

SUSTAINABLE MIDWIFERY PRACTICE TASKFORCE

Final Report 2020



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Taskforce members who agreed to be named:

Alix Bacon, RM, President, Midwives Association of BC (MABC)

Kathrin Stoll, PhD, Research Associate, Birth Place Lab, BC Women's Hospital

Luba Butska, RM, PhD, Assistant Professor of Teaching, Midwifery Program, University of British Columbia

Tanta Momtazian, RM, President, College of Midwives of BC (CMBC)

Marella Falat, RM & Colleen Fulton, RM, Engagement Working Group (MABC)

Kate Shapiro, Midwifery student & project assistant, University of British Columbia





SUMMARY

Informed by two years of data collection with BC midwives, the *Sustainable Midwifery Practice Taskforce* (SMPT) used an appreciative inquiry framework to identify solutions to occupational stress and burnout among BC midwives. Taskforce members included practicing and non-practicing midwives, representatives from the Midwives Association of BC (MABC) and College of Midwives of British Columbia (CMBC), midwifery researchers and educators, members of the MABC Engagement working group, and a midwifery student representative. We engaged midwives who left the profession because of burnout and stress in the taskforce and collected data from midwives who are no longer in active practice, to better understand the reasons why they left the profession.

The taskforce recognizes that there are points in a midwife's life when burnout and stress are more acutely felt. These vulnerable time points occur during school and the early years of practice; when midwives raise young children; when experiencing a critical incident; or if a midwife develops chronic health problems or disabilities. It is essential that we identify and deliver the supports that midwives need at these known points of vulnerability.

It is clear that developing a sustainable midwifery career begins in school, elevating the importance of how we train, guide and nurture our midwifery students. Over the past 18 months, the taskforce has spoken with key partners in BC and across Canada, to understand how midwifery practice can be more sustainable. We have spoken with midwifery association presidents and policy directors, psychologists and workplace wellness specialists, representatives from other health professional organizations, and researchers. The work of the Sustainable Midwifery Practice Taskforce has culminated in the development of this final report. The report summarizes the rationale for this work, the SMPT process and the research and discussions we conducted. It further includes actionable recommendations at all levels, from government to the individual midwife, to help improve the sustainability of midwifery as a career in BC and enhance the wellbeing of BC midwives. Finally, the report includes an appendix of relevant resources. We would like to thank the Stollery Foundation Midwifery Research Fund and the Midwives Association of BC for their financial support of this Taskforce. We would also like to thank the members of the SMPT who all contributed their time and expertise.

KEY RECOMMENDATIONS

Education

- Nominate a faculty or staff lead who works closely with the Midwifery Student Association on initiatives to promote student wellness.
- Reduce costs and social isolation of students (e.g. through fewer and longer placements).
- Some students report interactions with preceptors, faculty and staff that negatively impact their learning, and sense of psychological safety. We recommend reviewing and implementing additional programs and resources that improve communication between students, preceptors and faculty and a transparent complaint procedure that is trauma-informed, safe, transparent and responsive.

Research

- Conduct a Skills, Effort, Responsibilities and Working Conditions analysis or other Job Evaluation to better understand how midwives work and determine what is equitable compensation for midwives.
- Assess the state of the profession annually through a concise survey of midwives, measuring: work force issues, intention to leave, burnout, and recommendations for improvement.
 - Track changes in responses over time, use findings to inform strategic planning and share results with midwives.
- Create stronger collaborations between researchers and midwifery associations, departments and practices, to study and address midwifery practice and policy issues.

Regulator

- Examine how professional standards of practice might be adapted to improve midwifery wellness/reduce occupational stress.
- Work with the MABC to collect data annually from non-practicing midwives about why they are not currently in practice and what supports they need to re-enter practice.
- Participate in the development of a midwifery retention strategy.
- Participate in the midwifery mental health committee.

Association

- Continue to raise the profile of the profession and educate the public about the work that midwives do; highlight how midwives meet health system needs/fill gaps and the essential role they play during pandemics and disasters.
- Work with the BC Ministry of Health and CNMBC to develop a midwifery retention strategy to prevent burnout and attrition among practicing midwives and to assist midwives who left the profession, to re-enter practice. This midwifery retention/re-entry strategy would include:
 - Peer support following traumatic stress and time off to recover from critical incidents;
 - Enhanced benefits programs to access a wider range of mental health supports;

- An early career mentorship program modeled after similar programs in the UK and New Zealand and/or early career resources (e.g. see Association of Ontario Midwives website- member only content);
 - Establishment of a midwifery mental health committee to guide these programs; and
 - Working with midwifery researchers and individual midwifery clinics to compile a repository of clinic protocols or guidelines that support midwifery wellness such as sleep relief and taking time off during/after traumatic events (personal or work related). This information could be shared with midwives in BC (e.g. see *'This changed my practice'* [website](#) of UBC Faculty of Medicine).
- Create a research and policy branch of MABC and apply for funding through MITACS to collaboratively work with UBC graduate students and UBC midwifery researchers on a policy and research agenda to support sustainable practice.

Ministry of health

- Provide funding to Midwives Association of BC, to develop and deliver strategies to support and retain midwives
- Develop long-term relationships with the Midwives Association of BC, to better understand how midwifery is an essential part of a long-term maternity care strategy in BC
- Support midwifery scope expansion and provide funding, to ensure all midwifery work is remunerated
- Collaborate closely with midwives on the Maternity Services Strategy, to ensure it addresses:
 - Sustainability of the maternity workforce;
 - Recruitment, retention, compensation and employment conditions of midwives;
 - Equitable compensation for maternity care providers, including exploration of alternate payment models and funding for call;
 - Integration of senior midwifery leadership positions within the Ministry and health authority management structures and quality improvement activities; and
 - Funding for midwives to serve priority populations to enhance access to midwifery care among clients with complex needs.

Hospitals/health authorities

- Support integration of senior midwifery leadership positions within health authority management structures, including but not limited to, regional midwifery departments with funded department heads and administrative support staff, funded hospital-based midwifery division heads, and funded midwifery clinical leads to support quality improvement.
- Support midwives' participation at policy development and decision-making levels, including Medical Advisory Committees.
- Develop a clear and transparent process for provision of hospital privileges based on the HR plan, with privileging and credentialing processes led by regional midwifery department heads.

Midwifery clinics

- Develop and post clear guidelines and processes for sleep relief and taking time off during/after traumatic events (personal or work related); work with the MABC to access sample guidelines shared by other clinics.
- Institute lateral kindness and/or anti-bullying statements such as those linked in the resource section.
- Create time and space for midwives to discuss different philosophies of care, and different ways of working, for the purpose of enhancing mutual understanding and reducing intra-professional conflict.
- Have clear and transparent documentation on clinic expenses and finances available for midwives paying clinic fees. Lack of transparency contributes to conflict and burnout.

Midwives

- Assess your level of burnout regularly by clicking [here](#). If your score for any of the subscales exceeds 50, you are experiencing moderate to high burnout. If you score in this range, ask for help and consider saying no to any requests or tasks that do not support your emotional wellness and mental/physical health, take time off if possible, and try to establish daily self-care practices.
- If your score is close to 50 consider what may be putting you at risk of burnout and whether you can implement the strategies recommended in this report.
- Explore wellness resources that appeal to you. Many are listed in the resources section of this report.
- Share strategies and ways of working that enhance your wellbeing with colleagues so others can learn from your experience.
- Participate in conversations with colleagues about different ways of working as a midwife and how differences in care philosophies can be leveraged to benefit the team and clients.



BACKGROUND

Canadian studies show that midwifery care, and especially case-load/continuity-based midwifery care, meets the Triple Aims of health system improvement: positive experiences of care, good population health outcomes, and reduced per capita costs of care.

Scaling up access to patient-centered, high quality models of health care delivery is a provincial priority, yet the midwifery profession is facing numerous challenges that threaten its growth and sustainability. A 2017 study by Stoll & Gallagher [1] revealed that 40% of BC midwives have seriously considered leaving the profession in the preceding year and one in ten were making plans to leave. One in five reported that it is unlikely they will still be practicing as midwives in three years. Reasons for this included the negative impact of being on call on personal life; concerns about their mental and physical health; system-level issues such as lack of support for sick days or vacation coverage; professional costs (license, insurance, dues); dissatisfaction with working conditions; lack of career pathways/opportunities to progress; and experiences of bullying. The same reasons were reported by a subsample of midwives who had already left the profession. Midwives suggested many strategies to reduce stress such as a broadened scope, more off-call work opportunities, ability to bill for additional supports and services for clients with complex care needs, equity with other health care professionals and initiatives to reduce interprofessional conflict.

In October 2018, MABC surveyed all actively practicing registered midwives in the province. Questions focused on sources of midwifery income, satisfaction with pay, client profile, midwives' future plans, and an assessment of burnout. It also included a section where midwives were asked to rate 30 solutions and strategies, to reduce burnout and occupational stress on a scale from 0-100 based on utility and urgency. These 30 solutions were generated through qualitative analysis of open-ended comments from the 2017 survey. Of 302 invited midwives, 233 completed all or some sections of the survey (response rate = 77%). One in two midwives reported a caseload between 40-59 clients per year and 6% saw more than 60 clients per year. The majority (59%) were satisfied with their case load while 41.0 % were not. Midwives described the optimal number of courses of care being between 35-45. This caseload allows enough time for relationship building and enables midwives to provide high quality care while also maintaining work-life balance; however, many midwives noted that they carry higher caseloads to earn enough income. Midwives who were not satisfied with their caseload reported either not having enough clients (because of the expansion of midwifery care in their area) or they reported working too much and said this affected their work-life balance and ability to provide client centered care. Half of midwives would take a lower case load if pay per course of care was higher and one in three would carry the same case load. [2].

When asked about midwives' satisfaction with their income, 27% were dissatisfied or very dissatisfied and 22% were somewhat dissatisfied with their pay. All midwives were asked how likely it is that they will still be working as a midwife in the future. One in three midwives who participated in the 2018 survey said it is likely they will leave the profession in 5 years for reasons other than planned retirement. There was a 4% increase in the proportion of midwives who were taking active steps to leave the profession, between 2017 and 2018. In both 2017 and 2018, the negative impact of being on call was the most commonly cited reason for planning to leave, followed by concerns about midwives' mental and physical health. Higher on the list in 2018 were financial reasons (i.e. poor pay) and lack of support for sick days or vacation cover. Many midwives also reported dissatisfaction with current working conditions and lack of career pathways [2].

Three types of burnout scores were assessed: personal burnout, work burnout, and client burnout. Personal burnout scores were highest in both years, followed by work burnout and client burn out. A global scoping review of burnout among midwives revealed that BC midwives have among the highest personal and work related burnout scores reported in the international literature [11] and significantly higher burnout scores compared to Alberta midwives, who are also independent contractors, but receive approximately 30% more pay per course of care [14].

I think about leaving this work almost daily. I feel so stressed and overwhelmed by various aspects (difficulty obtaining privileges, difficult relationships with midwifery colleagues, lack of respect from consultants, fear of bad outcomes and liability, fear of having to be up all night and how over the years it is increasingly difficult to recover from an 'all-nighter', sadness about the impact on my partner and child when I am gone for long hours). [...] And I wonder why I continue doing this work. But I am in my mid-40's and I have no other career options.

The comments midwives provided on the 2018 survey tell a clear story: many midwives are experiencing burnout and struggle to provide high quality care within the current system. Many noted that it is difficult to maintain work-life balance, emotional well-being, and financial security while working under current conditions. Many are dissatisfied with their pay, provide care they cannot bill for, volunteer their time to serve in other midwifery roles, and experience a myriad of occupational stressors that impact their mental and physical health. Midwives are often not able to take time off to recuperate from burnout and stressful/traumatic events. Midwives desire system change and want to see work conditions improve. They are deeply committed to the work they do and report an increase in the number of complex clients (who require more support) without increases in monetary compensation. The strategies to reduce occupational stress and burnout that most midwives prioritized were: better support for taking smaller caseloads (e.g. professional fees, based on case load), pension program/health benefits, more 'off-call' job opportunities, increased

wages for RMs per caseload and equity with other health care providers (e.g. remuneration for meetings and funds for continuing professional development etc.)

These findings strongly suggest that we must invest in strategies and programming to retain midwives and to address the underlying issues and stressors that lead to burnout and attrition.

Burnout and high levels of stress are associated with poor physical and mental health, a higher risk of substance use in clinicians, family conflict, and impacts on quality of care [3]. Addressing these issues requires the collaboration of key stakeholders to develop an action plan for sustainable midwifery practice. To this end, we applied for and received funding to set up a task force, to review the literature and existing programs and fostering key collaborations, to find sustainable solutions to burnout, stress and attrition in midwifery.

TASKFORCE PHILOSOPHY AND PROCESS

We held five meetings between March 2019 and April 2020: March 12th 2019, May 21st 2019, Sept 18th 2019, Nov 6th 2019, and April 27th 2020. During early meetings we reviewed research about midwifery workforce issues, discussed priorities, and agreed on core principles (see below). Between February 2019 and July 2020 we met with key stakeholders to gather information and resources that might support the sustainability of midwifery practice and emotional wellness of midwives. We spoke with researchers in obstetrics, health human resources, midwifery and public health, psychologists with expertise in workplace wellness, leaders in the medical undergraduate and midwifery programs, midwifery association presidents, leaders in critical incident support and risk management, and others. Meeting transcripts were reviewed and informed the activities and recommendations of the taskforce.

While the model of care in BC is very responsive to the needs of childbearing people and their families, it is not responsive to the needs of midwives. One model does not fit all midwives. Many midwives desire part time work options and diversification of roles/career pathways, but currently they have few options. It is essential to increase paid positions for midwives (e.g. paid leadership roles within health authorities or in the Ministry of Health, paid positions in quality assurance, research and policy, counselling, risk management etc.), to support role diversification. It is also important to recognize unique work challenges at different career and life stages and provide additional options and supports for midwives during these critical time periods (see infographic in appendix 1). This should include part time work options and midwifery work that does not involve being on call/doing full-scope midwifery. Sustainable practice needs to start in school: some third- and fourth-year students already feel burnt out and feel hopeless about their professional futures. Burnout affects future generation of midwives because burnt out preceptors are not effective teachers.

The growth and sustainability of midwifery in BC require regulatory flexibility, organizational support, and a fundamental restructuring of how midwives are remunerated. The current system is set up for volume. Many midwives carry higher caseloads than they want to because they cannot

afford to work less. Higher caseloads contribute to burnout, negatively impact work-life balance, and can compromise quality of midwifery care.

We need to prioritize solutions to burnout and occupational stress that:

- ➔ DO NOT create new problems
- ➔ Center the importance of autonomy and control for midwives when recommending programs/supports. This means that supports for midwives should be optional and flexible.

We need to be mindful about how proposed solutions might affect:

- ➔ Midwives working in different practice arrangements and locations
- ➔ Clients/quality of care/public safety
- ➔ Interprofessional colleagues
- ➔ Access to midwifery care/access to physiologic birth

IMPORTANT CONSIDERATIONS

Recommendations described in this report are based on membership surveys, task force discussions and interviews with health professional leaders, the majority of whom identify as white women. Concepts described in this report such as burnout and psychological safety are euro-centric and were first coined by white people in the US. For example, “Psychological safety,” according to Harvard Business School professor Amy Edmondson is defined as “a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.” [4, 5] Psychological safety is now considered an integral part of health system improvement [6] and Canadian health leaders and organizations are encouraged to commit to psychological health and safety in the workplace because implementation of these standards have been shown to support a more positive work culture, improve staff well-being, and prevent stigma and discrimination [7,8]. While these concepts have been widely applied, they may not resonate with everyone and more time and resources must be devoted to explore how different communities experience midwifery work force issues and what solutions might work in different communities and settings.

We found some terms associated with discourses about burnout problematic or overly simplistic. For example, midwifery burnout is often seen as a failure of personal resilience. This belief blames the individual and fails to take into account systemic issues. Crowther et al., in their discussion paper about sustainability and resilience in midwifery note that “resilience may be interpreted as expecting midwives ‘to toughen up’ in a workplace setting that is socially, economically and culturally challenging. Sustainability calls for examination of the reciprocity between environments of working and the individual midwife.” [9]

Finally, the voices of midwives who are no longer in active practice are mostly absent from discourses about sustainable practice. There are many reasons why midwives leave the profession or feel forced out of the profession and it is unknown how many suffer from work-related mental health issues, moral injury, or PTSD as a result of their experiences. We want to acknowledge those who are no longer practicing and their journeys into and out of midwifery practice. It is our hope that the

recommendations in this report will help to keep more midwives in the profession, and support return to practice for those midwives who have left the profession.



RECOMMENDATIONS

University of British Columbia Midwifery Education Program

Burnout can begin in midwifery school; it is exacerbated by financial concerns, learning under preceptors who are themselves burnt out, and the stress of moving frequently and being far from social and family networks. In order to reduce stress and burnout for students we have made the following recommendations in collaboration with UBC midwifery students. The taskforce recognizes that midwifery education is significantly underfunded, compared to medicine. For this reason, we identify potential funding sources to ensure longevity of wellness initiatives, although core funding for student wellness is much preferred.

- Promote midwifery student wellness by seeking nominations from students for a UBC faculty or staff member who will have dedicated time and receive specialized training to focus on student wellness (30% FTE in year 1 and 20% for subsequent years). This faculty/staff member could work with a dedicated midwifery work learn student, nominated by the Midwifery Student Association (MSA), who collaborates with the student wellness faculty/staff lead and acts as a liaison with the MSA. Potential funding sources for these positions and for operating costs of wellness programs include the UBC Strategic Investment Fund (education pillar) and UBC Teaching and Learning Enhancement Fund.
- UBC faculty members who are also members of the Canadian Association for Midwifery Education (CAMed) should advocate for the inclusion of "wellness and resiliency" components as part of the accreditation process. The UBC Faculty of Medicine has had success with implementing expansive wellness strategies after this became part of the medical school accreditation criteria.
- Continue discussions with MD undergraduate program about curricular and extracurricular activities that promote student wellness (contact person: Dr. Courneya) and identify which are evaluated positively by medical students and might transfer to midwifery students or could be adapted (see appendix 3).

- Students report problematic interactions with preceptors that negatively impact their learning and sense of psychological safety. We recommend reviewing and implementing additional programs and resources that improve student-preceptor communication (see appendix for examples, including examples from Ryerson University that support preceptor/student communication). UBC recently advertised [new clinical teaching resources](#) including the [preceptor education program](#) for students and health professionals. The program ought to consult with the MSA, to determine whether these resources make a difference. It would also be a good idea to evaluate the impact of select programs and resources.

A taskforce member and senior midwifery student facilitated a discussion about potential solutions to student burnout and ways to improve the student experience. The following are a few of the recommendations from the UBC midwifery student body:

- Ensure student psychological safety throughout the Midwifery Program:
 - Follow a procedure for handling complaints from students which is safe, responsive and transparent;
 - Ensure the complaint procedure is easily accessible and understood by the student body. The new Faculty of Medicine mistreatment reporting system addresses some of these concerns; and
 - Minimize situations of conflict of interest between preceptors and tutors.
- Look at ways to include grief/bereavement training in the midwifery program as early as possible, as lack of preparedness for grief/bereavement is a significant challenge for students.
- Reach out to BC midwives and ask them what additional tools or supports they would like to have to assist their role as preceptors. Implement what is feasible.
- Create a document that outlines the projected costs of the program and share this with applicants and incoming students. This would involve surveying midwifery students about costs associated with the program (other than tuition). This document should be available and easily visible on the UBC Midwifery home page under the "Prospective Students" banner.
- Find ways to reduce costs through program changes (e.g. fewer and longer placements).
- Continue advocacy regarding sources of funding/loans such as a midwifery student lines of credit.
- Provide midwife preceptors and professors/instructors with mandatory training on psychological safety and culturally safe and trauma-informed teaching.
- Implement more opportunities for interprofessional collaboration among health professional trainees to encourage integration between midwives and other health professionals (e.g. [Dialogue and Shared Decisions course](#)).
- Reach out to the student body, seeking their ideas for additional wellness supports that they would like to see implemented.

Midwifery Research

- Assess the state of the profession annually through a concise survey of midwives to measure: workforce issues, intention to leave, burnout, and recommendations for improvement. Examine factors related to increased or decreased burnout and track changes in responses over time. Use findings to inform strategic planning by MABC. Disseminate findings and make recommendations as appropriate.
 - Work closely with Black, Indigenous and people of colour (BIPOC) and other minority communities, to ensure that concepts measured are responsive to the needs of midwives from these communities and intersecting vulnerabilities are taken into account.
- Administer a survey to BC midwives to collect information about sleep deprivation, how it affects wellbeing of midwives and client safety, and enablers and barriers to accessing sleep relief. This survey should include questions about ideal/optimal call schedules and the supports needed, to implement these schedules (see page 20 for more info).
- Work with midwives in BC, perhaps through a survey or focus groups, to understand the barriers or incentives to precepting midwifery students. Share information with the MABC and UBC midwifery program and collaboratively work to support sustainable preceptorship.
- Through analysis of provincial perinatal data, focus groups with midwives, and shadow billing of midwifery practices that serve a high proportion of clients with complex care needs, determine what proportion of midwifery clients have complex care needs and how midwives who care for these clients can best be supported. This research project can also inform training needs of midwifery students and establishment of priority populations who benefit from access to midwifery care (see page 21 for more details).
- Survey early career midwives (within their first 3 years of practice) to better understand their experiences and support needs.
- Conduct a Skills, Effort, Responsibilities and Working Conditions analysis or other Job Evaluation to better understand how midwives work and determine what is equitable compensation for midwives.
- Disseminate all findings and host discussion events for midwives to attend and learn about research results and discuss implications of result and next steps. Use this forum as a way to keep connected with midwives about the research they participate in and ensure the findings are brought back to midwives.

College of Midwives of British Columbia (CMBC)

- Examine how professional standards of practice might be adapted to reduce occupational stress and its impact on quality of care.
- Work with the MABC to collect data annually from non-practicing midwives about why they are not currently in practice and what supports they need to re-enter practice.
- Participate in development of a midwifery retention strategy/plan.
- Participate in the midwifery mental health committee.

Midwives Association of British Columbia (MABC)

At present, BC midwives can access a number of resources when they need mental health, legal, or practice support. These include counselling through employee and family assistance programs, legal support, and a dedicated midwife who is available to discuss and provide assistance with professional issues. These are important resources. Below we recommend several additional programs and ways to support the emotional wellbeing of midwives.

- Implement a critical incident peer support program for midwives, with the objective of providing timely access to emotional support during and after a critical incident or other traumatic event. Ideally this program would be accessible to midwifery students as well. See proposal in appendix 6 for more details.
- Establish a mental health committee comprised of midwives with the lived experience and expertise to contribute, as well as psychologists and other key stakeholders, with the aim of establishing a mental health strategy for midwives and providing guidance for program development. This committee could be modeled after a similar committee at BC Emergency Health Services.
- Work with midwifery researchers and midwifery clinics to compile a repository of clinic protocols or guidelines that support midwifery wellness with topics such as sleep relief and taking time off during/after traumatic events (personal or work related). Share this information with midwives in BC and feature selected strategies in a newsletter or on a website (see [‘This changed my practice’](#)).
- Work with a team of midwives to develop a full-cost accounting of the “time budget” of a midwife in order to outline all the regular activities midwives frequently engage in, paid or otherwise, that are required for their job; we need to accurately understand the demands on midwives, and the accompanying remuneration for their time, skills and expertise.
- Conduct a Skills, Effort, Responsibilities and Working Conditions analysis or other Job Evaluation to better understand how midwives work and determine what is equitable compensation for midwives.
- Using the data on critical points of stress for midwives, work with key stakeholders and interested midwives to develop specific targeted supports to assist midwives at those times. Communicate this information to midwives, as anticipating future challenges will assist them in being prepared and ensure they know where to turn for help if needed.
- Advocate with the Ministry of Health to broaden the scope of midwifery practice and allow for expanded and modified roles to uniquely fit the needs of midwives at different stages of their career and life. Anticipating common challenge) and developing alternate work arrangements will be a key element of this support. Enhanced work flexibility will enable more midwives to stay in the profession longer, retaining expertise and reducing burnout.
- Create a research and policy branch of MABC and apply for funding through [MITACS](#) to collaboratively work with UBC graduate students and UBC midwifery researchers on policy and research agenda to support sustainable practice; MABC would need to contribute \$7,500 for a 4-6 months internship and [MITACS](#) would match this.

- Chances of getting matched funding are nearly 100% and MABC is on the list of eligible institutions that can apply for funding.
- Explore whether the Institute for Healthcare Improvement's "*Finding Joy in Work*" framework would be suitable to promote among midwives.
- Provide midwives with resources and tools to further develop skills associated with the job (e.g. negotiation, leadership and communication skills). This could be supported through negotiating with the Ministry of Health a specified annual amount of money allotted to each midwife to pursue additional training of their choosing.
- Institute lateral kindness and/or anti-bullying statements, such as is linked in the resource section and/or sign-on to "*The Declaration of Commitment to Psychological Health and Safety in Healthcare*" and implement recommendations.
- Collaborate with stakeholders including WorkSafe BC, Doctors of BC, Physician Occupational Safety and Health (POSH), Canadian and International midwifery organizations to develop resources to support psychological and occupational safety for midwives.
- Develop an awareness campaign, position statement or other communication strategy with the goal of shifting the midwifery culture towards acceptance of a diversity of ways of working. It is important to reduce stigma for midwives who are on leave/currently not practicing and important to respect diverse ways of working as a midwife, to minimize stigma and intra-professional conflict.
- Invest in an early career mentorship program modeled after similar programs in the UK and New Zealand and/or make early career resources available on the MABC website (see AOM website for examples).
- Advocate for birth centers as midwives desire alternative ways of working.
- Set up a conflict management program and/or compile a list of resources to support communication and conflict resolution (e.g. Medical Council of Canada tutorials on [conflict resolution](#) and respectful communication). These tutorials were created to reduce bias (e.g. bias related to gender, ethnicity, cultural background, or health-care role) and use strategies to deal with conflict through negotiation and collaboration, while respecting the views and positions of others.
- Revisit opportunities for students to join the MABC's EFAP program.
- Consider partnering with UBC CPD to develop, endorse and/or fund workshops for midwives that are focused on self-care strategies and other ways to support emotional wellness.
- Partner with UBC CPD to develop a Business 101 course for students and midwives that outlines best practices for establishing and running a practice.
- Include a section in the MABC newsletter to highlight positive aspects of midwifery practice and ways of working that promote sustainable practice.
- Consider establishing a support group or online communication platform for midwives who have left the profession and may wish to connect with others.
- Explore the potential to create an urban locum pool and create more 'Midwife of the Day' (MoD) positions at busy urban hospitals such as those piloted during Covid-19 in Vancouver

and Calgary. These midwives would assess other midwives' clients, cover sick midwives, do discharges, accept postpartum transfers from OB, do normal newborn exams for OB patients, perform surgical assist etc.). These positions should be set up in a way that minimizes financial loss for midwives using the MoD.

- Raise the profile of the profession by developing long-term relationships with the Ministry of Health so that they fully understand how midwifery is an essential part of a long-term maternity care strategy in BC.
- Work with the Ministry of Health and Ministry of Advanced Education, to examine and improve the available training, support, and remuneration for midwifery preceptors.
- Work with the Ministry of Health and CMBC to develop a midwifery retention strategy, to prevent burnout and attrition among practicing midwives and to assist midwives who left the profession, to re-enter practice. This midwifery retention/re-entry strategy would include:
 - Peer support following traumatic stress and time off to recover from critical incidents;
 - Enhanced benefits programs to access a wider range of mental health supports;
 - An early career mentorship program, modeled after similar programs in the UK and [NZ](#);
 - Establishment of a midwifery mental health committee to guide these programs.

Ministry of Health

- In November 2019 the province signed off on a project charter for a Maternity Services Strategy (MSS). We recommend that the MSS address:
 - Sustainability of the maternity workforce through health human resourcing and workforce planning;
 - Recruitment, retention, compensation and employment conditions of primary maternity care providers;
 - Equitable compensation for maternity care providers, including exploration of alternate payment models, and funding for call;
 - Optimization of scope of practice; and
 - Better supports for midwives serving clients with complex needs
- Provide funding to Midwives Association of BC, to develop and deliver strategies to retain and support midwives.
- Current pay per course of care (CoC) makes it difficult for midwives to find work life balance because they need to bill for 60 CoCs in order to experience financial security. Pay in BC is lower than in other provinces like SK and AB, despite the high cost of living in BC. Increasing pay to levels received by AB midwives would address this issue and likely cause many midwives to reduce workload to 35-40 CoCs annually, which is a much more sustainable workload (see appendices 4 and 5 for details).
- Current systems of remuneration make it difficult for midwives to participate in collaborative care and other alternate practice arrangements; explore alternate compensation models for midwives wanting to work in these arrangements.

- A national survey of midwives showed that the majority of midwives prefer working in out-of-hospital settings [9]. BC lags behind Ontario and Quebec by not offering families birth centers as a choice for place of birth. Funding for birth centers will support patient choice and provide an alternative work environment that supports midwives as primary maternity care providers.
- Provide funded opportunities for midwives to develop leadership skills, to advance the integration of midwifery into the health system and to promote team-based care.
- Include midwives as senior policy staff within the Ministry of Health and adapt a midwifery lens to policy decisions.
- Integrate senior midwifery leadership positions within the Ministry and health authority management structures, as well as in quality improvement. Lack of leadership opportunities across health authorities and throughout the maternity care profession presents a large barrier to the recognition and integration of midwives and their ability to participate in the development of practice guidelines and protocols.
- Provide ongoing funding to MABC, to expand the research and policy branch of the organization.
- After appropriate consultation, approve expanded scope of practice for midwives to enable improved access to care, especially in rural and remote communities; maximize the capacity of interprofessional teams; and create opportunities for diversification of roles for midwives.
- Fund interprofessional education on scope of midwifery practice to support midwives to be able to work to full scope.
- Fund strategies and programs to enhance the psychological and occupational health and safety of midwives and promote recruitment and retention such as: critical incident support program for midwives and midwifery mental health committee.
- Ensure equitable remuneration for midwives sitting on interdisciplinary committees; and those participating in team building and facility engagement initiatives (i.e. equal pay to physician colleagues for the same non-clinical work).
- Establish supports for midwives/practices serving priority populations. In some provinces with employment-based models there are mandates or quotas for serving priority populations (25-50%). In other provinces such as Alberta, midwives can bill additional courses of care to recognize the additional time and care provided to priority populations.
- Fund workplace anti-bullying and harassment training for maternity care providers.
- Consider ways to acknowledge midwives' years of expertise, and possible financial compensation commensurate with years of experience.

Hospitals/Health Authorities

- Integration of senior midwifery leadership positions within health authority (HA) management structures, including, but not limited to establishing regional midwifery departments with funded department heads and administrative support staff, funded hospital-based midwifery division heads, and funded midwifery clinical leads to support quality improvement.
- Support midwives' participation at policy development and decision-making levels including Medical Advisory Committees.

- Undertake annual Human Resource planning of primary maternity care providers within each site, region and HA. This includes a community-based assessment of needs and inclusion of redundancy within a team to reduce burnout.
- Develop a clear and transparent process for provision of hospital privileges based on the HR plan with privileging and credentialing processes led by regional midwifery department heads.
- Work with stakeholders, including MABC, to implement “[Code Lavender](#)” or similar protocols in hospitals across the province. These protocols support integrated healing for health care professionals whenever needed.
- Put on events that promote interprofessional collaboration and relationship building and compensate midwives who attend these events.
- Include midwives in facility engagement initiatives, interprofessional rounds, perinatal committees, continuing education sessions, and quality improvement initiatives as part of the larger medical community.
- Ensure equitable ability for midwives to participate in medical staff associations and provide input into health authority and facility-based initiatives and policies.
- Ensure a hospital culture of practice which promotes inter-professionalism, joint decision-making, shared goals, accountability, and respect; work toward minimizing professional hierarchy (e.g. see model recommended in emergency training protocols like national neonatal resuscitation programs).
- Institute lateral kindness and/or anti-bullying statements (see resource section).

Midwifery Clinics

- Institute lateral kindness and/or anti-bullying statements (see resource section).
- Have clear and transparent documentation on clinic expenses and finances available for midwives paying clinic fees. Lack of transparency contributes to conflict and burnout.
- Have clear orientation procedures for midwives joining the team, including information about roles, responsibilities, how decisions are made and how money is allocated (see AOM for examples).
- Develop and post clear guidelines and processes for sleep relief and taking time off during/after traumatic events (personal or work related). Work with the MABC to access sample guidelines from other clinics.
- Create time and space for midwives to discuss different philosophies of care, and different ways of working, for the purpose of enhancing mutual understanding and reducing intra-professional conflict. When philosophies are divergent and conflict is apparent, commit to conflict resolution and consider how differences in opinion affects clinic members and clients.
- A national survey of midwives showed that the majority of midwives prefer working in out-of-hospital settings [10]. With the home birth rate in BC steadily declining and no options to work in birthing centres, strategies that increase the home birth rate should be explored. One strategy that has worked for practices in Alberta is to organize a social event/meet and greet with all of the families who are receiving care at the clinic. During these gatherings, conversations often turn to place of birth. Hearing about the safety of and positive

experiences of families who had a previous home birth normalizes this option. Hearing this information from peers rather than midwives is important. The taskforce also recommends creating a toolkit for decision support for home birth. This toolkit could include resources that practices with high home birth rates use and online decision aids. [Sarah Munro](#) and colleagues have built a decision aid that helps childbearing people in BC choose a provider and place of birth, based on their values and preferences.

Midwives

- Assess your level of burnout regularly by clicking [here](#). If your score for any of the subscales exceeds 50, you are experiencing moderate to high burnout. Burnout has been linked to a higher risk of depression, broken relationships, alcohol and substance abuse, and medical errors. If you score in this range, ask for help and consider saying no to any requests or tasks that do not center your emotional wellness and mental/physical health, take time off if possible, and try to establish daily self-care practices.
- Explore wellness resources that appeal to you. Many are listed in the resources section of this report.
- Share strategies and ways of working that enhance your wellbeing with colleagues so others can learn from your experience.
- Participate in conversations with colleagues about different ways of working as a midwife and how differences in care philosophies can be leveraged to benefit the team and clients, rather than become a source of conflict. If conflict and differences cannot be managed internally, engage a mediator or other support person.
- Consider exploring the tools and resources, which are in place through the College of Midwives of BC, Midwives Association of BC, Health Authorities, Hospitals or other avenues to support midwives should challenges arise. Let the MABC know if you feel that there are supports missing.
- Understand barriers and enablers to burn out and advocate for system change.
For example:
 - Understand the emerging evidence about fatigue and impairment;
 - Reflect and consider ways to mitigate the risks of fatigue and impairment in one's own environment;
 - Take responsibility for identifying and managing the risks of fatigue and impairment by identifying when this happens in the workplace and advocate for systems changes.
- Consider volunteering for a peer support/coaching group to assist midwives or accessing such a group as needed.



OTHER TASKFORCE ACTIVITIES AND OUTPUTS

Scoping review – click [here](#) to access

To support the direction of the taskforce, Kathrin Stoll worked with a team of interprofessional trainees on a scoping review about the prevalence of and factors associated with burnout in midwifery. A total of 1,034 articles were identified and reduced to 27 articles across 17 countries. Prevalence of burnout was highest among Australian, UK, Western Canadian and Senegalese midwives and lowest among Dutch and Norwegian midwives. We identified 26 factors that were significantly associated with burnout. The most commonly reported factors were: insufficient organizational support/poor or stressful work environment, non-caseload/non-continuity models of care (such as hospital shift work), younger age, fewer years in practice, high workload, exposure to traumatic events, interpersonal conflict with colleagues, low recognition of midwives, low job/task satisfaction (e.g. too much administrative work), and lack of support from family or colleagues. [11] Many of these factors were also cited by BC midwives.

Forging national and international research collaborations

Taskforce members connected with an interdisciplinary team of educators and researchers at McMaster University, who initiated the [Canadian Midwifery Study](#) in 2018. This team undertook both cross-sectional and longitudinal research with midwifery trainees and practicing midwives to better understand midwifery work force issues and midwives' experiences throughout their careers. The McMaster team has published several papers (see their website) and issued a report of findings. The longitudinal arm of their study is still in progress.

We submitted a panel presentation for the CAM conference in November 2020. The title of the panel is "*Health, Wellbeing, and Retention of the Midwifery Workforce.*" The panel includes members from three teams who are studying these issues across Canada, including SMPT members, the McMaster team, and Ivy Borgeault at University of Ottawa and her team who study leaves of absence and returning to work among health professionals (see details in appendix 1).

In addition to this national collaboration, Kathrin is a member of the international [WHELM](#) (work, health and emotional lives of midwives) consortium, a group of midwives and midwifery researchers from 10+ countries who study burnout, occupational stress, and intentions to leave among midwives. Kathrin was scheduled to present at a WHELM symposium with WHELM colleagues at the ICM conference in Bali (which was postponed to May 2021 due to COVID 19).

Luba is also scheduled to present at the upcoming ICM conference on the topic of continuity of care and burnout in Canada. There is significant interest among international midwives in the Canadian case load/continuity model as several countries are moving towards implementing or scaling up such models, and they want to do it in a way that supports sustainable practice.

Burnout self-assessment tool

We created an online self-assessment that includes the 19-item Copenhagen Burnout Inventory (CBI) and generates scores automatically for people who complete the tool. [12] Midwives can then review their scores on three subscales (measuring personal, work-related, and client-related burnout) and have the option of clicking on a link that takes them to an online report that shows the mean scores of all midwives who submitted data. This tool is meant for BC midwives only, can be completed multiple times and in the future will include a list of resources.



[Midwifery Burnout Self-Assessment \(click here\)](#)

PROJECTS IN PROGRESS

Surveying midwives about ways of working as a midwife that are linked to emotional wellbeing

The taskforce identified the importance of gathering information from BC midwives about sleep deprivation, sleep relief, and different ways that call schedules are organized. The most common reason why midwives wanted to leave the profession was the negative impact being on call has on their personal life and the physical and mental strain associated with midwifery work and being on call. Any strategies that address these issues have great potential to reduce burnout. In addition to the recommendations made in this report, we plan to ask BC midwives to participate in a short survey to collect more information about sleep deprivation, how it affects wellbeing of midwives and client safety, and enablers and barriers to accessing sleep relief. This survey will also include questions about innovative and pragmatic solution that midwives have identified, to address stress and burnout.

Systemic change and targeted supports are needed to promote sustainable practice, but we also want to hear from individual midwives about things that changed their practice and/or made

their practice more sustainable, so we can continue cataloging strategies and solutions. Ways of working as a midwife that are linked to emotional wellbeing could be featured in the MABC newsletter or other outlets under the heading ‘*This changed my practice*’ or similar name. We have created a draft survey and received ethics approval through UBC to disseminate the survey. A third-year midwifery student might want to collaborate with taskforce members on this survey (i.e. as part of their research capstone project) and we invite community midwives to contact Luba Butska (luba.butska@ubc.ca) or Kathrin Stoll (kstoll@alumni.ubc.ca) if they are interested in participating in reviewing and finalizing the survey.

Understanding the changing profile of midwifery clients between 2000-2018

Luba Butska, Kathrin Stoll, and Alison Campbell received funding in January 2020 to undertake a mixed methods study about midwifery clients with complex care needs. This study involves retrospective analysis of provincial perinatal data to examine the changing profile of midwifery clients over the past 20 years, outcomes of midwifery clients with complex care needs, and focus groups with midwives who care for clients with complex medical, emotional and psycho-social needs. We hope that the study results will help us understand how best to prepare midwifery trainees to work with clients with complex needs and how best to support midwives to care for these priority populations. This project might also include a shadow-billing pilot with selected midwifery clinics. Some employed nurse practitioners do shadow billing to document what types of patients they look after and to justify increased funding. As part of this project, we are also conducting a scoping review of the literature to better understand how complex needs and complex care are defined during pregnancy. The review will inform a concept analysis on the topic.

A preliminary review of midwifery births between 2000-2018 shows how different, on average, midwifery practice was in 2000 versus 2018: in 2000 close to one in three clients had a home birth, 75% of clients with prenatal midwifery care also delivered with a midwife, and intervention rates were low. [13] In 2018 some interventions have doubled (e.g. the proportion of multiparas with a CS or instrumental vaginal birth increased from 9-19%), the home birth rate is half of what it was in 2000 (14 % versus 27%), midwives deliver 10% fewer babies than in 2000 (as a proportion of clients with a midwife involved in care) , and one in two clients have an obstetric risk factor (see definition below).^a These changes impact how midwives practice, their compensation, and their levels of job satisfaction and burnout.

Due to falling rates of home birth and physiologic birth in BC, BC midwives find themselves less and less likely to be working in an environment that they prefer. In “A new approach to studying retention: following the professional journey of midwives in Canada”, Zeytinoglu et al 2020 [10]

a “Any risk”: One of the following are noted in the medical chart: prior neonatal death, prior stillbirth, prior low birthweight baby, prior macrosomic baby, prior Rh isoimmunisation, prior major congenital anomaly, bleeding < 20 weeks, antepartum hemorrhage at 20+ weeks, pregnancy induced hypertension, proteinuria, Rh antibodies, other antibodies, diabetes mellitus in pregnancy – insulin dependent, diabetes mellitus in pregnancy – non-insulin dependent, pre-existing diabetes mellitus – insulin dependent, pre-existing diabetes mellitus – non-insulin dependent, other abnormal glucose factor, heart disease Class I-IV or unknown class, high blood pressure (> 140/90), antihypertensive drugs prior to admission, hypertensive chronic renal disease, other hypertension, IUGR identified, prescription drugs risk, heroin/opioids, methadone, marijuana, cocaine, solvents, other drugs, unknown drug use, general depression, previous postpartum depression, anxiety, bipolar disorder, other mental illness, or unknown mental illness.

surveyed midwives across Canada and found most “prefer either birth centers or home as their birthing site.” [10] Most midwives who participated in the study were from Ontario, BC, and Quebec. Of midwives surveyed outside of Quebec, only 8% preferred hospital as a birthing site but 57% identified hospitals as their primary work site.” In Ontario and BC, midwives attend births predominantly in hospital but prefer to attend births outside of hospital. These significant differences in preferred and actual work environments and their relationship to burnout for Canadian midwives warrant further study.

Supporting midwives to care for clients with complex needs

In BC, there are currently no formalized mandates or supports to care for clients who face discrimination and/or those with complex care needs. In provinces where midwives are employed by health authorities they are usually expected to look after a certain proportion of clients with complex care needs (up to 50%) and the definition of what constitutes a complex client is broad. In Alberta, midwives can bill for an additional 7 courses of care, to cover additional time spent working with clients from priority populations and those residing in rural areas. One course of care equals 48 hours and midwives track the additional hours they spent providing care and reaching clients. In Ontario, midwives can access additional funding for caseload variables or CVs. When BC midwives were asked in 2018 which strategies would reduce burn out and enhance job satisfaction, higher pay per course of care and higher pay for more complex clients were high on the list.

APPENDIX 1: Midwifery Burnout over time

Midwifery Burnout OVER A CAREER

There are points in a midwife's life when burnout and stress are more acutely felt. It is essential that we identify and deliver the supports that midwives need at these known points of vulnerability.

STUDENT LIFE

01

Wellbeing can be impaired by:

- Physical and psychological safety concerns while in school.
- The financial burden of having to re-locate frequently for clinical placements.
- The loss of social supports while away from home.
- Conflicts with clinical preceptors.



02

EARLY CAREER

- Transitioning to autonomous practice has been shown to be challenging for early career midwives, increasing burnout rates.
- Challenges in obtaining hospital privileges, or struggling to pay off student debt may increase stress.



CARING FOR FAMILY

03

- Midwives with children under 5 experience significantly higher rates of burnout.
- Midwives report that while they provide client and family centred care, the profession itself is not family friendly.
- Midwives without children report that parenthood might be out of reach for them, under current work conditions.



04

EXPERIENCING A CRITICAL INCIDENT

- When dealing with the aftermath of a critical incident, midwives may feel isolated and experience emotions of sadness, anxiety, anger, fear of stigmatization, and shame.
- Symptoms of traumatic stress and PTSD may develop, especially if timely access to support is unavailable.



AGING OR FACING HEALTH ISSUES

05

- The on-call lifestyle can be very taxing for some midwives, particularly for those who are older, who have chronic health conditions and/or disabilities.
- Experienced midwives have much to offer the profession, but the current funding model rewards volume of births attended and does not make reduced call or part time work financially feasible.



APPENDIX 2: Canadian research teams working on midwifery workforce issues

This proposal is for a panel discussion for the CAM conference in November 2020. The theme of the panel is "*Health, Wellbeing, and Retention of the Midwifery Workforce.*" The panel will consist of three teams. Details of each team and their panel focus are included below:

TEAM STRUCTURE AND PRESENTATION ORDER:

Team 1

Authors: Zeytinoglu, I. U., HakemZadeh, F., Neiterman, E., Geraci, J., Plenderleith, J., Lobb, D.

Presenters in order: Johanna Geraci, Isik Zeytinoglu (on behalf of Elena Neiterman), Farimah HakemZadeh, all three presenters wrap up

Project Title: *A new approach to studying retention: Following the professional journey of midwives in Canada.*

Description: Isik Zeytinoglu (PhD) from McMaster University, Farimah HakemZadeh (MBA, PhD) from York University and Johanna Geraci (MSc.), a registered midwife, from the College of Midwives of Ontario, will present findings from a quantitative survey and qualitative interviews conducted with registered midwives across Canada. They will discuss their findings on midwives' intention to stay in the profession, work/life conflict and enhancement, job satisfaction, perception of physical demands, and preferences concerning various employment policies.

Team 2

Authors: Stoll, K., Butska, L., Pruiksma, P., Campbell, M., Bacon, A., Shapiro, K., & Momtazian, T.

Presenters: Luba Butska and Kathrin Stoll.

Project Title: *What makes midwifery practice sustainable? Exploring barriers and enablers to sustainable practice through data collection with British Columbia midwives and key stakeholders across Canada.*

Description: Luba Butska (RM, PhD) and Kathrin Stoll (PhD), from the University of British Columbia, will introduce the work of the Sustainable Midwifery Taskforce in BC and the research about burnout, occupational stress and intention to leave the profession among BC midwives that provided the impetus for the task force. They will present outcomes of the task force, including a summary of themes that emerged from interviews with midwifery association presidents across the country, about policies and practices that support sustainable practice.

Team 3

Authors: Freeman, A.; Chamberland-Rowe, C., Atanackovic, J., Benoit, C., Thiessen, K., Neiterman, E., Lawford, K., & Bourgeault, I.

Presenters: Angela Freeman and Caroline Chamberland-Rowe.

Project Title: *Leaves of absence and return to work among Canadian midwives.*

Description: Angela Freeman (RM, MSc (C)) from the University of Waterloo and Caroline Chamberland-Rowe (MSc, PhD (C)) from the University of Ottawa will explore considerations and challenges faced by midwives in Canada who take leaves of absence due to common mental health concerns. Analyzing qualitative interviews with midwifery stakeholders across Canada, we identify key barriers for taking a leave of absence and subsequently returning to work and highlight programs and policies that can facilitate both processes.

APPENDIX 3: UBC Medical undergraduate program components that support student wellness

Student wellness is currently not a component of the midwifery accreditation process, and there is no separate funding to support student wellness, unlike the medical undergraduate program at UBC. Taskforce members and two midwifery students met with Carol Ann Courneya, Assistant Dean of Student Affairs and co-lead for student wellness and resilience, to better understand the curricular and extra-curricular activities of the medical undergraduate program that support student wellness and resilience. Dr. Courneya welcomes midwifery faculty to contact her if they would like more information and she can also arrange for midwifery faculty and students to observe some of activities, to determine fit for midwifery students. These activities include:

1. Basics of resilience, a lecture for first year students that is focused on self-care;
2. A workshop that helps first year student recognize and address unprofessional and unethical behaviours using three scenarios/relationships – student to student, student to preceptor and student to patient;
3. Wellness Initiatives Network (WIN), a student led series of presentations about how to stay well during first year, residency etc.
4. Forum theatre led by Kathy O’Flynn McGee in Nursing. Forum theatre addresses bullying through role-play. The audience watches a scene with challenges between a student nurse and RN. The audience then gets a chance to put their hands up to sub-in to see if they could make the scenario better. This is a very useful tool for examining a situation from different perspectives and for brain-storming solutions.
5. The medical undergraduate program also hosts a program called “The Healers Art” where students attend five small group sessions with practicing physicians and explore what gives meaning to them and what inspires them as well as content on dealing with grief and loss. This program has to be delivered in person/on site.
6. The UBC MD undergrad program has student wellness and resilience tools that can be accessed [here](#).



APPENDIX 4: Midwifery Compensation Models and Impact on Occupational Stress

Research with BC midwives has shown great interest in ways of working that improve work life balance through better compensation (both salary and benefits) and more scheduled time off. While many midwives like being self-employed, others would like to see changes in the way they work and are compensated.

In this section we summarize how different midwifery compensation models impact occupational stress. The information in the table is based on taskforce discussions, available literature/resources and interviews with association presidents. The table covers information from the following provinces: BC, AB, SK, MB, ON, NS. In Quebec midwives are salaried but not employees; in all other provinces where midwives receive salaries they are also employees and in some provinces midwives are also unionized. Therefore, we compare below the most prevalent models for contract/payment: employee salaried and independent contractor.

| <u>Employee Salaried Model</u> | <u>Independent Contractor Model</u> |
|---|--|
| <p>Student Life</p> <ul style="list-style-type: none"> • Lack of Educational Programs (MB will open program in 2021) • Lack of bursaries/scholarships compared to other health professional students • May be reimbursed for expenses related to community work (e.g. mileage, phone, parking, equipment)” • May have additional expenses for community call work (e.g. a vehicle) | <p>Student Life</p> <ul style="list-style-type: none"> • Educational programs well established • Lack of bursaries/scholarships compared to other health professional students • Expenses related to community work (e.g. mileage, phone, parking, equipment) |
| <p>Early Career</p> <ul style="list-style-type: none"> • Privileges secured as part of employment agreement • Income stable/ guaranteed • No administrative/business work • Income varies across regions but is transparent (\$40-57/hour) • Time on call negotiated with employer (some regions offer time off in lieu of call time) • Time on call adheres to worksafe standards • All actual hours of work paid • Most regions have provisions that enhance access to midwifery care for priority populations • Problems recruiting midwives in some regions, because of perceived loss of autonomy from some midwives who are familiar with the independent contractor model. | <p>Early Career</p> <ul style="list-style-type: none"> • Privileges and stable work may be difficult to secure especially in urban areas • “Turf wars” common in small communities and also affecting larger communities • Significant financial impact of junior status: admin fees paid to practice partners; up to 30% of income garnished for locum work (BC) or may be compensated at a lower level per CoC (AB) • Business/administrative work not funded (except Ontario) • Fees that form base of income vary across provinces (Course of care \$3000-4600), not all work is billable • Time on call negotiated with practice partners • Time on call does not adhere to any standards • Complex/more time-consuming work recognized with COC adjustments in AB, ON, but not BC • Expansion of midwifery services to new areas/populations does not require specific government funding approval |

| | |
|--|--|
| <ul style="list-style-type: none"> • Problems with expansion as depends on government funding (i.e. not able to set up own clinic based on community need) | |
| <p>Caring for Family</p> <ul style="list-style-type: none"> • Parental benefits are available • Scheduled time off is protected by employment standards which may facilitate caring for others | <p>Caring for Family</p> <ul style="list-style-type: none"> • May be eligible for federal EI benefits for self-employed maternity leave; must pay into fund from own income for 12 months before collecting • Unpredictable nature of on-call work makes caring for others difficult • No protected sick time or time off (depends on supportive partners or hired relief) |
| <p>Experiencing a Critical Incident</p> <ul style="list-style-type: none"> • Funded and available counselling • Funded time off if in crisis | <p>Experiencing a Critical Incident</p> <ul style="list-style-type: none"> • Limited counselling options • Some provinces (ON) operate 24/7 support line for midwives, but not staffed by counsellor • No formal/paid time off unless negotiated in kind with practice partners |
| <p>Aging or Facing Health Issues</p> <ul style="list-style-type: none"> • Standard limits to long work hours • Most work still requires on call shifts, few off-call options • Pension benefits • Disability benefits | <p>Aging or Facing Health Issues</p> <ul style="list-style-type: none"> • Generally no limits on call shifts/long work hours unless negotiated with practice partners • Midwives who want to work in alternate practice arrangements (APAs) can apply through college (BC) • May have casual/part time reduced work options outside of APAs (BC) • No sick time, some provinces have limited disability benefits (ON,BC) • No pension benefits |

Note: The models should not be considered necessarily exclusive, although no provinces yet have both employee or salaried AND independent contractor models; there is no flexibility/option for models of payment for RMs except for some rare exceptions (e.g. First Nations funding of salaried RM in BC). But NPs and MDs have negotiated flexibility (e.g. in BC NPs recently negotiated an independent contractor option to be added to the employee model). Last year, MDs in BC negotiated a salaried (non-employee) option for new graduates.

APPENDIX 5: Comparing midwifery in Alberta and British Columbia [14]

Butska and Stoll in *“When Midwives Burn Out: Differences in the experiences of midwives in British Columbia and Alberta”* [13] compared rates of burnout and intention to leave in the two provinces, and found that midwives in Alberta had significantly lower burnout scores than midwives in BC, and BC midwives were more likely to state they were considering leaving the profession. Below, we compare working conditions of Alberta and BC midwives by considering the available literature, data collected from BC and AB midwives in 2017 as well as interviews with association presidents. Possible protective factors for burnout for independent contractor midwives who practice continuity are examined below: attending births in pairs, attending home births, and adequate levels of compensation for being on call.

Attending births in pairs

Two midwives are on call for each birth in Alberta, whereas most births are attended by a midwife and nurse in BC. This means that a full time Alberta midwife is on call for more clients: 40 “primary” clients and an additional 40 birth attended as a backup midwife. Although this results in more time spent on call, this difference may provide midwives with additional support since midwives work in pairs. Midwives are not on call alone. Midwives work in supportive partnerships offering each other sickness and emergency coverage, mitigating the stress of being on call. In addition, the payment structure supports midwives being able to bill for this backup support for all midwifery-led births in Alberta, whereas in BC midwives are only able to bill for backup provided at home, not in hospital. Since Alberta midwives are paid separately for up to 40 births attended as backup each year, this can significantly supplement a midwife’s income.

Home birth and intervention rates

Midwives also attend many more out of hospital (home and birth center) births in Alberta than in BC. The home birth rate in Alberta at the time of Butska and Stoll’s analysis was 48% compared to 14% in BC. Table 1 summarizes home birth rates in the two provinces and also shows that BC midwives attended more births with medical interventions. The home birth rate has also fallen steadily in the last 20 years in BC from 27% in 2000 to 14% in 2018 [13].

Table 1: Births and birth interventions by province 2015-16

| | | Home Birth | Births w/ Epidural | Births by CS |
|---------|----------------------------|------------|--------------------|--------------|
| BC | Of midwife-involved births | 14.0% | 33.0% | 20.6% |
| | Of all births in BC | 2.8% | 35.0% | 32.9% |
| Alberta | Of midwife-involved births | 48.0% | 13.0% | 7.0% |
| | Of all births in Alberta | 2.4% | 54.0% | 28.9% |

Compensation

Another striking difference between Alberta and BC is the history and level of compensation. After advocating for public funding for over a decade, when Alberta midwives negotiated their contract in 2009 it was with the hindsight that other independent contractor models in Canada were poorly funded. For example, a recent Ontario Human Right Tribunal of Ontario ruling found that Ontario midwives have experienced a gender penalty in their pay set by the government for almost two decades. Alberta midwives negotiated a contract with the knowledge that governments in other provinces had not appropriately valued or compensated midwifery work. In fact, private pay clients continued to pay midwives more privately for care in Alberta than what governments were paying midwives in BC and Ontario. This high private fee, as well as an organized consumer network, empowered midwives in Alberta to negotiate for appropriate compensation so that midwives in Alberta are now paid approximately 30% more per client than midwives in BC.

Because Alberta midwives are compensated much higher per course of care, they are paid for 40 clients what midwives in BC are paid for caring for 60 clients. As noted earlier, midwives in BC described the optimal number of courses of care between 35-45. This caseload allows enough time for relationship building and enables midwives to provide high quality care and maintain work-life balance. However, many midwives noted that they carry higher caseloads to earn enough income. In Butska and Stoll's study, 47% of midwives from British Columbia and none from Alberta highlighted poor pay and explicitly connected poor pay with their inability to successfully manage workload.

The private system of payment for midwifery that existed in all Canadian provinces before regulation disproportionately benefited economically privileged clients. Public funding of midwives in BC resulted in significant integration of midwifery into the maternity care system in BC and ensured midwives provided more care to more clients than in Alberta. Inequitable access continued for many more years after regulation in Alberta and is especially acute for Indigenous families, refugee and immigrant families, and families in rural areas of Alberta. With funding, BC midwives experienced more rapid expansion, providing more care in rural and remote areas and caring for a more complex and diverse clientele. However, these changes have come without accompanying increases in compensation. Recent changes in Alberta's contract incentivize work in underserved communities, recognizing the value of midwifery care and the need to expand midwifery to all communities. In spite of a longer history of caring for clients from underserved communities, BC midwives do not have any such incentives and the current model of compensation has fallen behind other provinces in recognizing priority populations and compensating midwives who care for priority populations.

APPENDIX 6: Peer support for midwives and midwifery students who experience critical incidents

BC midwives who experience critical incidents often feel isolated, experience complex emotions (loneliness, sadness, anxiety, anger, grief, fear of stigmatization and discrimination, shame etc.), and may develop symptoms of traumatic stress and PTSD, especially if timely access to support is not available. They are often advised not to discuss the incident with family, friends, and peers, further exacerbating feelings of isolation. Midwives who have experienced critical incidents may not have a support network of fellow midwives if they practice solo or experience conflict with midwives in the community where they live.

To address this issue, we recommend training a diverse group of midwives in basic counselling skills, trauma-informed counselling, and psychological and cultural safety, to provide peer support to midwives who have experienced a critical incident. It is important that this initial support is non-judgmental, accessible, and provided by midwives, because they understand the context. This solution supports midwives who are coping with a critical incident while providing some midwife peer supporters with diversification of skills and earning opportunities. Another important component of critical incident support is the option of taking time off to recover from the incident and access services. We discussed potential mechanisms for time off through a locum pool (although not realistic in most rural areas). Ideally a peer nomination and vetting process will be used, to identify midwife peer supporters; peer supporters will have regular opportunities to debrief and seek support from mental health professionals.

It is important to offer different levels of resources, to meet the needs of midwives on the mental health/burnout continuum and to ensure that these services can be accessed in a timely manner and are fully covered. Midwife peer supporters will be available to provide emotional support to midwives in need and can refer the midwife to additional services if need be (counsellor or psychologist with training in treating people with traumatic stress, PTSD etc. and a good understanding of legal issues surrounding critical incidents). The peer counselling sessions can be provided on a secure online platform and this platform can also house other resources such as an online support group. BC Emergency Services and the BC Women's Hospital Office of Workplace Wellness, Culture and Experience have developed similar peer support programs and we have had meetings with people from these organizations to understand more about the costs and logistics of running a peer support program.



This program might also be able to address student issues around coping with traumatic events.

For full project proposal and budget, please contact Kathrin at kstoll@alumni.ubc.ca

RESOURCES

| Author | Type | Resource | Description | Intended audience |
|---|--|---|--|---|
| University of British Columbia | Initiative with information and events | UBC Wellbeing - Thrive | This links to UBC's initiatives around wellbeing. The THRIVE month (November) seems to be a jump-off platform for information, and engagement with the student body. | UBC faculty, staff and students |
| University of British Columbia | Resources | Wellness Centre | This is a centre at UBC that is specifically focussed on promoting and supporting student wellness. There are "wellness peer educators" with whom you can meet and talk about any subject. There is also training to become a wellness peer educator. | UBC students |
| University of British Columbia | Resources | Empower Me Call 1 (844) 741-6389 | "Empower Me" is a free resource for life coaching and counselling support. They can help with anything you're concerned about. This resource is available 24 hours a day, 7 days a week. | UBC students |
| University of Toronto | Article | How therapy revealed the ills of residency | Dr. Shelly Dev talks about her personal story struggling with anxiety and depression stemming from stressors in medical residency, and how she overcame them with therapy. Shelly is encouraging others in the health care field to share their stories, and encourage a new paradigm. | Health care professionals and students |
| University of British Columbia | Video - BrainTalks | Burnout in Medicine | Dr. Marlon Danilewitz goes over the perils of burnout, what causes it in medicine in particular, identifies barriers to students seeking help for mental health ("I'm less intelligent" "help is risky" "help = weak" "faculty see me as vulnerable" "my peers think less of me" "less competitive for residency") | Health care professionals and students |
| McMaster University | Article collection | Midwifery student experiences and attrition | This links to research articles published, based on results from the Canadian Midwifery Study. The study involves research with midwifery students and practising midwives. | Health care professionals and students |
| Journal - Medical Teacher | Journal Article | Professional burnout among medical students | This study underlines the burden of burnout among medical students | Health care professionals and students |
| Journal - New England Journal of Medicine | Journal Article | Breaking the stigma - a perspective on self-care and recovery | This article tells the personal story of burn out, addiction, recovery, resilience and stigma for a physician. | Health care professionals and students, and policy makers |
| The Happy MD | Web resource | The Burnout Prevention Matrix | Many practical tips for reducing burnout for MDs. Free downloadable "The Burnout Prevention Matrix". | Medical Doctors, but is also suitable for midwives. |
| UBC Faculty of Medicine - Department of ObGyn | Web resource | Physician Wellness Resources List | A list of several resources, including the Happy MD webpage | Physicians, but is also suitable for midwives. |

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| UBC student health | Web resource | Understanding stress and the stress response | Tools and tips for stress management for students | UBC students |
| UBC | Training Program and Web resources | Stress Management and Resiliency Techniques | A training program for teachers (k-12, but seemingly very adaptable) regarding mindfulness | Educators |
| VOCERA | Web resource | Code Lavender: Transforming the human experience in health care | A brief introduction to the "Code Lavender" system which supports mental health and wellbeing in times of crisis. | Health Authorities, Hospitals, Health Care Workers |
| Ryerson University - Midwifery Education Program | Resources | Clinical Education Resources | This website has over a dozen very helpful clinical education resources and small training presentations aimed at Midwifery preceptors, students and tutors in Ontario. | Midwifery preceptors, tutors and students (in Ontario - but very applicable elsewhere) |
| Ryerson University - Midwifery Education Program | Resources | Guide to teaching, learning and assessment | An incredibly helpful guide for preceptors and students to support healthy interactions, and common expectations of learning and assessment. | Midwifery preceptors, tutors and students |
| McMaster University - Midwifery Program | Resources | Various helpful resources for preceptors and students | Several useful guides and information for preceptors and students, including a guide to professionalism and feedback checklist | Midwifery preceptors and students |
| Canadian Patient Safety Institute | Webinars and Resources | Webinar Series - Creating a Safe Space: Psychological Health and Safety of Healthcare Workers | A 2019 thorough guide on addressing psychological safety for healthcare workers. Also other resources, such as the "creating a safe space tool kit", an extensive toolkit on evidence for, the need for, and impact of peer support programs for healthcare workers. | Healthcare workers |
| John Hopkins Medicine | Resources | Roadmap to peer support tools and resources | The Armstrong Institute at John Hopkins Medicine has developed tools to help others develop and organize a peer support program for healthcare workers. Very useful and practical, how to, including elevator pitches, etc. Need to provide some basic info about yourself and your org, in order to access all the info. | Midwifery department, students, and MABC |
| Journal - Academic Medicine | Journal Article | Peer Support for Clinicians: A Programmatic Approach | Journal article showcasing the positive impact of a peer to peer support network for health care workers at Brigham and Women's Hospital. Details on what they did, and how. | Midwifery department, students, and MABC |
| The Risk Authority | Web Resource | Pioneering Peer Support Programs - Voices of Experience | Several video recording of discussions with experts on the need for peer support programs, and how to best develop them. One take away message - perceived appreciation and peer support were very highly correlated with professional fulfillment. | Health Organizations |

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| Peer Support Canada | Organization and web resources | Peer Support Canada | Peer Support Canada aims to raise awareness of the value of Peer Support Programs, and provide training, certifications and tools to support people becoming a peer supporter, and in the development of peer support programs. | Anyone interested in Peer Support training, programs, and the importance of peer support. |
| First Nations Health Authority, First Nations Health Council, and First Nations Health Directors Association | Document | Declaration of commitment: Lateral Kindness | A Declaration of Commitment to Lateral kindness, produced by the First Nations Health Authority, First Nations Health Council, and First Nations Health Directors Association. This is a very clear and useful document, outlining what behaviours constitute "lateral kindness". Very clear and applicable in any interpersonal interactions. | Indigenous Health Authorities, but more broadly to all who wish to join this goal of behaving with lateral kindness. |
| Association of Ontario Midwives | Web resource | AOM Position Statement on Bullying | Bullying is a common issue facing health care workers, including midwives. This is a position statement from the Association of Ontario Midwives denouncing bullying, and encouraging midwives to foster healthy engagements in all areas of their lives. | Midwifery Associations, Midwives |
| Mental Health Commission of Canada | Web resource | Declaration of commitment to psychological health and safety in healthcare | Raising the awareness of the importance of supporting psychological health and safety for healthcare workers. Sign the commitment and implement actions. | Health Authorities, Hospitals, MABC, Clinics |
| Peer Support Canada | Organization and web resources | Peer Support Canada | Peer Support Canada aims to raise awareness of the value of Peer Support Programs, and provide training, certifications and tools to support people becoming a peer supporter, and in the development of peer support programs. | Anyone interested in Peer Support training, programs, and the importance of peer support. |
| Canada Life | Resource, tools and education | Building Stronger teams - Supporting Effective Team Leaders | A thorough free resource on building stronger teams. Developed in Canada. | Anyone interested in building stronger teams |
| Centre for Mental Health in the Workplace | Resource, tools and education | Guarding Minds at Work | A set of free resources and tools to help protect and promote the health and psychological safety of people in the workplace | Workplaces of any size, from a hospital to a clinic |
| Mental Health Commission of Canada | Resource, tools and education | Caring for Healthcare | Begins with highlighting positive journeys of cultural change that health organizations in Canada have undertaken. Provides implementation strategies, process and tools to improve the psychological health and safety for health care workers in Canada. | Healthcare workplaces and organizations |
| Health Canada and Public Health Agency of Canada | Workplace Wellness Resource | Workplace Wellness | A Government of Canada resource for workplaces on promoting wellbeing for employees. Some useful links and strategies within this document. Helpful in a larger organization context, such as Health Authorities or Hospitals. | Workplaces, organizations |

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| Institute for Healthcare Improvement | Workplace Wellness Resource | Virtual Training | IHI has several online self-paced courses that may be relevant. These courses cost money but occasionally IHI offers courses for free. | Administrators, educators, folks leading a team or clinic. |
| TED Talks | Wellness and communication | Doctors make mistakes. Can we talk about that? | Talk by Dr. Brian Goldman on the importance of recognizing that all doctors sometimes make mistakes, and the importance of acknowledging them, talking about them openly to reduce shame, and picking 1 thing to learn each time, and share with others. | Anyone in the medical field. |
| Medical Council of Canada | Free online training resource on communication and cultural competence | The communication and cultural competence program | This website offers 8 unique learning modules centered on communication and cultural competence in a Canadian medical context. | Anyone in the medical field |
| Mental Health Commission of Canada | Toolkit | The Takeaways Toolkit Project | The Takeaways Toolkit is meant to guide other workplaces to help put the National Standard for Psychological Health and Safety into practice. | Employers |
| Canadian Centre for Occupational Health and Safety | Fact sheets | OSH Answers Fact Sheets: Mental Health | Easy-to-read, question-and-answer fact sheets covering a wide range of workplace health and safety topics | Employers and workers |
| Workplace Strategies for Mental Health | Steps to implementation and additional resources | Dialogue and Resources | How to implement the National Standard for Psychological Health and Safety in the workplace | Employers and workers |
| Centre for Addiction and Mental Health | Playbook and fact sheets | Workplace Mental Health Resource Centre | Information and tools to help business leaders learn more about mental health, take action, and share their support | Employers and workers |
| Duke University Press | Published book | On Being Included: Racism and Diversity in Institutional Life | What does diversity do? What are we doing when we use the language of diversity? Sara Ahmed offers an account of the diversity world based on interviews with diversity practitioners in higher education, as well as her own experience of doing diversity work. | Everyone |
| The Birth Place Lab | List of resources | Resources for Taking Action | Resources and readings on racism, anti-Black racism, oppression of Indigenous people, and mistreatment of LGBTQAI2S People | Everyone |
| Institute for Healthcare Improvement | Article | A Tool to Promote Psychological Safety During and After COVID-19 | Three-step approach to explicitly link psychological safety and empathy to quality initiatives during and after the COVID-19 pandemic | Health administrators and workers |
| University of British Columbia | List of principles and practices | Resources for Respectful Debate | Basic principles and practices of respectful dialogue and debate | UBC students, staff, and faculty |

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