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Factors that enable midwives to stay in the profession: why do midwives stay in midwifery?

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ABSTRACT

Background: There is a global awareness regarding the challenges facing midwives to remain in the profession.

Aim: The aim of this study was to understand why Western Australian (WA) midwives chose to remain in the profession.

Methods: This study was undertaken using grounded theory (GT) methodology. Semi-structured interviews were conducted with 14 midwives working in the clinical area. Participants were interviewed about why and how they remain in the midwifery profession. Data were collected from December 2017 to November 2018 and were generated through open-ended semi-structured interviews, together with memos and field notes. The interviews were digitally recorded, transcribed verbatim and analysed and interpreted with the guidance of Glaser and Strauss' (1967) coding stages.

Ethical approval for this study was granted by the Human Research Ethics Committee at Edith Cowan University (record 18747) on 23 November 2017.

Findings: The core category derived from the data was labelled: 'I love being a midwife; it's who I am'. The contextual factors that underpin the core category are labelled: 'My rosters provide me with good work–life balance'; 'You never know what's going to happen [but] I can deal with the bad days because the good days outweigh them'; 'I like my practice environment'; 'It's a juggling act but the women's appreciation is worth it' and 'By looking after myself I'm a good midwife'.

Bronfenbrenner's (1997) theory was applied to the findings in the process of developing them into a middle-range theory of the phenomenon of interest.

Conclusion: The findings of this study provide new insights into workplace and personal factors that contribute to enabling midwives to remain in their profession. Although this study represents midwives in only one geographical context it will be of value to professional and health care leaders.

Keywords: workforce, attrition, retention, midwives, qualitative, grounded theory, Evidence Based Midwifery

Introduction

There is a growing body of literature focusing on why midwives leave the profession. The challenges facing midwives in the workplace that lead to dissatisfaction and attrition are multifactorial. Harvie et al (2019) report the growing number of midwives who feel dissatisfied in their workplace due to the organisation they work for and the midwifery role itself. Similarly, Geraghty et al (2018) describe the work-related stressors midwives are exposed to, leading to burnout. Given the present global and national shortage of midwives (Australian Government 2019) it is imperative to determine what policy makers and health care providers can do, and how, to increase midwives' job satisfaction and intention to stay in the profession. In order to provide a sustainable midwifery workforce, the reasons underlying midwives' choices to remain in the midwifery sector must be understood to ensure sustainable means exist for midwives to remain in the profession.

A recent review undertaken by Bloxsome et al (2019) highlights the paucity of literature focusing on why midwives stay in the profession. It cannot be assumed that the reason midwives stay mirrors why they leave. Understanding this phenomenon will assist in the development of workforce policy and practices, and in turn will help retain midwives in the profession.

This paper reports one aspect of a study to understand why and how Western Australian (WA) midwives remain in the profession. The personal and workplace factors that enable midwives to stay in midwifery are described and explained.

Aim

The aim of this study was to understand why midwives across Western Australia choose to remain in the profession; it was conducted for the purpose of understanding the factors leading to midwives remaining in their jobs in midwifery practice.

Methods

Study design

Grounded theory (GT) methodology was used to undertake this study. Grounded theory has become widely employed by midwifery researchers: Roberts (2008) defines GT as '*seeking to identify and explain what is happening in a social setting*' (Roberts 2008:679). Grounded theory uses a process of constant comparative analysis, theoretical sampling, and theoretical coding (Glaser & Strauss 1967). An inductive process is used to generate substantive codes, later developing a theory from the discovery of emerging patterns of data (Schneider et al 2013).

Grounded theory was chosen as the methodology for this research as it facilitates the quantification and concentration of social data to derive a theory about a phenomenon of interest.

Study setting

The setting for this study was public and private metropolitan, rural and community midwifery practice sites within WA.

Participants

Participants were recruited through advertisement via a social media bulletin. The social media bulletin was posted on the Facebook page of the authors' employing organisation and was available for public view and to be shared in the midwifery community. Further participants were recruited through snowball technique and the final participants were recruited using a process known as theoretical sampling. Theoretical sampling was used to 'thicken' the data categories and generate a substantive theory of the factors that contribute to why WA midwives stay in the profession.

Prospective participants made contact with the primary author. A total of 23 midwives were provided with a study information sheet at their request: 16 consented to participate and 14 were interviewed on one occasion each. No participants withdrew from the study once they had consented to take part. The participants are described in Table 1.

Table 1. Demographic profile of the participants

Demographic variable	Category	Frequency
Years as a midwife	1–5	3
	10–20	8
	20–40+	3
Education	Masters of Midwifery Practice	2
	Post-graduate Diploma of Midwifery	5
	Bachelor degree	3
	Hospital-based midwifery program	4
Health service type – rural	Public hospital	4
	Private hospital	1
	Midwifery group practice	3
Health service type – metropolitan	Public hospital	3
	Private hospital	2
	Midwifery group practice	1
Gender	Female	14
	Male	0

Data collection

Semi-structured open-ended interviews were used; interviews varied from 60 to 120 minutes in duration (average length 60 minutes). Interviews were undertaken from December 2017–November 2018, with a total of 18.5 hours of interview data obtained. Interviews were conducted face to face, via Skype or over the phone depending on the participant's geographical location and/or choice.

The open-ended guiding questions asked to participants were:

- Can you please tell me how long you have been a midwife?
- Can you please tell me what service you work in?
- Can you please tell me what training you undertook to become a midwife?
- Can you please now tell me why you stay in midwifery?

All interviews were audio-recorded and transcribed verbatim by the primary author. All identifying information was removed to ensure participant confidentiality; all participants were given a code, for example, MW1 (which denotes the first participant midwife to be interviewed).

Data analysis

Analysis of the data was carried out adhering to the tenets of GT. This involved three levels of coding: open coding, selective coding and theoretical coding (Glaser & Strauss 1967).

Data were transcribed within one week of the interview by the primary author, manually coded using Microsoft Word and categorised using a constant comparative process. Line-by-line coding was applied: each incident was coded with a key word or phrase, these were then compared with one another as an iterative process involving all authors. Alike codes were then grouped together and given tentative names until no new information was heard (after six interviews); at this point theoretical saturation was reached (Strauss & Corbin 1990).

To ensure heterogeneity and to 'thicken' the emergent theory, theoretical sampling was employed; this was achieved after 14 interviews after which no new information was forthcoming.

Data management

All raw data were stored in password-protected computer files, along with transcribed interview data. Memos were stored in a locked filing cabinet. The research and data produced was managed in accordance with Human Research Ethics Committee guidelines and in accordance with National Health and Medical Research Council (NHMRC) requirements (NHMRC 2020).

Trustworthiness

A number of measures were employed to ensure the trustworthiness of the findings. This study was overseen by an experienced grounded theorist who was involved in every step of the research to ensure rigour of the process. A bracketing exercise was undertaken, prior to the commencement of the study, to ensure the primary author remained open-minded (Husserl & Boyce 1931). Memos and field notes were recorded during and after each interview in keeping with GT methodology (Glaser & Strauss 1967). Participants were involved in the clarification of findings to ensure accuracy (Creswell et al 2007), and a formal member checking group was undertaken involving the research team and three midwives in WA who had made contact and expressed interest in participating in the study. The group confirmed the interpretation of the findings and then agreed the theoretical stance.

Ethical considerations

Ethical approval for this study was granted by the Human Research Ethics Committee at Edith Cowan University (record no. 18747) on 23 November 2017.

Findings

Fourteen midwives who met the inclusion criteria took part in this study. The theory developed from their data, that describe why midwives stay in midwifery, was labelled 'I love being a midwife; it's who I am' and comprises three major categories. Contextual factors that explain how midwives stay in midwifery were also discovered and are reported below. A full description of participants and the report of the theory is available elsewhere (Bloxsome et al 2020).

Five factors were identified that enable midwives to stay in the profession. These were labelled:

- My rosters provide me with good work–life balance
- You never know what's going to happen [but] I can deal with the bad days because the good days outweigh them
- I like my practice environment
- It's a juggling act but the women's appreciation is worth it
- By looking after myself I'm a good midwife'.

One major category is three-dimensional, see Table 2.

My rosters provide me with good work–life balance

Participants unanimously agreed that one of the factors that enabled them to remain in the profession was their roster, for example, MW4 reported:

'I stay because I can work Monday to Friday 9–5.'

Similarly, MW2 stated:

'I stay [in midwifery] *because we have permanent night staff so I don't have to do night shift.'*

MW9 said that, because of the rosters, she was able to achieve a good work–life balance:

Table 2. Contextual factors that enable midwives to stay in midwifery

My rosters provide me with good work-life balance	You never know what's going to happen [but] I can deal with the bad days because the good days outweigh them	I like my practice environment			It's a juggling act but the women's appreciation is worth it	By looking after myself I'm a good midwife
		Dimension 1 Feeling part of a community is important to me – I have a sense of belonging	**Dimension 2** I can work within a culture I feel comfortable in with like-minded midwives	**Dimension 3** Being an autonomous midwife is important to me		

'I have good work/life balance I do my shift, and at the moment it works, I can pick and choose what on calls I want and what suits my family. It's really good I have a great work/life balance where I work at the moment.'

MW10 reiterates:

'I definitely feel I have a good work life balance where I work. They work around me and my children and the family and the community. It has to work for the family not just the individual.'

Managers of the participant midwives were also reported to support this work–life balance: they were very accommodating and provided flexible work arrangements. For example, MW3 stated:

'I'm doing my PhD … this is why my requests are like this … she [the manager] *was really, really good and said ok you need 12hr shifts on these days so we'll give them to you and she was really accommodating.'*

MW4 similarly reported:

'[My] *manager is particularly good with giving me the extra day depending on what shifts my husband is working. Sometimes I'll come in for one full day, sometimes it'll be 2 x 4hr shifts.'*

Another participant (MW11) reported working part time as helping her remain in the profession:

'One of the big reasons why I keep going is because I can work part time.'

MW13 described what balance meant for her: *'It's a balancing act for me … I work part-time.'*

You never know what's going to happen [but] *I can deal with the bad days because the good days outweigh them*

No two days in midwifery are the same, and participants reported enjoying this about the job and the variety and challenge this created.

MW3 said she felt '*one of the draws of labour ward is you never know what's going to happen*'. MW8 also liked the unpredictability of midwifery:

'I like the fact that with midwifery, your days are very unpredictable and in a funny way it makes your day interesting and keeps you alert.'

Similarly, MW12 said that because she worked in a rural hospital, she had a lot of variety:

'Rural is up and down and the quieter periods balance out the crazy. I like the variety I have here. No two births are ever the same.'

MW3 said she really liked the '*complexity of women*'. Variety in the backgrounds and identities of the women they cared for was also stimulating. MW7, as an example, spoke about how she enjoyed working with contrasting cultures:

'Midwifery can be a wonderful job, it's very challenging, particularly when you have that contrast between indigenous and non-indigenous women.'

Unanimously, participants also spoke about the 'bad' days, telling stories about difficult events, such as perinatal loss and not being able to locate the fetal heart, but these days were in a minority. MW14 said: '*It's 99% happy, we have well women*'. For MW2 this was also the case:

'Most of the time it's great, it's only that small amount of the time where it's not great'.

Likewise, MW9 said '*Things do go wrong, but the joyful times are more than the sad times*'.

I like my practice environment

Midwife participants came from private and public maternity hospitals, community midwifery teams, midwifery group practices and rural settings. However, despite their different contexts, all participants thoroughly enjoyed their practice environment.

One participant reported that she felt like part of the furniture: *'I've been at my hospital for 13 years, I know my surroundings, I'm comfortable, yes I feel part of the furniture'* (MW14). MW11 said her practice environment was like a second home to her, referring to her workplace as:

'The mothership': 'It's like my second home and the people that I work with, everybody that works in the labour ward and they've left and come back, they call it the 'mothership' and that is what it's like, it's like the mothership.'

Distance to travel to their place of work was another reported factor that enabled midwives to remain in the profession. Participants enjoyed being able to walk or take only a short drive to work.

One midwife, for example, said: '*The hospital is only 15 minutes away from my house which suits my family*' (MW2). Another said:

'I stay here because I know that from my bed to labour ward it's 20 minutes. So logistically it's a great way to work where I currently live" (MW7).

Another offered: '*I really enjoy where I work, I can walk to my work"* (MW10).

Participants reported enjoying their job, their workplace and the people they worked with, whether it be the model they worked in — '*I stay in midwifery because I work in a Midwifery Group Practice*' (MW5) — or because where they worked was just a really nice place — '*It's a really lovely place to work*' (MW2).

Dimension 1: Feeling part of a community is important to me – I have a sense of belonging

Feeling part of their wider community and having a sense of belonging was an important factor that was specific to participants working in a rural setting. These participants reported wanting to be part of a community because, for them, that's what being a midwife meant:

'When I say it's authentic, for me that's what I wanted, to be part of a community, to make a difference. It's that sense of community, that's what midwifery is, and that's the pleasure and the joy seeing those babies that have birthed here and you see them out and about, that's what I thought midwifery was meant to be, it's not only working with women, it's about working with women as midwives as a team and it's about being in the community' (MW5).

Safety for the women served by the rurally located midwives was another factor that these participants discussed. They felt that midwives were needed in rural towns so that women didn't need to travel hundreds of kilometres for midwifery care. MW9 reported feeling a duty to women:

'If you don't go to work, you don't do overtime, or on call, then the lady has to move out of her community and birth in [a regional centre many kilometres away]. *I do it for a bit of a duty I guess.'*

MW9 went on to say:

'It's my job, it's what I'm good at, it's what I like doing and you need midwives in the town … for better care, for women-centred care to stop that travelling 100kms for a birth. It's for safety.'

MW13 echoed MW9's sentiments: '*I stay in it because of safety; it's all about safety of the women in our community*.'

Dimension 2: I can work within a culture I feel comfortable in with like-minded midwives

A further emerging factor that enabled participants to stay in the profession was a workplace where they felt comfortable with like-minded colleagues. As previously mentioned, in the sub-category labelled 'I like my practice environment', participants' geographical location varied greatly, as did the model they were working in. However, regardless of their chosen model, participants described feeling at ease and able to be the kind of midwife they had always aspired to be in their work environment.

A participant who worked in a continuity of care model reported: '*I became a midwife to provide continuity of care. That's why I stay, because that's intrinsic to who I am as a midwife*' (MW1). Another midwife participant who worked in a private maternity facility stated:

'I can be the kind of midwife I want to be in the private system, I'm more than happy in the private model I see myself there for the rest of my life, I like being with the women without the stress added to it. We all work in different places that suit us and that suits me for where I am in my life and where my midwifery philosophy lies' (MW2).

Being able to stay true to oneself and one's philosophy was an important factor that emerged from the findings. For participants to be the midwife they wanted to be, they had to work in a place that matched their philosophy, with colleagues that felt the same and practised the same way. This is illustrated by MW5:

*'I stay in midwifery because I work in a Midwifery Group Practice, we are all a little bit different, but all have the same philosophy. I can actually practice as myself; I don't actually have to conform to the system in which I work in. I actually can be genuinely myself and practice midwifery as I want to practice midwifery, that matches my philosophy, that I feel is actually woman centred; it just matches me, I feel at ease, I feel comfortable, I don't feel stressed, I don't cry after shifts, I don't get to bed worrying what the 'f**k' have I done to woman today, what have I done to that woman'* (MW5).

Another participant reported that she moved to a very rural location to enable her to be the midwife she wanted to be:

'My enjoyment level improved greatly when I moved to the country because I could work in my full scope of practice' (MW9).

The same is echoed by a second midwife:

'I went to [remote town] *because I could actually work as a midwife,* [and] *that was far more congruent with the way I was taught to work'* (MW7).

Dimension 3: Being an autonomous midwife is important to me

Autonomous practice refers to the ability to provide up-to-date high-quality, evidence-based care to women throughout their pregnancy and their transition to parenthood (International Confederation of Midwives (ICM) 2017).

The value of 'autonomy' was held in high regard by participants and frequented the data set. Participants reported being competent and capable of making clinical decisions and knowing when to transfer or call a doctor. For example:

'I am competent, [and] *capable of making clinical decisions. We actually know what we are doing and we know when woman need to be transferred, we know when woman need to be transferred antenatally, we know when it's outside our scope and when we need that obstetric input'* (MW5).

MW9 also spoke about how fulfilling it is to be able to practise autonomously: *'I do like being autonomous we are very independent'*, as did MW4: *'It's a nice level of autonomy and being able to make those decisions and plan that care.'*

Other participants who had practised both in the city and beyond felt they could only be autonomous if they practised as midwives outside the metropolitan area. MW12 said: *'I like being more autonomous, that is the one thing I like about the country'* and the same view was voiced by MW7: *'It gave me more autonomy working rurally'*.

It's a juggling act but the women's appreciation is worth it

Participants reported that being a midwife in the 'system' was a juggling act. MW1, like others, described having *'so many balls in the air'*. Participants identified these as, for instance, *'the problems in the system'; 'constantly needing to negotiate and bend rules'; 'learning what battles to pick'* and *'learning to cater to the consultant's ego.'*

MW3 stated that she felt *'it was the 'culture vs the policies vs everyone's philosophy'*, and went on to say:

'It's finding that middle ground to keep them [consultants] *happy, the woman gets what she wants, and I can provide the midwifery care I want to.'*

Similarly, MW8 reported:

'It's hard to run that smooth balance in the whole room and not be upsetting the apple cart. So you're not showing up the doctor or dismissing him in front of the woman, not making the woman fearful of what might happen as well.'

Although participants reported finding it difficult to maintain that balance, many reported that they keep going by thinking back to all the thoughtful cards women had given them and reminding themselves why they are midwives. For example:

'When I've had the shittiest day … I think back to those cards we get, the women that go to the trouble of writing you a personal thank you card, I just think it's so amazing. Women that really want you to support them' (MW14).

By looking after myself I'm a good midwife

Participants recognised the need to look after themselves to enable sustainable long-term midwifery practice. As MW1 said, '[I] *allow myself on a couple days to put my own self and my own needs first for my own self-care; I am getting much better at doing that*'. MW7 supported this notion:

'You really have to get that balance right. Yes, you do and you have to live with the decision you make and not feel guilty. In order for me to be sustainable in my profession I needed to take a lot of self-care' (MW7).

Similarly, MW10 reports that '*we* [midwives] *need to learn to let others nurture us as we are such self-nurturers. I don't think we are very good at it sometimes*'. She goes on to discuss the importance of friends and family and how their support is crucial to remaining in the profession:

'I think we need to be more supportive and supporting people; having your friends around for lunch or morning tea is so important' (MW10).

Family, friends, neighbours, pets, colleagues, sleep, prayer, exercise, gardening, reading, crying, music and meditation were all reported as tools that participants used to look after themselves.

Finally, MW13 exemplified the responses of all the participants in relation to self-care in the following interview excerpt. She spoke of how she looks after herself and the importance of keeping a routine for this:

'Midwifery asks more out of your soul than any other job. I only work part time, so I can have my days off to recover. I do an exercise routine almost daily. We (my husband and I) go out together, we walk and we have just a couple of friends that I talk to and de-brief with, I also de-brief with the only other midwife. I pray and it takes a long time sometimes to get over the really bad experiences. It takes a lot of prayer and a lot of soul searching and a lot of insomnia. But I'm very strict, I keep getting up in the morning, I keep getting dressed, I keep doing my exercise, I keep praying and I can get through the really bad stuff' (MW13).

Discussion

The findings reported above represents how WA midwives are able to remain in the profession and highlight myriad contributing personal and environmental factors. The findings loosely resonate with earlier work (Papoutsis et al 2014) in which the determinants enabling midwives to remain in the profession were related to Herzberg's Motivator-Hygiene Theory (Herzberg 1968). However, the wider community component and its influence on the individual, which we would argue is extremely important to consider, is not referenced in the work by Papoutsis and team.

Skinner et al (2014) do, however, recognise the value to some of embedding the practice of one's profession in a broader community service context. Skinner and colleagues investigated work–life interaction in one industry in the health care sector and determined that individuals largely operate on life beyond work; they further assert that focusing solely on the individual, rather than the individual within the larger community, in terms of what underpins job satisfaction is incorrect.

Given this, Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner 1977), which focuses on

the interrelatedness of the microsystem, mesosystem, exosystem and macrosystem and their influence on humans (Bronfenbrenner 1999), provides a more helpful framework against which to explain our findings.

Bronfenbrenner's theory has been used as a theoretical framework in a number of published workforce studies; for example, Eriksson et al (2018) investigated the different uses of Bronfenbrenner's theory in the area of mental health research. They concluded that using the theory to demonstrate the interaction between people and the ecological system is a valuable tool for guiding public mental health policy and practice.

Bronfenbrenner's theory was also employed to develop a work–life fit model for workers in construction organisations in Melbourne, Australia (Turner 2013). In addition, Greenfield (2012) used it to conceptualise a range of aging-in-place (keeping people in their home) initiatives to guide research, practice, and policy.

In relation to the findings reported above, the microsystem relates to the midwife in her or his immediate environment — the workplace, including hospitals, birthing centres, community centres or women's homes.

The mesosystem comprises the interrelations and connections of the microsystem, which is the workplace setting and the people within this — women and colleagues. The focus at this level is on the relationships the individual has with these people in this setting.

The exosystem includes social structures, settings, or events; these can be formal or informal and involve the link between the social setting and the immediate context. The individual does not actively participate in these things but they do have an effect on them. In this study the participants referred to collegial support, social networks and, more formally, the model in which they work.

The macrosystem represents the 'blueprints' (Bronfenbrenner 1977:515) within which one works, for example, the overarching practice environment, health care policy that governs midwifery and maternity care and the professional rules and regulations to which midwives' must adhere.

To date, the principles of Bronfenbrenner's social-ecological model have not been applied in the context of midwifery. Due to the ageing midwifery workforce and the gradual annual decline in the number of midwives employed in the profession, it is imperative to enhance employee motivation within the workplace and improve job satisfaction and wellbeing.

The findings in this study have provided valuable insights into why and how WA midwives stay in midwifery practice. Participant midwives interviewed stay in midwifery because they love being a midwife and feel they make a difference to women in their care. The contextual factors that enabled participants to remain in the profession were factors relating to self-care and work–life balance.

Limitations

The data represent one geographical location and may not be generalisable. Additionally, the views of male midwives, new graduate midwives, or Aboriginal or Torres Strait Islander midwives are not represented. These limitations notwithstanding, the findings provide new insights into what drives retention in this profession.

Conclusions

The findings of this study provide new insights into the workplace and personal factors that enable midwives to remain in their profession. The application of Bronfenbrenner's theory has been used to demonstrate the empirical work on midwives and their work environment and has assisted in the development of a middle-range theory of the phenomenon of interest.

The factors that enable midwives to stay in the profession are individualised and multifactorial. Applying a whole systems approach to the issue of workforce retention would allow organisations and institutions to meet the diverse workplace needs of midwives. Further research is required to develop effective strategies to implement these findings in policy and practice.

The findings of this study provide new insights into workplace and personal factors that contribute to enabling midwives to remain in their profession. Although this study represents midwives in only one geographical context it will be of value to professional and health care leaders.

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