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Professional independence of midwives: Analysis of determining factors[1]

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Beata Szlendak[a], Grażyna Bączek[b], Hanna Mierzejewska[c], Oksana Stępień[d], Urszula Tataj-Puzyna[e] ✉, Barbara Baranowska[f]

[a] *Beata Szlendak[1], https://orcid.org/0000-0002-8227-8166*
[b] *Grażyna Bączek[2], https://orcid.org/0000-0001-7897-9499*
[c] *Hanna Mierzejewska[3], https://orcid.org/0009-0005-7854-2699*
[d] *Oksana Stępień[2], https://orcid.org/0000-0002-3993-5458*
[e] *Urszula Tataj-Puzyna[1], https://orcid.org/0000-0001-9800-3434*
[f] *Barbara Baranowska[1], https://orcid.org/0000-0003-2723-9604*
✉ *Corresponding author: Urszula Tataj-Puzyna, urszula.tataj-puzyna@cmkp.edu.pl*

[1] *Department of Midwifery, Centre of Postgraduate Medical Education in Warsaw, Poland*
[2] *Department of Gynecology and Obstetrics Didactics, Medical University of Warsaw, Poland*
[3] *Medical University of Warsaw, Poland*

Abstract: The professionalisation of the midwifery profession is a key process both from the perspective of the professional group itself and the quality of healthcare provided to women and their families. By definition, professionalisation is a collective strategy undertaken by a professional group to achieve recognised status and autonomy. The World Health Organisation (WHO) and the International Confederation of Midwives (ICM) emphasise the importance of education, legal regulations and strong professional organisations as pillars of this process. Despite global efforts, the pace of professionalisation is uneven – midwives in highly developed countries often function as independent specialists, while in many lower-income countries they lack access to formal education, licensing and systemic recognition. One of the most important indicators of professionalisation is professional autonomy, understood as the ability to make clinical decisions, provide continuous care and assume professional responsibility. The development of this autonomy is influenced by both systemic (legal, organisational) and psychosocial factors, including internal motivation, self-efficacy and the work environment. Generational differences also play an important role – younger generations of midwives (e.g. Generation Z) have higher expectations of autonomy and work-life balance, but also a higher risk of burnout and job insecurity. The aim of this article is to analyse the professional autonomy of midwives as a key factor in the professionalisation process, taking into account educational, psychological, generational and systemic conditions, with particular reference to the situation in Poland.
Keywords: generational differences, midwife, professionalisation, professional autonomy

Introduction

The professionalisation of midwifery is a crucial process not only for midwives themselves but also for women and society at large, as it is linked to delivering high-quality care in line with established standards (Prosen, 2022). Professionalisation is a collective and complex strategy pursued by an occupational group to attain recognised professional status (Vermeulen et al., 2019).

The World Health Organization (WHO), in cooperation with the International Confederation of Midwives (ICM), has long underscored the pivotal role of midwives in improving the health of mothers, newborns, and families (Kemp et al., 2021; Renfrew et al., 2014). It further emphasises that every woman and newborn should be cared for by a midwife who is educated and trained to international standards

1 Article in Polish language: https://stowarzyszeniefidesetratio.pl/fer/63P_Szle.pdf

and authorised to practise (The State of the World's Midwifery 2021: Building a Health Workforce to Meet the Needs of Women, Newborns and Adolescents Everywhere, 2021). When discussing professionalisation, these organisations identify three key domains: education, regulation, and professional organisations responsible for building professional identity (Kemp et al., 2021).

One indicator of midwifery professionalisation is growing professional autonomy, understood as the ability to make clinical decisions, provide continuity of care, and assume professional and legal responsibility. The autonomy of any professional, including midwives, is shaped by multiple factors-economic-legal conditions, health-system organisation, and midwives' psychological resources, which themselves are influenced, among other things, by generational differences.

The pace of midwifery professionalisation is uneven worldwide. In highly developed countries, midwives operate as independent specialists, whereas in many low- and middle-income countries they continue to face limited access to formal education, barriers to licensing, and a lack of recognition within health-system structures (Vermeulen et al., 2018).

In the United States, midwifery autonomy is determined by state law, and due to differences in education and certification, the scope of practice varies. In most states, midwives have full autonomy and independent prescribing rights (Yang et al., 2016). In New Zealand, midwives' competencies include prescribing and administering medicines, ordering and interpreting diagnostic and screening tests, carrying out comprehensive newborn assessments, and repairing most perineal trauma (Crowther et al., 2021).

In Europe, the drive to build midwifery autonomy gathered momentum in the 1980s and 1990s (Vermeulen et al., 2019). A cornerstone was the shift of education to the higher-education sector. The Bologna Process, launched in 1999, played a key role by standardising education across Europe through the three-cycle model (bachelor's, master's, doctorate) and by strengthening mobility among students and health professionals (Pop-Tudose & Radu, 2023). Differences nevertheless remain. In Belgium, midwives may prescribe medications and perform functional obstetric ultrasound examinations, but while prescribing is clearly regulated, implementing acts for functional ultrasound have not been issued (Nagórska, 2024; Vermeulen et al., 2016, 2019). In Greece, the perinatal care system positions midwives primarily under obstetrician-gynaecologists. Their role is often reduced to the technical execution of medical orders, limiting independent practice-especially in hospital settings (Kontoyannis et al., 2025). In Croatia, professionalisation began after 2008; consequently, comprehensive care during pregnancy, birth, and the postpartum period largely falls within the remit and responsibility of obstetrician-gynaecologists (Nagórska, 2024).

Midwives' professional autonomy depends not only on legal and systemic regulations but also on psychosocial factors such as intrinsic motivation and self-efficacy. High perceived professional efficacy supports independent clinical decision-making, enhances psychological resilience, and reduces stress and burnout- particularly among early-career midwives. Moreover, intrinsic motivation and a strong sense of meaning in the profession foster engagement, job satisfaction, and readiness for autonomous practice. The work environment is also decisive: recognition, autonomy, social support, and organisational culture positively influence midwives' capacity to function independently in clinical practice (Jasiński et al., 2021; Tzamakos et al., 2024).

Age diversity within the profession influences how the role is perceived, approaches to autonomy and teamwork, and the uptake of new technologies. Younger cohorts-especially Generation Z (born after 1995)- tend to be more open to change, place a higher value on work–life balance, and have stronger expectations regarding autonomy and development, while also showing increased risks of isolation, anxiety, uncertainty, and depression (Chicca & Shellenbarger, 2018).

This article analyses midwives' professional autonomy as a key driver of professionalisation, considering educational, psychological, generational, and systemic contexts. It is based on a non-systematic review of Polish and international literature and seeks to identify the main determinants of and barriers to developing midwives' autonomy in Poland.

1. Professional autonomy of midwives in Poland

In Poland, professionalisation began after the country regained independence, but the decisive transformation occurred in the 1990s. A milestone was the Act of 5 July 1996 on the Professions of Nurse and Midwife,[2] which granted midwives the right to independently provide health services in obstetric, gynaecological, and neonatal care (Bączyk-Rozwadowska, 2019; Karkowska, 2007; Wyrębek et al., 2024). The Act also opened the way for private practice and introduced a duty to maintain up-to-date knowledge through postgraduate education, thereby underpinning professional standards of care[3] (see also: Szlendak, 2000). The legal recognition of independent practice laid the groundwork for the Regulation of the Minister of Health and Social Welfare of 2 September 1997 on the scope and types of preventive, diagnostic, therapeutic and rehabilitative services performed independently by nurses and by midwives without a physician's order.[4] This regulation defined the range of services and procedures that midwives may perform autonomously, specified required qualifications, and noted that physicians should recognise midwives as co-participants in the care process (Karkowska, 2007). These changes, in turn, led to the Regulation of the Minister of Health and Social Welfare of 17 December 1998 on postgraduate education for nurses and midwives.[5] It established a new postgraduate training system with four forms: specialist training programmes, qualification courses, specialist courses, and continuing-education courses. For the first time in midwifery education, a state examination was introduced as the final element of specialist training. Postgraduate education became a key lever of autonomy, enabling midwives to acquire new competencies with a fundamental impact on care quality and women's safety (Regulation of the Minister of Health and Social Welfare, 1998; Szlendak, 2000). The first and crucial enhancement concerned physical assessment skills; the initial specialist curricula were prepared and approved by the Minister in 2000.[6] Another major step was granting rights to prescribe selected medicines, issue prescriptions, and refer for specified diagnostic tests (Grabowska et al., 2018; Zarzeka et al., 2018).

With regard to education, in line with EU requirements, since 2003 the only path to qualification as a midwife has been a three-year bachelor's degree at a medical university. Graduates may then pursue a master's degree or continue education through courses and specialisations, or via postgraduate programmes such as the Executive Master of Business Administration (EMBA) in healthcare (Wyrębek et al., 2024).

Under the Regulation of the Minister of Health of 28 June 2019 on education standards for the midwifery profession, first-cycle (bachelor's) studies in midwifery last at least six semesters and include no fewer than 4,600 teaching hours, of which at least 2,300 are practical.[7] Core areas include obstetrics and gynaecology, neonatology and paediatrics,

2 Sejm Rzeczypospolitej Polskiej. (1996). *Ustawa z dnia 5 lipca 1996 r. o zawodach pielęgniarki i położnej* [Act of 5 July 1996 on the professions of nurse and midwife]. *Dziennik Ustaw*, 1996(91), poz. 410. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=wdu19960910410

3 Ibidem.

4 Ministerstwo Zdrowia i Opieki Społecznej. (1997). *Rozporządzenie Ministra Zdrowia i Opieki Społecznej z dnia 2 września 1997 r. w sprawie zakresu i rodzaju świadczeń zapobiegawczych, diagnostycznych, leczniczych i rehabilitacyjnych, wykonywanych przez pielęgniarkę samodzielnie, bez zlecenia lekarskiego, oraz zakresu i rodzaju takich świadczeń wykonywanych przez położną samodzielnie* [Regulation of the Minister of Health and Social Care of 2 September 1997 on the scope and type of preventive, diagnostic, therapeutic and rehabilitation services performed independently by a nurse without a physician's referral, and the scope and type of such services performed independently by a midwife]. *Dziennik Ustaw*, 1997(116), poz. 750. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU19971160750

5 Ministerstwo Zdrowia i Opieki Społecznej. (1998). *Rozporządzenie Ministra Zdrowia i Opieki Społecznej z dnia 17 grudnia 1998 roku w sprawie kształcenia podyplomowego pielęgniarek i położnych* [Regulation of the Minister of Health and Social Care of 17 December 1998 on postgraduate education of nurses and midwives]. *Dziennik Ustaw*, 1998(161), poz. 1110. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU19981611110

6 Ibidem.

7 Ministerstwo Nauki i Szkolnictwa Wyższego. (2019). *Rozporządzenie z dnia 26 lipca 2019 r. w sprawie standardów kształcenia przygotowującego do wykonywania zawodu lekarza, lekarza dentysty, farmaceuty, pielęgniarki, położnej, diagnosty laboratoryjnego, fizjoterapeuty i ratownika medycznego* [Regulation of 26 July 2019 on education standards preparing for the practice of physician, dentist, pharmacist, nurse, midwife, laboratory diagnostician, physiotherapist and paramedic]. *Dziennik Ustaw*, 2019, poz. 1573. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20190001573

fundamentals of health care and health promotion, pharmacology, pathophysiology, diagnostics, and the basics of law, ethics, and communication.

Upon completion of the bachelor's degree, a midwife is qualified to independently, among other things: manage physiological labour and birth and provide intrapartum care; recognise abnormalities in pregnancy, labour, and the puerperium and refer the woman to a physician; deliver antenatal and postnatal education and provide preventive services and newborn care. Second-cycle (master's) studies last four semesters and are intended for bachelor-qualified midwives. They broaden knowledge and skills and prepare graduates to act as leaders of perinatal care, health educators, researchers, and clinical consultants.

The curriculum includes advanced obstetric and neonatal care, research methodology and biostatistics, organisation and management of health services, and professional ethics and legal aspects. A master-qualified midwife is prepared to conduct research and implement evidence-based practice (EBP), take on managerial roles in health-care teams, provide advanced health education, develop and implement care standards, and engage in population-level prevention and health promotion.[8] The transformation of midwifery education and the evolving scope of practice are closely aligned with the postgraduate training system, allowing midwives to gain new competencies in line with labour-market needs and their own ambitions and capacities. While Poland's educational system prepares midwives for autonomous practice, the health-care system-both inpatient (hospital) and community/family care-does not fully utilise their competencies or recognise their potential. Although autonomy is not restricted by law, its exercise is hampered by organisational barriers, limited systemic support, and public scepticism (Bączek et al., 2023). As shown in a study published in the European Journal of Midwifery, women's awareness in Poland of midwives' professional competencies is limited. The roles most often indicated were lactation education (78.7%) and perinatal care (78.9%). Far fewer women knew that midwives may prescribe medicines (23.1%) or collect cervical cytology samples (24.4%) (Wyrębek et al., 2024). In a study on the role of midwives in infertility care in Poland by Neneman et al. (2019), only 4.95% of couples believed a midwife was competent to perform ultrasound. Moreover, just 22.77% of respondents considered menstrual-cycle observation part of a midwife's remit, and 21.78% believed lifestyle education fell within the role. Only 7.92% of women reported that a midwife had performed cytology or a swab, and 6.93% of couples confirmed being referred for tests by a midwife (Neneman et al., 2019).

2. Psychological resources and professional autonomy

Psychological resources such as resilience, self-confidence, reflective capacity, empathy, and emotion regulation underpin midwives' professional autonomy. Developing these resources affects not only the quality of care for women but also midwives' own well-being.

Resilience-defined as the capacity to adaptively respond to adversity, stress, and workplace pressures-plays a particularly important role. Caiazzo et al. report that midwives with higher resilience exhibit markedly better subjective well-being (SWB), encompassing both life satisfaction and emotional well-being. In Italian maternity settings, moderate or high resilience correlated with greater job satisfaction and lower negative affect. Resilience thus not only supports coping with pressure but also protects against burnout and the emotional impact of stressors (Caiazzo et al., 2019). These personal skills help midwives remain calm and confident in daily practice, especially in difficult and unpredictable clinical situations (Sabzevari & Rad, 2019).

8 Ministerstwo Nauki i Szkolnictwa Wyższego. (2019). *Rozporządzenie z dnia 26 lipca 2019 r. w sprawie standardów kształcenia przygotowującego do wykonywania zawodu lekarza, lekarza dentysty, farmaceuty, pielęgniarki, położnej, diagnosty laboratoryjnego, fizjoterapeuty i ratownika medycznego* [Regulation of 26 July 2019 on education standards preparing for the practice of physician, dentist, pharmacist, nurse, midwife, laboratory diagnostician, physiotherapist and paramedic]. *Dziennik Ustaw*, 2019, poz. 1573. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20190001573

Perceived self-efficacy-defined by Albert Bandura as a person's belief in their capacity to achieve desired outcomes-also shapes professional autonomy (Bandura, 1997). Strong self-efficacy helps individuals face challenges and persist toward goals; low self-efficacy can have the opposite effect, fostering avoidance behaviours that undermine outcomes (Waddington, 2023). In eastern Iran, Azmoude et al. found a strong association between knowledge, self-rated competence, and actual implementation of evidence-based practice (EBP): midwives with higher self-efficacy more frequently engaged in guideline-concordant actions (Azmoude et al., 2017). In a cross-sectional study from China, Jiang et al. observed that moderate self-efficacy may be associated with burnout risk. Low self-appraisal and a weak sense of agency negatively affected both care quality and decisions to remain in the profession (Jiang et al., 2020). Polish research likewise links self-efficacy with autonomous decision-making: midwives with higher self-efficacy more often undertake independent clinical interventions (e.g., use of upright positions in labour), report higher job satisfaction, and experience less burnout (Guzewicz & Sierakowska, 2022).

The ability to cope with stress is another resource that may influence autonomous practice. A meta-analysis by Gheshlagh et al. showed that 71% of Iranian midwives experience high occupational stress, regardless of age or tenure. Such widespread exposure to chronic stress raises the risk of professional errors and reduces job satisfaction. The authors call for programmes to strengthen stress-management competencies, which could support autonomy and care quality alike (Gheshlagh et al., 2021). Moran et al.'s review also details links between coping, well-being, and professional resilience. Many workplace stressors-systemic barriers, workload, lack of organisational support-can become developmental opportunities when midwives possess adaptive mechanisms. Supportive team relationships, opportunities for independent decision-making, and mentorship were identified as protective factors that enhance resilience and job satisfaction (Moran et al., 2023).

Taken together, the evidence suggests that professional autonomy is closely intertwined with psychological resources. Resilience, belief in one's capabilities, and stress-coping skills reinforce one another and support autonomous decision-making, improve care quality, and protect against burnout. Strengthening these resources should be an objective of individual professional development and a deliberate priority of educational and managerial policy in the health system.

3. Generational differences and perceptions of autonomy among midwives

Contemporary midwifery brings together multiple generations-from those just starting their careers to those with decades of experience. Generation Z (born after 1995) is only beginning to assume active roles in the profession, bringing new values, expectations, and competencies that can significantly affect team functioning and how autonomy is understood and enacted in clinical practice (Chicca & Shellenbarger, 2018). As Singh et al. note, this generation came of age in a technology-saturated world shaped by digitalisation, social media, and rapid information flow. They are comfortable with multitasking and instant access to knowledge but may approach work differently from previous cohorts. Without recognising their needs and characteristics, organisations-including health care-will struggle to retain them (Singh & Dangmei, 2016).

In midwifery specifically, Kool et al. describe the experiences of newly qualified Generation Z midwives in the Netherlands. The first years of practice are particularly demanding due to the autonomous nature of the role and the responsibility it entails. The importance of being part of a team and of relationship-building within midwifery practice was not necessarily perceived as a value. Younger midwives also reported a strong need for work–life balance-something not always understood by more experienced colleagues (Kool et al., 2023). Tan and Chin likewise found marked intergenerational differences in nurses' professional attitudes and values. Younger cohorts emphasise work–life balance, whereas for older colleagues work more often defines a good life. Younger generations also seek greater power and autonomy at work, along with recognition and respect (Tan & Chin, 2023).

By contrast, older generations-such as Generation X (born 1965–1980)-grew up under different socio-economic and cultural conditions. Work was often viewed as a duty, sometimes embedded in family tradition, with success equated with advancement, prestige, and stability. Gümüşdaş et al. show that Generation X midwives were less likely to have chosen the profession voluntarily compared with Generation Y (born 1981–1994) and tended to adopt a more conservative stance toward professional power. Younger cohorts displayed higher professional development and motivation, which can create tension when differing work styles meet within one team (Gümüşdaş et al., 2021).

Understanding the specificity of Generation Z-now entering midwifery in greater numbers-is essential not only for building cohesive teams but also for the future of the profession itself. Their drive for self-realisation, digital fluency, openness to change, and ethical sensitivity can be powerful assets-provided workplaces recognise and support this potential. At the same time, older generations offer stability, experience, and valuable organisational perspective. Well-functioning midwifery teams combine youthful energy and freshness with experience and wisdom-regardless of generational differences.

At the individual level, autonomy also hinges on psychological resources such as resilience, self-efficacy, and stress-coping skills. Strong personal resources enable midwives to meet clinical challenges, make independent decisions, and shield themselves from burnout. Supporting these competencies should therefore be a priority for midwives themselves, leadership, and the education system.

Additionally, today's midwifery teams face challenges stemming from generational differences. Younger midwives from Generation Z bring fresh perspectives, openness to change, and digital fluency but often need stability and mentorship that current working conditions may not provide. Older generations, while sometimes more conservative in outlook, offer invaluable experience and organisational insight. Harnessing these complementary assets presents a major opportunity for the profession's development.

Poland now has the chance to fully realise the professional potential of midwives-thanks to a well-designed education system and clear legal frameworks. This will require a shift in how the midwife's role is perceived-both socially and within the health-care system-and the creation of work environments that actively support autonomy, development, and well-being.

4. Conclusion

The professional reality of Polish midwives is shaped by systemic, educational, psychological, and generational factors that together determine the degree of professional autonomy. Although, since the 1990s, the legal and formal frameworks have steadily expanded midwives' scope of practice, autonomy in day-to-day care remains underutilised. Legislation allows midwives to manage physiological birth, prescribe medicines, order diagnostic tests, and run independent practice, while the EU-aligned education system prepares them to perform these tasks at a high standard.

In practice, however, real-world independence is constrained by organisational barriers, limited systemic support, and low public awareness of midwives' competencies. Many women-and at times other health-care team members-do not perceive midwives as fully autonomous professionals.

Limitations

This article is based on a non-systematic literature review, which limits the representativeness of available scientific evidence. The cited sources offer valuable insights into midwives' autonomy and its determinants, yet selection was driven by availability and currency. To robustly assess the real impact of psychological, systemic, and generational factors on the level of midwives' autonomy in Poland, empirical studies are needed to provide objective data that can inform health-policy changes supporting the development of midwives' professional identity.

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