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Exploring Emotional Well-Being and Support of Midwives Who Provide Termination of Pregnancy Care: An International Survey

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ABSTRACT

Aims: Assess the psychological impact that providing TOP care beyond 12 weeks gestation has on midwives in Australia and New Zealand, improve understanding of TOP care and explore what support midwives have and what they might need to deal with their work experiences.

Design: Online survey.

Methods: A web-based, self-reported questionnaire with a total of 63 questions collected data from June to October 2022. Two validated psychometric tools were included to assess emotional well-being. Numerical data were analysed using descriptive statistics, frequencies, percentages and means. The STROBE guideline was used for reporting.

Results: Most midwives felt unsupported and affected by their experiences of providing termination of pregnancy care. Recognition and regular post-care debriefing with management were minimal. Lack of staff impacted the ability to provide individualised care. Mental health support was not commonly offered to midwives. Psychometric tools showed burnout and high levels of compassion fatigue, but also compassion satisfaction. To feel supported midwives need a fully staffed workforce, the ability to provide one-on-one care, recognition from managers and team support.

Conclusion: Midwives who deliver termination of pregnancy care are unsupported and at high risk of burnout and compassion fatigue. Providing appropriate support is vital to increase midwives' well-being and sustain women's access to safe, high-quality care.

Impact:

- Study addresses a knowledge gap about midwives' support needs when caring for women undergoing termination of pregnancy beyond 12 weeks.
- Findings show the urgent need to recruit and retain midwifery staff, acknowledge the mental health risks of termination of pregnancy care and implement mental health strategies for midwives.
- Research benefits midwives who provide termination of pregnancy care, midwife managers, healthcare organisations and professional bodies.

Patient or Public Contribution: No patient or public involvement.

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1 | Introduction

In the State of the World's Midwifery Report 2021, midwives are described as 'essential providers of primary healthcare...who, in addition to maternity care, also provide a wide range of clinical interventions and contribute to broader health goals, such as addressing sexual and reproductive rights, promoting self-care interventions and empowering women and adolescent girls' (Bar-Zeev et al. 2021, vi). Traditionally, midwives are known to care for women during pregnancy, birth and postpartum, although the midwifery scope of practice is expanding (Fullerton et al. 2018; Mainey et al. 2020). Globally, governments are moving to include midwives as termination of pregnancy (TOP) care providers to utilise the scope of practice the profession has to offer. This is a welcome shift as historically midwives have been known to offer services that included women's reproductive and sexual health (Armour et al. 2023). However, there has been little consideration regarding how best to support midwives, what a support framework should entail, or what strategies should be implemented to make this a sustainable service option for midwives.

2 | Background

Appropriately educated, midwives are capable of providing TOP services as well as other sexual and reproductive healthcare services and thus contribute to reducing the significant global morbidity and mortality associated with unplanned pregnancy and unsafe TOP (Fullerton et al. 2018; Mainey et al. 2020; World Health Organization 2021). As a safe and effective reproductive healthcare intervention in any stage of pregnancy, TOP may, in some instances, even be health- or life-preserving (Bar-Zeev et al. 2021; World Health Organization 2022). The majority of TOP happens in the first 12 weeks gestation by either manual vacuum aspiration or medication (Fullerton 2012; Mainey et al. 2020). After 24 weeks gestation TOP is rare. In New Zealand, the rate of TOP > 20 weeks gestation was 3% in 2022 (Perinatal and Maternal Mortality Review Committee 2022). Australia has no standardised data collection and reporting, however, South Australia Health reported a rate of 2.1% for TOP over 20 weeks gestation in 2021 (South Australian Abortion Reporting Committee 2023). Foetal anomalies detected on second trimester morphology ultrasound, genetic or chromosomal abnormalities, or deteriorating maternal medical conditions are the most common reasons for TOP after 20 weeks gestation (Rosser et al. 2022). Financial difficulties and gender-based violence including rape, which affect women's mental health negatively, may also be reasons for TOP beyond 12 or 20 weeks gestation (Riquin et al. 2021). For TOP after 20 weeks gestation labour is induced, or a caesarean section performed, either with or without a prior feticide (Rosser et al. 2022).

Due to the recent removal of some of the regulatory barriers, endorsed midwives in Australia can now prescribe the relevant medication for medically managed early TOP (*Inquiry Into Universal Access to Reproductive Healthcare* 2023). Endorsed midwives hold additional registration requirements that enable them to prescribe medications within their scope of practice. As termination is not legally regulated on a federal level, midwives may only do so in those Australian states and territories where they are included as legal prescribers by state law. In New Zealand, midwives are authorised prescribers within their scope of practice and may legally provide midwife-led medical TOP and act as a second, consulting health practitioner for TOP beyond 20 weeks gestation (Ministry of Health (NZ) 2021; Te Tatau o te Whare Kahu Midwifery Council 2023). A range of legal, regulatory, educational and financial issues are, however, still not resolved, which is slowing the implementation of midwife-led TOP care in both countries (Macfarlane, Stitely, and Paterson 2021, 2023; Mainey et al. 2020).

Midwives have already been providing aspects of termination care (Mainey et al. 2020), although much of this work so far has been under the directive and supervision of medical practitioners, and has therefore been poorly recognised and largely invisible.

Midwives support women as they engage with clinics and hospitals throughout their TOP journey, regardless of gestational age, and may be involved in counselling and diagnosis, provide psychosocial and emotional support, accompany women and families through feticide, give inter-pregnancy advice and provide post-termination care (International Confederation of Midwives 2014; Leichtentritt, Leichtentritt, and Mahat Shamir 2016). Under 20 weeks gestation, TOP care may not always be provided by midwives. However, during labour and birth, midwives in Australia and New Zealand are the most direct caregivers for women undergoing TOP, especially beyond 20 weeks gestation (Armour, Gilkison, and Hunter 2020), and their care and support are seen as essential to women's experience (Jones, Baird, and Fenwick 2017). Providing TOP care is a different, specialised role within midwifery (Armour, Gilkison, and Hunter 2020). Midwives welcome the ability to diversify their reproductive and sexual healthcare skills and most appreciate, that TOP care is part of their role (Andersson, Gemzell-Danielsson, and Christensson 2014; Christensen, Christiansen, and Petersson 2013; Parker, Swanson, and Frunchak 2014).

Providing TOP care presents professional, moral, ethical and emotional challenges for midwives (Carvajal et al. 2022; Cignacco 2002; Parker, Swanson, and Frunchak 2014; Teffo, Levin, and Rispel 2018; Zareba et al. 2020). These challenges are compounded as midwives must remain professional as they manage women's emotional responses (Andersson, Gemzell-Danielsson, and Christensson 2014; Chiappetta-Swanson 2005; Yang et al. 2016). The stigma that still surrounds TOP extends to midwives' workplaces and midwives themselves may be stigmatised by proxy for doing their job (Aniteye, O'Brien, and Mayhew 2016; Teffo and Rispel 2017). As the pregnancy reaches viable gestational age the burden of an alive born infant can be highly distressing for midwives (Armour, Gilkison, and Hunter 2020; Parker, Swanson, and Frunchak 2014; Yang et al. 2016). Thus, midwives who provide TOP care, especially beyond 12 weeks, are at higher risk of experiencing empathic distress, grief and burnout in their workplace (Carvajal et al. 2022; Mizuno et al. 2013; Teffo, Levin, and Rispel 2018; Zareba et al. 2020).

Globally, midwives have expressed a need for psychological and workplace support, education, legal updates and better

resources (Armour et al. 2023). Yet, the concept of 'support' for midwives who provide TOP care has so far been poorly defined. Known as an act of help, encouragement, financial or material assistance, a show of agreement during a difficult time or something that bears weight (McIntosh and Waterhouse 2024) 'support' may also be interpreted as a service that maintains the function of another service to keep it running. For this study, we used our own definition of 'support' that meant midwives' universal and individual needs were met to sustain their work, and their physical and mental health and well-being were maintained. An accepted expectation from authorities and healthcare organisations exists, that midwives muster the resilience to provide TOP care across the gestational period as part of their scope of practice without needing additional resources. This expectation also exists in Australia and New Zealand and so far no research has provided insight into what midwives need to feel supported when providing TOP care beyond 12 weeks gestation.

3 | The Study

3.1 | Study Aim

This study aims to assess the psychological impact that providing TOP care beyond 12 weeks gestation has on midwives in Australia and New Zealand, improve understanding of TOP care and explore what support midwives have and what they might need to deal with their work experiences.

4 | Methods

4.1 | Study Design and Data Collection

An international survey was carried out in Australia and New Zealand as the first phase of a larger, 2-phased mixed methods study. The study uses Pragmatism as its underpinning theoretical framework (Creswell and Plano Clark 2011) and further findings will be reported in future papers. This paper reports on the quantitative findings from the first phase of the study. Qualtrics was used for survey design and administration. The survey was pilot tested by five midwives who are experts in the field. The midwives' feedback was used to refine the questions and overall flow.

The survey had a total of 63 items: 53 questions were closed and 10 questions required open text responses. The questions for the survey were developed from previous research that explored midwives' lived experience when providing TOP care in the late second and third trimesters (Armour, Gilkison, and Hunter 2020). Midwifery care of women undergoing TOP beyond 12 weeks was explored to determine the psychological impacts and usefulness of support strategies for midwives. Two validated tools were embedded in the survey to assess the psychological impact of TOP care. The Copenhagen Burnout Inventory (CBI) and the Professional Quality of Life Scale (ProQOL; Kristensen et al. 2005; Stamm 2010) assess burnout, compassion fatigue and compassion satisfaction. Permission for the use of the ProQOL was provided by the ProQOL administration (Stamm 2010) in February 2022, and the CBI is freely available to researchers.

4.2 | Study Setting, Participants and Distribution

Midwives who were over 21 years of age, had provided TOP care beyond 12 weeks within the last 5 years and were living in Australia and New Zealand were eligible to take the survey. Eligibility criteria were assessed at the start of the survey, and only those meeting the criteria were able to proceed. The study used non-probability self-selective sampling and participants were recruited through social media advertising (Facebook, Instagram, and Twitter). A social media page was created on Facebook and Instagram to advertise the study. From this page, advertisements about the study were posted. Social media posts were shared by midwives, professional bodies, not-for-profit organisations and other researchers. Data were collected between 8 June and 31 October 2022.

4.3 | Ethics and Consent

Ethics approval was obtained from the Western Sydney University Human Research Ethics Committee (H14855). Consultation with Māori was sought to ensure the research design was respectful of Te Tiriti o Waitangi, the founding document of Aotearoa New Zealand. This is recommended when conducting research in New Zealand, especially if research might be relevant to Māori (Health Research Council of New Zealand 2010). Korero (discussion) was held with Māori midwives and midwifery experts from Te Wakahuia o Hine, a national independent Māori organisation in 2022. This met recommendations from the Komiti.

Participant information about the research project was provided through a link at the start of the survey. Information for accessing assistance in case of emotional distress due to participating in the survey was provided. Consent was obtained following the eligibility screening questions and participants were taken to the end of the survey if they did not consent. As the survey was anonymous, responses could not be withdrawn once the completed responses were submitted. In the final question, midwives were asked if they were interested in participating in a follow-up interview. A link took interested midwives to a separate platform to leave their contact details so their survey responses remained anonymous.

4.4 | Validated Tools

4.4.1 | Copenhagen Burnout Inventory

Burnout is a psychological syndrome defined as a work-related state of exhaustion that occurs amongemployees, that is characterised by extreme tiredness, reduced ability to regulate cognitive and emotional processes, and mental distancing. These four core dimensions of burnout are accompanied by depressed mood as well as by non-specific psychological and psychosomatic complaints' (Schaufeli, De Witte, and Desart 2020, 28). Burnout develops from an imbalance of insufficient workplace resources and high work demands and can be affected by external factors and personal vulnerabilities (Schaufeli, Desart, and De Witte 2020).

The Copenhagen Burnout Inventory (CBI) is a psychometric tool with three separate sub-scales to measure personal (six items), work-related (seven items) and client-related (six items) burnout in human service professions (Kristensen et al. 2005). The personal burnout scale is a generic scale, while the work- and client-related burnout scales assume that participants are employed and working in a capacity that involves contact with patients. There are 12 items that require frequency responses on a 5-point Likert scale. The points are grouped into always (100), often (75), sometimes (50), seldom (25) and never/rarely (0). The remaining 7 items require an intensity response and range from 'a very high degree' to 'a very low degree'. Scores <50 indicate low or no burnout, scores between 50 and 74 moderate burnout, 75–99 high burnout and scores of 100 severe burnout.

4.4.2 | Professional Quality of Life Scale (ProQOL)

'Professional quality of life is the quality one feels about their work as a helper' (Stamm 2010, 8). Healthcare providers can experience positive and negative effects of working with people who have experienced traumatic or stressful situations. These can influence how health carers perceive the quality of their professional life. Compassion satisfaction (CS) and compassion fatigue (CF) are two sub-dimensions that can arise from the positive and negative aspects of work life. Stamm (2010) describes CF as a combination of burnout and secondary traumatic stress (STS). Burnout, as described by Stamm (2010), is associated with feelings of hopelessness, not being able to cope with work or not being effective when carrying out tasks. Indirect exposure to trauma, by working with clients who are traumatised, can lead to STS (Beck and Gable 2012). Symptoms of STS can be similar to post-traumatic stress disorder (PTSD), where exposure to trauma is direct. Sufferers of STS can display and experience a range of emotional, physical and behavioural concerns, like sleeplessness, anxiety, feeling disconnected and numb, frustration, exhaustion and depression (Berger, Abu-Raiya, and Benatov 2016). Work-related trauma, however, may also be a combination of direct (primary) and indirect (secondary) trauma. The ProQOL has 30 questions to assess CS and CF (Stamm 2010). For the CS scale, a score above 23 indicates that a good deal of satisfaction and pleasure is gained from work. For the burnout and CS subscales, a score of below 23 indicates positive feelings about work, and low or no burnout/STS, a score between 23 and 41 is indicative of moderate burnout /STS and a score above 41 is indicative of a higher level and therefore concerning.

4.4.3 | Quantitative Analysis

Survey data were extracted from Qualtrics and cleaned by removing surveys that were less than 50% completed ($n=98$). The $>$ 50% completion rate cut-off meant that demographics and some important data responses were captured. IBM SPSS software (IBM 2023) was used to analyse the numerical data, including the CBI, by calculating descriptive statistics, frequencies, percentages and means. The ProQOL was scored by applying the syntax developed for the tool (Stamm 2010, 16).

5 | Results

5.1 | Demographics

There was a total of 221 completed responses. At the time of the survey 190 (86%) participants were living in Australia and 31 (14%) were living in New Zealand. The majority of respondents were born in Australia ($n=163$, 73.8%), followed by New Zealand ($n=29$, 13.1%), the UK ($n=15$, 6.4%) and other countries (Chile, USA, China, South Africa and Fiji; $n=8$, 3.8%). All participants were female. Five midwives identified as Aboriginal or Torres Strait Islander and six midwives were Māori. One midwife was from a refugee background. The highest level of education reported by midwives was the Bachelor of Midwifery ($n=87$, 39.4%), Graduate Diploma ($n=78$, 35.3%), or postgraduate qualification (PhD, Masters, Honours degree; $n=47$, 21.3%). Six midwives were hospital trained (2.7%) and three had received their qualification at a Polytechnic Institute (1.4%; see Table 1).

5.2 | Workforce Characteristics

Australian midwives worked predominantly in urban centres ($n=156$, 82.1%), consistent with TOP beyond 12 weeks gestation is most often performed in larger centres. Midwives from all states and territories in Australia responded with the majority from New South Wales (46.3%) and Victoria (21.1%). This geographical information was not captured for New Zealand midwives to minimise the possibility of identification due to the small midwifery workforce. The majority of midwives worked across the scope of practice but not within a continuity of care model (42.6%). In the Australian cohort, almost 20% of midwives worked in specialist roles (Clinical Midwife Educator, Clinical Midwife Specialist, Clinical Midwife Consultant) and 2% were privately practising. Not surprisingly, and consistent with the location where TOP is most common, the vast majority (86.8%) of respondents worked in public hospitals. In New Zealand, findings were similar with the majority of participants working in urban settings (87.1%), and most midwives were employed (67.7%) although 9 (29%) midwives worked as Lead Maternity Carer (LMC) in self-employment. These midwives worked within the community (29%), consistent with the LMC model of care. Reported workplace settings included bereavement, Maternal Foetal Medicine (MFM) and termination services, and 11 midwives working in a birthing unit or women's assessment ward (35.5%; see Table 2).

Over half of the respondents provided care during TOP less than monthly, while just under half ($n=104$, 47%) supported up to 6 women per month and four midwives (1.8%) provided TOP care to more than 6 women per month. The last time midwives had provided TOP care was within the last 28 days (43.9%, $n=97$), within the last 6 months ($n=48$, 21.7%), between 6 and 12 months (13.1%, $n=29$) and over 1 year but less than 5 years ago ($n=47$, 21.3%). Only 7% of midwives reported that the latest gestation they had provided TOP care for was 19 weeks. The majority of midwives ($n=141$, 73.8%) had supported women having a TOP between 20 and 28 weeks, and 63 (28.5%) had provided TOP care between 29 and 40 weeks.

TABLE 1 | Midwives' demographics.

	n = 221	Percentage (%)
Age range (years)		
21–29	42	19.0
30–39	68	30.8
40–49	60	27.1
50–59	36	16.3
Over 60	15	6.8
Highest level of education		
Hospital-trained	6	2.7
Polytech	3	1.4
Graduate Diploma	78	35.3
Bachelor of Midwifery	87	39.4
Postgraduate (PhD/ Masters/Honours)	47	21.3
Country of birth		
Australia	163[a]	73.8
New Zealand	29[b]	13.1
UK	15	6.4
Other Europe	6	2.9
Otherworld (Chile/ USA/China/SA/Fiji)	8	3.8

[a]190 participants lived in Australia.
[b]31 participants lived in New Zealand.

Midwives in Australia and New Zealand are legally able to express a conscientious objection to providing TOP care. Conscientious objection is the refusal of a healthcare professional to provide lawful medical services or treatment, that are normally within their scope of practice, on personal or religious grounds (Fiala and Arthur 2017). Most midwives (76.5%) were aware that TOP care was part of their job description when they started in this particular role, yet only 97 midwives (43.9%) were given the choice to express conscientious objection, and 81 (36.7%) were given no choice at all. The rest were either unable to recall or preferred not to answer.

5.3 | The Psychological Impact of TOP Care

Nearly two-thirds of midwives ($n = 161$, 73%) affirmed that they felt affected by their experience of providing late TOP care, although less than half ($n = 132$, 40.3%) had been made aware by their employer, that there may be a psychological impact.

5.3.1 | Copenhagen Burnout Inventory (CBI) and Professional Quality of Life Scale (ProQOL)

A total of 218 midwives (98.64%) completed the CBI (see Table 3). Mean CBI subscale scores were moderate (53.00) for personal and

TABLE 2 | Midwifery workforce characteristics.

Australian midwifery workforce	*n* = 190	Percentage (%)
Location of work		
Remote	3	1.6
Rural	31	16.3
Urban	156	82.1
State and Territories working[b]		
New South Wales	88	46.3
Australian Capital Territory	5	2.6
Northern Territory	9	4.7
Queensland	29	15.3
South Australia	5	5
Tasmania	1	0.5
Victoria	40	21.1
Western Australia	13	6.8
Midwife status		
Clinical Midwifery Consultant	4	2.1
Clinical Midwifery Specialist	20	10.5
Clinical Midwifery Educator	11	5.8
Maternity Unit Manager	7	3.7
Antenatal care	14	7.4
Labour and birth care	25	13.2
Postnatal care only	5	2.6
Working across scope but not in the continuity of care model	81	42.6
Private midwife visiting rights	1	0.5
Private midwife has no visiting rights	3	1.6
Continuity of care model	19	10
Workplace setting		
Public hospital	165	86.8
Private hospital	8	4.2
Birth centre	3	1.6
Community/private midwife	4	2.1

(Continues)

TABLE 2 | (Continued)

Australian midwifery workforce	*n* = 190	Percentage (%)
Other (Agency, Department Health manager, private caseload, MOETS, General Practitioner, mixed)	10	5.3
New Zealand midwifery workforce	***n* = 31**	**Percentage (%)**
Location of work		
Remote	1	3.2
Rural	3	9.7
Urban	27	87.1
Midwife status		
Caseload DHB employed	1	3.2
LMC[a] self-employed	9	29.0
Core midwife (primary/secondary/tertiary)	21	67.7
Workplace setting		
Birthing Unit/Women's Assessment Unit	11	35.5
Community LMC	9	29.0
Clinical charge midwife	2	6.5
Maternal fetal Medicine	1	3.2
Bereavement midwife	1	3.2
Antenatal ward	3	9.7
Other (CMS TOP services, community Midwife Ante-/Postnatal, lecturer, MQSP)	4	9.7
Combined workforce	***n* = 221**	**Percentage (%)**
Number of women cared for per month		
< 1	113	51.1
1–6	104	47.1
> 6	4	1.8
Last time TOP care provided		
Last 28 days	97	43.9
< 6 months	48	21.7
6–12 months	29	13.1
1–5 years	47	21.3
Latest gestational age provided care for (weeks)		
13–19	17	7.7
20–24	80	36.2
25–28	61	27.6
29–40	63	28.5

Abbreviations: CMS TOP, Clinical Midwifery Specialist Termination of Pregnancy Services; DHB, District Health Board; MOETS, Midwifery and Obstetrics Emergency Telehealth Service; MQSP, Maternity Quality and Safety Program (New Zealand).
[a]Lead Maternity Carer is the named health practitioner who provides and coordinates care during pregnancy, intrapartum and postpartum.
[b]Location of workplace not collected for New Zealand midwives to maintain confidentiality.

moderate (50.65) for work-related burnout. The mean score for client-related burnout was low (30.10; see Table 3). In this sample, 91 midwives (41.7%) experienced moderate personal burnout (score 50–74), 37 (17.0%) reported high burnout (score 75–99) and one (1) midwife experienced severe personal burnout (score 100). Work-related burnout was moderate for 105 (48.2%) and high for 47 (21.6%) midwives. Client-related burnout was low for 183 (83.9%) and moderate for 35 (16.1%) of the participants (see Table 4).

The ProQOL was completed by 207 midwives (94.95%). As shown in Table 3, Compassion Satisfaction (CS) was high among all age groups, with a mean score of 50.00. CS was reported the highest (55.44) for midwives aged 60–69 years. Midwives aged 40–49 reported a lower level of CS (47.88) than in the older and younger age groups, although burnout scores and secondary traumatic stress (STS) scores were overall high with a mean of 50.00 for both. Burnout scores were slightly lower for midwives aged 50–59 (47.81) and 60–69 (49.13). Secondary traumatic stress scores were highest (51.68) for younger midwives in the 20–29 years age group, reduced slightly with increasing age and were reported lowest (47.49) in the 50–59 age group (see Table 3).

Despite the psychological impact, 198 (89.6%) midwives had not considered leaving midwifery because of having to provide TOP care. Eighteen (8.1%) midwives reported that they had considered leaving midwifery. Additional comments provided by these midwives focused on their ethical/moral dilemma, distress when an infant is born alive, the psychological impact of TOP care, and a lack of support. The majority of midwives (*n* = 193, 87.3%) had not changed or considered changing their workplace because of having to provide TOP care. There were 26 (11.8%) midwives who had already changed or considered changing the workplace. Additional comments provided by those midwives focused on bullying, a lack of support, the psychological impact and the ethical/moral dilemma of the work.

5.4 | Support Available

Midwives did not feel supported when providing TOP care, with 80 (38.6%) of midwives reporting no or minimal support in this role and another 80 midwives (38.6%) ambivalent about the support they received. Only 47 midwives (22.7%) felt well supported (see Figure 1).

TABLE 3 | Copenhagen Burnout Inventory and Professional Quality of Life Scale.

Measure	*N*	Mean	SD
CBI			
Personal burnout	218	53.00	19.10
Work-related burnout	218	50.65	6.69
Client-related burnout	218	30.10	17.02
ProQOL			
Compassion satisfaction score by age	40	50.01	10.47
20–29	66	51.58	9.45
30–39	55	47.88	10.52
40–49	33	48.21	9.26
50–59	13	55.44	8.57
60–69	207	50.00	10.00
Overall average score			
Burnout score by age			
20–29	40	50.09	10.39
30–39	66	50.53	10.04
40–49	55	50.80	7.98
50–59	33	47.81	10.91
60–69	13	49.13	13.96
Overall average score	207	50.00	10.00
Secondary traumatic stress score by age			
20–29	40	51.68	8.74
30–39	66	50.52	10.47
40–49	55	49.96	9.35
50–59	33	47.49	10.48
60–69	13	48.63	12.50
Overall average score	207	50.00	10.00

Abbreviations: CBI, Copenhagen Burnout Inventory; ProQOL, Professional Quality of Life Scale.

5.4.1 | Psychological Support: Debriefing, Clinical Supervision and Counselling

Clinical supervision and counselling were not commonly offered to midwives who provided TOP care beyond 12 weeks. Only 45 (24.9%) respondents had been offered some form of psychological intervention (see Table 5). The majority of midwives ($n = 181$, 81.9%) did not participate in clinical supervision or counselling at work. In a follow-up question for those who had responded 'no' to receiving clinical supervision or counselling, almost 48% would participate if offered counselling by their employer and almost 45% would consider it. In a follow-up question for those who had responded yes to receiving clinical supervision or counselling, 11 midwives had one-on-one clinical supervision, nine participated in group clinical supervision and five midwives had one-on-one counselling. In a further follow-up question, 11 midwives (42.3%) felt that this was helpful, 14 (53.9%) found clinical supervision/counselling somewhat helpful and 1 midwife (3.8%) did not find this helpful at all. Some midwives ($n = 64$, 30.9%) had sought out their own counselling or mental health services outside of work. Debriefing with management was offered to less than a third of participants (30.2%) and less than a quarter (23.8%) had asked for debriefing following a particularly difficult experience during TOP care.

5.4.2 | Support Interventions at Work

As support generally comes from multiple sources, midwives were asked what was available to them. More than one answer could be selected. In total, 201 midwives provided answers ($n = 546$) to this question. Good team support was the most commonly selected answer ($n = 103$). Debriefing with the line manager ($n = 83$), as well as the ability to work one-on-one with women going through a TOP ($n = 56$) were also available to midwives (see Figure 2). Where 'other' or 'none of the above' was selected, 15 of the respondents provided further information. These were grouped into inadequate or no support ($n = 5$), staffing issues make time out or one-on-one care difficult ($n = 2$), short-term counselling through EAP accessed or offered by management ($n = 6$), debriefing or supervision with friends/colleagues/educator ($n = 4$), counselling with hospital psychologist ($n = 1$). One midwife would prefer debriefing with their manager, although this was currently not available.

TABLE 4 | Percentage of midwives experiencing none to moderate–severe personal-/work-/client-related burnout.

Burnout scale, *N* = 218	No burnout (< 50) *n*/%	Moderate (50–74) *n*/%	High (75–99) *n*/%	Severe (100) *n*/%
Personal	89/40.8	91/41.7	37/17.0	1/0.5
Work-related	66/30.3	105/48.2	47/21.6	0/0.0
Client-related	183/83.9	35/16.1	0/0.0	0/0.0

To identify what midwives felt could be most supportive to them if available, a numerical rating scale was used. The rating was 0 for 'not at all helpful' and 10 for 'most helpful'. The top three, out of 16 items, were (1) a fully staffed workforce (9.46), (2) the ability to give one-on-one care (9.18) and supportive management (9.02). Good teamwork between midwives, doctors and allied health (8.6), structured orientation to the role (8.07), skills updates and workshops (7.8), and grief and loss workshops (7.67) were also rated as important. The least ranked and therefore thought as the least helpful when it came to support were regular group clinical supervision (4.87) and regular group counselling (3.95) (see Figure 3).

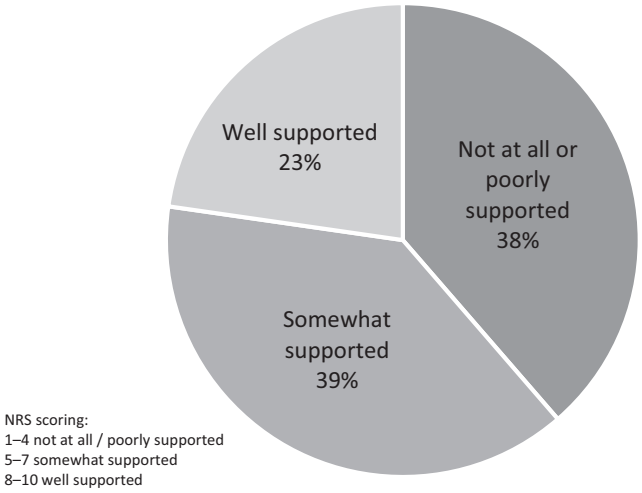

FIGURE 1 | How supported midwives feel when providing late TOP care.

TABLE 5 | Psychological support offered.

Psychological intervention	*N* = 45	%
Employee assistance program	25	55.6
Group clinical supervision at work	5	11.1
Group counselling at work	4	8.9
One-on-one clinical supervision at work	4	8.9
One-on-one counselling at work	5	11.1
Other[a]	2	4.4

[a]Staff was too busy to attend, the manager was unavailable for debriefing at set times, and EAP and group clinical supervision were offered.

6 | Discussion

This paper reports on midwives' experiences and the psychological impact of providing TOP care to women beyond 12 weeks gestation, the support they receive, and what they need. TOP care is an under-researched, stigmatised, and often invisible part of midwifery. Seen as part of a midwife's job, providing late TOP care is different, intense and often highly emotional (Armour, Gilkison, and Hunter 2020). While experience helps (Christensen, Christiansen, and Petersson 2013), providing any form of bereavement care is a vulnerable time for midwives and the complexities of late TOP can add another layer of personal and professional challenges. Midwives, due to the caring nature of their profession and their woman-centredness, are at higher risk of burnout and compassion fatigue than many other professions (Kristensen et al. 2005). So far research has not established what midwives need to feel well supported when giving TOP care, which gives governments, organisations and other regulatory bodies very little guidance to address this important issue.

6.1 | The Psychological Impact of Late TOP Care

Burnout is an increasingly common workplace health concern for midwives (Creedy et al. 2017; Matthews et al. 2022). The World Health Organisation (WHO) has recognised burnout as an 'occupational phenomenon' that is listed in the International Disease Classification as a syndrome but has yet to be classified

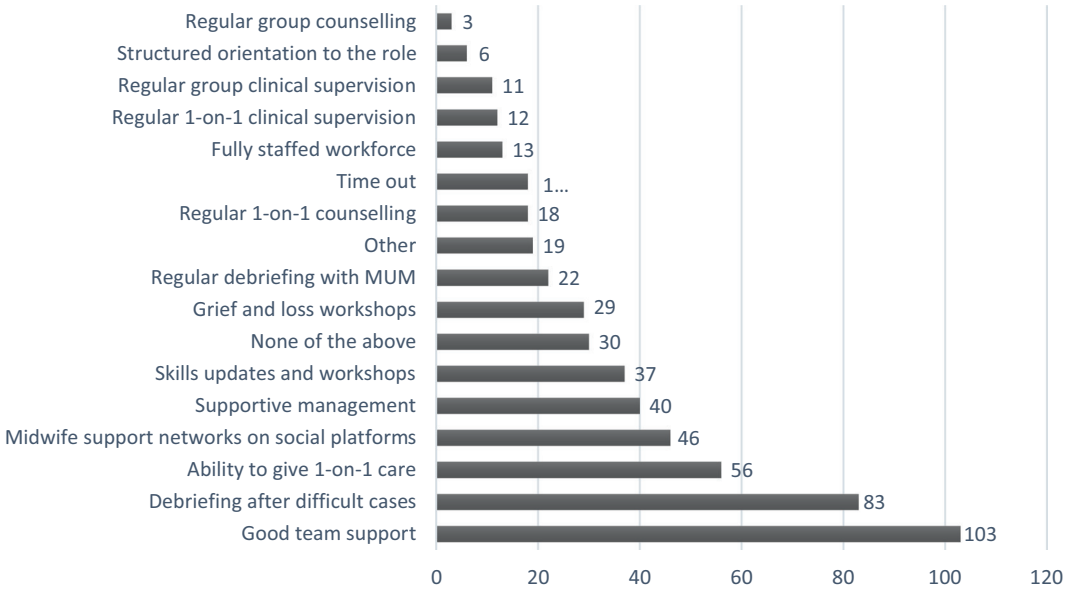

FIGURE 2 | Support available to midwives ($n = 201$).

FIGURE 3 | Support interventions identified as most helpful if available.

as a medical condition (World Health Organization 2019). Our survey showed that caring for women undergoing TOP impacts midwives' psychological health. This is not a new finding. Previous research from other countries has already demonstrated the stress, emotional burden and the rate of burnout and compassion fatigue midwives experience as TOP care providers (Banasiewicz et al. 2020; Mizuno et al. 2013; Teffo, Levin, and Rispel 2018). Our study, however, is the first to reveal that this is also the case for midwives in Australia and New Zealand. Midwives in the age groups 20–29 and 30–39 had the highest rates of burnout and secondary traumatic stress. This is a concerning result and echoes Hunter et al.'s (2019) findings that younger, early-career midwives are at higher rates of burnout. Left unaddressed these midwives may be at risk of developing an even more serious mental health condition, like Post-Traumatic Stress Disorder (PTSD), which contributes to increased workforce attrition (Hunter et al. 2019).

Stamm (2010) recommends that carers with high levels of burnout and secondary traumatic stress be removed from their work setting, and that modified work arrangements are implemented following a period of rest and treatment to ensure both conditions do not re-occur (Stamm 2010). With the significant workforce shortages currently troubling the healthcare sectors on both sides of the Tasman Sea and with an increasing shortage of midwives and nurses predicted (Australian Institute of Health and Welfare 2022), organisations would likely view this strategy as unattainable. Yet, increasing rates of burnout among midwives are associated with a lack of organisational support and appreciation, a stressful work environment (no breaks, poor skills mix), high workload and increased work hours (Harvie, Sidebotham, and Fenwick 2019). Further factors correlated to burnout are trauma, bullying and poor workplace culture, fragmented care models, inexperience and younger age (Sidhu et al. 2020). These factors are reasons why midwives and nurses leave their workplaces and the profession (Mannix 2021). Despite the psychological impact of late TOP care the majority of midwives in our study did not consider changing their workplace or leaving midwifery. This must be interpreted with caution. While late TOP care alone might not cause many midwives to consider changing the workplace or leaving the profession, the associated factors will.

Caring for high numbers of women undergoing TOPs has previously been found to increase the emotional impact and midwives' burnout (Mizuno et al. 2013; Teffo, Levin, and Rispel 2018). As client-related burnout in the context of TOP was low in our sample, the number of women each midwife supports during TOP is likely not a contributing factor for the work-related and personal burnout found in our study. Midwives have a high affinity for those they care for and in the context of TOP care often feel a personal connection with the women in their care (Armour, Gilkison, and Hunter 2020). Many midwives gain a good deal of job satisfaction from working in this role, as is demonstrated by the high rate of compassion satisfaction and low client-related burnout our study found. A range of factors may help mitigate some of the negative emotional impact, like the ability to give high-quality care, a positive appraisal of the care given and working in a supportive team. This is consistent with international research findings (Chiappetta-Swanson 2005; Teffo, Levin, and Rispel 2018; Wallbank and Robertson 2013).

6.2 | A Lack of Support

Our study showed that the majority of midwives felt unsupported when caring for women undergoing TOP beyond 12 weeks. While needs may differ, they include psychological, social, educational and physical support. This affirms a consistent thread

in the international literature spanning over at least two decades (Armour et al. 2023). In 2021, midwives in the USA still felt as unsupported as Swiss midwives, who were interviewed about their personal and professional challenges with TOP care two decades earlier (Cignacco 2002; Zwerling et al. 2021). A lack of support puts midwives at risk and, ultimately, those accessing hospital services.

In the context of safety, resources and risk assessment, in midwifery workplaces, the emphasis is predominantly on mitigating physical risks. For mental health risks, the onus has generally been on midwives to be resilient or 'tough enough' to withstand the challenging environment they work in (Crowther et al. 2016). Yet, a challenging work environment and exposure to trauma is a known and acknowledged risk to mental health in other frontline workers like the military, police, paramedics and doctors (Productivity Commission 2020). Crowther et al. (2016) posed that to sustain midwives, and thus the midwifery workforce, the workplace environment must change to one that nurtures well-being. In 2024 institutions continue to pay little heed to the evidence that midwives need to be supported to cope with difficult and traumatic situations, grief and stress.

Mental health risks must be part of risk assessments and organisations need to be proactive in minimising their potentially adverse impact to protect their employees' mental health (Harvey et al. 2014, 12). There is a range of actions and factors that contribute to a mentally healthy workplace (Productivity Commission 2020). Good leadership, building organisational and personal resilience, giving employees autonomy to decide how they do their work, minimising employee exposure to trauma and harm, fostering healthy interpersonal relationships among employees and leadership and encouraging early interventions for mental health needs are strategies that create mentally healthy environments (Petrie et al. 2018; Productivity Commission 2020). Even something as simple as receiving compassion from colleagues can be helpful in navigating difficult or stressful situations in the workplace (Ruiz-Fernández et al. 2021) and may improve mental health.

Making formal psychological interventions, like counselling or clinical supervision, available to all midwives who provide TOP care might seem the most common-sense approach. In Australia, clinical supervision has been endorsed as a key component of current professional nursing and midwifery practice since the release of a joint position statement between the Australian College of Nursing, the Australian College of Midwives and the Australian College of Mental Health Nursing in 2019 (Australian College of Midwives 2019). Contemporary research is evaluating if monthly group clinical supervision reduces burnout and improves perceptions of workplace culture among midwives in New South Wales (Catling et al. 2022). In New Zealand, early career midwives have been receiving mentorship and clinical guidance from experienced colleagues as part of the Midwifery First Year of Practice program since 2015, although the program started as early as 2007 (Chapman 2018). New Zealand midwives who provided TOP care commented on a lack of clinical supervision in 2018 (Armour, Gilkison, and Hunter 2020). Although seen as a vital part of professional practice (Calvert 2014), and endorsed by the New Zealand Nurses Organisation (New Zealand Nurses Organisation 2022), clinical supervision has yet to be implemented. It does not come as a surprise though, that group therapy and group clinical supervision were rated the least supportive of the options listed in our survey. Clinical supervision is a more recent strategy drawn on to improve midwives' mental health and increase staff retention (Catling et al. 2022) through a 'formal process of professional support, reflection, and learning that contributes to individual development' (Butterworth 2022, 20). Clinical supervision can occur with an individual but is generally delivered in a group format for nurses and midwives. For clinical supervision to be successful, the group must be a safe and confidential space where trust in peers and the facilitator is essential (Catling et al. 2023). Considering the concerns reported by midwives in our study a group setting may not be considered a safe space to reflect in. Group clinical supervision might also not offer enough formal psychological support and should, based on our findings, not be considered as a first-line support intervention.

In our study, only one quarter of midwives had been offered formal psychological support, mostly through an employee assistance program (EAP). EAP is a work-based intervention to improve employees' emotional and mental health by offering short-term, one-on-one counselling for three and up to six sessions with a mental health clinician (Dorney 2020). These interventions are paid for by the employer and designed for low to moderate mental health concerns (Dorney 2020). The uptake of EAP in Australia is low with only 6% of employees accessing EAPs across Australia (New South Wales Government 2022). Reported negative experiences might make midwives hesitant to access this option. Our findings show that midwives would prefer one-on-one counselling or clinical supervision. Access to a grief- and trauma-experienced clinician during work hours, where midwives could establish a trusting relationship and be certain that confidentiality was maintained, would be a viable option for formal psychological intervention and welcomed by midwives.

6.3 | What Midwives Want to Feel Supported

As recommendations for support for midwives who provide TOP care have so far mostly been from the perspective of others, our study opportunity allowed midwives to state their needs. The top four needs midwives gave were a fully staffed workforce, being able to give one-on-one care, support from their midwife manager, and a responsive work environment. In the current climate of already significant and further increasing midwifery workforce shortages in Australia and New Zealand, it did not come as a surprise that what midwives value the most is a fully staffed workforce. In 2022, Blackman and Shifaza found that the shortage of midwives in Australia directly impacted women by essential care being missed (Blackman and Shifaza 2022). A fully staffed workforce enables midwives to give one-on-one, woman-centred care which is not just vital to the woman's experience but also a positive experience for the midwife (Crowther et al. 2016; Gilkison et al. 2017).

Our study showed that support from managers is high on the list of midwives' needs when providing TOP care. There are

several strategies midwife managers can employ: An understanding of the role and awareness of its psychological impact on midwives, regular recognition and acknowledgement, enabling midwives to express their needs in a safe space, encouraging time-out and regular breaks not just during the shift but also from TOP care, the offer of debriefing following the conclusion of care and a culture-shift to normalising the provision of TOP services to eliminate stigma and judgement. These strategies would not just meet evidence-based, corporate HR recommendations on how to keep midwives engaged, retained and feeling valued (Macauley 2015). They would also meet midwives' needs and in turn ensure women receive ongoing, safe, high-quality care when undergoing TOP beyond 12 weeks.

6.3.1 | Strengths and Limitations

Our study has several limitations. We have interpreted the findings with caution due to the low number of responses. The findings may not be representative of the whole population of midwives who provide late TOP care in Australia and New Zealand. Those who chose not to respond could have higher or lower levels of burnout or compassion fatigue/satisfaction or have appropriate assistance. Some midwives might have also not participated due to pressure from their workplace or fears of professional retribution if they participated, despite the survey collecting data anonymously. The recent COVID-19 pandemic and subsequent workforce pressure could have been reflected in the answers midwives provided about burnout, professional quality of life and support needs.

The strength of this study is that this is the first study to explore the experiences and support needs of Australian and New Zealand midwives when providing TOP care and the associated emotional impact.

6.3.2 | Recommendations for Future Research

Our findings lead to several recommendations for future research. We suggest the development, testing and implementation of undergraduate and postgraduate teaching modules for all aspects of TOP care. We also recommend piloting the implementation of mental health strategies for midwives who provide TOP care (mental health coaching, counselling or individual clinical supervision) and measuring outcomes. Several recommendations for policy and practice also arise from our findings. Healthcare organisations must focus on the recruitment and retention of midwives. The provision of TOP care should be considered a midwifery specialty field. To ensure the service is sustainable workplace policy must include sensitive identification of those midwives who are comfortable to provide TOP care. Appropriate position descriptions should be developed and employment contracts should be reflective of the extended role and associated risks. Midwives working in the field should receive individual, regular, ongoing mental health support during work hours. In addition midwives should be able to provide one-on-one care, have regular meal breaks and receive an offer to debrief within a reasonable timeframe following TOP care.

7 | Conclusion

Our study has shown that midwives in Australia and Aotearoa, NZ who provide TOP care beyond 12 weeks are at risk of personal and work-related burnout, secondary traumatic stress and compassion fatigue. This is consistent with findings from other countries. Midwives are provided with minimal support in this role and health organisations continue to neglect their most important asset—their employees. Despite the significant psychological impact of TOP care, midwives did not identify counselling or clinical supervision as the most important strategy. Instead, they want enough staff to be able to provide woman-centred, one-on-one care so they can feel satisfied that they have given women the best care possible. They also need recognition from their line managers. Lastly, they want their midwifery, medical and allied health colleagues to provide a compassionate, non-judgemental work environment, even if they hold personal beliefs about TOP. These basic needs should have been met a long time ago.

Author Contributions

Susanne Armour: conceptualisation, data curation, formal analysis, investigation, project administration, visualisation, writing (original draft). **Hazel Keedle:** conceptualisation, visualisation, writing (review and editing). **Andrea Gilkison:** conceptualisation, visualisation, writing (review and editing). **Hannah Grace Dahlen:** conceptualisation, formal analysis, visualisation, supervision, writing (review and editing).

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Ethics Statement

The data utilised in this manuscript was lawfully collected. Ethics approval was obtained from the Western Sydney University Human Research Ethics Committee, HREC No. 14855.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared due to privacy and ethical restrictions.

Peer Review

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Statistics

The statistics were checked prior to submission by a Western Sydney University expert biostatistician: A/Prof Kingsley Agho k.agho@westernsydney.edu.au.

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