ARTICLE

Leave of Absence and Return to Work Among Canadian Midwives Who Experience Mental Health Issues: Pilot Study Findings

Congé et retour au travail des sages-femmes canadiennes aux prises avec des problèmes de santé mentale : constatations d'une étude pilote

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Challenging working conditions can pose mental health challenges leading to leaves of absence or attrition.

ABSTRACT

Despite the salience of mental health issues in midwifery, we have a limited knowledge of the experiences of midwives who take a leave due to personal or family-related mental health challenges. Our paper draws on a pilot study that aimed to address this gap in the literature by exploring the factors fostering or impeding midwives' decision to take a leave and to return back to work. In addition to a scoping review of the academic and grey literature conducted on these issues, we administered a pilot online survey completed by sixteen midwives and conducted interviews with seven midwives. Our findings show that challenging working conditions, common to midwifery, can pose mental health challenges impacting midwives' working ability and leading to leaves of absence or attrition. We also found that certain demographic factors make midwives more likely to leave their work due to mental health challenges. Our findings suggest that specifically targeted programs and policies might be very helpful in facilitating midwives' return to work.

KEYWORDS

midwifery, mental health, return to work, gender

This article has been peer reviewed.

RÉSUMÉ

Malgré l'importance des problèmes de santé mentale au sein de la pratique sage-femme, nous avons une connaissance limitée de l'expérience des sages-femmes qui prennent congé en raison de troubles de santé mentale personnels ou familiaux. Notre article se fonde sur une étude pilote visant à combler cette lacune dans la littérature en examinant les facteurs qui favorisent ou entravent la décision des sages-femmes de prendre congé puis de retourner au travail. En plus d'un examen de la portée de la littérature universitaire et grise sur ces questions, nous avons administré un sondage pilote en ligne auquel 16 sages-femmes ont répondu et nous avons réalisé des entrevues avec 7 sages-femmes. Selon nos constatations, les conditions de travail difficiles, situation courante dans la pratique sage-femme, risquent d'engendrer des problèmes de santé mentale ayant une incidence sur la capacité des sages-femmes à travailler et mènent à la prise de congés ou à l'érosion des effectifs. Nous avons aussi observé que certains facteurs démographiques rendent les sages-femmes plus susceptibles de quitter leur travail à cause de problèmes de santé mentale. Les résultats de nos recherches laissent entendre que des programmes et des politiques ciblés pourraient être très utiles pour faciliter le retour au travail des sages-femmes.

MOTS-CLÉS

pratique sage-femme, santé mentale, retour au travail, genre

Cet article a été évalué par un comité de lecture.

INTRODUCTION

The health care sector is an especially challenging working environment; some statistics show that health care workers are 1.5 times more likely to be off work because of illness or disability than are workers in all other sectors.[1] As do many other health workers, midwives experience high levels of stress and burnout at work,[2–6] and they are also susceptible to post-traumatic stress disorder.[7,8] Despite the salience of mental health issues for midwives, we have a limited knowledge of how such issues are managed through leaves of absence from work. We know little about the factors fostering or impeding midwives' decisions to take a leave of absence or how their return to work is enabled or impeded. This article presents the results of a pilot study that aimed to fill in these gaps in the literature. This article addresses the following questions:

- Which midwives experience personal or familial mental health issues to such an extent that they decide to leave work?
- What key factors—personal, family related, and work related—cause midwives to take a leave from work?
- What factors help to foster midwives' return to work?

PILOT STUDY METHODOLOGY

This pilot study utilized a mixed-method design that is currently being used in a larger study involving six other professional groups. We report on three sources of data: (1) a scoping review, (2) a short pilot online survey distributed to a small sample of midwives, and (3) in-depth, semi-structured interviews with seven midwives.

Scoping Review

The scoping review included published and grey literature sources. The published literature was identified through a systematic search of relevant keywords in consultation with the reference librarian from the University of Ottawa, using the following databases: PubMed, Wiley Online Library, EBSCO Academic Search Complete, Google Scholar, Scholars Portal, ProQuest, and JSTOR. These sources were augmented through the reference lists and from referrals from the project partners. To identify relevant sources of grey literature, we searched the websites of stakeholder organizations relevant to midwifery, focusing on Canada and undertaking broader Google searches. The exclusion/inclusion criteria we adopted at the outset helped us to narrow down our search according to date, language, document and study design, population, country, and content. Thirty-seven published and thirteen grey literature sources formed the basis of our pilot scoping review. The literature was extracted via pre-determined categories included in an Excel-based literature extraction tool , developed by our team members. Since the brevity of this article precludes us from fully reporting on the scoping review, we report on only some of its relevant findings.

Pilot Online Survey

A short online pilot survey was administered between May and October, 2017. The survey was distributed through the project and team member networks and those of our partner organizations. Questions explored mental health issues, leaves of absence, and return-to-work interventions among midwives. The survey was filled out by 16 midwives who were recruited from across Canada and who identified as females (Figures 1, 2, and 3).

Interviews with Midwives

Between August 2017 and March 2018, we conducted seven semi- structured interviews with registered midwives in Ontario, British Columbia, and Saskatchewan. Most of the respondents were identified through the online survey. Interviews took 30 to 60 minutes to complete. All interviews were conducted by phone, audio-recorded, and subsequently transcribed for thematic analysis of a priori and emerging themes. The a priori themes corresponded to the research questions, literature extraction, and survey questions.

EMERGING FINDINGS

Mental Health Experiences and Decisions on Whether to Leave Work

The results of our pilot study show that age, working experience, gender, family situation (i.e., having dependents), and personal financial situation are linked to midwives' decision to take leave due to mental health issues.

Figure 1. *Number of People Employed in Participants' Workplace*

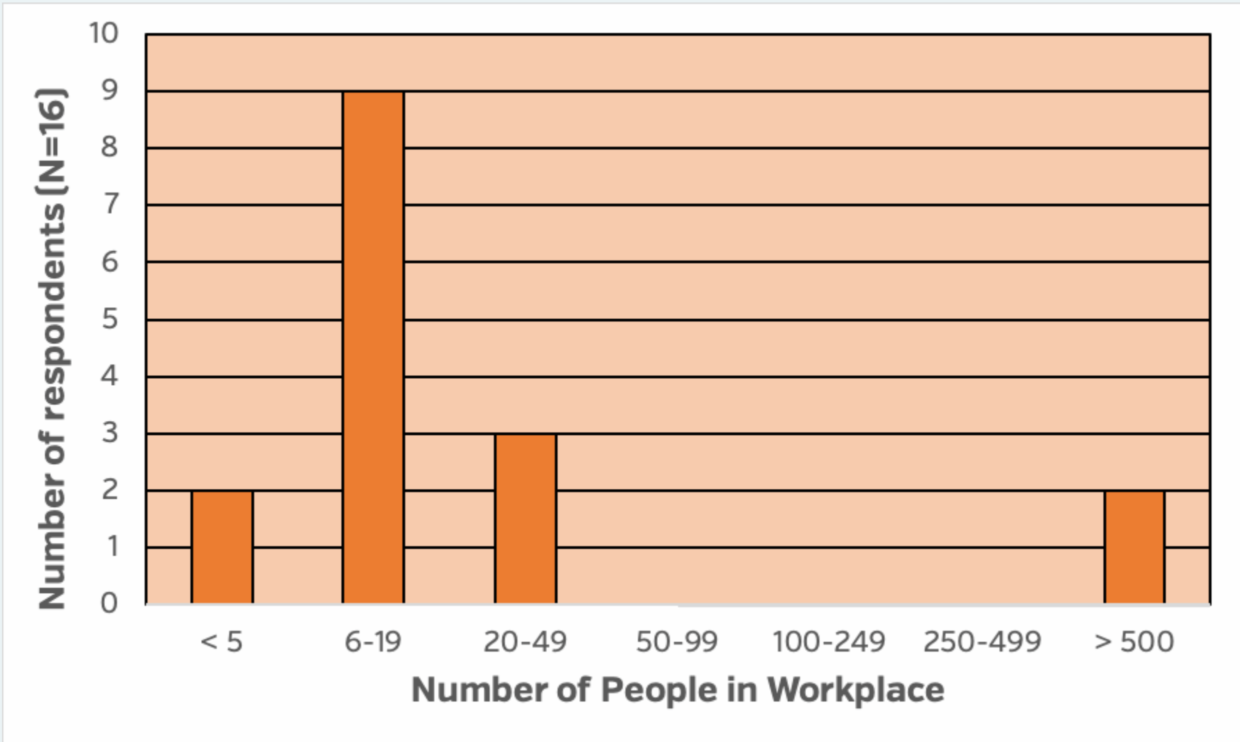


Figure 2: *Location of Participants' Workplace*

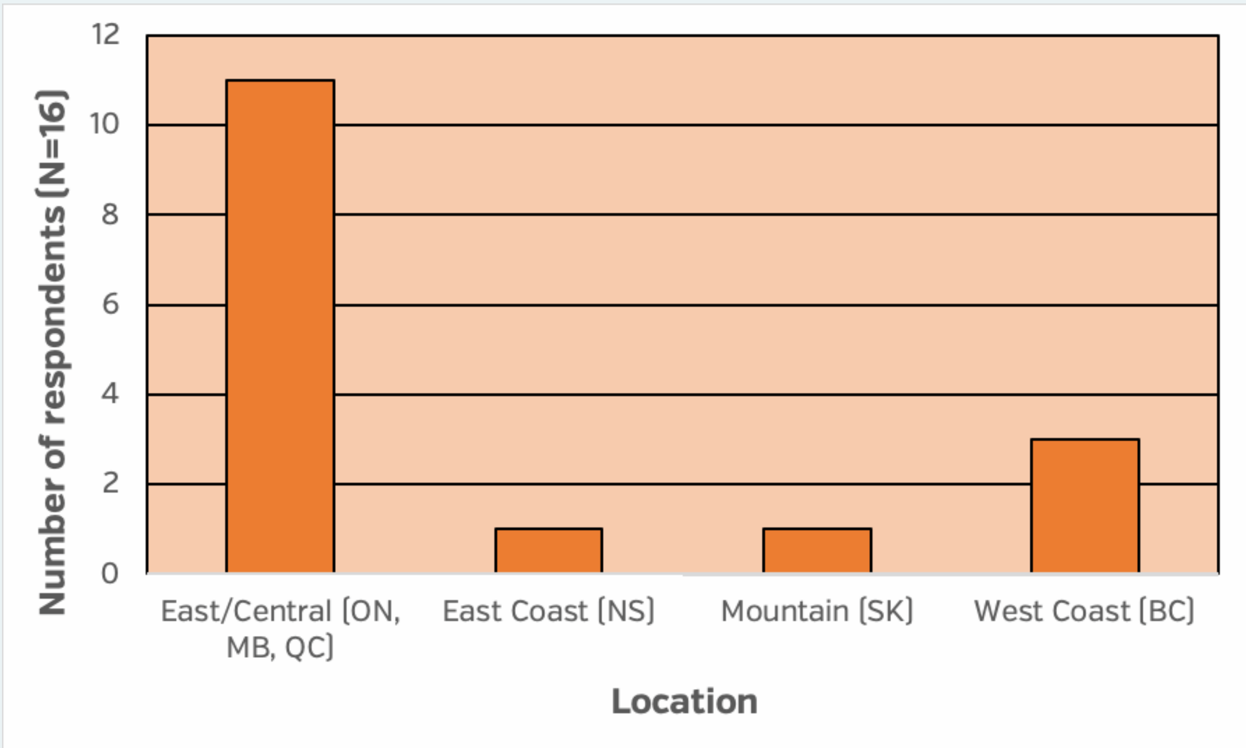


Figure 3: *Participants' Employment Status*

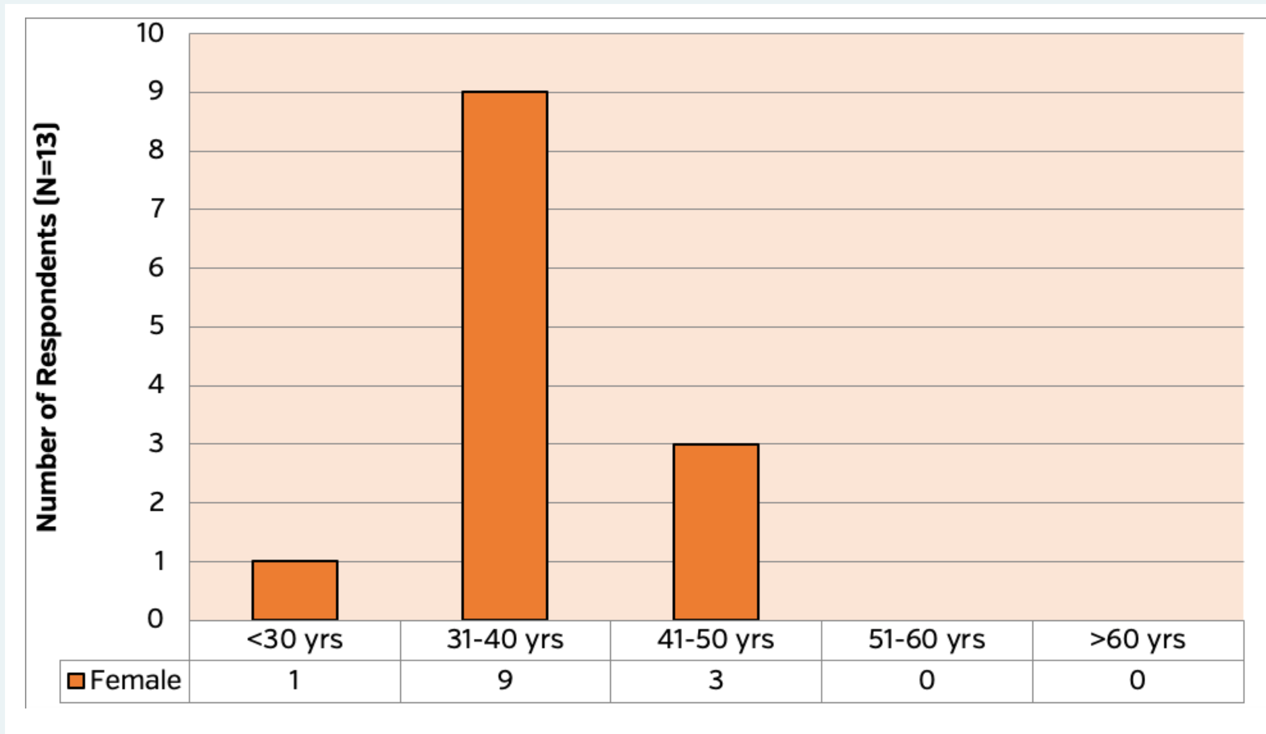
Midwives who responded to our pilot survey indicated that those aged 31 to 40 years (i.e., the child-bearing years), are most likely to be affected by mental health issues to such an extent that they decide to take extended leave (Figure 4). Our pilot survey data also indicated that having children is one of the key factors that can exacerbate mental health issues among midwives. This is supported by our scoping review, which found that burnout–described by Schaufeli and Greenglass as "a state of physical, emotional and mental exhaustion that results from a long term involvement in work situations that are emotionally demanding"[9] (and a significant factor in a decision to leave work)–occurs at a much higher rate among younger midwives and those who have worked for fewer than 10 years.[10]

The interviews revealed that while midwives may experience mental health challenges, some may opt out of taking a leave of absence because they cannot afford to be unemployed. One of our respondents explained that taking a leave was impossible for her despite her having suffered a severe episode of depression. She talked about the necessity to keep going to work despite her illness.

> *Well, I can't afford to take a leave of absence. In midwifery, if you don't work, you don't get paid, so I can't take a leave of absence, because I financially can't afford it.*

Whereas in some jurisdictions across Canada, midwives had access to sick leave, this option was not available in others. The survey data confirmed this finding, showing that midwives whose financial situation makes a leave possible are more likely to take it. For example, one midwife we interviewed in Ontario noted that taking a leave of absence was made financially possible through a "leave savings" plan, an option available to midwives through their provincial professional association: "So through the Association of Ontario Midwives, we have an option with every pay cheque to put money into something

Figure 4. *Age More Likely to Be Affected by Mental Health Issues to Extent of Causing Extended Leave*



called a 'leave savings.'"

Our interviews also revealed that some midwives decide to continue working while sick, a phenomenon known as *presenteeism.*[1] Describing such a situation and how it affects her job satisfaction, one respondent said the following:

> *I would love to just take a break, so that I could deal with the stress of it all, and I just can't. Is it healthy for me? No. Do I do it anyway? Yes. Does it take away my job satisfaction? Yes.*

Some respondents revealed that midwives might be unable to take a formal leave of absence, due to fear of losing their job or fear of stigma associated with disclosing mental health issues to others. One respondent put it as follows:

> *I was new at a practice. I didn't want my colleagues to know that I was having mental health concerns, because I didn't want them to fire me and I didn't want them to think poorly of me. And I didn't want to–for whatever reason–I didn't want to find myself in the situation where I wasn't working. Because I wasn't a permanent member of the practice.*

Similarly, another respondent stated,

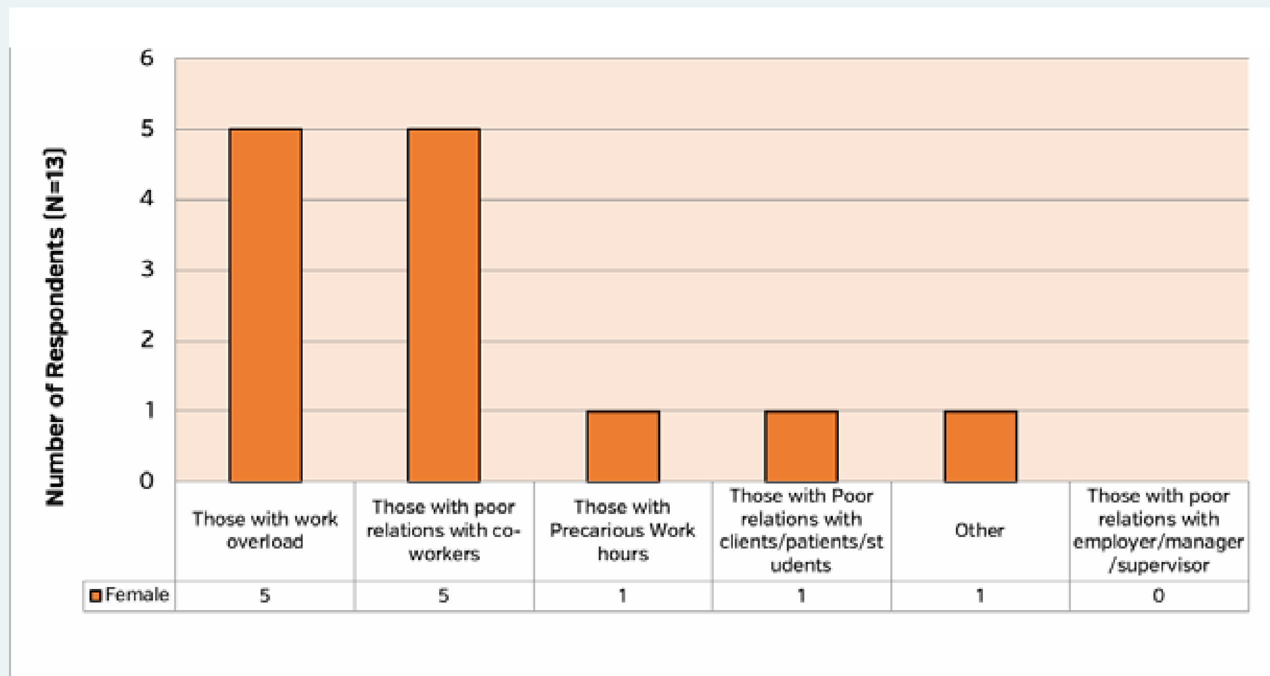
> *I think there's a lot of midwives who are burnt out and need to take a break, and they won't. And I think the burnout causes a lot of the bullying, which causes more stress, which causes more burnout.*

According to this last participant, the inability to take a break to get well creates further challenges that potentially lead to the exacerbation of mental health problems.

Workplace Factors That Cause Midwives to Leave Work

Many studies that we reviewed in our scoping review highlight how strongly work factors,[4,5,10,11] as

Figure 5. Those More Likely to Be Affected by Work-Related Factors More Likely to Cause Extended Leave



opposed to personal [12] or family factors,[13–15] influence midwives' decision to leave work. Indeed, poor work conditions—such as a lack of staff and resources; conflicts with midwifery colleagues, managers, and people from other health professions (e.g., nurses) with whom they often interact; the content of work; salary; inflexible hours; critical situations; threatening patients; and type of model of care—are what lead midwives to leave work.[5,10,11,15,16] Heavy workloads, long hours, and on-call work often lead to a significant amount of stress and burnout,[4,5,17] which affect midwives' work and their ability to maintain their work/life balance, and may lead to leaves of absence or attrition, even during professional training.[11, 13,18]

Our survey and interview findings, similar to findings from the literature, revealed that mental issues stemming from midwives' challenging working conditions play a significant role in their decision to take a leave of absence. Indeed, most of the survey respondents reported having known of members of the profession having experienced mental health issues to the extent of causing them to take extended leave. More than a third of respondents identified work overload or poor relations with co-workers (i.e., midwifery colleagues and other maternity care providers) as a likely work-related factor (Figure 5).

Explaining the link between midwifery work and the emergence of mental health problems, one respondent said the following:

> *I think that there's just an underlying aspect of this work that is not quite acute care, but that when you have to be on call and you have to be able to respond to somebody immediately, it just adds a level of adrenalin and, like, cortisol responses in your body.*

Some midwives also mentioned that difficult relationships with their colleagues may add to already existing stressors. One stated the following:

> *The most stressful piece for me is the lateral violence in midwifery. So, just the bullying and the way the model is set up of midwifery in Ontario, it creates power differentials. And I have been bullied pretty much since school, so I find the power differential between midwives is probably*

the most difficult part of my job.

According to this midwife, the challenges of midwifery practice can also stem from poor relational dynamics and the lack of support that some midwives experience in the workplace.

About a third of respondents who took part in our survey reported taking a leave of absence for mental health issues. Two of these leaves were attributed to anxiety and lasted from 4 months to over 6 months; two other, shorter leaves of 1 to 3 months were for other mental health challenges, including pre-existing mental health issues; and one leave, which lasted less than a month, was for stress.

The interviews revealed that midwives often take leaves of absence because of mental health issues such as stress, burnout, depression, anxiety, insomnia, borderline personality disorder, and post-traumatic stress disorder. In two of our respondents, post-traumatic stress disorder and insomnia were triggered by a negative or adverse clinical outcome. Midwives also reported taking leaves to care for family members with mental health concerns.Our review of the literature indicated that the model of care and organization of work may intersect with gender to have an impact on midwives' job satisfaction and their ability to respond to the demands of their stressful job. Indeed, some studies point to how the model of midwifery care can affect midwives' work satisfaction, affect their ability to maintain work/life balance, and precipitate burnout,[5,16,19,20] which in turn might influence midwives' decision to leave their jobs.[5,16] One Australian study, exploring the issue of work/life balance among midwives working within a caseload model of care, found that while "some of the midwives really embraced the flexibility of hours within a caseload midwifery model, and planned their workloads to accommodate their role of being a mother,"[16(p.314)] this was not the case for others involved in the study. The same study reported that uncertainty and on-call hours caused some of the study participants to leave work. It also showed that in addition to family support, the way in which work (that included reciprocal assistance within the team) was managed in the small group practice setting under study was important for helping midwives manage their flexible hours to better respond to family demands and achieve a work-life balance.[16] While some of our respondents recognized the importance of assisting each other, they also talked about how their taking a leave would result in a greater workload for their midwifery colleagues, and, in turn, more stress.

Factors Fostering Midwives' Return to Work

Our pilot study also revealed that, in addition to some personal factors, return-to-work (RTW) programs and policies might be helpful in regard to both shorter and longer periods of absence. In their study on an Australian Nursing and Midwifery Refresher program that aims to support the return of registered midwives and nurses to the workforce after a long absence, McMurtrie and colleagues found that more than half of applicants completed the program, after which many found a job in a health care sector.[15] Participants noted that the primary reason for returning to work was maintenance of registration, followed by children becoming older, the need for additional income, the desire to make a contribution to society and personal circumstances. The researchers noted, however, that some midwives could not participate in the program owing to inaccessibility in rural or remote local facilities, family responsibilities, ill health, or the inability to arrange clinical placement hours. Given the gender roles that relegate child care to women, it would be of interest to know the impact of gender on the RTW experiences of midwives with mental health issues. None of the reviewed studies explored this explicitly.

Most of the survey respondents who had taken a leave of absence for a mental health issue noted the presence of RTW policies or programs and noted that they were largely not difficult to access. Our interviews with midwives revealed that having an RTW plan that includes reduced hours and eliminates night work seemed to be very important in enabling the successful return to work of midwives suffering from mental health issues. For instance, for the first 2 weeks after her sick leave, one of our respondents was allowed to be on call from 8:00 am to 8:00 pm (instead of the regular 24 hrs,) which helped her return to work gradually and feel comfortable in the process.

The possibility of having a reduced workload

during the process of returning to work seemed to be especially important for midwives in a non-employee model of care where accommodations are not arranged with employers. However, as one midwife who was on leave and contemplating how best to return to work noted, working part-time in midwifery is difficult to do.

> *It's just that you have to do backup with your colleague, and if they're full-time and you're doing backup or they're doing backup for you, you end up working the same amount, even if I'm taking less of a load.*

A self-employed participant explained that although a short-term disability allowance available to Ontario midwives takes away financial stress while they are on leave, it takes them about a year in some practices to build a new caseload (i.e., get new clients) and receive financial compensation once they are back at work.

DISCUSSION OF EMERGING FINDINGS

Our pilot study begins to address some important knowledge gaps in regard to leaves of absence and return to work for midwives who experience mental health issues. Our review of the literature, as well as our pilot empirical components, indicates that the difficult working conditions a midwife faces—such as work overload, inflexible hours, and critical situations—may lead to mental health issues, which in turn cause the midwife to take a leave of absence. A cluster of factors is beginning to emerge as critical to leaves of absence: being 31 to 40 years old, having less work experience, having dependents, experiencing work overload and poor relations with co-workers, and being able to afford unemployment. This is an important revelation, given the relative lack of studies that explicitly explore the demographic characteristics of those who are more likely to have personal or familial mental health issues to such an extent that they leave work.

Our study also shows that some midwives decide to stay at work because of the stigma associated with mental health challenges and broader financial constraints. Despite the loss in productivity that presenteeism can cause (much greater than those incurred by absenteeism, according to some estimates),[21] the existing literature in both Canadian and international contexts does not address presenteeism among midwives who experience mental health issues. This is an important gap that needs to be explored.

Our survey and interview findings also show that midwives seem to be aware of RTW programs and that they do not face barriers to accessing such programs. Surprisingly, in our scoping review, we identified only a few studies that explicitly evaluate RTW programs, and those studies focused mostly on programs aimed at fostering midwives' return to practice after a longer absence.

Our pilot study provides some insights on the relatively unexplored issues of midwives' leaves of absence and return to work but is also a great starting point for future research. Areas in need of special attention include presenteeism in midwifery; RTW programs for midwives; and the impact of gender roles, relations, and norms on their experiences. The lack of attention to gender issues in the existing literature is surprising, given that midwifery is a profession disproportionally dominated by women.

LIMITATIONS AND NEXT STEPS

Although our study offers insights into these underexplored issues, our pilot study is small, and generalizing from our findings should be done with caution. This pilot study was intended to inform the next steps in our Healthy Professional Worker study. On this basis, we have designed a more extensive survey and interview guide that we are currently deploying across our seven case-study professions, including midwifery. Wider participation will enable our team to explore and compare midwives' experiences with mental health issues across different provincial contexts under different models of care. This in turn could enable our partner organizations to develop more gender-sensitive policies and programs to improve overall wellness at work and to respond in a more timely way when difficulties arise.

REFERENCES

1. Kitts J. Psychological health and safety in Canadian healthcare settings. Healthc Q. 2013;16(4):6-9.
2. Rice V, Glass N, Ogle KR, Parsian N. Exploring physical health perceptions, fatigue and stress among health care professionals. J Multidiscip Healthc. 2014;7:155-61.
3. Henriksen L, Lukasse M. Burnout among Norwegian midwives and the contribution of personal and work-related factors: a cross-sectional study. Sex Reprod Healthc. 2016;9:42-7.
4. Pezaro S, Clyne W, Turner A, Fulton EA, Gerada C. 'Midwives Overboard!' Inside their hearts are breaking, their makeup may be flaking but their smile still stays on. Women Birth. 2016;29(3):e59-66.
5. Stoll K, Gallagher J. A survey of burnout and intentions to leave the profession among Western Canadian midwives. Women Birth. 2019;32(4):e441–9.
6. Butska L, Stoll K. When midwives burn out: differences in the experiences of midwives in British Columbia and Alberta. Can J Midwifery Res Pract. 2020;19(2):20-30.
7. Beck CT, LoGiudice J, Gable RK. A mixed methods study of secondary traumatic stress in certified nurse midwives: shaken belief in the birth process. J Midwifery Womens Health. 2015;60(1):16-23.
8. Creedy DK, Gamble J. A third of midwives who have experienced traumatic perinatal events have symptoms of post-traumatic stress disorder. Evid Based Nurs. 2016;19(2):44.
9. Schaufeli WB, Greenglass ER. Introduction to special issue on burnout and health. Psychol Health. 2001;16(5):501-10.
10. Hildingsson I, Westlund K, Wiklund I. Burnout in Swedish midwives. Sex Reprod Healthc. 2013;4(3):87-91.
11. Kordi M, Mohamadirizi S, Shakeri MT, Modares Gharavi M, Salehi Fadardi J. The relationship between occupational stress and work ability among midwives in Mashhad, Iran. J Midwifery Reprod Health. 2014;2(3):188-94.
12. Schrøder K, Jørgensen JS, Lamont RF, Hvidt NC. Blame and guilt–a mixed methods study of obstetricians' and midwives' experiences and existential considerations after involvement in traumatic childbirth. Acta Obstet Gynecol Scand. 2016;95(7):735-45.
13. Neiterman E, Lobb DK. Women centred but not women friendly: understanding student attrition in the Ontario Midwifery Education Programme. Gend Work Organ. 2014;21(3):244-59.
14. Pugh JD, Twigg DE, Martin TL, Rai T. Western Australia facing critical losses in its midwifery workforce: a survey of midwives' intentions. Midwifery. 2013;29(5):497-505.
15. McMurtrie LJ, Cameron M, OLuanaigh P, Osborne YT. Keeping our nursing and midwifery workforce: factors that support non-practising clinicians to return to practice. Nurse Educ Today. 2014;34(5):761-5.
16. Fereday J, Oster C. Managing a work–life balance: the experiences of midwives working in a group practice setting. Midwifery. 2010;26(3):311-8.
17. Yoshida Y, Sandall J. Occupational burnout and work factors in community and hospital midwives: a survey analysis. Midwifery 2013;29(8):921-6.
18. Wilson R, Eva K, Lobb DK. Student attrition in the Ontario midwifery education programme. Midwifery. 2013;29(6):579-84.
19. Fenwick J, Sidebotham M, Gamble J, Creedy DK. The emotional and professional wellbeing of Australian midwives: a comparison between those providing continuity of midwifery care and those not providing continuity. Women Birth. 2018;31(1):38-43.
20. Newton MS, McLachlan HL, Willis KF, Forster DA. Comparing satisfaction and burnout between caseload and standard care midwives: findings from two cross-sectional surveys conducted in Victoria, Australia. BMC Pregnancy Childbirth. 2014;14(1):426.
21. Workman, C. Mental Health in the Workplace: Best Practices and Strategies for Organizations [November 28, 2019]. Available from: https://sprott.carleton.ca/parg/wp-content/uploads/

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