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Swedish midwives' perception of their practice environment – A cross sectional study

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ABSTRACT

Background: There is a shortage of midwives in Sweden. Evidence suggests that the work environment is likely to play a part in retention and attrition rates.
Objective: To explore the practice environment of Swedish midwives and factors associated with the perception of an unfavorable work environment.
Methods: 475/1000 (48.6%) members of the Swedish Midwifery association completed a questionnaire including the *Practice Environment Scale (PES)*. Differences in mean scores were calculated for the subscales of *PES* and midwives' background characteristics. Logistic regression was used to investigate factors most strongly associated with unfavorable working environment.
Results: The two domains that showed significant differences in terms of participant characteristics were the *Staffing and resources adequacy* subscale and the *Foundations of quality care* subscale. Midwives younger than 40 years, those with less than 10 years' experience and those with an additional academic degree rated these two domains more unfavorably. Protective factors for assessing the work environment unfavorable were mainly internal such as high quality of life and high self-efficacy. Swedish midwives were most satisfied with the midwife–doctor relationship and least satisfied with their participation in work place or hospital affairs. Midwives suffering from burnout, those who provided hospital based care and those without leadership position were more likely to assess their work environment as unfavorable.
Conclusions: This study identified personal factors as well as work related factors to be associated with midwives' assessment of their practice work environment. Establishing healthy work places where midwives feel recognized and valued could prevent midwives from leaving the profession.

Introduction

The role of the Swedish midwife has changed dramatically over the last five decades. Some 25 years ago, the shift from inpatient to outpatient services and to primary antenatal care has resulted in an ongoing decrease in the total number of hospital beds [1]. Originally community based, the midwife focused on supporting pregnant women and their families through what was considered a normal but significant life event. Midwives often lived and worked in their own communities caring from women across the continuum of their childbirth experience. Giving birth in small community based maternity units was common [2]. Throughout the 2000s, restructuring of services led to the concentration of highly specialized care in university hospitals but a continued reductions in beds. Most of the smaller maternity units have been closed due to a concern that so few births might impact safety [3].

Today, although Swedish midwives remain the primary providers of maternity care the models in which they now work are highly specialized and largely fragmented. Midwives in Sweden usual provide antenatal care in a community setting or work in a hospital setting providing either intrapartum care or postnatal care. In some hospitals midwives may rotate between the labor ward and the postnatal ward; however, this is uncommon. Virtually all births take place in hospitals and midwives collaborate with obstetricians in complicated cases to provide care when necessary. Thus the midwives' practice environment closely resembles that of her sister profession of nursing; acute care hospital environments albeit pregnancy care provided in the community setting. Providing continuity of midwifery carer across pregnancy, labor and birth and the early parenting period is rare [4].

At the same time childbirth has become increasingly medicalized. Work by Larsson et al. [5] has demonstrated that newly qualified midwives are becoming more and more comfortable with the use of technology during the labor and birth process and more dependent on

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written guidelines and medical support than those of previous generations. Safety demands and a fear of litigation have led to an increasing trust in technology instead of midwives' own clinical knowledge and judgment [5]. Intrapartum care is characterized by a dependence on technology, such as electronic fetal monitoring (EFM) and high rates of interventions, including labor augmentation, epidural use, and oxytocin to all women after birth, and blood samples for assessing umbilical cord pH on all babies, regardless of risk. This creates a situation where women become more fearful and midwives spend more and more time dealing with women's concerns and anxieties trying to instill confidence and plan positively for labor and birth.

In line with the international data [6] Sweden is facing a growing shortage of midwives, particularly in the urban areas of Sweden. There is also concern that the shortage has overburdened midwives currently working in hospitals which is discouraging others from entering the profession. At this point in our history a shortage of midwives is of particular concern given the overwhelming evidence that all women should have access to a known midwife throughout pregnancy, labor and birth and the early parenting period [7]. Such models have also been shown to be beneficial for midwives [8]. A maternity system that does not have adequate numbers of midwives is also at risk of becoming increasingly medicalized. Midwives operate from a social paradigm where childbirth is considered a normal but significant life event. Obstetricians however take a different point of view often only considering birth as normal in hindsight.

A healthy work environment is vital in recruiting new staff [9]. So called "Magnet hospitals", e.g. hospitals that are able to recruit and keep their work force are characterized by high levels of independency and control over work, better nurse–doctor relationships, higher staff retention, improved access to professional development opportunities, the ability to participate in hospital affairs and feelings of being supported to provide optimal patient care [10]. A large Swedish cohort study of 11,000 nurses (of whom some were also midwives) showed that the size of the hospital mattered, with nurses working in smaller hospitals and more rural areas rating their work environment better [11]. More recently a longitudinal study of 1500 Swedish nurses showed that some 20% of newly graduated nurses/midwives indicated an intention to leave the profession [12]. In addition, burnout was significantly associated with intention to leave the profession.

Most studies about work satisfaction in the Swedish health care sector have been performed among nurses, of which some are also midwives. While in other countries midwifery and nursing are considered separate professions, in Sweden midwifery remains conceptualized as a "speciality" area of nursing with common areas of practice [13,14]. More than 10 years ago Hunter [15] wrote of the need to further investigate the emotional aspects of midwifery work. She argued that we need to gain better insight into how midwives manage the emotional aspects of the encounters with women to improve their working life. It is therefore important to study what factors contribute to a healthy work environment among midwives in Sweden. Another important question is whether there are differences in work satisfaction and internal characteristics of individual midwives.

The aim of the present study was to explore the practice environment of a sample of Swedish midwives and factors associated with midwives' perception of an unfavorable work environment. The study is part of a program of international work seeking to explore midwives' emotional wellbeing.

Methods

Design

This study used a cross-sectional design. A random sample of 1000 midwives registered with the Swedish Midwifery Association was selected from the membership list using a computer program. Study packages, including an invitation to participate, several validated instruments measuring emotional wellbeing and work satisfaction, and a pre-paid envelop were posted to the midwives' home addresses. No name related material was collected; however, the packages were coded for tacking purposes to enable a one off reminder letter to be sent to non-responders after one month. In addition an advertisement was placed in the Swedish Midwifery Association's member journal to prompt midwives to complete the questionnaire.

Instruments

Midwives' practice environment

The quality of the midwives' work environment was measured using the revised Australian version of The Practice Environment Scale (PES-NWI) [16]. The original scale was developed by Lake [17–19] to measure the nursing practice environment. For this study the scale was modified slightly to accommodate a focus on midwifery language rather than nursing as well as being translated into Swedish. The scale contains 30 items each assessed on 4-point Likert scales ranging from "Strongly disagree" to "Strongly agree" (see example of items in Box 1). The items are grouped into five subscales [20]. The first *Participation in workplace/hospital affairs* sought to elicit participants' perceptions of career development opportunities, visibility of and access to senior midwifery management and involvement in policy decisions within the work environment (9 items). *Midwifery foundations for quality of care* asked questions about continuing education, standards of care and models of care (9 items). The items in *Midwife manager ability, leadership and support* explored the level of support and quality of leadership (5 items). *Staffing and resource adequacy* asked midwives to comment on staffing levels, time to provide quality care and communication with peers (4 items). The last subscale, *Collegial midwife/doctor relationship* asked questions about team work and collaboration with medical colleagues (3 items). The subscales could be used as continuous variables or be divided into unfavorable (mean <2.5) and favorable (mean >2.5) [19]. Higher scores indicate higher satisfaction with the work environment. All the variables were normally distributed.

Demographic characteristics

We collected data on midwives' background characteristics such as age, civil status, number of children, years of work experience, area of work, and hours worked per week. The main area of practice was divided into four groups; labor ward, other hospital ward, outpatient department and "other". In addition, we collected information about midwives' working position (clinical midwife or in a leading position), area of work/or rotation and if they had any of the following academic degrees (bachelor, one year master, master, doctoral degree).

Emotional wellbeing variables

The Copenhagen Burnout Inventory (CBI) was used to measure burnout. The scale was developed by Kristensen et al. [21] and consists of 19 statements divided into three subscales; Personal burnout, Work burnout and Client burnout. Each statement was assessed on a 5-point Likert scale ranging from "Never" to "Always". An example from the subscale Client burnout is: *Do you find it frustrating to work with women?*

The General Self-Efficacy Scale (GSE) measures "the beliefs in one's capabilities to mobilize the motivation, cognitive resources, and courses of action needed to meet given situational demands" [22]. The scale is based on Bandura's Social Cognitive Theory and the concept of self-efficacy and was demonstrated to have a Cronbach's alpha coefficient of 0.85 and a test–retest reliability of 0.78 [23]. The GSE is a one-dimensional 8 item scale. Items include questions like: