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Traumatised Midwives

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Professor Mavis Kirkham explores what happens when midwives are unsupported

Bullying has arisen as an issue in every study of midwives' experience I have conducted in the NHS. I am also approached by a steady stream of midwives who are experiencing bullying and contact me as someone who might understand their experience because I have written about it. These range from students to very senior managers.

Looking back over thirty years in midwifery, I am also aware that this is not new and some midwives suffered horribly at the hands of colleagues when bullying was a term only applied to school children and the term 'horizontal violence'[1] had not entered our vocabulary.

Outsiders are often struck by the level of bad manners and insensitivity within the NHS. This is observed by those training for health service work and patients. But students want to fit into their chosen profession and patients seek to please the carers upon whom they are dependant and often express sympathy with workers on the receiving end of ill treatment[2]. Stories abound of much worse behaviour in backstage areas away from patients.

The NHS is hierarchical in its structure and the current political and managerial climate has created tremendous pressure to get things done. Such a rigid power structure, under pressure, does not value kindness and consideration. Professionalisation is another contributing factor; pressures to be knowledgeable and expert lead to 'right' ways of doing things which define all other ways and those considering them as wrong. Such a culture breeds a lack of respect for the views of others. Birth is so important as the entrance to society that it is common for the way it is locally conducted to be seen as 'the best way, the right way, indeed the way to bring a child into the world'[3]. Change is always difficult in situations with such social and ritual importance. Yet there are plenty of circumstances where birth attendants treat women and each other with consideration, respect and due regard for their contribution [4].

The pressures outlined above, together with a technical and managerial climate which values and counts actions and interventions rather than less visible and measurable care, serve to undermine the very essence of midwifery which is embodied in relationships. Midwives' major source of motivation and job satisfaction comes from relationships with women[5]. As maternity care becomes more centralised, fragmented and short of resources many midwives feel that they cannot practice midwifery to the best of their ability. This leads some to leave[6] or experience stress, alienation or burnout[5]. In these

circumstances, relationships with colleagues and managers are very important.

Experience of relationships can be reflected in whether we feel valued. In recent research, the vast majority of midwives questioned gained job satisfaction from feeling valued by their clients (96%), 80% derived job satisfaction from feeling valued by their colleagues but only 47% report feeling valued by their managers[5]. A few midwives reported bullying and where this occurred the effect was devastating and extended far beyond the midwife being bullied, whether the bully was a colleague or a manager.

Those who return to midwifery after time out may be a useful barometer of the culture of midwifery within the NHS at present. Recent research on returners again showed a few experienced bullying with devastating consequences. For the majority however, their major concern on completing their Return to Practice Programme was 'appearing competent'[7]; not being competent but appearing to have a level of competence acceptable to their colleagues. Thus, just as women seek to please their midwives, who they see as very busy and so 'don't like to ask' them about their worries and concerns[2]; midwives don't like to ask their busy and overstressed colleagues for help and support.

NHS midwifery has a culture of coping. I wrote about this some years ago[8], but since then there are less midwives on the ground doing more work. But still we go on coping. Midwives who are seen not to cope can be treated very harshly by overstretched colleagues. Vulnerable groups of midwives include the newly qualified, those returning to practice, part-time workers and those who may be seen as not fitting in for various reasons. These groups together constitute the majority of practitioners and the future of midwifery.

Fear of repercussions, of not fitting in, of not being able to cope, and of how colleagues and managers will judge us, induces conformity and feeds into wider NHS fears, such as fears of litigation, to create a culture which is toxic for all concerned. Those who are fearful are more vulnerable and more likely to be bullied. The vicious circle continues.

There are also parallel processes at work.We tend to treat others as we ourselves are treated. How can midwives cherish and support women as individuals if they themselves are pressed to conform, experience little support and fear bullying as an ever present possibility? Midwives' experience and fear of bullying creates risk for women in their care[9].

Midwives don't want this situation. Every midwife I know chose this work in order to help women, many were motivated by the desire that others should have better birthing experiences than their own. I don't think anyone entered midwifery for the money, an easy life or in order to bully others. Most midwives want to support their colleagues. But the pressures to 'go with the flow'[2] are very great. I think midwives bully as a result of frustration, desperation and a misdirected deep envy of others with the high ideals which the pressures of practice have knocked out of them. It is a horribly distorted and destructive coping mechanism. This is not to condone bullying, but to acknowledge that to prevent it we need cultural and structural change.

Bullying is situated towards the end of a continuum of neglect and negative treatment of relationships

within the NHS. To change this we need a positive continuum of mutual support and cherishing of the NHS's greatest asset, not just pouncing upon bullies in a way which parallels their own behaviour. Bullying needs to be confronted and changed, positively, along with the whole culture of neglect and rudeness.

How can we change this situation? How can midwives support and cherish each other and use the same skills with women in our care?

There are situations where midwives are very supportive of each other. Independent midwives have extensive support networks which include colleagues and clients10, though they may suffer considerable external threats. Birth Centres and small midwifery units tend to be experienced as sites of really good colleague relationships, as well as good relationships between women and staff4. One to one midwifery schemes tend to foster supportive relationships between midwives as well as good continuing relationships between midwives and mothers11. New midwifery projects, whether birth centre or one to one schemes, can provide the context for the deliberate development and role modelling of enabling colleague relationships12.

There are two issues here: autonomy for midwives and the scale of the service provided to women. Close relationships with a caseload of women and a small team of colleagues enhances midwives' job satisfaction and makes it possible and worthwhile to work at improving both sets of relationships. This is not the case where we provide short bursts of care to an endless number of women we never see again and we move around a hospital relating with large numbers of colleagues. What matters there is fitting in and pleasing powerholders2. Within smaller scale settings, such as birth centres and case-holding teams, midwives exercise more autonomy and enjoy their work4, protected from the worst excesses of large, hierarchical structures. We know, from research in medicine13 as well as midwifery, that where professionals experience more autonomy they are likely to be more generous in their relationships with clients and colleagues, enabling them in turn to exercise more autonomy. Thus a positive spiral is created.

We need structures within which midwives and women feel safe to relate to each other and units of work which are small enough to promote supportive reciprocal relationships. Training is still needed, so that midwives can relate to women and colleagues in ways which are mutually enabling. Midwives who experience a degree of autonomy and feel trusted to practice well are likely to gain much from such training. Midwives need continuity of care and small scale units of work as much as women do. Until we can achieve this change in the scale and culture of practice traumatised midwives are unlikely to defend women or colleagues from being traumatised.

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