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Caring for future midwives

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Sarah Davies takes a look at trauma support for student midwives

Last year a psychotherapist colleague and I carried out a research study on the traumatic experiences of student midwives and how they were supported with such events.[1] We were keen to do the study because although some excellent research work has looked at midwives' experiences of trauma, there has been none to date on the experiences of students.

Research suggests that caring roles are associated with 'secondary traumatic stress', post-traumatic stress disorder and burnout. In relation to midwives, a literature review in 2008[2] concluded that midwives' empathic relationship with women places them at risk of experiencing secondary traumatic stress (p76), suggesting that this has harmful consequences for midwives' mental health and for their capacity to provide care for women. Recently a postal survey of 421 UK midwives with experience of a traumatic perinatal event found that a third of them were experiencing symptoms of posttraumatic stress disorder.[3] So it seems there is a very high level of unacknowledged distress amongst midwives, affecting the care they provide women and the support they can provide to student midwives.

For our study, we interviewed 11 student midwives who had experienced an incident they found to be traumatic. We deliberately chose not to predefine trauma, leaving it up to individuals to decide this for themselves. The approach was based on our understanding that trauma is 'in the eye of the beholder', as Tatano Beck has suggested in her research on women's traumatic birth experiences[4] The traumatic incidents that students recounted to us all took place in the context of busy obstetric units. We discuss our findings in full elsewhere.[1] In this article I will be focusing on midwives' working conditions because in many places these in themselves constitute a form of trauma, and until these are improved, any other initiatives to support students will simply amount to tinkering around the edges of the problem.

Most of the students we interviewed reported that they found the busy overcrowded hospital environment distressing, with women '*pushed through a system that isn't based around them*'. They witnessed fragmented care, lack of relationship, and task oriented work while the midwives attempted to '*process*' women and '*get (them) out of the hospital*'.

Working in large centralised units, which have heavy obstetric presence (for example in 'ward rounds' on labour wards) leads to lack of autonomy for midwives who find themselves pressurised to adhere to obstetric guidelines, rather than responding flexibly to women's individual needs. From our study it was clear that this 'conveyor belt', industrial model approach is damaging for all involved:

'It sounds horrible, but you are like a machine, you just do the tasks that need to be done and the workload, you have to do it because of the pressures of managers, like they are just trying to get the women out of the hospital. It is like a conveyor belt. Being in that situation it does affect your practice and you do get stressed and you do feel like rubbish and half the time I can understand why the midwives don't want to come into work.'

In this environment some students felt themselves coerced into practices that they felt were unethical. When this happened those students described feeling that they had betrayed women by not being able to stand up for them and ensure they were listened to.

Admittedly these were students who reported experiencing trauma, so they cannot be considered representative of all student midwives, but such a culture has been repeatedly reported and analysed by midwife researchers[5,6,7] over the years, and again in a recent survey of UK and Irish midwives.[8] Lack of autonomy, lack of time, and powerlessness to care properly for women have been identified as important factors in why midwives leave the profession.[9]

Coming to similar conclusions as a large study on resilience in midwives,[10] our study recognises the demanding emotional work midwifery entails, and suggests that resilience in student midwives may be fostered through frank discussion, reflection and promotion of self-care. We recognise that we as midwifery educators need to support students to discuss and make sense of the distressing events that are an inevitable aspect of midwifery practice.[1]

However, building resilience in students and midwives, while a crucial aim, will only go so far if the environment in which they work is toxic. Michael West from the King's Fund blogged recently: 'there is a danger that leaders could use a health and wellbeing strategy as a sticking plaster, instead of addressing the underlying and pervasive structural and cultural causes of low staff morale... We are creating conditions in which the health, wellbeing and quality of life of those who have committed their working lives to the NHS are being profoundly damaged'.[11]

In 1999 Jane Sandall examined burnout and working patterns of midwives and found that control over workload, continuity of care and meaningful relationships with women were protective factors[12] Burnout was associated with low control over decision-making and work patterns, low occupational grade and longer working hours.[13] Since that study was conducted, midwives' working conditions have deteriorated further. In the latest RCM staff survey three-quarters of senior midwives surveyed said they had to redeploy staff to cover essential services either very or fairly often, while vacancies for midwives were reported in three-quarters of UK units. Cathy Warwick CEO responded:*'Our maternity services are overworked, understaffed, underfunded and struggling to meet the demands being placed on them*'[14]

Midwives are currently working in unacceptable conditions which breach health and safety regulations. Indeed these conditions create the possibility for trauma. Physical damage, powerlessness and fear are three key elements in traumatic stress.[15] Long shifts (often on night duty) with inadequate breaks may cause physical damage; little control over organising off duty, and being moved by managers from area to area with little notice creates feelings of powerlessness; constant anxiety about making a mistake in a litigious culture means a climate of fear: all these elements contribute to a traumatic environment. In such conditions it is likely that only the most resilient will be capable of providing consistently sensitive care for women as well as support for students and newly qualified midwives. I am moved by accounts from students of those midwife mentors who continue to function as skilled empathic midwives and powerful role models, despite working in a system that is 'at odds with their mission'.[16] However, staff attrition and sickness is high, and there is no doubt that some resort to the distancing and withdrawal strategies which are recognised responses to work-related stress and anxiety.[17] This has been called 'a perversion of care',[18] where feelings of guilt and anxiety at failing to respond to human need are covered up with routinised adherence to ready-made policies and protocols. Such a perversion of care will reverberate throughout women's lives, because a negative or dismissive attitude on the part of the midwife, as well as being stressful for students,[19] is a significant factor contributing to post traumatic stress for women.[20]

There are guidelines for safe staffing for midwifery[21,22] But there appears to be no mechanism for Trusts to ensure they have adequate staffing, and no lines of accountability. One director of midwifery told the RCM staff survey *'As a head of service I feel powerless to affect change'*.[23] *Last year the House of Commons Public Accounts Committee reported that 'The Department (of Health) and NHS England struggled to articulate to us who is accountable for even the most fundamental areas of maternity care, such as ensuring the NHS has enough midwives*'.[24] This lack of accountability is a direct consequence of the NHS Health and Social Care Act (2012) which ended the Secretary of State's duty to secure health services across England.

It is to be hoped that the current NHS maternity review[25] chaired by Julia Cumberlege will have some clout and as well as calling for continuity of midwifery care, will underscore the importance of increasing the number of midwives. Perhaps it will call for 'compassionate design' where the most powerful people

in the organisation commit themselves actively to values that promote caring for staff as well as clients.[26] And a safety culture which adopts a positive approach, building on what goes right, as well as learning from mistakes.[27] But the review in itself will not be enough to mandate change. Such changes have been called for repeatedly, and promised by successive governments, with no improvement being made over the years. For example, despite a government guarantee that by the end of 2009 women in England would be able to choose where to have their babies, in 2012 only 4.2% had a full range of birth options.[28] Today, the remaining standalone birth centres in our area are under threat of permanent closure, while obstetric units regularly close (or 'deflect' - the new management-speak for temporary closure) due to bed/staff shortages. Increasingly women describe being told their planned home birth will be dependent on adequate staffing on the day.

The RCM's State of Maternity services (2015) has talked of a 'retirement time bomb'; stating that the number of midwives in England aged 50 or over has doubled.[29] Newly qualified midwives need support from more experienced midwives otherwise the burden of responsibility is too great and many will end up leaving midwifery; all the resources put into training them, and all the sacrifice and effort they have put in, are wasted. As an anonymous midwife stated succinctly: '*The workforce is now divided into those who are going to retire shortly, and those who are going to be pushed out because working conditions are so poor* '.[30] This is a serious problem that needs addressing urgently.

What can be done? Concerted pressure must be put on the government to recruit the 2600 midwives that are needed.[31] It can be pointed out that it makes no financial sense to skimp on midwives when maternity claims represent the largest payouts for clinical negligence in the NHS, 35% of the total[32] But it will not be enough simply to recruit more midwives if at the same time they are haemorrhaging out of the profession because they are unable to do the work that they love: '*to keep our hearts engaged, we need attachment and relationships that grow in depth and value*'.[16] Midwives must be valued for their essential work, and strategies to retain them through improving their educational experience and working conditions should be implemented urgently.

The recent Lancet midwifery series contains powerful evidence on the value of midwives and their key role in public health globally.[31] It is unacceptable that despite the findings of this landmark work, midwives' skills and autonomy (upon which childbearing women's safety depends) continue to be undermined by inhospitable institutions and unsustainable working practices. midwifery educators and mentors need to foster reflective spaces where students can safely process experiences, and be alert to the critical moments when extra support is needed.[1] At the same time, I believe the time is right to bring together two strands of activism: pressure groups' activism for continuity of care, and trades union demands for increased midwives and improved working conditions. This approach could unite parents and midwives, creating a powerful force for change.

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