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Original Research

# Understanding workforce experiences in the early career period of Australian midwives: insights into factors which strengthen job satisfaction ☆,☆☆,★

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ABSTRACT

*Objective:* The aim of this study was to explore the experiences of early career midwives in Australia and identify the organisational, work environment, personal factors and stressors that influence workforce participation.

*Design and Setting:* A qualitative study, using in-depth semi-structured interviews, was undertaken with midwives 6 - 7 years post-qualification. Qualitative content analysis identified key themes and sub-themes.

*Participants:* Twenty-eight midwives from one Australian university (graduating years 2007 and 2008) were included. Their pre-registration education was via either a Bachelor of Midwifery (direct-entry) or a Gradate Diploma of Midwifery (post-nursing degree).

*Findings:* Three themes were generated: (i) 'sinking and swimming'; (ii) 'needing a supportive helping hand'; and (iii) 'being a midwife … but'. The initial transition into midwifery was overwhelming for most participants, particularly when providing intrapartum care. Job satisfaction was strongly related to having a well-developed midwife-woman relationship in clinical care and being able to work to their full scope of practice. Dissatisfaction stemmed from remuneration concerns, inflexibility of rostering, high workloads, and poor managerial approaches. Experiences of bullying were ubiquitous. Factors inducing midwives to stay in their profession were not the absence of those that caused dissatisfaction. The midwife-woman relationship sustained their practice despite those factors that caused dissatisfaction.

*Key conclusions:* Building strategies that strengthen job satisfaction in midwives is vital. Strategies that provide relational aspects of midwifery practice, ongoing support, rostering flexibility, induce psychological wellbeing, and address workplace bullying, may assist in the early career transition. Access to continuity of midwifery care models as new graduates is warranted.

*Implications for Practice:* Continued professional development and career progression strategies are needed for midwives to cultivate their midwifery skills and work to their potential.

## Introduction

There are concerns, globally and in countries like Australia, that the number of midwives will not be adequate for future staffing level requirements (Health Workforce Australia 2012; World Health Organization 2016). Adequate staffing and skill mix are important for the provision of safe and effective woman-centred care (National Institute for Health and Care Excellence 2015). There is some uncertainty about whether Australia has enough midwives (Australian Government Department of Health 2019; Health Workforce Australia 2012). It

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is evident that there are issues with retention and maldistribution of the midwifery workforce between metropolitan, rural or regional and remote areas (Longman et al. 2017). Inconsistency of midwifery staffing distribution leads to inequitable access to midwifery care within Australia, notably for women who are socially or residentially isolated (Rolfe et al. 2017). Securing workforce stability in midwifery by providing maternity care settings with competent and reliable staff is integral for the safety and efficacy of health service delivery (Simpson, Lyndon & Ruhl 2016). Therefore, it is imperative to identify professional and personal factors which contribute to voluntary employment termination as well as those which boost retention in the Australian midwifery workforce (Sullivan, Lock & Homer 2011; World Health Organization 2016). Data regarding workforce participation and experiences are crucial for planning sustainable midwifery workforces (Becerril-Montekio et al. 2016).

Despite the number of new graduate midwives commencing, continuing, and completing pre-registration midwifery education being adequate for the Australian population (Australian Government Department of Health 2019), early career midwives are susceptible to burnout and to leaving the profession. In the United Kingdom (UK), younger and more recently qualified midwives working in clinical rotational roles have been shown to experience personal and work-related burnout (Hunter et al. 2019). It is not clear whether this is the same in Australia. Workforce research and data collection is limited in Australia and does not always identify stage of career and whether this has an impact on workforce trajectories beyond the first few years of midwifery practice. Most available research does not separate out midwives at the early, mid and late career time periods (Hunter et al. 2019). However, some Australian research on the new-graduate midwifery experience has been done (Cummins, Denney-Wilson & Homer 2015; Fenwick et al., 2012). This work showed the value of working in continuity of care midwifery models for new midwives as it strengthened collegial relationships between midwives, boosted the support available to new midwives, and contributed to the effective consolidation of their clinical skills. The development of meaningful relationships between midwives and women in these models has been shown for many years to heighten job satisfaction (Cummins, Denney-Wilson & Homer 2015; Sandall 1997). Fenwick et al's (2012) research also confirmed the importance of strong midwife-to-midwife relationships and employment in continuity models to promote confidence in new midwives.

Given the importance of developing and sustaining a fit-for-practice midwifery workforce, it is vital to explore the experiences of midwives and identify the factors which influence workforce participation trends and decision making. The aim of the paper, therefore, is to explore the experiences of a sample of early career midwives in Australia and identify the organisational, work environment, personal factors and stressors that influence workforce participation.

## Method

A qualitative study using in-depth interviews from a selection of the participants involved in an earlier phase of a wider project was undertaken Sheehy et al., (2019). The full study, a two-phased sequential exploratory research, examined early workforce participation trends, experiences and choices of groups of graduating Australian midwives. The study was approved by the university's Human Research Ethics Committee (ref no. 2007-219A) prior to commencement.

### *Sample and participants*

The study re-recruited participants from a previous longitudinal study, who were recruited as students in the final week of their midwifery course (Hammond et al. 2011). At time of sampling for Hammond et al's (2011) study, participants ($n = 113$) were the graduating cohorts from the Bachelor of Midwifery and Graduate Diploma of Midwifery from one university over two consecutive years (2007/2008). Consent to participate in the study included consent to be participate in future research with participants providing contact details, which were kept in a secure database. Recruitment for the quantitative Phase 1 arm of the study occurred in 2015. Phase 1 data collection was an online survey distributed 7- or 8-years post-recruitment. This time frame of recruitment was chosen to examine early career midwifery workforce participation trends, taking into consideration the Australian governmental findings of low retention of early career nurses (Australian Government - Department of Health 2014 ) . The response rate of the Phase 1 survey, reported elsewhere Sheehy et al., (2019), was 66%. Nearly 90% of these participants were still employed in the midwifery profession. Participants were asked in the survey to identify if they were willing to participate in a one-off phone interview. All 29 participants who had agreed to be participants in this qualitative Phase 2 arm, were contacted via telephone. After providing informed consent, a suitable time was arranged for a phone interview by the primary researcher. Ultimately, 28 individuals participated.

### *Data collection*

This exploratory research investigated participants workforce experience, career choices, work environment and personal factors which may have influenced workforce experiences. It utilised a semi-structured method, common in health care interviews (Hennink, Hutter & Bailey 2011). The interviewer engaged the participant with strategic and open-ended questions, to explore the research objectives of examining workforce experiences and choices of participants. This method provided guidance on discussion topics and built rapport with opening questions which steered conversation toward targeted questions about present and past professional experiences. The semi-structured method also permitted deviation from the pre-determined topics to pursue ideas and expand responses, thus unearthing noteworthy, more sensitive and complex information that participants may not have perceived to be relevant to the topic (Hennink, Hutter & Bailey 2011). Due to participants being in varied locations across Australia, interviews were undertaken via telephone and recorded. Interview duration was 60 - 90 minutes. The distribution of participants across Australia, the substantial sample size for qualitative research, and the interview duration generating substantial, insightful data were study strengths that allowed for in-depth data analysis.

### *Data analysis*

The analysis technique aimed to indirectly examine and interpret midwives' perceptions of their profession and employment by considering the way participants chose to communicate within the interview. Qualitative content analysis, whereby the researcher examines patterns of themes and core ideas of complex phenomena within multiple texts, was utilised (Drisko & Maschi 2015). In this instance, the text was the recorded and transcribed interview data. The language and latent content (vocal expression, narrative forms, patterns of speech) were examined closely (Drisko & Maschi 2015). Data were read and re-read systematically, with the aim of classifying the large amounts of text into a workable number of codes. This included the coding and sub-coding of each transcription, indexing and categorising of elements within these data into hierarchies. Analytic reflection by the research team of the distinct patterns within the codes and categories led to the development of themes and sub-themes (Leavy & Saldaña 2014). The circular, refining process of data analysis aimed for consistency and reliability of the develop themes. Adequacy of sampling size was revealed through data saturation. Preliminary analyses and eventual findings were undertaken by the research team, endorsing validity of findings. Finally, discussing the codes and themes with a variety of research participants helped to examine the faithfulness of the codes and findings to their unique experiences, which was another step in safeguarding against biased researcher

invention. Quotes are provided to exemplify the findings with their pre-registration course identified as BMid or GradDip in parenthesis.

## Findings

All participants identified as female and were aged from 30 to 56 years. The majority were working as midwives ($n$ = 22/28). Those not working in midwifery ($n$ = 6) were all working in health-related fields (nursing, university research, health officer for a local health district, staff member at a national health agency). All but one had at some stage worked as a midwife. Five of those working as a midwife also had other jobs in health-related fields. The 22 participants who were practising as midwives worked in varying roles and capacities within the hospital setting, ranging from working six days a week to one day a month (in full-time, part-time, agency and casual capacities, as well as in midwifery group practices). Their positions included: clinical midwife, clinical midwifery educator, clinical midwifery specialist, midwifery unit manager, and parent antenatal educator. The settings included both public and private sectors and in a midwifery care centre, tertiary level hospitals, secondary level hospitals, labour and birth suite, delivery suite, antenatal ward, postnatal ward, antenatal clinic, and high-risk pregnancy antenatal clinic. The distribution of the 28 participants was almost equal in terms of being educated from either a Bachelor of Midwifery or a Graduate Diploma of Midwifery.

There were three principal themes, each of which incorporated subthemes. The themes were:

1) 'Sinking and swimming' - the challenges of the transition into becoming a new midwife;
2) 'Needing a supportive helping hand' - the support requirements of being a new midwife; and
3) 'Being a midwife… but' - the conditions and experiences that lead to the long-term decision making about being, or not being, a midwife.

### *'Sinking and swimming'*

Commencing work in the role of the midwife was perceived as being swift and sudden, and sometimes an unprepared transition, rather than a measured or gradual one. 'Sink' or 'swim' alludes to feelings of being tossed into a 'sea' of clinical work, regardless of whether they felt equipped with 'sea-legs' or not, and feeling submerged or overwhelmed by the challenges of their new employment, for example:

> *It's a busy unit and you actually hit the ground running and so it was either you sink or swim* (BMid).

Confronted by the challenges of her new role, a participant was advised by her manager to:

> *"Deal with it. Sink or swim" she said. Sink or swim! It was very scary. It was sink or swim and I chose to swim. I refused to sink, but it was very frightening* (BMid).

There were five subthemes to this first theme:

(i) 'Possessing a readiness?' included the possession of necessary clinical skills and knowledge imperative for professional midwifery capabilities, including notions of competence and confidence. Expanding from elementary skills involved a hands-on doing and yielding to demanding and challenging scenarios. A common expression for feeling ready to practice was to 'fake it till you make it', subterfuge of displaying proficiency of skills the individual may not have yet acquired and mimicking the actions of seasoned midwives. One participant stated: *I didn't feel confident, I felt petrified…There is an element of bluffing* (BMid). Birthing unit was the setting which inspired fear amongst most of the participants, with statements like this that focussed on the rotational nature of the transitional year causing fluctuations in confidence. For example: *Rotating [through different clinical areas in the first year] gives you zero confidence when you get back to birth unit* (BMid).

(ii) 'Transitioning… and with a learning curve' highlighted the stress from the steep learning curve that the transition into midwifery employment entailed. It comprised of an exponential increase in skill acquisition and awareness of the complexity of providing maternity care. Participants felt strong and overwhelming emotions of: *Stress, heart pounding and mind going blank* (Grad Dip); and like their head was: *Going to explode* (BMid).

Participants felt surprised with what their role entailed, despite having trained in the clinical environment throughout their studies as explained here: *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 the reality of snapping a baby's clavicle* (BMid).

Some participants found it helpful to be employed in the hospital that they were educated in, which flattened the steep learning curve by knowing the hospital processes and systems. This provided participants a wider comprehension of the clinical setting and allowed them to understand the midwifery workforce role and demands which sometimes were broader than the woman they were caring for. Learning to be flexible was part of the learning curve. Last minute relocations to other wards was highlighted to be unhelpful in their transitional year, despite participants being aware this was a staffing stratagem to fulfill unpredictable staffing needs across the whole of maternity. One participant felt a shock in being moved from ward to ward saying: *I felt shock. It was like I was a bit of a pawn, a little midwife, and "She is going to go here and she is going to go there"* (BMid).

(iii) 'Enduring the eye rolling' referred to a profession that participants felt 'weathered' a new midwife, to season them into the realities of practice, and this was seen by senior midwives as an obligatory rite of passage that needed to be endured so as to acclimatise to their new profession. These two participants explained this by saying:

> *There was a lot of passive aggressive behaviour towards new midwives, sometimes quite subtle .. the body language, the eye rolling… that's really unhelpful* (BMid); and

> *"We've all had our turn crying in the pan room, now it is your turn"* (Grad Dip).

The participants felt that there was a perception that newly graduated midwives lacked ability and displayed mediocre skills. They reported receiving sarcastic comments due to their lack of experience, for example: *We were mocked. "Here we go again, she hasn't learnt yet that that's not the real world" and "Complications do happen"* (Grad Dip).

(iv)'Assuming responsibility' referred to how participants felt about the assumption of responsibility and a sense of autonomy, along with the real-life consequences of maternity care. These issues were not apparent to the participants when they were students. This participant explained: *I don't think people realise what the responsibility is until you are actually are graduated and working* (Grad Dip). They articulated that this responsibility was linked to anxiety regarding decision making amidst multi-factorial clinical situations, being unfamiliar with new clinical scenarios, and the importance of birth for women. One participant said: *Women carry their stories for so long in their lives. I'm really aware of that and I want to do a really good job* (BMid).

Frequently, participants wished to have a job that had less responsibility. Many said working in a fast food restaurant would be less stressful. After some discussion, for most this was not an actual desire to have less responsibility but a way of expressing their need for greater clinical support in their new role, due to the: *Dog-eat-dog nature of midwifery, every 'man' for himself, because no one is going to look after you* (BMid).

Positive impressions of autonomy and responsibility also emerged as participants translated theoretical knowledge into practical application of learned skills. The sense of autonomy strengthened clinical confidence and was: *Autonomy that I craved… and the ability to make my own decisions* (BMid). This sense of autonomy and responsibility gained in working in a midwifery group model in the early career period was strengthening to include skill advancement, self-resourcefulness, and professional

competence, for example: *In [midwifery] group practice [models of care] you must stand on your own two feet a little more and that gives you the opportunity to learn quicker* (Grad Dip).

(iv) 'Facing fear' invoked clinical experiences that generated a sense of fear which were universally presented in the interviews. Birthing unit was often perceived as a scary place to work as this participant said: *I remember being terrified a lot in [birth unit]* (BMid).

### *'Needing a supportive helping hand'*

Theme two, 'Needing a supportive helping hand', highlighted the importance of support and referred to various factors that supported early career midwives. The four sub-themes of this theme, discussed below, drew attention to the need for support from other as well as self. Promoting self-learning opportunities to progress and flourish in the profession was perceived as participants' supporting themselves.

(i) 'Personal and practice', the first subtheme about support, highlighted reasons for individuals to need support in their new role. When support was present, it positively influenced learning experiences in practice. Inversely, the absence of support negatively impacted the participants by placing them in clinical situations that participants felt were intense and emotionally demanding. The access to personal support was correlated to positive experiences in practice. Participants said that:

> *To help you stay in your role you need support all around you. You need a bath of support* (Grad Dip); and the
>
> *The intensity of the type of work requires support* (BMid), *because there is a lot of emotion in our work* (Grad Dip).

Midwife-to-midwife relationships were also positive mechanisms of interpersonal support within practice. Collegial relationships which enhanced midwifery morale, group cohesion, and permitted healthy emotional support were beneficial to participants. Such mechanisms of relationship-based support were perceived as vital for instigating good communication and the delivery of safe maternity care, as explained by these quotes:

> *Where I work we are a really cohesive group and we really support each other* (BMid); or
>
> *There is a lack of support, a lack of communication and workplace cohesiveness* (BMid).

Social activities outside of work extended midwifery collegiality. Relationships were said to be strengthened by out-of-work socialisation, which then enhanced practice when at work. For example: *There are a lot of social activities and that contributes to how everyone relates to each other* (BMid).

(ii) 'Mentoring and debriefing' described the processes that enhanced participant relationships with other midwives. These were either formal and hospital-instituted or informal and midwife-led workplace processes. Mentoring and debriefing occurred within relationships in which participants received clinical and emotional support as well as continued education and training. These relationships were with more senior midwives, midwifery educators, or midwifery peers. Most participants considered formal workplace mentoring to be lacking. The recognition by midwifery managers and senior hospital management of the importance of mentoring and debriefing was perceived as rare. Mentoring was important as it involved the personal development of relationships that helped guide the novice midwife. It was perceived as vital for the successful evolution of a new midwife. It was a form of collegial midwifery support, important in a hands-on profession, where: *You learn by doing and having someone who knows what they are doing and can show you physically with their hands* (BMid). These participants explained that:

> *You definitely need some form of mentoring process to help you process things… and learn* (Grad Dip), and
>
> *There wasn't enough value or structure around teaching people, how to teach you or what to teach you* (BMid).

Mentoring was more often undertaken in an informal midwife-led approach. Finding a mentor was strategic, whereby participants were supporting themselves to succeed in the new role. For example, one participant said: *I had my own personal buddy system happening and that is how I survived* (BMid).

Another supportive mechanism that occurred within relationships was debriefing. Debriefing with other midwives was spoken of as necessary to support the new midwife due to the experiential, hands-on nature of the role. The complexity of human experiences and clinical situations meant that participants were frequently being acquainted with new experiences and challenges as a new midwife. Participants needed to talk about situations which they found challenging, so feelings of insecurity, stress or worry did not compound. Debriefing was described as a way of eliminating the build-up of deleterious effects of the midwifery role, with this quote having explained that: *Debriefing is a bit like going into a contamination tent and showering down all the [emotional] contamination for the day and you can come out and feel refreshed* (BMid). Debriefing helped participants learn how to manage the challenges of the role. It was important as a learning tool and vital that it occurred within a safe context. Participants were aware of its importance, especially in its absence, as this participant said: *The lack of managed debriefing meant those experiences where you doubted yourself were just accumulated rather than processed* (Grad Dip).

(iii) 'Systemic support', the third subtheme about support, highlighted specific organisational structures within the hospital system which aided the midwife to work to the full scope of practice. The ability to practise in a full and meaningful way supported midwives to flourish in their new role. This subtheme also referred to participants needing to feel recognised and valued by the hospital system as contributing professionals. Participants often expressed a perception that systemic support was not strongly evident in their workplaces, for example: *There is a lack of clear understanding of the role of the midwife in that organisation. They are lacking policies and guidelines… So it becomes whoever you are working with on the day (*BMid).

Remuneration was often mentioned in the interviews and was perceived as unequal to a midwife's responsibilities. Rather than being a plea for higher wages, it was a demand for systemic acknowledgment of midwifery. This sentiment was repeated in most interviews: *We need more money, we need more midwives and we need more respect as a group* (Grad Dip).

Participants conceived leadership and management to be crucial sites of systemic support which greatly impacted upon staff morale and clinical efficacy. Clinical, hands-on managers were perceived as positive. One participant said: *A good manager should be able to step in when needed, down the pens when she sees her staff are going under* (BMid). Managers effected midwifery staff greatly and it was explained that: *The managers or leaders have the ability either to build the confidence and skills of the workforce or demoralise and deflate people… which doesn't bring about best work performance* (BMid).

Pragmatic and practical support was craved for by participants. This support was varied and diverse. One seemingly simple example were woman-centred policies and guidelines which support participants to know how to practice as a new midwife. Practical support was often seen as lacking in the hospital and it was challenging when access to staffing resources were sometimes scant. Access to designated meal breaks were often cited as elusive. Moreover, adequate staffing and skill-mix were crucial for both learning and safety in the clinical setting One participant mentioned that: *Some one-on-one time with the educators whilst on shift would have been good* (Grad Dip). When shifts did not have adequate staffing or skill mix, participants spoke of feeling: *Out of control. I pressed the buzzer, and no one came. Yeah that's the biggie, the lack of support* (Grad Dip).

Midwifery group practice (MGP) models or those which provided midwifery continuity of care were perceived to have strong staffing and positive skill-mixes. These models were sites of collective knowledge and non-hierarchical support. An example of this perception was: *MGP gave me space, gave me support, gave me time and gave me consistency… My confidence grew really quickly in that role* (BMid).

Unfortunately, most participants spoke of the inability to work in a MGP in the early career period due to: *A longstanding belief that new graduate midwives are not competent to work in continuity of care models* (BMid).

(iv) 'Support with women', the fourth subtheme about support, referred to midwives supporting one another which was at its core driven by the need to support women and provide woman-centred care. One quote, reiterated in varying phrases in the interviews, was: *I have a very strong desire to be a midwife to have the capacity to support women in an effective way* (BMid). Supporting women was perceived as an intangible connection between midwife and woman, for example: *I can be in a room with a woman and not even talk to her, just be there, but I know that she knows that I am there and know that she trusts me and I trust that she knows what she needs to do* (BMid).

A midwife who felt supported by colleagues, management, and the hospital felt better able to positively support women, for example: *When you are in a supportive work environment you feel like you can do more than just survive the hospital system. You feel like you can support women and provide woman-centred care* (Grad Dip).

### *'Being a midwife… but'*

The third and last theme, 'Being a midwife… but', referred to their experience once they had moved on from the initial transition from being a student into a new graduate into actually being a midwife. This theme highlighted the factors of being a midwife that brought satisfaction and dissatisfaction. The positive element was the sense of meaning awarded to the role, with negative aspects being those which inhibited the meaningfulness in their work. The love of midwifery came from a vocational vitality and an aspiration to promote good outcomes for women. Participants spoke of midwife being their '*calling*'. However, frustrations evolved from practising midwifery in a hospital setting and a dislike for negative elements in their job which adversely impacted on their desire to remain in midwifery. Encounters of bullying arising in toxic work environments, and an ethical moral discordancy with the role of a hospital midwife lead to personal ethical reservations about their obligations in the hospital setting. Hospitals were perceived as authoritarian organisations which sanctioned overtly medicalised care and regulated midwifery practice. Many participants spoke of wanting '*to be a midwife, but…*', hence the title of this theme. Although the many sources for job dissatisfaction outnumbered those that lead to satisfaction, those factors that led to satisfaction outweighed negative factors overall. This was due to the powerful satisfaction that arose from the productive, rewarding, and gratifying work experiences that were at the core of the midwife experience.

The four subthemes of this theme described the reward of being a midwife as being counterbalanced by dissatisfaction arising from some aspects of the role. These subthemes were:

(i) 'Being a midwife as a vocation' which described midwifery as a profession of integrity and self-pride with participants feeling: *They had made a difference to women and families* (Grad Dip). The vocational motivation for many participants was evident, for example: *I think midwifery is a vocation. For the majority of us it is a calling* (Grad Dip). Relationships constituted the primary drive for continuing in the profession and job satisfaction was gained by relationships with women. Continuity of care models heightened the sense of satisfaction due to enhanced relationships with women, working to the full scope of skills and ability, as well as these models allowed them to practice in a way that was congruent to their midwifery philosophy of supporting normal birth.

(ii) 'Learning about bullying and territorialisation' referred to the vulnerable position of new midwives in the workplace due to their less senior and authoritarian roles amongst their colleagues. The bullying culture was referred to as pervasive within the participants' work environments. One participant spoke of being belittled to the point of questioning her career choice, saying: *I wasn't valued, I was made fun of, I was picked on, I was bitched about… It was demeaning, demoralising. I questioned why I wanted to be a midwife* (Grad Dip). Another participant considered leaving midwifery due to her encounter with bullying from other midwives, explaining: *I was going to quit being a midwife actually, I experienced really bad bullying… and I was too demoralised and hated it* (BMid).

(iii) 'Managing ethical dilemmas as a new midwife' referred to the poor alignment between their values of maternity care and the actual practices in hospital midwifery. This included undertaking clinical tasks that participants did not feel were justified, thus creating a moral misalignment with institutional midwifery care. Participants spoke of the disconnect between university learning and hospital practices. Medical intervention was perceived negatively, for example: *The intervention is really a bother, there is so much intervention* (BMid). Subservience to medical staff due to their inexperience was discussed as well as the need to protect women against '*obstetric nursing*'. One participant stated: *I didn't feel like I had a voice to stick up for what I saw was happening that I didn't think was the right thing* (BMid).

(iv) 'Withstanding the power of the system' referred to the power to influence and authority to regulate behaviours. Participants spoke of legitimised, yet unjust, forms of power held by the legitimisation of medical authority in hierarchical institutional settings. Midwives spoke of feeling subordinated within the midwifery role, which effected the bodily processes and clinical care of women in the maternity system. The hierarchies were unspoken, tacit influences, as seen by one participant, within which some were privileged to exert power and govern what happened in women's pregnancy and birthing care, so that: *There are hierarchies of power that are not necessarily spoken. The culture 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 feel like an outsider and I didn't necessarily want to be an insider because I didn't always like what I saw happening* (BMid).

## Discussion

This study has highlighted that midwifery satisfaction and dissatisfaction are not necessarily two sides of the same coin. Job satisfaction is not generated purely by diminishing those factors that produce job dissatisfaction. Job satisfaction in new midwives requires the amplification of those factors which encourage the relational aspects of the midwife role and enhance the scope of practice. Availability to work in midwifery practice models such as those which enable continuity of midwifery care, and enhance relationships with women, were considered to be lacking. Continuity models were also distinguished as employment sites which conveyed job satisfaction. These models permitted midwives to work to their full capacity and also expanded, developed and advanced participants' competence and scope of practice. This is important as intention to remain in practice is strongly associated with high levels of employment satisfaction and low levels of professional burnout, with satisfaction being derived from positive relational role characteristics (Curtis, Ball & Kirkham 2006; Fenwick et al. 2018; Jarosova et al. 2016; Skinner, Madison & Humphries 2012; Sullivan, Lock & Homer 2011; Welford 2018). Compatible to other studies, this research demonstrated that remaining in midwifery practice was associated with being able to both develop and have relationships with women as well as make positive impacts for the maternity care of women (Collins 2010; Common 2015; Kirkham et al. 2006; Sandall 1997). The requirement for support for a successful translation to employed midwife was clear. Feeling supported and valued by colleagues and managers has been shown to be crucial (Pairman 2016; Perkins 2013), as is having ade-

quate organisational resources, sufficient staffing, and reasonable shift lengths (Dent 2018; Khademi, Mohammadi & Vanaki 2015). Perceptions of control and flexibility by having working hours meet personal circumstances is also important (Kirkham et al. 2006), with work-life balance identified as a recurrent finding in midwifery workforce research (Fereday & Oster 2010; Prowse & Prowse 2015). Possessing a degree of autonomy within the professional role and determining an individualised personal role as a midwife is another factor recognised as sustaining midwives in their role (Casey et al. 2015; Matthews et al. 2006). Perceptions of autonomy, role flexibility, self-determinism and career development within the midwifery role are known to be influencing factors for remaining in midwifery (Bloxsome, Bayes & Ireson 2019; Jarosova et al. 2016). Specific to the early career period, support programs have been shown to be an important factor in the retention of new midwives in the profession (Dixon et al. 2015).

Research has identified that high levels of dissatisfaction and burnout can be associated with mental health concerns and an increased intention to leave the midwifery profession (Creedy et al. 2017; Pugh et al. 2013). Positive mental health and well-being was evident in those nurses and midwives who reported job satisfaction in an Australian study, with intention to leave decreasing with increasing mental well-being (Perry et al. 2017). Strategies to improve workforce retention of midwives would benefit from the inclusion of interventions to improve quality of life for these professions. Distress and depression arising from negative experiences in the employment setting contributing to occupational burnout has been identified as a major contributor for intent to leave midwifery (Cull et al. 2020). Dissatisfaction with aspects of midwifery employment has been shown to influence decisions to leave the profession (Curtis 2006). In this research, participants spoke of being in ethical and moral disagreement with some practices of hospital maternity care, causing distress because of philosophical misalignment arising from obstetric subordination of the midwifery role. Moral distress has been shown elsewhere to be a consequence of perceived impaired quality of care and asymmetries of power and authority in the institutionalised model of maternity care (Creedy et al. 2017; Cull et al. 2020; Fenwick et al. 2018; Oelhafen, Cignacco & Oelhafen 2018). The data showed that experiences of bullying were described by most participants. This finding of the commonality of bullying experiences is comparable to other midwifery research findings, whereby bullying has been reported to be a widespread experience in midwifery workplaces ( Catling & Rossiter 2020 ). Strategies which address bullying in the workplace and decrease the risk of midwives' being exposed to mistreatment and harassment are important for overall workforce safety, stability, and retention. Universally, the participants spoke of distress and anxiety when working in birthing unit. The requirement for formal support frameworks for new midwives in birthing unit was compellingly evident in this research. This study also highlighted the similarity in findings between the Bachelor of Midwifery and Graduate Diploma of Midwifery cohorts.

### *Limitations*

Although participants were educated by both under-graduate and post-graduate pathways, they were solely recruited from one university. This limitation may be counterbalanced by participants working in varying roles and locations across Australia with data collection focusing on participant working life after graduation. Furthermore, the university is comparable to other Australian universities accredited by the Australian Nursing & Midwifery Accreditation Council. Data were collected at a time frame of 7 to 8 years post-graduation, which may have lead participants to remember and dwell on strongly felt experiences in their transitional year or after, both positive or negative, which were easier to recall and this may have affected participant recollection of their midwifery work as binary experiences of dissatisfaction and satisfaction. However, the timing of the data collection phase is valid due to this research being a study investigating the early years working as a midwife.

### *Conclusion*

The participants desire for the implementation of workforce strategies which enhance relational aspects with women and improve access to working in midwifery continuity models of care was strongly evident. Models of employment which permit fidelity to the full scope of the midwifery role and enhance autonomy and collegiality was also sought. Strengthening aspects of job satisfaction in the early career period, and delivering practical, real support mechanisms for the early career period and beyond, was highlighted by participants as key for midwifery retention. Birthing units were emphasised as needing the formal implementation of mentoring, debriefing and continued education for new midwives. Relieving the profession of all causes of job dissatisfaction is unfeasible. Institutional and workplace investment into strategies which support the psychological wellbeing and relational aspect of the midwifery role are required.

## CRediT authorship contribution statement

**Dr Annabel Sheehy:** Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing, Visualization, Validation, Project administration. **Ms Rachel Smith:** Conceptualization, Formal analysis, Visualization, Writing - review & editing. **Professor Joanne Gray:** Conceptualization, Formal analysis, Visualization, Writing - review & editing. **Professor Caroline Homer AO:** Conceptualization, Methodology, Formal analysis, Visualization, Writing - review & editing, Validation, Supervision.

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## Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2020.102880.

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