteration was using the terminology *woman that I care for* instead of *my recipients* to be indicative of the midwifery scope of the research.

All items are scored on a seven-point frequency rating scale ranging from 0 (*never*) through to 6 (*every day*). For example, a value of zero is given if the participant indicates (by circling the numeral 0 in a box) that they never experience the feeling or attitude described (Maslach & Jackson 1981). As described in Chapter 4, the items are used as a measure of three specific components of the single concept of the burnout syndrome. Three subscales are used as an operational theoretical framework reflective of the original conceptualisation of burnout by Maslach (1982). These 3 components operationalized into 3 subscales are:

(i) **Emotional exhaustion** The draining of emotional resources;
(ii) **Depersonalisation** A negative, callous attitude towards care recipients; and
(iii) **Reduced personal accomplishment** The tendency to feel incompetent and to assess one's work with other people negatively (Maslach, Jackson & Leiter 1996).

The scale is scored by the calculation of subscale means. In my study these means refer to the two participants groups BM and GD. Using cut-off scores for the means, based on data from a large normative sample of 1104 health professionals in the USA (Table 13), participants are classified as high, moderate or low burnout cases on the respective subscales (Maslach, Jackson & Leiter 1996). Non-parametric testing was conducted to establish the existence of statistically significant relationships between variables of interest. Missing data were allocated as the mean and there were no instances of there being more than ten percent of data were missing for an item.

Table 13 MBI subscale cut-off scores and categories

Subscale	Category	Cut-off scores
Emotional exhaustion (score 0-54)	High	27 or over
	Moderate	17-26
	Low	0-16
Depersonalisation (score 0-30)	High	13 or over
	Moderate	7-12
	Low	0-6
Reduced personal accomplishment (score 0-48)	High	0-31
	Moderate	32-38
	Low	39 or over

(Maslach, Jackson & Leiter 1996)

According to Maslach et al. (1996), burnout is reflected in high scores on the *Emotional Exhaustion* and *Depersonalisation* subscales and low scores on the *Reduced Personal Accomplishment* Scale. An average degree of burnout is reflected in average scores on the three subscales. A low degree of burnout is reflected in low scores on the *Emotional Exhaustion* and *Depersonalisation* subscales and in high scores on the *Personal Accomplishment* scale. It is important to note that a high integer result in the *Reduced Personal Accomplishment* scale reflects a low level of reduced personal accomplishment. Articulated otherwise, a high integer result on the *Reduced Personal Accomplishment* scale corresponds to high levels of personal efficacy. This is due to the items in each subscale being all framed in the same direction. Consequently, all *Emotional Exhaustion* and *Depersonalisation* items are phrased negatively, whereas all *Reduced Personal Accomplishment* items are phrased positively.

The MBI yields three, noncumulative scores which result in three separate scores, one for each of the three components of burnout. This is because knowledge of relationships between the three aspects of burnout is limited. Therefore, each component is considered

separately and not as a total combined score (Maslach, Jackson & Leiter 1996). These scores were then used to compare for any significant differences between groups.

According to Maslach and Jackson (1996), the three MBI subscales have good internal consistency, with a Cronbach α coefficient for the *Emotional Exhaustion* subscale reported of 0.9. In my study, the Cronbach α coefficient for that scale was 0.86. Maslach and Jackson (1996) report a Cronbach α coefficient of 0.71 for the *Reduced Personal Accomplishment* subscale. In my study, it was 0.78. The *Depersonalisation* subscale in my study was not above the preferred minimum level for reliability of 0.7 despite Maslach and Jackson (1996) reporting theirs at 0.79. As a five item subscale, the Cronbach α coefficient of the *Depersonalisation* subscale is influenced by the small number of items in the scale as it is difficult for short scales to achieve acceptable values. In this case, it was deemed appropriate to report the mean inter-item correlation to establish reliability of the subscale, the optimal range being between 0.2 to 0.4 (Briggs & Cheek 1986). Constructively, in my study, the mean inter-item correlation for the *Depersonalisation* subscale was 0.39, an indication of internal consistency for this scale.

5.2.2 Analysis methods for the Practice Environment Scale of the Nursing Work Index data

The intention of the Practice Environment Scale of the Nursing Work Index (PES-NWI) is to gauge the state of clinical practice environments in hospital settings. As per Lake's (2002) instructions, the participants were directed to rate the extent to which they agreed that each PES-NWI item was present in their current practice environment. This used Lake's 4-point Likert scale, with response choices of 1 (*strongly agree*) through to 4 (*strongly disagree*), hence higher scores indicate disagreement that the item is present in the environment. To prepare for analysis, scores for the items were reverse-coded, so that higher scores indicated greater agreement that a characteristic was present in the current job of the participants. Furthermore, item 31 of the PES-NWI was not considered appropriate for midwifery research purposes and was therefore removed from the scale. Item 31 measured participants' perspectives on the use of *nursing diagnosis* in clinical practice. Therefore, akin to previous Australian research of nursing samples that do not partake in clinical diagnosis (Middleton et al. 2008; Parker et al. 2010), the scale used in my study consisted of 30 items.

Modifications to other items translated the participant terminology from the word *nurse* to that of *midwife*; the word *patient* was replaced with *women/woman I care for*; *nurse manager* was replaced with *midwifery unit manager*, *director of nursing* was replaced with *director of nursing and midwifery*; *nursing administrators* replaced with *midwifery administrators*; and *physicians* replaced with *doctors*. Missing data were allocated as the mean and there were no instances of there being more than ten percent of data missing for an item.

A literature review examining the global use of the PES-NWI (Warshawsky 2011) reported that all 37 included studies scored the scale by averaging item responses across participants to derive mean item scores. Most also derived mean subscale scores by averaging item means for each subscale (Lake, 2002). To use the mean of a subscale score rather than item scores gives equal weighting to each subscale. Using an item score would differentially weight the composite score to those subscales with more items.

The five subscales were developed to measure organisational characteristics recognised in those environments supportive of professional nursing practice, these are (with terminology depicting the nursing foundations of the instrument):

(i) **Nurse participation in hospital affairs** Opportunities for staff nurses participation in policy decisions;
(ii) **Nursing foundations for quality of care** Reflecting the provision of preceptorship and continuing education programs for nurses;
(iii) **Nurse manager, ability, leadership and support of nurses** Indicating whether supervisory staff are supportive of nurse practice;
(iv) **Staffing and resource adequacy** Measuring whether there is adequate nursing staff to provide quality patient care; and
(v) **Collegial nurse-physician relations** Whether the relationships between physicians and nurses are positive.

Lake and Friese (2006) introduced a scoring innovation to categorise the favourability of practice environments. Practice environments were classified as favourable if four or five subscale mean scores were greater than 2.5, mixed if two or three subscale means were greater than 2.5, and unfavourable if none or one of the five subscales achieved a mean score of 2.5.The majority of the studies used the PES-NWI to test associations of the practice environment and participant outcomes, such as empowerment, job satisfaction,

job enjoyment, burnout, and organisational loyalty. Analyses that were undertaken in my study were testing for potential relationships between variables of interest via non-parametric testing.

The five PES-NWI subscales in my study demonstrated good internal consistency, each having a Cronbach α coefficient of above 0.7. The Cronbach α coefficient for the *Nurse participation in hospital affairs* subscale was 0.86; for the *Nursing Foundations for Quality of Care* subscale it was 0.74; for the *Nurse Manager, ability, leadership and support of nurses* subscale it was 0.84; for the *Staffing and resource adequacy* subscale it was 0.82; and lastly for the *Collegial Nurse-Physician relations* subscale it was 0.84.

5.2.3 Analysis methods for the Perceptions of Empowerment in Midwifery Scale data

The Perceptions of Empowerment in Midwifery Scale (PEMS) is a 22 item instrument, the purpose of which is to capture midwifery perceptions of empowerment in their working roles. Prior to conducting score evaluations, the negatively worded statements in the PEMS had to be recoded in IBM SPSS Statistics 22 to portray the results in the positive form. Akin to the MBI and PES-NWI instruments, following factor analysis Matthews et al (2009b) derived three sub-scales from the PEMS, these being:

(i) **Autonomous practice** Relates to being recognised both as a professional and for one's contribution to the care of birthing women;
(ii) **Effective management** Relates to being recognised, supported and valued by midwifery managers; and
(iii) **Woman-centred care** Relates to midwifery perceptions that they empower birthing women.

The authors consider it appropriate to calculate scores for each of the three subscales, as well as scoring for the overall empowerment scale from the whole PEMS. As per Matthews et al's (2009b) instructions, participants in my study were directed to rate the extent to which they agreed that each PEMS item was present in their current midwifery job. This used a 5-point Likert scale, with response choices of 1 (strongly agree) through to 4 (strongly disagree) with a mid-point of 3, hence higher scores indicate disagreement that the item is present in the environment. The higher the subscale score, the lower the level of perceived empowerment, and vice versa.

There are four items in the PEMS which are not included in the subscales due to the 2009 factor analysis research undertaken by the authors (Matthews, Scott & Gallagher 2009b). Therefore, these items (numbers 11, 14, 15 and 19) are not included in the subscale analyses in my study. However, these items were strongly endorsed in the Matthews et al.'s (2009b) psychometric testing as important to the construct of midwifery empowerment and were therefore included for evaluation of these as individual items. Psychometric analyses undertaken after data collection in my study (2015b) restructured the instrument to comprise of four subscales that incorporate these superfluous items. Future use of the PEMS would benefit from using the PEMS-R structure.

Mean scores were calculated for each of the subscales by adding scores from each of the items and dividing by the number of items in the subscale. This converts scores for each subscale to a consistent range from 1 to 5. Scores can range from 1 (Very high perceived empowerment) to 5 (Very low perceived empowerment) (Table 14). Descriptive statistics and subscale inter-correlations with variables of interest were generated for each of the subscales.

Table 14 Score categories for the sub-scales of PEMS

Mean scores of PEMS subscales	Corresponding description of level of perceived empowerment
1	Very high perceived empowerment
2	High perceived empowerment
3	Moderate perceived empowerment
4	Low perceived empowerment
5	Very low perceived empowerment

An overall score for the full PEMS was also calculated by summing the scores on each of the three sub-scales. The possible range for the PEMS was three to 15, with a mid-point of 9. This is shown below in Table 15.

Table 15 Score categories for the PEMS

Mean score on the *PEMS*	Corresponding description of level of overall perceived empowerment
3-5	Very high perceived empowerment
6-8	High perceived empowerment
9	Moderate perceived empowerment
10-12	Low perceived empowerment
13-15	Very low perceived empowerment

The internal consistency reliability of the three PEMS scales was established in my study using the Cronbach α coefficient. The Cronbach α scores for each scale were 0.84 (*Autonomous Practice* subscale); 0.84 (*Effective Management* subscale); and 0.73 (*Woman-centred Practice* subscale).

5.3 Analysis methods of interview data

5.3.1 Introduction

This section describes the process of analysing the textual data generated from the interview transcripts. This involves interpretation of the unique experiences of the participants and translation of these experiences into themes so that the meaning of these experiences can be concisely and coherently presented as themes that reflect the complexity of the real people who chronicled their workforce encounters. This entails organising and making sense of the numerous and potentially contrasting perspectives within the data. Following well-established methods of data analysis ensures the findings are yielded from within the data (Hennink, Hutter & Bailey 2011). These tasks and techniques will be presented shortly.

Firstly, the interpretative nature of the analysis in my study, whereby I understood, explained and interpreted the meaning of the interview narratives, is addressed. The analytic work was underpinned and inextricably linked to the manner with which I interpret the world around me. This theoretical underpinning is philosophy.

5.3.2 Philosophical analysis underpinning interview data analysis

It may seem superfluous for the data of a midwifery workforce study to be the object of philosophical enquiry. However, philosophical concepts and ideas were woven throughout the analysis, diverging from the conventional approach in midwifery research to locate the research within health services research. The reasoning was manifold. The application of philosophical methods and approaches is aptly suited to midwifery scholarship, demonstrated by the phenomenological basis for ethnographic studies, as an example. Containment of research can put limits on how questions are explored. Philosophy can be used to address questions that may not be answerable by midwifery and health research

alone. Midwifery research can be interpreted as an engagement in intensive critique of its founding assumptions.

I have an inherent fascination in philosophy, having read academic and popular philosophical texts for over twenty years as a hobby. As researchers, we bring our scholarly interests to work as an aid for idea development. I have a hope in the future that philosophy can play a larger role in the syllabus of future midwifery students. As a theoretical tool, it is incomparable in scope for the development of a future midwifery workforce in terms of its political, ethical, research and academic capabilities. This would entail a permeability of disciplinary boundaries within the education syllabus. Incorporating philosophy is potentially transformative. It can assist cross-disciplinary skill and conversations, and aid in the broader conception of good scholarship.

In my study, philosophy is conceived as one theoretical viewpoint. The researcher stands back from the question and locates it and thinks about it within a broader framework to give sense to the problem and give understanding to implicit and embedded conventions that may contribute to the issue. The researcher-come-philosopher places the research problem “in its wider context and thought about how it connects with the surrounding scenery” (Midgley 2014, p. 19). The outward gaze of philosophical enquiry can help envisage an imaginative vision or world-picture which sits as a background to the problem, exploring connections to offer new ways of thinking. Philosophy is a “conceptual geography which looks at the relation between subject-matters of various ways of thinking and tries to map it” (Midgley 2014, p. 19).

Philosophy can be understood to be made up of schools of thought or intellectual traditions which share common characteristics of outlook, viewpoint or subject matter. Well-known examples of these are Phenomenology, Cynicism and Pragmatism, the latter of which was used in this research as an assessment tool to think about which data methodology and methods to use. Although a pragmatic framework for questions of methodology was used in this research, pragmatism was not the analytic underpinning of the interview data analysis. Rather than using a specific intellectual tradition as the framework for interview data analysis, the data was considered by the question of: What does philosophy mean to you? Akin to Midgely’s (2014) portrayal of philosophy, it is to me an examination of the pieces of the world that are taken for granted and a delving into as an investigation as to whether they work in the assumed way. The aim? To gain a better understanding and a restructuring to the world we would prefer. Researchers are not

neutral spectators and knowledge generation does not transcend the researcher's experience of the world.

Varying modes of thought underpinned data analysis. At the outset, I came to my study as a midwife committed to midwifery workforce and system change and a conviction that strategic use of research can inform and develop midwifery practice and maternity care, as expressed in the *National Competency Standards for the Midwife* (Nursing and Midwifery Board of Australia 2006). It is research of partisanship, a research inherent with political leanings which impact upon research design and methodology, data collection and analysis, interview coding and thematic categorisation, and how findings are then interconnected within research literature.

A further mode of personal thinking that underpinned analysis is feminist philosophy, which engenders clinical practice and research. Feminist philosophy is a diverse and non-homogenous international theoretical, social, ethical and political task that is concerned with understanding and challenging the interconnections of gender, power, knowledge and social practices for lived, embodied, material bodies. Far from being an academic exercise, feminism arises from the real, socially-embedded experiences of women and is a multidisciplinary and trans-social political activity that affects real women with their multiplicity of experiences: Race, class, sexuality, ethnicity, nationality, religion, ableness and age (Alcoff & Kittay 2007).

Feminism is one of the lenses through which I analyse the world. Therefore, my research is feminist research. Feminist research is concerned with "documenting women's lives, experiences, and concerns, illuminating gender-based stereotypes and biases, and unearthing women's subjugated knowledge... [it] challenges the basic structures and ideologies that oppress women and other marginalised groups and feminist researchers often apply their findings in the service of promoting social change and social justice for women" (Brooks & Hesse-Biber 2007, p. 4).

Rather than promoting a conceited impression of my study, its feminist philosophy underpinnings position the analysis and findings as a document of the perceptions and experiences of a group of midwives. Feminist research creates the platform to be able to explore the reality of women's bodies and their lived experiences in a patriarchal world. Secondly, despite this being a minor project within the immense sphere of maternity care, it is research nonetheless. This theoretical work cannot exist as a sufficient response to the

complex challenges that abound in the current maternity workforce and services. So I offer this research as an intervention, albeit a quiet one, whereby I articulate the possibilities of political change within the current birthing system.

Philosophical concepts are defined by their relation to other concepts, thus producing a systematic relationship between concepts. Having spent half my life learning about the broad range of philosophical concepts has consolidated my research technique via expanding my world view.

Philosophy foundation of this research now discussed, attention will be directed to the details of the techniques used for the interview analysis.

5.3.3 Interview analysis techniques

Immersion into the qualitative interview data commenced after a few interviews had been undertaken as this was when transcription commenced. Starting transcription prior to concluding data collection allowed for preliminary analysis. When reading the data, it was apparent that it addressed the intended research aims (Polit, 2012). It also permitted a self-evaluation of technique to ensure the broad line of inquiry would adequately address the research aims. These transcripts were then reviewed by my primary supervisor for appraisal. Next, each interview transcription was typed as a Microsoft Word document and each transcript was allocated a code depending from which participatory group it emanated (Table 16). De-identification steps were undertaken to enhance participant anonymity. Interview participant codes for the interview data do not correlate to participant codes for the survey data and it is not possible to link the two data sources. Therefore, the code for an interview transcript (for example, BM 07 IP 1) is not the same participant as BM 07 SP 1 (the code for the paper copy of a survey).

Table 16 Interview transcription codes

Participatory group	Interview codes given
Bachelor of Midwifery group graduated 2007	BM 07 (BM 07 IP 1 through to BM 07 IP 8)
Graduate Diploma group graduated 2007	GD 07 (GD 07 IP 1 through to GD 07 IP 9)
Bachelor of Midwifery group graduated 2008	BM 08 (BM 08 IP 1 through to BM 08 IP 5)
Graduate Diploma group graduated 2008	GD 08 (GD 08 IP 1 through to GD 08 IP 6)

Following transcription the interviews were then analysed by carefully reading the text word for word, keeping in mind the research questions. Prior to this process was preparation of the text via formatting of a word document of interview text, for ease of analysis, into a two-columned table with data in the right-hand row and a blank column where coding and sub-coding were typed. This step was undertaken on the computer and not in print-on-paper form. As well as coding appearing in the left-hand column of the transcription table, certain phrases were highlighted using the text highlight colour and font colour applications of Microsoft Word. These phrases were ones that repeatedly recurred in the data or phrases which expressed themselves in visually-depictive or metaphoric styles. Interestingly, the use of imagistic symbolism emerged frequently in interview responses. Phrases in the data were differentiated using the italic or underline applications as a reminder to give attention to them in analysis and thesis text. Data preparation and code development shape later analysis, therefore maintaining quality of data preparation tasks is crucial to ensure rigour (Hennink, Hutter & Bailey 2011).

A program such as NVivo was not used for interview data entry and analysis as I was already familiar with this (perhaps antiquated) technique, having used it in my Honours research program (Sheehy et al. 2011). I like the viewing of text on a page, albeit a computer screen, the observing of phrases within a sentence, and a sentence within a paragraph, also with an ease of observing any latent content such as laughter, sighing, pausing, silence and crying that was transcribed in italics in parentheses in the transcription text. With this technique I felt that I could be familiarised with the text as both the text and the coding were visually accessible in its entirety on the page.

A code is a word or salient, short phrase that is representative of, and captures the essence of a portion of, in this case, language in interview text (Saldaña 2013). Coding is considered as an “interpretative act” (Saldaña 2013, p. 4), involved drawing attention to exact words from the text that captured key thoughts or concepts. Interpretation recurred throughout the entire process of data analysis, including preliminary analysis and coding through to the categorisation into themes. To ensure that the codes and themes were well-grounded in the data and accurately reflected the texts, they were revisited time and time again to allow for continuous reflection and ensure a systematic and comprehensive understanding of the data. These repetitive tasks of coding and interpretation were conducted in an inductive conceptual cycle to ensure a thorough understanding, and then a building up of analysis (Hennink, Hutter & Bailey 2011).

> "*The process of analysis involves continuously moving up and down the analytic spiral as you develop theory and then validate it with the data*" (Hennink, Hutter & Bailey 2011, p. 237).

The approach to analysis used in my study is called qualitative content analysis, which included the coding and sub-coding of each of the transcriptions, an indexing and categorizing of elements within these data into hierarchies. The aim is for a nuanced analysis rather than mere separation or amalgamating of codes into themes, the endpoint of which is knowledge creation for information about the research subject matter (Saldaña 2013). The outcome of analytic reflection on the codes and categorizations was the development of themes.

Due to the semi-structured format of the interviews, each interview differed from each other in terms of wording and sequencing. However, distinct patterns were common within the interviews. In this research, qualitative content analysis followed Hsieh and Shannon's (2005) definition that it is a "research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon 2005, p. 1278). Using a content analysis approach, my concentration was on characteristics and individualities within the text, focusing on the content or contextual meaning of the communicative language (Hsieh & Shannon, 2005).The language was examined closely, read and re-read, with the aim of classifying large amounts of text into a workable number of codes.

Codes were then sorted into broad categories depending upon how the correlated to one another. Following these steps, the categories were then developed, refined and defined. These categories of connected codes from the text data are presented in the research findings chapter of this thesis as themes and sub-themes. Chapter 8 provides exemplars for each code and category.

The circular, refining process of data analysis aimed for consistency and reliability. Trustworthiness of analysis was also spurred by the comprehensiveness of the interview data. Adequacy of sampling size was revealed through data saturation. Supervisory debriefing of preliminary analyses and eventual findings further endorsed trustworthiness. Peer review, in the form of discussion of results with recently graduated practising midwives, was also undertaken to gauge the authenticity of the findings. Settings for these discussions about the thematic findings were at university research forums, professional

conferences, hospital work settings and social gatherings. Confidentiality was maintained throughout this process. Finally, discussing the codes and themes with a variety of the research participants helped to examine the faithfulness of the codes and findings to their unique experiences, another step in safeguarding against overly biased researcher invention (Polit 2012). This was important as latent content was used in the data analysis.

The inductive research process was appropriate in my study due to its descriptive aim. Such an approach can be used when existing theory is limited, as is the case with the Australian midwifery workforce. This is not to say prior research literature had no deductive influence over conceptual mapping of the themes. The process of analysis is undoubtedly interlinked to its methodology as a workforce study.

5.4 Data integration

As a design decision made in advance to data collection, the data in my study were collected and analysed sequentially in two distinct phases. This sequential explanatory design was characterised by the collection and analysis of quantitative (numeric) survey data followed by the collection and analysis of qualitative (text) data. The two methods were integrated during the interpretation phase to help explain and elaborate upon, the quantitative results obtained from Phase 1 (Creswell 2003). In addition, the sequential design connects the quantitative and qualitative phases in the intermediate stage when Phase 1 results of data analysis guide the data collection in Phase 2.

The two phases were connected in the intermediate stage in my study using an iterative integration approach which emphasises connections between the two phases (Ivankova, Creswell & Stick 2006). The specific technique used for data integration is discussed in Chapter 9. The reasoning for conducting my study in this way was that the quantitative data and their subsequent analysis gave me an overall understanding of the workforce for new graduate Australian midwives. The Phase 2 qualitative data and their analysis gleaned more data about the issue and explained those statistical results by exploring some of the participants' views in detail. This helped explain why particular internal and external parameters, identified in the Phase 1, were significant or not significant predictors of midwives' persistence in their workforce (Ivankova, Creswell & Stick 2006). Due to the broad scope of quantitative and qualitative research questions within the four research objectives in my study, priority was given to both research methods. The results of the

quantitative and qualitative phases have been integrated within the discussion of the outcomes of the entire study in Chapter 9, which combines results to respond to the research objectives to obtain a full, meaningful representation of the complex research problem.

5.5 Conclusion

Chapter 5 presented the sequence and core analytic strategies, tasks and overall process of the data analysis in my study. This was quantitative analysis of numeric data in Phase 1 and qualitative analysis of textual data in Phase 2. Phase 1 comprised analysis of demographic and workforce trend variables, as well as results from the three previously validated and developed tools, the Maslach Burnout Inventory, Practice Environment Scale of the Nursing Work Index, and the Perceptions of Empowerment in Midwifery Scale. Data integration results are demonstrated in the discussion in Chapter 9. As a newly graduated midwife, adherence to reflexive processes enhancing credibility of the research analysis and findings was necessary. The trustworthiness of qualitative content analysis findings rests on having rich, relevant, and well-saturated data. Trustworthy content analysis begins with the development of data collection techniques and the careful preparation of the data and analysis once collected (Hsieh & Shannon 2005). The next three chapters report on the results of the survey and interview data.

Chapter 6: Survey demographic and workforce participation results

6.1 Introduction

This chapter presents the results of the data obtained from the surveys obtaining participant demographic information and workforce participation trends. The results from the three instruments used: the MBI, PES-NWI and the PEMS will be presented in Chapter 7. The interview results from Phase 2 will be presented in the Chapter 8. In this text, BM as an abbreviation refers to all participants graduated through the Bachelor of Midwifery route, whilst GD refers to those who undertook the Graduate Diploma of Midwifery.

6.2 Phase 1 MidTREC survey results

As described in Chapter 4, surveys were mailed out to 113 potential participants (*n* = 113), originally recruited to the UTS MidTREC research program by Hammond et al (2011). The database comprising participant consent and contacts provided was incomplete and numerous participants were not contactable via previously supplied addresses. This, being a common issue with research undertaken over various points-in-time, was expected to occur. Seven research pack envelopes were returned to sender to UTS by the present occupants of the addresses.

There were 75 respondents to the survey, giving a response rate of 66 percent, which is comparable to or greater than the research investigating health services workforce issues presented in Chapter 2. Regrettably, knowledge and information about the remaining 44 percent of participants who did not respond to the survey in the original sample is inadvertently missing from the original data collected in 2007 and 2008. This shortfall is more keenly felt because I was in communication with many of the sample when determining their present addresses. In this communication it was apparent that the vast majority were working as midwives.

This chapter is arranged according to the topic areas addressed within the survey, as described in Chapter 4. The topic areas included:

- Demographics
- Workforce data for those participants currently not working in midwifery
- Workforce data for those participants currently working in midwifery
- Maslach Burnout Inventory (MBI)
- Practice Environment Scale of the Nursing Work Index (PES-NWI)
- Perceptions of Empowerment in Midwifery Scale (PEMS)
- Future plans for those participants currently working in midwifery

Non-parametric analysis was conducted as general assumptions were not met. The sample was not random and it was small in size. Ages were not normally distributed and the assumption of adequate expected cell counts were not fulfilled (Pallant 2013).

6.2.1 Survey participant demographics

Sample characteristics were similar to those from Australian Institute of Health and Welfare (2015) data of the demographic characteristics of the Australian midwifery profession. Of the 75 respondents, 30 (40%) graduated from the Bachelor of Midwifery program and 45 (60%) from the Graduate Diploma program. Seventy-four participants were female and one was male. The youngest participant was 27 and the eldest, 56 years. Table 17 demonstrates the ages of the participants divided into three age groups (≤ 30 years, 31-45 years, and ≥ 46 years). The theoretical reasoning for these groupings is firstly for an even assemblage of ages, and secondly, these groupings make sense to distinctly show the average maternal age of Australian childbearing women, as the majority of the participants were women. The most recent data shows that the mean age of first-time childbearing is 30.1 years (Hilder 2014).

Due to the small numbers of participants in each of the four participant groups (BM 07, BM 08, GD 07, GD 08), analysis has been undertaken by collapsing them into two groups (BM 07 + BM 08; GD 07 + GD 08) (Table 17). This method was deemed appropriate to the research aim of comparison between the two pre-registration midwifery education routes.

Table 17 Frequency distribution showing participants in three age groupings

Variable	BM 07 + BM 08 (*n* = 30)		GD 07 + GD 08 (*n* = 45)		Total (*n* = 75)	
Age (years)	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
≤30	6	20	20	44	26	35
31-45	12	40	23	51	35	47
≥46	12	40	2	4	14	18
Total	30	100	45	100	75	100

The age of the majority of survey participants was in the two youngest groups ≤30 years (35%) and 31-45 years (47%). As a percentage of total participants, the sum of these two groups was 82 percent. A Chi-square test for independence indicated a significant association between types of pre-registration midwifery education completed and age groups when age was analysed in the three groups (≤ 30 years, 31-45 years, and ≥ 46 years), (x^2 (1, n = 75) = 23.66, p = 0.01). Bachelor of Midwifery participants were older than the Graduate Diploma of Midwifery participants: 80 percent of the Bachelor of Midwifery participants fell into the two oldest groups (n = 12 or 40% were 31-45 years old; n = 12 or 40% were ≥ 46 years old), whilst only 20 percent of participants (n = 6) were aged ≤ 30 years. Conversely, only two Graduate Diploma of Midwifery participants were in the ≥ 46 years (n = 2, 4%), whilst 20 (n = 20) Graduate Diploma of Midwifery participants were ≤ 30 years, and 23 (n = 23) Graduate Diploma of Midwifery participants were aged 31-45 years (44% and 51% respectively).

Presenting the ages of the two education groups as a mean also reveals the older ages of the BM participants as compared to their GD counterparts. The mean age of the BM participants was 7.6 years more than the GD participants (Table 18).

Table 18 Ages as a mean in two participant groups for all survey participants

Variable	Age (years)		
Age	**Number**	**Mean**	**SD**
BM 07 + BM 08	30	40.4	9.17
GD 07 + GD 08	45	32.8	5.45
Total participants	75	35.8	8.03

When assessing for mean differences between the two education groups, BM and GD, an Independent Samples Mann-Whitney *U* Test was used. As a non-parametric test for the difference in means, it revealed a significant difference regarding the distribution of ages

when separating the participants into the BM and GD groups with a *p* value of < 0.01. The BM participants were statistically significantly older than the GD group.

Sixty-one percent of the 75 survey participants had children aged ≤ 16 years living at home (*n* = 46). Table 19 shows that of the 29 participants who did not have children aged ≤ 16 years living with them, more Graduate Diploma participants did not (*n* = 20; 44% of a total of 45 Graduate Diploma participants) compared with Bachelor of Midwifery participants (*n* = 9; 30% of a total of 30 Bachelor of Midwifery participants). This may be because the Bachelor of Midwifery participants were older than the Graduate Diploma of Midwifery participants.

The frequency of those participants with children ≤16 years living at home was also examined as per the three age groups (Table 19). The two older age groups (31-45 years and ≥ 46 years) had more children living with them than did the youngest age group (≤ 30 years). In the age group ≤ 30 years (*n* = 26), 54 percent had no children (*n* = 14) and 46 percent had children (*n* = 12). About two-thirds of participants in this age group who had children had one child (*n* = 7; 58%). Twenty-five of the 35 participants who were in the 31-45 years age group had children aged ≤ 16 years living at home (71%). Nine of the 14 participants in the oldest group aged ≥ 46 years had children aged ≤ 16 years living at home (64%).

Table 19 Frequency distribution of participants with children ≤16 years living at home

Variable	BM 07 + BM 08 (*n*=30)		GD 07 + GD 08 (n=45)		Total (*n*=75)	
Children ≤16 yrs living at home	Frequency	Percent	Frequency	Percent	Frequency	Percent
0	9	30	20	44	29	39
1	9	30	10	22	19	25
2	9	30	12	27	21	28
3	2	7	2	5	4	5
≥ 4	1	3	1	2	2	3
Total	30	100	45	100	75	100

The majority (*n* = 59) of participants were married or in de facto relationships (79%) and 20 percent were single (*n* = 15). One participant had been recently widowed. Most were born in Australia (*n* = 56; 71%). Other places of origin were the UK (7%; *n*=5), New Zealand (4%; *n*=3), Europe and Asia (1% each; *n*=1 respectively). Other countries of origin for the remaining 12 percent were: The Netherlands, Germany, Lebanon, Africa, and Saudi Arabia. The majority spoke English as their primary language at home (93%). Eighty percent lived in

metropolitan areas (*n* = 60) and 20 percent lived in regional/rural areas (*n* = 15). No participants lived in remote areas. Only eight of the 75 participants had relocated their home for midwifery work. No participants were Aboriginal or Torres Strait Islander (ATSI), despite it being known that there was a small number of potential participants who identified as such.

The Graduate Diploma of Midwifery participants had worked in general nursing prior to commencing midwifery education for a mean of 2 years and 8 months. The minimum duration of practising as a general registered nurse was zero years, those participants having had gone straight into the Graduate Diploma of Midwifery after completion of their Bachelor of Nursing. The maximum time spent in general nursing was 10 years.

All but one participant registered with the midwifery regulatory body post graduation (Nursing and Midwifery Board of Australia), thus allowing 99 percent of participants to legally practice as a midwife. The one participant who did not register at all was a Bachelor of Midwifery participant. The majority of participants registered as a midwife within one year post completion of midwifery education (*n* = 68; 91%). Five registered within two years (*n* = 5; 7%) (*n* = 3 Bachelor of Midwifery participants and *n* =2 Graduate Diploma of Midwifery participants). A Bachelor of Midwifery participant unwittingly delayed registration due to childbearing and due to having worked as a midwifery researcher had been able to register within three years (*n* = 1; 1%)[8].

The distribution of the participants amongst the midwifery workforce participation trends is indicated in Table 20 on the next page. Over three-quarters of the participants were working as a midwife at time of data collection (*n* = 59; 77%). More Bachelor of Midwifery participants remained in the midwifery workforce than did Graduate Diploma of Midwifery (87% and 74% respectively). Of those who did not work as a midwife, only four had never worked as a midwife, four practised midwifery and then returned to nursing, and eight practised midwifery and went into another career.

[8] The Nursing and Midwifery Board of Australia and the Australian Health Practitioner Regulation Agency stipulate that for midwives to be eligible to practise they must register as midwives within two years of completing their midwifery education.

Table 20 Participation trend frequencies of the participants

Variable	BM 07 + BM 08 (n=30)		GD 07 + GD 08 (n=45)		Total (n=75)	
Midwifery workforce participation trends	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Still in midwifery practice	26	87	33	74	59	77
Never practised midwifery	2	7	2	4	4	5
Practised midwifery returned to nursing	n/a	n/a	4	9	4	5
Practised midwifery went into another career	2	7	6	13	8	11
Practised midwifery then retired from the workforce	0	0	0	0	0	0
Total	30	100	45	100	75	100

One Bachelor of Midwifery participant had retired from the workforce after having worked as a midwife since graduation in the intermediate period between Phase 1 and Phase 2 data collection points. As such, Phase 1 data captured her as a participant still working in midwifery practice and her Phase 2 data reflected her newly retired state.

The survey results now continue with those 16 participants who were not currently working in the midwifery workforce at the time of Phase 1 data collection. After that, the results of the 59 participants still working in the midwifery workforce will be considered.

6.2.2 Participants currently not working in midwifery

Of the 16 participants not working as a midwife, four had never worked in the midwifery workforce. One of each of these four participants came from BM 07, GD 07, BM 08 and GD 08. Dissatisfaction with midwifery (*n* = 2) and family commitments (*n* = 1) were the main reasons they gave for never working as a midwife. One participant did not respond to this question.

Responses to how long the participants worked as a midwife prior to ceasing varied, from 6 to 12 months through to more than five years. Of these, one-third (*n* = 5) worked for two to three years prior to ceasing. Similarly, the time frame of realising that the participant wanted to leave the midwifery workforce after initially commencing work as a midwife

varied, but the highest percent of responses was two to three years (31%). This suggests that there was not a prolonged period between wanting to leave the midwifery workforce and then actually leaving.

The two most frequent main reasons for not working in midwifery, for both those midwives who had at some stage worked as a midwife prior to leaving and also those midwives who left the profession without ever working in it, were: Dissatisfaction with midwifery (*n* = 2) and family commitments (*n* = 5).

The youngest participant not working as a midwife was 28 years, with the oldest being 42 years. The mean age was 33 years. Ten were aged between 31 to 45 years (*n* = 10; 62.5%) and 6 were ≤ 30 years old (37.5%). These age groups are similar to the Australian maternal mean age of 30.1 years, which is important to consider when the main reason for leaving midwifery given by these participants who were out of the midwifery workforce was for family commitments. All but three of this group had children ≤ 16 years.

Family commitments may also explain the participants' direction away from full-time employment, with half of them not being in any paid employment (*n* = 8). Of those eight who were working, three were in full-time work, four in part-time work, one was casually employed and one self-employed. The type of employment varied however, many of the participants had remained in a health-related field with jobs ranging from: Registered nurse (*n* = 2), university research assistant (*n* = 1), child and family health nurse (*n* = 2), Calmbirth™ practitioner (*n* = 1), Health Care Complaints Commission staff member (*n* = 1), and a health district role (*n* = 1). One participant working in a non-health related field worked as a tour leader overseas (*n* = 1). Six of the 16 participants had obtained further qualifications since graduating as a midwife. These qualifications were listed as a Bachelor of Midwifery honours degree (*n* = 2), Calmbirth™ course (*n* = 1), Certificate IV in Workplace Training and Assessment (*n* = 1), Graduate Certificate in Child and Family Health (*n* = 1) and a Master of Public Health (*n* = 1).

The participants were asked to indicate whether they were more satisfied with their current job than when they were a midwife. Of the 12 who had worked as a midwife: two surveys had missing data for this question, four indicated they were more satisfied and six indicated they were less satisfied. No significance can be drawn from these results. However, only two of the 16 participants not working as a midwife would not recommend

the career of midwifery to others, of these 16, 12 (75%) of them were considering commencing/re-commencing employment into the midwifery workforce.

Written responses to the open-ended question about whether they would recommend midwifery as a career to others were solicited. Even though these responses were solicited from participants who were not working as a midwife, the responses put the profession in a positive light:

> *It's an amazing job where you get to work with women and their families during a very important life event* (BM 07 P13); and
>
> *It is a wonderful profession and provides immense job satisfaction. I believe it is a truly special job* (GD 08 P9); and
>
> *I love it! It is a very rewarding job/vocation* (GD 08 P8); and lastly:
>
> *Nursing and midwifery are very rewarding: Lots of different career options and flexibility* (GD 08 P18).

However, the following participant did not agree with this flexibility and superfluity of employment opportunities:

> *If there are gaps in employment it can be difficult to secure employment. Increasingly more part-time positions* (GD 08 P19).

One response emphasised the participant's mixed feeling about being a midwife in the hospital sector, saying that there was:

> *Opportunity for rewarding work and a broad scope to apply skills. I love that there's the potential to assist women in improving their sense of self, and make this rite of passage all about them, though this can be hard in current hospital system* (BM 07 P5).

Similarly, the following participant valued her relationship with women, but considered there to be negative traits of the profession:

> *I love being a midwife and I love being with women during this most important time of their life. Would I choose this path again? Probably not. The hours are long, the pay is poor, it is very stressful, and you burnout very quickly* (GD 07 P18).

This response drew attention to the difficulties of shift work saying that midwifery is a:

> *Great job as you get to do satisfying work, work with people. Depends on personality and how you cope with shift work (how hospital deals with roster etc.) but overall I would recommend it* (GD 07 P10).

These two responses spoke of midwifery as not being a personal fit for them:

> *Midwifery is an excellent choice for many people- just not for me!* (BM 07 P3); and
>
> *For the right person it can be a very rewarding career* (BM 08 P10).

The final part of the survey for those participants who were not working as midwives regarded career advice that they would provide to others who were interested in embarking upon a midwifery career. Some responses indicated the need to be equipped with knowledge and skills prior to embarking on a midwifery career, for example:

> *Make sure you are suited then go for it* (GD 07 P10); and
>
> *Obtain some work experience if possible, especially to know if you are able to cope with the shift work* (GD 08 P9).

One participant considered being a registered nurse was beneficial to the role of a midwife in the era of rising acuity of women, when she wrote:

> *Be sure to train as a RN first as many women are unwell these days and this knowledge has helped me endlessly* (GD 09 P8).

The next response drew attention to the possibility and utility of having a mentor:

> *Find a mentor who inspires you and stick to them like glue* (BM 07 P3).

This participant thought it was important to address what she thought as the reality of being a midwife in a hospital:

> *Be realistic about what options are available to you e.g. shift work in a hospital, fragmented care and high levels of intervention!* (BM 08 P10).

The following response indicated that to this participant, the fundamental issue was the relationship with women:

> *If you have a passion for helping women, empowering and caring for women and families and babies, then this is the profession for you* (GD 08 P10);

Whilst this last quote alluded to the need to be certain about career intentions and ideology, due to the intersection of politics and the midwifery profession:

> *At this stage, I feel people considering midwifery would have to be quite committed to the profession, to know their intentions, as the politics can be very challenging, and if you are unsure about your intentions, you could easily be deterred* (BM 07 P5).

These written responses revealed some views of working within the midwifery profession. The next section presents the survey results from those participants who were currently working in midwifery at time of data collection.

6.2.3 Participants currently working in midwifery

Of the 59 participants who were working in the midwifery workforce, only one was male (*n* = 1). The mean age was 37 years, the minimum being 27 years, the oldest being 56 years. Mean age for the Bachelor of Midwifery participants was 41.2 years, whilst that of the Graduate Diploma midwives was 32.9 years (Table 21). As the ages of the participants were not normally distributed, non-parametric testing was conducted. Independent Samples Mann-Whitney *U* Test revealed a significant difference regarding the distribution of ages when separating the participants into the BM and GD groups with a *p* value of ≤0.01. The BM participants were statistically older than the GD group.

Table 21 Ages as a mean in two participant groups for participants working as midwives

Variable	Age (years)		
Age	**Number**	**Mean**	**SD**
BM 07 + BM 08	26	41.2	9.4
GD 07 + GD 08	33	32.9	6.1
Total	59	36.5	8.7

In terms of their relationship status, 76 percent were married or in de facto relationships, 22 percent were single and 2 percent, or one participant, were widowed. When considering those who had children ≤ 16 years and those who did not was approximately a 50:50 split. The majority lived in a metropolitan area (83%), whilst the remaining 17 percent lived in a regional or rural setting.

A greater percentage of BM than GD participants were currently working as a midwife. Twenty-six of the Bachelor of Midwifery participants were working as midwives (*n* = 26; 86%), whilst 33 of the Graduate Diploma of Midwifery participants were (*n* = 33; 73%). This shows that participants from the Graduate Diploma of Midwifery were slightly less likely to be working, an occurrence which could possibly be due to their younger age and its relation to childbearing years. Additionally, two of the Graduate Diploma of Midwifery participants had returned to the nursing workforce and, thus, contributes to this participant group being less likely to be working as midwives. Despite this small difference in working rates, a Chi-square for independence indicated no significant association between type of pre-registration midwifery education completed and midwifery workforce retention rate, x^2 (1, *n* = 75) = 3.123, *p* = 0.38, *phi* = 0.20.

In terms of work status, 46 percent of all participants were employed full-time (*n* = 27), 34 percent worked part-time (*n* = 20), 14 percent worked in a casual capacity (*n* = 8), 3 percent worked for a midwifery agency (*n* = 2), and 3 percent were self-employed and not working in a hospital (*n* = 2). Therefore, all but two worked in a hospital setting. Only ten of the 59 participants worked on set days (*n* = 10; 17%). No statistical association between having children or not and full-time work status existed.

Participants were asked to state the number of hours per week they worked as a midwife. Although only asked to respond with a definite number, participants unfortunately answered in two ways: With one number or as a range. For those participants who replied with a definite number (*n* = 52), the mean hours worked in a week was 31 hours, the minimum 8 hours and the maximum 40 hours. Seven participants responded to the question with a range of working hours, indicating that their hours worked each week were noticeably variable. The mean for the lowest figure given for hours worked, if a range was given, was 17 hours. The mean for the highest figure given for hours worked, if a range was given was 34 hours. The minimum response when a range was given was 5 hours and the maximum was 60 hours. The education stream the participants came from did not seem to have a bearing upon the hours worked.

Nineteen of the 58 participants working in a hospital (*n* = 19; 33%) worked additional un-rostered hours, equally distributed across the two education streams. The mean of these extra hours worked for these 19 participants was two hours per week. The minimum given by one participant was one hour extra and the maximum given by another participant was 14 hours. Of those who worked extra hours, a little over a half of them stated they got paid

for them (*n* = 10; 54%). Written responses given for the reason for working these extra hours were short-staffing, poor skill-mix, having no meal breaks, staying back to complete tasks when shifts were busy, they elected to work extra hours if asked for extra pay, the administrative responsibilities of being a midwifery unit manager, and staying over-time to attend to a woman's birth. One participant responded straightforwardly: "increased activity with decreased staff levels" (GD 07 P14).

Most of these participants worked in a hospital (*n* = 50; 85%), 12 percent worked both in a hospital and in the community (*n* = 7), and 3 percent were self-employed (*n* = 2). The two self-employed participants were Bachelor of Midwifery graduates. Besides these two who were self-employed, the public sector employed the majority of the participants (*n* = 53; 90%) and the private sector only 5 percent (*n* = 3). One (*n* = 1; 2%) worked in both the public and private sectors. All participants, even the two self-employed participants, had at some stage been employed by a hospital as a midwife. Table 22 depicts the number of hospitals employed by in terms of frequency and percent of participants. Most had worked in one or two hospitals as a midwife.

Table 22 Frequency of workforce patterns in BM and GD participation groups

Variable	**BM 07 + BM 08 (*n* = 26)**		**GD 07 + GD 08 (*n* = 33)**		**Total (*n* = 59)**	
Number of hospitals employed by	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
1	9	35	18	55	27	46
2	10	38	12	36	22	37
3	5	19	0	0	5	8.5
≥4	2	8	3	9	5	8.5
Total	30	100	45	100	75	100
Variable	**BM 07 + BM 08 (*n* = 24)**		**GD 07 + GD 08 (*n* = 33)**		**Total (*n* = 57)**	
Length of time worked at current hospital	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
<6 months	2	8	2	6	4	7
6-12 months	1	4	0	0	1	2
1-3 years	8	33	6	18	14	25
4-6 years	13	55	25	76	38	66
Total	24	100	33	100	57	100
Variable	**BM 07 + BM 08 (*n* = 25)**		**GD 07 + GD 08 (*n* = 33)**		**Total (*n* = 57)**	
Length of time worked in current midwifery role	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
<6 months	2	8	6	18	8	12
6-12 months	3	12	3	10	6	11
1-3 years	13	52	9	27	22	38.5
4-6 years	7	28	15	45	22	38.5
Total	25	100	33	100	57	100
Variable	**BM 07 + BM 08 (*n* = 26)**		**GD 07 + GD 08 (*n* = 33)**		**Total (*n* = 59)**	
Title of current midwifery role	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Clinical midwife	23	88	24	73	47	80
Clinical midwifery specialist	0	0	3	9	3	5
Management	0	0	2	6	2	3
Clinical education	0	0	3	9	3	5
Research	1	4	0	0	1	2
Antenatal education	1	4	1	3	2	3
Privately practising homebirth midwife	1	4	0	0	1	2
Total	26	100	33	100	59	100

Table 22 cont… Frequency of workforce patterns in BM and GD participation groups

Variable	BM 07 + BM 08 (*n* = 26)		GD 07 + GD 08 (*n* = 33)		Total (*n* = 59)	
Work area of current midwifery role	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Rotational position	6	23	10	30	16	27
Birthing wards	6	23	8	24	14	24
Continuity of care model	5	19	5	15	10	17
Antenatal/postnatal ward	6	23	2	6	8	13
Parent education	1	4	2	6	3	5
Antenatal clinic	1	4	1	3	2	3
Midwifery education	0	0	3	10	3	5
Community midwife (e.g. Midwifery Support Program, outreach program, home visiting)	0	0	1	3	1	2
Private practice	1	4	0		1	2
Management	0	0	1	3	1	2
Total	26	100	33	100	59	100
Variable	**BM 07 + BM 08 (*n* = 26)**		**GD 07 + GD 08 (*n* = 33)**		**Total (*n* = 59)**	
Work pattern of current midwifery role	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Combination AM/PM/night shifts	17	65	16	49	33	56
On call/continuity	6	23	6	18	12	20
Day shift only	2	8	5	15	7	12
Other	1	4	4	12	5	9
Night shift	0	0	2	6	2	3
Total	26	100	33	100	59	100

The length spent employed in the participants' current hospital is also shown in Table 22. 'Current' referred to the hospital that the participants were working in at the time of being surveyed. For those participants working in a hospital, 38 had been employed for 4 to 6 years (*n* = 38; 66%) and 14 for 1 to 3 years (*n* = 14; 24%).The table also shows the length of time all of the 59 participants who were working in the midwifery workforce had worked in their current midwifery role.

The majority were employed in a clinical midwife position (*n* = 47; 80%) (Table 22). As a percentage, more Bachelor of Midwifery participants worked in a clinical position than did the Graduate Diploma of Midwifery participants (88% and 73% respectively). All eight of the participants who worked in roles that were a progression from working in a clinical capacity (clinical midwifery specialist, management, clinical education) were educated in the Graduate Diploma of Midwifery route. The privately practising midwife had undertaken the Bachelor of Midwifery course.

Participants were also requested to indicate the work site or area in which they were employed in their midwifery role. The four most frequently sites were firstly, as a rotational midwife working in all clinical areas (*n* = 16; 27%), next in birthing wards (*n* = 14; 24%), and then in a continuity of care model (*n* = 10; 17%), and then in antenatal/postnatal ward[9], (*n* = 8; 13%) (Table 22).

The most frequently worked pattern was shift work across all shifts with over half of the participants working a combination of morning, evening and night shifts (*n* = 33; 56%). An on-call or continuity pattern was worked by 12 participants (*n* = 12; 20%), and working only a day shift or office hours by seven (*n* = 7; 12%). Two only worked night shift (*n* = 2; 3%). The 'other' patterns specified in written responses were 12 hour day/night shifts (*n* = 3; 5%), casual hours for childbirth education (*n* = 1; 2%), and evening and weekend classes (*n* = 1; 2%). These results indicated a varied pattern of work within a 24 hour period.

Eleven of these 59 participants were also required to work in general nursing (*n* = 11). Ten of these (*n* = 10; 91%) would have preferred to work only in a midwifery role. Three of the participants who stated that they were required to work in general nursing had undertaken the Bachelor of Midwifery education course and looked after women with reproductive health conditions. All three also preferred not to work in a general nursing capacity.

A total of 17 participants (29%) had spent time out of their career (range three months to three years). The mean was one year. Sixteen responded to a question asking them to specify the reason for the time out of midwifery work. For seven participants (*n* = 7; 12%) it was to care for dependent children. For one it was to work in a job other than midwifery and eight responded 'other' and specified their response. These written responses varied from burn out, stress, full-time study both internal and external to the midwifery profession, no available employment in a rural hospital, evaluating whether midwifery was

[9] Antenatal/postnatal wards are sometimes referred to as maternity wards.

what the participant wanted to do as a chosen career, and overseas travel. Only eight participants had also worked outside of midwifery (*n* = 8; 14%). The jobs specified by these eight participants were: Casual lecturers at university, registered nurse in an emergency department, photographer, church ministry, office administration, and casual work assisting a friend's business.

Twenty of this group had obtained further qualifications. Most of these qualifications were within the health disciplines, and many were midwifery related. Health related further qualifications were specified as: Graduate Certificates in Family Planning, Child and Family Health, Immunisation, Sexual Health, Masters of Public Health, Health Service Management, and in International Public Health. Midwifery specific courses included: Advanced Life Support in Obstetrics (ALSO), Childbirth and Parenting Education, Hypnobirthing™, Graduate Certificate in Midwifery and Prescribing, Lactation Consultant, Masters of Midwifery, Bachelor of Midwifery Honours and three participants were undertaking a Doctorate of Philosophy in Midwifery. Two participants had completed education qualifications, namely a Graduate Certificate of Adult Education and a Certificate IV in Education and Training. These two qualifications are often undertaken by people who are employed in a midwifery lecturing capacity at a university or in an education role such as a hospital clinical midwifery educator. One participant was concomitantly working in church ministry had completed some religious studies. Therefore, the range of qualifications obtained by these 20 participants could either be utilised to further their careers within the midwifery profession, move outside of midwifery but remain within a health discipline, or entirely step outside a health related job.

6.3 Conclusion

Chapter 6 presented the results of Sections A, B and C of the survey. These showed that all but one of the 75 survey participants were female, their ages ranging from 27 to 56 years. The Bachelor of Midwifery participants were older than their Graduate Diploma of Midwifery counterparts. Most had children ≤ 16 years living at home with them. Most lived in metropolitan areas. Seventy-seven percent of the participants were working as a midwife at the time of data collection. Family commitments and dissatisfaction with midwifery were the two most commonly cited reasons by those participants who were not currently working in the midwifery workforce. Of those working as a midwife, just less than half (46%) were working in a full-time capacity. The least amount of hours worked in a

week was five, the most was 60. All but two of the participants worked in a hospital and 90 percent were employed in the public sector. Eighty percent of the survey participants worked in a clinical role.

Now that a demographic representation and an understanding of workforce patterns has been attended to, the rest of the survey results will be presented. These are the results of three instruments: MBI, PES-NWI, and the PEMS. Chapter 7 provides these findings.

Chapter 7: Results of the survey instruments

7.1 Introduction

This chapter presents the results from the burnout, practice environment and empowerment data for those participants who *were* currently working as midwives. Those not currently working as midwives did not undertake these sections of the survey. The three instruments were the Maslach Burnout Inventory (MBI), the Practice Environment Scale of the Nursing Work Index (PES-NWI), and the Perceptions of Empowerment in Midwifery scale (PEMS). Similarly to the demographic methods discussed in the previous chapter, due to the small number of participants in each of the four participant groups (BM 07, BM 08, GD 07, GD 08), analysis has been undertaken by combining them into two groups (BM and GD) as we were interested in differences between courses rather than between years.

The presentation of the data analysis of the three instruments firstly focuses on the mean scores. Then secondly, the results of the non-parametric Independent Samples Mann-Whitney *U* Test analysis are given. The following independent variables were used in the analysis:

- Bachelor of Midwifery participants versus Graduate Diploma of Midwifery participants;
- Full time work versus part time work;
- Age of participants in three groups;
- Clinical versus non clinical midwifery role;
- Continuity model versus non continuity model;
- Metropolitan versus regional address;
- Prepared by midwifery education versus not prepared by midwifery education;
- Considered leaving midwifery versus not having considered leaving midwifery;
- Public versus private sector;
- Rather work in other midwifery area versus not rather work in other midwifery area;
- Plan to continue working as a midwife versus not planning to continue working as a midwife; and
- Plan to change hours of midwifery work versus not planning to change hours of midwifery work.

With the aim of minimising the possibility of finding any statistical significance purely by chance, it was elected that due to the small sample size in this study and the large number of comparisons, a smaller *p* value ($p \leq 0.01$) would be used.

7.2 Burnout

The Maslach Burnout Inventory (MBI) is comprised of three scales: *Emotional exhaustion*, *Depersonalisation* and *Reduced personal accomplishment*. Each participant's scores were classified as pertaining to either high, moderate or low levels of burnout on each of the respective subscales. Each scale is scored by calculating subscale means (Table 23).

Table 23 Mean scores of MBI subscales

Pre-registration midwifery education groups	Number (% of total participants)	MBI-HSS subscale scores		
		Emotional exhaustion Mean (SD)	**Depersonalisation** Mean (SD)	**Reduced personal accomplishment** Mean (SD)
BM	26 (44%)	18.3 (10.3)	3.8 (6.6)	41.3 (11.3)
GD	33(56%)	18.5 (10.7)	4.3 (4.4)	39.5 (5.9)
Total	59 (100%)	18.4 (10.4)	4.1 (5.4)	40.3 (8.6)

*Only the 59 working as midwives were included

Scores for the total 59 participants as a single group of working midwives revealed moderate levels of emotional exhaustion, a low level of depersonalisation and a low level of reduced personal accomplishment (high level of personal accomplishment). These results indicate the participants perceived moderate levels of being emotionally overextended and exhausted by their work, low levels of an unfeeling and impersonal nature towards women in the care and high levels of workplace efficacy.

Non-parametric Independent-Samples Mann-Whitney *U* testing indicated no significant difference for each of the three MBI subscale scores when comparing the education groups. This suggests firstly, that any feeling of being emotionally overextended and exhausted by one's work was not dependent upon the participant's midwifery education type. Secondly, the education course may not affect levels of insensitivity or impersonal responses toward women. Thirdly, it indicates that a feeling of competence and successful achievement may be experienced regardless of educational group.

Other non-parametric testing was undertaken for the other variables. These will be presented by considering each of the three subscales, starting with *Emotional exhaustion*.

7.2.1 'Emotional exhaustion'

The *Emotional exhaustion* subscale for those participants who had seriously considered leaving midwifery (*Md* = 25, *n* = 27) differed as compared to those who had not (*Md* = 12, *n* = 32) (*p* value ≤0.01). The median score for those participants who had seriously considered leaving the profession suggested these participants perceived moderate levels of being emotionally overextended and exhausted by their work. Those who had not considered leaving had a median score suggestive of low levels of emotional exhaustion.

7.2.2 'Depersonalisation'

The *Depersonalisation* subscale for those participants who had seriously considered leaving midwifery (*Md* = 5, *n* = 27) differed as compared to those who had not (*Md* = 1, *n* = 32) (*p* value ≤0.01). These results suggest that the participants who had considered leaving had greater levels of an unfeeling and impersonal nature towards women in their care. Despite the differences, both groups of participants (those who had considered leaving the profession and those who had not considered it) scored a low level of depersonalisation in the MBI *Depersonalisation* subscale.

There was a statistically significant difference for the *Depersonalisation* subscale for those participants working in a continuity role (*Md* = 0.5, *n* = 12) and those working in a non-continuity role (*Md* = 2.0, *n* = 55) (*p* value ≤0.01). This suggests that those midwives working in a continuity role experience less unfeeling and impersonal responses toward women in their care.

7.2.3 'Reduced personal accomplishment'

The *Reduced personal accomplishment* subscale for those participants who had seriously considered leaving midwifery (*Md* = 38, *n* = 27) differed as compared to those who had not (*Md* = 43, *n* = 32) (*p* value ≤0.01). This suggests feelings of competence and successful achievement in work was lower in those participants who had considered leaving.

No other statistically significant differences were achieved between the independent variables and the three MBI subscale scores. Data analysis in relation to the environment in which the participants practised will now be presented.

7.2.3 Summary of MBI

Maslach Burnout Inventory scores revealed moderate levels of emotional exhaustion, low level of depersonalisation and low levels of reduced personal accomplishment in the 59 participants who were working as midwives. No statistical differences were revealed between the BM and GD participants in the three MBI subscales. When assessing subscales scores, those participants who had seriously considered leaving scored higher on all the *Emotional exhaustion* and *Depersonalisation* subscales and lower on the *Reduced personal accomplishment* subscale, suggesting these participants, as compared to those who had not considered leaving, perceived a lack of enthusiasm and motivation and feelings of cynicism and ineffectiveness. Results for the *Depersonalisation* subscale for those participants who worked in a continuity of care model were lower than those participants who did not, suggesting that greater feelings of cynicism were associated with working outside of a continuity model.

7.3 Practice environment

The Practice Environment Scale of the Nursing Work Index (PES-NWI) comprises of five subscales: *Staffing and resource adequacy*, *Collegial midwife-doctor relations*, *Midwife participation in hospital affairs*, *Midwife manager ability, leadership and support of midwives*, and *Midwifery foundations for quality of care*.

Each participant's scores were classified as pertaining to either in agreement, disagreement or neutral with each of the respective subscales. These subscales are factors which have the potential to have a favourable or unfavourable impact upon the participants midwifery work (Table 24). These results will be discussed, as will be the non-parametric analysis of the same independent variables that were used for the MBI non-parametric analysis. As with the MBI analysis, a *p* value of ≤0.01 was used.

Table 24 Mean scores of PES-NWI subscales

Pre-registration midwifery education groups	Number (% of total participants)	PES-NWI subscale scores				
		Midwife participation in hospital affairs Mean (SD)	**Foundations for quality midwifery care** Mean (SD)	**Midwifery leadership** Mean (SD)	**Staffing and resources** Mean (SD)	**Midwife-doctor relationships** Mean (SD)
BM	26 (44%)	2.45 (0.48)	2.81 (0.49)	2.71 (0.71)	2.40 (0.69)	2.87 (0.62)
GD	33(56%)	2.64 (0.47)	2.81 (0.42)	2.76 (0.54)	2.48 (0.68)	3.0 (0.63)
Total	59 (100%)	2.56 (0.48)	2.81 (0.49)	2.75 (0.62)	2.45 (0.68)	2.94 (0.62)

Across the 59 participants, four out of five mean scores of the PES-NWI subscales were above 2.5. This indicates that the participants considered the practice environments were favourable as regards to *Midwife participation in hospital affairs*, *Foundations for quality midwifery care*, *Midwifery leadership* and *Midwife-doctor relationships* in their workplaces. There were negative impressions of *Staffing and resources* as this subscale's results were less than 2.5 for the Bachelor of Midwifery participants and Graduate Diploma of Midwifery participants, as well as when combining all of the total 59 participants from both of these two midwifery education groups.

There were no significant differences for each of the five PES-NWI subscale scores between the two education groups. This was also the case for the *Midwife participation in hospital affairs* subscale despite the BM participants scoring less than 2.5 (a perception of poor midwifery participation in hospital affairs in participants' practice environments) and the GD participants scoring greater than 2.5, (a perception of positive midwifery participation in hospital affairs in participants' practice environments).

The mean scores of each item were analysed due to the clarity of the constructs underpinning each item and the sound relationship each has to midwifery. The individual items which scored below 2.5 suggested a negative view of those aspects of the practice environment and the lack or absence of these factors in the participants work were those focusing on adequate support to spend time with women, adequate staffing for the provision of quality care, supportive leadership positions and being given recognition of work done. The items were: Item 1 – *Adequate support services allows me to spend time with the women I care for* (*Mn* = 2.4, *SD* = 0.88); Item 9 - *Enough registered midwives to provide quality care to women* (*Mn* = 2.2, *SD* = 0.88); Item 11 - *A Director of Nursing and Midwifery who is highly visible and accessible to staff* (*Mn* = 2.4, *SD* = 0.86); Item 12 - *Enough staff to get the job done* (*Mn* = 2.3, *SD* = 0.81); Item 13 – *Praise and recognition for a job well done* (*Mn* = 2.4, *SD* = 0.72); Item 21 – *Administration that listens and responds to employee concerns* (*Mn* = 2.4, *SD* = 0.70); Item 28 (*Mn* = 2.4, *SD* = 0.62).

7.3.1 'Midwife participation in hospital affairs'

A statistically significant difference for the *Midwife participation in hospital affairs* subscale for those participants working in a clinical role (*Md* = 2.6, *n* = 50) from those working in a

non-clinical role (*Md* = 3.2, *n* = 6) was found (*p* value ≤0.01). Non-clinical midwives scored higher on this subscale suggesting that they perceived their participation, as midwives, in hospital affairs was significant as compared to the clinical participants.

7.3.2 'Foundations for quality midwifery care'

A statistically significant difference for the *Foundations for quality midwifery care* subscale for those participants working in a continuity role (*Md* = 3.06, *n* = 12) from those working in a non-continuity role (*Md* = 2.78, *n* = 53) (*p* value ≤0.01). These results suggest that those midwives working in a continuity role felt more favourable about midwifery professional development in their practice environments.

7.3.3 'Midwifery leadership', 'Staffing and resources' and 'Midwife-doctor relationships'

There were no significant differences for the *Midwifery leadership*, *Staffing and resources*, and *Midwife-doctor relationships* subscales as regarding the list of independent variables used.

7.3.4 Summary of PES-NWI analysis

The results indicated that the participants considered their workplaces favourable work environments as only one area scored unfavourably. Participants held negative impressions of the staffing and resources in their practice environments as indicated by the *Staffing and resources* subscale scores. No statistical differences were evident between the BM and GD cohorts. Non-clinical midwives scored higher on the subscale measuring perceptions of midwifery participation in hospital affairs, suggesting that they perceived their participation, as midwives, in hospital affairs was significant as compared to the clinical participants. Those midwives working in a continuity role felt more favourable about midwifery professional development in their practice environments as opposed to those midwives working outside of this model.

7.4 Midwifery perceptions of empowerment in practice

The Perceptions of Empowerment in Midwifery (PEMS) measures perceptions of their own empowerment as regards to conditions within their working roles that are important to facilitating this perception. Table 25 presents the PEMS score results.

Table 25 Mean scores of PEMS subscales

Pre-registration midwifery education groups	Number (% of total participants)	**Total PEMS scores** Mean (SD)	**PEMS subscale scores**		
			Autonomous practice Mean (SD)	**Effective management** Mean (SD)	**Woman-centred practice** Mean (SD)
BM	26 (44%)	7.13 (1.96)	2.51 (0.81)	2.56 (0.79)	2.06 (0.66)
GD	33 (56%)	5.99 (1.17)	2.11 (0.52)	2.15 (0.58)	1.74 (0.46)
Total	59 (100%)	6.49 (1.66)	2.29 (0.69)	2.33 (0.7)	1.88 (0.57)

Examining the results for the Total PEMS score for all 59 midwives revealed their score as sitting in the category of high perceived empowerment. The BM cohort scored in the category of high perceived empowerment, whilst the GD cohort scored in the category of very high perceived empowerment. There were no significant differences between the BM and GD participant groups. There were no other associations identified between the Total PEMS score and those variables of interest, also measured in the MBI and PEMS analyses.

Moderate to high levels of perceived empowerment were revealed in the *Autonomous Practice* and *Effective Management* subscales when examining the participants as a total group of 59 midwives, as well as for the BM and GD participant groups. High to very high levels of perceived empowerment were revealed in the *Woman-centred Practice* subscale when examining the participants as a total group of 59 midwives, as well as for the GD participant groups. The BM participant group scored in the moderate to high bracket in this subscale. None of the three subscale scores revealed a significant difference between the two different education groups. The lack of difference suggests that perceptions of possessing midwifery empowerment via autonomous practice, having effective management and feeling their practice was woman-centred may not be dependent upon the participant's midwifery education type.

Other non-parametric testing was undertaken for other variables of interest. These will be presented by considering each of the three PEMS subscales.

7.4.1 'Autonomous practice'

Statistical differences in the *Autonomous practice* subscale between those participants working in a continuity role (*Md* = 1.8, *n* = 12) as compared to those who did not (*Md* = 2.3, *n* = 57) were found (*p* value ≤0.01). This suggests that those midwives working in continuity roles perceive more autonomy in their work. There was also a significant difference in the *Autonomous practice* subscale between those participants who would like to work in another midwifery area (*Md* = 2.6, *n* = 41) as compared to those who did not (*Md* = 2.0, *n* = 18) (p value ≤0.01). The higher the integer result the lower the level of perceived empowerment. This suggests that those participants wanting to move out of their midwifery area perceive less autonomy.

7.4.2 'Woman-centred practice'

Statistical differences in the *Woman-centred* subscale between those participants working in a continuity role (*Md* = 1.3, *n* = 12) as compared to those who did not (*Md* = 2.0, *n* = 57) (*p* value ≤0.01).

Those participants who wanted to work in another area of midwifery had significantly lower scores on the *Woman-centred practice subscale* (*Md* = 1.6, *n* = 41) compared to those who had no desire to move midwifery areas (*Md* = 2.0, *n* = 18) (*p* value ≤0.01).

Statistical differences in the *Woman-centred* subscale between those participants who had seriously considered leaving midwifery (*Md* = 2.00, *n* = 27) as compared to those who had not (*Md* = 1.6, *n* = 32) were found (*p* value ≤0.01).

These findings suggest that those midwives (i) working in continuity role; or (ii) not wanting to work in another midwifery area; or (iii) not having considered leaving the midwifery profession perceived their practice to be more woman-centred in nature.

7.4.3 'Effective management'

There were no significant differences for the *Effective management* subscale using the list of independent variables (*p* value ≤0.01).

7.4.4 Additional instrument item results

The results for the four items which were not part of the PEMS subscales, but important in the concept of midwifery empowerment, will be briefly presented as frequency distributions of possible responses.

7.4.4.1 "I am adequately educated to perform my role"

The majority of responses agreed with this statement: 25 percent strongly agreed (*n* = 15; 25%) and 63 percent agreed (*n* = 37; 63%) with regards to feeling adequately educated. No differences were found between the two education routes (*p* value ≤0.01).

7.4.4.2 "I do not know what my scope of practice is"

The majority of responses disagreed with this statement: 58 percent strongly disagreed (*n* = 34; 58%) and 36 percent disagreed (*n* = 21; 36%) with regards to not being cognisant of their scope of practice. No differences were found between the two education routes (*p* value ≤0.01).

7.4.4.3 "I am accountable for my practice"

All of the 59 participants agreed with this statement. Sixty-eight percent of responses were in strong agreement (*n*= 40; 68%) to this item and 32 percent were in agreement (*n*= 19; 32%). No differences were found between the two education routes (*p* value ≤0.01).

7.4.4.4 "I do not have access to adequate resources for staff education and training"

Nine percent strongly agreed (*n* = 5; 9%) and 54 percent agreed (*n* = 32; 54%). Fourteen percent of responses were neutral (*n* = 8; 14%), 22 percent disagreed (*n* = 13; 22%) and one participant strongly disagreed (*n* =1; 2%). No differences were found between the two education routes (*p* value ≤0.01).

7.4.5 Summary for PEMS results

The participants as a total group of working midwives scored in the high perceived empowerment category in the total PEMS. No significant differences resulted in the analyses when considering any variances between the two pre-registration midwifery education groups for either the total PEMS or any of its three subscales. Those who would rather have worked in another midwifery area scored lower on the *Autonomous practice* and *Woman-centred practice* subscales. Those who had considered leaving midwifery

altogether were more likely to score lower on the *Woman-centred practice* subscale. Most participants responded favourably to the items "I am adequately educated to perform my role" and "I am accountable for my practice". Most participants answered un-favourably to the item "I do not know what my scope of practice is". The spread of responses for the item "I do not have access to adequate resources for staff education and training" were distributed over all of the five possible responses, with the two largest response categories as 54 percent agreeing and 22 percent disagreeing.

The results of the final section of the survey entitled 'Future plans' are now presented.

7.5 Future Plans

The last section of the survey questioned those participants who were working as midwives about their future plans for their work in midwifery. Almost all (52 of the 59) stated that they would continue to work as a midwife (*n* = 52; 88%). Seven responded that that they did not know whether they would (*n* = 7; 12%).

Just over half of the participants had never considered leaving the midwifery profession (*n* = 32; 54%), whilst 39 percent had in the past (*n* = 23). Only four were currently considering leaving midwifery (*n* = 4; 7%). The majority would recommend midwifery as a career to others (n = 52; 88%).

Over half (*n* = 31, 53%) did not plan to change the number of hours they worked. Twenty-seven percent planned to decrease their hours (*n* = 16; 27%), whilst 20 percent planning to increase the hours they worked (*n* = 12; 20%).

No statistical significances were evident between the Bachelor of Midwifery and the Graduate Diploma of Midwifery participant groups for any of these findings, thus suggesting that any decisions about continuing to work as a midwife, leaving midwifery, recommending midwifery as a career to others, and changing the number of hours worked, were not associated with the pre-registration midwifery education course that the participant undertook.

Participant reasons for current or previous considerations for leaving midwifery were given. These were: Burnout (*n* =11), unpredictable nature of shift work/ long hours (*n* = 5), staff shortages (*n* = 3), politics of the hospital setting (*n* = 2), feeling undervalued (*n* = 2), bullying (*n* = 1), poor family and life/work balance (*n* = 1), poor pay (*n* = 1), leaving for another

career (*n* = 1) aged in mid-twenties and wanting to explore other career opportunities (*n* = 1), and not having the opportunity to work in a continuity model (*n* = 1).

Nearly half of the participants planned to stay in their current role (*n* = 27; 46%). Progressing in the profession while staying in a clinical position (*n* = 7; 12%) and moving into another midwifery area (*n* = 6; 10%) were the next two largest categories in this item. Only three participants planned to move into a managerial position (*n* = 3; 5%).

Midwifery work had become more enjoyable overall for 58 percent of participants (*n* = 34; 58%), had stayed about the same for 29 percent (*n* =17; 29%), and had become less enjoyable for only 14% (*n* = 8; 14%). Around half of the participants considered that in the future their midwifery work would stay about the same in terms of how enjoyable it is (*n* = 33; 56%). A total of 34 percent (*n* = 20; 34%) thought it would become more enjoyable over all, and only 9 percent (*n* = 5; 9%) considered it would become less enjoyable over time.

Again, no statistical significances were evident between the education groups for any of these findings, thus suggesting that any consideration about future midwifery role plans, or the perception of work enjoyability over time, were not associated with the pre-registration midwifery education course that the participant undertook.

Written responses regarding recommending midwifery as a career to others were solicited. Many of the comments which drew attention to negative aspects of being a midwife were from the Bachelor of Midwifery participants. Some of these comments were that in midwifery there are:

> *Long hours, shift work, poor pay for a lot of responsibility with more than one life* (BM 07 P1);
>
> *Low pay, shift work, pressure of job, stress and enormous responsibility* (BM 07 P3); and
>
> *Midwifery practice takes the passion out of midwives. The constant battle of advocating for women against hospital policy and procedures/doctors/other midwives is exhausting. Zero reward for such a hard job. Women don't appreciate the effort* (BM 07 P4).

However, not all comments were in a negative vein by the Bachelor of Midwifery participants, as midwifery was specified to be:

> *An opportunity to support women and their partners as they become families, to share knowledge amongst like-minded professionals, enjoy a dynamic multifaceted career* (BM 07 P11); and
>
> *The reward for experiencing pregnancy and birth with women is priceless! The job gives back so much!* (BM 08 P4).

The Graduate Diploma of Midwifery participants who had commented on whether they would recommend midwifery as a profession seemed more positive, with comments highlighting the honour of the midwifery role:

> *It is a privilege to assist women and their partners through the journey of pregnancy, birth and beyond. They enrich our lives as much as we do theirs* (GD 07 P 3); and also
>
> *It's a privilege to be a midwife. Different areas to work in if you choose. You can travel with midwifery* (GD 07 P5); and lastly
>
> *I LOVE my job!!* (GD 08 P71).

The final part of the survey was written advice provided by these participants regarding career advice that should be supplied to others who were interested in embarking upon a midwifery career. Many responses referred to carefully researching into what midwifery is really like before entering the profession and finding out the hospital and model of care that would best suit that individual, with comments like:

> *Really investigate and do your homework* (BM 07 P1);
>
> *Explore all the different opportunities and get lots of experience in different hospitals/ practices/ places* (BM 07 P8); and
>
> *Make sure you know what you are getting yourself into before you start your education!* (BM 07 P3)

Some participants suggested potential midwives should have particular attributes:

> *Only do it if you have thick skin* (BM 07 P4); and
>
> *I think having done my nursing before midwifery is very useful* (GD 07 P5); and
>
> *Keep healthy- it is a physically and emotionally demanding job* (GD 08 P5).

Once in the profession, this participant put forward a multifaceted piece of advice:

> *It is important to have a balanced personal life. Be emotionally stable. Choose a good university and an appropriate hospital for midwifery practice with a range of complexities and good preceptor programs* (GD 07 P14).

And more succinctly:

> *Avoid burnout (BM 07 P15);*

Unambiguously, with regards to choosing a career in midwifery, one participant simply asserted:

> *DO IT* (BM 08 P3).

7.6 Conclusion

The 'Future plans' section concludes the survey results. The survey included demographic and workforce data information and three instruments utilised for collecting work place/force information in health care and midwifery sectors. The last section of the survey gathered information about the future plans of the participants. The results of these data will be considered in the discussion in Chapter 9, where they will be examined in light of prior research, as well as being synthesised with the interview results.

The interview results will now be presented in Chapter 8.

Chapter 8: Interview results

8.1 Introduction

Chapter 6 presented the methods of interview analysis used. Chapter 8 now presents the findings from the textual data gathered in the interviews in Phase 2 of the study, firstly by presenting demographic information about the participants, an overview of the findings and then through textual evidence of each theme.

8.2 Interview participant demographics

Twenty-eight participants took part in the interviews, 13 having undertaken a Bachelor of Midwifery and 15, a Graduate Diploma of Midwifery.

All of the interview participants were female. As such, when referring to the participants, the gender-specific terms 'she' and 'her' shall be used. The ages of the interview participants ranged from 30 to 56 years. The relationship status of the participants varied from being married or in de facto relationships with/without children and single with/without children. One participant was widowed.

The majority of the participants were working as midwives (*n* = 20). One 61 year old participant was retired, one was caring for her children at home, and the other six not working in midwifery were all working in health related fields (nursing: *n* = 2; university research: *n* = 2; health officer for a local health district: *n* = 1; staff member at a national health agency: *n* = 1). All but one had at some stage worked as a midwife. Therefore, all but one had worked in a hospital as a midwife. Five of those who were working as a midwife also had other jobs, four were in health related fields (clinical trials management, physiotherapy, university education, and a community midwife at a chemist). One worked in a religious ministry.

The 20 participants who were practising as midwives had varying employment status within a hospital setting ranging from working five and six days a weeks to one day a month (in full-time, part-time, agency, and casual capacities). Their roles included: clinical midwife, clinical midwifery educator, clinical midwifery specialist, midwifery unit manager, parent

antenatal education, working in continuity of carer models and in midwifery group practices. The settings included: community midwifery care centre, tertiary level hospitals, secondary level hospitals, public sector, private sector, labour and birth suite, delivery suite, antenatal ward, postnatal ward, antenatal clinic, and high risk pregnancy antenatal clinic.

The majority lived in NSW, with five living in other states or territories. Four had at some stage worked as midwives in remote settings across different Australian states and territories.

8.3 An overview of the interview results

The findings are separated into three principal themes, each of which incorporates subthemes (Table 26). Considering that the aim of Phase 2 was to examine the participants' workforce experiences and choices in their transition from being a midwifery student and then into the first years of working, part of the data focuses on being a new graduate midwife and part is comprised of what it is like simply to be in the midwifery workforce. This is because the aim of the research was to look at the experiences and workforce choices of the participants, as well as reasons for turnover and retention.

The three themes were:

(i) **Sinking and swimming** (5 subthemes): This theme includes data on the challenges of the transition into becoming a midwife;
(ii) **Needing a helping hand** (2 subthemes): This theme includes data on being a midwife; and
(iii) **Being a midwife… but** (4 subthemes): This theme includes data on the conditions and experiences that lead to the making of long term decisions about being or not being a midwife (Table 26).

Table 26 Overview of interview themes

Sinking and swimming *Theme (i)*	Needing a helping hand *Theme (ii)*	Being a midwife… but *Theme (iii)*
Possessing a readiness? **Transitioning… and with a learning curve** **Enduring the eye rolling** **Assuming responsibility** **Facing fear**	**Calling for support** **Progressing in the profession**	**Being a midwife as a vocation** **Learning about bullying and territorialisation** **Managing ethical dilemmas as a midwife** **Withstanding the power of the system**

Quotes illustrate the themes and subthemes and exemplify ideas that the themes encompass. Several of the names of identified themes were derived from language used by participants, sometimes from exact wording. When this is the case the text will be in bold.

As 20 of the participants were currently employed as midwives at the time of the interviews, their reflections about midwifery were about both their past and present experiences. Theme (i) concentrated upon their past experiences, whilst Theme (iii) focused upon more recent ones. Theme (ii) included data about both past and present experiences. The guiding sentences preceding the quotes indicate the point in time that they refer to.

Theme (i) will now be presented.

8.4 Theme (i): Sinking and swimming

This section draws upon the perceptions of commencing work in the role of the midwife as being brisk, sudden, and perhaps an unprepared start, rather than a measured, gradual one. ‘Sink or swim’ alludes to feelings of being tossed into a frenetic sea of contemporary

maternity healthcare, regardless whether they felt equipped with 'sea-legs' or not. One of the quotes referred to the words of the theme's title:

> *It's a busy unit and I think you kind of actually hit the ground running and so it was either you **sink or you swim*** (BM 08 IP 2).

Confronted with the challenges of her role as a new midwife, one participant was informed by management that she just had to cope, when the manager:

> *Told me to deal with it. "**Sink or swim**", she said. "**Sink or swim**!"* (laughs). *It was very scary… It was just **sink** or **swim** and I chose to **swim**, I refused to **sink**, but it was frightening* (BM 07 IP 5).

Instead of using the word *or*, the use of the word *and* in the title makes reference to the concurrent experiences of both sinking and swimming when a new midwife "hit[s] the ground running". Various conditions and encounters in their new workplaces generated a sense of *sinking*, being submerged and overwhelmed by the challenges of the new transition, and *swimming*, the sense of yielding to the challenges, learning from, and surmounting them.

The subthemes of Theme (i) 'sinking and swimming' are presented below, to recapitulate, they are:

a) Possessing a readiness?;
b) Transitioning… and with a learning curve;
c) Enduring the eye rolling;
d) Assuming responsibility; and
e) Facing fear.

8.4.1 Subtheme a) Possessing a readiness?

Readiness to practise included the possession of the necessary clinical knowledge and midwifery skills that are imperative for the demonstration of the many professional capabilities necessary as a midwife. It included notions of competence and confidence within the midwifery role. The extension of the elementary skills of the participants was caused both by a hands-on doing, as well as yielding to demanding and challenging scenarios. A commonly expressed modus operandi for feeling ready to practice was the

sensibility of “faking it until you made it”, an approach for fitting in within the new work environment. This was subterfuge for displaying proficiency of required practical skills, and feeling ready for practice, “swimming” instead of “sinking”, through mimicking the actions of a seasoned midwife, despite feeling not ready for the role.

Participants spoke of not being ready to practice. For example, one spoke about lacking essential midwifery skills to help a woman give birth, which ultimately led her not to work in birthing services:

> *When I think about those deliveries that I did* [in my first year]*, I had no idea what I was doing at the end of that bed. I had no idea at all… I didn't have any idea what was happening to that woman's body. I now know what happens and I think it is really sad now because I think I would have been fantastic if I had just been a little more supported in that first year… It was just horrible and for me basically, I wouldn't want someone down the end of my bed that didn't know what they were doing… My final conclusion from all that* [was] *if I can't do this really, really well, then I'm not going to do this* (BM 07 IP 6).

One rationale for not feeling practically ready for practice was due to the hands-on nature of the role, for example:

> *It is one of those professions where you can intellectually know a whole lot of information but there is so much other knowing that comes through experiences* (BM 07 IP 8).

Perceptions of a lack of hands-on ability required an attitude of ‘faking it until you make it’ when participants felt unprepared for the complexity of the midwifery role. One aim of emulating behaviours and practices considered to be of a proficient midwife was to pilot these skills into reality, prior to their actual presence, so as to be equipped to work. One participant told of her experience where she was imposed upon to work in a capacity in which she did not feel safe or supported, as a team leader in the postnatal ward on the first day as a practising midwife, she states:

> *I did not feel confident, I felt petrified because you were like: “Oh my God I am being let loose”, but I felt like I had been given enough knowledge to make me safe and I think ignorance was bliss. Maybe I thought I knew more than what I actually did* (laughs) *and that helped me bluff my way through it a little bit. There is an*

> *element of bluffing. In your new grad year you really have to fake it until you make it (BM 08 IP 2).*

A 'Faking it until you make it' notion of self-credence had limited efficacy in truly having proficiency in the new role. Possessing confidence to practice was also important. A distinction between competence and confidence was evident. Participants could feel they were competent midwives and ready to practice, but were not yet feeling confident. For many, lacking confidence seemed to come from infrequent practical application of skills prior to registration, for example:

> *I was competent but I probably wasn't confident* (laughs). *I don't think I was going to kill anyone but I am sure I doubted myself for the whole time* (GD 08 IP 5).

This participant spoke about her lack of confidence being associated with real fears of contributing to significant adverse events:

> *Definitely not confident* (laughs)*, I think for the first few months, if not longer. There is that fear that you are going to end up basically killing somebody by accident* (laughs)*. I think that fear takes a long time to go away* (GD 08 IP 6).

Some midwives were deemed by their colleagues as more ready for practice. The nature of the Bachelor of Midwifery course was reasoned for contributing to the lack of confidence when it came to the commonplace midwifery task of drug administration. One quote highlights the insecurity associated with hands-on practicality:

> *I didn't feel very confident with drug administration, I didn't feel incompetent, but it made me feel nervous. I guess that is one of the differences with coming through the Bachelor of Midwifery, rather than the Graduate Diploma, in not doing your nursing first you have much less exposure to drug administration* (BM 07 IP 2).

The rotational rostering employment structure for new midwifery graduates was suggested as intensifying feelings of poor self-confidence:

> *You might have eight weeks in antenatal, three months in postnatal and eventually get to delivery suite and by that time your delivery skills could sometimes be six months old depending on the timing…* [it] *just gives you zero confidence when you get back up there* (BM 08 IP 5).

The next quote identifies competency of the required skill base, rather than confidence, and an ability to ask for help from other midwives was part of being ready for practice:

> *I think I felt competent enough at the level that was expected of me... There were no disasters where I felt completely at sea. I felt competent to a minimal extent and not particularly confident, but knowing that there were always resources that were important, others who could help when needed (BM 07 IP 3).*

Midwifery training seemed to provide participants with basic skills for practice, which needed further development:

> *The skill set, we have to learn so much stuff being midwives and I came out of my basic training knowing how not to kill someone basically and from then on any kind of actual skill development, to become competent, not even competent, to become a confident skilled midwife was a whole different ball game and I think that's what as a junior, junior person that's what you are looking for support with* (BM 08 IP 3).

The custom of 'weathering' new midwives into their profession through stretching clinical abilities to their limits was part of senior midwives getting their junior counterparts ready for practice. Receiving a high or difficult workload was common:

> *Very, weird, very frightening introduction into the reality of midwifery. But in a way it sort of toughened me up for my time and made me realise it is sink or swim and I would really have to be on my toes, and get my act together and just be with it* (BM 07 IP 5).

Senior midwives using authority to spur a new midwife to display a readiness for practice was common. New midwives were expected to work harder and promptly grasp what was required of them as part of 'toughening them up' for the midwifery workforce. Being allocated women with high medical needs was part of this process:

> *You sit in handover and you knew who you were going to be allocated* (laughs) *because it was all the hard work. It sounds really terrible but you'd have to run around. That's because they are breaking you in, the team leaders or the experienced midwives. The midwives who have been there for years and years are testing you out, pulling your ear, cracking the whip, crack, crack, crack!* (BM 08 IP 4).

Having no choice in clinical allocation played a part, for example:

> *"I can't manage both of these women" and the educator at the desk said: "No, you have to learn to", in quite a narky[10] way. The in-charge midwife, who was quite of a bully to me said, it wasn't you'll be fine or anything, it was: "You have got no choice"* (GD 07 IP 4).

Confidence could be strained and new midwives expressed feeling ill-prepared for practice when they were intimidated into undertaking new tasks, for example being a team leader in the first week of practice:

> *I had in-charges[11] before I felt ready. I thought that you had to have an in-service to be an in-charge, that didn't happen. I was just thrown into the deep end. I didn't even know what an in-charge had to do. I didn't appreciate getting thrown into the deep end but I got nowhere when I tried to raise it with management… It was terrifying and I remember having a bit of a confrontation with my nursing unit manager saying: "This is absurd, I am still wet behind the ears and I am in charge of the whole ward!" I was really quite frightened if anything went wrong... She said: "You are registered… it is not my fault it is your training that's going to let you down, not us, you are a RM[12], get used to it". That was my initiation* (laughs). *When I threatened to say that: "I am going to go home because I don't feel safe"… she threatened disciplinary action if I left* (laughs). *That was my first week, oh God, I just prayed that nothing would go wrong, luckily nothing went wrong. But I was terrified the whole shift. I was just glad when it was all over and no-one died* (laughs) (BM 07 IP 5).

Gaining confidence was partly from fortifying fundamental midwifery skills. For one participant, increased self-confidence lead to perceptions of self-efficacy alongside her colleagues:

> *The more skills that I have gained and the more confident that I feel in my skills the more enjoyable that it has become... I really feel like I am a contributing member of my team* (BM 07 IP 1).

[10] An adjective meaning bad-tempered or irritable.
[11] "In-charge" refers here to when the staffing of midwives on a shift is organised as a team that works together with a specified team leader who guides the roles and duties of each of the individual staff members.
[12] Registered Midwife.

A burgeoning familiarity with the skills and tasks needed in midwifery, and not identifying fear as a primary reaction in a challenge, was one way this participant recognised she possessed a readiness for what was expected of her, as she had learnt and acquired the required skills for clinical emergencies:

> *I might have been a year or two into my career as a midwife and it dawned on me one day because it was so busy and I was asked to go answer a bell and it was a 'resus' and I remember at the time thinking: "Oh my Gosh, I don't think I am actually scared", not that it wasn't scary, but my brain was actually clear enough to look at the clock and write things down and help and know where the equipment was. I knew how to help with the 'resus' of the baby rather than feeling frozen and confused* (laughs) (BM 08 IP 4).

Differentiation between notions of competence and confidence were a part of the subtheme entitled 'Possessing a readiness?' Feeling ready to practice was a mixture of feigning self-confidence, hands-on doing, and getting stretched beyond initial competencies.

8.4.2 Subtheme b) Transitioning… and with a learning curve

The transition into midwifery was a steep and challenging learning curve comprising an exponential increase of learning. A rapid acquisition of complex skills was needed for practising. For one participant, being a new midwife and not a student was akin to being a student again:

> *I felt like I was on a whole new **learning curve** again* (BM 07 IP 4).

All participants negotiated a learning curve as a new midwife. Varying perceptions and experiences of traversing the learning curve were given, however, all perceived the journey as challenging. One reflection of the first year as a midwife was:

> *I was stressed frequently while I was working in that first year* (BM 07 IP 3).

Most participants experienced strong and overwhelming emotions which were overtly physical manner, such as:

> *Stress, heart pounding, mind goes blank* (GD 08 IP 9); and
>
> *Your head just gets filled up with so much stuff. It's going to explode* (BM 08 IP 3).

A highly medicalised birth could be traumatic and challenging and evocative of intense emotions. The surfacing of these emotions required learning how to manage them. One participant said:

> *At the end of a horrible birth… a PPH, a huge episiotomy and then an emergency caesar, and all of those horrible things. And I can remember sitting there and I was just bawling my eyes out, and not just for a few seconds, but for ten minutes* (GD 08 IP 7).

The challenges brought about by feeling a newcomer in the workforce, despite having trained in the hospital setting in student clinical placements, were evident when participants expressed feeling surprisingly unfamiliar and unaccustomed with realities of midwifery work. It was very nearly like the substance or subject matter of their work was alien. One participant spoke of stress borne in a clinical emergency as a particularly challenging and unaccustomed experience to traverse:

> *I don't want to do this, this is not what I signed up for, and this is not what I was taught. You never get taught about a cord snapping, or fracturing a baby's clavicle* (BM 07 IP 4).

The transition into the unexpected and unfamiliar challenges of shift work and night duty delivered unanticipated difficulties for several participants, for example:

> *I found that the toll of night duty, like the physical toll was really high. I didn't expect that, I was really surprised by that!* (BM 07 IP 2); and
>
> *I felt like maybe someone should have mentioned along the way… We don't really talk about the physical and psychological toll that shift work can take* (BM 07 IP 2).

To help minimise the unfamiliarity of these transitional challenges, one participant thought being acquainted with hospitals prior to starting out as a midwife was important, so that students:

> *Think about a lot more things than I did, so I think that thing about choice of hospital, knowing what sort of hospitals have what sort of care and I don't feel like I knew much about hospitals and hospital structure* (BM 07 IP 8).

For some, challenges of the learning curve in the transition could be lessened. One participant felt that part of her skill set was already in hand due to her commencing work in the same hospital where she had undertaken her clinical practice:

> *I felt comfortable in Sydney because that was the hospital that I trained at. I knew of all the policies, I knew of all the procedures (GD 07 IP 3).*

Perceptions of newness sometimes extended beyond feelings of unfamiliarity. References were made to unsettling, destabilising or jarring experiences seemingly resulting from a disparity between what participants expected of their new work, and what the real situation turned out to be. The transition into the midwifery workforce called to attention a difference in priorities and pressures of being a student as opposed to being registered. The skilfulness of balancing an individual woman's needs as well as the hospital's needs became necessary. Some participants mentioned the perception of women as being situated on a conveyer belt of time and hospital pressures. One midwife said:

> *They have this time shift where they have to be out of here in two hours. And if they are not, they will say: "Why is your lady still here?" It is just ridiculous, there is just no flexibility: Ship them out, ship them out, next, next. It is like a production line, it is impersonal. And that is really frustrating for me and I am finding that hard to cope with* (BM 07 IP 5).

Participants' focus moving beyond their individual student learning needs to the wider workforce demands was newly observed.

Learning to be flexible was part of the challenge in the transitional learning curve. Last minute relocations to other wards, a frequent staffing stratagem utilised by management to fulfil unpredictable staffing requirements across the various wards, were unsettling to the new midwives because they were unaware they were moving to another ward:

> *I found that a real shock. Just the hierarchy and the, I won't say the way they push you around, that sounds terrible, but… It was like I was a bit of a pawn because I was a pleb, a little midwife* (laughs) *who was like: "Oh she is going to go here and she's going to go there". But they forget to tell you and you're the midwife* (BM 08 IP 4).

The transitioning ascent of the learning curve was intensified by tense working environments. Working within the hospital environment was a challenge for this participant:

> *You don't know what you are doing, you are starting from scratch, you feel like a student all over again. I think emotionally I think that is quite challenging to deal*

> *with. You have all that on board while you are trying to learn new skills in a very high, fast-paced environment and dealing with all the personalities at work* (GD 07 IP 2).

When discussing the transition into midwifery, participants identified the extensive range of necessary skills and abilities needed in the role as challenging. Skills never executed as a student had to be frequently undertaken, for example caring for a woman who had chosen to undertake a physiological rather than active third stage of labour or putting on and assessing a cardiotocograph on a labouring woman with twins. Learning the specific skills of high risk maternity settings was challenging when student practice was conducted in lower risk hospitals and the care within the higher risk settings could be frightening, a perception exacerbated by the busy environment. One participant realised she had a new skill set to instantly learn when she started working as a midwife in a different hospital than her student years:

> *I think the scariest thing was the previous hospitals that I had worked in did not accept births under 34 weeks, it was a whole new world that had opened up that there were babies that were born at 26 weeks, 28 weeks…. and the women were much higher risk so I was opened to a whole new world of things that I had never seen in the three years of my studying* (BM 07 IP 4).

Not possessing a skill needed for a critical incident in which a woman sustained a fourth degree perineal tear ultimately led her to leave birthing services in midwifery:

> *Unfortunately the educator left me towards the end of* [a birth] *and I didn't recognise the signs that I was meant to recognise and by the time they came in and one of the girls told me to do an episiotomy, I'd never done an episiotomy, I didn't even know what to do. So I'd said: "I can't" and she went to do it and it just happened* (BM 07 IP 6).

Developing new communication skills were sometimes required when working as a new midwife, such as:

> *Talking to women and their families, talking to colleagues, talking to medical staff, talking in an emergency, giving information, discerning information* (BM 08 IP 3).

Learning the necessary skills of midwifery could be challenging if their previous nursing experience as a Graduate Diploma of Midwifery participant was very different from

midwifery. One participant had worked in intensive care prior to becoming a midwife and was challenged when cultivating new skills of rapport and communication explained:

> *It was challenging because I had to learn how to talk to women for the first time or to talk to a client for the first time because before most of my patients were asleep and not talking to me and intubated and sedated. So for me to have to build a relationship with a woman in a short space of time, that was definitely an unfamiliar skill that I had to learn for the first time in midwifery* (GD 08 IP 5).

A common word used by participants within discussions about the initial transition period was the perspicuous and unambiguous word *survival*. The first few years working as a midwife was something to survive through, one participant said:

> *I don't know how I survived, I just survived* (BM 07 IP 5).

The use of this word drew attention to the struggle and challenge as a new midwife. One participant saw mere survival as a midwife, rather than flourishing in the workplace, was due to poor levels of support within the complexity of the hospital system:

> *When you're not in a supportive environment, you have to survive through it and the workload the health system in itself is creating, is certainly not assisting the issue, because people are just tired and people work like dogs* (GD 08 IP 8).

Another participant used the word differently when referring to unkindnesses amongst midwives as being part of an identity politics and a perverse form of displaying fortitude and perseverance in a challenging profession that involved working closely with mortality:

> *In the system, it's like a survival thing… It's almost like a chip on the shoulder or an identity thing where they need to prove themselves… I think because it is a bit life and death* (BM 08 IP 4).

The transition into being a new midwife was commonly experienced as challenging amidst a steep learning curve. It was a time of unfamiliarity and stress, and positively, of new skill acquisition. Surviving through this challenging transition was regarded a rite of passage. Helping the participants successfully traverse this journey was successfully learning new and unfamiliar skills, having commenced practice in the same hospital as their student years, and recognising their competence in the new role. The learning curve was acutely felt when participants sensed emotions stemming from the new role, when aspects of the midwifery role and environment were perceived as unfamiliar such as night shift and shift

work, when they felt they were undertaking tasks outside of their scope of practice, being required to move wards at last minute for staffing commitments, and when they felt an absence of support systems in place for the new midwife. Discussions about support were extensive and comprise a later theme.

8.4.3 Subtheme c): Enduring the eye rolling

Spoken about in the interviews was a midwifery profession that considered 'weathering' a new midwife into the profession an obligatory rite of passage and a challenge that needed to be endured. The unproductive endeavours associated with 'weathering' a new midwife could hinder procuring support from others and the tenacity of self. Withstanding poor attitudes from other midwives is the subject of the third subtheme of 'sinking and swimming' and is entitled 'enduring the eye rolling' which includes accounts of injurious deeds and behaviours directed to them by other midwives. Occasions of eye rolling, derisive vocal tone, or aggressive body language from experienced midwifery staff towards the newer midwives heralded these negative viewpoints, as one participant states:

> *There was quite a lot of that kind of behaviour* [passive aggressive behaviour towards new midwives]*, sometimes quite subtle and the same kind of stuff that probably everyone talks about, you know the body language,* ***the eye rolling****, that sort of business, that's really unhelpful* (BM 07 IP 2).

The perception that new midwives lacked ability and displayed mediocre skills was considered a reason for the derision, as explained here:

> *Lots of eye rolling and: "You guys* [new graduates] *are terrible and you don't know what you're doing"* (BM 08 IP 3).

Sarcastic sentiments aimed at new midwives were based on poor opinions of new midwives as being naïve to the complicated nature of birth, for example:

> *You were a bit mocked or: "Here we go, here's another one, she hasn't learnt yet that that's not the real world", sort of thing, and: "Complications do happen"* (GD 08 IP 7).

Derision could be concealed within comments meant to praise, like this one:

> *"Oh, you were a direct entry midwife, wow, you'd never know"* (laughs) *and I'm like: "Because how would you know, how should you know?" Does it matter?* (BM 08 IP 2).

One dangerous outcome of this derisive and intimidating behaviour could be an environment which inhibited new midwives from feeling safe to solicit clinical advice, thus obstructing patient safety, as explained by this Graduate Diploma midwife:

> *There was a* [woman with a] *cord prolapse and it was all nice and eventful.* [The midwife] *was nice to me after that in a way, but it was like you really had to prove that you could manage a difficult situation to get respect. And sometimes that's not going to work well. Because if you scare someone so they're not going to come and ask you any questions, then you are going to have a really big problem where you are going to get someone not going to get a VE checked, not knowing that it is a brow and they are going to push on it for two hours* (GD 07 IP 4).

Another quote shows the safety implications of a clinical environment which intimidates younger midwives into feeling too scared to ask for advice or assistance:

> *She huffed and puffed about coming to check it, she said: "Can't you even do a VE on your own?" And I felt like such an idiot to have to come out and ask someone to check it, like knowing that I was doing the right thing and then being told that I was being stupid* (GD 07 IP 4).

Scornful attitudes also arose from differences in clinical practice, something which one participant felt the need to defend, a position which unquestionably requires certain self-assurance:

> *I'd get eyes rolled at me, someone would say: "Well that's not the right way"… "It's not how we do it". Hands off the peri*[13] *for example, they are very hands on, very, very, very hands on. Fingers in, stretching the perineum and they couldn't accept that I wouldn't do it. I refused to do it. So there are all these little quirks of practice that I really had to defend, and say: "Well you can do it, but I really don't find the need to" and I would try and back it up with evidence, it was a bit of a battle* (BM 07 IP 5).

[13] Perineum

The transition of stepping into the midwife role was affected by questionable support, occupational customs directed towards newer midwives, feelings of survival rather than flourishing, and senior midwifery attitudes of 'what comes around, goes around', such as one participant's experience with a senior midwife whereby:

> *In front of staff, criticising me in front of the women I was looking after. Saying things like: "Oh we've all had our time crying in the pan room, now it looks like it is your turn"* (BM 08 IP 3).

New midwives were cognisant of their experience not being unique. A common attitude of 'we've all been there' existed and participants were made to feel foolish for displaying stress in clinical situations, as displayed in this quote:

> *A lot of them were like: "I am too busy for this, so do your thing, get on with it or get out", kind of thing. There's a toughness I guess for midwives and there's an attitude like: "I had to, we all had to be students, we all had to get through this and we all had to be new grads at one point in time, so just get on with it and stop whinging"* (BM 08 IP 1).

This subtheme encompassed subtle or overt behaviours of senior midwives directed at new midwives. At times, the rationale for this behaviour seemed to be to 'season' the new midwives, acclimatise them to the stresses of midwifery, and solidify new skills into being customary. However, at other times the behaviour was perceived as bullying, a topic in a later theme.

8.4.4 Subtheme d): Assuming responsibility

A stark abruptness of the assumption of responsibility, as well as a sense of autonomy, upon graduation and commencement of employment and an awareness of the real life consequences of midwifery practice, make up the subtheme 'assuming responsibility'. Participants spoke of being strongly aware of responsibilities in the first stages of practice, as exemplified here:

> *We have got such a huge responsibility; really we do have the potential of managing a life or death situation* (BM 08 IP 5).

Some participants were not entirely aware of the absolute responsibility towards the women in their care until they were working, like this quote:

> *I don't think people realise what the responsibility is like until you actually are graduated and you are working. As a student you always know that the midwife you are working with is responsible but when you are out there I think it is very overwhelming* (GD 07 IP 2);

Awareness of responsibility included being cognisant of legal ramifications that this responsibility carried, for example:

> *You are then given responsibility to make clinical decisions and sometimes you make the wrong clinical decisions and as a new grad you are learning as you are going with each new experience and there is always that if this turns out badly I am totally responsible for this and it is going to come crashing down on my head and I will get hauled before the HCCC[14] for you* (BM 08 IP 2).

Responsibility was perceived differently. One participant felt her mature age intensified her sense of responsibility, when she said:

> *I think being an older student when I went in I didn't have that automatic confidence of youth, you know, nothing's going to go wrong* (GD 08 IP 6);

Assuming a mentor role when being paired with a student midwife in the transition was considered to be premature and added responsibility, something which was hard for this participant, for example:

> *There were times where I was in delivery suite and I was supporting a student when I barely knew what was happening and that made it hard on me* (GD 07 IP 3).

The very real consequences of practice and the real life outcomes of care were overwhelming for some. The hoped for healthy mother and baby was an onerous responsibility to many participants, one example being:

> *"Oh wow, I have to make these decisions and I have to think of all these things and I need to know when to refer and I am asking all these questions and this is all up to me. I am looking after this woman and her baby. And the outcome is a baby, you know, babies are really important to their parents, to everybody* (BM 08 IP 3).

[14] Health Care Complaints Commission

Necessary decision making within the multifaceted clinical pathways when looking after women and the responsibility of clinical decision making arose as a concern for some, for instance:

> *It is one of those processes and jobs where there isn't you know necessarily a defined sequence of events, things happen in all sorts of orders and all sorts of ways* (BM 07 IP 8).

Being faced with unfamiliar situations was regarded to be a challenging part of assuming responsibility, for example:

> *You are constantly presented with situations that you have never been in before and so you are just thinking: "Oh my God how do I deal with this. Is this the right decision?" So it is just learning as you go* (BM 08 IP 2).

Anxiety about decision making in clinical scenarios was illuminated by one participant who remarked that:

> *As a finished midwife it was as scary as hell. Yes it is scary… Having the responsibility. Because once you are a midwife you are accountable and you are responsible for that VE, that progress of that woman, woah, it is big, it is big. And your decisions can affect the outcome. Whether you decide to put them in the bath or stick them on the toilet or take them to delivery suite* (GD 07 IP 1)

Participants encountered professional responsibility profoundly, for example:

> *Women just carry their stories for so long in their lives often, I'm really aware of that and I really want to do a really good job* (BM 08 IP 3).

Some mentioned possessing responsibility to the profession of midwifery and not only to the women and babies in their care. Responsibility to women and the profession was a significant reason for remaining as a midwife despite the hardships of the work, one midwife remarked that:

> *One part of me goes: "Why don't you just stop being a midwife? Why don't you just go and do something else that probably pays you better, is not so stressful, you don't carry all this stuff around with you all the time?" But I just have such a strong sense of responsibility towards the women and towards the profession* (BM 08 IP 3).

Very frequently, the stress and fear stemming from the assumption of responsibility lead to the desire to work in a job perceived to hold minimal responsibility. This sentiment, facetiously called the 'MacDonald's effect', due to the large number of participants wistfully longing to work at a fast food restaurant like McDonald's, was a desire for less workplace accountability. Many of the participants wanted to be employed in a job that did not involve the potential for life or death outcomes, for example:

> *I could just go and be a clothes designer or something or bring things from overseas for a shop* (BM 08 IP 3); and another:
>
> *The thing that really dissatisfies me is if there is an adverse outcome and then you just think: "Oh I would rather work at McDonalds"* (laughs) (BM 08 IP 2).

Awareness of professional responsibility was difficult, for example:

> *Sometimes I go: "I just want to go work in a shop". I don't want to have to think so much about what I do, and feel so much about what I do and bring so much of what I do home* (BM 08 IP 3); and
>
> *It can be exhausting, sometimes I just think about it, because I used to work in a coffee shop, and the simplicity of that is very appealing* (laughs)*. You know, the worst thing that can happen is someone's coffee is too hot, you know, but then I think I would get bored* (GD 08 IP 9).

Underpinning this desire seemed to be a perceived lack of clinical support, further highlighted in a later theme. Autonomy was represented as lonesomeness derived from a lack of support. One midwife maintained that:

> *The dog-eat-dog nature of midwifery….is dog-eat dog, every man for himself, isn't it? Dog-eat-dog. That just means, no-one is going to look after you, you have to just look after yourself. When you're in the workplace you just have to stand on your own two feet and you know, if you are a registered midwife you have to be making clinical decisions and there's responsibility that comes with that and dog-eat-dog is kind of like, maybe it's like, no-one cares* (laughs) (*BM 08 IP 1).*

However, positive impressions also emerged, with the responsibility and accountability arising from recently gained responsibilities considered to be newfound autonomy, one midwife observed that:

> *In the context of a new grad[*uate*], the autonomy that I craved and that I got was the ability to make my own decisions about how I was going to manage certain scenarios for women* (BM 08 IP 3).

Autonomy was a good thing for one participant who recognised the translation of her theoretical midwifery knowledge into employment of practical skills, which then further promoted the acquisition of knowledge, so that:

> *I just feel like I am using all of my midwifery knowledge and gaining more knowledge every day* (BM 07 IP 1).

A sense of newfound autonomy could strengthen clinical confidence and encourage an expansion of skill sets, for example:

> *When you can use your autonomy it just makes you feel free and makes you love your job more, because you want to learn more because then you can do more and it is like a self-feeding thing when you have more knowledge. It is just different when it can add to your satisfaction, and you can work to your full potential (GD 07 IP 1);* and:

Experiences of autonomy depended upon models of midwifery practice. Working in a midwifery group practice enhanced autonomy, thus augmented learning, one midwife believed that:

> *In group practice you just have to stand on your own two feet a little more and that gives you a bit more of an opportunity to learn quicker* (GD 08 IP 5).

Variances in clinical autonomy were not merely an impression but something that had tangible outcomes, impacting upon skill progression, for instance:

> *One of the things that I really struggle about working as a general shift midwife is the lack of autonomy… I have come to this unit where I can't discharge women from birth suite without talking to a doctor but the group practice midwives can* (BM 08 IP 3).

One feature of being a new midwife which invoked concern was the newfound assumption of responsibility. For some, however, the sense of autonomy procured from clinical self-determination enhanced skill acquisition through recognition of self-resourcefulness.

8.4.5 Subtheme e): Facing fear

Experiences that generated a sense of fear were universally presented in the interviews. The word *fear* was frequently voiced and sources of alarm were many, such as the care of a low risk birthing woman, and the virtually paradoxical fear provoked by the process of normal birth, as illustrated by this quote:

> *The **fear** of, the **fear** of mother and baby. There is something really frightening about a woman that is young and healthy and a baby inside and the problems that could go wrong and it can be very frightening* (GD 08 IP 3).

Delivery suite, often the name of the hospital ward where birth occurs, evoked plenty of discussion, particularly in relation to fears of clinical duties and tasks. It was put forth to be a scary place, for example:

> *Delivery suite in a tertiary hospital is a scary place* (BM 08 IP 5); and also:
>
> *I remember being terrified a lot of the time on delivery suite* (BM 07 IP 1).

The midwifery tasks associated with delivery suite induced stress and fear, for example:

> *The very nature of what occurs in delivery suite, and the very nature of the responsibilities that you have as a midwife, are stressful* (BM 07 IP 2).

Discomfort could be all-consuming, as shown here:

> *Oh my God I'm on delivery suite and looking at the board*[15] *and going I don't want to care for her, I don't want to care for her, I don't want to care for her. There is nobody there that I feel comfortable caring for* (BM 07 IP 1).

Certain conditions heightened fear. The customary practice of rotating new midwives through all clinical areas ensures varied experience in maternity care. However, for some, this intensified stress and fear, as shown here:

> *There is a delay getting up there and then constant [rotation]. The whole system of three months here, three months there is crap. It has to be changed so that you are continuously exposed to all areas on a weekly basis…* [and] *your skill level never*

[15] The "Board" refers to a whiteboard used in maternity wards, such as antenatal, postnatal or delivery suite, that lists the women currently on the ward as bed number, gives a brief description of their health history and physical conditions, and displays the midwife who is allocated to caring for her.

> *slips in any area and you don't walk through any area with your heart racing, thinking: "Am I going to make a small mistake and it being extrapolated into something major", just because you are nervous and you are not thinking clearly* (BM 08 IP 5).

Some did not want to work in delivery suite due to stresses engendered therein:

> *I didn't like delivery suite. I have a very negative aversion to delivery suite. I had a couple of bad experiences, where I wasn't supported by staff members and I didn't want to work in delivery suite. I spoke to the manager about not having to do a placement in delivery suite because of the experiences. It gave me really bad heart palpitations and anxiety attacks having to go back there* (GD 07 IP 3).

A factor that curbed fear was being supported in delivery suite by colleagues. One participant said she:

> *Loved it because I was in group practice where… everyone was generous in spirit. I felt safe in the delivery suite, and that's where I needed to know that I was safe* (BM 07 IP 7).

'Facing fear' is the final subtheme in the 'sink or swim' theme. Fear arose in specific clinical circumstances, particularly linked to the hospital setting of birth, donning professional responsibility, and the being taken aback by the many possibilities of outcomes in clinical decision making.

The results for theme (ii), called 'needing a helping hand', are now presented.

8.5 Theme (ii) Needing a helping hand

A variety of workplace conditions, circumstances and events impacted upon being a midwife. Support was a strong mediator influencing perceptions of themselves as midwives and their transition into the profession. Many participants spoke of needing help in a variety of situations in the early years of midwifery. In all interviews, the words 'help', 'helps', 'helped', 'helping', 'helper' and 'helpful' were frequently used in reference to those elements which would aid, assist, support and encourage the participants in their midwifery roles.

The terminology of the title highlights the giving and receiving of support as central to the midwifery role: providing a helping hand to support others, midwives and women, and then receiving support to be effective as a midwife. Participants spoke of helping women as central to their profession. The fundamental enterprise as a midwife was helping others.

'Needing a helping hand' also emphasises the physical support required as a new midwife, especially assistance from the hands of other midwives. For example, one participant said of a midwifery colleague:

> *She was really **helping** me getting everything done because as you know you don't have five **hands*** (GD 07 IP 4).

Hands are significant in midwifery. Hands provide bodily touch, tangible reassurances and succour in a caring profession. They also are the midwife's tool, providing assistance to women in a variety of ways: palpating a pregnant belly, aiding a newborn's birth, or helping a mother when she is breastfeeding.

'Helping' also referred to personal enrichment, development and progress in a midwifery career. For one participant, learning new skills:

> *Was putting your **hand** up for **help**, and feeling like you are practicing to your whole scope* (BM 07 IP 2).

'Needing a helping hand' includes two subthemes:

a) Calling for support; and
b) Progressing in the profession.

8.5.1 Subtheme a): Calling for support

'Calling for support' is the first subtheme of 'needing a helping hand' theme, and is comprised of the grounds for needing a helping hand. Help was expressed in the interview data in a framework of support. The moniker 'calling for support' is meant to evoke a few meanings of the term. Firstly, it insinuates the physical act of a midwife calling out to others for help and support in a clinical situation or a time of need. Secondly, it represents the proposal for policies and strategies of midwifery support to be seriously considered for forestalling midwifery shortages. Support from multiple sources both for the novice and the experienced midwife enveloped a lot of the participants' thinking. As such it is

multifaceted in its conceptual underpinning. Therefore, subheadings are provided to help guide the reader through this wide-ranging subtheme.

8.5.1.1 Why support?

The absence or presence of support was influential in experiences of learning. Support was considered crucial in the workplace. One quote captures this, as a need for:

> *Support, from your manager, support from your educator and from other midwives as well. And I think that your peers, the other midwives are important too and sometimes if they are overworked they cannot help you, you know. It just becomes too stressful. So I think that to help you stay in your role you need support all around you, you need a bath of support basically* (GD 07 IP 1).

Needing to be in a "bath" of support in the first years as a midwife was due to the gravity of the role, complexity of clinical skills required, and working as a midwife whilst still learning, for example:

> *You are looking after lives. You could stuff up when reading a CTG[16] and potentially have a dead baby. This is not just some office desk job where if you don't finish your work on time or if you forget to sign one paper, you know you will be fired. This is, if you miss one deceleration on a CTG, you could have serious consequences. You really need to be supported through this, especially while you are learning, while you are gaining experiences, especially while you are in the first couple of years as a midwife. You know, you really are responsible for life; you can't mess around with that. And I think if you are not supported through that in the first few years while you are consolidating your skills and your knowledge, you can make mistakes, and you don't want to make mistakes when you are playing around with life* (GD 08 IP 1).

Having support was a form of protection for this participant, both for the midwife and the woman in her care, meaning:

> *It is a buffer in a way. You feel like it's not just you if something does go wrong or if something bad happens. You have that buffer, you are not stranded on your own*

[16] A cardiotocograph is an electronic means of simultaneously and continuously monitoring the fetal heart rate and rate of maternal contractions.

> *and you have got somebody who is more experienced who can take over if necessary* (GD 08 IP 6).

The need for support was also discussed in relation to the hands-on nature of the role and the continuing learning needs of a new midwife, because:

> *It is a practical hands-on job and it's also an emotional thing, you are looking at a human being going through a process and… you have to understand by feel and… it's a skill that you can only learn by doing* [and having] *someone who knows what they are doing and can show you physically with their hands* (BM 07 IP 6).

The personally demanding aspect of midwifery as a giving profession warranted the need for support. Reciprocal support was required to manage the emotionally taxing aspect of the role, one midwife stated:

> *There is a lot of emotion involved in our work and what we do is give, the midwife mothers the mother. In midwifery you are giving a lot all the time emotionally. It's not just a practical job where you sort of have to tick a bunch of boxes and press a bunch of buttons. It's working with people in an incredibly important part of their life where there are often highly-charged emotions* (BM08 IP 1).

Many participants referred to increased complexity in birth was cause for support and necessitated help. Increased acuity of health care needs and the brevity of length of hospital stays necessitated support, for example:

> *It is just the intensity of the type of the work that you choose to do. Because it is a profession that's never really been seen as risky as it is now, so we're doing such more complex stuff* [than in previous years]… *So what we do in the hospital is much more complex work and the expectations are a lot greater on midwives and the pressure, and their women are in there for a lot less time. So overall it's high pressure, it's the turnover, but also the complexity that you have got in there with the interventions* (BM 07 IP 6).

The subheading *Why support?* encompassed the reasons for needing help. Being a midwife was put forth as a clinically complex and giving role and support was deemed crucial.

8.5.1.2 Leadership as support

Various forms of support were presented. Leadership support was considered crucial, especially in the first years as a midwife. Management were very important sites of support

of midwifery practice. Many discussed feeling like a number, rather than an individual employee, as being partly generated by management. The need for recognition from managers meant:

> *Respect for the role and the person that you are and appreciating you for what you do for work and not just expecting you to be a number, a person who has no emotions* (GD 07 IP 2).

Clinical contributions by managers were frequently mentioned, such as:

> *A good manager has a nice middle ground of being involved just enough to let us know that, you know, they are there and be supportive, but still lets us have a little bit of say in how we run our thing* (GD 08 IP 2).

The idea of a 'good' manager was recurrent in discussions. An approachable manager, visible in the hands-on running of the wards and provided practical support was deemed as 'good'. Good managerial support needed to impact upon the clinical roles of midwives. These next two quotes display this, as wanting management readily available to help clinical staff when needed, so that:

> *I think a good manager should be able to, when needed, step in. I know they are not in the clinical role but the respect that I have for a good manager is when she downs that pen, sees that her staff are going under, and she goes in and sits beside the well and helps them out. And you know what; no-one does that* (BM 07 IP 4);

The above quote demonstrates the use of conceptual metaphors to elucidate the desire for hands-on support: "downs the pen" and "sits beside the well". Metaphors strengthen rhetorical effect, thus highlighting the importance of the topic for the participants. Other participants also utilised metaphor to express what a good manager was:

> *Put down her books because we were just too run off our feet* (BM 07 IP 4);
>
> *She thinks: "How would I like to do it?" She puts herself in our shoes* (GD 07 IP 1);
>
> *Gets their hands dirty* (BM 08 IP 5); and
>
> *Are available and have their finger in the pie* (BM 07 IP 7).

Incidences of inadequate management and the impact this had upon staff morale and working conditions featured in the interviews. Managers were:

> *Quick enough to tell you when you have done something wrong but they are never there to tell you when you have done a good job* (BM 07 IP 4).

Management was said to be able to affect staff morale and performance efficacy, for example:

> *The managers or the leaders in the work place have the ability either to build the confidence or skills of the work force or demoralise and deflate people and when people are feeling demoralised and deflated it doesn't bring out the best in their work performance* (BM 08 IP 3).

Lengthy accounts were given of poor managerial support during and after serious critical clinical emergencies in which management added to the distress of the situation. This next quote speaks of a midwifery manager's words to a participant after a clinical incident where a woman, suffering an amniotic fluid embolism, received an emergency caesarean in the birthing room. The participant spoke about feeling cheated from managerial support during this traumatic period when she said:

> *My direct manager in delivery suite that day, the only words she said to me were, after hearing everything in hand over, was: "She has run out of fluids, are you putting up more fluid?"* (bitter laughter). *That's what I got from my manager* (GD 07 IP 4).

Poor management led some to leave midwifery or relocate to another hospital, for example:

> *There was lack of good management where I worked. It was not the main reason I left but it certainly was something that gave me the impetus to be able to do it* (BM 07 IP 7).

The subheading *Leadership as support* illustrated how the participants desired practical and visible support for their midwifery work. People in leadership and management positions influenced experiences in the workforce.

8.5.1.3 Mentorship as support

Mentoring was considered an important form of support and was sought after. It was considered to be helpful in the early career period. Described as many different things, including being formal and hospital-instituted and informal and midwife-led, it was considered to be a personal developmental relationship in which a more-experienced and

more-knowledgeable midwife helped to guide the less-experienced and less-knowledgeable novice midwife in the techniques and customs of the midwifery role. Mentorship was a necessary supportive measure for clinical skills advancement in the first years as a midwife, for example:

> *I* [had] *accumulated un-answered questions about what did happen and un-answered ways of approaching those things in future, dealing with things differently and I just felt you definitely need some sort of mentor, some sort of formal debriefing process as a midwife to help you process things so they don't just pile up as stressors, that you actually feel that you start developing knowledge that means that you do things differently* (BM 07 IP 8).

Mentorship meant consistent and planned contact with one midwife:

> *I think I needed to be rostered at the same time with the same person for more shifts for the first while and that certainly wasn't the case* (BM 07 IP 6).

Equally, it was suggested to be:

> *Some one-on-one time with the educators would have been helpful while on the shift* (GD 08 IP 1)

Mentorship could be established by participants themselves:

> *I would check who was on in birth unit and I had my own little personal buddy system happening, it is the only way that I survived* (laughs) (BM 07 IP 5).

A crucial consideration when mentorship was formally employed by the hospital was the individuals working in those roles, so that:

> *It only takes one person to be disengaged and not necessarily invested in doing a great job in their role and the flow on effect of that for students and new graduates… are really massive* (BM 07 IP 2).

Shift work impacted upon the mentoring relationship, for example this participant:

> *Missed building a rapport with one midwife because there was always a different midwife on shift* (BM 08 IP 4).

There was not a culture of recognition of mentoring in the workforce, for example:

> *There wasn't enough valuing or structure around teaching the people you were going to work with: How to teach you or what to teach you* (BM 07 IP 8).

The lack of a formal mentoring program was positioned as contributing to a participant leaving midwifery:

> *I don't think they were doing much at all in terms of educating the new grads. This is a bit of a thorny issue to be honest because there was no mentoring, there was no buddying system… To be honest, I found that to be really poor, the institutional support for that first year in this particular workplace, I found massively lacking. It would have been great to have someone formally identified as a mentor or a buddy, there was just this big gap there and that was really hard and I do think that contributed to my decision to leave* (BM 07 IP 2).

The subheading *Mentorship as support* presented data about mentorship, either formally instituted by the hospital or informally arranged by individual midwives, as being a vital component of the successful evolution of a new midwife.

8.5.1.4 Debriefing as support

Participants vocalised a need for debriefing for support due to the experiential, hands-on nature of midwifery and was considered an important tool for learning within a safe context. Debriefing was:

> *Having someone that you can go to and say things without feeling you are going to get criticised or that it going to be said back to the person you may be talking about maybe and that freedom of debriefing and learning from that* (GD 08 IP 2)

Like mentorship, debriefing was described differently. One participant symbolically described debriefing as a way of eliminating the build-up of the deleterious effects of the role, when she stated that:

> *Debriefing is huge, not just debriefing to your work colleagues, but someone that you could go and off-load to. You know, a bit like going in a contamination tent and showering down all that contamination for the day and you come out and you feel refreshed* (BM 07 IP 4).

Formal education days arranged by the hospital's education team were important opportunities for debriefing with other newly graduated midwives, as shown by this quote:

> *Just to debrief what we had been going through and realise that we were all in the same boat. Because we were sometimes just too busy to have a chat while we were around on the ward. So those study days were something that we looked forward to and just kept us going* (GD 07 IP 2).

Debriefing was considered a vital aspect of learning as a new midwife by a participant who did not receive formal debriefing, for instance:

> *I had those experiences where you started to doubt yourself and they were probably all quite normal experiences, perhaps, but again that lack of managed debriefing or working through those issues, I think just meant they accumulated rather than, processed them as part of the learning* (BM 07 IP 8)

Some commented that shift work and busy workloads meant that midwives' contact with each other was irregular, making informal debriefing difficult to carry out, thus being a rationale for formal pre-arranged debriefing sessions, meaning that:

> *The way midwives work, and they were busy, and they work shift work, there wasn't the opportunity then to stop and talk through, you know soon after, and learn from all those experiences and be able to ask questions and be able to say: "What was going on there?"* (BM 07 IP 8).

Data collected under the subheading *Debriefing as a form of support* revealed in what manner debriefing was considered to be helpful. Be it formal or informal, debriefing was considered to be a much needed form of support in the first years of midwifery practice, both as a tool for learning and as a supportive stress outlet.

8.5.1.5 Having pragmatic support

Another form of support was pragmatic support. The word 'pragmatic' refers to a practicality of support that participants appeared to crave. Approaches that improved the efficacy of their new roles as midwives pragmatically addressed professional measures that functionally helped performing their roles. Collegial support, the physical environment and the resources of the hospital, having access to designated break times, and the support that midwifery group practice models of care provided were cited as features of pragmatic support.

Collegial support was having other midwives present and available for advice and hands-on assistance. Anxiety resulted from a lack of collegial backing. Participants were cognisant of

potential clinical ramifications and safety issues when new midwives were poorly reinforced by other midwifery staff:

> *I felt so un-sup-port-ed. On my first shift in delivery suite I was told I had to look after a woman who was being transferred interstate, thirty weeks with twins, and it took me over an hour to find the second fetal heart and I asked numerous times for help and was basically told that everyone else was too busy and that I had to do it. To be treated like that really didn't want to make me go back there and you know if we want to keep midwives in the job we have to look after them* (BM 07 IP 1).

Intention to leave the profession and staff shortages which generated a lack of support of other midwives was frequently mentioned, such as:

> [I felt] o*ut of control. I remember this one shift where I had this woman who was pushing in delivery suite and she was getting hot, she was pushing and the baby wasn't coming and I remember I needed help. And I pushed the buzzer and no one came so I went out and had a look around but no one was there. It was a night shift. And I just had this moment where I thought this is shit, I can't do this anymore, I'm not doing this anymore. I just had this feeling of dread... I guess it was the lack of support. The lack, yeah that's the biggie, the lack of support* (GD 07 IP 1).

Pragmatic support encompassed the work environment. The physical bricks and mortar of the hospital environment were mentioned as important, regarding supporting midwives and women. The artificial and overly lit environment was considered unhealthy to work in:

> *In terms of a workplace environment, I don't like the hospital environment as somewhere to spend time so spending a whole shift inside with fluoro lights, no natural light, air conditioning isn't, isn't somewhere that makes me feel happy and healthy* (BM 08 IP 1);

Thoughts which are echoed by this next participant:

> *One of the things about working in hospitals is that they're quite challenging physical environments, they're unpleasant and they're quite unhealthy in many ways* (BM 07 IP 2).

Hospital resources were considered as either supportive or detrimental to working conditions. Having supportive infrastructure giving rise to adequate staffing was important, for example, this midwife who was well supported said:

> *I felt my stress levels just go* (noise that depicts a downward trend) *because just the fact that I always said, they had enough equipment, they had lactation consultants, two of them, every day of the week, they had partners could stay, and they had pull-out beds for them to stay and there was classes every day about breast feeding, parenting, whatever. It felt like it was really supportive* (BM 07 IP 3).

An absence of physical space which could accommodate and protect autonomous birthing practices of midwives was considered as contributing to the medicalisation of midwifery practice and was regarded as insufficient pragmatic support, as shown by this quote:

> *We didn't have that separate normal birthing protected space… I think this push to normal birth and if there were more strategies that meant there were more protected normal birth spaces and they needed more midwives for those and they were strong midwifery learning places* (BM 07 IP 8).

Sufficient and relevant midwifery staffing compatible to the needs of both the midwifery team and women was considered a helpful resource. For example, the creation of a new role was a resource that decreased midwifery workload and aided antenatal women:

> *We actually have a midwife that has recently started, it's what we call a triage role. So she oversees the whole clinic and answers phone enquiries and makes sure that women are put up to be seen and aren't missed, so that has been helping with their communication* (GD 07 IP 6).

Multiple shifts across 24 hour working days contributed to periodic and patchy support. Midwifery support roles were a resource not available at all times of the midwives' working day, for example:

> *Being seven thirty on a Sunday morning I was thinking: "Where can I go for appropriate support because no one else is going to provide support?"* (GD 07 IP 5).

Working around the clock necessitates eating at work. The meal break was coveted as a form of pragmatic support and was mentioned in most interviews, the manner being predominantly cynical. Participants regarded them as unobtainable due to high work load. The laughter inherent in meal break discussions was sarcastic and derisive. It was also unifying, establishing a sense of collective recognition of a commonly held viewpoint that midwives do not receive meal breaks. Getting a meal break was frequently presented as contributing to a good shift, so that to:

> *Obviously if I have my meal breaks* (laughs)*, that would be a good day* (GD 07 IP 2).

However, meal breaks were considered extravagant rather than a basic requirement. When referring to a midwifery manager who supported meal breaks, this participant said:

> *She would step in clinically and was absolutely adamant that everybody got breaks and she would take over… Yeah, it's pretty luxurious at the moment* (BM 08 IP 2).

Meal breaks were not always recognised by management, for example:

> *Not a real lot of recognition that half the time we don't eat at work, all that stuff, all those clichés, you don't get to go to the toilet, you don't eat, you don't stop* (BM 08 IP 3).

An area designed for food preparation and consumption was not always a given in some hospitals, thus inhibiting the taking of meals in the work place:

> *We don't actually have a tea room in our unit anymore* (GD 07 IP 5).

Midwives shouldering some of the responsibility for not taking a meal break, rather than solely apportioning blame upon others, was noteworthy in this quote:

> *Where I am now the culture is that you don't have a morning tea break, you don't have a coffee break in your shift, you just have a meal break, so everyone just grabs a coffee and keeps going. But often they will have a meal break, you know a meal break is also flexible* (laughs) *it doesn't always happen* (laughs)*. But I say: "You know we are actually entitled to sit down and have a coffee without having to do everything, to have a drink, a coffee in one hand and write notes with the other…We know we should have meal breaks and that we should make a fuss about it and get people to come in and cover and go and sit and have a meal break. But we just don't* (GD 08 IP 4).

The subheading *Having pragmatic support* discussed a range of sources of pragmatic support, such as the physical presence of other staff and an aptly organised physical environment. These were things that helped midwives to carry out their role effectively.

8.5.1.6 Midwifery group practices as support

Midwifery group practices were mentioned within many of the interviews as sites of support, as said here:

> *I was buddied up with someone for the first year that I felt very comfortable with and I was able to ring her at any time that I didn't feel that* [comfortable with something] (BM 07 IP 4); and also:
>
> *They all were all just: "Call me at any time if you have got any questions"* (BM 08 IP 3).

The collective knowledge of a non-hierarchical midwifery group practice was considerable support to this participant who had:

> *Never once approached anyone and thought I was asking a stupid question. I never felt that they looked down on me. Collectively in that group they have got probably 100 years of midwifery experience against my, at the time, five years. So I never once felt that I was inferior to them in my knowledge* (BM 07 IP 4).

Most participants spoke of the inability to move into a group practice model after initially completing their education because:

> *There was a longstanding sort of belief that new graduate midwives are not competent to work in continuity of care programs* (BM 07 IP 2); despite the commonly perceived benefits of new graduates working in such a model of care. One participant said a group practice:
>
> *Gave me space, it gave me support, it gave me time and it gave me consistency in all the areas to be able to, my confidence grew really quickly in that role* (BM 08 IP 3).

Data collected under the subheading *Midwifery group practices as support* revealed that despite the barriers to working in a group practice straight after graduation, the participants considered these midwifery models positive supports.

8.5.1.7 The system as support

Another important form of support, aptly introduced by the following quote, is that of support from the system, including organisational structures that aid the midwife to practise to the full scope of her ability, whereby:

> *Support is not just a physical presence in terms of an educator or a manager that is supportive, but I think of the infrastructure in place for you doing your job and doing it well. And by infrastructure I mean an appropriate number of beds for the*

> *women that you are seeing, and the appropriate resources at your fingertips so you don't have to bugger around for half an hour to find things that you need for something simple. It's a support of the resources and the infrastructure, but also the, having the physical presence as well* (GD 07 IP 5).

One aspect of support from the system was the sense of feeling recognised, valued and then suitably compensated for undertaking one's working role. Throughout the interviews, many of the participants expressed feeling undervalued by the hospital and health system of which they were contributing members, as expressed by this participant's critical remark:

> *It is the system. We need more money, we need more midwives, we need more nurses and we need more respect as a group, as a concept. Like health just gets it in the butt. We don't get anything extra. They have just spent so much money on these jet fighters, they don't get it. What about the people, overall, that is what I have realised, it is our whole industry. Health care is not valued in the public eye… No it's not valued by governments* (GD 07 IP 1).

A foundation for the lack of appreciation for midwifery and maternity service was perceived to lie with:

> *Politics, politics, politics, politics and the structure of the hospital system and the endless negotiating and battling with for change and improvements to services… Not feeling appreciated by my employers* (BM 08 IP 3);

Whilst another participant considered her midwifery group practice as being undervalued and threatened to be terminated, when she said:

> *Our group practice is fairly under constant threat of closure. So that always makes you think of what else you can do* (BM 07 IP 1).

The lack of legal support hospitals provide employees in cases of employee fault worried a few participants, for example:

> *If anything happens, as a midwife said: "Don't expect support from the hospital, you are on your own". So you can imagine the trepidation and anxiety I felt when I was in charge, because they said: "If anything goes wrong, the hospital won't back you up, you are on your own". Whether that was factual or not, I don't know, but it was very frightening, especially when you are a new grad* (BM 07 IP 5).

One midwife stated she did feel moderately valued by the hospital, due to staff shortages, feeling valued:

> *For the most part, definitely. Probably because they are so desperate for staff half the time* (laughs). *They are grateful for anybody* (GD 08 IP 6).

The system as support included those strategies allowing new midwives to perform their roles to the best of abilities and skills. Health guidelines were seen by some participants as endorsing the midwifery profession. These next quotes pointed to the dearth of documentary material as unsupportive to midwifery role, as:

> *There is a lack of clear definition of the role of the midwife in that organisation. They are really, really lacking in any policies or guidelines… I think that would really help if there was something that said midwives do have the ability to be autonomous within these kinds of contexts… There is nothing I can refer to that actually says here's this document that supports midwifery autonomy in normal women. So it just becomes about whoever you are working with on the day and whether they feel comfortable* (BM 08 IP 3).

The subheading *The system as support* made reference to support from the system originating from the government, the hospital and the general public's stance regarding the value of health care.

8.5.1.8 Relationship-based support

One crucial form of support for the new midwife was the development of midwife-to-midwife relationships which incorporated working relationships, staff morale, and the treatment of others within the midwifery profession. Particular midwives were considered to be supportive and were:

> *Nice midwives, in the sense that they are supportive and non-judgmental, they are genuine, those sorts of midwives are really nice* (BM 07 IP 5).

Midwifery relationships and staff morale were considered as constitutive factors of work group cohesion. Cohesion was explained by this participant to be:

> *You walk in the door and it's like: "Okay, we're a team, this is what we have got to do, this is what is ahead of us today, how are we best going to attack this?"* (BM 08 IP 5).

Cohesion was also considered important for idea sharing and emotional support, for instance:

> *I am lucky where I work that we are a really cohesive group and we really support each other well so we can bounce ideas off each other and there is always someone willing to give you a hug* (BM 07 IP 1).

Whereas support, communication and cohesiveness were all considered as linked and important to this participant in their absence, when she said:

> *I think it is a lack of support, the lack of work place communication and work place cohesiveness* (BM 07 IP 5).

Similarly, a lack of value placed on communication skills training was identified as detrimental to the cohesion of a midwifery group, as:

> *There is not enough group behaviour and communication training. And a lot of the midwives that are senior are given a lot of responsible with training students and working with students and new grads, which is great, but they are not getting training or supervised in how they are training them* (GD 07 IP 4).

Social interaction outside of the hospital setting also contributed to cohesion between midwifery staff when at work, because:

> *There are a lot of social activities and so they all socialise outside of work. There are a lot of nights out and farewells and dinners and things like that and I think that really contributes to the how everyone kind of relates to each other* (BM 08 IP 2).

Similar philosophies of midwifery care underpinned work group cohesion for some, especially working within midwifery group practice, as displayed here:

> *Working towards the aim of an outcome for a woman… All the midwives are very much supporting what the woman's decision is so there is that consistency. Even though you might be looking after her for only eight hours and advocating for her and buffering her between her and the doctors to support her decision, when you hand over that care there is a constancy with the philosophy and that's not common at lots of hospitals* (BM 08 IP 2).

Seniority and familiarity with each other imparted cohesive work place relationships, because:

> *When you get to a certain level of experience that there tends to be a kind of collegial environment and it's a bit more supportive* (BM 08 IP 2).

Unfortunately, one participant noted that refraining from providing support for new midwives could affect the whole midwifery team, when:

> *There are some midwives practising in that field who actually enjoy making it awful for new graduates and so that it not that great for social cohesion* (BM 07 IP 2).

The denial or provision of support to midwives emerged when participants spoke about midwives looking after their own. Many participants felt that midwives did not create an environment whereby they supported one another:

> *We don't look after our own, we totally don't. Midwives don't look after their own… There is this kind of, it's not that it's competitive, but this sort of toughen up and deal with it, like it's weird, it's all these women in the workplace yet instead of nurturing each other they sort of put shit on each other* (BM 08 IP 1);

Conversely, some spoke of a culture of midwife-to-midwife support whereby support systems were informally created by keeping in touch with fellow midwifery students once graduated through Facebook groups, get-togethers and continued friendships, so that there was:

> *A larger network, a lot of us who came through our course together kept talking to each other and kept supporting each other through those first years* (BM 07 IP 2).

The use of alcohol was frequently mentioned to be part of the midwifery way of life as a defence against poor support:

> *There is a big culture in drinking and perhaps this is linked to this lack of support that we get. When midwives go home they sort of get stuck into the booze. It is a big part of the midwifery culture. Whether or not this is linked to this lack of support and it is a coping mechanism* (BM 08 IP 1); and in a similar vein:

> *You kind of talked amongst your own rather than go to management, to go to higher. The things are in place there but do you access them. I think we do a lot of wining and bitching. Wining as in drinking* (BM 07 IP 4).

This next quote, besides being visually evocative, describes this participant's observation of midwives looking after their own in conjunction with the imbibing of alcohol:

> *I remember going to this party and boy! Do they know how to let their hair down. It was like they knew how to drink, they knew how to have fun. I've never seen anything like it. It's like because they view such tension in their working day… But it was like because they band together in the tough times, they all experience the stress and the joy of what it's like to work with women in birth, it's like they have this excessive ability to let their hair down. I will never forget it, because it was just pouring with rain and they were all half, more than half-pissed, and they were all out in the rain dancing, kicking their shoes of and having this wild time. It was great* (BM 08 IP 4).

The subheading *Relationship-based support* included data which showed relationships as being important mechanisms of support. It incorporated workplace communication and morale, leading to collegial cohesion, as well as relationships that spilled over into personal time.

8.5.1.9 Supporting women

The impetus of midwives supporting one another was, at its core, supporting midwives in the taxing yet rewarding role of looking after women in emotional and physical transition. Positive and negative qualities of the midwife-woman relationship emerged in the interviews and support given to women was presented as multifaceted and intricate in nature. Supporting women was seen as an intangible connection between midwife and woman, for example:

> *I can be in a room with a woman and just not even talk to her, just be there, but I know that she knows that I'm there and I know that she trusts me and I trust that she knows what she needs to do* (BM07 IP 4).

One participant left midwifery as she felt that she could not provide the type of care and support to women that she had hoped for, when she stated:

> *Trying to balance my own sense of what was right and what was good for me with my desire to be a midwife, because I did actually have a very strong desire to be a midwife in order to have the capacity to support women in a really effective way, but what I found was that I wasn't actually able to support women in an effective way and so that was what was really underneath the crisis. So once I got to the point at the end of that first year where I would go home from the hospital and I*

> *would be making dinner or doing the dishes and I would be just quietly weeping* (BM 07 IP 2).

Rather than midwifery as being with woman, one participant talked about her perception of an adversarial relationship between midwives and women. Women merely meant more hard work in an unsupported work environment, so that:

> *There is this kind of feeling of: "it's them and us", like the woman and the births against the staff which I find that a bit hard to work with* (GD 08 IP 4);

The women coming in to the hospital to birth were considered "them" and the midwives were "us". The stressful and taxing nature of the midwifery role engendered this discordance, as each individual woman was perceived as extra "work", in a work environment where they felt over-worked.

The next quote is alarming and disheartening and concerns a discriminative lack of support of women. One participant described the insidious presence of racism extended towards women by midwives, a midwifery behaviour that is the antithesis of being with woman:

> *We deal with a lot of non-English speaking women so I think a lot of these midwives think that they can get away with anything. Which is quite tragic and I disagree with that. Because they don't speak English I think we have to be even kinder to them, but it doesn't work that way. And they're the ones who go: "If you want to practice your cannulation go in this one she doesn't speak English". It is really quite vile. I sort of look at them and say: "Really? So because she doesn't speak English, she doesn't feel pain? We can use her as a guinea pig?" It is really quite horrible and I hate to say this but a lot of midwives who I work with are very racist. They're Caucasian and a lot of our clientele are Turkish and Islamic and they have no respect for these women as clients. I hate to say clients, but people who come in to have their babies. "She's going to have her sixth, seventh baby and go on welfare". It's horrible, it's quite demoralising and they are so racist, they laugh at the women and say how smelly they were and they are not wearing any underwear, it's quite depressing sometimes because it is just so racist* (BM 07 IP 5).

The subheading *Supporting women* presented evidence of how helping women was considered central to the midwifery role. However, negative elements of this care relationship existed such as cynicism due to high workloads and racism.

'Calling for support' is the first subtheme of Theme (ii) 'needing a helping hand'. The presentation of the data in 'calling for support' depicts the need for support as both complex and crucial in the working life of a midwife. Throughout the interviews the woman was positioned at the heart of midwifery, with the core purpose of midwifery being supporting women. 'Calling for support' illustrated the necessary workforce conditions and parameters that function as supportive to the midwifery role. According the midwife these supportive structures supports midwives to support women.

The second subtheme of 'needing a helping hand' will now be presented.

8.5.2 Subtheme b): Progressing in the profession

The second and final subtheme of 'needing a helping hand' focuses upon the capacity for self-help in career development. It includes perspectives of flourishing as a practitioner through facilitated learning opportunities, and the opportunity for promotional advancement in the midwifery profession. Midwifery was regarded by some to be a diverse career allowing for the development of varied professional capabilities, for example:

> *Midwifery is so diverse, and not only in each of the clinical areas, you've got education, there's management roles, there's teaching, there's work overseas if people want to do that. There are lots of opportunities for people to develop and grow in their career if they choose to* (GD 07 IP 6);

Midwifery was seen as a means to travel and a stepping-stone into other health related fields, when this participant said that:

> *Part of the reason I went into midwifery was because I really wanted a career that could allow me to travel and also to kind of step into doing international health* (BM 08 IP 2).

However, the prospects for career progression in midwifery were not all positive and were limited to the clinical setting, for instance:

> *Why just keep our career development opportunities to clinical practice. Why not expand and get more involved in, beyond our clinical one-on-one care… I think we are great in clinical practice but there's just a lot more that midwives can learn* (GD 08 IP 1).

Holding expertise in academic or clinical-based research was seen as a conduit to career advancement in the midwifery profession. However, difficulties of studying as a new midwife were frequently mentioned:

> *If you are research orientated there are good pathways. If you are a clinical practitioner, not quite so much. Although you can go into specialised areas, you know maternal fetal medicine unit, but look, when you are working full time it is hard to study* (BM 07 IP 1).

Promotional advancement was considered an ongoing personal process of managing learning and work. Development of skills and knowledge enabling informed decision-making about education, training and career choices were also discussed. Continued professional development (CPD) requirements were put forth as a positive pressure to continue learning as a midwife, advantageous to career development and safe clinical practice. However, issues with ward-based training and course training were mentioned:

> *CPD is a good way to improve practise, change outdated ideas and learn from each other. A one hour in-service with buzzers, interruptions while trying to eat lunch is not quality education. Hard to remember things when tired, hungry and stressed about what is happening on the ward. The other issue is the cost of really good workshops. They are expensive, usually more than one hundred, two hundred dollars. And this comes out of your own pocket. Teamed with the fact you have to do it in your own time, it feels like a massive hurdle and another obstacle to the very thing that would enhance practice and add value to the job* (GD 07 IP 1).

One participant underestimated her career progression. Despite undertaking advanced clinical skills in her role, this participant did not feel that she desired any promotional advancement in her midwifery career, despite her saying that:

> *At the moment I am just happy to be a clinician, for lack of a better term. I just love to be a midwife but I'm getting myself, like I am cannulating and doing perineal repair, so I am doing all these extra things but I am happy with where I am, I don't want anything else* (BM 07 IP 5).

Conversely, this next participant deemed her involvement in modifications in ward-based practices as an expansion of the midwifery role, and led to increased job satisfaction, so that:

> *I am quite happy in postnatal because there were a lot of changes that came through that I helped to participate in* (GD 07 IP 3).

Nursing, rather than midwifery, was put forth as a better foundation into hospital leadership positions by one participant:

> *If I was going to be very strategic about my career and if I really had huge aspirations to get into executive roles you'd be better off bouncing from that nursing background* (GD 08 IP 3)

One participant mentioned forfeiting her part-time working status in order to progress into an educator role that she aspired to:

> *I didn't want to do full-time work. But I had to make that sacrifice to become an educator. I knew that that was what I wanted to do… The Director of Nursing did not approve of job sharing positions because she has had previous bad experiences so I either had to accept it as a full-time position, or miss out altogether* (GD 07 IP 2).

Lastly, the importance of identifying midwifery 'champions' who can help guide one's career is described well in this quote:

> *It's trying to work out where, a journey to where you are going to go without a map. You know, if you are not confident enough to ask people what to do, then it's going to take you longer to get there* (BM 07 IP 4)

'Needing a helping hand' can be considered as the requirement of the new midwife, who is 'sinking and swimming' in her recently commenced midwifery role. This theme, the second of three, included a comprehensive mapping of midwifery support needed, in order to support women effectively. Help and support were considered necessary for positive integration into the profession. Once working, the progression within the profession was driven by further education and training, within a supportive work environment.

The third and last theme, discussed next, is 'being a midwife, but…'

8.6 Theme (iii) Being a midwife… but

Having endured the overwhelming experience of the initial transition into midwifery employment, represented in the first theme as an experience of 'sinking and swimming',

and not being submerged by the challenge, perhaps due to the provision of support, represented in the second theme as 'needing a helping hand', the new midwife moves onto dry land and into a different period of midwifery practice.

Experiences of this ensuing period of midwifery practice are encapsulated in the third theme as 'being a midwife… but'. With the dust settled once the midwife was securely on dry land and having had looked around, participants viewed their working life as a dichotomy. Participants employed language to convey clear-cut demarcations between the positive and negative aspects within their experiences of working as a midwife. Accounts of those elements of midwifery that brought satisfaction and content and dissatisfaction and resentment gave the data a dichotomous form, whereby there was an opposing dynamism between the positives and negative aspects of the role.

The positive element was the compelling sense of meaningfulness awarded to the role of the midwife. The negative aspects of midwifery were those that inhibited this sense of meaningfulness. A dichotomy of a perception of fruitfulness and fruitlessness in their work led to the impression of love and hate within the interview data, both of which are strong emotive qualities to be linked to a job.

The *love* of midwifery came from a vocational vitality, attributable to an aspiration to yield good outcomes from the care provided within the midwife-woman relationship. However, frustrations evolved from practising midwifery in the hospital setting, and a *hate* for elements of their job emerged as a negative undertone within the interview data, which had an adverse effect upon the volition to continue as a midwife.

Encounters with bullying, arising within aggressive or toxic workplaces, and an ethical and moral discordancy with the role of a hospital midwife lead to personal ethical reservations about their obligations in the hospital setting. The hospital, as an authoritarian organisation, was seen as instrumental in sanctioning both a prevailing construct of overtly medicalised care of women and also regulation of midwifery practice. Participants appeared to question their career as a midwife in the interviews. An overriding sentiment in most of the interviews was I want to *be a midwife… but*. An impression of cathartic complaining, defined as a sense of satisfaction when discussing various aspects of their midwifery work that brought dissatisfaction to their working life, was evident in the interviews. Giving rise to the cathartic complaint was the dichotomous love/hate relationship the participants had with their profession, as shown by this quote:

> *I didn't have any romantic ideas about midwifery. But when I started doing it I was like: "Oh my God I can't believe it, I absolutely love it. This is great, I love it". I hate it but I love it* (laughs) (BM 08 IP 2).

The value and reward arising from 'being with woman' was what allowed participants to see midwifery favourably. This content, however, was jarred by an attitude of:

> *Everybody's lives just seem to suffer from giving to this profession (GD 08 IP 7)*.

Descriptions of participants foregoing aspects of themselves, characteristic of those who dedicate their lives to vocational disciplines, as expressed in the language of asceticism, was a notion of sacrifice, whereby in being a midwife:

> *You have to be willing to be the type who is willing to fight, to be willing to work really hard and it is not easy… You have to realise that there are sacrifices to be made* (GD 07 IP 2).

Theme (iii) portrays emotive and impassioned characteristics within the interview data. The four subthemes of the theme 'being a midwife… but' are:

a) Being a midwife as a vocation;
b) Learning about bullying and territorialisation;
c) Managing ethical dilemmas as a new midwife; and
d) Withstanding the power of the system.

The titles of these subthemes were not directly derived from participant quotes. Rather, these themes were named as being representatives of the experiences commonly portrayed in the data.

8.6.1 Subtheme a): Being a midwife as a vocation

The driving motivation in the midwifery role was largely understood as having a vocational dimension. This subtheme addresses the vocational element of midwifery, recurrently expressed in the data. Transecting this subtheme is the sense of satisfaction derived from relationships with women and the dissatisfaction experienced from workplace and organisational matters.

Participants held optimistic perceptions of being a midwife, evident by frequent positive views crediting the significance of a midwifery career in a favourable light. Midwifery was

endorsed as a career of integrity, as well as being a source of enthusiastic verve, self-respect and pride. Persistently evident was the perception that an underlying vocational drive was the basis for seeking a career in the midwifery profession. The intentions of the vocational drive were generating both good outcomes for women and babies and positive experiences for women and families. Another large impetus for the vocational drive was the relationships of care with women.

It was clear that what initially drove the participants into the profession and what kept them there was predominantly one and the same, namely relationships. Once working as a midwife, participants expressed that what drove feelings of enjoyment within their work, and a sense of job satisfaction in their role, was predominantly having a sense of relationship with women, akin to the driving force that moved them into the profession in the first place. The source of job satisfaction, namely relationships with women in their care, seemed to be a central motivation for remaining in the profession, and appeared to be a disincentive to leave midwifery and was in contrast to the multitude of sources of job dissatisfaction, that were chiefly workforce issues.

Of significance then were sources of job satisfaction and dissatisfaction did not hold an inverse relationship with each other. Job satisfaction was not believed to be the result of a diminishment of the factors that contributed to job dissatisfaction. Rather, a source of job satisfaction as a midwife was what impelled them to midwifery practice and retained them within their profession, despite the job dissatisfaction commonly expressed, and that was relationships.

As the originating factors of job satisfaction and dissatisfaction were not one and the same, this meant that workforce measures that strengthened the sources of participant's job satisfaction, for example, strategies that enhanced continuity of care with women and strengthened the relational aspect of the midwifery role, did not appear to seamlessly resolve the issues of job dissatisfaction. Participants expressed that in order for that to occur, the sources of job dissatisfaction themselves would also need to be attended to. It likewise meant that stripping the profession of the causative factors of job dissatisfaction would also not be enough. An injection of strategies and policies that enhanced the vocational dimension of midwifery appears to be crucial.

In brief, there was a strong sense of vocational passion amongst participants. Many of them discussed their career in midwifery as being vocational in character. The term

'vocation' was used by participants to express an enthusiastic zeal held for the midwifery profession. As mentioned, the core of the vocational drive was the desire for good outcomes for women and babies, in terms of their health and birthing experiences. For many, job satisfaction was linked to both vocational drive and good outcomes. Possessing a vocational drive contributed to job satisfaction and also contributed to the perception that their midwifery role impacted upon the delivery of good outcomes for women and their babies.

> *I think* [midwifery] *is a vocation, I think it's, for the majority of us, a calling and there's passion behind it. We want better outcomes for women, we are dealing with people's lives, we are dealing with a baby's first transition into life. I think that is where doctors and midwives are so incredibly different because we almost see it as a spiritual* (GD 08 IP 9).

Central to this sense of vocation was the perceived positive impact midwives could have upon a woman's experience, an impact that was considered valuable and empowering. The value of the midwife was commonly spoken about in terms of making a difference to a woman, such as:

> *It is such an important time and I walk away thinking: "I have made a difference for the better"* (GD 07 IP 5); and also:
>
> *Midwives make a difference. They are there at the heart and soul of the beginning of families. It's that real primal stuff that everyone needs a midwife* (BM 07 IP 7).

A sense of making a difference is what gave many participants a sense of value and job satisfaction:

> *Seeing that I make a difference in the lives of families, and finding that my efforts are being helpful to them during the labour and afterwards, so that is nice and rewarding, it validates what I am doing* (BM 07 IP 5).

The tone of speech and verbal expression of participants, when they discussed this vocational force driving their career, was both animated and emotive, reinforcing their dedication towards the midwifery role. Midwifery was considered, by most, to be more than a job. Conveying this was a strong emotive and expressive quality within the data. The next two quotes are demonstrations of this emotional connection participants had with their midwifery career:

> [Being a midwife] *was almost like coming home* (BM 08 IP 4); and also:
>
> *I don't think midwifery is just a profession. I think it is almost like a calling. Being a midwife isn't just a job, it is part of who you are and it's that dedication and passion that keeps midwives in their job* (GD 07 IP 5).

The second quote above articulates the idea commonly expressed, that a vocational drive drew participants to the midwifery profession, and it is this drive that creates "dedication and passion that keeps midwives in their job" (GD 07 IP 5). Conceivably, workforce measures that target and enhance the focus of this enthusiasm, in the data understood to be the relational aspect of midwifery, could assist with the retaining of midwifery staff.

This sense of vocation was an attribute that prompted many participants into the profession. Retaining a strong vocational urge past the new graduate period was akin to job satisfaction, the sustenance of which was vital to remain in the midwifery profession:

> *I have said around the lunch table: "If I didn't look forward to coming here, I love being a midwife, it makes me want to wake up in the morning and come to work, I look forward to another adventure, the day that stops is the day that I change careers", and they go: "Oh Gosh, that happened to me ages ago and I'm still here", and I say: "Well I would change careers if the passion wasn't there". To me it's not a job. It's, it's what I breathe, it's my life… Some of them should really retire, leave their job and move on for those who are passionate about it* (laughs) (BM 17 IP 5).

Job satisfaction existed in achieving fidelity with the perceived role of a midwife, when the role permitted them to work to the full scope of the midwife. The complete use of midwifery skills was akin to autonomy and satisfaction and was:

> *Having the autonomy to practice to my full scope of practice* (BM 08 IP 3).

The ability to comprehensively utilise midwifery knowledge in practice led these participants to feel job satisfaction:

> *I can work anywhere. That's the good thing (GD 07 IP 4).*

Job satisfaction was often explained through the notion of a good shift. One participant, when asked about sources of job satisfaction, stated that:

> *A good shift is one where I can catch a baby, hopefully from start to finish* (BM 07 IP 5).

The provision of comprehensive care was important to many, for example:

> *A good day is actually I do all my appointments along with my paperwork as well and I have given the woman my full, the capacity of what I do, so that's a good day to me* (BM 07 IP 4).

One participant employed in midwifery group practice felt that this model allowed her to practice how she thought a midwife should be:

> *On group*[17] *you feel like a midwife because you are doing everything from booking in to discharging, that's really satisfying seeing them grow through their pregnancy and seeing them breastfeeding their baby at the end* (GD 08 IP 9).

Midwifery roles, which permitted adherence to the philosophy whereby birth is perceived as a normal physiological yet transformational life event, seemed to provide satisfaction. Participants drew attention to the importance of facilitating normal birthing processes and the role of this philosophy in job satisfaction, for example:

> *So absolutely do midwifery if you are woman focused and you truly believe that birth is a normal physiological event* (BM 07 IP 1).

The 'woman focused' relational aspect of midwifery care once again highlights relationships with women. A connection with women was both vital for the participants' job satisfaction as well as job motivation. The relational aspect of the midwifery role was considered as being of utmost value, as shown by this quote:

> *I think that it is THE most important thing. I think it probably surpasses anything else really as a midwife. That, you know, trying to develop a rapport and trust with a woman is paramount* (BM 08 IP 2).

Working within a continuity of midwifery care model enabled the building of relationships and the ability to practice to the full scope of one's profession. Due to the repeated and individualised contact between midwife and woman generated within such a maternity care structure, continuity models afforded a greater sense of the relational aspect of the midwifery role for many of the participants, and were seen as a means to gain greater job satisfaction, so that:

[17] Midwifery group practice.

> *It is a lot more satisfying as a midwife to know your women and I feel that by knowing them, I feel it a lot more satisfying because we already have a relationship and it is nice to see their satisfaction as well* (GD 08 IP 5).

Demonstrating the notion that the grounds for job satisfaction and dissatisfaction differ is this next quote. One participant working in a continuity of care model said her job satisfaction resulted from the clinical and relational aspect of the role. Conversely, the affairs of politics of the hospital were perceived as leading to job dissatisfaction:

> *Definitely that satisfaction is through the clinical work that I do, through the relationships with the families that I care for and my colleagues, and not in a lot of the politics of it, like the micro-managing. We also have managers who like to think that they do it really well and we get these directives handed down from the local health district about what we should be doing as well. And I think that sometimes it's really difficult when people don't work within our model for them to actually appreciate what it is that we do. Sometimes you just have got to suck it up and get on with it and sometimes it's worth the fight* (BM 07 IP 1).

The preceding quote adeptly shifts the presentation of data from job satisfaction and towards those data of job dissatisfaction. Part of the strain is that many of the participants spoke about the job being a 24/7 lifestyle, for example:

> *It's not just a job, you walk in and you walk out of, it's something that I would take home with me, I take the thoughts, the smells, the experience, the adrenalin, everything, it's very hard to just shut off and go home and watch the telly* (BM 08 IP 4).

Cathartic complaining was ubiquitous amongst the participants, with them happily yielding information about aspects of their profession that caused discontent in their jobs. Together with the pervasive quality of the job, permeating into out-of-work life, this section is complex and involved and subheadings will be a guide to the reader.

8.6.1.1 A fiscal shortfall

A common thread in discussions of job dissatisfaction was monetary remuneration. Most participants gave the impression that they were not receiving an adequate wage on par with other professions, due to the heightened sense of responsibility and duty they felt. In spite of the relative prosperity of Australian midwives as compared to many peoples across

the globe, one participant expressed her perception of this disparity with a sense of cast-iron certainty when she said:

> *The salary is a pittance really for what we do. So yeah, salary, it's a joke (BM 07 IP 1)*.

The data revealed a sense that the pay they received was a concrete representation of midwifery work not being valued by the wider community, for example:

> *I think the whole undervaluing, the lack of parity, or any sort of, parity is not the word I want to use, the lack of association I suppose between pay and responsibility is so glaringly obvious. So although you don't go into it, into this profession for money, when the chips are down and you are not getting a whole lot of other things out of it, and it's under-valued to that extent, I think that is another big structural thing, just the feeling of being under-valued and I think that's probably another big midwifery management thing, you totally felt like you were just a number, you were totally under-valued. When you are under-valued by management, and in terms of pay, it just does build up, a picture that means everything else has got to be going right to keep you there* (BM 07 IP 8).

The poor correspondence between pay and the obligation of their duty led many participants to question whether they would remain a midwife, for example:

> *And for the amount of effort that we put in for work and the amount of, I know that it's not about money* (nervous laughter)*, the amount of pay you get and for the hours that you work, and the emotional and physical toll it takes, I did think: "Is this all worth it?"* (GD 07 IP 4).

The subheading *A fiscal shortfall* referred to participant's discussion of pay. Remuneration was perceived as inadequate to the expectations of the midwifery role.

8.6.1.2 Work scheduling and structure

As well as inadequate financial recompense for their jobs, difficulties of shift work and the lack of control over work scheduling emerged as a common moot point. The physical toll of shift work and the added difficulty of night shift were frequently discussed:

> *Shift work is hard* (laughs)*. I've never been good with night shift and it takes me long time to recover from them. And now that I have two little kids it's near impossible* (GD 08 IP 2).

Fatigue and the invasion of shift work into other aspects of life was a cause for concern for most participants, for instance:

> *Full-time work! I can remember being so tired I couldn't do anything else, all I did was sleep and work, I was just consciously exhausted and I didn't even have kids* (BM 08 IP 2).

Much attention was given to the physical impact that shift work could have on those undertaking it, one participant declared that:

> *Shift work is really so bad for you, so you know I can imagine quite a lot of people thinking they can't do this, I'm unhealthy, I don't sleep, I have turned into an insomniac, I've put on weight, I'm depressed, I've got diabetes. I mean we are so unhealthy, we are stuck inside* (BM 08 IP 2).

However, some participants liked doing shift work because it worked well with their body clock and had benefits, such as missing the politics and busy day tasks of working in the day, aspects of their role that they had disliked, for example:

> *I love shift work. After a while there is always some days where you want a nine to five job. But for the most part I love it. I am a night person, so I pretty much only do night shifts… There are fewer chefs in the kitchen* (GD 08 IP 6).

Shift work, frequent overtime, a lack of flexibility and control of rostering, the inability to organise child care due to indefinite work days, and the reality of the difficulties of working the busy job of a midwife all made it difficult for participants to feel balanced in their work-life and out-of-work life. A lack of control over hours of work and having no regularity to days worked presented repeatedly in the interviews. One participant stated that:

> *The lifestyle, the shift work, the lack of control of my time, only being able to put my requests in, finding out what my roster is two weeks before the month starts, I feel like I am constantly missing out things in my life and the shift work puts a real strain on my family and I kind of think that is really unfair. I think work asks a lot of me and ask a lot from my family* (BM 08 IP 3).

Many participants, predominantly the Bachelor of Midwifery participants, spoke about their lack of awareness of what it would be like to work a shift work role until they were employed as midwives, so that:

> *We had no understanding what we were doing at the time and what our roles were going to be and what type of roles we were actually going to be doing when we actually came out, and the impact it would have on the family* (BM 07 IP 6).

Once working as a midwife and having increased awareness of the impact of the hospital schedule upon their out-of-work lives, many participants reduced their hours of work in order to improve their work-life balance, for instance:

> *I have decided to work two-three days a week, basically the minimum, it works out better since I took a drop in hours, the work-life balance is good* (GD 07 IP 1)

Many of the participants changed their work status from full-time to either casual or part-time in order to obtain some control over their rostering so as not to miss out on special occasions, improve work-life balance and to reduce fatigue and stress:

> *Being able to be on pool*[18] *has made it, has made me able to have time off when I need it* (GD 07 IP 4).

Moving to a casual position was also used as a tactic to ensure that participants chose the area of midwifery work where they were employed, rather than being moved into other areas by management to cover sick leave and staff shortages, for example:

> *I always got moved to wherever was busiest so I never got to go to the ward if it was quiet, they would move me to delivery suite because it was busy. So being able to be casual meant that I had more control telling them when I wanted to work and where I wanted to work and it meant that I didn't have to do nights if I didn't want to* (GD 07 IP 4).

However, the reduction of work hours could have a bearing on more than a midwife's control of roster scheduling as suggested by one participant, who mentioned the downside of reducing working hours as the potential loss of clinical skills, when she said that:

> *Now that I am casual the manager is worried that I am not going to get back on the horse. She doesn't want me to fall off the horse. She wants me to keep my skills up otherwise it's harder to go back into that environment the longer you stay away* (BM 08 IP 4).

[18] "On pool" refers to working in a casual capacity as a midwife.

The *Work scheduling and structure* subheading showed how the frustrations concerning the lack of control over work scheduling and the impact this had upon their lives was universally expressed. Many participants addressed the pressure of the shift work structure by working in part-time or casual positions.

8.6.1.3 Feeling overburdened with workload

The high workload in midwifery contributed to a perceived poor work-life and family balance. An excessive workload referred to one that was disproportionate to the ability to carry out the tasks both effectively and safely. Participants revealed that once they began working, the recognition of the workload as unremitting and excessive soon ensued. For example:

> *It's just full-on from the minute that you walk into that door until the minute you leave. I walked out twice in my whole career of five years thinking I had two really good days* (BM 07 IP 4).

Although aware of the hurried tempo of midwifery practice as a student, the newfound autonomy conferred a different perspective of the pace. Where once the pace was thought stimulating and a chance for learning, now graduated and given increased responsibility, the workload was commonly perceived as excessively high. The workload was a cause of dissatisfaction as it lead to feelings of futility and was prohibitive to a sense of accomplishment. For example:

> *I always felt when I came out of working in that hospital that: "What have I done today?" Nothing, I've just been run off my feet all day. "What have I done for that woman? Aren't I supposed to be here caring for a woman? What have I done for that woman? Nothing"* (BM 07 IP 4).

Emerging from midwifery education that espoused woman-centred care, dissatisfaction arose from not being able to deliver care that they thought women deserved. The excessive workload was perceived to preclude adequate time to address important aspects of women's care, as shown here:

> *The workload… does get frustrating sometimes because you want to give a certain level of care and you are not always able to because there is too many women to see* (GD 07 IP 6).

As well as impacting upon their ability to practise in a woman-centred philosophy, the high workload had the potential to negatively affect women's health and safety. Many participants spoke about practising whilst feeling unsafe, for example:

> *The workload was actually scary. Like I felt unsafe at my first hospital and so that is why I moved… There was just not enough staffing. There were no people who you could turn to, you really just had to rely on yourself a lot, you had to be really resourceful to get through the day* (GD 07 IP 1).

Inadequate staffing contributed to high workload and the potential for safety mishaps in the clinical setting. Scant staffing led many participants to talk about job dissatisfaction and the provision of care that they perceived as inadequate, for instance:

> *I should probably say that I don't enjoy it because it is way too busy. I don't ever feel like I am finishing my work properly. There is quantity. I don't feel like there is quality to the care that I provide. Yes, the care that I provide is quite limited because there is just not enough time to finish things completely. It is because of workload…. It is a staffing thing. If there were more midwives we would have less patients and that would make it a lot easier* (GD 07 IP 1).

The impression was given that staffing was rarely, if ever, adequate, with staffing aimed at supporting the new graduates appearing haphazard, so that:

> *It was just a nightmare, no-one stopped. And it wasn't uncommon to have staffing like that, it was very rare to have fully qualified, experienced midwives on every shift* (GD 07 IP 3).

Another cause for high workloads was increased patient acuity in the contemporary clinical setting. Despite having had worked less than a decade as a midwife, many participants spoke of the changing nature of women's clinical care over this period. Observed causes for an increase in medical treatment leading to less normal births and higher workloads were provided as reasons for the intensifying workload. Increased birth rates and age of women, increased medical complexity of women, a higher caesarean rate, inadequate hospital resources for bed needs, and the push for women to leave the hospital as soon as possible were mentioned:

> *I was talking to one of the midwives in the lift yesterday and I said do you notice that is has become busier in the last four years? I don't know if that is true, I*

> *suppose we would have to look at how many women are coming through the doors and see if that is a factor. Maybe they are taking on more women, maybe the population, maybe we are getting older as we have our babies, maybe there are more medical conditions. The workload is heavier because of the medical stuff that is going on in the background. There is less normal stuff* (GD 07 IP 1).

The work load contributed to participants having to frequently work overtime, which was often unpaid, for example:

> *Realistically who gets out of work at the end of a shift?* (BM 07 IP 1); as well as the workload as being very physically demanding:
>
> *Normally I feel absolutely exhausted when I am leaving* (GD 07 IP 3).

Rather than alcohol being used for entertainment and bonding purposes, as mentioned before in the subtheme about support, its use was also mentioned by many participants as a stress-reliever. Once at home after a shift, the high workload was a grounds to steer midwives towards relaxing via imbibing alcohol, something potential leading to ill-health. For example:

> *You would get home from work and go: "Oh my God, I need a wine after today*" (BM 07 IP 4).

Despite having worked only a small number of years, the high workload was a factor in experiences of burnout. One participant, who was a midwifery unit manager at the point of interview, discussed a previous experience of burnout despite working in a part-time capacity in the early years of her career. Now as a manager, she worried about the impact of the midwifery role upon burnout in the profession, when she stated that:

> *I was sitting in her office, bawling, going: "I don't know how much longer I can take this for." Because the stress, I was burnt out and I think I was only part-time at the time, yeah, I was 0.89 FTE, doing twelve hour shifts, I was only there six days a fortnight and I was burnt out. That's the fear that I have for the staff now, with asking for over-time every day last week and this week and the constant go, go, go, because of the acuity, the numbers, the bed block, that's why midwives leave* (GD 07 IP 5).

One participant linked being overworked to both burnout and sick leave, stating there is:

> *Excessive sick leave and that is due to being overworked, we think. People are just so tired that they just don't want to come to work anymore. So they call in sick and we can't replace sick leave* (GD 07 IP 2).

The data included under the subheading *Feeling overburdened* refers to how a contributing factor to job dissatisfaction was feeling overburdened by regularly experiencing a high workload that was demanding and exhausting. Clear in the interviews was just how readily inclined participants were to discuss their discontent. An impression of satisfaction appeared to result from emitting these issues. The sense of vocation held in their midwifery roles was a stark contrast to the workplace factors leading to job dissatisfaction. It was this sense of vocation that forged their determination to remain in the profession despite its many challenges.

8.6.2 Subtheme b): Learning about bullying and territorialisation

A subtheme called 'learning about bullying and territorialisation' emerged within the 'being a midwife…. but' theme. As midwives lacking in seniority and perhaps authority in the workplace, the participants experienced a distinctive and vulnerable position in regards to the experience of bullying.

Bullying appeared to be pervasive within the hospital environment, within which all but one participant currently worked or had worked in. Many of the participants discussed experiences of bullying from management, colleagues, and medical staff, the possible reasons for it occurring in the midwifery workplace, and different manifestations of bullying as verbal, physical, psychological and exclusion in the workplace. Many, if not most of the participants had been involved in bullying, either as victims, perpetrators, or as observers, and this is reflected in the large amount of data collected on this issue. One participant said:

> *As much as it shames me to say it, I think bullying and harassment is a massive issue* (GD 07 IP 5).

Participants spoke of bullying by midwives impacting upon the cohesiveness of a unit. Discussion of submitting formal complaints due to emotional and physical assault by midwifery colleagues was found in the data. It was confronting to participants that bullying

was allowed to persist within the hospital work environment. Participants learnt personal tactics to protect themselves from bullying.

That experiences of bullying could affect work turnover was evident in several of the interviews. One participant was bullied in her workplace and left it to work in a different hospital. Speaking of wanting to leave the profession and the personal toll it had on her where she:

> *Was going to quit being a midwife actually…* [I] *experienced really bad bullying there and I ended up putting in a bullying complaint about one of my colleagues and even though they kind of dealt with it sort of, management, I was too demoralised by then and just hated it* (BM 08 IP 3).

Another participant spoke of being belittled to the point of questioning her career choice:

> *I wasn't valued, I was made fun of, I was picked on, I was bitched about, like it was just really awful*… [It was] d*emeaning, demoralising, it questioned why I wanted to be a midwife in the first place* (GD 07 IP 5).

A suggestion that the bullying culture of midwifery would be more keenly felt if one was younger and less sure of oneself when one midwife stated that:

> *If I was like in my early twenties and still a bit finding my feet in the world, I would have found it hard. I think I would have given it up because some of those midwives can be quite brutal* (BM 07 IP 5).

Styles of bullying behaviour differed, for example:

> *She had worked in delivery suite and was very good at what she did, but it was very, how can I say, she was domineering, intimidating, she could be humiliating, she really embarrassed me once or twice, like in front of a lot of people and seniors and things, which is just so unpleasant when you are just trying to learn something new. It was just awful* (GD 07 IP 1).

Participants speculated upon reasons for bullying either observed or experienced. Despite being informed by senior midwives that it was due to midwifery predominantly being a female profession, one participant suggested poor management and reduced accountability for bullying behaviour was a cause:

> *Everyone was just saying: "Oh this is just midwifery, it's because it's a woman-centred work force and this is what women are like, they are bitchy". But I don't think that's true at all… Things would just get swept under the carpet…It was kind of allowed to flourish because there was no leadership from management or anything else going, saying: "Hey, no, pull your head in, that is an unacceptable way to treat your colleagues or junior staff or beginning students"* (BM 08 IP 3)

Another speculated whether the crossing of physical thresholds, as occurs in birth, led to the situation where other thresholds, such as respectable work behaviour, occur and presents as bullying, when she said:

> *I wonder if it's something to do with in situations which have crossed boundaries already, you don't normally see somebody's vagina so close up or you know talk about poo so openly or all those sort of things that are normally so hidden. So once that has become acceptable, maybe there's a blurring of lines, you know, whether or not it becomes acceptable to do other things that you wouldn't normally do* (GD 08 IP 7).

The irregularities of shift work hours were also cited as a cause for bullying not being addressed, thus allowing it to flourish, for example:

> *I think it's about shift work. So no one ever deals with it at every shift all the time, so because it gets fragmented I thinks that's why they get away with it for so much longer than, in a work place where you all worked exactly the same hours and you saw those people all day every day, I don't think they'd get away with it then* (BM 07 IP 8).

Issues of hierarchy, inequalities of power, gender issues, and the devaluing of junior employees were considered as causes for the bullying culture witnessed in the workplace, as suggested by this quote:

> *The very hierarchical nature of the hospital institution that means that people pass on that thing from the top and the people at the bottom feel under-valued and don't know how to deal with it, and so they just pass that frustration down to the next person down the level… I suspect it's something to do with power and lack of equality and then you will probably find the gender thing as well. The lower*

> *echelons are dominated by women and the upper echelons are dominated by men and I suspect that is the other key thing* (BM 07 IP 8).

Bullying was widespread and all participants had witnessed or experienced it. Bullying was considered a behaviour that negatively impacted upon collegiality, practice and clinical safety. A variety of suggestions were made as to the cause of the widespread experiences of bullying, most of these referencing the hierarchical nature of working within healthcare.

Another workplace relation issue affecting both feelings of cohesiveness with colleagues and job satisfaction occurred due to the separate functioning of the various sectors, wards and models of midwifery care within the hospital. The perception of compartmentalisation where each sector functioned as solitary units led participants to see them as separate and disengaged factions. This impression shaped staff relationships amongst differing models of maternity care, differing health professions, and even levels of seniority and experience.

Participants spoke about strained collegial relations causing workplace stress and job dissatisfaction due to poor rapport and conduct between the different teams of staff members within the maternity setting. For example, poor rapport presented itself as midwives having no one to hand over women's care to and having to stay and work overtime, blaming other maternity sectors for issues, damaging gossip about colleagues, rivalry, poor communication practices, not feeling included if you were agency staff, unclear role demarcations and role delineations, and poor collaboration.

These issues gave a sense that the profession and workplace was comprised of separate *gangs*. Staffing in a large tertiary hospital is arranged by means of individual midwives working in only one area, rather than rotating throughout the different wards. This appeared to lead to an inward-looking culture in the various wards, for instance:

> *In the larger units they are more stratified, they are more insular, you know, you get employed to work in labour ward and that's where you stay for the rest of your days* (BM 08 IP 2).

Feeling under pressure from an overwhelming workload and a perception that other sectors in the hospital had it easier, was suggested as a reason for the dividedness of the varying sectors, so that:

> *It was cut throat, it was horrible. I guess it's from two teams that have different workloads but are both under a lot of pressure, so you can't see it from the other*

side because you are just so overwhelmed with your own workload (GD 08 IP 7); as well as this quote that describes the perception aptly:

They are sometimes territorial I must say. Sometimes there is a bit of us and them: "Oh those delivery suite midwives, oh my God they just want to just keep on pushing them through and we haven't got the other ones out yet", you know we haven't discharged these, bringing people before they even bring on more people and the delivery suite are like "Oh those lazy postnatal midwives, what are they doing stressing me". Everyone thinks that they work the hardest but we all work hard (laughing). We all work hard, you know? And we kind of pick at each other because you want someone to blame, it is just human nature isn't it? Blame each other for our workload and stress, like "Oh you brought me another woman, oh my God, you are a bitch" (laughing), you know, no not like that. "You are bringing me more work and more stress basically". So you look at your peers, at your colleagues, and you think, you start to turn on them because you know, you are hungry or tired and um yeah, it is not very good, it doesn't really help morale much. You just hate everyone then (laughs) (GD 07 IP 1).

Participants working in group practice models were acutely aware of feeling singled out in a negative way by midwifery colleagues, an example of a quote being:

They are all so very separate to just the sort of general labour ward/clinic stream. So you had the birth centre and the beautiful home birth and all these great models but if you just work in labour ward it was a very different… It was very much us and them, that's how I kind of felt, that it was very divided (BM 08 IP 2)

This sense of separation could lead to the need to defend the group and provide extra support to ones in the group practice, for instance:

Group practice midwives unfortunately seem to be, seem to be separate and different from the rest of the gang and so there is a bit of banding together that goes on and we'll all look after each other cause no-one else is looking after us kind of thing so we were all extra supportive of each other because there was that kind of sense that no-one else was going to help us out (BM 08 IP 3).

The impression of separate gangs referred to relationships between medical and midwifery staff, with quotes drawing attention to safety issues that could arise from poor

communication and rapport in the healthcare setting, with one participant saying that there is:

> *A lot of antagonism between the medical and midwifery staff, there is a lot of mistrust. There is not a lot of collaboration and that makes me feel disrespected and unsafe too* (BM 08 IP 3).

This sense of divide could impact upon how maternity care is delivered to women, as this final quote of the subtheme shows:

> *I think the morale has been low for so long … At the moment there is, almost like a, like a divide between doctors and midwives… There have been adverse outcomes as the result of junior midwifery staff and it makes the doctors practice more obstetrically focused as opposed to women-focused* (GD 07 IP 5).

It was evident from this data that the observation or experience with fragmentation between maternity sectors, midwifery colleagues and medical colleagues, and maternity models of care negatively impacted upon the experience of new graduate midwives.

This finishes the presentation of data in the subtheme of the 'being a midwife… but' theme, called 'learning about bullying and territorialisation. The next subtheme, called 'managing ethical dilemmas as a new midwife', will now be presented.

8.6.3 Subtheme c): Managing ethical dilemmas as a new midwife

Participants spoke of being in ethical and moral disagreement with the maternity care offered to women in the hospital setting, as well as undertaking clinical tasks which went against their ethical beliefs and perceptions of what good midwifery care is. This led to a feeling of moral misalignment and disconnection with hospital maternity and birthing practices. Lacking seniority and confidence in the workplace could lend to vulnerability, leading participants to work in a way with which they were uncomfortable. Participants referred to a discontinuity between the midwifery care taught at university and the reality of care when they commenced practising, for example:

> *At uni we learnt all the beautiful midwifery stuff, the continuity of care and being with woman and yet doing training in a tertiary hospital was just, again, every woman would you know was deemed an obstetric nightmare until she was proven otherwise* (BM 07 IP 1).

One participant stated that, as a student and then as a new graduate, she did not feel as comfortable in her knowledge about normal processes of birth as she did in the medical care of it:

> *I do believe that we did not really understand normal birth as much as we understood instrumental, complex, high risk births* (BM 07 IP 6).

Medical intervention, into what participants felt was a normal physiological event, felt wrong, whereby:

> *The intervention is really a bother, there is so much intervention* (BM 07 IP 5).

The term *obstetric nursing* frequently arose as a negatively expression of over-medicalised practices and subordination of birthing practices to the medical profession, for example:

> *I felt like an obstetric nurse, just doing what I was told to do* (BM 07 IP 1); and also:
>
> *They weren't midwives, they were obstetric nurses and that is not what I wanted to be* (GD 07 IP 5).

Some felt, as new midwives, they were not respected by medical staff, thus impacting upon their ability to freely communicate at work. One participant felt a sense of subservience to doctors, as well as feeling that things were being done to women that were not right, when she mentioned that:

> *I didn't feel like I had a voice to stick up what I saw happening that I didn't think was the right thing* (BM 08 IP 1).

One participant identified an evolution of working out that her loyalty rested with the women, as a means to being comfortable practicing in the hospital setting, she said:

> *We're the advocates of these women, we also have to, we're there for the hospital as well, for the obstetrician who is in charge. We are answerable to a lot of people. So to me it was really hard to know where my loyalties lay, was it with the women in my care, was it to my hospital, to my fellow midwives? Who do I want to like me the most, you know? And in the end I decided I don't care, I'm here to be a midwife, I am here to be with woman, I am going to put the woman and her partner in their childbirth experience as a focus of my midwifery. To me that's what being a midwife is all about and the rest can just fall in to place and I don't give a rats* (BM 07 IP 5).

Determining individual approaches to practice included realising there were midwifery tasks with which they were uncomfortable and diverged from their ethical perspectives of what it is to be a midwife. Some participants discussed the undertaking of clinical practices in opposition to their principles with which the participant felt uncomfortable. It was a:

> *Moral sense that that's just not a place where I belong. I don't feel like I can do what the hospital wants me to do with women basically… I wasn't fundamentally doing normal birth, I wasn't doing the stuff that I wanted to do and I was doing stuff that I didn't always agree with and I didn't like doing* (BM 08 IP 1).

The participant explained the inability to compromise her sense of ethical care, whereby:

> *I wore this uniform and name tag that sort of meant that I belonged to the hospital and I found it really difficult to carry out things that were policy or that I had been directed to do that I didn't actually believe were the right thing to do in that scenario feeling like I had to compromise my, my morals I guess* (BM 08 IP 1).

When being told by senior midwives to encourage women to have epidural analgesia in labour, one participant said she felt the need to protect the woman and did so by lying about clinical situations:

> [The team leader] *will actually come in and say: "Look, you have to do this by then, we have got a deadline here, make it happen or otherwise get her an epidural", so there is a lot of epidurals, "Well talk her in to an epidural, she needs an epidural", that kind of thing. I really find that hard to cope with. So sometimes I just lie and say: "She really doesn't want the epidural", she doesn't want it but I just buy extra time and what have you and there is an anterior lip for a long time sometimes* (laughs)*… I just find that I have to fudge a lot, in a safe way. 'Safe fudging' I call it* (laughs) (BM 07 IP 5).

The inability to care for women in the manner that they ethically resonated with was cause for thoughts of leaving the profession, as this participant shows when saying her decision to leave was:

> *Upsetting, having put so much work into it and having so much passion. I was simply looking at leaving because I felt so defeated. Because I couldn't provide the care that I wanted to provide* (GD 07 IP 5).

Directives from the hospital to act against principles appeared to derive from organisational influence, affecting the capacity in clinical situations to behave in line with personal ethics. This leads into the final subtheme within the 'being a midwife… but' theme, named 'withstanding the power of the system'.

8.6.4 Subtheme d): Withstanding the power of the system

Power, here in the last subtheme of 'being a midwife… but', means the potential to influence behaviours of people. The term *power* was used by many participants as an expression of that meaning. The term *authority* was also used to denote a legitimised, yet perhaps unjust, power. Power was perceived to be exercised from above with participants sensing a power of subordination upon their midwifery role. Discussions about these concerns were imbued with an antiauthoritarian sentiment.

The source of power was not exclusively possessed by any singular individual. Rather, a variety of sources were acknowledged, as quotes will show. Power or influence was portrayed as having material expression, tangibly affecting bodily processes and daily clinical care of women in the maternity system. Power was considered as a subtle influence existing within the organisational health care structures governing women's care. Hence, the idea of there being an incorporeal authority, or a non-bodily and subtle exertion of power, was presented by the participants. Structures that form the maternity health care system were perceived as restrictive of the midwifery role, as suggested by this participant who resigned from her position midway through her first new graduate year and said that:

> *There is no way I would have ever survived in that environment. There was no way I was going to survive in that. I had no understanding of the restrictions that were in place in that institution, it is an institution and I could never function within that restrictiveness* (BM 07 IP 6).

The influence of power appeared to have a directional orientation. The term *hierarchy* was frequently said. The hospital itself, was presented to exert power onto and over the participants, with statements put forth implying an organisational structure which was inhibitive upon the midwifery profession, and junior midwives in particular, so that:

> *The hospital it has its own little code* (BM 08 IP 2); where there is:

> *That upstairs-downstairs mentality, the hierarchy sucks* (BM 08 IP 5); making the participants feel like they are:
>
> *Back at the bottom again and that's not always a pleasant place to be* (BM 08 IP 1).

The hierarchy was seen as an unspoken, tacit influence, by one participant, within which some were privileged to influence power, so that:

> *There are hierarchies of power that are not necessarily spoken… But the culture, it is like the unspoken things that happen in the place and there is a real sort of outsider-insider culture in maternity services and that is part of what I fear where I always felt like an outsider and I didn't necessarily want to be an insider because I didn't always like what I saw happening there* (BM 08 IP 1).

The hospital hierarchy was felt to create an unfavourable work environment, for example:

> *I'm not really good with authority and the super-structure of a hospital is just kind of the most bizarre environment ever. It is really abnormal, an unhealthy environment, very insular, it is very narrow-minded* (BM 08 IP 2).

The impression of hierarchy was also created through seniority of practice, when midwifery and medical staff were considered to be undesirably constrictive of new midwives' ways of caring and advocating for women, so that:

> *It's hierarchical, I didn't feel like my position on the hierarchy supported that kind of action and I guess that that's what the hesitation is, you kind of know that you speak up that you're going to step out of your position in the hierarchy and you are going to bring attention to yourself and that means that you are potentially going to be criticised and or ostracised* (BM 07 IP 2).

That midwives have to wear an uniform, whilst doctors do not, was perceived as belittling to the midwifery professional, and considered to further legitimate the subordination of midwives, as discussed herein:

> *I feel really dissatisfied that the doctors swan around in their normal clothes and get to look like intelligent human beings and we all have to wear those ridiculous navy blue scrubs that make us look like a bunch of idiots, that says 'I'm the 'pleb' and they're the smart person, we should listen to them and not us... Even just that,*

> *the differentiation between medical staff and midwifery staff just upsets me* (BM 08 IP 3).

An approach of care, referred to as the medicalised model of maternity care, was perceived negatively by most participants. The word *medicalised* had negative connotations signifying an approach to care which disregards the philosophy of care founded on the normal physiological processes of pregnancy and birth. For midwifery, medicalisation was the upshot of working within a hospital, so that:

> *In the big hospitals where you are incorporated into, it can be very medicalised at times, and necessarily so with sick women, it goes back to that medical model and the whole hierarchy and medical model is rife and it will be for, and has been forever, and as far as I can work out no one is making any changes against it* (BM 08 IP 5).

The perception of the midwifery and obstetric professions as unequal in standing within the hospital system was endemic within the data, for example:

> *There is still a lot more obstetric involvement in normal birth, so there wasn't that space for midwives and women and normal birth, so there wasn't that protected space and so there was a lot more, it felt like obstetric involvement and that's where the care was always led from, so you rarely saw midwifery being seen on an equal footing* (BM 07 IP 8)

For one participant, the medicalised model is complex, pervasive and subtle:

> *Exists all the way from the very micro scale all the way up to the really big picture stuff, it is everything from culture, society, you know, inter-personal relationships, all the way down to the sort of hospital management stuff, about bed-block and booking inductions, and everything is just set up in a way that supports that particular approach, which you know in midwifery we refer to as the bio-medical approach* (BM 07 IP 2).

The hierarchy and medicalisation within the hospital system inhibited participants to practice their role in a satisfying and autonomous way, thus suppressing self-resourcefulness and autonomy, at a time where these qualities were deemed important to self-proficiency. Participants felt restrained in their capacity to practise as to how they felt were appropriate, as suggested by this quote:

> *It was like you couldn't use your own initiative to do things, you know you were all told, it was prescribed what you had to do and the obstetricians had the run of the delivery suite* (BM 07 IP 1).

The inability to work autonomously limited the means of support participants could provide women, for instance:

> *I felt in that environment I couldn't support women effectively and so what does that mean? Well I guess that means, to me supporting women is about supporting them to come to their own decisions and make their own choices about what happens to them during labour and birth* (BM 07 IP 2);

And restricted participants' ability to communicate effectively with others, meaning there was a:

> *Lack of choice, the lack of real discussion, even with women, I still find surprising… I still struggle with the way the whole discussion in this institution happens because you can so easily makes things not a discussion but rather a telling of women of what they have to do and what they're allowed to do* (BM 07 IP 8).

Not only did all this impact upon their working roles, participants were concerned about the impact the medicalised hierarchy could have upon women's bodies through regulating maternity care practices and the corporeal control of women's bodies'. Commonly expressed in the interviews were participants feeling the hospital system was regulating individuals' experiences of birth, for example:

> *The hospital system is still not putting women in the driving seat of their own birth* (GD 08 IP 4).

The systematic nature of the hospital was put forth as influencing control of women's experiences, because:

> *The hospital is an organisation and so it operates under rules and regulations. Women come in to that system can tend to lose, they become subject to the system, they tend to lose their autonomy, I guess, to a certain degree because they fit in to how the system works* (BM 08 IP 4).

In order to inspire hard work and dedication in her midwifery role, this participant stated that she:

> *Shifted loyalties to the women in my care. I thought it's about them, stuff the hospital, stuff the management, they are a bunch of so-and-so's, they don't care, I am just a number, I am just there to plug in the gaps. I accepted that as sad as it sounds. So I just shifted my priorities to the women in my care, I made them the focus* (BM 07 IP 5).

The curbing of women's autonomy was evident when women were excluded from decision-making, as well as when interventions occurred without involvement of either midwives or women, as commented upon here:

> *I didn't have a strong sense that I would be able to practice autonomously, and that was not because the culture of the unit was restrictive or really over-medicalised, it was more just because the nature of the way that the system is set up prevents you from making autonomous decisions. By the time that women reach you, a lot of the decisions for their care have been made, and so it is just then sort of enacting the procedures that have been decided upon for that woman, by people other than yourself. And all you can do is kind of hope that the woman has involvement in making those decision (uncomfortable laughter)* (BM 07 IP 2).

At times, women were said to need midwifery protection against corporeal control so that births could proceed as a normal physiological process, for example:

> *This surveillance by the obstetric team and this sort of hanging around, it was almost as if the sharks were circling and you are trying to protect a woman and trying to protect her opportunity to have a normal birth and there was this tide of intervention coming your way* (BM 08 IP 1).

Enduring power and medicalisation was not an option for all. This participant spoke of the medicalisation of care that thwarted midwifery and women's autonomy and affected physical outcomes, and was the reason for her leaving the profession:

> *I just felt like I saw so much unnecessary intervention that led to really mediocre and/or compromised outcomes for women and babies and I didn't want to be part of that anymore* (BM 07 IP 2).

The hospital system within which the participants practised was positioned as suppressing the capacity and scope of midwifery practice. Women's experiences were also bound within these situational pressures. Producing this structure was the medicalisation of

pregnancy and birth, the processes of which were perceived as normal physiological processes by the participants.

8.7 Conclusion

As evident from the presentation of interview data, a considerable amount was generated as participants displayed a propensity for discussion when 'talking shop'. The participants incorporated stories of women and scenarios of midwifery care to emphasise their experiences of work and to elaborate on the meanings they were trying to portray. Upon examination, emergent issues from these narratives arose as evident from their reiteration and recurrence, which through the analysis process, were fashioned into three themes, namely: 'sinking and swimming', 'needing a helping hand' and 'being a midwife… but'.

The first theme, 'sinking and swimming' focussed upon the initial period of being a practicing midwife. This included varying perceptions of preparedness, the jolting unfamiliarity of a steep learning curve during transition, and coming to grips with the reality of working within the profession. Different things that helped or hindered the transition process were revealed, such as attitudes of other midwives, a sense of autonomy and feelings of fear in their role. Fear commonly arose as an emotion felt within aspects of clinical care. The acutely felt sense of responsibility once midwives were graduated and not students also emerged as significant in the early career period.

The second theme was called 'needing a helping hand'. The subthemes here centred upon workplace circumstances that exposed the participants to the realities of being a practising midwife. The provision or denial of support impacted on the participants' conception of themselves as midwives and their contentment within the role. The subtheme 'calling for support', deciphered a large mass of data which regarded support as integral to the new midwife. Needing support from others through the transition into a working midwife, the absence and presence of varying support mechanisms and the impact this had, all during the support of women through a momentous physical and psychological life transition signalled the significance of support. Professional progression, career possibilities and training was also part of this theme, as these were considered as a sense of self-support.

The third theme, 'being a midwife… but' addressed the opposing positive and negative impressions the data gave for the way participants felt about midwifery. Cathartic complaint constituted a large portion of data and some participants reported desires or

intent to leave their midwifery role. The varying professional and relational characteristics of the midwifery profession that garnered both job satisfaction and dissatisfaction were presented. The relational aspect of the caring role was central to enjoyable work experiences and was a key stimulus for the vocational drive perceived by most participants. Dissatisfaction centred upon pay, ineffective management styles, shift work, poor family-life balance, and occupational bullying. Weak affiliation with, and discordant viewpoints of, the ethics underpinning hospital maternity practices led to participants feeling unsure of their role. Participants discussed of experiences of discomfort and distress arising when performing physical acts upon women that went against ethical philosophies of woman-centred care. Tangible and intangible effects of institutional authority over birthing and midwifery practices led to internal struggles and an impression of diminished midwifery authority.

This now completes the presentation of Phase 1 and Phase 2 data analysis. Chapter 9 will present a discussion of the results, integrating the numeric and textural data, within a context of previous research.

Chapter 9: Discussion

9.1 Introduction

Chapters 6 and 7 presented the survey findings of Phase 1 of the study and provided a demographic picture of the participants plus a pattern of their workforce patterns. Chapter 8 presented interview findings from Phase 2 of the study. Those were grouped into three themes. The sequencing of data collection and analysis enabled results from the qualitative data to elucidate and explain the results of the quantitative data.

The discussion in Chapter 9 explores the factors affecting the participants' experience as midwives and their career choices by integrating the quantitative and qualitative findings. The integration of the two sources of findings is further supplemented by quantitative and qualitative studies published on the topic. The integrative process of a mixed methods sequential explanatory research design expands and elaborates findings from Phase 1 (Fielding 2012).

Data integration was undertaken by exploring the results in detail through the lens of the objectives that guided the study. They were to:

1. Identify workforce participation trends, workforce experiences and career choices;
2. Identify organisation and work environment factors that may influence workforce participation trends;
3. Identify personal factors and stressors that influence workforce participation trends; and
4. Identify and compare workforce participation trends by program (Bachelor of Midwifery or Graduate Diploma of Midwifery).

This discussion will be followed by the final conclusion to the study, which provides an overall conclusion to the study.

9.2 Organisation of discussion chapter

Firstly, a synopsis of the key survey findings relating to workforce patterns is provided in Section 9.3, then, next, a synopsis of interview findings in Section 9.4. The method for the data integration process is discussed in Section 9.5, with reference to mixed methods research methodology which guided the integration approach. A comparison of the two data sets, surveys and interviews, is provided in Section 9.6. Then the greater part of the discussion chapter, Section 9.7, is comprised of an integration of the two sets of results through discussion of the findings. Limitations of the study, suggestions for further research, and a conclusion then follows.

9.3 Overview of survey findings

Most of the 75 respondents to the survey had remained in the midwifery profession and were currently working at time of data collection (*n* = 59). Of those 16 participants not working as a midwife, 12 of them were considering commencing/re-commencing employment into the midwifery workforce. Four had *never* worked in midwifery, citing dissatisfaction with the profession or family commitments as their rationale. The mean age of participants not working in midwifery was 33 years, correlating to the Australian maternal mean age of 30.1 years and the main justification being family commitments. All but three of this group had children ≤ 16 years. Further supporting the grounds of caring for young dependents is that only three of the eight participants not working in midwifery were in full-time work.

The desire or ability to work full-time was also problematic for those 59 participants working as a midwife. Almost half of the participants who were working did so in a full-time capacity, with part-time, casual, agency and self-employed work patterns comprising the other fifty percent. However, no association between having children or not and full-time work status existed. The mean number of hours worked per week was roughly 31, with a wide range of eight to 40 hours. All participants, except the four who had never worked in midwifery, had commenced working as a midwife in a hospital setting. Over 80 percent worked in metropolitan settings, 80 percent in clinical roles, and 90 percent in the public sector. The most frequently worked pattern was shift work across all shifts, with quite a uniform spread across all maternity sectors. However, working in a rotational capacity comprised 27 percent and working in a continuity model comprised 20 percent of all

participants working in midwifery. One-third of the currently working midwives had spent time out of their career, ranging from three months to three years, mostly for child rearing purposes. However, burnout and stress also featured as a reason. The only significant association between the pre-registration education route and demographic and work pattern variables was that the Bachelor of Midwifery participants were older than the Graduate Diploma of Midwifery participants.

MBI scores revealed moderate levels of emotional exhaustion, low levels of depersonalisation and low levels of reduced personal accomplishment. Results suggested participants who had considered leaving perceived less enthusiasm and motivation and greater cynicism and ineffectiveness. Scores for those who worked outside of a continuity of care model suggested they had greater feelings of cynicism.

PES-NWI results indicated participants considered their workplaces favourable work environments yet held negative impressions of their staffing and resources. Non-clinical midwives had more positive perceptions of their participation in hospital affairs. Midwives working in a continuity role felt more favourable about midwifery professional development in their practice environments.

PEMS scores indicate the participants perceived high levels of empowerment in their midwifery role. Midwives who would rather have worked in another midwifery area scored lower on the *Autonomous practice* and *Woman-centred practice* subscales. Those who had considered leaving midwifery altogether were more likely to score lower on the *Woman-centred practice* subscale.

9.4 Overview of interview findings

Twenty of the 28 interview participants were working as a midwife, divided almost equally amongst the Bachelor of Midwifery and the Graduate Diploma of Midwifery groups. They comprised a variety of working roles, employment locations and working hours and patterns. Three themes emerged from the interview data, namely: ‘sinking and swimming’, ‘needing a helping hand’ and ‘being a midwife… but’.

The first theme, ‘sinking and swimming’ focussed upon the initial period of being a practicing midwife, varying levels of preparedness, the unfamiliarity of the steep learning

curve, and the things that helped or hindered. Fear commonly arose as an emotion felt within clinical care, as well as the acutely felt notion of responsibility.

The second theme called 'needing a helping hand' centred upon the workplace realities of being a practising midwife. The provision of support was integral to the new midwife, with its denial impacting greatly upon conceptions of themselves as midwives and contentment in the role. Professional progression, career possibilities and training was also part of this theme as these were considered as a sense of self-support.

The third theme, 'being a midwife… but' addressed the opposing positive and negative impressions of the varying professional and relational characteristics of the midwifery profession that conferred both job satisfaction and dissatisfaction. The relational aspect of the caring role was central to enjoyable work experiences and was a key stimulus for the vocational drive perceived by most. Dissatisfaction centred on pay, poor management styles, shift work, poor family-life balance, and occupational bullying. Poor affiliation with the ethics underpinning hospital maternity practices was also evident in many participants. Discordancy felt when performing physical acts upon women that went against personal ethical philosophies of woman-centred care, led to internal struggles and perceptions of diminished authority. These were aspects of job dissatisfaction.

9.5 Method for data integration

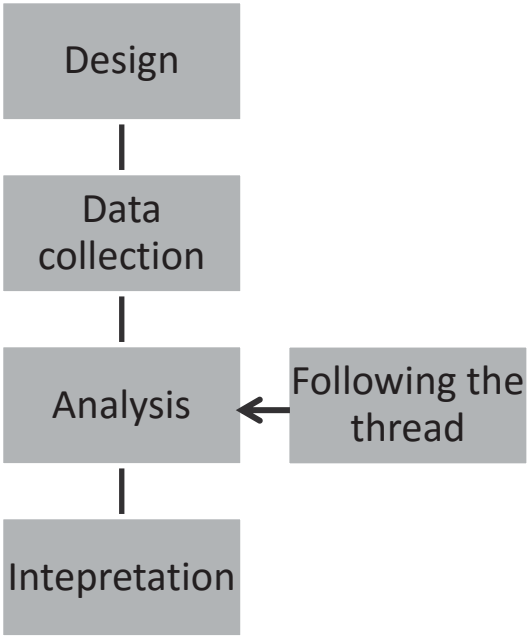
As referred to in Chapter 4, the *Good Reporting of A Mixed Methods Study (GRAMMS)* guide is an aid to assist researchers with clear definition within the research process. (Table 5) (O'Cathain, Murphy & Nicholl 2008). As per *GRAMMS*, for there to be clarity of methods in my study, it must include a description of where and how data integration occurred, as well as an account of any limitation of the methods used, and the insights gained from integrating the data (O'Cathain, Murphy & Nicholl 2008). The thesis undertakes these objectives in this section onwards.

For the purposes of my study, data integration refers to the interaction between the qualitative and quantitative phases of the study, in essence a conversation between the two parts. Studying the research question by different methods aimed to gain a more complete picture. Combining the components aimed to provide more knowledge than separate analysis undertaken independently could (O'Cathain, Murphy & Nicholl 2010). Data integration occurred at the interpretation stage of the study, when both data sets had

been analysed separately. Results from the two phases were assessed for where the findings from each method agreed (convergence), offered complementary information on the same issue (complementarity), or appeared to contradict each other (discrepancy) (O'Cathain, Murphy & Nicholl 2010). Reflection upon the inter-method discrepancy enriched my understanding of the research question (O'Cathain, Murphy & Nicholl 2010).

The specific technique used for integrating the findings can be illustrated by the hands-on action of 'following a thread', this physical real world imagery evoking the pragmatic underpinning of this study (Moran-Ellis et al. 2006). The point at which this technique was applied is depicted in Figure 6. This technique comprised an initial analysis of each phase to identify key findings as well as any uncertainty requiring further exploration. A thread emerges when a question or theme arising from one phase is selected and followed across to the other phase (O'Cathain, Murphy & Nicholl 2010). Firstly, the preliminary findings from the quantitative data generated inquiry for examination to assess whether the qualitative data supported the findings. Following this, the 'thread' was followed back to the quantitative data to help interpret the findings. After further analysis of the quantitative data, the 'thread' was followed back into qualitative findings. A backward and forward technique of analysis allowed for observation of the varying aspects of the phenomenon under study which arose from the different methods used (O'Cathain, Murphy & Nicholl 2010).

Figure 6 Point of application of 'following a thread' data integration technique in the mixed methods research process (O'Cathain, Murphy & Nicholl 2010)



The outcome of the integration of the quantitative and qualitative findings is reported firstly through a comparison of the two data sets and secondly, through the narrative of the discussion, whereby the 'threads' of convergence, complementarity, discrepancy or dissonance are merged through a process of 'weaving' (Fetters, Curry & Creswell 2013). This refers to the use of the two data sources together in the discussion narrative to present the interweaving pattern of the findings.

9.6 Comparing the findings from the two research methods

This research included a quantitative study and then in-depth interviews with individuals from the sample in order to depict experiences that the standardised scales could not comprehensively address. Evident in the relationship between the results from the two research phases are incidences of congruence and discrepancy (O'Cathain, Murphy & Nicholl 2010). The comparison of the two data sets will begin by an appraisal of the differences, because it is imperative to integrate the discrepant inferences generated by the qualitative and the quantitative phases of the study (Slonim-Nevo & Nevo 2009).

When both the data sets were brought together during analysis a noticeable discrepancy was found with qualitative data presenting a particularly negative viewpoint of midwifery. Difference in the findings between data sets has been suggested to be due to a lack of correspondence of outcome measures in the two phases of the research (Moffatt et al. 2006). However, the discrepant findings were elicited despite each phase having had related lines of inquiry, and the discrepancy does not detract from the credibility of the research. Moreover, the inconsistencies of results from the two methods could be seen as a probable occurrence, as correlating multiple methods together all but customarily gives rise to a certain degree of discrepant findings (Moffatt et al. 2006).

Complexity in the phenomenon under investigation and the provision of a diversity of viewpoints of the phenomenon by the differing methods can give rise to a lack of congruence. The possibility for methodological limitations or problems is also an explanation (Slonim-Nevo & Nevo 2009). For example, several sampling problems exist in this study. Firstly, the response rate was 66 percent, with 38 potential respondents not returning the survey. Secondly, not all the 75 survey respondents were interviewed, with only 28 participants taking part in Phase 2 data collection. Thirdly, the survey participants self-selected themselves to take part in the interviews.

The findings obtained via the qualitative investigation could therefore be said to be affected by a bias arising from the study design whereby not all survey respondents took part in the interview data collection. In essence, interviews are individual stories allied only to the experiences of those who tell them. As such, a further bias also lies in the unidentified motivations for taking part in the interviews. Lastly, differences between the ability of the two distinct methods to make objective evaluations of subjective experiences of the complex phenomenon of the midwifery workforce are expected.

An observed gap between methods arises because alternative methods measure varying aspects of social reality. A survey which elicits information about midwifery workforce experiences assesses evidence only relative to the items on the instrument as per the scale. Quantitative methods do not necessarily permit access into the internal, subjective, and complex world of the individual and illicit findings that are distinct from qualitative methods, despite similarity in outcome measures being sought (Slonim-Nevo & Nevo 2009).

Adopting a 'complementary' interpretation of conflicting data, the discrepant findings are considered not as a contradiction to one another. Rather, an attempt to display credible and consistent sense of the different aspects of research is possible and conflicting sets of data can be accepted as reliable (Slonim-Nevo & Nevo 2009). The exploration of why these differences transpired is potentially as informative as occasions of congruence (Moffatt et al. 2006). Therefore, the potential reasons for incongruity and inconsistency between the interview and survey data has been explored.

In my study, the qualitative data showed evidence of significant amounts of experienced stressors and frustrations with the lack of opportunity to practice across the full scope of midwifery care. Despite many workforce factors presented negatively in the interview data, the burnout results from the MBI and the empowerment results from the PEMS contradict these findings. Conflicting accounts are therefore portrayed of stress and burnout, and empowerment and autonomy.

Low levels of burnout were suggested by the MBI results and high levels of empowerment from the PEMS data. Although not specifically measuring burnout and empowerment, the interview data gave rise to a lot of evidence which indicated the participants experienced many factors which contributed to each phenomenon. Furthermore, many participants disclosed experiences of work-related stress, overload and exhaustion plus inhibited

professional autonomy, woman-centred care practices and empowerment which they ascribed to experiences of burnout and disenfranchisement.

The MBI and PES-NWI do not provide total scores from cumulating all the subscale scores unlike the PEMS scores will do. Burnout as measured by the MBI was evident in the *Emotional exhaustion* subscale with moderate scores seen for this subscale. However, with only one subscale scoring moderately and the other two low levels of burnout, the results are considered to be evidence of low level of burnout in the participant group. Nonetheless, the moderate level of emotional exhaustion is still a significant finding and does correlate with the qualitative evidence depicting many individual experiences of emotional stress in midwifery.

Similarly, with only one out of the five subscales of the PES-NWI scoring unfavourably, overall these results indicate the participants considered their workplaces to be positive work environments. This is conflicting to the interview data which suggests participant's experiences with management, inadequate leadership, midwife-doctor work relationships, insufficient ability to contribute in decision-making processes, scant training and education programs. These workforce factors were examined in PES-NWI subscale analysis with all being perceived of favourably by the participants. However, the subscale regarding to staffing and resources had negative results. This finding is in congruence with the interview data on the perceptions of poor staffing and resources which impacted greatly on how the interview participants perceived their work. Poor staffing and resources were considered to have major bearing upon how the participants considered many aspects of their work, such as inadequate staffing impacting upon limited ability to form relationships with women, safety and collegial communication, due to heightened busyness and inadequate skill mix. Poor staffing and resources also were perceived to limit access to, and provision of, training and education. Poor resources were suggested to envelop much of midwifery management's attention and contribute to unsatisfactory managerial input at the ward level.

When comparing the PEMS data about perceived empowerment as midwives with the qualitative findings, the overall PEMS suggests high or very high levels of empowerment perceived by participants. These findings conflict with qualitative findings which indicated that most interview participants felt frustrated with their levels of professional empowerment, felt disenfranchised within their midwifery roles in the hospital setting, and considered their professional autonomy to be sharply curtailed. What can be said to

counteract this discrepancy between the findings from the two methods is that those in continuity of models of care scored higher scores on the *Autonomous practice* and *Woman-centred practice* subscales. These findings support interview findings in which participants held positive regard for those midwifery models of employment which promote working to the full scope as a midwife and espouse the relational aspects of the midwife-woman bond.

Regarding the qualitative interview process, many participants found the interview to be a positive, supportive, and insightful experience and appreciated participating in the experience. Interview data presented many grievances about a profession that held vocational significance for them. Rather than condemning their profession, the midwives' concern for their profession was emancipatory, reproaching elements of their job that they were passionately advocates for. In describing the many adverse elements of their job, participants wanted for the opposite. Participants' engagement in the research was part of wanting to be heard:

> *"All emancipatory movements begin with complaints that are dismissed. Getting people to accept them as legitimate is key to their achieving success"* (Baggini 2010, p. 18).

As such, part of the interview participants' engagement with the research project was acknowledgment of collective concern about their profession. A quote from a novel supplies a further impression of the interview data saturated with cathartic complaint. The interview data suggested participants felt good when complaining about things in their job when things were not as they should be, even though to change them appears an unsurmountable task. Knowing what is not right enabled the interview participant to unburden feelings of despondency and reaffirm their sense of how things should really be (Baggini 2010). A nurse in the said novel considering the reason why her colleagues complain about their jobs as the act of complaining satisfied them, said:

> *"All the secret satisfaction she heard in their voices when they complained about the exhaustion and the thanklessness of it all"* (Thomas 2014, p. 38).

Midwives are trained to have a preference for narrative prose in communication (Gould 2010). A tendency towards narrative in the interviews, the relating of issues of concern through accounts or stories of events and experiences, furnished the qualitative data with intensity. Possibly the itemised methodology of the quantitative phase confined the quantitative findings, and may be a cause for the discrepancy of findings between the two

methods. Like the nurse characters spoken about in the above quote, participants in my study readily and opportunely gave complaint, reporting their shortage of other opportunities to do so.

The timing of data collection may also be a factor. Data collection occurs at a point in time and can be influenced by stressors of the day. Furthermore, qualitative data is more reflective in nature and in my study, offered a mixture of past and present reflections. These elements may have contributed to the disparity between the results from the two research phases.

Despite their grievances, they felt strongly about their advocacy for their profession, and the discussion about their dissatisfaction was akin to a protest. Their fulfilment with midwifery was very much present despite the many factors detracting from their satisfaction. The fact that participants did portray such fondness for their profession, despite giving much evidence which revealed many factors which detracted from their job, reveals the considerable passion participants held for their job. It is these elements which contribute to fulfilment and which should be fostered in the midwifery workforce, in support of retaining new midwifery graduates.

The comparison of the findings from the two research methods demonstrated areas of divergence and convergence. Presenting the evidence for where the quantitative and qualitative data supported and conflicted with one another comprised the first task of integrating the data. The second task, presented below, is the discussion, which weaves the two sets of findings into a narrative, supported by existing literature and research on the topic, to depict where the two data sets converge and correspond.

9.7 Integrating the results through discussion of the findings

This section of the discussion chapter commences with a discussion of the key results pertaining to workforce trends and patterns of work that was identified from Section 1 of the survey. Elements of the midwifery profession that recount the workforce experiences and career choices are then discussed. This includes identifying the organisational and work environment factors that influenced their workforce participation. An overview of the personal factors and stressors that influenced workforce participation then follows. Lastly, differences found between the two different education courses are provided.

9.7.1 Workforce trends

There is not much data available which describes the working trends of new graduate midwives in Australia. This seems detrimental to a profession for which research shows the initial years in the workforce are pivotal. Due to the lack of reliable data focused specifically on midwives in the early career period, the workforce participation trends of the participants in my study cannot be compared with Australian midwifery statistics of new midwives. Therefore, the workforce trends which arose in my study will be contrasted to government data representative of the Australian midwifery profession, and not just newly graduated ones, as well as Australian and international research.

Both similarities and differences existed in the demographic and workforce participation characteristics between the participants in my study who were working as a midwife and those of recent Australian midwifery workforce data (Australian Institute of Health and Welfare 2015a) (Table 27). Similarly to government statistics of the Australian midwifery workforce was the overtly female gender of the participants and the survey participants in my study were comprised mainly of clinical practitioners. In comparison to the general Australian midwifery workforce data, a greater proportion of participants in my study held a Bachelor of Midwifery, owing to the recruitment period coinciding with the recent commencement of the undergraduate midwifery course in Australia. A greater percentage than national data were working in the public health sector. A significant association between education course and age existed with the Bachelor of Midwifery participants being older than their Graduate Diploma of Midwifery counterparts.

Table 27 Participant characteristics compared to Australian data

Characteristic of interest in those working as midwives	Study data of new graduate participants	National data of all midwives
Percentage of employed midwives who were female	98.3%	98.4%
Hold a nursing registration	56%	99.9%
Average age	36.5	48.9 years
Percentage aged over ≥ 50 years	13.5%	52.7 %
Average hours worked per week	31 hours	23 hours
Employed in full-time work	46%	52.3%
Employed as a clinician	80%	88.6%
Employed in public health sector	90%	70.2%
Identified as Aboriginal or Torres Strait Islander	0%	0.9%

(Australian Institute of Health and Welfare 2015a)

In Australia, the number of those employed in midwifery is less than the number registered because not all registered midwives are employed in a midwifery role (Australian Institute of Health and Welfare 2015a). In my study, 21 percent were not working in midwifery (*n* = 16). Half of these 16 participants who were not working in midwifery were working in other occupations. Of note is that six of these eight were working in health-related occupations, albeit outside the hospital setting. Four of these six had abandoned shift work. Two of the nurse-qualified midwives returned to their previous clinical areas of practice, reporting having undertaken their Graduate Diploma of Midwifery as a 'completion' of their nursing skill foundation. Then once in midwifery, they realised their preference was still in nursing.

These findings bear similarities with the employment patterns found in the '*Why midwives leave*?' (*WML*) study, with regards to their participants who had left midwifery. Most participants in the *WML* study had continued in the labour market, the majority employed within a health related field (Curtis, Ball & Kirkham 2006b). Reasons for not working in midwifery given by those participants in my study who had remained in the labour market were pragmatic ones, in which their current employers were better suited to their out-of-work lives than was midwifery, or because of a moral and vocational misalignment with midwifery. This finding was also comparable to the *WML* study, in which the main reasons given for leaving midwifery were dissatisfaction with the way they were expected to practise, not being able to provide the kind of midwifery care they wanted to, and not being able to develop meaningful relationships with women in their care (Curtis, Ball & Kirkham 2006c).

Two participants had remained outside of any type of employment and were in caring roles which had warranted their exits. Their ages were 32 and 61 years, recognised ages for caring for children or elderly parents (Australian Institute of Family Studies 2016). Both discussed the possibility for their return to midwifery, however in a diminutive capacity, once the caring roles that presently engaged them allowed for their return. Akin to Curtis, Ball and Kirkham's (2006b) findings is that, except for the sexagenarian, these participants who had withdrawn from midwifery were 40 years or under, representing a loss of many potential years of employment in the profession.

Affecting the samples work productivity were that one-third of the currently working midwives had spent time out of their career. The timeframe of return to midwifery employment ranged from three months to three years, thus a sizeable variation in amount of time. The main reason given was for child birth and rearing. This variation is in accord

with Australian data, which reveals a considerable variation in timeframes and different patterns of return to work by mothers, with an average of 6.5 months (Australian Institute of Family Studies 2016).

The desire or ability to work full-time appeared problematic for the 59 midwives. A large proportion of them were not working in full-time positions. Less than half were employed in a full-time capacity (*n* = 27; 46%). Those employed part-time constituted 38 percent (*n* = 22; 38%), whilst those in casual midwifery work was 10 (*n* = 10; 16%). This trend for part-time and casual work corresponds to government workforce statistics that women constitute 69.6 percent of all part-time employees, 35.4 percent of all full-time employees, and 55.3 percent of all casual employees (Australian Bureau of Statistics 2014a). These work status findings were anticipated due to required flexibility needed to meet the requirements of their family and caring roles of the predominantly female midwifery profession alongside the rise of the number of mothers in Australian employment. Part-time work is more prevalent than full-time work for mothers with children of all ages (Australian Institute of Family Studies 2016).

Interestingly however, no association between having children or not and work status existed, although the numbers were too small for certainty. When looking at all of the 59 midwives, a wide range of hours were worked per week, from eight to 40 hours. As they were working roughly 31 hours per week, they were working more hours than the average 23 working hours per week of national midwifery workforce data (Australian Institute of Health and Welfare 2015a). Most likely this longer working week is due to the mean age of the participants (36.5 years) being younger than the Australian mean (48.0 years). A large discrepancy between study and national data was evident when considering the proportion of participants over the age of 50 years, which was only 13.5 percent in my study as compared to 52.7 percent in the national midwifery workforce. This smaller proportion of midwives aged over 50 years in the study would have contributed to the study's participants working longer hours than the national midwifery average. This is because hours worked per week in Australia decreases as age increases (Australian Institute of Health and Welfare 2007). The variance in age from the Australian average was foreseeable due to the sample being recently qualified midwives and therefore as recent students, most likely, younger. The majority of higher education students began their course directly, or relatively soon after finishing secondary school (Australian Bureau of Statistics 2014b). The mean age of participants when they graduated was 29 years. Although slightly older

than the age of graduating students who move straight into university from secondary education, it is younger than the mean age of Australian midwives.

The evaluation of the data to address a depiction of their workforce trends now leads into a discussion of the workforce factors which shaped experiences and influenced workforce participation.

9.7.2 Facilitators and impedances to workforce participation and experiences

Various features of the midwifery role and the hospital work setting were identified to impact, either negatively or positively, on participation in the midwifery workforce, as well as their experiences. The following sections endeavour to assemble the varied, diverse, complex, multi-factorial experiences of midwifery practice into eight sections. The cohesive structure of this part of the discussion is aided by subtitles, which all make reference to the role of midwifery as a practice.

The word 'practice' aims to represent the multiple subtexts of the term *midwifery practice*: the exercise and pursuit of the profession, the actions and processes involved in being a midwife, as a role arrived at by experience, the repeated performance and exercise of the midwifery role for the purposes of acquiring skill and proficiency, the established methods of conducting oneself as a midwife, and the habit and custom of midwifery. The multiple definitions of practice and their use in the subtitles also serve as a reminder of the complex phenomenon that the midwifery workforce is.

9.7.2.1 Work scheduling practices

Practices surrounding work scheduling emerged time and time again in the data. For example, the mean weekly working hours for those in full-time employment was 38.5 hours and 27 hours if working in a part-time capacity. Those participants working in casual employment worked on average 21.5 hours per week. Interview data revealed that many of those participants working as midwives wished to downsize their hours, either from full-time to part-time or from part-time to casual. Of particular concern were reports of an inability to contribute to rostering and scheduling in a significant way and the powerlessness that this imbued in managing family-work balance. Moreover, participants described difficulties in accessing leave.

Research has indicated the potential of flexible work scheduling and practices which allow for adequate work-life balance has for recruiting and retaining midwives (Hampton & Peterson 2012; Jarosova et al. 2016; Prowse 2015; Skinner et al. 2011). Employers not enabling scheduling strategies that accommodate employees is outdated policy, especially in a current labour market that delivers diversity and choice. The prerequisite of course, for organisations to deliver flexible rostering strategies is sufficient staffing levels (Prowse 2015), a challenge due to the workforce shortages and increased patient acuity highlighted throughout this thesis.

Nonetheless, scheduling practices that give a degree of control and predictability to the employee and assist midwives in managing their out-of-work lives have merit. Evidence identifies the value of accommodating these strategies for midwives (Prowse 2015). Many of the interview participants disclosed that the duel challenges of working outside of conventional hours and only being aware of their rostered working days approximately four weeks in advance, were stressful. Many iterated that they were maintaining their job as a midwife through reducing their hours and not working in a full-time capacity. Working in part-time or casual employment was a strategy of control over out-of-work and family demands. This diminution of working hours and relinquishing of financial security over flexibility is evident in other research as well (Skinner et al. 2011).

The considerable challenges in adapting to the many demands of midwifery in their first years post graduation included adjusting to rotating shift work. Many of the interview participants reported not wanting to work the conventional hospital shifts, especially night shifts, entirely irreconcilable to the continuous 24 hours daily staffing requirements of hospital birthing work. The traditional pattern of shift work in midwifery is comprised of working different shifts at different times of the day and night and concurring to a pattern that is often unpredictable. Participants changing to, or considering changing to, casual work was a self-selection away from the frequent irregularity and unpredictability of shift work. It also reduced exposure to the unwanted aspects of night shift. These are a greater likelihood of accidents and errors, the physiological circadian alterations in mood and physiology, fatigue from a lack of sleep, sleep disturbances, resentment at working outside conventional hours, working hours conflicting with the social schedule of the predominant community, and incompatibility with family circumstances (Teclaw & Osatuke 2015; Tremaine et al. 2013).

A large Australian nursing study indicated that the most important factor determining long term work-related fatigue problems was the pattern of shifts worked, particularly rotation including night duty, and working multiple shifts, including night duty (Winwood, Winefield & Lushington 2006). These unpredictable shift rotations, including night duty, are typical in midwifery, especially for new midwives. As midwives progress in seniority of rank they are more likely to work more conventional hours (Teclaw & Osatuke 2015), which are less detrimental to health. Interestingly, the younger and less experienced nurses report higher levels of fatigue and poorer recovery as compared to their elders (Winwood, Winefield & Lushington 2006). Younger, less experienced midwives may need more support than is currently provided, especially when research of new graduates reveals a picture of exhaustion and disorientation stemming from the confusion and uncertainty that represents the reality of this period (Duchscher 2001).

Midwives recounted in the interviews of not being entirely cognisant of what shift work would be like, even having had worked shifts in their clinical placements. This lack of comprehension seemed more acute in the Bachelor of Midwifery participants who had not previously worked in a shift work capacity as a nurse. Familiarisation strategies with the realities of hospital midwifery whilst a student may have significance here (Cummins et al. 2014). Written suggestions given in the qualitative section of the survey for securing a straightforward transition into the profession were to be alert to the realities of hospital shift work prior to employment and access sufficient work experience prior to graduation.

Working outside of conventional 9am to 5pm working hours has been shown to affect employees' work attitudes (Teclaw & Osatuke 2015). A nursing study indicated that shift nurses employed outside of conventional work hours were dissatisfied with their work-life balance. Nurses working at these times reported less satisfaction with supervisory performance, possibly due to having less frequent interactions with their supervisors when working at night and on weekends. This finding was also evident from interview data in my study, with some participants reporting often needing unavailable supervisory assistance in early morning hours.

Conversely, some interview participants in my study reported choosing to work outside of conventional hours due to reduced supervisory interactions, fewer scheduled elective procedures, more comradery amidst a relaxed atmosphere, and less medical interventions due to less medical presence. Nursing research reveals similar findings with nurses choosing to work off-hours for these reasons (Hamilton et al. 2007). Despite Teclaw and

Osatuke's (2015) findings which revealed overall job satisfaction and intent to leave were not affected by whether nurses work inside or outside of conventional hours, many of the interview participants reported feeling dissatisfied with aspects of working across the 24 hours in their shift work role.

The most frequently worked pattern was shift work rostering which included a combination of morning, evening and night shifts. One-third of midwives worked in a rotational capacity across all clinical areas, whilst one-fifth were working in caseload in continuity modes of care. Therefore, a good proportion of those working as midwives were able to provide their employers with valuable flexibility, being able to be assigned to all clinical areas of maternity care (Becker, McCutcheon & Hegney 2010; Rudy & Sions 2003). This flexibility also serves the midwife as it provides them with diverse clinical opportunities giving rise to multi-skilling and knowledge extension. The 'transferable' midwife, who is competent in all areas of clinical care, may assist in the delivery of high standards of patient care and safety (Richardson & Allen 2001).

Work scheduling practices emerged in the data as an important domain influencing both experiences and participation. Findings highlight that casualisation of working hours were a tactic participants used in an attempt to gain control of their work-life balance. Australia nursing research has shown a trend towards increasing casualisation of staffing (Duffield, Diers, et al. 2011), which has been shown to produce unstable units (Creegan, Duffield & Forrester 2003). This highlights the complicated process of balancing individual needs versus organisational requirements. Midwifery collaboration in decision making processes surrounding how their wards are staffed is important to ensure that engagement in the midwifery workforce is not lessened to where stability and safety of the work environment is affected.

9.7.2.2 Caseload continuity models of midwifery practice

One model of employment which attempts to enhance midwifery engagement in the workforce as well as impact positively on women's experiences and safety is caseload midwifery. In Australia, and in my study, the rotational mode of employment in the hospital setting is the most common initial form of midwifery employment. This form of employment encourages the reinforcement of most of the skills needed as a midwife due to the allocation of new midwives in all clinical arenas. However, working in caseload or continuity models as new graduates has also been shown to fortify skill acquisition

(Cummins, Denney-Wilson & Homer 2015). Furthermore, it has also been positioned as one solution for the requirement for continuous midwifery staffing (Hartz et al. 2012).

Many of the interview participants working in standard midwifery care reported an interest in working in a caseload model, yet had eschewed this manner of employment as they wished to have certainty of their days and hours of work. Discussions surrounding their decision-making about potential caseload employment often encompassed a ‘ better the devil you know than the devil you don’t’ attitude, thus calling attention to those strategies and clinical placements acquainting new midwives with caseload midwifery models of employment, both as students (Carter et al. 2015; Dawson et al. 2015; Rawnson 2011; Skirton et al. 2011) and as new graduates (Cummins, Denney-Wilson & Homer 2015). Programs seeking to address the disproportionate amount of time spent in hospitals during their clinical placement experience are those that ensure engagement in low risk care, such as birth centres and with midwifery group practices. New midwives must be exposed to a variety of midwifery work environments and maternity care philosophies (Young 2011). For example, new midwives must be supported to feel comfortable with newer models of care despite many of their clinical experiences having been undertaken in high risk care (Barker 2014). Research has demonstrated that new midwives learn through role modelling in clinical practice, meaning copying, replicating and adapting the practice of their midwifery colleagues (Young 2011). Being subjected to limited experiences within the medical model will limit the potential for varied decision making approaches when registered and practising.

For those interview participants who currently were or had worked in caseload models of midwifery care, such as midwifery group practices, the impetus for doing so, as evidenced by other research, lay with the professional satisfaction achieved from providing continuity of care and forming relationships with women and their families (Collins et al. 2010; Newton et al. 2014; Sandall 1999; Sandall et al. 2015). Keeping in mind the altruistic, vocational inclinations of the participants in my study, there was a perceived gap between the generality of institutional maternity care driven by the regulation-bound hospital system and the particularities of individual women’s experiences. Such individualised care approaches are relatively new, given that the public service, which the majority of the participants worked in, is a system that values detachment for the purposes of equity of care of large numbers of people with finite resources (O'Connell & Downe 2009). Some

participants conceived caseload models of care as a bridge between the gap between the anonymity of centralised maternity hospital care and the needs of individual women.

The participants in my study described much satisfaction gained from the rewarding relational care of continuous clinical care with known women of their caseload. They discussed being rewarded by a measure of intrinsic personal return provided by the altruism of delivering care to women that were known to them. Collegial rapport, intra-group support and friendships were also signposted as beneficial elements of working in caseload models. These factors correspond with Newton et al.'s (2014) research which demonstrated that enhanced professional relationships contributed to the job satisfaction of caseload midwives.

Reservations regarding the sustainability of caseload midwifery have been proposed due to the risk of burnout associated with impaired work-life balance resulting from long working hours and on-call work (Collins et al. 2010; Yoshida & Sandall 2013). The participants in Newton et al.'s (2014) study working in a caseload capacity also identified various negative features of caseload practice, such as being on-call and long working hours. However, these aspects did not bring about burnout in the caseload midwives as compared to those working in standard care practice models. Similarly, interview data in my study revealed a dislike of the unpredictable nature of the caseload role. Yet the fidelity to the role of the midwife and the ability to comprehensively and autonomously practise, using the full scope of midwifery skills in roles which enhanced the midwife-woman relationship, counteracted the challenges of caseload work. Furthermore, working caseload gave participants some measure of control over working hours. These beneficial features of the role have been suggested by Newton et al. (2014) to be protective against the experience of burnout.

Although using a different instrument than the burnout measure in Newton et al.'s (2014) study, those participants in my study who worked in a continuity of care model scored lower on the *Depersonalisation* subscale of the Maslach Burnout Inventory (MBI) as compared to those participants who did not work in a continuity model. This suggests that greater feelings of cynicism towards women were associated with working outside of a continuity model. Depersonalisation can manifest as a stress response to negative and intensive interactions with patients and colleagues and can adversely affect interactions with patients in the form of cynical and negative attitudes. Increased stress can give rise to responses of depersonalisation and is an element of burnout (Prinz et al. 2012). Despite researchers being aware of the potential unsustainability of high workloads and resulting

stress and burnout for those working in caseload models (Newton, Forster & McLachlan 2011), my study suggests that the ability to form relationships with women is a positive aspect of the midwife role, and is a moderator of stress and burnout.

Caseload continuity models of midwifery practice were considered as first-class care for women and their babies. Benefits for midwives from working in this model of employment were also presented by the participants. Despite keen interest in working in this way, unfamiliarity with the mechanisms involved in this style of employment threatened the appeal of the model. Familiarisation practices in student and new graduate years which acclimatise new midwives to caseload models would be of benefit here.

9.7.2.3 Midwifery practice as a vocation

For all participants working in the whole gamut of styles of midwifery employment, employed in a caseload model of midwifery care or not, the considerable motivating factor for choosing a career in midwifery and going to work each day was the relational and interpersonal midwife-woman connection. Studies demonstrate that being a midwife confers a strong sense of meaning and satisfaction in an individual's life, with midwifery work being described as a vocation (Downe, Simpson & Trafford 2007; Skinner et al. 2011). Vocation comes from the Latin *vocātiō*, meaning being called or summoned, inferring that a vocation is a career that is a call to which you respond (Svendsen 2008). A vocational disposition was almost universally expressed by the interview participants in my study.

As Downe et al. (2007) highlight, the notion of vocation in midwifery has been driven from favour in midwifery research as a consequence of the move towards professionalism and the necessary focus on high quality standardised education and centralised qualification. In saying this, however, a vocational intent was the driving force for the majority of interviewed midwives in my study, an intent inextricably connected to the care of women and their beliefs in the physiological process of birth, and the drive for good outcomes for women and babies. Text data solicited in the surveys about wide-ranging perspectives on midwifery conveyed the vocational aspect of working in midwifery, as well as the midwife-woman relationship being the driver for entering and staying in the job. Participants represented their identity in life as being 'tied up' with midwifery. Getting paid was not central to their idea of work.

Correspondingly, financial reward was put forth as not the primary consideration for a career in midwifery. However, as other research shows, when poor remuneration is

accompanied with other factors such as high workload and an unpleasant work environment, remuneration for the role may not be perceived as sufficient compensation despite the vocational drive of these occupations (Shen, Cox & McBride 2004). Dissatisfaction with pay was voiced often in the interviews. However, pay was found not to be a major factor for midwives to leave despite perceptions of low pay.

Overall, despite negative aspects of their jobs, participants shone a positive light on their profession. Remarkably, 88 percent of all 75 participants would recommend midwifery as a career to others (*n* = 66; 88%), with 14 of the 16 participants not working as midwives reporting that they would recommend the career to others. Only 13 percent of those working as midwives considered that during their time as a midwife their job had become less enjoyable over time (*n* = 8; 13%). Almost all (52 of the 59) stated that they would continue to work as a midwife (*n* = 52; 88%).

Contentedness in midwifery work and a sense of meaningfulness are important for health organisations, just as much as for the individual midwife. Research has indicated that active job performance suffers when employees feel a sense of powerlessness and meaninglessness in their work (Tummers & Den Dulk 2013). Powerlessness, the sense of having no influence in their work, and meaninglessness, feeling that work is not worthwhile, negatively influence organisational commitment. Indicators of active job performance that can be affected are work effort, self-starting and pro-active behaviours, and the undertaking of workplace tasks and activities beyond that of basic requirements (Tummers & Den Dulk 2013).

The Dutch national survey study (*n* = 1278; RR = 61%) revealed that in particular, a sense of meaninglessness was significantly undesirable for midwives (Tummers & Den Dulk 2013). A high-quality and committed midwifery workforce is contingent upon the meaningfulness that midwives attach to their jobs. Having a high sense of meaning was also highly important for the midwives in my study. What gave the midwives meaningfulness, in both the Dutch study (Tummers & Den Dulk 2013) and mine, were relational factors within the midwife-woman relationship, as well as quality collegial relationships amongst staff.

Meaningfulness was also enhanced when the values and beliefs of the individual aptly aligned with the midwifery role and organisational setting (Tummers & Den Dulk 2013), an element shown to be vital for organisational loyalty in my study. Those interview participants who felt their ethical values to be acutely adverse to the expectations of the

hospital employing them resigned from their work setting. A sense of powerlessness was also a significant finding in my research, with many participants expressing a lack of influence in their role. A feeling of incapacity was specifically related to experiencing curtailed autonomy in practice. This feeling was also experienced by interview participants working in an organisation which they felt belittled the midwife-woman relationship, by not providing adequate staffing and thus shrinking their time available for relational aspects of the caring role.

Considering midwifery practice as a vocation did not diminish the professionalism of the career for the interview participants. The nucleus of this vocational impulse was the midwife-woman relationship and the impact for positive outcomes and experiences for women brought about by this relationship of care.

9.7.2.4 Autonomous and relational aspects of practice

Another finding commonly mentioned by participants was the concept of professional autonomy. Generally speaking, part of having a sense of autonomy is a perception of choice (Smith 2014). Participants referred to professional autonomy as a personal sense of control to practise to their full ability, and the potential to practice in a way which resonated with what a midwife's role meant to them. Different perceptions of what the midwife's role entailed generated somewhat different conceptions of autonomy. What was well-defined in the interviews was that that being provided with the opportunity to practice using the full spectrum of maternity care (Homer et al. 2009) led to job satisfaction.

In my study, PEMS results showed that those midwives who would rather have worked in another midwifery area scored lower on the *Autonomous practice* subscale, suggesting that satisfaction in one's current role was linked to perceptions of autonomy. Interview data identified that those midwives who were limited in their autonomous capabilities were frustrated in their roles. Conversely, some participants were utilising the continued professional development framework of professional registration as vehicles of expanding their professional autonomy and the scope of their individual practice. Examples of this were participants undertaking a midwifery prescribing course, developing clinical capacity through extension of their skills and abilities, and undertaking post-graduate education and undertaking research.

Therefore, as well as encouraging professional satisfaction and personal wellbeing, practising within a role that was faithful to the scope of a midwife invigorated their commitment to woman-centred care and the provision of normal birth. This meant conducting care practices that enhanced partnership between midwife and women and supported notions of choice and promoted decisional autonomy for women (Smith 2014). Despite asserting their desire to provide woman-centred care alongside supporting normal birth, the practice settings in which they worked were reported to destabilise their ability to do so owing to the powerful cultural norms in place (O'Connell & Downe 2009). Organisational cultures that support midwifery positions allowing them to work to the full scope of practice and encourage the relational aspects of their role are vital. When interview participants felt they were working in such organisations, they felt proud and happy to work there.

Practicing midwifery with autonomy was related to having a perception of choice in their employment role, as well as practising to the full scope of their ability. Autonomy was also an element of providing woman-centred care that helped address the lack of choice and control in maternity that participants perceived was curbed by the organisational setting of the hospital. Autonomy in one's role and working in a role that enhanced women's autonomy was linked to job satisfaction.

9.7.2.5 Relinquishing relationship to practice demands

Where participants spoke passionately about building relationships with women and these being a major source of job satisfaction, much dissatisfaction was directed at factors of the job that reduced one-on-one time with women. This dissatisfaction was articulated in many ways, a common thread however, was a visual image of scarcely being able to sit on the bedside and be with a woman.

Nursing research has identified comforting patients and talking to them as being the most frequent nursing task that is not achieved (Duffield, Diers, et al. 2011). Similarly, the participants in my study felt the more relational aspects of their role were neglected in favour of medical tasks. The prioritisation of medically prescribed tasks in traditional ward-based care in maternity settings presents significant barriers to the provision of relational midwifery care (Hunter, Magill-Cuerden & McCourt 2015). Participants, mostly those working outside of continuity models, felt that their practising time with women was severely curtailed due to being assigned an allocation of women and babies disproportionate to their ability to provide quality, woman-centred care. Evidence of

feelings of frustration and despondency, powerlessness and resentment were apparent when participants discussed snatching moments with the women they were caring for.

Stress occurs when individuals feel like they have little control over work or how they cope with its demands (Leka, Griffiths & Cox 2003). On the other hand, the ability to exercise control over work has been demonstrated to be a useful tool in reducing stress (Savery & Luks 2001). Nursing research demonstrates that new graduate nurse job satisfaction is diminished from experiences of stress related to role ambiguity, not being able to influence others and having too little authority (Chang & Hancock 2003). Research also shows that factors associated with stress in midwives are work overload and time pressure, lack of support, organisational issues and poor conditions (Wheeler & Riding 1994). Accounts of experiences of these factors which contributed to stress and an undermining of the midwife-woman relationship emerged in the interviews, particularly during postnatal care of women. Participants wanted sufficient time for the relational aspects of care. Having to complete a seemingly escalating number of tasks, inadequate midwife-to-woman ratios due to staff shortages and inadequate skill-mixes, large amounts of paperwork, and increased acuity of women's medical needs were mentioned.

Organisational support, planning and development strategies that reduce excessive workloads and enhance the relational aspects of midwifery care are crucial. Both qualitative and quantitative data from my study supports this. Excessive workloads were frequently and ardently discussed by the interview participants as playing a role in the disengagement with women. When assessing the MBI results from my study, those participants who had seriously considered leaving midwifery scored higher on all burnout subscale scores, reporting higher levels of emotional exhaustion and depersonalisation and lower levels of personal accomplishment in their work. This suggests these participants, as compared to those who had not considered leaving, perceived a lack of enthusiasm and motivation and feelings of cynicism and ineffectiveness.

Additionally, results from the Perceptions of Empowerment Scale (PEMS) revealed that those participants who would rather work in another midwifery area scored lower on the *Woman-centred practice* subscale. Moreover, those who had considered leaving midwifery altogether were more likely to score lower on the *Woman-centred practice* subscale as well. These findings suggest that fulfilment in the midwifery role and an intention to stay in employment is associated with an ability to practice in a way that is considered woman-centred.

Organisational factors contribute to decisions to leave midwifery, with real or perceived staff shortages being an integral element of intention to leave (Curtis, Ball & Kirkham 2006c). Particularly since the 1990s, nurses and midwives have reported issues with the delivery of patient care due to insufficient staffing levels and excessive workloads. Nursing and midwifery workloads have gathered strategic attention in disputes and negotiations about pay and employment conditions (Twigg et al. 2011). Forty percent of the survey participants in my study reported not being paid for working over-time. Furthermore, of critical importance is research that indicates addressing disparities between nursing workload and nursing staffing improves a number of patient outcomes (Twigg et al. 2011). Results of the *Staffing and resources* subscale scores of the Practice Environment Scale of the Nursing Work Index (PES-NWI) suggested that participants held negative impressions of the staffing and resources in their practice environments.

Mean PES-NWI scores of individual items below 2.5 suggest participants perceive a lack or absence of these factors in their workplace. Two items in my study that scored below 2.5 were *adequate support services allows me to spend time with the women I care for* (*Mn* = 2.4, *SD* = 0.88) and *enough registered midwives to provide quality care to women* (*Mn* = 2.2, *SD* = 0.88), which further confirms the negative impressions the midwives had about *Staffing and resources*. Additionally, interview data corroborated the quantitative evidence of perceptions of inadequate staffing and resources, giving extra credence to the participants' views of poor staffing levels in their workplaces. Theme (iii) entitled *being a midwife…. but* presented evidence for participants' dissatisfaction with workloads and frequently feeling overburdened with no capability to recover emotionally and physically between shifts. For example, a commonly voiced confirmation for high workloads was the inability to take meal breaks, an occurrence which many participants had been informed by their midwifery managers as owing to poor time management practices.

This censure discredited their diligence and efforts, with many participants expressing resentment and sentiments of feeling under-appreciated for their toils. All interview participants conveyed working under pressure from excessive workloads, thus suggesting the widespread occurrence of high workloads in midwifery. Being a shared experience, across a range of hospital settings, reveals high midwifery workloads as being characteristic of the midwifery work environment rather than attributable to the shortcomings of individual midwives.

In actuality, time management is recognised as an important component of controlling overall performance when practising in a hospital, as research, albeit of nurses, shows (Waterworth 2003). Situations in a hospital can be exceptionally demanding, complicated and often necessitate swift responses. Time management, therefore, may not exist within orderly parameters. Rather, time management is complex, comprising a combination of many actions and interactions. Nurses use a range of time management strategies and a variety of actions which often involve a team approach. Strategies identified were routinisation, prioritisation, delegation, catch-up and 'juggling' (Waterworth 2003). As said, many of the participants in my study had experiences of being advised by their managers that their temporal plan of work was mismanaged. However, Waterworth's (2003) research identified time management to be greatly influenced by other individual practitioners, as well as organisational factors. The organisational element producing glitches in midwifery time management in my study was suggested, by the participants, to be excessively high workloads.

There are many aspects, responsibilities and tasks associated with being a midwife. However, integral to the practice of midwifery was the midwife-woman relationship. Interview and survey text data drew attention to the ramification of excessive workloads such as detracting from their wellbeing and stress. The workload demands of midwifery practice also impacted upon the quality of the care they provided and the ability to form meaningful relationships with women.

9.7.2.5 Fear undermining practice

Midwifery practice was as much a site for anxiety as it was for satisfaction from relational care. Hospital work was the norm for most of the midwives, with all but the four participants who had *never* worked in the midwifery profession, having had commenced working as a midwife in the hospital setting. Most participants considered their transition into the hospital workforce as difficult and overwhelming (Hughes & Fraser 2011; Kensington 2006). When discussing the hospital as their place of work, interview participants often drew the focus to the clinical setting of intrapartum care known as delivery suite by most participants.

Drawing attention to the delivery suite highlighted its significance for the participants during the period when the participants were novices. The difficulty of the transition was particularly acute if a long delay occurred between graduation and being assigned to their rotation on delivery suite. Theme (i) identified that *sinking*: being submerged and

overwhelmed by the challenges of the new transition, and *swimming* was the sense of yielding to the challenges, learning from, and surmounting them. This wavering and stormy transition into midwifery practice has been observed in other research which also utilised similar aquatic metaphors (Fenwick et al. 2012; Hughes & Fraser 2011).

One subtheme of Theme (i) called entitled *facing fear*, emerged from the numerous accounts of feeling fear when working in delivery suite. The delivery suite was perceived as an area of unpredictability. The dynamics of time and work were perceived as not being laid out neatly and providing care in the delivery suite was presented as a demanding job. Other research is in accord with this finding. The delivery suite can be a site where midwives feel stressed, feel like they have too little time to perform tasks, express difficulties communicating with medical staff and experience the intense emotional demands of labouring women and their partners (Mackin 1999). When, in my study, little supervisory support was provided, the challenge was deemed more stressful and difficult.

The delivery suite was considered to demand marked levels of support for new midwives. Unforeseen stress resulting from their unfamiliar and changing professional role is evident from anxiety of their newfound elevated levels of responsibility of being new midwives. The *assuming responsibility* subtheme from Theme (i) *sinking and swimming* revealed that, in the initial years of practice, most were very worried about making mistakes even in commonplace clinical situations. The complexity of midwifery care meant that despite possessing clinical knowledge of practice situations, the practical application had often been untried. Examples of this were looking after women with twins or those undergoing physiological third stage.

Apprehension of responsibility has been demonstrated in other research which depicts how new graduates experience unanticipated, enhanced levels of responsibility and accountability when newly graduated. The perplexing shortfall of envisaging their imminent responsibility was due to an inability to be afforded genuine responsibility when students (Duchscher 2001). Interview participants in my study reported being shocked by the feelings of sheer responsibility when a registered midwife. The accountability of being a registered midwife differed from the student experience when they felt their responsibility and practice decisions were under the umbrella of another midwife.

The magnitude of their responsibility to other persons, the emotional involvedness and physical intensity of the midwifery role, and the multiple clinical pathways potentially

feasible when practising midwifery care were given as grounds for their need for support. The desire for support when working in delivery suite had at its core an objective of safety. Unfortunately, the interviews depicted a dearth of support. This is injudicious particularly when support was clearly demanded for in this specific clinical area.

Some participants 'resigned' from delivery suite, abandoning working across all the clinical areas of midwifery. Ceasing work in birthing services and establishing themselves in a single clinical area such as the antenatal or postnatal ward was an intentional strategy to remove themselves from situations where they felt vulnerable. Inadequate transitional support from fellow clinical midwives, midwifery clinical educators, or units contributed to their perceptions of work environments which lacked support. The absence or deficiency of appropriate support was experienced either in isolated clinical incidents such as maternal emergencies or when experiencing a significantly heightened workload, or as generalised impressions of absence of support across many working days. Experiences and encounters of poor support were often coupled with perceptions of low self-confidence in the midwifery role, leading many participants to question their competence.

9.7.2.6 Competence and confidence in practise

Competence is complex and depends on the capacity of the individual to be accountable for their own practice (Barker 2014). Employment as a registered midwife is undertaken when competence within the midwifery role is intimated, firstly from successful completion of midwifery education and registration with the national registration body (Australian Nursing & Midwifery Council 2006) and secondly, is regulated through appropriate job interview performance. Eighty-eight percent of survey participants considered themselves adequately educated to perform their role as per the PEMS data (*n* = 52; 88%). Despite this, many of the participants in my study reported inadequacies of confidence in their ability to provide care as new midwives, particularly in the birthing setting. An individual who is objectively competent in their abilities may indeed want for confidence (Downe, Simpson & Trafford 2007). However, a perception of confidence in one's capacity to provide competent care is vital for the provision of safe and efficacious midwifery care (Green et al. 2015).

What competency denotes in the midwifery graduate at point of registration has been interpreted by a group of midwives working in a wide variety of roles: new graduate, teachers, educators, assessors, and clinical midwives (Butler, Fraser & Murphy 2008). For those study participants, a new midwife possessed competence if she had the experience

required to fulfil the role, had knowledge and skills required for safe practice, displayed effective communication and attitudes of commitment, motivation, kindness and caring. A competent midwife displays a degree of self-sufficiency, has contemporary knowledge, and exhibits self and professional awareness (Butler, Fraser & Murphy 2008).

The most important requirement for competence in the Butler et al. (2008) study was that a midwife displays competence if she is safe and can practise safely at registration. The participants in my study also conceived competence in a framework of safety and many gave accounts of seeking out support when they did not feel competent to undertake tasks, particularly when in delivery suite. The ability to ask questions and seek advice, or having a midwife readily available to practically provide assistance, had as their objective, safety. An occasion of a new midwife not being able to locate the position of a fetal heart rate, and being told there was no one to help them by another midwife, was distressing to the participant due to her concern for the wellbeing of the fetus.

Perceptions of decreased confidence, particularly within the intrapartum care setting, are significant findings. The possible consequence of having low confidence may be diminished competence in caring (Hunziker et al. 2013), and result in stress (Zupiria Gorostidi et al. 2007). Experiences of insecurity, indecision, apprehension, distress, nervousness, anxiety, fear, dread and panic were conveyed in the interviews as feelings endured when working in delivery suite. Not only did these states of mind have a bearing upon participants' personal well-being and their intentions to leave birthing services, these emotions also weakened convictions of their capacity to assume responsibility for intrapartum care as a result of decreased levels of self-confidence.

One study which examined self-perceptions of confidence and competence in a sample of British midwives throughout a process of organisational change in intrapartum services presented noteworthy findings (Shallow 2001a). The midwives had recently modified their way of practising midwifery being newly required to work in all clinical areas of their maternity service including the delivery suite, rather than only being employed in a single setting. This change in their practice led to feelings of diminished confidence, fear and anxiety of unaccustomed aspects of their new midwifery role.

Both new and experienced midwives reported a sense of disempowerment and feeling devalued (Shallow 2001a). New midwives were fearful of making mistakes and became self-conscious. Levels of sick leave rose. The primacy and urgency of acquiring and then

securing competency in obstetric-related medical tasks and interventions required in the aspects of their midwifery roles negatively influenced the participants' ability to preserve their midwifery values of birthing care. Participants with previous minimal exposure to intrapartum care considered delivery suite stressful and many experienced anxiety when arriving to work. Fear was related to feelings of poor confidence and apprehension of making mistakes. Descriptions by midwives experiencing dread and terror at the thought of working in delivery suite were also present in my study.

Shallow (2001) highlighted the structure of the hospital as fostering these anxieties, due to its self-serving organisational agenda which required a midwifery workforce to rotate through all areas at late notice and provide care for several birthing women at once. Furthermore, the participants in the Shallow (2001a) study described a midwifery staff that was unable to provide adequate support and supervision to each other due to high workloads and a focus upon medical tasks and methods, rather than on inter-collegial instruction of midwifery knowledge and care (Shallow 2001a). Features of Shallow's (2001a) research that resonate with my study are the work conditions that generated a sense of fear of the delivery suite. For example, the focus on medical intervention rather than a midwifery approach to care, their identification of high workloads giving rise to deficient support and supervision, and the dissatisfaction of having insufficient notice when being transferred to different wards to cover sick leave. Therefore, having a set rostering system that indicated when participants were positioned in clinical areas was considered helpful to the participants in my study.

Recent research using diary and interview data of 12 midwives (with a range of four to 27 years of clinical experience) working in intrapartum care settings in three hospitals in the UK, demonstrated the crucial contribution that collegial support plays in midwives' perceptions of self-confidence in their practice (Bedwell, McGowan & Lavender 2015). Confidence in those participants was positioned as a fragile condition, easily threatened out of existence. Readily impacted by midwifery inter-collegial support and displays of trust, an individual's confidence could be enhanced or impaired by positive or negative interactions by other, often more senior midwives. Key findings were that the confidence of even experienced midwives was vulnerable (Bedwell, McGowan & Lavender 2015). This finding suggests that the confidence of new midwives may well be susceptible to heightened levels of vulnerability on account of them being less accustomed to the midwifery role.

Bedwell et al.'s (2015) research revealed that those midwives, who were through prior experience, familiar with the kind of midwifery care that they now had to practice, displayed confidence. A sense of autonomy and control also conferred a sense of confidence, whereas feelings of helplessness negated their levels of confidence. For example, feeling bound to provide midwifery care that was aligned with a philosophy of care alienated from their philosophy of birth but abiding to a cultural norm of their workplace, threatened their levels of confidence.

Similarly, of concern to the interview participants in my study was that despite being objectively competent as registered and employed practitioners, participants spoke of losing confidence in their abilities upon entering the hospitals as employees. For some, this was linked to doubting the customs and beliefs of the hospital and finding them alien to their personal values. The hospital was also regarded by many participants to engender an approach to maternity care which contrasted to that which was espoused within their educational settings and was foreign to them. This has been identified as cause for concern for other midwives with research indicating that for some, practising in an environment where normal birth is not valued can contribute to emotional stress and experiences of dissonance (O'Connell & Downe 2009; Shallow 2001a; Shallow 2001b).

Like those in the Bedwell et al. (2015) study, some participants in my study had the impression that their actions were under surveillance if their practice techniques differed from other midwives, or they had philosophies of midwifery care different to others (Bedwell, McGowan & Lavender 2015). Examples of this were feeling scrutinised and instructed during care of birthing women using 'hands-on' instead of their preferred 'hands-off' techniques in second stage[19], or when the hospital was very quiet allowing a woman to linger a bit longer than usual to rest in delivery suite after birth instead of swiftly transferring her to the postnatal ward. Another example was being goaded by midwifery colleagues to partake in openly demeaning racist mocking of women in spite of personal and practice beliefs which despised this behaviour. This is appalling considering immigrant women in Australia have poorer perinatal experiences and many report their experiences as negative ones and deserve respect and consummate care (Yelland et al. 2015).

[19] This refers to a caregiver placing or withholding their hands on the fetal head as the baby is born. Practices differ with regards to this and opinions vary as to the best techniques for minimising maternal and infant morbidity.

For many midwives, their practice was hindered and their confidence undermined by experiences of fear and anxiety, and self-doubting their clinical competence. These feelings were heightened when practicing in delivery suite. When participants' philosophy of maternity care deviated from that of their employment setting, they felt thrown off balance and questioned whether they wanted to practise in the organisational setting. Clinical support, as an ameliorative to these unsettling experiences, is important for the new and established midwife alike.

9.7.2.7 Collegialism and support in practice

This section incorporates both the positive and negative attributes of collegial relationships and supportive measures in the midwifery workforce. Occasions of relationships which prevented positive new graduate experiences were reports of being isolated from peers and being unsupported by their managers if they questioned or did not adhere to the norms and conventions of their unit (Parsons & Griffiths 2007). One example is the midwife who was assigned to the team leader position in maternity ward on her first shift. When disputing the safety of this with her manager, she was threatened with disciplinary action and humiliated in front of her colleagues. Factors detrimental to safety in maternity services have been proposed as increased medical complexity of women and medical intervention of childbirth, lack of resources and staffing, inadequate skill mix, inadequate training and education, poor management, and low staff morale (Smith, Dixon & Page 2009). This participant's experience is a striking example of all of these factors in action.

Cliqué or in-group behaviour such as this as was uncovered in my study generated work conflicts and damaged participants' perceptions of self-confidence (Bedwell, McGowan & Lavender 2015). Divisive factions between different clinical areas contributed to uneasy relationships between midwives, further amplified by hierarchical variances of authority within the hospital setting. Some interview participants attributed the 'separate gang' mentality to insupportable workloads, holding their colleagues responsible for their work stressors because it was them, and not senior administration, with whom they had daily contact with. The interview data also gave a sense that participants were belonging simultaneously to many subcultures within midwifery which were shaping their identities and beliefs, almost like groups-within-groups. These fractures were also evident in the '*Why Midwives Leave?'* study, which the authors suggested were based upon rank of seniority, academic credentials, practice philosophies and years of experience (Curtis, Ball & Kirkham 2006d).

Avoidance practices by self-isolation were used by some midwives as coping mechanisms. Staying in the birthing rooms or relinquishing meal breaks to evade contact with other midwives on a shift to minimise conflict and criticism (Bedwell, McGowan & Lavender 2015). Strategies of seclusion have the potential for safety risks both to the personal safety of the midwife due to the potential for falling victim to patient/family-midwife violence (AbuAlRub & Al-Asmar 2014), as well as safety to women. Self-isolation may lead to practices of concealment, whereby new midwives who feel scrutinised curtail open discussion with supervising midwives. Midwives, who feel under-surveillance, due to having exhibited moral and practice misalignment with hospital norms, may not be truthful about the clinical situation of a woman. New midwives can also feel too vulnerable to solicit help when needed. All these situations were relayed in the interviews of my study and are alarming because new midwives must be able to seek help when needed.

Open communication practices are vital in clinical care. The hierarchical context manifest in the organisational culture of the hospital leads to groups of employees who perceive themselves as lacking in power. The dispossession of power can lead to censured communication as those lacking in power communicate to those with higher authority using mitigating speech. Those less powerful defer to authority in accord with subtle, entrenched and tacit conventions and values of the hospital (Gould 2010). Impediments to clear communication between health professionals in maternity services are endemic when employees, immersed in a system, may not recognise these culturally-entrenched behaviours (Gould 2010).

Participants in my study conveyed experiences in which the subordinate rank of the new midwife conferred a sense of having no voice to state their views in clinical situations. Their silence, they acknowledged, suggested acquiescence in clinical situations where they felt that others' judgements were wrong. The cultivation of a less authoritarian culture in the hospital work environment is critical. Command hierarchies are unmistakably necessary due to varying levels of skill, experience and scopes of practice. However, collaborative approaches to communication and decision-making, which allow new midwives to be considered vital members of the work team, would facilitate juniors to express their opinions and ask questions of senior staff members.

9.7.2.8 Creating positive workplaces to practise in

The findings of vulnerability of the new midwife in my study together with previous studies on confidence (Bedwell, McGowan & Lavender 2015; Shallow 2001a), highlight the

importance of focused supervision of new midwives and the creation of positive workplace cultures which allow non-hierarchical decision-making. Having initial placements in models of care which generate confidence and support are important (Hughes & Fraser 2011). At the outset of their practice, participants presented a picture of themselves in which confidence did not necessarily shadow their objective displays of competence. If they were supported within an environment of respectful trust, confidence and competence co-evolved and they felt more at ease in their new midwifery role. For example, as shown by a midwife responding to emergency neonatal care without the burden of self-doubt and uncertainty, she realised her confidence had grown due to her experience of clinical support.

Many participants in my study appointed midwifery group practices as being sites of non-hierarchical collegialism, which championed support and skill development of new midwives. Many participants also decried the lack of access as new midwives to these models, expressing their desire to have had worked in these models if they had been given the opportunity. Group practice models were put forth as having the potential to foster both a sense of community and commitment between colleagues, be sites of positive leadership, education and support, and also bestow upon the new midwife the ability to practise autonomously.

These findings are similar to Cummins et al. (2015), whose study of newly registered midwives working in group practices across Australia reported receiving supportive supervision from senior midwives. This led to enhanced development of their clinical skills and positive socialisation into the organisation through building mentoring relationships of trust. The shared, supportive mentoring relationship that the new graduates in Cummins et al.'s (2015) study experienced with experienced midwives was key to their positive transitions into the midwifery workforce in the midwifery group practices. Specific qualities of a mentor that were valued were their knowledge and wisdom and accessibility (Cummins, Denney-Wilson & Homer 2015). Those midwives in my study who had worked in group practices also reported the immensity of midwifery knowledge in the group and an approachability of their colleagues was helpful. Seeking advice and support was a straightforward process and these factors were powerful determinants for their successful integration into the midwifery workforce. Having a shared philosophy of the normality of birth and a collective with-woman standpoint also gave participants in my study a sense of integration into the group and elicited willing support from other midwives.

Notable in the findings was that when participants referred to encounters with hospitable and supportive midwives they invoked the concept of qualities that engender a 'good' midwife. This concept, the subject of a qualitative interview study undertaken in the UK, identified one feature of a 'good' midwife as having skilled competence (Byrom & Downe 2010). This meant holding superlative knowledge, skill and competence of the role. The other was being in possession of particular personality traits which imparted a sense of emotional intelligence and empathetic capability.

When describing those midwives who readily provided support, a frequent description, given by the participants in my study was people that were approachable and willingly proffered practical and pragmatic support. Research shows that the decision-making process for midwives is a socially negotiated activity whereby midwives consult each other as sources of information (Young 2011). 'Good' midwives as per Byrom and Downe (2010) are approachable, display warmth and friendliness and generate a work culture of mutual respect, fairness and trust, within which new midwives could readily consult, and felt supported by and were then able to reach their maximum potential (Byrom & Downe 2010).

As revealed in the interview data, varying levels and availability of formal support were provided by the hospitals employing the participants. Self-resourcefulness, implied by electing a midwifery mentor for guidance and education, was frequently reported as a strategy for garnering support and successful integration into the midwifery workforce. Midwives chosen were exemplary practitioners and displayed expert qualities, considered as excellent or experienced midwives. The exemplary midwife as conceived by Downe et al. (2007) is one who possesses wisdom and intuition, knowledge, skilled practice, confidence in clinical skills and communication, and vocational strength (Downe, Simpson & Trafford 2007).

The participants in my study felt sanctioned to confidently set about their daily work when they worked with midwives who trusted their abilities. If they were treated with kindness and compassion by senior colleagues and an ethic of care was enacted towards them, participants felt they flourished in their new role. This context of fellowship facilitated uninhibited communication between midwives, vital for new midwives requesting help and soliciting advice and support. These conditions were presented in thematic data about *mentorship*, *debriefing* and *relationship-based support*. Consigning the mentorship process to individual midwives may work for some new midwives, however, it should not be

regarded as standardised approach. Formal mentoring programs are considered beneficial to new midwives and as suggested by many participants, the mentorship system needs sponsorship within hospitals and mentors require adequate training and support (Finnerty et al. 2006).

Nursing research has shown that new nurses employed in a culture of support, built on shared experiences and positive teamwork, contributes to their retention in the organisation (Zeller et al. 2011). Furthermore, creating cultures of mutual respect and fellowship is an important strategy to safeguard against those defensive strategies of isolation and seclusion which compromise frank communication and ultimately, the care and safety of women and babies. The inclusion of ongoing inter-professional communication and social skills training in hospital mandatory training is important (Alimoradi et al. 2013; Ammentorp et al. 2014).

Unlike Byrom and Downe's (2010) research which only identified positive attributes of 'good' midwives, my study also explored negative characteristics, which summoned a complete, sometimes disagreeable, picture of those qualities which were considered to be unsupportive to a new midwife. A work title featuring prominently as commonly being an unsupportive factor in workforce encounters, was the midwifery manager, understood here as the immediate supervisor of the staff midwife.

Characteristics portrayed of 'bad' managers were being unapproachable or inaccessible, misuse of authoritative power, having poor communication skills, intimidating or bullying their staff, not involving their staff in clinical decision-making, being inflexible with rostering and leave processes, treating their midwifery staff impersonally as if they were a 'number', only giving negative feedback and never providing positive reassurances and recognising the value of their midwifery staff.

This lengthy catalogue of pessimism is a good indicator of what a 'good' manager is if the counter behaviour is considered. Indeed, the participants gave animated and expressive depictions of what a 'good' manager does. This was iterated in Chapter 8, with the presentation of metaphorical language used in the quotes revealing what participants considered a 'good' manager to be (for example, "puts down her books" and "gets her hands dirty").

Management and leadership have been identified in other research as playing a crucial part in the development of positive working environments in hospitals, staff job satisfaction and

positive patient outcomes (Clarke et al. 2012; Duffield, Roche, et al. 2011), and certain characteristics of 'good' managers have been revealed. Duffield et al. (2011) identified these characteristics as those that consult with staff on daily problems and procedures, provide flexible or modified work schedules, and are highly visible and accessible to staff, and praise and give recognition for a job well done. These characteristics correlate with the qualities as provided by the participants in my study when they considered *leadership as support*.

Those in management positions were sometimes chosen by participants as people to go to when needing to debrief their clinical experiences. More often, participants discussed reaching out to other new midwives or more senior midwifery colleagues for this. Debriefing was understood by the participants to be a practice of retrospective analysis of critical incidents (Ireland, Gilchrist & Maconochie 2008) and a form of stress-reduction (Cant & Cooper 2011). The vivid picture given by one participant of a debriefing 'tent' that douses your body and washes away all stress and trauma of the working day clearly alluded to the power debriefing can have.

Other participants considered that in the absence of quality formal transition support, debriefing and reflecting on clinical experiences either amongst equally-ranked or in particular, with senior midwives was good to enhance their future performance, their midwifery skills and improve the quality of their midwifery care (Cant & Cooper 2011; Fanning & Gabba 2007). Debriefing was considered to be an experiential learning process of an individual midwife most frequently undertaken in the work setting (Cant & Cooper 2011). The unpredictable nature of shift work and random rostering was considered detrimental to the debriefing when participants wished to reflect on a situation with midwives also involved in clinical incidents. Social events with midwifery colleagues outside of work time were a form of relationship-based support and informal group debriefing, and were valued as a stress-reliever amidst people who understood the nature of the job.

Supportive work relationships were considered crucial for the successful transition into the midwifery workforce and positive experiences of midwifery practice. Although many participants reported seeking out midwifery mentors themselves, they stressed their desire to see hospital-instituted formal mentoring and debriefing programs as common practice.

9.7.2.9 Occupational stress and bullying in practice

The nature of the midwifery job is that it is demanding and challenging (Hunter 2004; Hunter & Warren 2013, 2014; Rice & Warland 2013; Sheen, Spiby & Slade 2015). It requires great concentration often over long and irregular working hours and midwives are required to meet intense emotional and physical performance expectations (Schluter, Turner & Benefer 2012; Schluter et al. 2011). Midwives practice in a health setting where life-threatening or stressful incidents can occur (Sheen, Spiby & Slade 2015). Interview data revealed a sometimes daunting context in which the participants worked, with narratives given of maternal and neonatal emergencies, deaths and hostile or aggressive patient incidents.

As a midwife facing the many heightened emotions of anxiety, fear, pain, joy and grief, this all demands complex emotional capacity, a feature of the role which is not always acknowledged, valued or supported (Hunter 2010). One participant recounted her experience, in her first years of practice, when she was caring for a birthing woman who required a caesarean in her birthing room after suffering a cardiac arrest. Expecting support from her midwifery manager after the frightening incident, she was shocked when she was told to clean up some blood on the floor and then watched her manager go eat pizza with other managers. Clearly, her manager also required support and sought it from her peers. However, the participant in my study reported never receiving any debriefing, even from her manager, something which she desired and considered would have helped. All these years later, the recollection of the event was distressful and saddening for her.

Another participant gave an account of a clinical incident with a birthing woman which necessitated emergency care. After this event, not receiving adequate debriefing support, she left midwifery, not knowing whether she would return. Months later, moving to a different hospital in a different role 'midwifed her' as she said, back to feeling confident to practise. These were critical moments of adversity, when support should have been enacted towards them to promote their resilience and positive transition through the experience (Hunter & Warren 2014).

These occupational demands can contribute to stress and ill-health (McNeely 2005). Text data from the survey concerning would-be advice participants would provide individuals considering a career in midwifery involved the importance of maintaining physical health and emotional wellbeing. Frequently arising in the interviews was discussion of the habitual use of alcohol for unwinding from the stress of work. This is worth mentioning due to the

potential harmful effects of alcohol on health for the user and potential consequences for the workplace such as absenteeism, inefficiency or accidents (Erøy Edvardsen et al. 2014).

The large Australian and New Zealand e-cohort study showed that almost 14 percent of the 4419 nurses and midwives surveyed engaged in harmful daily drinking. Significant associations between long working hours and harmful daily alcohol consumption were seen (Schluter, Turner & Benefer 2012). The issue of work-related stress is a significant issue for midwives as revealed by research that has identified the relationship between stress amongst midwives and various psycho-social and organisational characteristics of their job (Banovcinova & Baskova 2014; Carlisle et al. 1994; Mollart et al. 2013; Pikó 1999; Sato & Adachi 2013; Sheen, Spiby & Slade 2015; Wheeler & Riding 1994). The wellbeing and performance of midwives has critical importance for the functioning of the profession. Health awareness efforts aimed at reducing stress and improving workplace environments would be constructive considering these findings.

Further detriment to the wellbeing of participants was their ubiquitous experiences of bullying, as evidenced from interview and survey text data. Bullying negatively affects job satisfaction (Roche et al. 2010). Bullying is also injurious to emotional health, with health effects identified as anxiety, fatigue, exhaustion and depression (Hutchinson et al. 2008). Work morale, performance and productivity also can be affected as victims may reduce their working hours due to sick leave or cutting down their rostered hours (Hutchinson et al. 2008). Bullying can also be disruptive to careers as it has shown to be a cause for exiting an organisation or the profession (Allen, Holland & Reynolds 2015).

There was a lot of evidence that many interview participants found their work environments to be hostile and harmful (Hutchinson et al. 2010). Many had experienced the long-established tradition whereby ‘midwives eat their young’ (Race & Skees 2010). These professional socialisation processes entailed senior midwives making it difficult for new midwives, ‘weathering’ them through the steep learning curve of their transition, from novice to competent practitioner. Rather than helping to build competent practitioners, research shows that this behaviour erodes perceptions of competence and professional reputation (Hutchinson et al. 2008). Hostile behaviours are contrary to professional norms and seem illogical within a caring profession. Examples of these incidents were being allocated excessively high workloads or clinically difficult women. These behaviours were reported to be normalised as customary behaviour and tolerated within the work environment (Hutchinson et al. 2008).

Escalating the severity of hostilities, participants spoke of a wide range of experiences: being humiliated and belittled in front of other health professionals, being gossiped about, harassed, intimidated by colleagues and managers, experiencing physical assault, isolated and excluded from the team, and observing racist resentment of women. The nature of bullying is that it is targeted, repeated and cumulative and often only draws to a close when the victim relocates (Hutchinson et al. 2008).

Participants spoke about how bullying expedited their exits from the midwifery profession, one, for example, after a prolonged experience of bullying and perceived mismanagement of the protracted experience. Other research depicts health professionals leaving workplaces due to bullying experiences (Hutchinson et al. 2008). Another participant moved her place of residence and relocated her country town to escape from the targeted bullying directed at her. This participant's experience highlights how bullying is repeated and perpetuated. She did not report it as the perpetrators were the midwifery manager and the senior medical physician of the small town in which she lived. Under-reporting of workplace hostility and bullying is commonly reported by nurses (Fry et al. 2002). Some chose, in my study, to move to different clinical areas of maternity to retreat from the bullying. Yet others moved hospitals to escape being the recipients of bullying, whilst others moved hospitals to remove themselves from organisations in which they were a daily witness to negative behaviours.

The professionals identified in the interviews as perpetrators of bullying were generally staff midwives, although managers and medical staff also were referred to. The commonness of accounts of bullying within the data supports Hutchison et al.'s (2008) conception of bullying as being borne from organisational processes, structures, and routines that function to reward and perpetuate bullying, as opposed to it being merely isolated incidents of interpersonal conflict which will be responsive to conflict resolution between the individuals involved. Midwifery research also supports the organisational rather than individualistic, model of the bullying culture in midwifery (Curtis, Ball & Kirkham 2006a). Furthermore, perceptions of bullying and violence in a workplace have been linked to adverse patient outcomes through an association, amongst other things, with instability in the work environment and high workloads (Roche et al. 2010).

Workplace bullying seems paradoxical in a caring profession such as midwifery, and yet the interview data were crowded with participant experiences of this form of harassment. As the participants practised across Australia in varying locations and hospitals, the

organisational model of bullying is supported by the data from my study. Practising ethically as a midwife includes the responsibility of exercising collegiality towards others. This must be made a priority in organisations if the midwifery profession is to retain its 'young' and foster the future.

9.7.3 Personal factors and stressors

Another aim of my research was to identify personal factors and stressors that may influence workforce participation. Personal factors and sources of stress were only cause for concern for a small number of participants, physical illness and injury being the most notable here. Two participants were unable to work due to their inability to work in a job that involves physicality. Time out of the profession was also evident in a few nurse-qualified midwives living in remote or regional areas with small populations. Midwives are often needed to work in dual roles when living in these locations in Australia. Their professional role becomes one of a multi-skilled generalist (Yates et al. 2013).

Other personal sources of stress that brought about some midwives to leave the profession were personal beliefs engendering a moral misalignment with the care practices in the hospital. Data regarding this is evident in theme (iii), in the subthemes entitled *managing ethical dilemmas as a new midwife* and *withstanding the power of the system*. For a few participants theme (iii) conveyed their sentiments of *being a midwife…. but* I don't want to be, due to their negative perceptions of the medical interventions used in the routine care of birthing women. Research has revealed the experience of lengthy personal struggles of acceptance when deciding to leave midwifery (Barry et al. 2013). This was also how the midwives in question encountered their exit from their profession.

Decisions to leave the profession for which they had trained arose when they felt they could not provide what they considered as autonomous, 'real' midwifery. The assessment of the nature of hospital birthing practices as over-medicalised is not unique, as other research indicates (O'Connell & Downe 2009). As per O'Connell and Downe's (2009) findings, the participants in my study considered the ability to practise autonomously were thwarted due to the culture of power and control. Rather than complying with these norms (O'Connell & Downe 2009), the midwives chose to leave the profession as they felt they were causing harm to women.

9.7.4 Comparing educational groups

The last objective of this study was to ascertain the presence of any comparison in the workforce participation trends by education. The only statistically significant variance seen between the Bachelor of Midwifery and Graduate Diploma of Midwifery participants was that the latter were statistically younger. It also could be suggested that the interview data indicated a possible variance as regards to the Bachelor of Midwifery participants' initial transitions into the workforce and experiences of bullying. The Bachelor of Midwifery participants were in the first two years of the course's inception in NSW. It was suggested, by numerous Bachelor of Midwifery participants, that many of their midwifery colleagues acknowledged their unease about the new route into the midwifery profession. Some participants felt they were targeted as victims of bullying due to the course in which they were educated. Additionally, some Bachelor of Midwifery participants spoke of feeling nervous and awkward with some practical skills of midwifery such as medicine administration and managing intra-venous lines, for example.

The propensity of the Bachelor of Midwifery participants to feel the transition and skill acquisition more acutely cannot be said to be a legitimate finding. Different individuals find different skills more difficult. Some of the nurse-qualified midwives reported feeling difficulty and apprehension with their communication skills, the midwifery ones needed so dissimilar to the ones needed in their previous area of nursing practice.

What these issues highlight is the need for transitional support, mentorship, positive work environments and cultures and beneficial managerial practices in the midwifery workforce, that aspire to successfully acclimatise each individual midwife into the profession in which they spent much effort to gain entry.

9.8 Limitations of the study

Explicit reflection upon methodological limitations of research is a critical process to contribute to its quality and credibility. This thesis endeavoured to transparently present the chosen methodology, methods and findings. Reflexivity regarding competing interpretations of the findings augmented the transparency provided by the detailed mapping of the study's methods. The conceptualisation of my study within the framework

of workforce research was apt and appropriate to the research question and the findings were congruent to the research question.

The multiple theoretical approaches, data sets, and analyses used as part of this research project provided rich data. However, they cannot hope to answer a research question in all its complexity. Despite addressing certain existing gaps in evidence pertaining to new graduate midwives in Australia, a number of features in my study demonstrate methodological weaknesses which require careful and critical assessment.

Due to the sample size, the single recruitment setting of one Australian university, and the inclusion of only two of the three available midwifery pathways in Australia, the external validity of this study cannot be assured. In addition, the generalisability of the findings beyond the specific sample of midwifery graduates from one Australian university cannot be guaranteed. The uncertainty of the representative distribution of the population does not, however, render the results useless because the results can be considered applicable to the Australian midwifery profession. Owing to the sample possessing sufficient similarities to relevant midwifery university graduate populations from other Australian universities, the findings can be considered representative of many Australian midwives and made use of outside of the limits of its sample population. This is because as a mixture of Bachelor of Midwifery and Postgraduate Diploma of Midwifery participants of varying ages, practising across varying locations, the sample is not atypical of the heterogeneous midwifery community in Australia. In favour of the findings being transferable to the wider midwifery community in Australia is that the participants were employed in various States and Territories, maternity settings and midwifery roles.

Whilst the sample is broadly representative, sample size limitations inhibited meaningful exploration of the experiences of distinct population groups such as those from rural settings or Indigenous Australians. Current enterprise by the Aboriginal and Torres Strait Islander community and its advocates to improve the health of Indigenous women and babies has included the championship of Indigenous midwives. The sample was known to include participants who identify as Indigenous. Unfortunately, no Indigenous participants responded to the survey and were therefore not interviewed. This is a weakness of this study, as midwifery research aims to be inclusive of all peoples. Further research is recommended for research into the new graduate workforce participation, experiences and choices of Indigenous midwives in Australia. Likewise, the disparities in health amongst

geographical divides in Australia necessitate further research for new midwives working in rural settings.

Various challenges to the internal validity of the study existed. For example, in retrospect, the omission of specific questions in the survey inhibited thorough provision of data for analysis which could have helped address particular lines of inquiry that emerged in the analysis and interpretation phase of the study. For instance, an instrument that is used to measure the domain of job satisfaction could be useful in the assessment of workforce experiences. Job satisfaction was inferred by several items in various sections of the survey, sections in the three validated instruments, as well as using interview data. Revision of the survey would be of benefit for future research.

Another issue in the study is that of researcher bias. As a practising midwife, complete objectivity within the research process cannot be assumed. Although, the disclosure of this bias does not eliminate it, processes of reflexivity within the study aimed to reduce it. Also of concern was the response rate of 66 percent of a sample of 113, introducing a potential bias relating to the unknown motivations for responding to the survey and self-selecting to undertake the interview. This limitation was introduced in Chapter 9 in the section regarding the discrepant findings. Unfortunately, the 66 percent response rate meant that 38 of the sample did not respond and knowledge of their participation in the midwifery profession is therefore unknown. This limitation is compensated by the benefit gained from the workforce information garnered from the 75 participants who did respond to the survey.

The representation of experiences as more significant may also arise, due to particularities of individual participants, such as participants who had negative experiences may have been more likely to respond to the survey and take part in the interviews than those who had not had negative experiences. The data collection period coinciding with the recent introduction of the Bachelor of Midwifery course in NSW and the newness of midwives educated in this way may have intensified the experiences of Bachelor of Midwifery participants due to them being perceived as foreign within the hospital system.

Adding to the potential bias introduced by undetermined responder motivations are issues surrounding the memory of events, although current employment was contemporaneous to data collection, graduation was six to seven years prior to the study. Despite this time frame being relatively recent, memories of events may have been shaped by individual

participant experiences and the selection of memories dependent on factors external to the data collection process. Attribution of positive workforce experiences to the exercise of midwifery agency, but then attributing negative ones to the organisational dominance of the hospital work environment may also be present in individual's narratives, due to recurrent impressions of midwifery disempowerment.

Although the interview findings were firstly, endorsed by several midwives practising in Australia to be believable, credible and relevant to the new graduate experience and secondly, repeatedly reassessed by the supervisory researchers, findings were not verified by all of the interview participants themselves. Supporting the credibility of the research findings however, is that they are congruent with other research on the topic, as demonstrated in the discussion chapter.

9.9 Further research

Research into workforce participation and experiences in the early career period of Australian midwives would benefit from a larger sample size, and the inclusion of midwives educated as both nurse and midwife via the dual degree of Bachelor of Nursing/Bachelor of Midwifery, to improve representativeness and the generalisability and transferability of findings. Examination of sub-group populations, as mentioned above, is also important. Studies, this research and others, have revealed the early career period of the new midwife to be the critical period it is. Methods for extracting information about this critical period from national midwifery data would be beneficial as well. Studies which incorporate mechanisms for correlational analysis between workforce experiences of the new midwife with turnover and retention would increase rigour for use for midwifery education, administration and practice.

9.10 Conclusion

Effectual articulation of the research process is paramount in research. One aspect of the method of this study was the integration of quantitative and qualitative data. This analytic process, and the outcome, was presented in the Discussion Chapter. The method of integration was undertaken through a process akin to 'following a thread' among the results, back and forth between the two methods, distinguishing issues of significance, and points of similarity and discordancy. Notably, the findings revealed the participants to be

strong advocates for the midwifery profession. No differences were seen between the two education groups apart from the Bachelor of Midwifery participants being older than their Graduate Diploma of Midwifery counterparts. Altogether, the proportion of participants who were working as a midwife far outweighed those who had left their profession. Most had left due to child-rearing, although burnout, work-related stress and moral misalignment were also causes. Many of those who had left the profession were considering a return. The relationships between midwives and women were paramount as reasons for entering and remaining in midwifery, and underpinned the vocational impetus of the participants. An ability to work to the full scope of ability within a woman-centred practice framework was cause for job satisfaction. Factors of their workplaces, namely the hospital setting, detracted from the relational aspects of their midwifery practice. Organisational factors such as high workloads, inadequate staffing, and insufficient support of employment models which boost relational aspects of care were to blame. Factors which could be considered relational elements of the work setting also negatively impacted upon participant job satisfaction. Poor transitional and managerial support and bullying seemed endemic to the experience of a new midwife. The findings also call for a midwife-centred approach for employment, rather than chiefly organisational, to increase flexibility of rostering and look at ways of making shift work more sustainable over the long term. The study's findings suggest that job satisfaction and job dissatisfaction as a new midwife are not two sides of the same coin. Job satisfaction is not generated purely by diminishing those factors that produce job dissatisfaction. To beget job satisfaction in new midwives will require the amplification of those factors which encourage the relational aspects of the midwife role. The findings from this study can be used by midwifery educators and employers to assist in the implementation of suitable, adequate and timely support for new graduate midwives as they transition into their profession and move into the years of their early career period.

9.11 Final conclusion to the study

This study researched two cohorts of midwifery participants with the aim of observing their level of participation in the midwifery profession, the manner in which they were participating in midwifery employment, their workforce experiences, as well as the organisational factors which influenced decisions about how they engaged in the midwifery workforce. Further attention upon potential variances between those trained via the

undergraduate Bachelor of Midwifery and the postgraduate Graduate Diploma of Midwifery were also incorporated into the study. Regrettably, graduates from a dual degree of Midwifery and Nursing were not included in the sample.

The context driving the research was threefold. Firstly, current and predicted shortages of nurses and midwives, both in Australia and internationally, have led to recognition of the value of knowing characteristics of these workforces for development of ameliorative strategies targeting sustaining their numbers. Secondly, various sources of Australian and international nursing workforce data have indicated that numbers of the recently graduated have either been thinking about leaving their profession or indeed leaving entirely. And thirdly, the bulk of national midwifery workforce statistics are housed under the umbrella of joint nursing and midwifery workforce data. As such, it has not been clear whether the turnover that the nursing profession is experiencing with its recently graduated has been similarly occurring in the midwifery profession.

For those 75 participants who responded to the survey, the majority were employed as a midwife, mainly in the hospital setting, with almost half of them in full-time positions. Except age, no statistically significant differences between the two educational groups existed. Data from the 28 interviews revealed that experiences within midwifery employment were varied. Nonetheless, similar accounts emerged which were fashioned into three themes to help make sense of the copious data from these 28 narratives. These themes encompassed challenging experiences of the initial transition into midwifery and factors which helped or hindered this transition. The requirement for support for a successful translation from student midwife to employed midwife was unambiguously conveyed in the data. It was evident that support, from the various sources discussed, was needed when adapting to the working life of a midwife, as well as when well established in the profession. The last theme brought to light the organisational factors which influenced decisions regarding remaining in midwifery, despite many of these factors being undesirable.

Despite the negative aspects of being a midwife that were presented in the survey and interview data, a strong motivation stimulated participants from both educational groups to enter into midwifery as well as continue in the profession. This inherent vocational drive, targeted at improved outcomes and experiences for women and their babies, was nourished by instances where meaningful aspects of relational care could occur. Occasions

of care which endorsed both the midwife-woman relationship and practising to the full scope of midwifery knowledge and ability reinforced the vocational drive.

The decision as to what capacity to be employed in as a midwife was largely dependent on family life, unsurprisingly, due to all participants except one, being women. However, another significant reason presented was that to maintain their working life as a midwife, participants refrained from working full-time and instead chose part-time and casual employment. Working in this capacity afforded a sense of control over those aspects of employment which generated a sense of instability in their working lives. These were unaccommodating work scheduling and rostering practices, excessively high workloads and patient acuity, feeling unsupported by management and leadership, and being opposed to the philosophical approaches to care within the hospital environment. The data gave an impression that participants withdrew from the midwifery workforce so as the many challenges and difficulties of working as a midwife in the hospital system would not undermine their professional vocational intent.

This disengagement from the midwifery profession is not conducive to participating in the crafting of strategies of transformation aimed at fashioning a work environment into being more favourable to midwifery aspirations. Despite the various limitations of this study mentioned in the Discussion Chapter, this study has disclosed elements of the profession that require attention, strategy development and new approaches, all prudent in the face of knowledge of workforce shortages. Supporting many studies in the canon of previous midwifery research, this study has identified the midwife-woman relationship to be the primary element of content for those working as a midwife. Strategies which provide continued and revitalised support of this relationship are paramount to the sustainability of the midwifery profession. Researchers endeavouring to collect workforce participation data on the Australian midwifery workforce will benefit from the presentation of methods and findings of this study. Future research that develops and embarks upon practical projects aimed at enhancing individual engagement in the midwifery workforce will also find value in this study.

Appendices

Page

UNIVERSITY OF TECHNOLOGY SYDNEY

14 February 2008

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Professor Caroline Homer
CB10.07.211
Faculty of Nursing Midwifery and Health
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Caroline,

UTS HREC REF NO 2007-219 – HOMER, Professor Caroline, GRAY, Ms Joanne, SMITH, Ms Rachel - "Transitioning into Midwifery: The MidTREC Study"

Thank you for your response to my email dated 11 December 2007. Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics clearance is now granted.

Your clearance number is UTS HREC REF NO. 2007-219A

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9615.

Yours sincerely,

Mr Peter Trebilco
Acting Chairperson
UTS Human Research Ethics Committee

THINK.CHANGE.DO

Midwifery Turnover Retention Experiences and Choices

Dear UTS Midwifery Graduate,

Thank you for doing this survey. Your time is much appreciated.

This survey will be used by the MidTREC researchers to find out what groups of newly graduated midwives (2007/2008) have been doing in their work life since their midwifery graduation. This information is important in the quest for a stable and satisfied midwifery workforce.

The University of Technology, Sydney has given approval for the study to be undertaken. The UTS HREC REF No is 2007-219A. Do not hesitate to contact Annabel Sheehy for any further details (contact details below).

Those midwifery graduates who ARE working in a midwifery role need to complete sections: A, C, D, E, F, and G (thus leaving out section B).

Those midwifery graduates who are NOT working in a midwifery role need only complete sections A and B.

You can also self-elect to be part of a confidential interview with Annabel Sheehy, which will focus on work-life. This is for all UTS Graduates, regardless of what area you are currently working in.

Please mail the completed survey and interview contact details form (if you have chosen to be interviewed) in the supplied post-stamped envelope to the UTS address.

Thank you.

Kind regards,

Annabel Sheehy

(RM, UTS PhD candidate)

21 Tillock Street

Thornleigh NSW 2021

UNIVERSITY OF TECHNOLOGY SYDNEY

MidTREC

Midwifery Turnover Retention Experiences and Choices

Our MidTREC research team is very interested in finding out what the midwifery graduates of 07/08 are currently doing. This survey asks for information about your work, regardless of whether you are employed as a midwife or not.

SECTION A	**About you**
SECTION B	**Midwives who are NOT currently working in the capacity of a midwife**
SECTION C	**Your current midwifery employment**
SECTION D	**Your job and colleagues**
SECTION E	**Your working environment**
SECTION F	**Your role as a midwife**
SECTION G	**Your future plans**

This questionnaire is anonymous

We would be grateful if you would return the questionnaire to the research team by the Friday November 8th 2013.

A pre-paid envelope has been included for your convenience

Thank you for your help

Section A: About you

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

Please indicate the **most** correct response for you by marking a cross [X] in the box next to the **most** correct response

QA1. What is your gender?

Female ☐ Male ☐

QA2. What year were you born?

__ __ __ __

QA3. In which country were you born?

Australia ☐ New Zealand ☐

United Kingdom ☐ Europe ☐

Asia ☐ Other *(Please specify)*_____

QA4. Are you of Aboriginal or Torres Strait Islander origin or both?

No ☐ Yes, Aboriginal ☐

Yes, Torres Strait islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

QA5. What is the best description of your current personal relationship status?

Currently married or De facto ☐ Single ☐

Other *(Please specify)*_____

QA6. How many children under 16 years old live in your household?

No children ☐ One child ☐ Two children ☐

Three children ☐ ≥ Four children ☐

QA7. Is English your primary language spoken at home?

No ☐ Yes ☐

QA8. Which of the following best describes the area in which you live now?

Metropolitan ☐ Regional/Rural ☐ Remote ☐

QA9. In which Australian State or Territory did you do your midwifery education?

Queensland ☐ New South Wales ☐

Australian Capital Territory ☐ Victoria ☐

Tasmania ☐ South Australia ☐

Western Australia ☐ Northern Territory

QA10. What pre-registration midwifery education have you completed?

Post-graduate diploma or masters of midwifery ☐

Direct entry bachelor of midwifery ☐

Double degree of bachelor of nursing/bachelor of midwifery ☐

QA11. If you were a registered nurse prior to graduating as a midwife, how long did you practice general nursing?

— — — —

QA12. In what year did you first register as a midwife?

__ __ __ __

QA13. What is your current midwifery grade?

__ __ __ __

QA14. How would you describe your current work status? One response please:

Employed: full-time ☐ Employed: part-time ☐

Employed: casual ☐ Full-time home duties or home-carer ☐

Student ☐ Unemployed or looking for work ☐

Retired ☐ Permanently ill/disabled/unable to work

Other *(Please specify)*_____

QA15. In your time as being a midwife, how many hospitals have employed you as a midwife?

None ☐ One hospital ☐ Two hospitals ☐

Three hospitals ☐ Four hospitals ☐ Five or more hospitals ☐

QA16. Are you currently working in the capacity of a midwife?

No (Go to QB1) ☐ Yes (Go to QA17) ☐

QA17. If you are currently working as a midwife, has there been a time when you were **NOT** working as a midwife since registration?

No (Go to QA20) ☐ Yes (Go to QA18) ☐

QA18. If yes to the question "a time when you were **NOT** working as a midwife since registration", please indicate:

How many years and months in total you have NOT been working as a midwife since registration?

____year/s and ____month/s (Go to QA19)

QA19. What was your single main reason for your time out of midwifery?

To care for dependent children ☐

To work in a job other than midwifery ☐

To care for dependent relatives ☐

Ill health ☐

Other *(Tick and specify below)* ☐

addition to your midwifery job(s)?

QA20. Have you relocated your home in order to work as a midwife?

No ☐ Yes ☐ *(Tick and specify below)*

QA21. Did you feel your midwifery education prepared you for working as a midwife?

No *(Tick and specify below)* ☐ Yes *(Tick and specify below)* ☐

QA22. Have you obtained any further qualifications since graduating in midwifery?

No ☐ Yes *(Tick and specify below)* ☐

Respondents <u>NOT</u> currently working as midwives please continue onto <u>Section B</u>

Respondents currently <u>working</u> as midwives please continue onto <u>Section C</u>

QB1.Are you currently working in the capacity of a midwife?

No (Go to QB2) ☐

Yes (Do not answer this section, go to QC1) ☐

Section B:
Midwives who are *NOT* currently working in the capacity of a midwife

This section is only for those people who are **NOT** currently working in the capacity of a midwife. This includes those who have initially worked as a midwife and then ceased, as well as those that never commenced work as a midwife.

QB2. Have you at any stage worked as a midwife?

No (Go to QB3) ☐ Yes (Go to QB4) ☐

QB3. What was your single main reason for never working as a midwife?

Dissatisfaction with midwifery ☐ (After answering go to QB5)

Hours of work ☐

Work conditions ☐

Family commitments ☐

Planned career change outside of midwifery ☐

Planned retirement ☐

Ill health of self ☐

Returned to nursing ☐

Chose to relinquish dual qualification of midwifery (If also a RN) ☐

QB4. What was your single main reason for leaving midwifery?

Dissatisfaction with midwifery ☐ (After answering go to QB5)

Hours of work ☐

☐

Work conditions ☐

Family commitments ☐

Planned career change outside of midwifery ☐

Planned retirement ☐

Ill health of self ☐

Returned to nursing ☐

Chose to relinquish dual qualification of midwifery (If also a RN) ☐

Other *(Tick and specify below)* ☐

QB5. Are you currently working in paid employment?

No (Go to QB9) ☐ Yes (Go to QB6) ☐

QB6. What is your current job? _____

QB7. In your current job, do you work:

Full-time ☐

Part-time ☐

Casual-position ☐

Self-employed ☐

QB8. If you at one stage worked as a midwife, are you more satisfied with your current job than when you were working as a midwife?

No ☐

Yes ☐

QB9. How long had you worked as a midwife at the time of ceasing working as one?

Never practised as a midwife ☐

0 to 6 months ☐

6 to 12 months ☐

1 to 2 years ☐

2 to 3 years ☐

4 to 5 years ☐

5 to 10 years ☐

QB10. How long after initially working as a midwife did you realise that you wanted to cease working as one?

Never practised as a midwife ☐

0 to 6 months ☐

6 to 12 months ☐

1 to 2 years ☐

2 to 3 years ☐

4 to 5 years ☐

5 to 10 years ☐

QB11. Are you considering commencing/recommencing working as a midwife?

No ☐

Yes ☐

QB12. What midwifery grade did you hold at the time of ceasing working as a registered midwife?

__ __ __ __

QB13. Overall, would you recommend midwifery as a career to others?

No ☐

Yes ☐

Please expand on the reason why:

QB14. What advice would you give to people considering midwifery as a career?

Thank you to those who are NOT currently working in the capacity of a midwife - you have completed the survey

Would you agree to being interviewed by the researcher of this midwifery workforce research project about your experiences and career choices? If so, please supply your name and contact details – all of which will be strictly confidential. In supplying these details, you are giving the researcher permission to contact you.

IF YOU AGREE TO BE INTERVIEWED PLEASE FILL IN THE ATTACHED CONTACT DETAILS FORM AND MAIL BACK WITH YOUR COMPLETED SURVEY IN THE SUPPLIED ENVELOPE.

THANK YOU

Respondents currently working as midwives please continue onto Section C

QC1. Are you currently working in the capacity of a midwife?

No (Do not answer this section, you have completed the survey) ☐

Yes (Go to QC2) ☐

Section C: Your current midwifery employment

QC2. Please indicate where you mainly work as a midwife:

Hospital ☐

Community ☐

Both hospital and community ☐

Self-employed ☐

Other *(Tick and specify below)* ☐

QC3. The health service you work for is in which of the following:

Public sector ☐

Private sector ☐

Self-employed ☐

Not for profit ☐

Other *(Please specify)*_____

QC4. Which of the following single response best describes your midwifery employment?

Full-time ☐

Part-time ☐

Casual-position ☐

Self-employed ☐

Agency midwife ☐

QC5. How many hours a week does your current midwifery role require you to work?

_____ hour/s

QC6. On average, how many extra hours a week do you work on top of those required hours?

_____ hour/s cannot estimate as I work on-call ☐

Please specify the main reason for working these extra hours

QC8. If you work part-time, what is your single main reason for working part-time?

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

I choose to work part-time ☐

I have been unable to negotiate full-time hours ☐

Not applicable (Work full-time) ☐

Other *(Tick and specify below)* ☐

QC9. If you work full-time, what is your single main reason for working full-time?

I need to work full-time (Financial reasons) ☐

I choose to work full-time ☐

I have been unable to negotiate part-time hours ☐

Not applicable (Work part-time) ☐

Other *(Tick and specify below)* ☐

QC10. If you work in a hospital, how long have you been working at your current hospital?

Less than 6 months ☐

6 to 12 months ☐

1 to 3 years ☐

4 to 6 years ☐

7 to 10 years ☐

10 to 15 years ☐

15 years or more ☐

QC11. How long have you been working in your current midwifery role?

Less than 6 months ☐

6 to 12 months ☐

1 to 3 years ☐

4 to 6 years ☐

7 to 10 years ☐

10 to 15 years ☐

15 years or more ☐

QC12. What one title best describes that of your main current midwifery role?

Clinical midwife ☐

Clinical midwifery specialist ☐

Management ☐

Clinical Education ☐

Research ☐

Higher Education midwifery education/lecturing ☐

Other *(Please specify)*_____

QC13. Which one area of midwifery work best describes your main current role?

Rotational position ☐
Community midwife (eg. Midwifery support program, outreach program or home visiting) ☐
Antenatal clinic ☐
Antenatal/postnatal ward ☐
Birth centre ☐
Labour and birth suite ☐
Midwifery education ☐
Neonatal nursery ☐
Maternal Fetal Medicine Unit ☐
Parent education ☐
Continuity of care model ☐
Private practice ☐
Education ☐
Management ☐
Other ☐
(Please specify)_____

QC14. If you work in a hospital, are you required to work in general nursing?

No ☐
Yes ☐
Not applicable (Not a RN) ☐

QC15. If you are required to work in general nursing, would you prefer to work in midwifery only?

No ☐
Yes ☐
Not-applicable (Do not work in general nursing) ☐

QC16. Which one 0pattern of midwifery work do you undertake in your current role?

AM shift ☐
PM shift ☐
Night shift ☐
Combination AM/PM shifts ☐
Combination AM/PM/Night shifts ☐

Combination PM/Night shifts ☐

Office hours ☐

On call/continuity ☐

Other *(Please specify)*_____

QC17. Do any of these work patterns apply to your current midwifery role?

Set days ☐

Annualised hours ☐

Job share ☐

Self-employed ☐

On-call ☐

Agency shifts ☐

Not-applicable ☐

QC18. Would you rather work as a midwife in another area?

No ☐

Yes *(Please specify which area)*_____

If yes, please specify the main reason for not working as a midwife in this area at this point?

QC19. Do you currently work in any other paid jobs outside of midwifery?

No ☐

Yes *(Please specify which job)*_____

Please continue survey at Section D

QD1. Are you currently working in the capacity of a midwife?

No (Do not answer this section, you have completed the survey) ☐

Yes (Go to QD2) ☐

Section D: Your job and colleagues

The purpose of this part of the survey is to discover how you view your job and the people with whom you work closely

Instructions

In the following table, printed on this page and the next, are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. To indicate how often you have had a feeling, circle the appropriate number in the column corresponding to how often you believe you have experienced the feeling written in the statement.

Question Number	STATEMENT	How often?						
		Never	A few times a year	Once a month or less	A few times a month	Once a week	A few times a week	Every day
QD2	I feel emotionally drained from my work	0	1	2	3	4	5	6
QD3	I feel used up at the end of a workday	0	1	2	3	4	5	6
QD4	I feel fatigued when I get up in the morning and have to face another day on the job	0	1	2	3	4	5	6
QD5	I can easily understand how the women I care for feel about things	0	1	2	3	4	5	6
QD6	I feel like I treat some women I care for as if they were impersonal objects	0	1	2	3	4	5	6
QD7	Working with people all day is really a strain for me	0	1	2	3	4	5	6
QD8	I deal very effectively with the problems of the women I care for	0	1	2	3	4	5	6

Question Number	STATEMENT	How often?						
		Never	A few times a year	Once a month or less	A few times a month	Once a week	A few times a week	Every day
QD9	I feel burned out from my work	0	1	2	3	4	5	6
QD10	I feel I'm positively influencing other people's lives through my work	0	1	2		4	5	6
QD11	I've become more callous toward people since I took this job	0	1	2	3	4	5	6
QD12	I worry that this job is hardening me emotionally	0	1	2	3	4	5	6
QD13	I feel very energetic	0	1	2	3	4	5	6
QD14	I feel frustrated by my job	0	1	2	3	4	5	6
QD15	I feel I'm working too hard on my job	0	1	2	3	4	5	6
QD16	I don't really care what happens to some women I care for	0	1	2	3	4	5	6
QD17	Working with people directly puts too much stress on me	0	1	2	3	4	5	6
QD18	I can easily create a relaxed atmosphere with the women I care for	0	1	2	3	4	5	6
QD19	I feel exhilarated after working closely with the women I care for	0	1	2	3	4	5	6
QD20	I have accomplished many worthwhile things in this job	0	1	2	3	4	5	6
QD21	I feel like I'm at the end of my rope	0	1	2	3	4	5	6
QD22	In my work, I deal with emotional problems very calmly	0	1	2	3	4	5	6
QD23	I feel the women I care for blame me for some of their problems	0	1	2	3	4	5	6

Please continue survey at Section E

QE1. Are you currently working in the capacity of a midwife?

No (Do not answer this section, you have completed the survey) ☐

Yes (Go to QE2) ☐

Section E: Your working environment

The purpose of this part of the survey is to find out what you think about the quality or characteristics of your working environment

Instructions

In the following table, printed over two pages, are 30 statements of characteristics of your working environment. Please indicate the extent to which you agree to the statement PRESENT IN YOUR CURRENT JOB. Indicate your degree of agreement by circling the appropriate number.

Question Number	STATEMENT	Strongly agree	Agree	Disagree	Strongly disagree
QE2	Adequate support services allow me to spend time with the women I care for	1	2	3	4
QE3	Doctor and midwives have good working relationships	1	2	3	4
QE4	A supervisory staff that is supportive of the midwives	1	2	3	4
QE5	Active staff development or continuing education programs for midwives	1	2	3	4
QE6	Career development/clinical ladder opportunity	1	2	3	4
QE7	Opportunity for clinical midwives to participate in policy decisions	1	2	3	4
QE8	Supervisors use mistakes as learning opportunities, not criticism	1	2	3	4
QE9	Enough time and opportunity to discuss problems associated with the care of women with other midwives	1	2	3	4
QE10	Enough registered midwives to provide quality patient care	1	2	3	4
QE11	A midwifery unit manager who is a good manager and leader	1	2	3	4
QE12	A Director of nursing and midwifery who is highly visible and accessible to staff	1	2	3	4

Question Number	STATEMENT	Strongly agree	Agree	Disagree	Strongly disagree
QE13	Enough staff to get the work done	1	2	3	4
QE14	Praise and recognition for a job well done	1	2	3	4
QE15	High standards of midwifery care are expected by the administration	1	2	3	4
QE16	A Director of nursing and midwifery equal in power and authority to other top-level hospital executives	1	2	3	4
QE17	A lot of team work between nurses and doctors	1	2	3	4
QE18	Opportunities for advancement	1	2	3	4
QE19	A clear philosophy of midwifery that pervades the care of women	1	2	3	4
QE20	Working with midwives who are clinically competent	1	2	3	4
QE21	A midwifery unit manager who backs up the midwifery staff in decision making, even if the conflict is with a doctor	1	2	3	4
QE22	Administration that listens and responds to employee concerns	1	2	3	4
QE23	An active quality assurance program	1	2	3	4
QE24	Clinical midwives are involved in the internal governance of the hospital (e.g., practice and policy committees	1	2	3	4
QE25	Collaboration (joint practice) between midwives and doctors	1	2	3	4
QE26	A preceptor program for newly hired midwives	1	2	3	4
QE27	Midwifery care is based on a midwifery, rather than a medical, model	1	2	3	4
QE28	Clinical midwives have the opportunity to serve on hospital and midwifery committees	1	2	3	4
QE29	Midwifery administrators consult with staff on daily problems and procedures	1	2	3	4
QE30	Written, up-to-date midwifery care plans for all women	1	2	3	4
QE31	Clinical midwifery staffing allocations that foster continuity of care, i.e., the same midwife cares for the woman from one day to the next	1	2	3	4

Please continue survey at Section F

QF1. Are you currently working in the capacity of a midwife?

No (Do not answer this section, you have completed the survey) ☐

Yes (Go to QF2) ☐

Section F: Your role as a midwife

The purpose of this part of the survey is to discover how you view your role as a midwife and your colleagures and the women with whom you encounter in your job

Instructions

In the following table, printed over two pages, are 22 statements of characteristics of your midwifery working role. Please indicate the extent to which you agree to the statement PRESENT IN YOUR CURRENT JOB. Indicate your degree of agreement by circling the appropriate number.

Question Number	STATEMENT	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
QF2	I am valued by my manager	1	2	3	4	5
QF3	I am not an advocate for birthing women	1	2	3	4	5
QF4	I am involved in midwifery-led practice	1	2	3	4	5
QF5	I have the skills required to carry out my role	1	2	3	4	5
QF6	I have the back-up of manager	1	2	3	4	5
QF7	I am not recognised for my contribution to the care of birthing women by my manager	1	2	3	4	5
QF8	I have access to adequate resources for birthing women in my care	1	2	3	4	5
QF9	I do not have a supportive manager	1	2	3	4	5
QF10	I have effective communication with management	1	2	3	4	5

Question Number	STATEMENT	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
QF11	I am not informed about changes in my organisation that will affect my practice	1	2	3	4	5
QF12	I am adequately educated to perform my role	1	2	3	4	5
QF13	I have support from my colleagues	1	2	3	4	5
QF14	I am able to say no when I judge it to be necessary	1	2	3	4	5
QF15	I do not know what my scope of practice is	1	2	3	4	5
QF16	I am accountable for my practice	1	2	3	4	5
QF17	I am recognised as a professional by the medical profession	1	2	3	4	5
QF18	I have control over my practice	1	2	3	4	5
QF19	I empower birthing women through my practice	1	2	3	4	5
QF20	I do not have access to adequate resources for staff education and training	1	2	3	4	5
QF21	I have autonomy in my practice	1	2	3	4	5
QF22	I am not listened to by members of the multidisciplinary team	1	2	3	4	5
QF23	I am recognised for my contribution to the care of birthing women by the medical profession	1	2	3	4	5

Please continue survey at Section G

QG1. Are you currently working in the capacity of a midwife?

No (Do not answer this section, you have completed the survey) ☐

Yes (Go to QG2) ☐

Section G: Future plans

QG2. Have you ever seriously considered leaving midwifery?

No (Go to QG3) ☐

Yes, in the past ☐

Yes, I am currently considering leaving ☐

If you answered yes to QG2, please explain your **MAIN** reason for considering leaving midwifery?

If you answered yes to QG2, do you intend to leave midwifery within the next:

6 months or less ☐

12 months ☐

1-5 years ☐

>5 years ☐

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

No ☐

Yes (Go to QG4) ☐

Don't know ☐

If you answered 'No' or 'Don't know' to QG3, please explain your **MAIN** reason why you may not continue working as a midwife:

QG4. Do you plan to change the number of hours that you work in the foreseeable future?

0 No plans to change my hours at the moment (Go to QG5) ☐

0 Yes, increase my hours ☐

0 Yes, decrease my hours ☐

If you answered yes to QG4, please explain the **MAIN** reason for considering changing your hours worked:

QG5. Which of these best describes your plans for your future in midwifery?

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 to a permanent position ☐

I would like to move into midwifery education ☐

I would like to move into another area of midwifery ☐

*(Please specify)*_____

I would like to progress, but still retain my role as a clinical midwife ☐

*(Please specify)*_____

Other ☐

*(Please specify)*_____

QG6. During your time as a midwife, do you feel your job has become:

More enjoyable overall ☐

Less enjoyable overall ☐

Stayed about the same ☐

QG7. In the future, do you think your job as a midwife will become:

More enjoyable overall ☐

Less enjoyable overall ☐

Stay about the same ☐

QG8. Overall, would you recommend midwifery as a career to others?

No ☐

Yes ☐

Please expand on the reason why:

QG9. What advice would you give to people considering midwifery as a career?

Thank you midwives who are currently working in the capacity of a midwife - you have completed the survey.

Would you agree to being interviewed by the researcher of this midwifery workforce research project about your experiences and career choices? If so, please supply your name and contact details – all of which will be strictly confidential. In supplying these details, you are giving the researcher permission to contact you.

IF YOU AGREE TO BE INTERVIEWED PLEASE FILL IN THE ATTACHED CONTACT DETAILS FORM AND MAIL BACK WITH YOUR COMPLETED SURVEY IN THE SUPPLIED ENVELOPE.

THANK YOU

Midwifery Turnover Retention Experiences and Choices

I AGREE TO BE INTERVIEWED BY THE UTS MidTREC RESEARCHER, ANNABEL SHEEHY (UTS PhD CANDIDATE), ABOUT MY POST-GRADUATION WORK LIFE.

The interview will either be face-to-face or via the telephone. It will be audio-taped. All data collected will be totally confidential and de-identified.

PLEASE FILL IN THE ATTACHED CONTACT DETAILS AND MAIL BACK WITH YOUR COMPLETED SURVEY IN THE SUPPLIED ENVELOPE.

Name_____

Address_____

Home Phone_____

Mobile_____

Work Number_____

UTS Midwifery Education Course_____

Year Graduated_____

Signature_____

Date_____

Thank you

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