PROFESSIONAL BURNOUT AMONG MIDWIVES: CAUSES AND CONSEQUENCES

E. BRIE THUMM, CNM, PHD, MBA
Work came to evoke the same response as getting caught in LA rush hour traffic. Hopelessly helplessly stuck somewhere I didn’t want to be; there was seemingly no way for me to get where I wanted to go. The system in all its complexities felt to be specifically and particularly bent on impeding my efforts to provide quality, efficient and effective care.

Anonymous midwife
OBJECTIVES

Objective 1: Define burnout, including causes and symptoms.

Objective 2: Identify conditions of provider distress related to and frequently mistaken for burnout.

Objective 3: Compare the prevalence of burnout among CNMs/CMs to related groups.

Objective 3: Identify structural characteristics of midwifery practices that are related to high levels of burnout.

Objective 3: Identify modifiable characteristics of the midwifery practice climate that are related to high levels of burnout.

Objective 6: Create strategies to cultivate engagement and prevent burnout.
I was burned out from exhaustion, buried in the hail
Poisoned in the bushes an’ blown out on the trail
Hunted like a crocodile, ravaged in the corn
“Come in,” she said, “I’ll give you shelter from the storm”

Bob Dylan
A psychological condition in which an individual responds to chronic professional stressors with pathologic levels of:

- Emotional exhaustion
- Depersonalization/Cynicism
- A sense of lack of personal accomplishment/efficacy

(Maslach et al., 2001)
The extinction of motivation or incentive, especially where one’s devotion to a cause or relationship fails to produce the desired result.

(Freudenberger, 1974)
I felt like a pod person---every activity of every day was just a mindless process of going through the motions---the minimal amount of activity just to get through---from getting up, to showering, to getting dressed, getting to work and then being at work---just rote motion after rote motion after rote motion. I just felt like my motor completely died---I had zero reserve---and yet I just kept going, kept pushing even though I couldn't really think. I felt dead.

匿名助产士
SYMPTOMS OF BURNOUT

- Exhaustion
- Impaired concentration
- Insomnia
- Anxiety
- Loss of appetite
- Feeling hopeless
- Increased illness
- Loss of enjoyment
- Cynicism
- Detachment
- Isolation
- Irritability
DIFFERENTIAL DIAGNOSES
- Compassion Fatigue
- Moral Distress
- Vicarious trauma
- Post Traumatic Stress Disorder
“Progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and exposure to stress… a state where the compassionate energy that is expended by [midwives/NPs] has surpassed their restorative processes, with recovery power being lost.” (Coetzee, & Klopper, 2010)
MORAL DISTRESS

“The person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing.” (American Nursing Association, 2015)
“The response of those persons who have witnessed, been subject to explicit knowledge of, or had the responsibility to intervene in a seriously distressing or tragic event” (Lerias & Byrne, 2003)

• Also known as secondary trauma
Posttraumatic Stress Disorder

Exposure to actual or threatened death, serious injury, or sexual violence in one of the following ways:

- Directly experiencing the traumatic event.
- Witnessing, in person, the event as it occurred to others.
- Learning that the traumatic event occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event (e.g. first responders collecting human remains).

Burnout

Moral Distress

Compassion fatigue

PTSD

Vicarious trauma

Stamm, 2010; Mathieu, 2012
## Consequences of Burnout

<table>
<thead>
<tr>
<th>Level</th>
<th>Consequences</th>
</tr>
</thead>
</table>
| **Patient level**| Patient satisfaction<sup>1</sup>  
                 | Quality of care<sup>2</sup>  
                 | Failure to rescue<sup>3</sup>  
                 | Longer discharge recovery time<sup>4</sup>  
                 | Hospital acquired infections<sup>5</sup>                                                      |
| **Provider level**| Physical health  
                    | • Hypothalmic pituitary axis<sup>6</sup>  
                    | • Alcohol dependence<sup>7</sup>  
                    | • Depression<sup>8</sup>                                                                     |
| **Organization level**| Job satisfaction<sup>9</sup>  
                    | Absenteeism<sup>10</sup>  
                    | Intention to leave one’s job<sup>11</sup>                                                  |
| **Profession level**| Leaving the profession  
                    | • UK<sup>12</sup>  
                    | • Sweden<sup>13</sup>                                                                     |

<sup>1</sup>Aiken et al., 2012,  
<sup>2</sup>Aiken et al., 2002,  
<sup>3</sup>Halbesleben & Rathert, 2008,  
<sup>4</sup>Cimiotti, Aiken, Sloane & Wu, 2012,  
<sup>5</sup>Pruessner, Hellhammer & Kirschbaum, 1999,  
<sup>6</sup>Sinokki et al., 2009,  
<sup>7</sup>Govardhan, Pinelli & Schnatz, 2012,  
<sup>8</sup>Govardhan, Pinelli & Schnatz, 2012,  
<sup>9</sup>Hanebuth, Meinel, & Fischer, 2006,  
<sup>10</sup>Leiter, M. P., & Maslach, 2009,  
<sup>11</sup>Leiter & Maslach, 2009,  
<sup>12</sup>Gregory et al., 2009,  
<sup>13</sup>Hildingsson, Westlund & Wiklund, 2013
### TABLE 2
Prevalence of burnout by group studied within obstetrics and gynecology specialty

<table>
<thead>
<tr>
<th>Group</th>
<th>Year of most recent study</th>
<th>Rates of burnout$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetricians/gynecologists$^g$</td>
<td>2015</td>
<td>~52%$^b$</td>
</tr>
<tr>
<td>Residents$^{54}$</td>
<td>2012</td>
<td>58%</td>
</tr>
<tr>
<td>Labor and delivery nurses$^{37}$</td>
<td>2013</td>
<td>49.7%</td>
</tr>
<tr>
<td>Midwives$^{55}$</td>
<td><strong>1986</strong></td>
<td>8.2—21.4%</td>
</tr>
<tr>
<td>Gynecologic oncologists$^{56}$</td>
<td>2015</td>
<td>32%</td>
</tr>
<tr>
<td>Chairs of departments of obstetrics and gynecology$^{57}$</td>
<td>2008</td>
<td>45%</td>
</tr>
</tbody>
</table>

$^a$ Calculated based on high emotional exhaustion or depersonalization levels on Maslach Burnout Inventory unless otherwise specified;  
$^b$ Approximation based on deduction from bar graph in study.

Dear Fellow Midwife,

In the next week, you will be receiving an email with a link to the first national midwifery survey about burnout, engagement, and your practice. Please take the time to respond so that our profession can begin to understand what keeps midwives invigorated and fulfilled in their work lives, and what contributes to feelings of exhaustion and cynicism characteristic of burnout. Participants will be entered to win a $100 Amazon gift card. Your experience from your practice setting is important—please share it!

Brie Thumm, PhD(c), CNM
Principal Investigator
brie.thumm@ucdenver.edu
University of Colorado College of Nursing

Endorsed by American Midwifery Certification Board, Inc.
n=3442 CNMs/CMs responded to survey (30.8%) 

n=2887 met inclusion criteria 
(555 did not meet inclusion criteria) 

n= 2685 completed all or part of the scales 
(202 did not complete any scale items) 

n=330 x 2 subsamples (n=660) of 330 respondents who completed MPCS in its entirety randomly selected for EFA and CFA 

Remaining 2025 respondents assessed for missing data 

352 cases removed for missing >20% of any of the 5 scales 

n=1673 remaining sample for model testing
### Burnout Survey (n=2,333) vs. ACNM 2012 (n=1,970) vs. AMCB 2013 (n=1,323)

<table>
<thead>
<tr>
<th>Category</th>
<th>Burnout Survey</th>
<th>ACNM 2012</th>
<th>AMCB 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>47.23 (11.8)</td>
<td>51.4 (11.6)</td>
<td>45.5 (15.2)</td>
</tr>
<tr>
<td><strong>Years as a midwife</strong></td>
<td>13.86 (10.3)</td>
<td>15.9 (10.8)</td>
<td>19.3 (8.0)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2273 (99.0)</td>
<td>1925 (97.7)</td>
<td>348 (26.3)</td>
</tr>
<tr>
<td>Male</td>
<td>20 (0.9)</td>
<td>19 (1.0)</td>
<td>4 (0.3)</td>
</tr>
<tr>
<td>Transgender</td>
<td>2 (0.1)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Missing/Unknown</td>
<td>38 (1.6)</td>
<td>26 (1.3)</td>
<td>971 (73.4)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>6 (0.3)</td>
<td>5 (0.3)</td>
<td>6 (0.4)</td>
</tr>
<tr>
<td>Asian</td>
<td>17 (0.7)</td>
<td>9 (0.5)</td>
<td>13 (1.0)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>84 (3.7)</td>
<td>58 (2.9)</td>
<td>38 (2.9)</td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>2064 (90.0)</td>
<td>1804 (91.6)</td>
<td>724 (54.7)</td>
</tr>
<tr>
<td>2 or more races</td>
<td>64 (2.8)</td>
<td>NA</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (0.6)</td>
<td>43 (2.2)</td>
<td>4 (0.3)</td>
</tr>
<tr>
<td>Unknown/missing/not reporting</td>
<td>83 (3.6)</td>
<td>48 (2.4)</td>
<td>519 (39.2)</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>1849 (79.3)</td>
<td>1392 (70.7)</td>
<td>529 (40.0)</td>
</tr>
<tr>
<td>Part-time</td>
<td>387 (16.6)</td>
<td>379 (19.2)</td>
<td>202 (15.3)</td>
</tr>
<tr>
<td>Per diem</td>
<td>95 (4.1)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Unknown/missing</td>
<td>2 (0.1)</td>
<td>4 (0.2)</td>
<td>369 (27.9)</td>
</tr>
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</table>

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<thead>
<tr>
<th></th>
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<th>ACNM 2012 (n=1,970)</th>
<th>AMCB 2013 (n=1,323)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital/university-affiliated hospital</td>
<td>596 (25.6)</td>
<td>543 (27.6)</td>
<td>363 (27.4)</td>
</tr>
<tr>
<td>Private hospital/medical center</td>
<td>441 (18.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational Institution</td>
<td>NA</td>
<td>238 (12.1)</td>
<td>115 (8.7)</td>
</tr>
<tr>
<td>Private physician-owned group practice</td>
<td>513 (22.0)</td>
<td>414 (21.0)</td>
<td>197 (14.9)</td>
</tr>
<tr>
<td>Private midwifery-owned group practice</td>
<td>86 (3.7)</td>
<td>157 (8.0)</td>
<td>91 (6.9)</td>
</tr>
<tr>
<td>Private solo CNM/CM practice</td>
<td>60 (2.6)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Private birthing center</td>
<td>88 (3.5)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>HMO</td>
<td>114 (4.9)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Community health center</td>
<td>222 (9.5)</td>
<td>148 (7.5)</td>
<td>81 (6.1)</td>
</tr>
<tr>
<td>Family planning clinic</td>
<td>41 (1.8)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Nonprofit Health Agency</td>
<td>NA</td>
<td>83 (4.2)</td>
<td>71 (5.4)</td>
</tr>
<tr>
<td>Military hospital or sites</td>
<td>61 (2.6)</td>
<td>25 (1.3)</td>
<td>17 (1.3)</td>
</tr>
<tr>
<td>Federal Government</td>
<td>NA</td>
<td>35 (1.8)</td>
<td>19 (1.4)</td>
</tr>
<tr>
<td>Correctional facility/detention center</td>
<td>2 (0.1)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Other</td>
<td>108 (4.6)</td>
<td>119 (6.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Unknown/missing</td>
<td>1 (0.0)</td>
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Instruments

Midwifery Practice Climate Scale (10 items)
- 2 subscales (Support for the Midwifery Model of Care and Practice Leadership and Participation)
  - Cronbach’s alpha coefficient 0.87-0.90 (Thumm, 2017)

Maslach Burnout Inventory (22 items)
- Gold standard in burnout instruments (Maslach & Jackson, 1981)
- 3 subscales (emotional exhaustion; depersonalization; lack of efficacy)
  - Cronbach’s alpha in U.K. midwife sample 0.69-0.80 (Sandall et al., 1998)

Utrecht Work Engagement Survey (9 items)
- 3 subscales (vigor, dedication, absorption)
  - Cronbach’s alpha in 2 Irish midwife samples 0.88 and 0.90 (Freeney & Fellenz, 2013a, 2013b)

Job outcomes scale (4 items)
- 3 items with low Cronbach’s alpha (0.32) (Van Bogaert, Kowalski, Weeks, & Clarke, 2013)
  - Inter-item correlation “fair to moderate” (0.15-0.21)
  - Personal communication with author of scale reported the “scale” performed well in modeling

Midwife-perceived quality of care scale (2 items)
- Items validated to correlate with standard care indicators (Aiken et al., 2012)
  - Cronbach’s alpha in Irish midwife sample 0.75 (Freeney & Fellenz, 2013a)
PREVALENCE OF BURNOUT AMONG CNMS/CMS

- BURNED OUT: 40.6%
- Not Burned Out: 59.4%

n=2,333
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THE 3 ELEMENTS OF BURNOUT

- **Emotional Exhaustion**: 23.9 (12.61)
- **Depersonalization**: 5.47 (5.38)
- **Lack of Sense of Personal Efficacy**: 40.98 (5.66)
<table>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>22 (5.53)</td>
<td>32.9 (9.70)</td>
<td>23.6 (11.03)</td>
<td>20.23 (11.20)</td>
<td>23.9 (12.61)</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>7 (5.22)</td>
<td>9.1 (4.35)</td>
<td>7.10 (5.74)</td>
<td>4.98 (4.83)</td>
<td>5.5 (5.34)</td>
</tr>
<tr>
<td>Lack of Personal Efficacy</td>
<td>43.7 (7.34)</td>
<td>45.8 (5.97)</td>
<td>21.2 (11.10)</td>
<td>34.5 (7.53)</td>
<td>41.0 (5.66)</td>
</tr>
</tbody>
</table>
CONSEQUENCES OF BURNOUT
BURNOUT $\rightarrow$ WORKFORCE STABILITY

$\beta = .488, p < .001$

$r^2 = .238, p < .001$

n=1673
I saw no alternative but to get out; but now I’ve lost far more than my income. I’ve lost my community. I’ve lost purpose and meaning, an identity that I had had for most of my adult life.

Anonymous midwife
BURNOUT $\rightarrow$ QUALITY OF CARE

$\beta = -.340, p < .001$

$r^2 = .115, p < .001$

$n = 1673$
I felt so mad at both of them [patient and family member]. I felt myself blaming them in an ugly, of course, unwarranted, way, mad at myself, of course, just mad---and exhausted.

匿名助产士
CAUSES OF BURNOUT
Do I feel supported by my practice?
STRUCTURAL CHARACTERISTICS
Patient SES: NO
Patient acuity: YES
Attend births: NO
Practice location: YES
Training of decision-makers: YES
Patient insurer: NO
Daily patient load: YES

All findings p<.05, n=2333
Birth Location
Number of Birth Locations
Size of practice
Shift versus call
Birth volume
Shifts Worked

All findings p<.05, n=2333
F(3,2294)=2.93, p=.032; n=2298

Urban (n=936) 2.61 (1.41)
Rural (n=353) 2.68 (1.40)
Suburban (n=550) 2.58 (1.37)
Mixed (n=459) 2.82 (1.41)
DELIVERY LOCATION

$F(6, 1863), p = .018; n = 1868$

<table>
<thead>
<tr>
<th>Location</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (n=1625)</td>
<td>2.65 (1.38)</td>
</tr>
<tr>
<td>Birth center (n=49)</td>
<td>2.65 (1.27)</td>
</tr>
<tr>
<td>Home (n=27)</td>
<td>1.70 (1.44)</td>
</tr>
<tr>
<td>Hospital &amp; birth center (n=118)</td>
<td>2.70 (1.34)</td>
</tr>
<tr>
<td>Hospital &amp; home (n=14)</td>
<td>2.14 (1.30)</td>
</tr>
<tr>
<td>Birth center &amp; home (n=28)</td>
<td>2.83 (1.40)</td>
</tr>
<tr>
<td>Hospital, birth center &amp; home</td>
<td>2.64 (1.12)</td>
</tr>
</tbody>
</table>

n=1870; p<.05
**BIRTH VOLUME (BIRTHS/YEAR)**

- <50 (n=113): 2.07 (1.42)
- 50-199 (n=380): 2.70 (1.35)
- 200-499 (n=630): 2.75 (1.41)
- >500 (n=745): 2.60 (1.34)

$F(3,1864) = 8.35, \ p < .001; n=1868$
DAILY OUT-PATIENT PATIENT LOAD

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10 pts/day (n=178)</td>
<td>2.21 (1.36)</td>
</tr>
<tr>
<td>10-15 pts/day (n=530)</td>
<td>2.50 (1.33)</td>
</tr>
<tr>
<td>16-20 pts/day (n=868)</td>
<td>2.75 (1.37)</td>
</tr>
<tr>
<td>21-25 pts/day (n=437)</td>
<td>2.76 (1.43)</td>
</tr>
<tr>
<td>&gt;25 pts/day (n=181)</td>
<td>3.17</td>
</tr>
<tr>
<td>I don't work in an out-patient setting (n=104)</td>
<td>2.16 (1.38)</td>
</tr>
</tbody>
</table>

\[F(5, 2292) = 14.00, \ p < .001; n = 2298\]
PATIENT ACUITY

F(2,2295) = 20.21, p < .001; n = 2298

- Low risk (569): 2.41 (1.38)
- Moderate risk (n = 1350): 2.66 (1.37)
- High risk (n = 379): 3.00 (1.49)
TRAINING OF PRIMARY DECISION-MAKER

\[
t(2122.45) = -9.05, \quad p < .001; \ n = 2,294
\]
SHIFTs WORKED

Nights (n=51) | Day (n=654) | Mixed days/night (n=1589)
---|---|---
1.97 (1.23) | 2.63 (1.44) | 2.67 (1.38)

$F(2,2291)=6.66, p<.001; n=2,294$
Employment Status

*F*(3, 2295) = 7.58, *p* < .001; *n* = 2,299

- Full-time (n=1823): 2.72 (1.40)
- Part-time (n=383): 2.43 (1.35)
- Per diem (n=91): 2.24 (1.52)
PRACTICE CLIMATE
BURNOUT RISK FACTORS:
THEORY OF WORKLIFE MISMATCH

Leiter & Maslach, 1999

- Reward
- Control
- Community
- Fairness
- Values
Practice Leadership and Participation

Support for the Midwifery Model of Care

Thumm, 2017
Practice Leadership and Participation

I feel valued in my practice environment.

Practice leadership is open to midwife ideas to improve patient care.

Midwives are represented on important committees in my practice and/or hospital.

Practice leadership takes midwife concerns seriously.

Practice leadership makes efforts to improve working conditions for midwives.

I regularly get feedback about my performance from my practice leadership.

There is effective communication between midwives and practice leadership.
My practice environment understands the Midwifery Model of Care.

My practice environment values the Midwifery Model of Care.

Midwifery care is based on a Midwifery Model of Care, rather than a medical model.
PRACTICE LEADERSHIP AND PARTICIPATION

$\beta = -0.506, p < 0.001$

$r^2 = 0.256, p < 0.001$

n = 1673
SUPPORT MIDWIFERY MODEL OF CARE

$\beta = -0.40, \ p < 0.001$

$r^2 = 0.156, \ p < 0.001$

$n = 1673$
THE INTERSECTION OF STRUCTURE AND CLIMATE
Training of decision-makers: 3.6%

Daily patient load: 1.7%

Patient Acuity: 1.5%

Practice Climate: 21.4%

Practice Climate: 23.4%

Practice Climate: 23.5%

BURNOUT 25.0%

BURNOUT 25.3%

BURNOUT 25.0%

*NOTE: ANALYSIS CONDUCTED USING HIERARCHICAL REGRESSION ANALYSIS, % REFERS TO VARIANCE IN BURNOUT SCORE EXPLAINED; ALL SIGNIFICANT AT p < .001
Training of Decision-maker 3.6%
Practice Climate 21.4%
???
75%
WHAT CAN WE TO PREVENT AND TREAT BURNOUT?
• Practice/Management Level

• Individual Level

• The Midwife Level
MANAGEMENT LEVEL

• Increase participation of midwives on meaningful committees
• Improve leadership
• Allow for employment status flexibility
• Foster support for the midwifery model of care
• Start the conversation with your organization about midwife well-being
I HAVE COME TO BELIEVE THAT CARING FOR MYSELF IS NOT SELF INDULGENT. CARING FOR MYSELF IS AN ACT OF SURVIVAL.

AUDRE LORDE
THE MIDWIFE LEVEL
1. Create HR toolkit
2. Participate in inter-disciplinary trainings
3. Clinical teaching/shadowing
4. Talk with colleagues about midwifery
5. Become involved
6. Give positive feedback
7. Allow colleagues to have boundaries
8. Integrate a 3-5 minute mindfulness mediation into staff meetings/handoffs
9. Random acts of kindness for each other
10. Graciously allow for flexibility of practice members
11. Monitor your practice for burnout
12. Avoid stigmatization and judgement around burnout
If you want others to be happy, practice compassion. If you want to be happy, practice compassion.

14\textsuperscript{th} Dalai Lama
WHAT ABOUT THE MIDWIVES WHO DIDN’T RESPOND?

WHAT CAUSES THE OTHER 75%?

DEVELOPING AND TESTING INTERVENTIONS BASED ON THESE FINDINGS?

HOW SHOULD WE DISSEMINATE THESE FINDINGS TO CHANGE PRACTICE?
WHERE TO NEXT MIDWIVES?


