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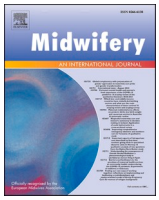

Why UK midwives intend to stay in or leave the midwifery profession: A conceptual model of push, pull and mooring factors

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ABSTRACT

Problem: Retention and recruitment of midwives is of global importance as workforce shortages impede the quality and safety of care provided.
Background: Midwives' intentions to leave the profession require examination in a post COVID-19 pandemic context, yet their data is often conflated with nurses.
Aims: To a) measure UK midwives' intentions to leave midwifery, b) explore the reasons behind them using qualitative methods, and c) map these reasons to create a model of push, pull and mooring (PPM) factors.
Methods: This convergent parallel mixed-methods study included UK midwives (n = 575) who completed an online survey consisting of a three-item scale paired with open text response options. Items were scored on a 7-point Likert scale. Mean composite intention scores were calculated. Framework analysis was used to make sense of the qualitative data collected.
Findings: The composite mean score for intention to leave midwifery in the sample was 4.15 (SD 1.87). Themes related to midwives' intention to leave included: Too much pressure (stressful, poor mental health); Poor workplace cultures; Planned retirement or career change; Feeling undervalued; professional constraints and preserving physical health. Themes related to midwives' intention to stay included: No perceived alternative; Their ability to move away from clinical midwifery practice; Being new to the profession; Considering the alternatives to midwifery but staying as the hours and money are good; Professional identity overriding the rough days, and Job satisfaction. Distinctively, our findings reveal a paradox in that although professional identity acts as a pull factor, its connection to burnout and excessive endurance demonstrates that it is not uniformly advantageous.
Discussion: Drawing from PPM theory, we present the first conceptual model of PPM factors for midwifery. The presenteeism identified poses threats to quality and safety.
Conclusion: Findings offer important opportunities to minimise push factors, enhance pull factors and strengthen mooring factors for optimal recruitment and retention in Midwifery.

Statement of significance

Problem or Issue	The recruitment and retention of midwives is of global importance.
What is Already Known	Data relating to midwives is often conflated with data relating to nurses, though they may be different, particularly in a post COVID-19 context.
What this Paper Adds	We offer the first conceptual model of push, pull and mooring factors for midwifery as a profession, and uniquely demonstrate that while professional identity serves as a pull factor, its linkage with burnout and excessive endurance can render it paradoxically detrimental.

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Background

Recruitment and retention strategies in healthcare remain a priority

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(Barriball et al., 2015; Moncrieff et al., 2023; Weyman et al., 2023). Moreover, the scaling up of midwifery is required to reduce global perinatal mortality rates (Renfrew et al., 2014; UNFPA, 2021). Nevertheless, there remains a shortage of approximately 900,000 midwives worldwide (UNFPA, 2021). The United Kingdom (UK) maintains a persistent national shortage of 2500 midwives according to the Royal College of Midwives ((RCM), 2022). Where there is understaffing, more harmful incidents are reported (Turner et al., 2024). Furthermore, inadequate staffing levels are influential in determining midwives' leaving intentions (Dent et al., 2024), meaning services may continue to recruit without ever replenishing the 'leaky bucket'. Recent research describes midwives feeling "trapped" and unable to leave (Pezaro et al., 2022). Such feelings may be linked to a lack of engagement (Brown et al., 2024). Poor workplace engagement may also lead to presenteeism (Jiang et al., 2023), and quiet quitting (Jantjies et al., 2024), which may subsequently have consequences for the quality and safety of care. These early insights highlight the importance of gaining more nuanced understandings, particularly where a paucity of studies exist (Brown et al., 2024; Parry et al., 2023).

Many midwives consider leaving the profession globally due to the stress of their work, role dissatisfaction, and a lack of support (Parry et al., 2023). Other recent studies have explored the intentions of midwives to leave midwifery in the UK specifically (e.g., Cull et al., 2020; Feeley and Stacey, 2024). UK midwives' inability to provide the kind of care they valued has been cited as the most significant reason for them leaving the profession previously (Curtis et al., 2006; Feeley and Stacey, 2024). Other UK midwives intending to leave the profession cited this was similarly because they were 1) not happy with staffing levels at work; 2) not satisfied with the quality of care they were able to give; 3) not happy with the workload; 4) not happy with their working conditions; and 5) not happy with the model of care they were working in (Leversidge, 2016). Yet the UK's regulator for nurses and midwives, the Nursing and Midwifery Council (NMC) identified soon after the COVID-19 pandemic that the most common reasons given for leaving their register were 1) retirement (2 personal circumstances, and 3) too much pressure (stressful, poor mental health), the latter of which was most frequently cited by registered (e.g., licenced to practise) midwives ((NMC), 2022). Indeed, midwives can experience both occupational and organisational sources of work-related psychological distress (Pezaro et al., 2016), and levels of burnout, stress, anxiety, and depression have been found to be significantly higher in UK midwives than the general population (Hunter et al., 2019). Other reasons for NMC registrants deregistering related to poor workplace cultures, registrants leaving the UK and the Covid-19 pandemic ((NMC), 2022), the latter of which has further exacerbated levels of stress and anxiety in perinatal staff (Erin et al., 2022; McGrory et al., 2022). Whilst significantly, the NMC conducted their survey with those who had already left it's register after the Covid-19 pandemic had started ((NMC), 2022), its findings in relation to midwives were largely conflated with those of nurses and nursing associates. Yet whilst both nurses, nursing associates and midwives play key roles in the promotion of health and the prevention of illness (as do many other professions), midwifery aligns with a holistic model of care in the context of childbearing (a physiological event), while nursing incorporates various models pertaining largely to ill health (Pezaro et al., 2024a). As such, UK midwives' reasons for staying in or leaving the profession may be different from those of nurses and also may have changed in the years following the pandemic. Consequently, there is now an opportunity to explore UK midwives' intentions to leave midwifery exclusively prior to them leaving the NMC's register, and in a post pandemic context.

As well as examining why UK registered midwives intend to leave the profession, it will also be important to explore why they might stay (Weyman et al., 2023). Previously, the feeling of making a difference has been identified as UK midwives' predominant reason for staying in the midwifery profession (Kirkham et al., 2006), along with professional autonomy being a mediator of job satisfaction, strong working relationships, feeling well supported, financial incentives and flexible working. Newer findings highlight specialist job roles, autonomy, and belonging as being related to UK midwives' intentions to stay (Feeley and Stacey, 2024). Elsewhere, professional self-image and a sense of pride in the profession have also been found to be important components of staff retention (Brown et al., 2024; Pezaro et al., 2024b). To elicit deeper understandings, we draw from the Pull-Push-Mooring (PPM) theory (Lee, 1966; Moon, 1995), which has historically been used to understand the reasons behind human migration (Chang et al., 2014; Hou et al., 2014), and later, turnover intentions (e.g., Haldorai et al., 2019; Semmer et al., 2014). In this context, push factors reflect the negative aspects that create dissatisfaction and "push" a professional towards leaving. Pull factors are the positive aspects of the *current* profession/job/organisation that "pull" a professional towards staying. Mooring factors relate to the moderating reasons that anchor someone to their current career situation, making them less likely to leave, even in the presence of push or pull factors. Essentially, when push factors outweigh pull and mooring factors, the professional is more likely to develop intentions to leave. Equally, strong pull and mooring factors can counteract the effects of push factors, decreasing the likelihood that the professional will leave. Thus, it will be important to map midwives' intentions leave the profession to PPM to minimise push factors, enhance pull factors and strengthen mooring factors accordingly.

Considering the above, along with the NHS's 10-year plan focussed on retention and workforce reform (UK Government, 2025), and driven by the need to address severe staff shortages and improve safety, the aims of this research were to a) measure UK midwives' intentions to leave midwifery, b) explore the reasons behind them using qualitative methods, and c) map these reasons to create a model of PPM factors.

Methods

We took a convergent parallel mixed methods approach in meeting our aims (Creswell and Clark, 2017). Such approaches are particularly useful because they integrate both post-positivism and interpretivism as philosophical frameworks (Fetters, 2016), and join both qualitative and quantitative data to meaningfully explain research findings (Dawadi et al., 2021). We gathered quantitative and qualitative data simultaneously for more holistic and nuanced understandings (Mertens, 2023). Our approach was equivalently driven by both quantitative and qualitative elements (Moseholm and Fetters, 2017). We used a web-based survey, taking a separative approach to collect both qualitative and quantitative data on a large scale and in parallel. Quantitative and qualitative data analyses were conducted independent of each other prior to a final merging and interpretation of the two strands (Fig. 1). The Good Reporting of a Mixed Methods Study (GRAMMS) checklist was used to guide reporting (O'Cathain et al., 2008).

We measured UK midwives' intentions to leave midwifery quantitatively. Our qualitative approach enabled us to explore and explain the 'why?' behind our quantitative results by interpreting participant perspectives (Tracy, 2024). The collection of qualitative data via large scale online surveys is also established as an exciting and flexible method with numerous accessible applications (Braun et al., 2021). This design in particular offered us a wide-angle lens to reach many eligible participants, and was less demanding of time and resources, leaving the research team more time for analysis, which can often be hindered (Braun et al., 2017). We remained focussed on the profession rather than the job/employer to bridge further gaps in the evidence base (Brown et al., 2024), and to provide practical recommendations to retain UK midwives in the profession itself.

With regards to positionality, SP remained reflective of their own intentions to leave or stay in the midwifery profession. Whilst intentions may change over time, these experiences have enabled SP to identify deeply with many participant reflections. This brings a legitimacy to our analyses as we sought to find meanings which may resonate within the wider profession. Potential confirmation biases were challenged by KM

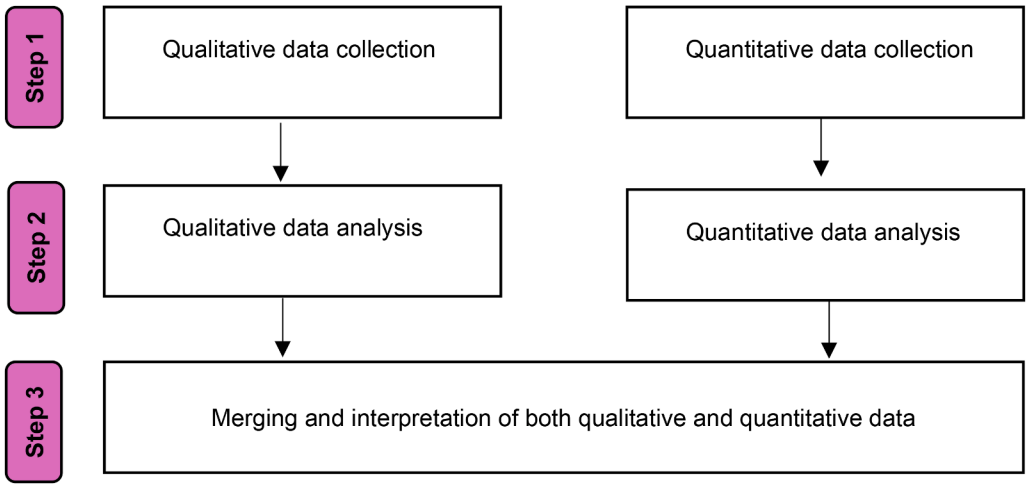

Fig. 1. Convergent parallel mixed method design.

as an occupational psychologist with no midwifery experience. KM and SP both hold PhD's and are highly experienced in conducting mixed-methods research.

Sample

Our sampling strategy was purposive. Participants were recruited via advertising placed within an editorial published in the British Journal of Midwifery, and MIDIRS. The recruitment advert was also shared among the research team's professional and social networks, and via 'Make Birth Better'. Online posts via Facebook were boosted with funding acquired from the Iolanthe Midwifery Trust to reach a greater number of potential participants and thus achieve the highest sample size possible. Recruitment materials highlighted a broad range of contemporary workforce issues in UK midwifery as part of a wider research project (e.g., health risks, substance use and workplace engagement) and was open in inviting all UK midwives to participate.

Eligibility required participants to be aged over 18 and registered to practise as a midwife with the NMC. Participants self-selected to participate by clicking on a linked URL or scanning a QR code taking them directly to read information about the research and confirm their consent.

Data collection

Data were collected via a self-administered anonymous online survey between March and November 2021. Demographic data were collected in broad categories for age (< 30yrs, 31–40, 41–50, >50), employment type (full-time, part-time, bank/agency, unemployed), and highest educational qualification (diploma, undergraduate degree, postgraduate degree, doctorate, professional, other).

Intentions to leave the profession were assessed via three items (Meyer, Allen and Smith 1993), adapted for midwifery populations. The three items were 1. *how frequently do you think about getting out of midwifery*, 2. *how likely are you to explore other career options*, and 3. *how likely are you to leave midwifery in the next year*. Items were scored on a 7-point Likert scale, whereby higher scores indicated a greater likelihood of leaving and scores were averaged across items to create composite intention scores. Participants were then invited to share the reasons behind their intentions via open text responses (e.g., "*Please use the space below to explain your responses*").

Ethical considerations

Recruitment began following ethical approval via the lead authors institution (Project: P116723). Midwives included in our analyses gave informed consent to participate. Their data remained anonymous and confidential throughout.

Analysis

We used descriptive statistics to make sense of the quantitative data collected. The internal consistency of the intention to leave the profession scale was measured using Cronbach's alpha (Cronbach's $\alpha = 0.81$) (Connelly, 2011). Mean composite intention scores were also calculated for the three items of the adapted intention to leave scale (Meyer et al., 1993). To make sense of the qualitative data collected, we undertook a Framework Analysis (Ritchie and Spencer, 2002), deliberately avoiding the quantification of qualitative data to prevent equating frequency with importance. The analysis was conducted using a combination of software and manual tools. The data were prepared and managed in Microsoft Word and indexed using Excel and manually via Post-it notes for visual mapping. The process involved five rigorous and collaborative steps:

1. Data familiarisation: The first author transcribed the data, and both authors read the entire data set to gain a holistic understanding.
2. Identifying our thematic framework (initial coding): Our framework was developed using a mix of deductive (*a priori*) and inductive (emergent) concepts. High-level categories for midwives intending to leave were deductively informed by the NMC survey ((NMC), 2019) and previous UK research (Ball et al., 2002; Feeley and Stacey, 2024; Hunter et al., 2018), while themes related to midwives intending to stay were guided by a review of the literature (Bloxsome et al., 2019). New sub-themes were also generated inductively from the text.
3. Indexing: Multiple coders were involved in this process. Primarily, the first author systematically applied the entire framework to the full dataset, coding segments of text with the relevant thematic labels in Microsoft Excel. The second author then independently cross-checked the application of the framework to a subset of the data to establish inter-rater consistency. Discrepancies were resolved through a series of focused academic discussions and consensus meetings between the authors, which led to the refinement and finalisation of definitions and the iterative adjustment of the framework's structure.
4. Charting to summarise the indexed data: The indexed data were then summarised and "lifted" into a thematic matrix created in Microsoft Word, facilitating data reduction while maintaining context.

Mapping and interpretation of patterns found within the charts: Patterns (e.g., themes and subthemes) were identified, interpreted, refined using Post-it notes, and summarised for reporting.

Data integration

Mixed-methods research is characterised by the integration of qualitative and quantitative data, and in convergent designs, it is vital to merge these distinct data types to leverage both and provide a holistic and comprehensive response to the research inquiry (Fetters et al., 2013). Here, we employed a simultaneous bidirectional approach, whereby quantitative and qualitative data strands were analysed independently and subsequently utilised to inform a final integration and interpretation of findings (Moseholm and Fetters, 2017). Integration was explicitly achieved through a conceptual and narrative weaving strategy (Fetters et al., 2013) that adopted the PPM model as the core framework for convergence. This process involved first conceptually mapping the themes and sub-themes generated by the Framework Analysis directly onto the three main PPM model components (Push factors, Pull factors, and Mooring factors). This established a shared structure for merging the datasets. We then conducted a simultaneous comparison of the results, presenting the mean composite scores from the quantitative intention to Leave items alongside the corresponding qualitative themes for each PPM component. For instance, quantitative data reflecting the magnitude of turnover intent were contextualised by qualitative themes that described push factors (e.g., poor working cultures), while the spread of other qualitative themes helped to explain the variation observed in other composite mean scores. By structuring the final interpretation around the PPM model and ensuring both quantitative scores and qualitative narratives were woven together equally, we maximised the trustworthiness and depth of the resultant model overall.

Model development

Similar to the development of turnover intention models applied to nursing (Cowden and Cummings, 2012; Penconek et al., 2024), our approach to model development utilised the literature (via our thematic framework), along with the integration of primary data. As described by our approach to data integration above, we also mapped PPM theory to all themes and subthemes to develop a new theoretical model of PPM factors associated with midwives' intentions to leave midwifery.

Results

Details of our sample ($n = 575$) along with a comparison to the study population and the composite mean scores for intention to leave midwifery are presented in Table 1. The majority of participants were assigned female at birth, educated at undergraduate level, aged between 31–50 and working full time.

The composite mean score for intention to leave midwifery in the sample was 4.15 (SD 1.87). This is towards the higher end of the available scale and represents a general tendency towards an intention to leave in our sample. Composite mean scores are available for each of the demographic groupings in Table 1. However, the low number of participants in categories for sex, employment type and educational level mean that inferential analyses were not carried out for these demographic variables and any interpretations should be made with caution. An inferential comparison of the composite mean scores was conducted for the age categories using a univariate analysis of variance and found no significant difference between the age groups for intentions to leave midwifery (F (3, 571) = 0.67, p = .56). This suggests that for our sample midwives' intentions to leave the profession is broadly similar across age groups.

Table 1
Sample and population demographics with composite mean scores for intention to leave midwifery.

	POPULATION N (%)	SAMPLE DEMOGRAPHICS N (%)	INTENTION TO LEAVE MIDWIFERY COMPOSITE MEAN (SD)
TOTAL	45,060 (100)	575(100)	4.15 (1.87)
SEX			
FEMALE	(99)	574(>99)	
MALE	(<1)	1(<1)	
AGE			
<30	(19)	111(19)	3.98 (1.72)
31–40	(27)	183(32)	4.24 (1.95)
41–50	(23)	177(31)	4.22 (1.90)
>50	(31)	104(18)	4.04 (1.84)
EMPLOYMENT TYPE	n/a*		
FULL-TIME		355(62)	3.96 (1.85)
PART-TIME		194(34)	4.38 (1.81)
BANK/AGENCY		20(3)	4.77 (2.16)
UNEMPLOYED		6(1)	5.44 (1.97)
EDUCATION	n/a*		
DIPLOMA		39(7)	4.44 (1.91)
UNDERGRADUATE		406(71)	4.13 (1.83)
MASTERS		95(16)	4.23 (1.98)
DOCTORAL		14(2)	3.38 (2.02)
PROFESSIONAL		9(2)	4.30 (2.00)
OTHER		12(2)	4.64 (1.60)

* Data are not available from the NMC for midwives as a distinct occupational group due to being aggregated with nurses.

Qualitative findings

Following our framework analysis, two overarching themes related to midwives' intentions to either 1) leave or 2) stay within the midwifery profession. Twelve subthemes were captured overall. A description of each of these is presented below, with salient participant quotes used to highlight key sentiments within them. Grammatical corrections have been made to aid readability. Table 2 presents our final framework of analysis.

Why midwives intend to leave the midwifery profession

Those reflecting on why they might intend to leave the profession described 1) Too much pressure (stressful, poor mental health), 2) Poor workplace cultures 3) Planned retirement or career change, 4) Feeling undervalued, 5) professional constraints and 6) Preserving physical health.

Too much pressure (stressful, poor mental health). Many participants described excessive workplace pressures, stress and poor mental health. One midwife outlined how they ***"can't bear it anymore"*** (P181), others

Table 2
Framework of analysis.

Theme	Subthemes
Why midwives intend to leave the midwifery profession	Too much pressure (stressful, poor mental health)
	Poor workplace cultures
	Planned retirement or career change
	Feeling undervalued
	Professional constraints
	Preserving physical health
Why midwives intend to stay in the midwifery profession	No Perceived alternative
	Ability to move away from clinical midwifery practice
	Being new to the profession
	Considering the alternatives to midwifery, but staying as the hours and money are good
	Professional identity overriding the rough days
	Job satisfaction

described how midwifery work is ***"too stressful and unsafe"*** (P74), or how they were ***"constantly afraid of doing something wrong or becoming burnt out"*** (P219)

> ***"I can't go on like this on the wards as they are. It's reaching unbearable levels"*** (P292)

For some, midwifery was seen as too stressful and demanding to be a lifetime career. As one participant describes, ***"I do not want to work in midwifery all my life. I find it too physically and emotionally stressful"*** (P418).

Poor workplace culture. Numerous midwives who expressed their intention to leave communicated that this was due to ***"toxic***" (P1) workplace cultures widespread with ***"blame"*** (P14), ***"undermining"*** (P189), and ***"uncaring and unsympathetic"*** (P57) approaches toward staff. One participant urged action on this by expressing the following: ***"Please call out the shocking bullies… they crush midwives rather than building them up. It's horrendous"*** (P485). Due to such workplace cultures, another expressed that they would leave ***"as soon as they can"*** (P137).

> ***"The culture of midwifery feels more hostile, less supportive than it did 10 years ago. The threat of being disciplined or referred to the NMC is very pervasive due to elitism and superiority within the profession"*** (P6)

Planned retirement or career change. Within this subtheme, many described how they either ***"want to retire"*** (P143), are ***"approaching retirement"*** (P151), or are ***"going to retire early"*** (P17), some "***as soon as [they] can"*** (P130).

Others described ***"actively seeking different employment"*** (p107), or ***"trying to build up alternative career opportunities before leaving"*** (P122).

Feeling undervalued. When expressing their intentions to leave, many described feeling ***underappreciated"*** (P86), "***demoralised and undervalued"*** (P262), and as if ***"no one cares"*** (P153). One midwife described how they ***"do not feel valued or listened to at work by managers"*** and feel that they are ***"just a number"*** (P135). Another described how they ***"looked for another job when felt undervalued by senior manager"*** (P318). At times feeling undervalued was also expressed via the receiving of ***"poor pay"*** (P271).

Other midwives expressed feeling undervalued by the ***"government and society"*** (P83).

> ***"I Feel massively underappreciated by clients …like they don't know what a great service they are getting from me"*** (P349).

Professional constraints. Within this subtheme, intentions to leave were described in the context of professional constraints such as an inability to provide the kind of midwifery care participants valued. These were often linked to limited resources such as not having ***"enough time"*** (P125). Midwives also described having ***"no opportunities to progress"*** (P12) and workplaces being ***"very inflexible and not family friendly or supportive at all"*** (P505).

Delivery of care was also attributed to participants intending to leave such as the ***"rise in medicalisation"*** (P189). Also, one midwife explains, ***"trying to force continuity of carer has caused a mass exodus at work"*** (P562).

Preserving physical health. Many midwives described intending to leave the profession because their ***"heath is suffering"*** (P66). One midwife illustrates this by declaring; ***"I can't stay. It's literally my health or my job"*** (P65). Another describes how **"excess glove wearing"** had made their ***"eczema flare"***, and that consequently, they ***"soon will not be able to work clinically"*** (P171).

Vaccine hesitancy and refusal was expressed as preservation of health, ultimately resulting in an intention to leave as one participant describes how they would ***"not take the COVID vaccine"*** (P49), which would be required of them were they to practise clinically.

Why midwives intend to stay in the midwifery profession

When reflecting on why they might intend to stay in the profession, midwives broadly described 1) No perceived alternative, 2) Their ability to move away from clinical midwifery practice, 3) Being new to the profession, 4) Considering the alternatives to midwifery, but staying as the hours and money are good, 5) Professional identity overriding the rough days, and 6) Job satisfaction.

No perceived alternative. Sentiments captured within this subtheme describe midwives wanting to leave but remaining because they saw no alternative. One participant describes this conundrum as; ***"I am not really qualified for anything else, so I'm trapped really. I was mis-sold the dream"*** (P105). Such comments highlight how the expectations of the job have perhaps not been met in some cases.

Others described how they intended to stay in the profession simply due to having ***"bills to pay"*** (P214). Others described the ***"guilt of leaving women uncared for"*** (P267) or adding to the ***"problem of there being less midwives***" (P565) as reasons for why they felt unable to leave, potentially alluding to presenteeism.

Ability to move away from clinical midwifery practice. Where midwives were able to move away from clinical midwifery practice, they described intentions of staying where they may not otherwise have done so. As one midwife describes, if they ***"were still working clinically"*** their "***answers would be very different"*** and they ***"would be leaving"*** (P541). Similarly, one participant describes how they have ***"accepted a new role non-clinical",*** yet ***"if this doesn't work out"***, they will ***"leave midwifery"*** (P362).

Being new to the profession. Perhaps not surprisingly, many outlined their intentions to remain in the profession as they were ***"newly qualified"*** (P459). Having recently qualified, there was seemingly a desire ***"to progress"*** (P493). As one midwife describes, ***"I wouldn't quit until I was a confident practitioner. May seem counterintuitive, but I won't stop until I feel I have completed the task"*** (P334).

Considering the alternatives to midwifery, but staying as the hours and money are good. Evidently some midwives consider leaving the profession and yet intend to remain within it due to feeling like the hours and money are good. One participant for example had intentions of leaving the profession and had explored doing so for a few years and yet describes how it was ***"not the right time to leave for [their] family",*** because the ***"shift pattern and money suits [them] at the moment***" (P307). Another midwife was ***"retraining as a psychotherapist"*** but was still ***"using midwifery as an income source"*** (P351).

Professional identity overriding the rough days. Some midwives who describe being deeply dedicated to the profession ***"go through love and hate phases"*** (P429) and yet stay ***"despite the pressures"*** (P507). These sentiments were often attributed to midwives' professional identity, with many exclaiming how ***"being a midwife is who I am"*** (e.g., P190, P195, P485).

Whilst their professional identity motivated them to remain in midwifery, this was not always encouraging. For example, one midwife described how although they were ***"completely burnt out"***, they ***"still wouldn't consider leaving the profession"*** (P419). Concerningly, another describes not being able to seek help for their ***"addiction"*** for fear of losing their job, exclaiming how ***"midwifery is not just a job for me, it is who I am, so actually I would lose a part of myself"*** (P234).

This reveals a paradox in that while professional identity can serve to retain midwives in their roles, its benefits may be diminished or even counterproductive.

Job satisfaction. Within this subtheme, midwives broadly describe how they ***"love"*** (P400) midwifery and are satisfied in their job. Such job satisfaction was attributed to an ability to make ***"a difference"*** (P394), ***"feeling valued and supported"*** (P391) and ***"feeling trusted"*** (P433). Some also ***"enjoy the challenge"*** (P468) of midwifery.

> ***"I love being a Midwife, it's a job that still inspires me after 30 years!"*** (P436)

Mixed-Methods interpretations

Integration of the data revealed both diverged and expanded insights in relation to midwives' intention to leave. For example, the quantitative results offered a concerningly high composite mean score for midwives' overall intention to leave midwifery (4.15 (SD 1.87)). This high intention score is contextualised by strong qualitative themes such as the overwhelming stress of "Too much pressure (stressful, poor mental health)" and the burden of "Poor workplace cultures" (push factors). Higher composite mean scores were specifically observed for those who were unemployed (5.44 (SD 1.97)) and those working as Bank or Agency staff (4.77 (SD 2.16)). Whilst this may reflect those who cite "Preserving physical health" or pursuing a "Planned retirement or career change" as primary push factors, wider generalisable claims are limited due to the number of participants in each of these groups and warrants further investigation. The lower composite mean scores were measured in those working full-time (3.96 (SD 1.85)) which may be explained by some of the qualitative findings related to Job satisfaction being a pull factor, the pragmatic reality of considering the alternatives but staying as the hours and money are good, or other mooring factors such as having no perceived alternative to staying.

When reflecting on findings related to attrition across career stages, it is important to note that composite scores related to leaving intentions were broadly similar across age groups ($F\,(3, 571) = 0.67$, $p = .56$). This lack of a statistically significant difference across age groups indicate that the systemic push factors driving attrition (e.g., "professional constraints" and feeling "undervalued") are equally pervasive and corrosive throughout a midwife's entire career, rather than being confined to specific career entry or exit points. Consequently, the challenge of midwife retention can be viewed as a systemic issue that necessitates comprehensive improvements to the working environment and support structures, rather than age-specific or targeted retention interventions.

The quantitative finding that midwives holding a Doctoral degree reported the lowest intention to leave score (3.38 (SD 2.02)) across all educational subgroups suggests that successful transition to research, academic, or higher-level leadership roles may provide a vital career pathway with potential to mitigate the frontline stressors that drive attrition in the broader midwifery workforce. Indeed, qualitative insights revealed how one's ability to move away from clinical midwifery practice (e.g., into education or management) serve as powerful mooring factors in this context. However, the number of participants in this group were low in our sample which limits generalisable claims regarding intentions to leave the profession and may reflect the ratio of these posts available as a pathway, particularly given the current climate of higher education in the UK. Further work is needed to assess how open an academic pathway may be for those who wish to continue in midwifery away from clinical practice. Despite the limitations, our quantitative and qualitative dimensions point towards the idea that intrinsic reward along with pragmatic necessity currently counterbalance severe systemic stress. To synthesise this complex interplay of push, pull, and mooring factors into a cohesive structure, drawing directly from the integration of our primary data with relevant contemporary literature (via our thematic framework), we formally present a new conceptual model of PPM factors associated with UK midwives' intentions to leave midwifery as our final contribution (Fig. 2).

Discussion

This study offers the first conceptual model of push, pull and mooring factors for midwifery. It also contributes to understandings on the complexities of staff recruitment and retention in perinatal services. Much like the findings of the NMC's post pandemic post leavers survey ((NMC), 2022), poor workplace culture, too much pressure (stressful, poor mental health) and retirement were frequently given as reasons why midwives intended to leave the profession. Yet whilst personal circumstances (e.g., leaving the UK) were listed as the second most common reason for those leaving the NMC register ((NMC), 2022), this was rarely referenced in our findings. This may be because such changes in personal circumstances are rapid in onset, rather than reflective of one's intention to leave in a broader sense. Equally, there was no mention of COVID-19 being the specific reason behind any intentions to leave in this sample as there had been in the NMC leavers survey ((NMC), 2022). Yet this may be understandable given that survey respondents had already largely worked through the COVID-19 pandemic.

Participants cited feeling undervalued along with inflexible professional constraints as reasons why they intended to leave the profession. The antitheses to these factors have been cited as reasons why midwives stay elsewhere (Bloxsome et al., 2019). This suggests a need to focus on making midwifery more flexible with clear career pathways and trajectories built in to retain and promote talent. Where midwives were more able to move away from clinical midwifery practice, they were also more likely to intend to stay. This is in line with other research findings (Feeley and Stacey, 2024), and may indicate that clinical midwifery is the area of practice perceived to be most problematic, and thus where retention issues are most in need of address. In this task, the role of the 'retention midwife' who explores intentions to leave and introduces support systems along with restorative clinical supervision sessions and wellbeing away days alongside other activities such as escalating staff concerns shows early promise, particularly where their presence is linked to slight reductions in midwives' intention to leave (Feeley and Stacey, 2024).

Here, 'elitism and superiority' was linked to poor workplace cultures, a strong push factor for participants. It is often a sense of privilege which acts as the foundation for elitism, propagating unearned advantages and access to resources and powers that solidify the belief in the inherent superiority of a select few (Khan, 2021). Elsewhere, overly strong professional identities and focusing on the 'privilege' of being a midwife are similarly known to be harmful in midwifery (Pezaro et al., 2024a; Pezaro et al., 2022)). Moreover, whilst midwives often view their role as a "privilege," this framing risks inadvertently obscuring the considerable responsibilities, inherent stressors, and specialist knowledge required for the profession. Such characterisation may also minimise systemic inequities that constrain both professional autonomy and access to equitable care. Furthermore, framing the role as a "privilege" may inadvertently reinforce existing hierarchical power dynamics, potentially further marginalising midwifery relative to dominant medical paradigms. As such, it will be essential to critically reframe midwifery, not only to influence future workplace dynamics and ensure narratives truly represent its value and challenges, but also to address systemic injustice.

With the midwifery workforce already under resourced (Nove et al., 2021), the potential absenteeism and presenteeism which may result from midwives simply staying as the hours and money are good, places an additional modifiable burden on service delivery. Indeed, the mooring factors reported here may be linked to continuous and/or normative commitment which has poorer predictive validity for turnover than affective commitment (linked to pull factors)(Meyer and Allen, 1993). Overall, it will be important to enhance pull factors and

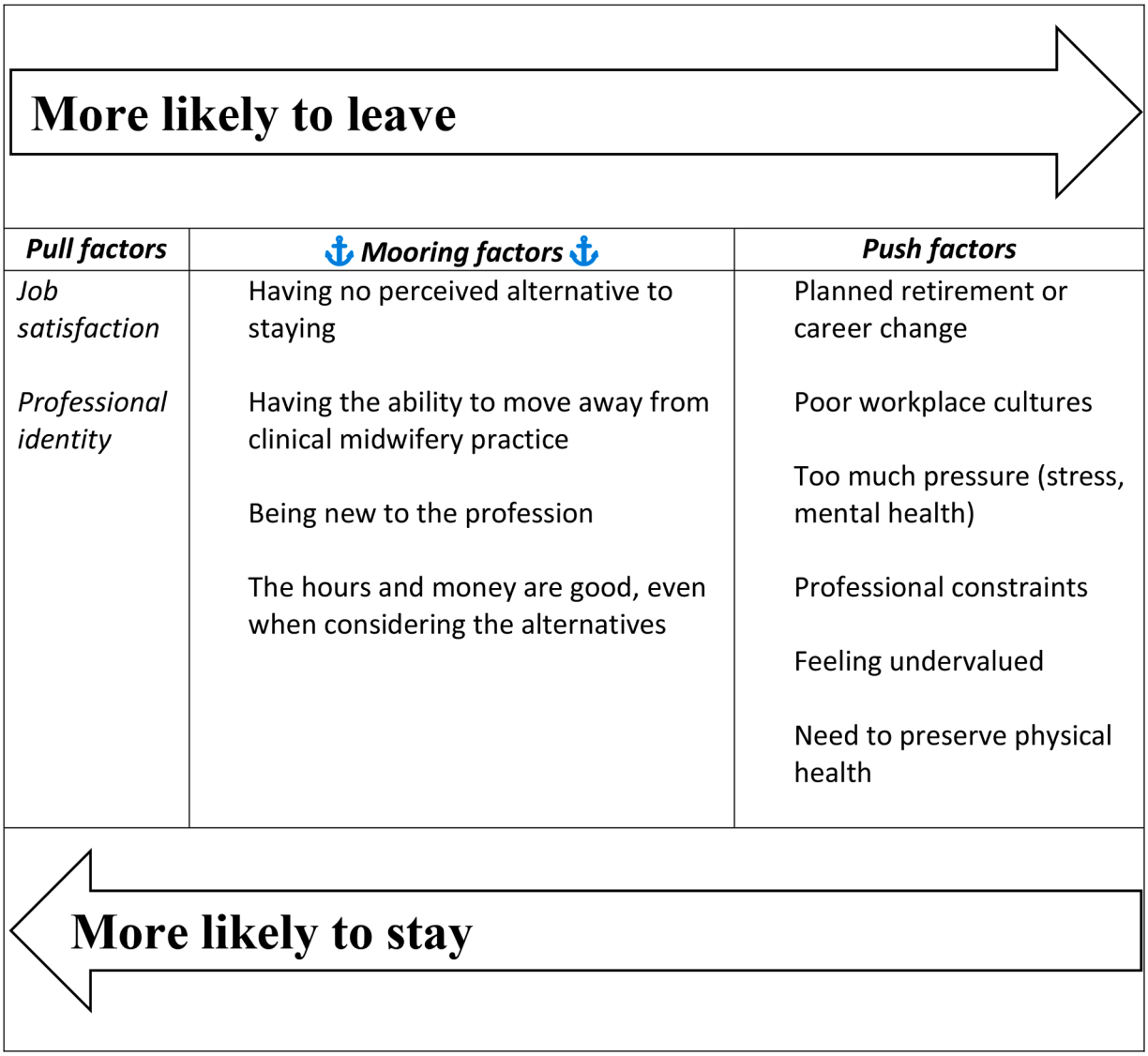

Fig. 2. Conceptual model of push, pull and mooring factors in Midwifery.

reduce push factors identified, as well as consider ways in which the mooring factors can be enriched to drive more affective commitment. Ensuring satisfaction with pay for example may strengthen mooring factors directly through a reduction in leaving intentions (Hayes et al., 2006) but may also reduce push factors by reducing feelings of being undervalued and enhancing job satisfaction (Judge et al. 2010). However, the impact of pay on intentions to leave is inconsistent in the literature with the work environment and professional opportunities having a greater effect especially within healthcare (Hayes et al., 2006). Thus, it is important to consider minimisation of environmental stressors as well opportunities for career growth through greater role diversity both within and outside of clinical practice. Availability of alternatives was highlighted as a mooring factor in our data and when jobs are scarce, turnover is shown to be low (Hayes et al., 2006). Given that our study was conducted during a period of economic instability during the pandemic, the scarcity of alternative options may have been more salient to our participants at the time of data collection. Planned retirement suggests a fixed point for exit, however some participants indicated that they were retiring early due to workplace burnout which highlights the wider calls to address stressors within the work environment to retain healthcare staff (Kinman, Teoh and Harris 2020).

This research contributes to broader understandings as to why UK midwives intend to leave or remain in the profession (Gammon et al., 2024; Moncrieff et al., 2023). The composite mean scores for intention to leave midwifery reported here are notably higher than those similarly reported from the nursing professions (Arslan Yürümezoğlu et al., 2019; Wang et al., 2023). Whilst several models have focussed on nurses' turnover intentions (e.g., Boyle et al., 1999; Cowden and Cummings, 2012; Ejebu et al., 2024; Gilles et al., 2014; Metersky et al., 2024; Sasso et al., 2019; Taunton et al., 1997; Tourangeau and Cranley, 2006), we present the first conceptual model of PPM factors to understand intentions to leave the midwifery profession. Some factors in our model mirror those in nursing models (e.g., poor workplace cultures, feeling valued, job satisfaction, financial remuneration and professional constraints) (Cowden and Cummings, 2012; Penconek et al., 2024). The reasons given for intending to leave are also not dissimilar to those given by nurses (Bahlman-van Ooijen et al., 2023), or doctors (De Vries et al., 2023; Lock and Carrieri, 2022) elsewhere. Moreover, the reasons why UK midwives intend to leave are not dissimilar from the reasons given by midwives from the Netherlands (Feijen-de Jong et al., 2022), Sweden (Hensing et al., 2025), Australia (Matthews et al., 2024), Canada (Stoll and Gallagher, 2019), Ethiopia (Muluneh et al., 2022), or elsewhere (Jarosova et al., 2016; Parry et al., 2023). Nevertheless, what has uniquely surfaced here is that whilst professional identity may be

considered a beneficial pull factor for midwives remaining in the profession, it may not always be beneficial given its linkage with burnout and excessive endurance associated with unsafe patient care (Hodkinson et al., 2022). Such overly strong (rather than healthy) professional identities in midwifery are also reported elsewhere (Pezaro et al., 2024a), and can further exacerbate poor working cultures (e.g., via incivility and bullying) along with poor teamwork and resistance to change (Stevens, 2013). Thus, future research could usefully work to promote healthier professional identities, perhaps through the cultivation of strong midwifery leaders recruiting and retaining staff in tandem with the promotion of psychological safety in positive and compassionate workplace cultures (Pezaro et al., 2024a) or even public arts-based instantiations (Pezaro et al., 2024b).

Research into midwifery recruitment and retention serves as a critical indictment of the NHS's ability to manage its workforce, indirectly fuelling and informing the political rationale for radical structural reforms like the abolition of NHS England (Ham, 2025). The consistent evidence highlighting severe staff burnout, unsafe working conditions, and the resultant midwife exodus puts extreme pressure on the UK government. Ultimately, this study offers strong support for transformation, especially as the NHS's long-term workforce plan aims to 'Retain and Reform' by improving the culture, leadership, and wellbeing of its future workforce (NHS England, 2023).

Limitations

This study has enabled midwives to be heard as a unique group, rather than have their voices conflated with nursing populations. We have also been able to ensure anonymity. Nevertheless, our sample is younger than the midwifery population as a whole and due to the nature of demographic data collection within midwifery in the UK being conflated with nurses, full representativeness of our sample to the population is difficult to ascertain.

Low numbers of respondents in some of demographic categories has limited our ability to understand intentions to leave midwifery in relation to personal characteristics. Findings should be interpreted with the representativeness of the sample in mind and future research is needed to capture midwives' attitudes towards leaving the profession across the broad spectrum of characteristics (e.g. community vs hospital roles, urban vs rural, high vs low sociodemographic region) reflected within the profession.

We acknowledge that the PPM model is theoretical (rather than empirical) in nature. We did not subject its constructs to statistical validation but rather used it to structurally organise our data. Furthermore, whilst the PPM model has previously been applied to nurses (e.g., Sasso et al., 2019), and is thus still considered useful in understanding situational factors related to health care professionals' intentions to leave, it was originally developed for geographical migration, a context fundamentally different from midwifery workforce retention. Our findings illustrate this mismatch. For instance, while professional identity pulls midwives to remain in midwifery, an overly strong commitment to the profession often compels them to endure circumstances that lead to the push factors identified (e.g., the need to preserve physical health). This excessive endurance may even compromise patient care (Hodkinson et al., 2022). Such a paradoxical linkage transforms a beneficial pull factor into a source of potential injury, effectively delaying a midwife's departure until the point of inevitable collapse when push factors eventually override all sense of professional duty. This demonstrates how the dynamic interactions impacting retention can be more complex than the PPM taxonomy allows.

Ultimately, our mixed-methods approach enabled us to enhance the interpretation of our data overall by bridging the explanatory gap between quantitative results and qualitative context. However, a key consideration for the generalisability of these findings is that this study is UK-centric. Given the systemic pressures and unique institutional 'Mooring' factors identified, future research is essential to test the applicability of our conceptual PPM model in other contexts. Comparative studies of this nature, potentially enhanced with larger sample sizes and disaggregated data across various professional groups and healthcare systems, would provide the broader, globally relevant retention strategies required in the scaling up of midwifery worldwide.

Conclusion

We present the first conceptual model of PPM factors for understanding intentions to leave the midwifery profession. Uniquely, we demonstrate that whilst professional identity acts as a pull factor for midwives remaining in the profession, it may not always be beneficial given its linkage with burnout and excessive endurance. Paradoxically, it may be detrimental. Overall, our findings offer important opportunities for preventative action in a context where critical staff shortages remain. Initiatives which seek to promote healthy professional identities, and the value placed upon the profession along with the cultivation of compassionate workplace cultures will be key in this pursuit.

Ethical approval

Ethical Approval was granted by Coventry University (Project reference P116723).

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CRediT authorship contribution statement

Sally Pezaro: Writing – original draft, Visualization, Validation, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Karen Maher:** Writing – review & editing, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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