Australian midwives' experiences of their workplace culture

Statement of Significance

Problem or Issue	The environmental culture is arguably one of the most important aspects of a workplace. Little is known about the midwifery workplace culture in Australia.
What is Already Known	There have been adverse events and negative outcomes in workplaces with negative environmental cultures. There are high rates of attrition in the nursing and midwifery workforce.
What this Paper Adds	Midwives are frustrated by organisational attitudes that affect their work and describe how this hampers their ability to give quality care. This contributes to fatigue and a sense of powerlessness within the workplace.

Introduction

Health policy is constantly concerned with improving safety and quality of care and rightly so. This

can be seen with perpetual health institution restructures, changing skill-mix and models of care, and

the introduction of new innovations, policies and protocols. All of these can make a difference to cost,

efficiency and streamlining of a health service, but do not always improve safety and quality.[1] One

aspect of the health workplace that may make the most difference to quality and safety is the

assessment, monitoring and improvement of the culture of the workplace.

We all live within cultures that distinguish who we are, what we do and how we do it. Similarly, our

workplaces develop a complex cultural environment that influence how things are done, who does

what, and defines the hierarchical structure of an organisation. Workplace culture (or 'organisational culture') can loosely be seen as the shared ideas, customs, and social behaviour of a particular group of people or community.[2]

A number of researchers have attempted to define the culture of health institutions, although overall it remains poorly defined.[3] Manley,[4] in a discussion paper, described elements of an effective workplace culture as those that develop staff engagement, job satisfaction and empowerment. Essential for a culture of safety both for staff and patients were; shared governance, role clarification, transformational leadership, open communication, teamwork, safety, person-centeredness, support and challenge, lifelong learning and the involvement and participation of stakeholders in the workplace. She attributed the development of a workplace culture to leadership style and efficacy and described the underpinning assumptions of the 'taken for granted' beliefs that define the values and actions of an organisation. The unconscious enactment of those values and beliefs are what staff, visitors and patients 'feel and observe' within an organisation and are often more powerful than what is formally articulated by the organisation itself.

These 'soft' elements of workplace culture can be described as 'social capital'.
These were found to be important in health workplace cultures in Sweden.[5] Social capital, in this instance, is defined as how people interact with one another; a resource and investment in relationships with a likelihood of reciprocity. Other features of social capital include recognition, vertical trust (managers to employee), horizontal trust (employee to employee) and reciprocity[5] These factors in turn influenced job satisfaction and workplace engagement which were predictive factors in the safety and health of both patients and staff. The authors found that social capital affected every aspect of the healthcare facilities in their study. They argued that for an effective workplace, collaboration, trust and justice were essential features of improving workplace relations both horizontally and vertically. Walsh[6] found substantial social capital in a small standalone birth centre in England. He argued that this facilitated exemplary communication, loyalty, job satisfaction and quality care, and that the size of the unit was pivotal to this. Other researchers have stated that a

positive workplace culture is one in which there are shared values, beliefs and attitudes;[7] a caring, progressive, positive team-oriented environment;[8,9] where decision-making is a shared process;[10] and where there is interdisciplinary respect and collaboration.[9,11]

There are many documented reports of health institutions where a poor culture has contributed to negative outcomes of care.[12] Two of the most publicised examples occurred in the Mid Staffordshire[13] and Morecombe Bay Foundation Trusts[14] in the UK. Both the related public inquiry reports documented communication breakdowns between staff, institutions and regulatory bodies that contributed to patient morbidity and mortality and the continuance of a poorly operating workplace. This included severe workforce shortages, a lack of compassionate and quality care, and a failure to take patient, relative and staff complaints seriously. In Australia a culture of dysfunctional behaviours including bullying, intimidation and non-sharing of information has been reported within health services in Queensland[15] Western Australia[16] and New South Wales.[17] Within these institutions, there can be departments that vary widely on the workplace culture spectrum.[3] For example, the Francis report detailed horrific care of patients on some general wards and departments, and exemplary care in others.[13]

Good workplace cultures can have positive effects on retention rates of staff. For example, in the USA, Gifford et al.[18] found that organisational culture was positively associated with obstetric nurses' quality of work life factors, and cultural values were positively related to job engagement, commitment and satisfaction, but not to their intent to leave their jobs. Similarly, predominantly in the USA, 'Magnet' hospitals that are organised around a nursing/midwifery model, have higher staff and patient satisfaction rates, positive outcomes and lower mortality rates.[19,20] These hospitals are so-named as they satisfy a set of criteria that measure the strength and quality of their nursing, and attract staff and patients to their facilities. These hospitals have been linked to greater staff autonomy, and interdisciplinary collaborative relationships that enhance communication and consequently, the retention rates of staff within these institutions are higher.[19]

Literature is limited that specifically focuses on midwives' experiences of their workplace culture in Australia. One study that focused on the provision of postnatal care found midwives felt a lack of ownership towards change brought about by third parties, and a general negative culture existed within the postnatal workplace.[21] Another qualitative study by Hastie and Fahy[22] studied the collaboration in 10 maternity units in Australia and found that doctors and midwives were influenced by the local culture and organisational factors that promoted or inhibited positive interactions.

Midwives in Australia mostly work in public or privately funded hospital-based maternity units but can also work in health centres, General Practitioner practices and private rooms with obstetricians, as well as their own private practice. There are a number of models of maternity care available, including obstetrician-led, GP shared care, and midwifery-led care. Midwifery-led models of care may consist of individual or group practices and involve varying degrees of continuity of care. Midwives in Australia may work in either medically-led or midwifery-led care models. Some midwives provide care to women across the spectrum of antenatal, labour, birth and postnatal care, whereas others focus on only one aspect of care e.g. intrapartum care. A number of midwives work in private practice as well as within hospitals. Hence Australian midwives' workplace, environment and experience of workplace culture can differ widely. Differing cultures may impact on safety, as seen in the study by Cheyney et al.[23] who described the sociopolitical differences and 'cross-cultural interactions' of midwifery and obstetrics when transferring women with labour complications to hospital from home (p. 453). This study outlined the differing perspectives on risk and philosophies in relation to childbirth between midwives and obstetricians which lead to a lack of respect and understanding, and a breakdown in communication.

The culture of a particular organisation can arguably be one of its most important aspects from the perspective of those who work there. This study asked 'what comprises the midwifery workplace culture in Australia?' and aimed to broadly explore the midwifery workplace culture from the perspective of midwives themselves. It discussed the need to further examine the culture of the

maternity workplace in order to retain midwives in the workforce and provide safe high quality care to women and their families.

Methods

The underpinning methodology used was qualitative description using methods by Milne and Oberle.[24] Group and individual interviews were undertaken of urban, regional and rural-based midwives in Australia. Participants were purposively recruited from three capital cities and three regional/rural areas in Australia, using online midwifery social networks. The cities were chosen as these were the most populated urban cities in the country, and the regional/rural midwives were selected through a snowballing method as participants notified their colleagues and wider midwifery networks to join the study.

Using the neurophysiological SCARF® framework,[25] semi-structured interview questions were asked related to participant's Status, Certainty, Autonomy, Relatedness and Fairness within their workplace (Box 1). Each domain of the SCARF® framework related to feelings and perceptions of staff within the workplace. This framework has been used in practice to explore how individuals engage with their environments within the discipline of business as well as nursing[26] where the authors stressed the importance of the nursing workplace culture in relation to its domains. In our study, we drew on the framework to inform the initial research design, using the domains identified in the framework as the basis for creating interview questions. This gave structure and focus to the interviews, but did not appear to constrain the free expression of participants. Data analysis was inductive, and it was not intended to use the SCARF® framework as an analytic framework.

Box 1. The SCARF® framework[24]

The SCARF® framework consists of five domains that underpin how individuals engage with their environments. These are:

- Status: The status of employees can be raised by recognition of their work through praise, compliments and valuing their contribution to the organisation. With a hierarchical approach, a managerial dominance over employees can promote fear and despondence.

- Certainty: A sense of reward is felt by employees when there are defined role classifications and boundaries within practise. Conversely, a lack of support and a lack of certainty regarding roles and tasks creates stressed employees.

- Autonomy: Employees will have a sense of control over events and have a degree of workplace autonomy within their scope of practise. They are not micromanaged, and have the ability to make decisions in the course of their work. A lack of autonomy creates despondent, under-confident employees.

- Relatedness: Employees will have a sense of safety with others. There will be workplace collegiality and an effective team philosophy. A lack of relatedness within a workplace creates mistrust, fear and unproductivity.

- Fairness: Transparency within a workplace, shared decision-making and open managerial processes involving input from all staff encourages a sense of fairness within a workplace. A lack of fairness may be felt when managers do not involve staff in workplace decisions, and there is an 'us and them' mentality

Interviews lasted up to two hours and took place in participant's homes, over the telephone, as well as locations in three capital cities in Australia. The interviews were audio recorded, transcribed and inductively coded within NVivo using thematic analysis by the first author.[27] This was an iterative process that begun with coding raw data and later grouping these into larger themes. Codes were discussed with co-authors, refined and sent to participants to further authenticity and validation. All

transcriptions were de-identified, and participant anonymity was assured. Ethical approval for the study was given by the University (HREC ETH16-0399).

Results

There were 23 participants in this study. Most participants (n=19) worked in hospital maternity units, two of which were private hospitals. Eleven participants worked in a continuity of care model (e.g. midwifery group practice, private practice), and three were located in rural and regional units (see Table 1). Most participants in this study were senior midwives (median age 51 years) who had worked in various midwifery roles for a median of 21 years (range 3 months – 51 years); there were two new graduate midwives and one was a Bachelor of Midwifery student (i.e. not nurse-trained). All participants spoke passionately about their jobs and how their workplace affected their ability to practise midwifery. Five themes were identified from the data. These were *Bullying and resilience, Fatigued and powerless midwives, Being 'hampered by the environment',* and *The importance of support for midwifery.* These themes will be explored in more detail below.

Table 1. Demographic data of participants

Workplace	Hospital	Community	Community and hospital-based		
	19	2	2		
Model of care	Continuity of Care model*	Obstetric-led private	Obstetric-led public	Private practice	
	10	2	10	1	
Role§	RM^	CMC#	Manager~	Student	Lecturer
	14	1	6	1	1
Length of practice	Range		Median		
	3 months – 51 years		21 years		

Hours of work	Full time	Part time	Casual	
	10	8	6	
Age	Range		Median	
	24-61 years		51 years	
Educational Level	Bachelor's degree	Master's degree	Midwifery certificate	PhD students
	7	7	5	3
Region	Urban (population >100,000)	Regional (population ~25,000)	Rural (population ~5000)	
	20	1	2	

* This was described as Midwifery Group Practice, Continuity model, Team midwifery, GP/midwifery and caseload

^ RM=Registered midwife

§ This describes the role of the participant in their workplace. All participants (bar the student) were RMs.

CMC= Clinical midwifery consultant

~ The managers also described a clinical component to their work

Bullying and resilience

Many participants spoke about being aware of bullying and conflict in their workplace, and some spoke of instances where they were victims of bullying. Bullying was seen as being linked to 'us and them' cultures with hierarchical structures. In particular, new midwifery staff and students felt they

were targeted, and were seen as 'outsiders' to the organisation. One midwife explained that she thought some victims were too tired to fight the perpetrators:

> *It's like having the words to be able to counter the staff that do the backstabbing and unpleasant words. I like the phrase: 'the standard you walk past is the standard you accept', you have to be strong in your own beliefs to say 'that's not acceptable', it's hard to deal with conflict in these situations. A lot step back in order to protect themselves and are too tired to fight. C1*

The same midwife had been a registered nurse for many years before coming into midwifery and felt that in comparison with nursing there was less conflict and bullying working as a midwife, stating:

> *There is only nibbling of their young, they* [the midwives] *don't actually eat them C1*

The midwives who worked in midwifery-led continuity of care models (or 'midwifery group practices' [MGPs]) discussed how they were sometimes marginalised within the wider unit, which led to antagonism. Midwives who work in MGPs often work in a separate area to those who work in labour wards (usually an alongside birth centre). They may not wear the regular hospital uniform, often work in pairs or small teams and have responsibility for a caseload of women, caring for them throughout the spectrum of pregnancy, birth and the postnatal period. One midwife had seen the antagonism towards MGP midwives elsewhere, as well as her own workplace. She said:

> *I've noticed that within other hospitals too – 'you think you're special, we will bring you down a peg or two'.* R3

Another midwife expressed disbelief at this ongoing resentment towards midwives who were able to work in a continuity of care model:

> *Why are we so negative towards the people* [midwives] *who are able to give such great care? I don't understand it.* S5.

There appeared to sometimes be a hierarchy of midwives on the ward. This participant described 'factions' of midwifery staff on her unit that had a specific hierarchical structure. She said:

> *.. Then you have the students, who are frequently in the pan room* [or sluice] *crying, and then you have MGP midwives who are at the bottom of the pecking order* R3

However, MGP midwives were not alone in their demotion to the low end of the hierarchy. Midwives working as antenatal educators also described this treatment:

> *The way we are treated is extraordinary - often we are treated like air hostesses or tour guides and we are spoken to as though that's all we do and some people who are in charge of shifts don't like to make a room available to show the women and yet if those women came in and had never seen a room before, we would get the blame for it* M10

The bullying within a workplace contributed to one midwife expressing physical symptoms of stress. The same midwife was contemplating leaving her workplace. She said:

> *I get palpitations when I walk into work, it's very, very stressful. I've stopped sleeping; I lie awake at night and think about my future* R3

Some midwives demonstrated their own resilience strategies to cope with the interpersonal conflict and relationships. One junior midwife stated how she found the social/interpersonal side of working as a midwife much more challenging than learning the clinical midwifery work. This midwife kept a diary of all the little things that she learnt and needed to remember; in particular the names and personalities of midwives were vital:

> *I find that so far the clinical skills in the job haven't been difficult for me, it's the orientation to people when you don't know anyone that can be challenging. You don't know which midwives in charge are easy to relate to, which senior midwives are going to walk off from you when you want to do a drug check with them.. just learning 'people' is the thing that is taking the time* C6

Another senior midwife, being new to an organisation, went to great lengths to know her colleagues and be accepted into the maternity unit, although she explained that this was difficult to do, given all the other things she had to learn by being new to the organisation. She also kept a diary and would often run to the toilet to write things down in private in order to remember them and bring them up in conversation with her colleagues:

> *I've tried to be really, really friendly. I carried a book and wrote down names, their children's names, some people's pets, things that were happening; there was so much to learn I was feeling overwhelmed, I couldn't hold all the other stuff in because I was trying to build relationships* R3

This theme encapsulated how horizontal violence between midwives remained an issue within the Australian maternity workplace. Some participants showed elements of resilience and coping mechanisms, but it was apparent that bullying caused great stress, dismay and even physical symptoms in some.

Fatigued and powerless midwives

Participants discussed their sense of powerlessness to change things within their workplace, and as a consequence of this, midwives felt fatigued and fatalistic about their workplace. There was a great sense of not being heard by the organisation and this contributed to their helplessness and sense of lack of fairness in the workplace. One midwife expressed this:

There is a great sense of fatigue and 'you can't change things' and 'you can't change this' and 'it's always been like this', 'it doesn't matter anyway', 'I don't have a voice', 'we tried that it didn't work', that sort of story, that's the narrative, we just shrug our shoulders and do what we have to toe the line R3

Another expressed how she was tired of having to stand up to midwives who acted unfairly to other staff:

Whereas once I might have said 'hey give her a chance, she's only been out for about 6 months', I try to ignore it as it's another battle I just don't have the energy to fight at the moment. It's probably how quite a few people feel so therefore these poor new grads are getting picked on just constantly, the cycle never ends S5

One midwife described how she felt insignificant and ignored regarding unanswered emails to managers about workplace issues:

Given I'm a pawn in an industrial assembly line, I have very little [power], *except when I'm in charge, slightly more ... within the organisation there is an almost sadistic delight being taken in oppressing initiative, discouraging staff through lack of consultation and collaboration in the workplace ... I currently have five outstanding emails that have been completely ignored – about clinical concerns.* M4

All participants described feelings of not being heard and having little if any input into the organisation. This was amplified if staff were working casually (i.e. similar to having a 'zero hours' contract); participants discussed how they did not get group emails or notifications relating to their workplace. In many cases, suboptimal practice brought to the attention of managers was not addressed. In one whistleblowing case, a participant stated that her concerns were not taken further:

I reported it and put it in the notes and I got hauled over the coals about it. 'It's a big allegation – this doctor has been around for a long time, you've just been here a year'. I said 'perhaps I'm the first to speak up about it' M4

Participants were described as having a lack of energy to join committees to help improve and change practices to keep in line with evidence. This was due to organisations that often do not provide for, or encourage midwives to do more than work shifts on the ward/unit. One participant expressed this:

You have to use your private time if you want to change things, for example change a policy. We have review committees for people that are interested and you can join a working group and help but there is a lot of time and effort involved and full-time midwives don't have the energy for it C8

Other midwives described some midwives as having 'compassion fatigue' meaning that they had lost their ability to feel empathy and compassion towards women, and in turn were not practicing woman-centred care. These midwives were described as working in a task-oriented way because of time constraints and large workloads. They said:

I think much of the burden in the hospitals is from midwives who have been there far too long, who have compassion fatigue, task oriented staff who are not woman-focused M2

Other midwives who do not have the passion have just been beaten, their workloads are too big, and they don't have the time they need to do the observations, give drugs. There are so many caesarean sections, they all need their trial of voids[1] etc. Everyone is focused on tasks and not on people because there is no time to care.. It's got worse over time, they get bashed

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[1] A 'trial of void' is a way of assessing the ability of the bladder to empty. Women's bladders are often assessed after birth.

down, every time you try to do something you get bashed down. There are a few of us that do

care, but others think 'why bother, let's come to work, get paid and go home' M3

As a consequence of being powerless, participants expressed a lack of investment and belief in their workplace. For example:

I have no investment or interest in contributing to that workplace … I'm looking forward to [retraining in a field outside of midwifery] *as an alternative to the system I work in that I am increasingly disgusted in* M4

Just under a third of participants felt they were able to provide enough input into their workplace and were satisfied that any concerns they had, or changes they wished to make were taken seriously and considered. These participants were from smaller units in rural areas and/or worked in MGPs.

Being 'hampered by the environment'

Participants discussed how they worked in a system that often inhibited woman-centred care. This was due to excessive workloads, risk-averse policies and a fragmented, task-oriented workplace. In order to work in the way they wanted to, midwives described how they 'manipulated' their work to become more woman-focused. For example, midwives can selectively report on women's progress in the second stage of labour to afford them more time to spontaneously give birth, rather than be rigid about timespans written in guidelines. Midwives felt this was necessary for good outcomes in the women they cared for. For example:

We know that we can be manipulative midwives for the better of women S1

As you become more experienced and confident, you don't care to some extent how many people 'tell you off' for working a little outside the guidelines – but its enjoyable to say that doing it that way actually worked for that woman – that's being 'woman-focused' M6

However, this came with a need to justify your practice to others, as expressed by this participant:

You continually have your antennas out to protect your women, and protect yourself S2

A number of participants expressed how 'real midwifery' was hard to practice in their units. Instead they considered that they operated as 'obstetric nurses'. 'Real midwifery' could be loosely described as being able to provide individualised continuity of care to women within a social model of care, focusing on normal physiology and her needs, not those of the organisation. One participant described how she was actively discouraged from providing one-on-one care in labour and providing women with informed choice and individualised care:

The basis of the conflict is that in order to survive, they have thrown 'midwifery' out because you can't do that and survive in this unit, and they want me to do that but I'm resisting… The job itself is fantastic, but the workplace is terrible, so there is an immediate misfit – you can't do your best work because you are hampered by the environment and the attitudes, and they are attitudes that are held with authority, so I have had quite a bit of conflict because I'm too old and too cranky to be told I can't stay with the woman when it's on my contract R3

Many participants expressed their love of midwifery, but their dismay with their workplace. One participant left midwifery for two years because of the workplace environment and seeing '*emotional and physical abuse of women*' M6. Another stated how she was aware of colleagues leaving the workplace due to the conditions and culture, but having no exit interviews, this was not recognised or acknowledged. Another, aware of the quality care she provided to women, and described wanting to leave her workplace:

I can't explain in words how I love midwifery – my passion for the job. But I hate working where I work at the moment. Not only that, I want to leave, which makes me sad as I love working in a place offering a service that women get for free, that they can come to and get first class service S4

Participants described working in public health organisations which were very obstetric-focused; the power of the organisation was with the medical staff and there was a lack of midwifery leadership. One participant described how this negatively affected the care of women in her unit:

New registrars come in and they have their own ideas, but they practice with such conservatism due to the need to keep the VMOs [i.e. visiting medical officers/consultants] *happy. They are frightened of the VMOs … it's quite horrifying, and the VMOs don't see each other's practice so old habits are regenerated. They practice with a lack of evidence, it's just abysmal … episiotomy rates of 14% and 30% caesarean are anathema to me – we had that* [caesarean section rates] *at 15% in 1988, its concerning that it's gone backwards so quickly. What do you do about it? Also concerned about leadership – for change, we need leaders that fight in there with you and for you. I'm just not seeing that* C5

One participant who worked within a private institution described how difficult it was to witness suboptimal care, and how she actively changed her working environment to increase her job satisfaction and ensure women had quality midwifery care:

The decisions are made by the obstetricians, not often informed decisions made by the women. They are led by the obstetrician's philosophy so trying to give them more information so they have more freedom of choice and information is very difficult… I still find that challenging, which is why I started working privately with these women in a private

midwifery practice. This is what nourishes me, what gives me great joy and makes me feel like

a midwife M1

Another important aspect of providing midwifery care was the level of control participants had over their work. The participants who worked in a continuity of midwifery-led care model described higher levels of autonomy and control over their work than the ward midwives. They could schedule personal appointments for themselves and balance their work with their colleagues, or stay later to make up their hours. Other workplaces had an active 'time in lieu' system. For example:

In caseload it was great – we were answerable to ourselves and our women, we work flexibly

and know what our week was going to be like. We did not get pulled into Delivery Suite and

we had two weekends off a month and changed our days off to suit our clinics and births. We

managed it ourselves and it worked wonderfully S1

In contrast to this, the participants who worked on the wards described little control or flexibility over their working day. One participant had suggestions on how flexibility could be introduced for midwives with childcare commitments:

I get no control whatsoever, even though the midwives on the wards looking at the staffing

sheets see where there could be some flexibility and creativity. For example, midwives with

school age kids could do a 9am-2pm shift S4

The importance of support for midwifery

Participants spoke of the resources and support in their workplace that enabled good quality midwifery care and contributed to a positive workplace culture. Many spoke of exemplary support from their colleagues, managers and other allied health and medical staff, whilst others stated the lack of support and resources hampered their care of women and families. All participants discussed

colleagues who they felt were role models and some felt they had mentorship from some influential leaders in midwifery in the past that fueled their desire to provide quality midwifery care.

One participant working in a rural area described the support between two teams in her unit:

> *Everybody is helpful. We have two teams here, a midwifery group team, and a core midwifery staff. We have done some work on how we interact between each other … it's hard for each team to support the other when they are busy, but I think we are doing the best we can. Sometimes it's so busy that it's hard, but within the MGP team absolutely it's supportive when someone's busy you can usually find somebody to come in and help you out* R2

Another working in a large urban hospital stated:

> *In terms of clinical support, I have been supported well thus far. Lots of midwives come and say 'do you need anything?' It's nice having somebody available to you as back up* M6

One aspect of working in a cohesive, functioning team was recognition for a job well done. This enhanced a staff member's self-esteem, and enabled a feeling of satisfaction that her colleagues recognised and valued the often difficult, physical and emotional work of midwifery. Participants described various ways this was done in their workplace. One participant working in a rural GP/midwifery shared care unit stated:

> *I find that the midwives are very supportive of each other so things like congratulating each other for a job well done … so say you have been part of a beautiful, gentle birth so at handover it's not uncommon for the midwife who was perhaps present at the birth helping the accoucher to sort of say 'So and so did a great job with that birth!' So that recognition of your role, the appreciation … we do that well here* R1

The workplace culture is closely linked to staff well-being and morale, and their ability to work effectively in their jobs. Enabling midwives to give good quality care to women necessitated having enough staff within the workplace. All participants described how their workloads were excessive at times due to poor staffing and they were aware of how this affected their ability to care for women. Staffing crises became a perpetual situation for one participant who worked in a private organisation. She described her experience:

> *In the private system there is no time to care about the women because their ratios are so high - sometimes 1:10 or 2:10 ratio - and you are sharing with an EEN* [endorsed enrolled nurse] *and so the women aren't really getting very good care ... we work on the lowest possible – what we can 'just get away with' so at the end of the shifts we go 'whew – got away with it again'.. it's all crap day after crap day after crap day, but it's like 'you did it last week, so you can do it again'* M1

Others described how there was no pool of midwives in which to draw on when staff have sick leave. This meant that staff were asked to work double shifts to cover the shortfall. This led to one participant expressing there were *'tired and exhausted midwives on shifts and especially in the last year we have been continuously full, so we are often not able to give the care that women need and deserve'* C8

All participants expressed their desire for facilitating normal birth. However, resources to enable this were lacking in some organisations. One participant expressed how she felt her workplace environment negatively affected women's ability to have a normal birth:

> *It doesn't have the resources because it's not woman-focused and so there's insufficient equipment to use in order to assist women properly and thoroughly in the birth process, and the architecture of the place speaks volumes about their focus. It's absolutely horrendously horribly ugly and industrial and machine-focused and the rooms are really small* R3

Another important human resource was the midwifery management team. Strong stable and visible midwifery leadership and management was a vital element in a functioning workplace. Without it midwives were left floundering unsupported and unhappy. A number of participants described great leadership from their managers. One said:

I work in a postnatal ward and I think our culture is extraordinary because of the leadership; we have a director who believes in respect and kindness and she is extremely careful and connected to every midwife in the unit, so she is a role model for everybody C9

Others described poor managerial support and what that meant for them and the women they cared for. One participant described the effect of poor management on a maternity unit:

You can't hold those models – sustain them - if you don't have the support from management… It's been a centre of excellence, there have been lots of models that have grown here and it's the place where everybody wanted to work. We have slowly been witness to it disintegrating which makes me personally very sad, because the winners are certainly not the women, not the midwives and certainly not the obstetricians S5

Overall, the themes in this study show the Australian midwifery workplace culture is a complex environment. It is underpinned by the quality of managerial and peer support, environmental and policy factors that dictate midwifery practice, and the level of input and power available to midwives within their workplace.

Discussion

This study found a diversity of midwifery workplace cultures. Dominant themes were *Bullying and resilience, Being 'hampered by the environment', Fatigued and powerless midwives,* and *The*

importance of support in midwifery. Limitations include the all-female small sample size and small numbers of rural/regional-based participants compared to the urban-based participants. Participants had a high median age (51 years), although this was reflective of the median age of Australian midwives nationally.[28] Participants may have also been more likely to have strong views regarding their workplace as they self-selected to take part in the interviews, knowing the subject of the study. As such, participants may not be reflective of the wider midwifery population, and the findings of this study may not be generalisable.

Participant's responses resonated with the SCARF® framework domains. This could have been partly because the domains were used to structure the questions to participants (although domains were not used to code the data). However, throughout the interviews participants raised these issues independently, outside of the questions asked, for example in the *Bullying and Resilience* theme, participants raised issues that cut across the domains of status, autonomy, relatedness and fairness. Their **status** in the workplace was discussed widely in relation to how valued they felt by peers and managers; most participants had a defined scope of practice at work (**certainty**); **autonomy** was important - most felt this was lacking, however others (often working in continuity of care models) experienced significant autonomy; there was a wide range of collegiality experienced amongst participants (**relatedness**); but most felt they had little input or voice within the organisation (**fairness**). Participants discussed the relationships with their colleagues at length and there were reports of great collegiality and collaboration, but also clear evidence of undermining behaviours and bullying.

Despite governmental, organisational policies and in-service training, bullying remains a major issue within the workplace. This study found that this occurred both from managers, colleagues and obstetricians, with a hierarchical nature to the behavior. Midwifery students were targeted, as were new staff. This has been seen elsewhere,[29] and in Victoria, Australia, Farrell and Shafiei[30] found that a third of nurses and midwives experienced bullying from colleagues or managers/supervisors. In the UK, Hunter and Warren[31] found midwives employed many approaches to deal with workplace

adversity, which included conflict and bullying. Resilience-building strategies included engaging collegial support, separating work from home and having a strong sense of self that was able to transcend the undermining behavior. Midwives in the current study also described some of these resilient approaches: having personal self-esteem, optimism and seeing oneself as having resilient attributes enhanced their ability to cope with the bullying behaviours.

Bullying has many consequences, both at an individual, group and organisational level.[32] The Illing Report on bullying state there are negative psychological, physical and relationship concerns along with higher rates of sickness, job dissatisfaction, turnover and a consequent lower quality of patient care. Taking these factors into account, it is estimated that the annual cost of bullying to UK organisations is over 13 billion pounds (26.4 billion AUD). This report, as well as the Francis Report and the Morecombe Bay report prompted the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK to develop a comprehensive kit to improve workplace behaviours in this area.[33]

Recent work by Crowther et al.[34] exploring concepts of sustainability and resilience, argued that 'the environment will look after us, if we also look after the environment' (p.46), meaning that in order for midwives to flourish, there needs to be significant sociopolitical and infrastructural changes to enable midwives to have more control over their working environment. Our study showed that some midwives described workplaces with high levels of peer and managerial support, flexibility and collegiality, whereas others reported the opposite.

New models of care may create tensions as well as offering solutions, especially by creating sub-cultures. Participants described hostility towards those that worked in MGP models. This, as well as philosophical clashes, has also been reported in other states in Australia and a general lack of support towards MGPs within organisations themselves.[35] Greater emphasis needs to be placed on providing positive cultures across all environments, and in particular, giving midwives input into, and control over their workplace.

One of the other main themes in the data was that of midwives not feeling heard by their management; they felt fatigued and powerless to change aspects of their work and workplace. This has been reported elsewhere, with additional barriers of overwhelming bureaucracy and centralisation contributing to feelings of powerlessness and repression.[36] Some reported that their concerns about safety issues within the workplace were not taken seriously. In particular, one 'whistleblower's' concerns were not only ignored, but dismissed as not valid; the reason given that she was 'new to the workplace'. Whistleblowing, or having avenues to escalate serious quality and safety concerns in the public interest, is encouraged and recognised by the Australian government.[37] However studies on health professionals and whistleblowing have highlighted the too often isolating outcomes for these professionals. Workplace relationships are highly important in providing safe avenues for staff concerns and whistleblowing, especially when it concerns malpractice and vulnerable groups.[38]

As well as having collegial relationships within the workplace, the ability to practice in a woman-centred way was important to participants. Whilst midwifery guidelines and codes of practice in Australia stress the importance of a woman-centred framework, in some areas, this was found to be very difficult to adhere to. This study showed that midwives were often dismayed at their workplace environment and were forced to work more as 'obstetric nurses' in some obstetrically dominated hospitals rather than use their midwifery skills. This has been called an 'industrial model of childbirth',[39] where routine practices were promoted and a task-based approach prevailed. It was clear that midwives felt unfulfilled when practising this way. Similarly, a study by Hunter[40] showed that midwives needed to actively manage and work on their emotions, particularly during interactions with their colleagues and the organisation, and that the source of this was often when they came up against different ideologies of midwifery practice.

Because of the organisational pressures to work in a more task-oriented fashion, this study showed that sometimes experienced midwives worked a little outside of the guidelines/policies to enable woman-focused care. In Australia, midwives are encouraged to work within professional and local

guidelines, however, working outside them and exercising 'covert autonomy' (p. 320) has been found to occur both in Australia and in the UK, especially when midwives work within a medical and managerial dominated hospital institution.[41] Kirkham[39] classically called this doing 'good by stealth' (p. 736). This meant that midwives often worked covertly in their own way, and were less likely to take steps to make systemic change possible.

Years later, little has changed. Organisational restrictions on the autonomous practice of midwives are common and a lack of interdisciplinary professional respect predominates.[42] In addition, organisational change and escalating work demands placed on the midwives by their managers were found to be detrimental to the working relationships with their colleagues and clients.[43] Notably, this study suggested that the midwives' believed the system was seen as more important than the midwives themselves, and the bureaucratic pressures of working in a large maternity unit further exacerbated this. The current study also included many accounts of large workloads, excessive documentation and the inability to give quality care to women due to systematic processes and box-ticking.

In contrast, some midwives, in particular those working in smaller practices and continuity of care models, were able to work to their full scope of practise in a woman-centred manner, and this was what they loved about their jobs. They also had a great level of control, autonomy and flexibility over their work, and this was supported and encouraged by their managers. Positive workplace environments within small practices have also been found in the UK.[6] Working in models where midwives are able to build a relationship with women and their families has been found to be protective of stress and burnout and linked to higher workplace satisfaction.[44] Given organisational support, these models could be key to sustainability and retention of midwives, as well as improved outcomes for women and babies. This resonates with qualitative work from Hunter and Warren[31] who described how midwives' sense of professional identity contributed to the development of resilience in the workplace. In the current study professional identity was most apparent in the responses of participants who worked in continuity of care models.

The importance of having support was a major theme in this study. Participants described very busy workplaces, but through having the support and recognition from their peers and managers, the stress of a busy workplace was mediated. Other studies have found midwives' stay in their jobs due to good relationships with women, peers and managers,[45-47] so it could be inferred that having poor relationships, or having limited opportunity to develop relationships, could be reasons for midwives to leave. It is known that there is high attrition of midwives and nurses in the workforce including new graduates,[48] indeed a study from Western Australia found nearly half of the study participants planned to change jobs within five years and/or leave midwifery.[49] Given the ongoing population increases, the ageing workforce and the 39,000 projected shortfall of Australian nurses by 2025 (which includes midwives),[50] providing support within a positive workplace culture to encourage retention of midwives would be a valuable direction to take.

The study findings have relevance not only for midwives 'on the ground' but also for those in managerial and leadership roles. Better understanding of the factors that make a positive or negative working environment is critical for effective leadership, especially as strong leaders exert powerful influence on workplace culture by acting as role models. This study has identified the importance of workplace cultures that optimise support, collegiality, control over the working environment and autonomy, and where midwives feel valued and heard at all levels of the organisation. The findings resonate with and add to the knowledge provided by the existing SCARF® framework, and enhance the evidence base for effective leadership in midwifery.

Conclusion

This study has illuminated both positive and negative aspects of the midwifery workplace culture in Australian health care; there was much that resonated with the existing literature. However, this study showed that both new and experienced midwives felt frustrated by organisational environments and attitudes, and expressed strategies to cope with this. This ranged from manipulating their work to ensure woman-centred care to writing diaries to help them form better relationships with their peers in

order to improve their worklife. It is vital that steps be taken to ensure the wellbeing and satisfaction of midwives in order to maintain the midwifery workforce. One practical and likely long-term solution to retaining midwives is to create positive workplace cultures. Midwifery comprises a mixture of technical and practical aspects, as well as the emotional skills to work in partnership with and nurture women and families. In turn, a positive maternity workplace culture has the ability to nurture the midwives within it, enabling them to succeed and flourish in their work and careers. This would enable high quality care and contribute to the positive outcomes of mothers and babies. Larger studies involving quantitative work as well as qualitative studies exploring midwives' experiences of working in urban, rural and remote areas would contribute to our knowledge of the Australian midwifery workplace culture.

References

1.   Dwyer JM. Australian health system restructuring – what problem is being solved? *Australia and New Zealand Health Policy* 2004; **1**(1): 1-6.
2.   Oxford Dictionary. Definition of culture. 2016. http://www.oxforddictionaries.com/definition/english/culture (accessed 27 May 2016).
3.   Davies HTO, Nutley SM, Mannion R. Organisational culture and quality of health care. *Quality in Health Care* 2000; **9**(2): 111-9.
4.   Manley K. The way things are done around here; Developing a culture of effectiveness: A pre-requisite to individual and team effectiveness in critical care. *Australian Critical Care* 2008; **21**(2): 83-5.
5.   Strömgren M, Eriksson A, Bergman D, Dellve L. Social capital among healthcare professionals: A prospective study of its importance for job satisfaction, work engagement and engagement in clinical improvements. *International Journal of Nursing Studies* 2016; **53**: 116-25.
6.   Walsh D. Improving Maternity Services: Small is beautiful-Lessons from a birth centre: Radcliffe Publishing; 2006.
7.   Minvielle E, Sicotte C, Champagne F, et al. Hospital performance: Competing or shared values? *Health Policy* 2008; **87**(1): 8-19.
8.   Peterson WE, Mannion C. Multidisciplinary Collaborative Primary Maternity Care Project. A national inititative to address the availability and quality of maternity services. *The Canadian Nurse* 2005; **101**(9): 25-8.
9.   Beasley S, Ford N, Tracy SK, Welsh AW. Collaboration in maternity care is achievable and practical. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2012; **52**(6): 576-81.
10.   Barden A, Quinn G, MT., Donahue M, Fitzpatrick J. Shared governance and empowerment in registered nurses working in a hospital setting. *Nursing Administration Quarterly* 2011; **35**(3): 212-8.
11.   Downe S, Finlayson K, Fleming A. Creating a collaborative culture in maternity care. *Journal of Midwifery & Women's Health* 2010; **55**(3): 250-4.
12.   Walshe K, Shortell SM. When things go wrong: how health care organizations deal with major failures. *Health Affairs (Project Hope)* 2004; **23**(3): 103-11.
13.   Francis R. Independent inquiry in to care provided by Mid Staffordshire NHS Foundation Trust - January 2005-March 2009. London: HMSO, 2010.
14.   Kirkup B. The report of the Morecombe Bay investigation. London, 2015.
15.   Van Der Weyden MB. The Bundaberg Hospital scandal: the need for reform in Queensland and beyond. *The Medical Journal of Australia* 2005; **183**(6): 284.

16.   Mclean J, Walsh M. Lessons from the inquiry into obstetrics and gynaecology services at King Edward Memorial Hospital 1990-2000. *Australian Health Review* 2003; **26**(1): 12-23.

17.   Faunce T, Bolsin S. Three Australian whistleblowing sagas: lessons for internal and external regulation. *Medical Journal of Australia* 2004; **181**(1): 44-7.

18.   Gifford B, Sammuto R, Goodman E. The relationship between hospital unit culture and nurses' quality of work life. *Journal of Healthcare Managment* 2002; **47**(1): 13-25.

19.   Kelly L, McHugh M, Aiken L. Nurse outcomes in Magnet® and non-magnet hospitals. *Journal of Nursing Aministration* 2011; **41**(10): 428-33.

20.   McHugh M, Kelly L, Smith H, Wu E, Vanak J, Aiken L. Lower mortality in Magnet hospitals. *Medical Care* 2013; **51**(5): 382-8.

21.   McKellar L, Pincombe J, Henderson A. Encountering the culture of midwifery practice on the postnatal ward during Action Research: An impediment to change. *Women and Birth* 2009; **22**(4): 112-8.

22.   Hastie C, Fahy K. Inter-professional collaboration in delivery suite: a qualitative study. *Women & Birth: Journal of the Australian College of Midwives* 2011; **24**(2): 72-9.

23.   Cheyney M, Everson C, Burcher P. Homebirth Transfers in the United States: Narratives of Risk, Fear, and Mutual Accommodation. *Qualitative Health Research* 2014; **24**(4): 443-56.

24.   Milne J, Oberle K. Enhancing rigor in qualitative description. *Journal of Wound Ostomy & Continence Nursing* 2005; **32**(6): 413-20.

25.   Rock D. SCARF: a brain-based model for collaborating with and influencing others. *Neuroleadership Journal* 2008; (1): 1-9.

26.   Tillott S, Walsh K, Moxham L. Encouraging engagement at work to improve retention: Sarah Tillott and colleagues explore how a social interaction tool can help managers recruit and retain staff, and boost patient care. *Nursing Management* 2013; **19**(10): 27-31.

27.   Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative research in psychology* 2006; **3**(2): 77-101.

28.   Australian Institute of Health and Welfare. Who are nurses and midwives? 2016. http://www.aihw.gov.au/workforce/nursing-and-midwifery/who-are-they/ (accessed September 15 2016).

29.   McKenna L, Boyle M. Midwifery student exposure to workplace violence in clinical settings: An exploratory study. *Nurse education in practice* 2015.

30.   Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: A descriptive survey (the SWAB study). *International journal of nursing studies* 2012; **49**(11): 1423-31.

31.   Hunter B, Warren L. Midwives' experiences of workplace resilience. *Midwifery* 2014; **30**(8): 926-34.

32.   Illing J, Carter M, Thompson N, et al. Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision-making in the NHS. 2013.

33.   Royal College of Obstetricians and Gynaecologists. Improving workplace behaviours: dealing with undermining 2016. https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/ (accessed 26 May 2016).

34.   Crowther S, Hunter B, McAra-Couper J, et al. Sustainability and resilience in midwifery: A discussion paper. *Midwifery* 2016; **40**: 40-8.

35. Menke J, Fenwick J, Gamble J, Brittain H, Creedy DK. Midwives' perceptions of organisational structures and processes influencing their ability to provide caseload care to socially disadvantaged and vulnerable women. *Midwifery* 2014; **30**(10): 1096-103.

36. Sidebotham M, Fenwick J, Rath S, Gamble J. Midwives' perceptions of their role within the context of maternity service reform: An Appreciative Inquiry. *Women and Birth* 2015; **28**(2): 112-20.

37. The parliament of the Commonwealth of Australia. Inquiry into whistleblowing protections within the Australian Government public sector. 2009. http://www.aph.gov.au/parliamentary_Business/Committees/House_of_Representativ es_Committees?url=laca/whistleblowing/report.htm (accessed May 27 2016).

38. Jones A, Kelly D. Whistle‐blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. *Sociology of health & illness* 2014; **36**(7): 986-1002.

39. Kirkham M. The culture of midwifery in the National Health Service in England. *Journal of Advanced Nursing* 1999; **30**(3): 732-9.

40. Hunter B. Conflicting ideologies as a source of emotion work in midwifery. *Midwifery* 2004; **20**(3): 261-72.

41. Sidebotham M, Ahern K. Finding a way: The experiences of UK educated midwives finding their place in the midwifery workforce in Australia. *Midwifery* 2011; **27**(3): 316-23.

42. Frith L, Sinclair M, Vehviläinen-Julkunen K, Beeckman K, Lotyved C, Luybens A. Organisational culture in maternity care: a scoping review. *Evidence Based Midwifery* 2014; **12**(1): 16-22.

43. Deery R. An action-research study exploring midwives' support needs and the affect of group clinical supervision. *Midwifery* 2005; **21**(2): 161-76.

44. Yoshida Y, Sandall J. Occupational burnout and work factors in community and hospital midwives: A survey analysis. *Midwifery* 2013; **29**(8): 921-6.

45. Kirkham M, Morgan R, Davies C. Why Do Midwives Stay? Women's Informed Childbearing and Health Research Group. Sheffield: University of Sheffield, 2006.

46. Sullivan K, Lock L, Homer CS. Factors that contribute to midwives staying in midwifery: a study in one area health service in New South Wales, Australia. *Midwifery* 2011; **27**(3): 331-5.

47. Ball L, Curtis P, Kirkham M. Why do midwives leave? London: RCM, 2002.

48. Hughes H. Factors influencing attrition rates in midwifery students. *Nursing Standard* 2013; **27**(26): 42-8.

49. Pugh JD, Twigg DE, Martin TL, Rai T. Western Australia facing critical losses in its midwifery workforce: A survey of midwives' intentions. *Midwifery* 2013; **29**(5): 497-505.

50. Commonwealth of Australia. Australia's future health workforce - nurses. Canberra: Health Workforce Australia, 2014.