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Original Research – Quantitative

The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity

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ABSTRACT

Background: Continuity of midwifery care contributes to significant positive outcomes for women and babies. There is a perception that providing continuity of care may negatively impact on the wellbeing and professional lives of midwives.
Aim: To compare the emotional and professional wellbeing as well as satisfaction with time off and work-life balance of midwives providing continuity of care with midwives not providing continuity.
Method: Online survey. Measures included; Copenhagen Burnout Inventory (CBI); Depression, Anxiety and Stress Scale-21; and Perceptions of Empowerment in Midwifery Scale (PEMS-Revised). The sample (n = 862) was divided into two groups; midwives working in continuity (n = 214) and those not working in continuity (n = 648). Mann Whitney U tests were used to compare the groups.
Results: The continuity group had significantly lower scores on each of the burnout subscales (CBI Personal $p = .002$; CBI Work $p < .001$; CBI Client $p < .001$) and Anxiety ($p = .007$) and Depression ($p = .004$) sub-scales. Midwives providing continuity reported significantly higher scores on the PEMs Autonomy/Empowerment subscale ($p < .001$) and the Skills and Resources subscale ($p = .002$). There was no difference between the groups in terms of satisfaction with time off and work-life balance.
Conclusion: Our results indicate that providing continuity of midwifery care is also beneficial for midwives. Conversely, midwives working in shift-based models providing fragmented care are at greater risk of psychological distress. Maternity service managers should feel confident that re-orientating care to align with the evidence is likely to improve workforce wellbeing and is a sustainable way forward.

Statement of significance

Problem or issue

Perceptions of excessive workloads, long hours on-call, professional isolation and difficulty achieving work-life balance have hindered the widespread roll-out of midwifery caseload care.

What is already known

Caseload care is a primary, social model of health where the midwife provides continuity of perinatal care. Compelling evidence shows that caseload midwifery care yields significant benefits for mothers and babies.

What this paper adds

Australian midwives providing continuity of midwifery care reported lower levels of burnout, depression and anxiety and higher levels of professional identity and autonomy compared to those working in non-continuity models. Re-orientating maternity care to align with the evidence around midwifery continuity and caseload models may improve workforce wellbeing and satisfaction.

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1. Introduction

There is strong evidence of the benefits of continuity of midwifery care to childbearing women and their babies,[1] and increasing evidence of the advantages it bestows on midwives.[2–4] In the last decade, Australia has introduced government policy, legislation and midwifery education standards[5–9] to drive evidence into practice and promote the re-orientation of maternity services to ensure more women have access to continuity of midwifery care. Despite this, changes to mainstream service delivery and expansion of existing midwifery continuity models remains slow with less than 10% of women reported to have access to a known midwife.[10] In part, some of the resistance to re-orientating services is born out of a commonly voiced perception that providing continuity of midwifery care may negatively impact on midwives' emotional wellbeing.[4] Despite a lack of empirical evidence excessive workloads, long hours on call, professional isolation and difficulty achieving a work-life balance, potentially contributing to burnout, have been suggested as reasons why maternity organisations should be cautious about supporting the transition of mainstream services towards a midwifery continuity model.[4,11–14] Professional discourses of this nature may well be contributing to the inertia around implementing new services providing continuity of care, expansion of existing continuity/caseload practices and sustainability overall.[4]

Extending our understanding about how providing continuity of care impacts on midwives' professional and personal wellbeing will inform discussion about this issue of concern. In line with some of the earliest published work on this topic (see for example Sandall[15,16] and Stevens and McCourt[17]), recent research confirms that midwives providing continuity of care in a caseload model report high levels of professional fulfilment and satisfaction.[3,4,18] Having the capacity to develop meaningful relationships with women, working across the full scope of midwifery practice, experiencing occupational autonomy and flexibility, and acknowledging their ability to make a difference for women have all been identified as reasons why those midwives providing continuity are highly satisfied.[3,4,14,18–21]

In contrast to earlier thinking, the flexibility afforded by activity based work patterns inherent in caseload is rated highly by midwives.[3,18,19] Australian researchers demonstrated that midwives readily learned how to manage the 'on-call' aspect of continuity of care in relation to workload and their family commitments.[3] The result was a better work-life balance.[3,19] These findings are also in line with a growing body of work emerging from New Zealand where midwifery continuity delivered in a caseload model is a well-established norm for most women.[2] Relationships with colleagues, working in partnership with women and having autonomy around workload and work life balance were all key factors that contributed to the satisfaction and sustainability of providing continuity in a caseload model.[21,22] More importantly there appears to be mounting evidence that providing midwifery continuity of care to women may be protective of burnout as opposed to a contributor.[2,4,21,23]

The study outlined in this paper sought to contribute to the debate about the sustainable organisation of midwifery care by comparing the emotional and professional wellbeing, including satisfaction with time off and work-life balance, of a large number of Australian midwives providing continuity of care with midwives not providing continuity. For the purposes of the paper continuity of care was defined as midwifery care provided by one or two midwives (no more than three) to a defined number of women across the antenatal, intrapartum and post-natal period (commonly referred to as midwifery caseload care).

2. Method

The data reported in this paper were collected as part of the Australian arm of the WHELM study (Work, Health and Emotional Life of Midwives).[24] The overarching aim of WHELM was to explore midwives emotional wellbeing and examine relationships with their work environment. Participants completed an online survey distributed by the Australian College of Midwives to College members and by the researchers through professional networks. The survey consisted of several validated tools including the Copenhagen Burnout Inventory (CBI),[25] Depression, Anxiety and Stress Scale-21 (DASS-21),[26] and Perceptions of Empowerment in Midwifery Scale Revised (PEMS-Revised)[27] (summarised in Box 1). Midwives rated their satisfaction with time off and work-life balance (low vs high). One thousand and thirty seven surveys were received. Ethical approval was obtained from Griffith University (NRS/39/11/HRC) (see Creedy et al.[24]; Hildingsson et al.[28] for more detail about WHELM research design).

2.1. Statistical analyses

Data for this study were extracted from the larger WHELM Australian data file. Responses from registered midwives working in a clinical midwifery role are reported. Those midwives employed predominantly in research, education, management or administrative roles were excluded. The sample was divided into two groups (continuity vs non-continuity) separating those midwives who indicated they were working in a 'continuity of midwifery care model' defined as '*providing midwifery care to a woman across the continuum of pregnancy, labour and birth, and the early parenting period*'.

Preliminary analyses compared demographic and work related characteristics of the two groups. Non-parametric statistics were used given the non-normal distribution of scale scores. Chi square tests (for categorical variables) and Mann–Whitney U tests (continuous variables) were conducted along with appropriate effect size statistics. Cohen's criteria were used to evaluate the size of the phi and z coefficients (.1 = small effect, .3 = medium effect, .5 = large effect). Mann Whitney U tests compared groups on their levels of burnout (CBI), emotional wellbeing (DASS-21) and perceptions of empowerment (PEMS-Revised). Given the number of analyses undertaken in this study a more conservative alpha level of $p < .01$ was used to assess statistical significance.

3. Results

3.1. Sample characteristics

The sample consisted of a total of 862 midwives, with 214 (24.8%) working in a continuity of midwifery care model and the remaining 648 (75.2%) working in positions not involving continuity of care. The demographic characteristics of each group are shown in Table 1 and were similar to those of the general midwifery population such as gender, age and marital status.[29] The national data set, however, does not facilitate comparisons in terms of model of care.

The only difference between groups detected at the adjusted alpha level of $p < .01$ was the size of city/town ($p < .001$). This difference recorded a small effect size. The highest proportion of midwives working in continuity of care were located in small rural communities (40.2%) and remote locations (38.7%). Although not reaching statistical significance, on average midwives in the continuity group tended to be older (M = 47 years) than those working in the non-continuity group (M = 45 years), and had worked in midwifery longer (M = 16 vs M = 15 years).

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