



When Midwives Burn Out: Differences in the Experiences of Midwives in British Columbia and Alberta

*Quand les sages-femmes souffrent d'épuisement
professionnel : différence des expériences des
sages-femmes de la Colombie-Britannique et de
l'Alberta*

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ABSTRACT

Background: Internationally, continuity of care has been identified as a possible strategy to prevent burnout. The majority of midwives in British Columbia and Alberta practice within a continuity-based model of care, but British Columbia midwives have significantly higher burnout scores.

Methods: We compared data from midwives from Alberta and British Columbia who responded to the Canadian arm of the WHELM [Work, Health, and Emotional Lives of Midwives] survey through invitations via their professional organizations. The survey included demographic questions, items about work patterns, occupational stressors, burnout, and intentions and reasons to leave the profession.

Results: Workload was the most commonly reported stressor in both British Columbia and Alberta. Midwives in British Columbia were more likely [54%] to have seriously considered leaving the profession in the last 12 months than midwives in Alberta [26%]. One-third of British Columbia midwives and no Alberta midwives cited poor pay as a reason to leave the profession. In answers to open-ended questions, 47% of respondents from British Columbia, but none from Alberta, highlighted poor pay as something that would need to change in order for them to successfully manage workplace stress.

Discussion and Conclusion: Our comparison of similar midwifery contexts in Western Canada suggests burnout and intention to leave the profession are associated with how the care is remunerated. Midwives in British Columbia and Alberta care for a similar volume of clients and are paid with a similar type of payment system, but midwives in British Columbia are paid significantly less per course of care. A revised payment system or a significant increase in pay per client may ensure that midwives in British Columbia can continue to provide high-quality relationship-based care while maintaining longevity in the profession.

KEYWORDS

burnout, continuity of care, funding, midwifery, midwives, work

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RÉSUMÉ

Contexte : À l'échelle internationale, la continuité des soins a été identifiée comme une stratégie possible de prévention de l'épuisement professionnel. En Colombie-Britannique et en Alberta, la majorité des sages-femmes pratiquent dans un modèle de soins axé sur la continuité, mais celles de Colombie-Britannique présentent un score d'épuisement professionnel considérablement plus élevé.

Méthodes : Nous avons comparé des données de sages-femmes de l'Alberta et de la Colombie-Britannique qui ont répondu au volet canadien de l'étude WHELM [travail, santé et vie émotionnelle des sages-femmes] à la suite d'invitations de leur organisme professionnel en 2016. L'enquête comportait des questions démographiques et d'autres portant sur les régimes de travail, les facteurs de stress professionnel, l'épuisement professionnel, l'intention d'abandonner la profession et les raisons de cette décision.

Résultats : La charge de travail a été le facteur de stress le plus souvent mentionné tant en Colombie-Britannique qu'en Alberta. Les sages-femmes britanno-colombiennes sont plus susceptibles [54 %] d'avoir sérieusement songé à quitter la profession au cours des 12 mois précédents que leurs homologues albertaines [26 %]. Un tiers des sages-femmes britanno-colombiennes ont donné les bas salaires comme raison de quitter la profession, alors qu'aucune sage-femme albertaine n'a indiqué ce motif. En réponse à des questions ouvertes, 47 % des sages-femmes britanno-colombiennes ont établi un lien plus explicite entre les bas salaires et leur incapacité à bien gérer la charge de travail, mais aucune sage-femme albertaine n'a fait ressortir cette relation.

Discussion et conclusion : Il faut démêler certains aspects du modèle de continuité des soins pour envisager les constatations sur l'épuisement professionnel dans le contexte de la manière dont ce modèle est mis en pratique et rémunéré. La capacité de maintenir le service sur appel exigé dans un modèle

canadien de soins peut dépendre d'une rémunération adéquate, afin que les sages-femmes bénéficient d'une autonomie relativement à leurs conditions de travail.

MOTS-CLÉS

épuisement professionnel, continuité des soins, financement, pratique sage-femme, sages-femmes, travail

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BACKGROUND

According to the World Health Organization, burnout is “a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed.”¹ A recent scoping review of the existing literature on burnout in midwifery revealed an overall high level of burnout for midwives. The most commonly reported associated factors were less work experience, the practice of non-caseload/non-continuity models of care (such as hospital shift work), younger age, high workload or fewer days off work, and trauma or stress experienced at work.² There has been increasing interest in how models of midwifery care impact the well-being of midwives,³⁻⁷ after earlier studies found that continuity midwifery models were associated with lower levels of midwifery burnout.^{8,9}

To better understand burnout and the experiences of Canadian midwives, a team of researchers in the Division of Midwifery at the University of British Columbia led the Canadian arm of a survey developed by the international Work, Health, and Emotional Lives of Midwives (WHELM) research consortium (<https://www.transformingmaternity.org.au/work-health-and-emotional-lives-of-midwives-whelm/>), led by researchers from Australia¹⁰ and the UK.¹¹ In this paper, we compare Alberta and British Columbia's results for the Canadian arm of the WHELM survey. Midwives in the two neighbouring provinces adhere to the Canadian Model of Midwifery Care,¹² which includes seven core principles: professional autonomy, partnership, continuity of care provider, informed choice, choice of birth place, evidence-based practice, and collaborative care. British Columbia [BC] and Alberta midwives also practice

within a similar independent practitioner model of payment based on course of care or per client funding.

METHODS

In 2016 and 2017, the Royal College of Midwives in the UK commissioned Cardiff University [UK] and Griffith University [Australia] to develop the WHELM survey as part of a larger program of research aimed at understanding occupational stress among the midwifery work force. The survey has been administered in the UK, Australia, New Zealand, Sweden, Norway, Germany, and Canada. The WHELM survey includes a demographic section; several questions about midwives' intention to leave the profession and the reasons why; and several scales, including the Copenhagen Burnout Inventory [CBI]. In the current analysis, CBI scores are reported as continuous scores. The authors of the CBI categorize scores of 50-74 as moderate burnout, scores of 75-99 as high burnout, and a score of 100 as severe burnout.¹³ The subscale that measures work-related burnout included questions such as “Do you feel burnt out because of your work” and “Are you exhausted at the thought of another day of work ?” Questions such as “How often do you feel worn out?” measure personal burnout. The client burnout subscale assesses whether midwives feel stress, exhaustion, and burnout specifically with respect to working with clients (e.g., “Are you tired of working with clients?”).¹³

The Canadian arm of the WHELM study was led by a team of researchers in the Division of Midwifery at the University of British Columbia; findings from the study were published in 2018.¹⁴ The survey was minimally adjusted to the Canadian context by a

Workload is a known contributor to midwifery burnout.

team of midwives, researchers, and representatives from the Midwives Association of British Columbia [MABC]. The MABC then distributed the Canadian version of the survey to midwives in BC. Requests to distribute the survey were also sent to midwifery organizations in Alberta and Ontario, and the Alberta Association of Midwives also distributed the survey to midwives in Alberta.

During the original analysis, significant differences in overall burnout scores between BC and Alberta midwives were documented. This led our team to compare midwives from these two provinces more closely; specifically, in the current analysis their respective survey results are compared to explore potential reasons for the differences in burnout, occupational stress, and intentions to leave the profession.

RESULTS

Midwives in BC were more likely to respond to the survey; 129 [46%] of practicing midwives in BC responded, whereas 28 [26%] of those in Alberta responded. The mean age for midwives in both provinces was 41 years. Experience and years in practice were similar: Alberta midwives had been practicing an average of 8 years, and BC midwives an average of 10 years. The proportion of complex cases [i.e., women with complex social or medical needs] that midwives care for were also similar: complex care was estimated at 2% among midwives in both provinces. Midwives in BC reported that they provide continuity of care to an average of 43 women, versus 34 women per year for Alberta midwives. The number of annual vacation days were lower in BC [37 days] than in Alberta [45 days].

In terms of CBI scores, BC and Alberta midwives differed in several ways. Midwives in BC scored much higher than Alberta midwives: Overall median CBI scores were 49 in BC and 36 in Alberta. Midwives in BC scored higher on all the subscales except the client burnout subscale, on which the midwives in both provinces scored similarly [29 in BC and 27 in Alberta]. Midwives in BC with children 5 years of age or younger had a much higher median burnout score [54, considered “moderate”] on the CBI than Alberta midwives with young children had [34, or “low”].

Intentions to Leave the Profession

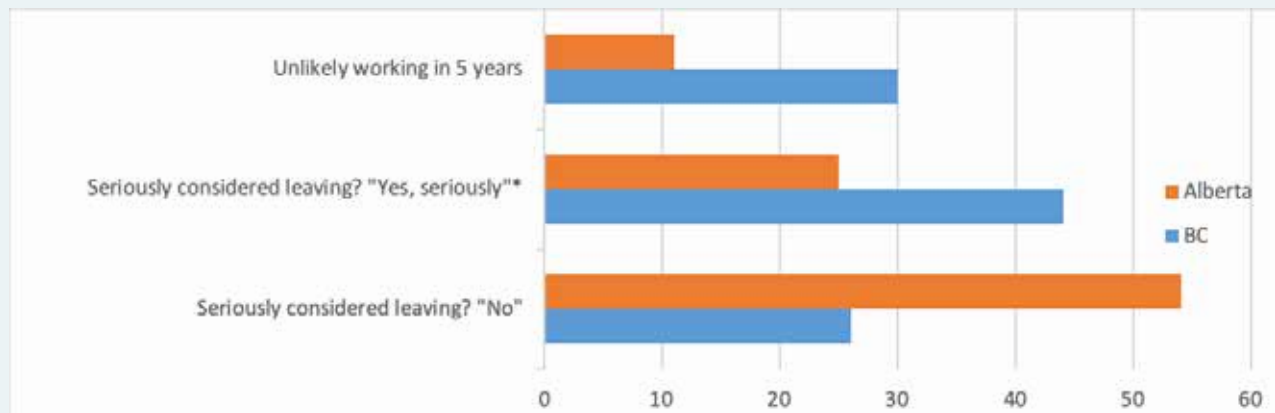
Figure 1 shows the responses to the question, “Over the last 12 months, have you considered leaving the midwifery profession?” Most midwives in Alberta [57%] had not considered leaving midwifery. Most BC midwives [67%] answered that they had considered leaving. Midwives in BC were more likely to have *seriously* considered leaving the profession in the previous 12 months than were respondents in Alberta [44% versus 25%]. More midwives in BC [30%] than in Alberta [11%] also replied that it was unlikely or very unlikely they would be working in 5 years.

Common and Different Stressors

Table 1 lists the occupational stressors that midwives experienced during the 12 months preceding data collection, stratified by province. Respondents were asked to check the response only if they had experienced stress as a result.

Workload was a commonly reported stressor in both BC and Alberta; 67% of respondents in BC and 54% of those in Alberta cited “too much work/not

Figure 1. Intentions to leave work



* Includes responses "Yes, seriously, but no plans made" and "Yes, seriously, I have made plans."

enough time off" as an occupational stressor.

Midwives who responded that they were considering leaving midwifery were then also asked to identify factors that contributed to such consideration. More BC midwives ($n = 86$) than Alberta midwives ($n = 12$) answered this question [since more BC midwives had considered leaving the profession]. The most common reasons given in both provinces were being on call and its impact on their personal life, their own mental and physical health, and the lack of support for sick days and vacation coverage [Table 2].

We observed differences between BC and Alberta midwives in terms of the most commonly cited reasons for considering leaving the profession [see Table 2]. For the small number of Alberta midwives who had considered leaving the profession, fear of litigation was the most commonly cited reason, whereas in BC litigation was not a common reason for leaving the profession. Reasons for leaving given more often by midwives in BC than by those in Alberta were financial reasons, including professional costs [55%] and poor pay [30%]. Many more midwives in BC also cited family commitments as a reason for considering leaving midwifery [38%]. This difference is consistent with the result noted earlier—namely, that midwives in BC with children 5 years of age or younger had much higher median burnout scores than Alberta midwives with young children. The three reasons cited more by BC midwives than by Alberta midwives were

professional costs [55% of BC midwives vs. 8% of Alberta midwives], poor pay [30% vs. 0%, and family commitments [38% vs. 17%].

As noted above, the most dramatic difference in survey responses between Alberta and BC midwives was evidenced in answers to the survey question, "What reasons have contributed to you considering leaving the midwifery profession?" Recognizing that many more BC respondents than Alberta respondents cited financial reasons [poor pay and professional costs], we decided to analyze responses to open-ended questions that were embedded within the survey, focusing on individual-level midwifery compensation. Midwives surveyed were asked the following open-ended questions: "What would need to change for you to experience less occupational stress and greater job satisfaction?" and "Are there any other comments you would like to make before submitting your responses?" Of Alberta midwives, 75% ($n = 21$) offered a response to one or both of these open-ended questions; 85% ($n = 110$) of the midwives in BC responded.

We created the category "midwifery compensation" by including comments that included the following words or phrases: "pay," "money," "compensation," "income," "benefits," "financial," "billing," "earn a living," "salary," and "income." We excluded the word "funding," as this word was used most often to comment on government policy and support for midwifery as a maternity care option

Table 1. Proportion of Midwives Who Reported Selected Occupational Stressors, Stratified by Province

Stressor	BC (n = 129)	Alberta (n = 28)	Difference
Work load too high/not enough time off	67%	54%	13.00
Too little work	22%	7%	15.00
Conflict with midwifery colleagues	37%	50%	-13.00
Conflict with other health care professional colleagues	40%	54%	-14.00
Conflict with hospital administrators or staff	18%	21%	-3.00
Conflict with clients and/or families	28%	29%	-1.00
Poor maternal or newborn outcomes	37%	54%	-17.00
Problems with maintaining or obtaining hospital privileges	12%	7%	5.00
Actual or threat of disciplinary action	5%	14%	-9.00
Difficulties supporting normal physiologic birth in hospital	37%	29%	8.00
Other	30%	36%	-6.00
No work-related stressors	5%	4%	1.00

rather than as individual compensation. Answers including one or more of these words were re-read to confirm that comments related at least in part to individual-level midwifery compensation. All responses were read individually to ensure that all referred to individual-level payment or compensation.

Of the responses received from BC midwives, 52 of 110 (47%) included the search words for the category midwifery compensation. None of the responses from Alberta midwives included any of the words in the compensation category. This supported the finding of the earlier survey results—namely, that financial reasons for leaving midwifery were unique to BC.

One midwife in BC explicitly noted that pay for midwives was not commensurate with the level of responsibility and stress in her profession.

“I am underpaid for the level of responsibility and stress I experience.”

Midwives in BC said that poor pay had prevented them from choosing sustainable workloads. Some made an explicit connection between poor remuneration and their high volume of work.

“(We are) forced to work so much clinically in order to earn enough money.”

“I love my job. I just wish I could get a salary sometimes and not feel like its all about the money... with breaks, I like midwifery. The pace I work is obviously not sustainable, but [I have] overhead and bills/loan payments”

“My personal practice is very emphasized on making money as we don't have pension or other benefits... this leads us to take more clients than one can sometimes reasonably take care of and still provide decent patient care and have some work/-life balance.”

Midwives in BC said that poor pay had prevented them from taking enough time off, as the cost of hiring someone was prohibitive.

“We also find it impossible to find space to take holidays, due to finances...so, I work and work and work and don't get breaks.”

“More time off with longer recovery between shifts. Physical exhaustion from long shifts impacted scheduled

Table 2. Answers to “What reasons have contributed to you considering leaving the midwifery profession?”

Reason*	BC n = 86	Alberta n = 12	Difference
Planned career change	5%	0%	5
Family commitments	38%	17%	21
Planned retirement	10%	0%	10
Physical health	59%	50%	9
Mental health	80%	92%	-12
Poor pay	30%	0%	30
Dissatisfaction with the model of midwifery care	36%	33%	3
Issues with gaining or renewing hospital privileges	8%	0%	8
Interprofessional conflict	24%	33%	-9
Dissatisfaction with my role as a midwife	19%	33%	-14
Conflict with other midwives	10%	50%	-40
Fear of litigation	15%	58%	-43
Barriers to maintaining competency	8%	0%	8
Scheduling challenges	30%	50%	-20
Challenges related to practicing in a rural area	14%	0%	14
Lack of career pathway/opportunities to progress	40%	25%	15
Inability to find off-call work	40%	25%	15
Professional costs	55%	8%	47
Lack of support for sick days or vacation cover	52%	42%	10
Dissatisfaction with working conditions	44%	58%	-14
Dissatisfaction with level of consultation about workplace policy	14%	33%	-19
Experience of being bullied	35%	33%	2
Negative impact of on-call schedule on personal life	84%	92%	-8
Other	23%	17%	6

* Reasons given more often for leaving by midwives in BC than by those in Alberta are noted in boldface.

plans and days off. Cannot afford to take time off.”

One midwife in BC who commented on low pay also noted the difficulty of attending long labours with no option for relief.

“A sensationalization of the ‘hero’ archetype who can stand by her client for so many hours that she is technically intoxicated...This is not a safe working environment

for midwives or their clients. I feel trapped by this profession, and I mourn my life, even though I LOVE my job and want to continue.”

Responding about what needed to change, another BC midwife noted the stress of not being able to find another midwife so that she could attend to her own sick children.

“The ability to find coverage when sick or child is sick. It is difficult

feeling like there is no room in this work for illness or to take time off for family emergencies."

The need for better or different compensation in rural communities where BC midwives often work as solo midwives was particularly noted.

"A salary in rural/remote setting, to mitigate financial stress. More affordable call coverage options for solo practitioners"

"Salary-based compensation with expanded scope for well women and baby/child care for rural and remote midwives. This would allow two midwives to stay gainfully employed in service to a community and reduce the solo practice burnout problems."

One BC midwife commented on the feasibility of BC's rural locum program, which provides top-up funding for a midwife to hire a locum for a maximum 15 days per year but requires host midwives to pay a base fee for locum call coverage out of their own earnings.

"There were months where I couldn't make ends meet. I have two little kids...The rural locum program is not feasible for someone who doesn't have clients every month. There was no support! There was no private time, no weekends off! I would have needed a set income so losing a birth here or there wouldn't have financially impacted me."

"The doctors were supportive and would cover me if needed, but that meant women didn't have midwifery care and I had no money."

None of the responses from Alberta midwives mentioned individual compensation. All 21 of the Alberta responses were re-read to ensure that no responses related to compensation were missed. When asked what would need to change, six respondents noted the provincial funding cap (which prevented the expansion of midwifery), and eight expressed a desire for more time off call. Seven of the written Alberta responses to this question were left blank or were positive. One midwife responded

with the following:

"I feel lucky and grateful that after 37 years my avocation and vocation are still in harmony. I love being a midwife!"

DISCUSSION

The World Health Organization describes burnout as a distinct occupational phenomenon resulting from chronic workplace stress that has not been successfully managed. Workload is a known contributor to midwifery burnout, and the potential for midwife burnout in the Canadian system was anticipated by Benoit and Heitlinger in 1998,¹⁵ the year of midwifery regulation in both BC and Alberta. Midwives in our study in both Alberta and BC noted a high workload and the negative impact of being on call. Although overall, BC midwives care for more clients as the primary midwives, Stoll and Gallagher's original study found that the number of clients cared for was not significantly associated with burnout.¹⁴ In fact, Alberta midwives are on call for and attend more births per annum in total, since two midwives are required to be on call and to attend all midwifery-led births in Alberta. Whereas BC midwives have the support of nursing staff for all hospital births and rural home births, Alberta midwives attend more births as "second" midwives. Attending more births as a second attendant supplements an Alberta midwife's income; the average income per course of care is approximately 30% more in Alberta. [The 2018 scoping review by Thiessen et al. provides an overview of employment models and compensation in the two provinces.]¹⁶

Stoll and Gallagher's study confirmed that in Western Canada, midwife burnout increases with less time off.¹⁴ As the number of vacation days increased, burnout decreased, and midwives who considered leaving the profession also had fewer vacation days compared to those who did not want to leave (38 days vs. 43 days). In our results, midwives in Alberta reported having more vacation days. In both Alberta and BC, midwives are not employees and are thus not eligible for paid days off or vacation days. However, higher levels of pay in Alberta likely allow midwives to more readily arrange for more time off.

Neither province restricts the number of hours a midwife may work in a row. There is obvious potential for exhaustion when midwives provide continuity throughout a long labour. A study by Yoshida and Sandall found that working more hours was significantly associated with higher levels of emotional exhaustion for midwives in both community and hospital models of care.⁷ BC midwives also noted in their responses to open-ended questions that poor pay in BC resulted in midwives' working more hours to make ends meet and being unable to pay for relief. The result, according to one midwife, is midwives who are so tired that they are "legally intoxicated." This may be more of a problem in BC, where midwives work alone typically for call periods of at least 24 hours, whereas midwives in Alberta work in pairs. The pay structure may also discourage midwives in BC from calling for relief, since only one midwife is paid to attend hospital births, and so midwives pay out of pocket for relief in hospital. In both provinces, various midwifery practice groups and midwives may arrange more-supportive call structures, with payment arrangements to prevent long working hours.

Providing round-the-clock care in a payment model that is volume based makes maternity particularly difficult to sustain for midwives and physicians who work in rural or remote areas of BC. Compensation for rural midwives in BC is low, as most are paid as independent contractors by volume of births, even if they are the only maternity care providers in their community. (For example, midwives are the sole care providers at several "1A" maternity sites in rural BC, where there is no local access to childbirth through cesarean section.) From open-ended comments, it is clear that midwives in rural areas of BC are experiencing particularly stressful work that is related to unstable pay. As noted by Barclay and Kornelsen, new and innovative models of payment should be considered in rural areas of BC; the current volume-based system is not financially viable for rural midwives.¹⁷ Their call for alternative forms of payment should be heeded in Alberta as well, as that province expands midwifery to historically underserved rural communities.

LIMITATIONS

A major limitation of this study is the low rate of response from Alberta midwives, which prevents us from generalizing the findings to all Alberta midwives. Most midwives in Alberta did *not* reply to the question of why they wanted to leave the profession; only those who had considered leaving responded. Thus, the analysis of litigation as a reason why Alberta midwives want to leave must be interpreted with caution. We recommend that a short survey assessing intentions to leave the profession, occupational stressors, and burnout be distributed to midwives across Canada at regular intervals (every 2 to 3 years) to track these important data points. Ideally, most or all midwives should respond to such surveys in order to make reliable claims about midwives' intentions to leave and related factors.

Another major limitation of this study is that it did not address specific and different ways in which midwives experienced on-call time, which they identified as a main stressor. Significant differences in some of the ways that midwives in BC and Alberta practice affect the midwives' on-call arrangements—for example, time spent on call actually doing work, what that work is like, where the work is done, and whether and when other midwives are available for relief. Given that not enough time off was the stressor most commonly experienced in both provinces, we recommend further study into how midwives in different regions of Canada arrange for and experience their on-call time, with special attention to working hours and sleep deprivation. The study should include questions about the length of time midwives spend on call, their access to support for long labours, the amount of time that can be taken off for illness and vacation, and the impact of pay and benefits on the particular call arrangements. Research should explore how midwifery is implemented, specifically in communities where burnout rates are low.

Research should also explore how work preferences and actual work sites relate to burnout and retention. In their recent pan-Canadian study of 720 midwives, Zeytinoglu et al. found that most midwives preferred out-of-hospital locations as birth sites.¹⁸ Our study did not address birth sites, but at the time of our survey, 48% of midwifery

Compensation can affect midwives' ability to effectively manage workplace stress.

births in Alberta were out of hospital [at homes and at birth centres], whereas 14% of births in BC were at home [BC has no birth centres]. The relationship between birth site, midwifery work site preference, and burnout should be explored.

CONCLUSION

Our study shows that compensation for midwifery care can affect midwives' ability to effectively manage workplace stress. Alberta midwives experience high workload but are paid well and intend to stay in the profession. Midwives in BC are paid a third less for similar care and have significantly higher burnout scores than Alberta midwives; many are considering leaving the profession. Poor pay in BC encourages a higher volume of work, more hours working, and less time off. Open-ended comments by BC midwives show their struggle to maintain safe and financially viable work while providing high-quality midwifery care.

Although the independent practitioner model of payment might appear to promote the independence and autonomy of midwives, the results of this survey show that independence—in terms of the ability to choose the workload and time off—may be compromised when pay or remuneration is low. Continuing research and efforts toward equitable work and payment models for midwifery in Canada are essential to ensure career longevity for Canadian midwives.

In February 2020, after a very long pay equity challenge, the Human Rights Tribunal of Ontario, recognizing that midwives in that province have experienced gender discrimination, ordered a

pay raise. The Association of Ontario Midwives continues to advocate for pay equity during the ongoing legal battle. Without attention being given to the realities of midwives' working conditions, midwives will continue to struggle with the "caring dilemma" noted in 1998 by Benoit and Heitlinger, who wrote that Canadian midwives "have the capacity to show altruism towards others [birthing women] but have not yet gained sufficient work autonomy to organize their caring activities in such a manner that they avoid being subservient."¹⁵

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Kathrin Stoll is a midwifery researcher at the Birth Place Lab, Midwifery Program, University of British Columbia. She is a member of an international consortium of researchers who study burn out and attrition among midwives around the world, with the goal of identifying sustainable models of midwifery practice and ways of working. Kathrin collaborates with community members and clinician-researchers on several provincial, national, and international projects about respectful maternity care and person-oriented models of care delivery. Kathrin is an instructor in the European Master of Science in Midwifery program and serves on several PhD committees for midwifery doctoral students in Europe and Canada. In these roles she has built research and publication capacity for trainees from different communities and from different health professional backgrounds.