

**Providing Care under stress:
Creating Risk**

**12 Midwives experience of horizontal violence and the effects
on the provision of midwifery care**

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degree of
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**Frances McIver
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Abstract

Bullying, harassment, horizontal violence, whatever the name used, this behaviour is a problem for the midwifery profession. While the problem has been acknowledged in New Zealand there is a paucity of research that is relevant to the New Zealand situation and to midwifery internationally.

The experience of horizontal violence, and the effects of that experience on the provision of midwifery care have been explored using a qualitative approach for data collection, and thematic analysis to analyze the data. Twelve midwives from a variety of practice settings and modes, for example self-employed, employed midwives and midwives working in team practices participated in in-depth semi-structured interviews that were audio taped.

Each participant provided their personal understanding of the term horizontal violence, and common characteristics of their understanding are presented, as is a short explanation of their experience of horizontal violence. As a number of the midwives referred to being bullied in their understanding and experience of horizontal violence the use of the term bullying appeared to be used interchangeably by the midwives in the study.

Categories from analysis of the data are separated into the experience of horizontal violence and the effects on the provision of midwifery care. Key categories from the experience are 'fractured relationships' and 'hanging on: surviving the experience'. 'Providing care under stress: creating risk is the key category in relation to the effects on the provision of midwifery care.

Midwives who took part in this study were personally and professionally affected by the experience of horizontal violence and consequent bullying behaviour. Relationships between midwives, and midwives and women suffered and affected the midwifery care that midwives were able to provide. Where midwives practiced in isolation the potential for risk for women was greatly increased. Themes that support the main category of 'providing care under stress: creating risk' and which illustrate the effect on the provision

of care are centered on the issues of risk, isolation in practice, surviving the experience and feelings of guilt.

Recommendations arising from this study include:

- The development of policies and protocols that address the issue of horizontal violence and workplace bullying in facilities in which midwives work and women give birth.
- Midwives working in group practices need to document a commitment to zero tolerance of horizontal violence.
- Communication skills and assertiveness training must be included within any midwifery education syllabus.
- A study that is more representative of the New Zealand midwifery workforce is necessary to determine accurately the true situation within the profession in respect of the effects of horizontal violence on practice.

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It is hard to comprehend that this journey is over. I had no intention of completing any further university education after obtaining my bachelor's degree at Massey, carried out to prove that I could get a degree. What started out as a feeling of 'I'd better be seen to be doing something' when applying for a new job, attempting one masters paper was just the start. My journey over the last four years has resulted in immense personal growth. I have experienced all the emotions; times of excitement when progress was being made, misery when I couldn't seem to progress, doubt over my ability to be able to do it, but underneath and overriding all else, a quiet confidence that it was possible and also an important study to complete.

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Chapter 1

Orientation to the study

Introduction

'Bullying, harassment, horizontal violence-whatever the name, this behavior is a problem for the nursing profession' (O'Connor, 1998, p.22). Although such a statement has not been explicitly made about the midwifery profession, as a midwife I question if these behaviors are an issue for many midwives practising midwifery in New Zealand.

This thesis is a descriptive study of the experience of horizontal violence of twelve registered midwives and the effects of that experience on their provision of midwifery care.

In this chapter I present an introduction to the study. It contains a rationale and justification for the study, and includes definitions and a brief discussion of horizontal violence, bullying and bullies, and the perception of being bullied. The chapter concludes with an overview of the structure of the thesis.

Aims of the Study

Using a qualitative approach of thematic analysis this thesis addresses three main aims, which are to describe

- the twelve participants understanding of the term horizontal violence.
- the experience of horizontal violence of twelve registered midwives, and

- the effects of the experience of horizontal violence on their provision of midwifery care.

Situating the research

The area chosen for study arose from my experience of working as a midwife. My midwifery experience was gained in a small rural unit where I practised in a sole midwife position as a new practitioner, as well as in a small town maternity unit and in secondary and tertiary hospitals. I undertook a hospital based education programme leading to nursing registration. The training involved heavy workloads and study within a rather regimented 'family' regime, where more experienced nurses guided the less experienced, but there was never any unkindness or nastiness.

Midwifery education, also hospital based, was the complete opposite. Undertaking further education as an experienced practitioner, albeit in another field, seemed to be a catalyst for a number of the registered midwives to make life as difficult as possible for us as students. I had no specific name for this behaviour at the time, but recognized that they seemed reluctant to share knowledge, were unkind, lazy and set the student up to fail.

Fifteen years later settling in to work as a midwife in a large tertiary unit was a difficult personal transition. What I recognized later was that the behaviour of a number of midwives towards new staff, irrespective of experience, was reminiscent of the behaviour metered out during my student midwife days.

I currently practise in a tertiary level institution as a team leader. The role is both challenging and stimulating and includes some clinical practice. I work with midwives who have assumed a variety of roles, which have become a feature of midwifery in New Zealand since late 1990, when the Amendment to the Nurses' Act 1977 was passed. Midwifery practitioners are either employed by the hospital as a core, or team midwife, or are self-employed and have an access agreement to use the facilities of the hospital maternity unit. As a manager I noticed an increasing number of staff and access holders

coming to talk with me about the distress they felt about the treatment they were experiencing from other midwives. They felt hurt, de-valued and badly treated and unable to work effectively.

As a team leader I needed to develop a greater understanding of this behaviour, in order to enable me to manage a unit that is safe for the practitioners and for the women who have midwifery care provided there. Concern about professional relationships and the sustainability of the midwifery profession became further motivating factors influencing my decision to explore this topic. I considered the literature and came up with an understanding that what I had previously experienced and was now hearing about and witnessing was called horizontal violence.

The New Zealand Midwifery Workforce in the 1990s.

In New Zealand the 1990 Nurses' Amendment Act (New Zealand Government, 1990), returned to midwives the statutory right to practise autonomously. Previously, midwives were required to have a doctor present at every birth. The passing of the amendment to the Act made it possible for a midwife to be responsible for a woman's care throughout normal pregnancy, childbirth and the post natal period. Many midwives took the opportunity to act as a Lead Maternity Carer¹ and were now able to choose to be self-employed, be employed by an independent provider who contracts for funding from a government agency, or to remain working in a range of midwifery roles within the publicly funded health system (Hunter, 2000). In addition, what this means in practice is put particularly well by Calvert, (1998, p.18) when she says:

¹ Lead Maternity Carer : Professional who takes responsibility for providing antenatal, intrapartum and postnatal care. The Lead maternity carer may be a midwife, an obstetrician or a General practitioner.

Midwives could now prescribe medicines for women and babies within their care, they could access diagnostic services and claim the same payments for their services as medical practitioners. Whilst these changes occurred with much opposition from the medical profession, midwifery in New Zealand has regained its independence.

While education gives midwives the foundation for safe practice, what makes each midwife different is her personal knowledge base. This is influenced by an individual philosophy of midwifery, choice of practice setting, experience and the requirements and wishes of the women for whom care is being provided (Calvert, 1998).

Not surprisingly a degree of tension developed between employed and self-employed midwives, and between midwives employed by hospitals in continuity of care schemes. Issues of dissatisfaction centred on salary, choice of practice setting, degree of autonomy in practice and conflicting expectations about the amount of support expected, or needed by self-employed or midwives working in team midwifery schemes. Experienced midwives left hospital practice in large numbers and this impacted on staffing and experience levels in hospital maternity units (Hunter, 2000).

Inadequate numbers of midwives training in the 1980s is the probable reason for the shortage of midwives currently being experienced in New Zealand. Between the years 1979-1989 graduates numbered around twenty-five yearly, when the number required to sustain the midwifery workforce was around two hundred (Guilliland, 2001). From 1992, one hundred and fifty midwives have been educated yearly. In 1992 Direct Entry Midwifery programmes commenced in Otago and Auckland, in 1996 in Waikato and in 1996 a programme commenced in Wellington. (S.Pairman, personal communication 17/3/02). The shortage of midwives is particularly evident in rural areas, but some city hospitals also experience recruitment and retention issues. Continuous recruitment of midwives from overseas has been necessary to help maintain midwifery staffing (Guilliland, 2001). Workforce statistics, which are sourced from the New Zealand Nursing

Council, state that there are 905 midwives who are case loading (self-employed) and 1,025 midwives providing midwifery care within a core hospital facility (New Zealand Health Information Service, 2000).

Another possibility for the continuing shortage of midwifery staff may be that midwives are choosing to leave the profession because of an experience of horizontal violence.

What is Horizontal Violence?

The International Council of Nurses' has defined violence as, 'being destructive towards another person' and abuse as 'behaviour that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual' (BullyOnline, 1999, p.1). Expanding on this definition, Blanton, Lybecker & Spring (1998) define horizontal violence as:

...harmful behaviour, via attitudes, actions, words and other behaviours, that is directed towards us by another colleague. Horizontal violence controls, humiliates, denigrates or injures the dignity of another. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights (p.1).

Horizontal violence may be both overt and covert. It may be non-physical hostility or can be exhibited by acts of hostility, sabotage, infighting, scapegoating, criticism, acts of unkindness, constant nit-picking, with-holding information, aggression, a lack of respect for each other, backstabbing and undermining. In addition professional jealousy, ambition, lack of co-operation and exposure to negativity may also act as contributing factors (Duffy, 1995; Hastie, 1995; Clements, 1996; Farrell, 1997; Beasley & Rayner, 1997; Begley, 2001). These behaviours have often been dismissed as personality clashes. In addition they are often falsely associated with women working together (Clements, 1996),

but such behaviours are represented within many professions and groups of workers, for example, teachers, television production staff (Adams, 1992), bank officers, secretaries (The Working Women's Centre of SA Inc, 1997a), Inland Revenue and CYPS (Children and Young Persons Service) (Storey, 1999).

Behaviours associated with horizontal violence have many of the same characteristics as bullying. The terms horizontal violence and bullying will be used interchangeably throughout this thesis.

Bullying

The definition of a bully according to the Concise Oxford Dictionary (Sykes, 1984, p.120) 'is a person who uses strength or power to coerce others by fear', to bully is to 'oppress, persecute, physically or morally, by (threat of) superior force'.

Bullying may be recognizable as disgraceful treatment of one person by another in the workplace, which may be considered unreasonable and inappropriate (Working Women's Centre of SA Inc., 1999a). Expanding on, or perhaps intensifying the previous definition is one by Randall (1997) where he describes the occurrence of bullying as, 'the aggressive behaviour arising from the deliberate intent to cause physical or psychological distress to others' (p.4).

Trying to deal with the bully and bullying can be particularly difficult for people whose self-esteem has been under attack. Recognizing behaviour as bullying may be problematic because it is hardly ever limited to insulting comments and violent behaviour but as Adams (1992) comments 'It can be subtle, devious and immensely difficult to confront for those whose confidence and self esteem have been exposed to a misuse of personal power and position (p. 17).

In contrast, Briles (1994, p.46) raises the issue that feelings of low self-esteem may be used in a damaging way when she says:

Those feelings can become a breeding ground for resentment against those who are doing better by making more [money] including women in management and supervisory positions, or women who are beginning to move up the career ladder and out of the lower-status groups. Women executives and professionals who feel held back and underpaid also resent others who they see moving ahead.

Her belief is that women who feel they are in a weak position and underpaid, resent what they see as others progressing. Where that resentment is acted upon the most probable victims will be other women (Briles, 1994).

Adult bullying behaviour in the workplace is not new (Spurgeon, 1997) and can be both horizontally and vertically focused and is equally damaging to those who are subjected to the behaviour. Beginning practitioners may undermine more experienced colleagues just as contemporaries may display aggressive and destructive behaviour. The person exhibiting bullying behaviour may be a peer, manager or a supervisor (Thomas-Peter, 1997; Working Women's Centre SA Inc. 1999 b).

Perception of being bullied

Bullying is defined in terms of its effect on the receiver of the bullying and not the intention of the bully and this definition will always be a focus for variations in personal perception (Turnbull, 1995; Quine, 1999). The perception of either or both of the individuals involved in any incident may not actively reflect the reality of the situation, as 'the initiator feels that she is being assertive or being 'firm' but the recipient feels that it is aggressive' (Hadikin & O'Driscoll, 2000, p.44).

Turnbull (1995) gives a further example:

A manager may employ a legitimate approach in supervising an employee by exploring an aspect of work in depth. Although this might feel uncomfortable to some, it will only constitute bullying if the employee experiences some negative reactions to the process and when the intent is to humiliate him or her

(Turnbull, 1995,p.25).

Bullying often occurs when there is no one around to witness the violence. It is almost impossible to prove without actual details, 'But if it is a person's perception that they are being bullied, then the bottom line is that **they** must be believed' (Adams, 1992, p.16).

According to Hadikin & O'Driscoll (2000) bullies frequently target people who they see as weak and vulnerable. Randall (1997) suggests that as a result of the persistence of the behaviours of bullying victims feel unable to do their job, their self-esteem is at an all time low, and they feel defenseless to fight back. It is the systematic undermining of self-esteem and self-confidence over a period of time that is so damaging (The Working Women's Centre of SA Inc., 1997).

While definitions of bullying may differ in their intensity and focus, there is agreement that bullying behaviour is destructive to the individual, costly to organizations and results in an increase in sick leave, long-term health problems and absenteeism. In addition it leads to the loss of experienced and skilled staff, and impacts negatively on the confidence, self-esteem and health of people subjected to the experience. A further negative aspect is that departing employees will give negative messages about their previous place of employment, and this could lead to further workforce issues of recruitment and retention (Adams, 1992; Cole, 1996; Randall, 1997; The Working Women's Centre of SA Inc, 1997; Hadikin & O'Driscoll, 2000).

Justification for the study

Despite some acknowledgement that horizontal violence does exist (O'Connor, 1998; Waitere, 1998; Fell, 2000; Wilson, 2000; Beck, 2000; Calvert, 2001), it has not been well researched as an issue in the New Zealand health service, particularly in regard to midwifery. There is therefore a paucity of research findings available that are relevant to the New Zealand situation.

Fell (2000, p.21), describes the terms horizontal violence and workplace bullying as 'emotive words used to describe a phenomenon within the nursing profession', while Bickley (1998), questions why nurses are so harsh on one another when they might just as easily support, value and respect their colleagues. Beck (2000), a nurse with twenty years experience, suggests that while bullying is found in many organizations it is particularly dreadful in nursing where peers can be blatantly uncaring and mean, and exhibit a distinct lack of support for each other.

To date the focus of the discussion on horizontal violence in the literature has been concerned mainly with nursing, but the topic may be equally relevant to midwifery and may go some way to explaining the non-caring behaviour of some midwives (Hastie, 1995).

The issues of horizontal violence and bullying as presented in the literature are explored in greater depth in Chapter two of the thesis. I will identify the gap in the knowledge of horizontal violence in midwifery practice in New Zealand and the potential impact of this on quality of care. Addressing this gap provides the justification for exploring this important issue in maternity care.

Summary

Midwives have a central role in contributing to optimal health outcomes for mothers, babies and families. A strong and autonomous midwifery profession with midwives

remaining within the profession will assist with this. Conversations with midwives support a feeling of unease that anecdotally midwives are choosing to change jobs, and in some cases leave the profession, as a result of horizontal violence. My other concern is that horizontal violence impacts on the care that women receive, through preventing midwives from providing the best care possible. Therefore I explored twelve midwives' experience of horizontal violence and the effect of that experience on their provision of midwifery care.

This chapter has described my personal journey as a midwife and the experiences that have ultimately led to my interest in the topic of horizontal violence. The lack of available literature pertaining to the New Zealand situation as demonstrated in Chapter 2 is proposed as a justification for this study. A definition of the term horizontal violence and an alternative term, bullying are provided. Both terms are used interchangeably throughout this thesis.

Structure of the Thesis

Chapter 2, the literature review, reveals the state of the existing knowledge in the area of horizontal violence and bullying. The discussion of the literature enables my research to be placed within a national and international context.

Chapter 3: describes in detail the methods to explore the issue of horizontal violence in midwifery.

Chapters 4, 5, 6 and 7 describe the research findings.

Chapter 4 details each participant's understanding of the term horizontal violence and the experience of horizontal violence.

Chapter 5, which is titled ‘Fractured Relationships’, is the first of the two data chapters in which the experience and the consequences of horizontal violence by the midwife participants is detailed.

Chapter 6 is titled ‘Hanging On: **Surviving** the Experience’.

In this chapter the participants describe the emotional and physical effects resulting from the experience of horizontal violence.

Chapter 7 titled ‘Providing Care under Stress: Creating Risk’ is the fourth of the data chapters. It focuses on the effects of the experience of horizontal violence on the provision of midwifery care.

Chapter 8 concludes the thesis with a discussion of the findings and explores the implications for practice, education and research and the limitations of the study.

Chapter 2

Literature review

Introduction

The literature review places this research within the context of existing knowledge about the experience of horizontal violence. A literature search was performed in the course of preparing the research proposal. The literature search was undertaken using the databases of CINAHL, Medline, ERIC, MIDIRS, PsycLit and Wilson Social Sciences for the period 1980-2001. The following key words and word combinations were used: midwifery, horizontal violence, violence, workplace violence, bullying and workplace bullying. Reference lists were manually searched and articles were identified relating to the research questions.

Many of the articles identified were anecdotal in nature rather than research based and detailed personal experiences of nurses and midwives who had been subjected to bullying or horizontal violence. Nonetheless these stories raise awareness and increasing acknowledgement of horizontal violence being present within the midwifery profession (Spurgeon, 1997), and so were considered relevant.

The literature reviewed in this chapter is considered with regard to horizontal violence and bullying from a national and international perspective, including popular media.

Horizontal Violence and Bullying in the International Literature.

Farrell (1997), an Australian academic, voiced concern regarding the current literature on horizontal violence, stating: 'most of these studies are theoretical accounts and based on anecdotes or on very small samples' (p.501), and questioned the actual significance of horizontal violence for staff who were involved in clinical practice as the main focus of

their job. He conducted a two-part study that considered firstly nurses' views on their experience of aggression in the workplace, and secondly sought information on the extent of, and importance that nurses attached to, aggression from colleagues. Farrell (1997) talked broadly in his article about the concept of aggression and the difficulty of defining aggression adequately due to the subjective or the perceptual opinion of any act deemed as aggressive. No definition of aggression was offered to the participants with Farrell (1997) preferring to accept that '...[a] concept like aggression is best defined in terms of what people say it is' (p.503) and while this allowed for a wide diversity in the incidents that were reported as aggression, a broad definition of aggression may have proved helpful.

Of the twenty-nine participants in the study, comprising of university based and clinically based staff all nine lecturers were from the university where the researcher worked. This might suggest a degree of potential bias or a level of compulsion to participate in the study. A potential problem was that clinical staff were not given a questionnaire to record their experiences of aggression prior to being interviewed because of time constraints. Their interviews lasted a maximum of fifteen minutes as opposed to one hour for the academics and were also not audiotaped. Although nurses cited doctors, patients and relatives as being difficult or aggressive at times, a significant finding to come from the study which was surprising to Farrell, was that the nurses were most concerned about intra-staff aggression, which occurred frequently and was considered 'more upsetting and problematic to deal with than aggression from patients' (Farrell, 1997, p. 503). Nurses reported being subject to withholding of information, putdowns, threats, intimidation and innuendo, being refused help, ignored in conversation, being subject to malicious gossip and actual physical violence. Not surprisingly nurses were most concerned about the non-physical acts of aggression, described by Farrell (1997) as 'the all-pervasive hostile undercurrent of what can best be described as professional terrorism' (p. 504).

In 1995 a Nursing Times article on bullying in the workplace was published along with a questionnaire requesting readers to write down personal experiences of bullying (Turnbull, 1995; McMillan, 1996). The first 220 replies that were received described how respondents suffered a loss of confidence, anxiety, unjustified criticism of work, excessive

scrutiny of work, humiliation in front of others and being denied access to opportunities. Readers were also invited to write fuller accounts of their experience, and in an effort to encourage replies and preserve anonymity, they were not required to sign their accounts. The majority of the people who replied declared that they were being bullied at the time of the survey, and one third of those respondents had been bullied for a period of two years, with three quarters identifying their manager as the perpetrator of the bullying (McMillan, 1995).

Many nurses responding to the survey were frightened of being recognized from information that they had contributed. In fact they 'felt so intimidated by those bullying them that they said that no details from their testimonies should be published in case they were identified' (McMillan, 1995, p.42). According to Turnbull (1995) & Cole (1996) staff who have been bullied may feel powerless to change the situation. Reporting of the incident may lead to further bullying particularly if the incident is seen as trivial and no action is taken or the incident is seen as an inability to cope.

Fear of suffering retribution may stop nurses responding to even an anonymous survey in a professional journal. It is therefore likely that incidences of horizontal violence and bullying are under reported. Information on the number of nurses who had witnessed others being bullied in the Nursing Times survey would have provided a further dimension as evidenced in the following survey by Quine.

Quine (1999) surveyed all staff working in a United Kingdom community trust using a structured questionnaire. The trust offered a range of services that included mental health, learning disability, primary care and child health services, comprising both residential and community support care. Consequently there was a wide range of staff employed by the trust including nurses, doctors, and other allied health professionals. Unqualified staff that were employed by the trust also participated in the survey. The survey had three aims:

To determine the occurrence of workplace bullying

To look at the connection between bullying and work-related health outcomes

To examine the link between support at work and bullying

In her introduction to the study Quine (1999) raises the difficulty of consensus around what represents adult bullying. She concludes that

Bullying is defined in terms of its effect on the recipient not the intention of the bully, that there must be a negative effect on the victim and that the bullying behaviour must be persistent (p.2).

Including a requirement for the bullying to be persistent narrows the definition and could exclude people who have been bullied once and who live in fear of the bullying being repeated (Randall, 1997).

The questionnaire used by Quine was divided into sections. A 20-item list of bullying behaviours was designed for the study and information was collected that determined the participant's qualifications, hours of work and the degree of supervisory responsibility. Further sections contained scales to measure job satisfaction, job induced stress, tendency to leave, levels of anxiety and depression and support structures at work.

Of the 1,580 questionnaires distributed to all staff 1,100 were returned, a response rate of 70%. Thirty eight percent of respondents indicated that they had experienced bullying in the preceding year, and 42% indicated that they had witnessed the bullying of others but did not report being bullied themselves. This may point to a greater incidence of bullying occurring but the study does not specify where this bullying was observed. Consequently if the observed bullying was not within the Trust's operations it may not be relevant data to include in this report. The author also does not indicate whether the witnessing of bullying was in relation to staff or patients. Quine (1999) therefore suggests that the study indicated that bullying behaviour is not simply a 'subjective phenomenon' (p. 5).

In order to lessen potential bias from the number of non-responses a check was undertaken to verify the sample profile of staff working within the trust. This was organized by checking with the personnel department, that the sample correctly reflected the trust

profile 'in terms of age, sex, and occupational group' (Quine, 1999, p. 3). Results of the survey indicated that where staff had experienced bullying they reported lower levels of job satisfaction, higher levels of employment-induced stress, had a higher possibility of suffering clinical levels of anxiety and depression and as Quine (1999, p.4) reports 'higher scores on the propensity to leave scale'. Of sixty-one people in the survey who reported health effects, twenty had taken time off work, to a total of 335 days. A positive aspect of the study was that participants found a supportive work environment provided some defense against some of the harmful aspects of bullying by acting as a barrier against stress. The author further suggested that increased autonomy and a high personal sense of self worth might also be factors that could act as protection (Quine, 1999). Particular workplaces and circumstances within those workplaces may influence bullying behaviour.

Adams (1992) was a broadcaster and journalist. Her writing on abuse in the workplace was as a direct result of two radio programmes, *An Abuse of Power* and *Whose Fault is it anyway?* Her initial interest in the subject of workplace bullying resulted from hearing a story about fifty bank workers who over a four year period were affected by the systematic intimidating and humiliating tactics of their manager leading to undermining of their personal and professional confidence. This led Adams to seek support to expose the extent of adult bullying, and acknowledge that bullying was a significant issue. The response to the radio programmes was overwhelming, from adult men and women, numbers of who had never talked about their experience. The book gives detailed personal accounts from the perspective of the person being bullied and from people who are responsible. While it can be argued that the radio programmes and subsequent inclusion of experiences of workplace bullying in the resulting book are from a self-selected convincing group, the text is a valuable resource. In addition Adams details ways of recognizing and dealing with the experience. The text serves as a catalyst for bullies and bullied workers to identify and address the issue by raising awareness of bullying as a legitimate experience.

Neil Crawford (cited in Adams, 1992) a psychotherapist intensifies the depth of the writing by giving insight into the why of bullying. Crawford, works with bullies, victims of bullying and the organizations where both bullies and victims work and where

organizations are proactive about setting up policies to protect staff. He sees a bully as a person who has not been able to successfully resolve conflicts that occurred in childhood. He offers the view that the 'health state' of an organization will impact negatively or positively on the employees. Where the organization is 'hostile, the worst sides of an individual will be brought to the surface' (Adams, 1992, p.153), while in a caring concerned workplace although not perfect, bullying would be unable to thrive. He further suggests that listening to people new to an organization is a good way of gauging what is really going on in a workplace.

Field (1996) writes about his experience of being bullied that led to a nervous breakdown. Particularly significant at the beginning of the text is a health warning, advising people who have experienced bullying to seek support at the time of reading to guard against suffering Post Traumatic Stress Disorder. Field suggests that 'bullying is about projecting one's own weaknesses and failings onto others' (p.19) and in his text gives victims of bullying an understanding of what is occurring, the reasons why, why the symptoms they are experiencing are 'normal' and strategies for documenting and dealing with the bullying.

Oudshoorn (1999), a Dutch midwife, suggests that it is a combination of horizontal violence, burnout and frustration within the profession that leads to many midwives being individually focused and divided as a group. She argues that midwives need to be professionally united and strong in order to survive as co-workers. She suggests that it is our history of social control that has resulted in learned helplessness and a continuing paternalistic attitude being portrayed by midwifery leaders. Her view is that midwives display non-professional behaviour by isolating other midwives with different views, that they lack tolerance, are dogmatic in attitude and show little respect for others. She argues for midwives to learn to respect each other and to develop non-aggressive communication skills. This would result in a decrease in horizontal violence and less burnout and frustration

Hadikin & O'Driscoll (2000) have written *The Bullying Culture*, which takes a considered approach to the issue of bullying, defining what bullying in the workplace means, has a health service focus but on midwifery in particular. Within the text, case studies are used to demonstrate specific instances of bullying behaviours. What for one of the authors started out as research for an article on morale in midwifery led to telephone interviews with midwives to discuss the experience and the background to the occurrence of bullying. Hadikin was concerned about the possible extent of the problem in midwifery. As a Royal College of Midwives' steward Hadikin sought support to commence a quantitative survey. A questionnaire was designed that would seek to assess the number of midwives being bullied and who was responsible for the bullying. One thousand questionnaires were sent to a randomly selected group of Royal College of Midwives' members. The number of returned surveys is not stated which creates a difficulty in determining the significance of the findings. The results showed that 51% of midwives had been bullied by a senior colleague, 41% by a midwife manager and 21% by their midwife supervisor (Hadikin & O'Driscoll, 2000). Hadikin then invited midwives who had experienced bullying behaviour to write to her relating their own stories. Concern is raised about the possibility of midwives bullying the 'next one down the line', in particular, the woman. Hadikin, had this to say:

The midwife who is being bullied sometimes retaliates by using similar behaviours with more junior colleagues, ward clerks or ancillary staff. They may even bully the women or their relatives (p.99).

She further suggests that a midwife bully may try to keep hold of her authority by failing to give the woman the support and information she needs to parent and thereby undermines her self-confidence. In light of this concern in Hadikin & O'Driscoll (2000), and elsewhere (Robinson, 2000; Battersby, 2000) the section on bullying of women by midwives is small, and more information on what to look for, and measures to deal with the situation would have been helpful. What is particularly valuable is the information about anti-bullying interventions and the suggested use of external and independent

supervisory (counseling/coaching) services, to support both bullies and bullied staff. There is an increased ability to challenge people, if as an independent provider coaching or supervising, you are not required to work together every day.

McCarthy, Sheehan & Wilkie (1996, p. vii) define bullying as 'the act of repeatedly putting a weaker person under stress' and suggest that bullying is so common in Australian schools that it is just accepted as part of the passage of childhood. They further suggest that restructuring and job evaluation which was aimed at increasing productivity in the Queensland Public Service is having the opposite effect as payouts for stress have risen 200 per cent in the years 1993-1995. A conference in Australia convened in 1994, *Beyond Bullying-Towards National Guidelines* concentrated on bullying as a critical problem in schools, homes and workplaces and led to the Beyond Bullying Association. A main focus of interest was on the behaviour of organizations and the apparent deliberate harassment of workers by supervisors in workplace restructuring.

First round discussions at the conference indicated that school bullies, domestic abusers and corporate victimizers all appeared to be using similar tactics in their bullying behaviour. This prompted the idea that programs intended to decrease school bully behaviour might be modified to assist in preventing domestic violence and victimization in the workplace. A book, *Bullying From Backyard to Boardroom* by McCarthy et al. (1996) arose out of an identified need to raise public awareness of the problem of bullying. The papers that were presented at the conference were from an extensive group of professionals including psychiatrists, lawyers, specialists in school bullying, human resource management and communication experts, who all had experience of bullying within their field of expertise.

What emerged was that bullying, whether it occurred in the home, at school or within a management situation, caused the same distress. Another point to emerge was that the act of witnessing the victimization of another and failing to take action is very harmful to those witnesses and McCarthy et al. (1996) suggest that 'a society unwilling to stand up to bullies is vulnerable to totalitarianism' (p.x). One possible explanation for the similarity of

the bullying amongst all groups was that bullies perfected their techniques as school bullies. To this end McCarthy et al. (1996) conclude, that it is imperative to decrease the incidence of bullying in schools and train children to report incidences of bullying, if the incidence of bullying in the workplace is to begin to be addressed.

The big danger for organizations is that everybody in the workplace is affected, not just the victim. It can be very traumatic for witnesses as well, and it brings the morale of the whole organization down (Field, 2001, cited in Dempster, 2001), as it may sensitize witnesses or lead to an ongoing fear that they may be next. As well, feelings of guilt may surface as a result of witnesses failing to go to the aid of the victim.

Randall (1997) a psychologist and the Director of the Family Assessment and Support Unit was responsible for commencing a community anti-bullying project including a hotline for children. He was shocked to discover that a third of the callers were adults who were experiencing bullying. He argues strongly that bullies are

The scourge of workplace, community and family, adult bullies create polluted environments where self-esteem withers, confidence is lost and talents are stifled (Randall, 1997, p.vii).

Another point that Randall (1997) strongly advocates is that people, who are bullied, feel ashamed that they are unable to retain control over their own lives. He firstly places emphasis on an awareness of the issue of adult bullying and advances to discussing the reasons why particular people become bullies and why others succumb to bullying practices. He uses case studies as graphic illustrations to demonstrate bullying behaviour from the perspective of both the bully and the person suffering the bullying. As a psychologist he has interviewed more than two hundred bullies and victims of bullying. Randall (1997) argues that for behaviour to be considered bullying, the behaviour need only happen once, it does not have to be repeated. Once may be enough to cause fear of the aggression being repeated. The detrimental effect of violent television programmes on children bullying others is raised

by Randall, as is the influence of deprived family circumstances where bullying occurs, and leads to situations where children become bullies. Finding solutions to the problems is a main focus of the text and centres on strategies aimed at prevention, based on a knowledge and acceptance that adult bullying does occur, and that it occurs most commonly in the workplace and in the community.

Dempster (2001) writes that 'workplace bullying is alive and well' (Dempster, February 11) and details the danger one worker was subjected to in the course of her job. The worker had received no training in handling dangerous chemicals, yet her job as a laboratory attendant at a university required her to do this. An unreasonable and heavy workload coupled with a distinct lack of help and threats from colleagues contributed to her decision to resign. Dempster (2001) also raises the issue of initiation rituals on teenage apprentices or initiation ceremonies in the armed forces as instances of bullying. Bullying is estimated to cost the Australian economy around \$3 billion yearly (Dempster, 2001).

Workplace Bullying in the International Literature

Rayner & Hoel (1997) who conducted a summary review of literature relating to workplace bullying concluded that adequately defining adult bullying was difficult as opinions varied. They suggest that physical bullying is reported less often than the use of verbal and subtle intimidating tactics. They broadly group bullying behaviour into five categories:

- Threat to professional status (e.g. belittling opinion, public professional humiliation, accusation regarding lack of effort)
- Threat to personal standing (e.g. name calling, insults, intimidation, devaluing with reference to age)
- Isolation (e.g. preventing access to opportunities, physical or social isolation, withholding of information)
- Overwork (e.g. undue pressure, impossible deadlines, unnecessary disruptions)

- Destabilization (e.g. failure to give credit when due, meaningless tasks, removal of responsibility, repeated reminders of blunders, being set up to fail (Rayner & Hoel, 1997, p.183).

The Workplace Bullying Project was undertaken to record the type and occurrence of workplace bullying, and to determine the health, safety and welfare effects that the bullying had on people. In addition there was a requirement to estimate the cost to organizations of workplace bullying, and the development of strategies to deal with the problem. Data were obtained by questionnaires from the 342 participants who self-selected, and from case studies from seven people who agreed to be interviewed. Interviewing was considered in order to record the insights, feelings and reactions to the experience. Selection attempted to include participants from both the public and private sector and to reveal the type and range of bullying practices that workers may be exposed to.

Focus groups were used to look at issues that had not been considered in the questionnaire and focused on finding solutions. The group members were varied in terms of the occupational groups represented and included nurses, employers and union and agency officers. The similarity was that they were all involved in the management of bullying. The nursing group included enrolled nurses, registered nurses and a former nursing director.

Findings from the report identified that workplace bullying perpetrated by employers, managers or colleagues is for the most part either not recognized or is misinterpreted. Further, bullying had a harmful and debilitating effect on people subjected to the behaviour, which resulted in major organizational costs because of increased use of sick leave, resignations and decreased productivity (The Working Women's Centre, 1997).

Findings from research on psychological abuse within family relationships demonstrate in a lot of instances that 'bullies in families tend to have low self esteem, poor communication skills, problems in developing personal relationships and a revenge and

retaliation mentality' (Working Women's Centre SA Inc., 1999). They suggest that these same traits may lead workplace bullies to invent or overstate perceived weaknesses in others in addition to undermining the strengths and skills of other people in an effort to disguise their own inadequacies.

What the data and information that were gathered during the project accomplished was to support previous anecdotal experience gathered by the Centre, that bullying was a serious, but largely unacknowledged problem. It was evident that there was increased potential for bullying to surface when restructuring occurred, staff shortages were acute, budgets were reduced and workloads increased. Uncertainties about gaining subsequent employment resulted in staff remaining and tolerating 'offensive and frightening behaviour' (Working Women's Center SA Inc. 1997, p.7), and while each person is responsible for the way they treat others, a great deal of the responsibility for improvement belongs with management.

Bullying in the Nursing Profession

Literature detailing the experience of horizontal violence relates primarily to nursing (Duffy, 1995; Clements, 1996; Glass, 1997). Midwives and nurses have historically worked within strongly hierarchical power structures and Kirkham (1986) suggests that the way the midwife or nurse feels about her position within this structure has an immense effect on the care she provides. Roberts (1983) contends that nurses are like other oppressors when she says 'they exhibit self-hatred and dislike for other nurses' (p.27), although this behaviour may indeed be subtle and difficult to recognize.

McCall, (1995), Duffy, (1995), and Leap, (1997) maintain that nurses adopt the adaptive strategies of oppressed groups by directing their antagonism, frustrations and dissatisfaction inwards towards themselves, each other and others who are in a less powerful position. These strategies, I suggest, may be equally relevant to midwives, and as (Smith, Droppleman & Thomas 1996), suggest lead to antagonism and mistrust among co-workers, rather than mutual support

Horizontal violence continues to exert an influence on the working lives of nurses and midwives as they are exposed to stressful encounters with their peers (Duffy, 1995; Hastie, 1995; Clements, 1996; Glass, 1997). Within the disciplines of nursing and midwifery, Leap (1997, p.689) suggests that 'social, political and economic inequalities are linked to gender, subservient division of labour, medical and managerial domination, and lack of autonomy', and that it is these issues that lead to an exacerbation of poor self-esteem.

Is horizontal violence an appropriate term to describe the behaviour that occurs? It is inaccurate to describe the behaviour as purely horizontal as where people in more powerful positions, for example managers or supervisors, and who are responsible for the violence, the behaviour is vertical (Wilson, 2000). Bullying as a concept much more accurately describes the behaviours that midwives and nurses are subjected to as a result of horizontal violence.

Stories about bullying within nursing also featured prominently in Australian newspapers. Charmaine Hockley, a nurse with thirty years experience studied the effects of bullying among female nurses and found as a result of her study, which included interviews with nurses from across Australia, that bullying and victimization were endemic among female nurses in Australia. Hockley (1999) also raised the issue of nursing administrators admitting they felt bullied by junior colleagues who tried to undermine their positions. Hockley went on to say that while bullying was widespread, the majority of nurses chose to disregard it and accepted it as 'part of the job'. Her research showed that nurses felt that the care given to patients appeared unaffected by the conflict that occurred in the workplace, but Hockley commented that 'although nurses appeared to be able to care for their patients they don't necessarily care for their colleagues or themselves' (cited in Dasey, 1999, p.30). Dasey during his interview with Dr. Hockley about bullying commented 'Dr. Hockley said there had even been a few instances of nurses committing suicide as a result of bullying' (Dasey, 1999, p.30).

Hastie (1995) recounts a distressing story about the tragic and unnecessary death of a midwifery colleague from suicide as a result of horizontal violence and the bullying she received. Using the letter that the midwife wrote before her death, Hastie suggests that it is the way that the midwifery profession treats women that led to the midwife feeling so desperate. Feeling that she could never reach an unrealistic standard, that she would never be able to effect change, that her contribution was not valued led to a feeling of hopelessness in the midwife.

As a result of the midwife's death, Hastie reflected on her own position where she felt that constant compromise, a lack of desire by management to staff appropriately, no commitment to provide quality care and personal damage to her reputation were affecting her ability to practice ethically. Working as an agency midwife in one particular maternity unit exposed her to offensive, challenging, hostile and disapproving behaviour from a midwife with a bullying reputation who managed the labour ward at night. What is shocking is that Hastie, a mature and extremely experienced midwifery practitioner, was intimidated to a degree that she did not challenge the bully instead, as she relates, as a consequence of the bullying, she 'became bumbling, inept and clumsy' (Hastie, 1995, p. 7) which immediately intensified the bullying. The author challenges midwives to confront the issue of horizontal violence, to think about the complex political and social context of midwifery practice before blaming midwives who are unable to cope with undeserved damaging behaviour from colleagues and to take responsibility for their own behaviour.

It is time to change. Time for each of us to examine our
behaviour and our aspirations: to ask ourselves whether we
are part of the problem or part of the solution

Hastie, 1995, p.8.

Middle management in health care institutions are often identified as the main perpetrators of both bullying and horizontal violence, and there are numerous examples given of how this may be identified: lack of leadership, substandard management practice, a lack of

support for research, lack of support when staff are bullied, obstruction to creative initiatives and a failure to reward excellent work (Duffy, 1995; Hastie, 1995; Leap, 1997; Smith, Droppleman & Thomas, 1997; Rayner & Hoel, 1997).

While studying the problem of horizontal violence, McCall (1995) suggested that middle management might feel threatened by the increasing education level of clinical nurses, leading to insecurity in terms of position and their power base. McCall used a feminist methodology to document the stories of nurses who described their experience of workplace horizontal violence. Nurses were also asked to comment on the reasons they considered that oppression still persisted. McCall states that the study sample was small but does not clarify the exact number of participants. Nurses in her study cited instances where nurses in middle management positions constantly acted in a fickle manner, colluded with hospital managers and the medical profession, and as a result failed to provide appropriate support to clinical nurses.

A lack of support, amongst midwives was also found by Brodie (1996) in her study on team midwifery, where unit-based midwives demonstrated their bias and revealed that their loyalty lay with the doctors within the unit, rather than with their midwifery colleagues. They demonstrated this by their lack of support for their midwifery colleagues who were providing continuity of care, by their excessive scrutinizing of the midwives' clinical practice while not applying the same scrutiny to the practice of doctors.

Oppression

McCall (1995), an Australian nurse, conducted a research project using a feminist methodology to document stories of nurses that illustrated their experience of horizontal violence within their place of work and additionally, the nurses' opinions on why oppression of nurses continued. An oppression checklist was used to confirm answers to questions concerning exploitation and authenticity. A paper to present the research findings titled *Horizontal Violence in Midwifery: The Continuing Silence* (McCall, 1995) identifies midwives in the title but refers to nurses throughout. This may be because a

midwifery qualification in Australia is regarded as a postgraduate qualification; midwifery is not regarded as a separate profession at this time and all midwives are referred to as nurses.²

McCall (1995) identified three main reasons as the cause of oppression and continued horizontal violence. These are gender bias, aspects of education and the notion of collusion and acquiescence. Gender bias was described as a continued perception by other professionals in the health field, particularly doctors but also management, that nurses are not health professionals in their own right but remain handmaidens. In regard to education the participants acknowledged that education had contributed to correcting some of the inequality within the profession of nursing, but nurses perceived there was a lack of respect and value for nursing despite the education and experience of the nurses. The third reason suggested by McCall (1995) that oppressive behaviour continued, was that nurses continued to adopt the position of being a victim or 'sub-oppressor' and so nurses continued the status quo. Although nurses in this study appeared conscious of the conditions that are responsible for the continuance of repressive behavior McCall (1995) found that they made little effort to improve their circumstances, instead they appeared to accept the unwarranted and unjust behaviour.

Leap (1997), a midwifery practitioner, also raises the notion of midwives not becoming 'stuck in a victim role' (p.689) and suggests that models of care that offer autonomy and positive intra-professional collaboration with a subsequent increase in self-esteem for midwives, and a crumbling of old hierarchies may provide a way forward.

According to Clements (1995) nursing needs radical feminism to deal with the issue of horizontal violence and she looked at the notion of oppression and a perceived uneasiness of the nursing profession with feminism. She further emphasizes the idea that 'midwives failure to recognize their own oppression often obstructs ways of reducing horizontal violence in the workplace and affects their relationship with other midwives' (Clements,

² A three year direct entry midwifery programme commences in 2002 in South Australia (Foureur, 11/2/02, personal communication).

1995, p. 9). Radical feminists are interested in ways of organizing the world to free it from dominant structures. They are woman centred, and seek to make visible male control, as it is experienced in all spheres of women's lives (Clements, 1995). Radical feminism stresses both the personal as political and the need for collective action and responsibility. Clements (1995) suggests 'that by remaining fragmented nurses and midwives only serve the interests of the dominant group' (p.13). She further offers the view that a feminist perspective would be helpful in overcoming the divisiveness that currently exists.

Duffy (1995) based her analysis of the literature around horizontal violence on the assumption that fundamentally nurses are an oppressed group, around issues of patriarchal oppression, inequitable power relations, powerlessness, dominant/submissive relationships and the need for change. Duffy argues strongly for change for nursing as a result of '...inequities of power and horizontal violence' (Duffy, 1995, p.15), which were identified in her study. Simply identifying the issues is not enough. It is by altering the perceptions of power relations in nursing practice, and consequently increasing the level of critical consciousness in regard to the political nature of nursing practice that, according to Duffy (1995), provides an impetus for change. Accordingly it remains important that nurses and midwives not succumb to the notion of oppression and become, as Duffy (1995) describes, self-pitying victims, but rather, after examining the causes, should act responsibly, because to do nothing is to condone oppression as a subversive influence within nursing.

On a positive note, McCall (1995) and Glass, (1997) suggested strategies that nurses and midwives might use to change the situation, specifically those for consciousness raising on the issue, refusing to play the game and thereby providing no victim, and endeavouring to see conflict as a positive thing.

Glass (1997) discusses some of the findings from a research study, in which she investigated the 'lived experience of women academics in universities' (p. 15), with particular emphasis on horizontal violence and the connected healing strategies the participants used to move from situations of negativity. The author argues that nurses work in a harsh competitive working environment and are subjected to constant negativity,

stressful occurrences, professional jealousy and horizontal violence. She located her study in a feminist postmodern theoretical framework and used participant observation, reflective journaling and interviewing as methods of data collection. The study was located over two universities with five participants from each campus.

Participants reported that they were exposed to minimizing behaviours, rejection, sabotage, humiliation and invalidation from their colleagues. A key emergent theme from the research was the value of having holistic healing strategies that were related to and used in the participant's workplace. Strategies that the nurse academics described and actively used to confront negativity were 'mutual respect, collaboration, a hopeful lens and confronting issues head on' Glass (1997, p.19) who described it thus: ' they were creating work environments that were places of care and healing' (p. 19), that commenced with recognizing and examining their hurt alongside healing strategies.

Bakker, Groenewege, Jabaaij, Meijer, Sixma & deVeer (1996), in a study looking at burnout amongst Dutch community midwives, identified that the level of social support that midwives received had a direct relationship to workload capacity, and the level of burnout experienced. If the midwife was well supported socially, the expectation was that her capacity for work was higher. Social support was described as a concept that recognized another person's worth, and included valuing and helping the person.

Horizontal Violence and Bullying in the New Zealand Media

Recently published newspaper reports indicate that the practice of bullying is rife in New Zealand society and affects schools and workplaces. It is pervasive in all categories of workplace in New Zealand. A human rights commissioner recently resigned over claims she had used her position to bully a police officer over a traffic infringement notice (Milne, 2001), while the Chief Executive Officer (CEO) of Te Papa, The National Museum of New Zealand, is being cited in a \$500,000 employment suit. The CEO is accused of creating a climate of fear for employees by swearing at and abusing staff (Laugesen, 2001). There is alleged to be a lack of respect for employees, an unsafe

working environment, a lack of opportunity for professional development and a lack of effective management within the museum workplace.

Currently seven senior college students are appearing in the High Court in a major New Zealand city charged with attempted sexual violation and sexual violation as a result of an appalling act of bullying that occurred at a party. While this is an extreme case of bullying resulting in a criminal charge, what is particularly alarming is an alleged comment from one of the perpetrators that he had previously suffered the same horrendous act, and an inference that 'it happens' and that 'you get over it'. Believing that you have to suffer bullying behaviour is not acceptable in a caring society. Schools are mirroring the increasingly violent attitude that is prevalent in New Zealand society today (McCurdy, 2002).

Beck (2000), an experienced nurse, was interviewed by a New Zealand Herald reporter over the topic for her thesis, 'Bullying in nursing' and commented that the nursing profession is full of bullies. Beck believes that those most at risk are new graduates. As a new graduate herself 20 years ago she was subjected to that kind of behaviour. Her belief is that 'bullying is a factor in many nurses leaving the job' (Beck, 2000, cited in Johnston, 2000, p. A3), and is responsible for a shortage of nurses in hospitals. She further suggests that hospitals should follow the example of schools where anti-bullying programmes have been introduced (Johnston, 2000).

The Eliminating Violence Programme, a National Specialist Education Service Programme, has been successfully used in two New Zealand cities and this year, a Wellington school is participating in the programme. The emphasis of the programme is to encourage children to become assertive in non-violent ways, and encourage the development of a pro-social school environment. The Wellington school principal believes that school should be a safe place for everybody. Although she does not believe her school has a particular problem; she is aware that '... there's a lot of verbal stuff that goes on. It's amazing the number of put-downs that children will deliver' (Heinz, 2001, p. 11, cited in

Scollay, 2001, p.11). The message is that responsibility for changing attitudes to violence and behaviour is a community responsibility.

Television programmes that intentionally put people down may well create the impression that this behaviour is normal and acceptable for the society we live in. The television game show *The Weakest Link* is an example. The programme demonstrates bullying as acceptable, as it shows adults criticizing and putting each other down with cutting remarks and giving 'the sack' to a contestant voted off the programme as the weakest link. While the programme is aimed at an adult audience, Norton (2001) an educationalist, had this to say

Kids learn to score points by putting other people down.

They learn that the only way to get a laugh out of your friends is to put someone else down.

(Norton, 2001, p.11, cited in Stratford, 2001, p.11).

Horizontal Violence within the New Zealand Nursing context

O'Connor (1998), a New Zealand nurse and Co-editor of *Kai Tiaki: Nursing New Zealand* questioned whether bullying was a problem for the nursing profession and concluded that it was. She cites the case of a New Zealand Nurses Organisation delegate whose life and that of her family was made unbearable by bullying behaviour and horizontal violence thought to be carried out by a colleague. The delegate received intimidating telephone calls, and threats of physical mistreatment and damage to her car.

Constant change within the health area is a factor in bullying behaviour. A lack of awareness of what constitutes verbal and emotional harassment, entrenched behaviour and resistance to change, strong personalities wielding power and isolating colleagues who are perceived to be different are raised as evidence of the behaviour that is occurring. In addition the disturbing issues of a lack of support from colleagues to confront and deal with the issue of bullying, and the potential for bullying of patients by peers who not treat their colleagues well is raised.

Wilson (2000), an experienced New Zealand nurse and professional development trainer, expresses the point of view that it is nurses' reaction to their perceived inability to influence and change service delivery, that leads to anger and frustration, and that these responses are consequently inappropriately expressed in the 'negative and destructive behaviour known as horizontal violence' (Wilson, 2000, p.24). She contends that nurses need to take responsibility for their own behaviour and work towards better treatment of each other. Whilst advocating strongly for good role models, suitable appointments to key positions in nursing and appropriate support systems Wilson (2000) also advocates the need to evaluate accurately the occurrence of horizontal violence.

Fell (2000) a nursing student writes that she believes that students are exposed to horizontal violence from tutors, charge nurses and other nurses in the workplace while on clinical placement. She relates being subjected to a lack of respect and obvious rudeness characterized by being ignored, talked about 'as the student', and exclusionary behaviours.

As a result of the constant negativity of nitpicking about practice issues, putdowns in front of patients, lack of acknowledgement of skills and hurtful remarks, Waitere (1998), speaking about enrolled nurses, had this to say: 'so how do these negative things make us feel? Apathetic, angry and lacking in self-esteem' (p. 24). Secondary to the lack of self esteem is a lack of confidence, brought about by experiencing horizontal violence, which led to some enrolled nurses believing they would not be able to effect change. They displayed this lack of belief in their ability to effect change by not contributing to the local enrolled nurse section of the New Zealand Nurses Organization, not supporting other nurses in their work, and failing to correct misinformation about the role and professional competence of enrolled nurses.

Horizontal Violence within the New Zealand midwifery context

There is little information about the occurrence and experience of horizontal violence within the New Zealand midwifery context. Calvert (2001), a New Zealand midwife, raised the issue of poor behaviour experienced by midwifery students for whom she was

responsible. This occurred in their clinical placement both within the hospital and in the community settings. Apart from referring to not being treated with respect Calvert does not detail these behaviours, but likens it to the same treatment she experienced as a student midwife twenty years earlier. It is an indictment on the midwifery profession that the bullying behaviour that was prevalent twenty years ago has changed little. Calvert argues that this treatment of students is reminiscent of oppression, and has little to do with the social model of care that midwives in New Zealand are currently educated within. She expands further on this by saying that student midwives 'expect to work actively in partnership with women and health professionals, they find this dominant behaviour difficult to cope with and believe it unnecessary' (Calvert, 2001, p.28).

It appears from the lack of documented research that the issue of horizontal violence as an issue amongst New Zealand midwives has been ignored.

Summary

Within the midwifery workforce in New Zealand today, there are numerous challenges to practice in the face of constant change, fiscal restraints and staff shortages. Shortages of midwifery staff affect midwives who are providing midwifery care in both employed and self-employed situations. From the literature it would appear that these conditions contribute to and foster the escalation of horizontal violence and bullying. In this chapter I have reviewed literature on the subject of horizontal violence and bullying from a national and international perspective, including relevant information from multi media sources. Particularly significant was the amount of anecdotal literature on bullying behaviour amongst nurses. The possible reasons for the anecdotal literature need to be addressed from two aspects, that of the lack of available research and the possible scale of the problem of bullying in the nursing and midwifery workforce. Bullying behaviour as a legitimate experience is well documented. Of concern is the possible poor treatment of women by midwives and nurses who bully their peers (Robinson, 2000; Battersby, 2000). The responsibility for acts of horizontal violence or bullying clearly lies with those who carry them out whether they are children in schools, doctors, nurses or midwives in practice or workers and management personnel in the workplace.

Justification for the study is inclusive of the fact that for midwives, horizontal violence has not been researched in relation to midwifery and the effects of that experience on the provision of midwifery care.

In Chapter Three I describe the methodology and methods used to explore the issue of horizontal violence in midwifery.

Chapter 3

Methodology

Introduction

A qualitative method using Thematic Analysis was chosen to analyze and describe the experience of horizontal violence of twelve registered midwives and the effects of that experience on their provision of midwifery care. The details of the methodology used in the present study are presented. The actual method utilized in the study is described including gaining ethics committee approval, the process of obtaining informed consent, the procedure of recruitment, interviewing and analysis. The issue of maintaining validity is also addressed. The five principles suggested by Tolich & Davidson (1999) to determine ethical conduct in social science research are discussed in relation to this study. Thematic analysis as a qualitative method of analysis is discussed, with information gained from a combination of authors, namely, Burnard (1991), Tolich & Davidson (1999), Boyatzis (1998), and DeSantis & Ugarriza, (2000). The stages of data analysis are set out using the framework recommended by Burnard (1991).

Qualitative Research

According to Sandelowski, (1986) and De Santis & Ugarriza, (2000) qualitative methodologies are integral to nursing and midwifery research. Tolich & Davidson (1999) suggest that a reason for choosing qualitative research is 'about boundary crossing, peering into another's world to understand as best we can, as reflexively as we can, that person or that group's perspective' (p.183), while Sandelowski (1986) suggests that 'qualitative research depends on human subjects with vivid stories to tell' (p.32). In this study qualitative research provides the means for the participants to tell their story and the significance they attach to it from their perspective.

Recruitment of Participants

Before recruiting of participants could begin, the study had to receive ethics approval from the Massey University Human Ethics Committee, Manawatu- Whanganui Ethics and the Wellington Ethics Committees. The original proposal was accepted unconditionally by two ethics committees, and with minor alterations by the third committee.

Participants were not actively recruited from the regional hospital where I am currently employed in recognition of the need to guarantee anonymity and prevent the suggestion or possibility of coercion. In an effort to recruit possible participants copies of an advertisement (Appendix A) giving details about the study was sent to three maternity facilities outside the Wellington region. The study was also advertised in the New Zealand College of Midwives Wellington newsletter. I also made a short oral presentation on the study at the Wellington College of Midwives Wellington monthly meeting.

Registered midwives who were employed within health care institutions, or self-employed midwives, who had an access agreement to use the facilities of hospital maternity units and who were providing midwifery care, were eligible and invited to participate in the study. Midwives who expressed an interest in the project were given a written information sheet about the study (Appendix B) with sufficient time allowed to consider participation in the study, before consent to be involved in the study was sought.

My initial expectation was that I would recruit between ten to fifteen participants. Intense interest was shown in the study by possible participants, which resulted in telephone conversations about the study and information sheets being sent to more than twenty midwives. Midwives who wished to participate in the study self-selected. The first twelve who responded and met the inclusion criteria were accepted.

The Participants in the Current Study

All twelve participants who took part in the study were female. No male midwives sought information or expressed an interest in being participants in the study. All the participants identified themselves as having experienced horizontal violence in their work situation. The participants had received their midwifery education in five different countries. At the time of entry into the study eleven held dual registration as a nurse and a midwife, while two midwives had completed a Direct Entry midwifery programme as their original entry qualification into the midwifery workforce.

The need to protect the rights of the participants in this study required that ethical principles were followed.

Ethical Considerations

Research is fundamental if midwifery as a profession is to move forward. For both the researcher and for the participants involved in the research it was essential that ethical principles were adhered to. As a midwife I was guided by the Midwives' Code of Ethics (New Zealand College of Midwives, 1993), the principles of the Massey University Code of Ethical Conduct for Teaching and Research involving Human subjects and the principles recommended by Tolich & Davidson (1999).

Tolich & Davidson (1999) suggest that there are five principles, which may be used to determine ethical conduct in social science research. They state these as:

- Do no harm
- Voluntary participation
- Informed consent
- Avoid deceit
- Confidentiality or anonymity' (p.70).

Application of each of these principles in the present study is discussed in the following sections.

Do no harm

Hicks (1996) would suggest that the researcher must never do anything knowingly to cause harm or upset to any of the participants. At the outset of the study it was believed that no long-term harm would come to the participants in the study. Nevertheless it is possible that the research may have harmed participants in ways that are not readily apparent, for example by revisiting an experience that had caused distress when it originally occurred and causing distress to reoccur (Tolich & Davidson, 1999).

The expected possibility that participants may become distressed when 'telling their story' eventuated for some of the participants. Support service numbers were listed on the consent form. In addition participants were encouraged to seek support from the Employee Assistance Program (a confidential service provided for hospital employees) where they were employed midwives, and from their own professional supervisor, a Chaplain or a trusted colleague where the participants were self-employed. Three participants chose to have professional supervision after taking part in the interview.

Even in the interviews where participants became distressed or in the case of two interviews where participants were extremely distressed throughout the interview, all the participants expressed their satisfaction at having taken part. An opportunity for terminating the interviews where participants were extremely distressed was offered but declined by both participants.

Where participants had become particularly distressed during the interview I made phone contact within two days of the interview to make certain that the participant had been able to make contact with her preferred choice of support person or service.

Voluntary participation

Deciding to be a participant in the study was voluntary. There was no obligation to take part but participation was seen as an opportunity to 'tell their story'. This was immensely important to a number of the participants. Prospective participants were given a copy of the information sheet (Appendix B) pertaining to the study and were asked to contact the researcher if they had any questions or wished to take part in the research project.

Informed consent

Written informed consent from the participants was obtained before the study commenced. The information sheet that was supplied to the participants clearly outlined the study and what consenting to being a participant involved. Each participant had time to have particular questions about the study answered before written consent was obtained. Both the participant and the researcher retained a copy of the signed consent form (Appendix C).

The consent form contained the following elements (LoBiondo-Wood & Haber, 1998; Tolich & Davidson, 1999; Massey University, 1999).

- A statement that the study involved research.
- An explanation of the reason for the research and detailing the length of time the midwife could expect to be involved in the interview.
- An explanation of the course of action to be followed.
- A statement describing how anonymity and confidentiality of the material gained from the interview would be maintained.
- Details of who to contact for answers to questions about the research and participants rights.
- Details of what would happen to the completed research, and who would have access to it.

- A statement that all participation is entirely voluntary and that the person can withdraw from the study and have all data destroyed before the transcript is returned to the researcher for analysis.

Avoid deceit

Deliberately deceiving participants who consent to participate in research is unethical, as is misleading participants about the nature of the research, the identity of the researcher or who a particular sponsor for the research is (Tolich & Davidson, 1999). I believe no deliberate deceit occurred throughout this study

Confidentiality or anonymity

Confidentiality, as defined by LoBiondo-Wood & Haber (1998), ensures that ‘...individual identities of subjects will not be linked to the information they provide and will not be publicly divulged’ (p. 286).

The issue of the need for support people to maintain confidentiality and the method of addressing this concern were raised as an issue of concern by one ethics committee. The issue did not arise, as no support person accompanied any participant although this was a choice open to all twelve participants. Midwives who decided to participate in this study were asked to describe their experience of horizontal violence and the effect of that experience on their provision of midwifery care. Although these descriptions were the data provided by the study participants, they had a right to expect that they and the people they discussed would not be identified or identifiable.

The participants were asked to choose a pseudonym. All were agreeable to this and none chose one already in use. However after asking three participants to read the data chapters for authentication of the way in which their transcript data had been used to support the identified categories, they felt all that there was the potential for some situations and participants to be easily identifiable. They suggested that it would be entirely possible for

a story to be pieced together by following a pseudonym through the data chapters. After discussion with my supervisor about the concerns of the three participants, it was decided to omit pseudonyms entirely from the data chapters to lessen the likelihood of verbatim quotes being linked to individuals who could be identified. As well, at the request of some participants, certain words were changed or left out to protect them. In no case did this minor exclusion of words detract from the meaning of the quote.

Because of time constraints and my lack of previous experience with transcribing tapes I used the services of a transcribing typist. The transcribing typist was required to sign a confidentiality agreement (Appendix D) prior to receiving any tapes for transcribing. She was unaware of the names of any of the participants or indeed where they came from, or of any other identifying information. All participants were aware of my intention to use a transcribing typist and of the requirement that she sign a confidentiality agreement.

The transcriber discussed the emotion she felt when transcribing the content of some of the tapes. She did not feel the need to use any support service but felt saddened by the unhappiness evident in several of the interviews she transcribed.

The tapes and transcriptions contained the names of other midwives, midwifery managers, family members, hospitals, towns, cities and countries. When using verbatim quotes that contained any reference to identifiable people or places and in order to preserve anonymity these have been referred to as 'the midwife' 'the manager' 'small town', 'city', 'foreign country'. All names of family members mentioned by participants have been changed.

The information gathered from the interviews was kept in a locked filing cabinet. Each tape and transcription was only identified by the participant's chosen pseudonym. No other identifying information was left with the tapes and transcriptions. I did keep an identification sheet with each participant's Christian name and pseudonym in order to ensure that transcripts were returned to the correct participant. This identifying sheet was stored in a separate locked cabinet. My supervisor has a copy of each transcript to provide

verification of the data. This action has been taken because all pseudonyms have been withdrawn to protect the participants.

All participants received a copy of the transcription to enable them to sanction the content and to provide opportunity for them to consider exclusion of any of the data. Participants were informed that they could remove material from the transcribed interview. Changes were mostly in relation to grammar and slang expressions but as previously indicated also included the removal of some identifying words in relation to people and places.

The content of the tapes belongs to the participants who took part in the study. The transcripts remained in safekeeping until completion of the study. Massey University guidelines require that sensitive material be archived for a period between three to five years. Material that is not considered sensitive must be stored in a secure location by the researcher and retained for audit purposes. Tapes from the study will be destroyed after this period of time or handled in accordance with the participants' wishes. The data resulting from the tapes will also be archived in a locked cabinet. The participants in the study were informed about the uses of the data, that would include the development of a thesis, and that the findings of the report may be published in professional journals and presented orally at conferences. A summary of the findings has been offered to each participant. A copy of the completed thesis will be available in the Massey University Library.

Cultural Issues

To cover the possibility that Maori Midwives may have sought inclusion in the study the Maori Health Unit at Capital and Coast District Health Board was contacted. Advice was sought on specific cultural issues that may need consideration. Their advice as detailed below was offered to all participants:

- Midwives may wish to consider suitable places for interview.
- That they (Maori Midwives) may wish to be accompanied by *Whanau* [family/support].

- Consider the possibility of a blessing before or after the interview.

The Maori Health Unit provided a letter detailing suggestions and support for how the research could deal sensitively with any cultural issues that may have arisen. They offered ongoing help throughout the course of the project, but no help was sought. The specific recommendations of the Maori Health Unit were addressed in the ethics proposal.

Data Collection

Semi-structured interviews were used as a method of collecting the data for the study, in order to gain a description and detail of the experience of horizontal violence and the effect that experience had on the provision of midwifery care in the participant's own words. Polit & Hungler (1995) suggest that the structure of the interview needs to be 'open' enough to guarantee adequate freedom for the participants to provide data that are relevant to them.

Participants were invited to take part in individual in-depth interviews, which varied in length from forty minutes to one hundred and fifty minutes. Each interview was audio taped, each participant signing a separate consent form for the audio taping of the interview. Participants were informed that they could have the tape recorder turned off at any time. The tape recorder was turned off during some of the interviews for short periods of time to enable the participant to regain composure and for the researcher and the participant to enjoy a restorative coffee.

There was provision for a second interview to give participants the opportunity to expand on particular issues or for me to seek clarification on points that had been raised in the interview (Tolich & Davidson, 1999). I met briefly for a second time with eight of the twelve participants when they returned the transcribed transcripts. For four of the participants the second contact was by telephone, and transcripts were returned by post due to their work commitments and the distance required for travel to meet with them.

The interviews were carried out between August and December 2000, a period of five months. Two of the interviews took place at my home, four in the homes of participants and six within a hospital setting. The participant decided on the choice of venue for each interview. Before each interview commenced I explained to each participant the format of the interview.

Three generic questions were asked of each participant. These were to define each participant's area of practice, length of practice and their individual understanding of the term 'horizontal violence'. The questions were:

- How long have you practiced as a midwife?
- What has your area of practice been as a midwife?
- What do you understand by the term Horizontal Violence?

Participants in this study had been in practice as midwives for intervals ranging between three years and thirty-two years. Seven of the midwives had practiced midwifery both within a hospital setting in an employed capacity, and in a self-employed role working from a community base. Five midwives had gained all their midwifery experience within a hospital setting.

The interview then proceeded with the question:

- Can you tell me about the effects of your experience of horizontal violence and the effects of that experience on your provision of midwifery care?

Thematic Analysis

The data gathered as a result of interviewing twelve midwives were analyzed using Burnard's (1991) method of thematic analysis. He describes the aim of analysis to be:

...To produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system (p. 461-462).

In order to use the method described by Burnard (1991) it was necessary to carry out semi-structured open-ended interviews, which were recorded in full and fully transcribed.

Themes emerge through becoming immersed in the data both by reading and re reading data or by repeated listening to taped interviews, and may be seen as a frequent consistent factor emerging from the analysis of qualitative data (Tolich & Davidson, 1999, De Santis & Ugarriza, 2000). Other authors, among them Boyatzis (1998) describe thematic analysis as 'a process for encoding qualitative information' (p.v1), and 'as a way of seeing' (p.1), while from a phenomenological perspective van Manen (1997) refers to a theme as an 'element which occurs frequently in the text' (p.78) and thematic analysis as 'the process of recovering the theme or themes' (p.78). He further suggests that the notion of theme is simply a vehicle for dealing with the idea that we are addressing and as a way of organizing research and writing (van Manen, 1997). DeSantis & Ugarriza (2000) endeavoured to define the word theme in order to have a consistent meaning of 'theme' across qualitative research methods. Themes are not the precise words rather as DeSantis & Ugarriza state 'themes are the exact meanings implied and inferred from words, behaviours and events' (p.358).

Burnard (1991) also reminds the researcher in the qualitative field to be systematic, and aware of the difficulties of understanding the perceptions of others. He does however acknowledge some problems connected with the method. Issues he raises are the degree to which it is reasonable and accurate to compare the words and worldviews of interviewees, and he questions whether themes that appear to be 'common' really are. Burnard concludes that in this method, it is a reasonable thing to do, at the same time warning the researcher to be alert for complications and not to expect that the method can be dealt with in a 'doing by numbers' way (Burnard, 1991, p.34).

Analysis of the data

In order to utilize thematic analysis as outlined, by Burnard (1991) notes were made at the end of each interview to document what seemed to be crucial points. The degree of distress that appeared to be caused in each participant at the time of interview was also noted. Recording the distress level was also a prompt to check with the participant about their emotional status following the interview.

When I first read the transcripts I listened to the tapes in order to check the transcriptions against the tape, to begin familiarizing myself with the data, to note words in the transcript that the transcribing typist had misunderstood and to also note incorrect spelling of medical terminology. I made corrections to the transcripts where necessary and then made two copies of each transcript. Each participant received a copy of their transcript to enable them to read and then delete or amend any part of the transcript that they did not want included in the analysis. One participant deleted a short piece of transcript as she felt it was too easily identifiable, while another waited many weeks before she was able to open the envelope containing the typed transcript. She commented that she was frightened of how she would feel and react when reading the transcript, but wanted her data to be included. Other deletions requested were all in conjunction with the use of 'slang'.

When participants returned the amended transcripts, the necessary corrections were made and then three further copies of the transcripts were made. One copy was given to my supervisor; one copy was used to write notes on to enlarge on general themes that were apparent throughout the reading of the transcripts and one copy was kept as a complete record to allow for direct referring to during the writing up process (Burnard, 1991).

As well throughout the process of the research project the writing of 'memos' helped in categorizing of the data. Memos enabled me to note observations, ideas and theories that emerged during the early stages of data analysis. For example at one interview I wrote a memo that noted that the participant was working independently, was isolated and

practicing avoidance techniques for survival and I first noted the theme of risk. (Burnard, 1991; Holloway & Wheeler, 1996; Tolich & Davidson, 1999).

To become immersed in the data, I reread the transcripts and made notes on general themes during the reading. Listening to the distress apparent in a number of the tapes was an uncomfortable and difficult experience but allowed the opportunity to check notes made during the interview where I perceived that participants were distressed. The tapes were separately played on many occasions as I tried to hear and understand what the participants were saying. The transcripts were reread and placed under headings which are also described by Burnard (1991) as a 'category system' (p.34), and which described and accounted for nearly all aspects of the data. Dross, which is described as issues that are not related to the topic were excluded, for example material that related to an experience a participant experienced in her first year of nursing training was not considered. Burnard (1991) describes this stage as 'open coding' (p. 34).

The category list was then further collapsed into similar broader categories. These categories were then revised to eliminate duplication of similar headings. Further reading of the transcripts was necessary to check that categories included all interview features. Each segment of transcript was then colour coded to a category or subcategory, and then each coded section was cut out and grouped together under the correct category or subcategory. To maintain the context in which they were said, sections of text either side of the coded section were retained. This was done because once sections of interviews are removed 'the whole of the interview is lost' (Burnard, 1991, p. 35), and the background of particular sections of conversation may be altered. (Burnard, 1991).

Maintaining Validity

Validity of the categorization process is necessary, and Burnard (1991) suggests that the researcher must try to 'offset his own bias and subjectivity' (p.36), during the process of gaining understanding of the interview data. A factor that may influence my understanding of the data is my previous experience as a midwife and my exposure to an incident of

horizontal violence. Burnard (1991) recommends two methods by which validity may be checked. One method involves the researcher, requesting colleagues who are not involved in the study, but who are familiar with the practice of category generation to read three transcripts and develop categories. These are then discussed and compared with the categories developed by the researcher. I chose the second method recommended by Burnard (1991), that of asking three participants to read their transcripts and identify what they saw as the most important points of their interview. These lists were then compared with mine and after discussion, minor adjustments were made. Throughout the period of category generation and analysis, feedback was received from my supervisor, a midwife academic.

Presentation of the study findings

The study findings are presented in the following four data chapters. The first of these, chapter four, provides an understanding of the term horizontal violence from the perspective of each participant. Common themes where participants concur in their understanding of horizontal violence are grouped together. A brief explanation of the experience of horizontal violence of the participants' is given. The following two chapters, titled 'fractured relationships' and 'hanging on: just trying to survive' present the categories and sub-categories that were generated from the data about the experience and consequences of horizontal violence for the participants. Chapter seven titled 'providing care under stress: creating risk' presents the categories and sub-categories that are applicable to the aim of the research related to the effects of the experience of horizontal violence on the provision of midwifery care by the midwives.

Key to data excerpts

A key to the data excerpts follows:

- Participant's speech is indented and *italicized*.
- Where participant's words are underlined this indicates their emphasis.
- [] Indicates where comments are used to provide an explanation to a word, or when a name is substituted to maintain confidentiality.
- ...Indicates edited data.

Summary

This chapter has described the method of thematic analysis that was used to analyze and categorize the data obtained as a result of conducting in-depth semi-structured interviews with twelve midwives about their experience of horizontal violence and the effects of that experience on their provision of midwifery care. I have acknowledged the potential influence my previous experience as a midwife and my exposure to an incident of horizontal violence may have on my interpretation of the data. Obtaining ethics approval, the application of ethical principles in this study, advertising for participants and the procedure used for gaining consent are detailed. Validity as an issue is addressed according to a manner advised by Burnard (1991). An overview of the data chapters is included together with a key for clarification of symbols used in the data excerpts.

Chapter 4

The Participants' Perceptions and Experiences of Horizontal Violence

Introduction

This chapter as the first data chapter provides an understanding of the term 'horizontal violence' from the perspective of each of the twelve participants who took part in the current study. A requirement for obtaining ethics approval from one ethics committee was that a definition of horizontal violence be part of the information sent out to potential participants. The committee was concerned that the term may not be well understood. The definition is included, as is the definition of horizontal violence generated from the data of each participant. In addition common characteristics of horizontal violence are detailed, as is a short explanation of the experience of horizontal violence of the participants.

Definition of Horizontal Violence

The definition of horizontal violence included on the information sheet and sent to each potential participant was one defined by Blanton, Lybecker & Spring (1998, p. 1) as previously stated in the orientation to the study (Chapter 1).

...harmful behaviour, via attitudes, actions, words and other behaviours, that is directed towards us by another colleague. Horizontal violence controls, humiliates, denigrates or injures the dignity of another. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights.

Participants' understanding of horizontal violence

Each definition was obtained in answer to the third generic question all participants were asked at the beginning of the interview:

- **What do you understand by the term Horizontal Violence?**

Although all participants received an information sheet with one recognized definition of horizontal violence, not all participants had read the definition. However those who had, commented that the definition only helped to confirm their views, not shape them. For one participant the term was new but the 'problem is an old one and very familiar to me'. Each definition is included as discussed at the beginning of each interview and prior to listening to the participant's experience. Comment is added following the definition where participants added clarification at the time of the original question.

I think horizontal violence is verbal or emotional put down between midwives to each other. I think it could be physical as well but I have never seen that.

Violence across the peer groups, probably from people on the same level, to each other, which I suppose, would normally not be physical because it's normally work related, it would normally be verbal and non-verbal.

This midwife elaborated that the non-verbal behaviour she was subjected to included eyebrow raising, 'humphring' [described as making a disparaging noise but without talking] and withering looks, destined to intimidate. She described loud sighing, the use of a sneering tone of voice when being talked to, butting in on, and stopping social conversations that the midwife attempted to have.

It's the way that you are poorly treated as a person by a fellow colleague, whether it be mental or in the physical sense.

This participant was the only midwife to describe an actual physical attack. She give an account of being pushed while in the supermarket and later being rammed with a supermarket grocery trolley, by the person responsible for the horizontal violence.

I see it as a form of bullying, not so much physical bullying but actual mental bullying, that's how I see it. People saying things, doing things and being aggressive with their peers within the workplace.

For this participant horizontal violence was perceived as mental bullying, explained as a constant 'wearing down' and an association with aggressive behaviour.

It's the behaviour of one midwife towards another, with a specific purpose of degrading, or just squashing the personality of the midwife who is the recipient.

For this participant describing the personal attack that she was subjected to, and the explicit intent she perceived behind the behaviour caused distress as she talked about her understanding of horizontal violence.

Horizontal violence means the undermining of peers' clinical or personal abilities usually either in front of colleagues or in front of clients [women] and their families and it can also happen not just with peers, but management also.

This participants' understanding placed emphasis on both the clinical and personal aspect and suggested that it was possible to be carried out by both peers and management.

Another participant identified horizontal violence as:

To me that means it could be emotional, bullying tactics really between peers, yeah so midwife to midwife.

Horizontal violence is possibly when I perceive that we [I] might be asking for help and people, by their body language, by the way they verbalize things to you, generally that sort of thing, they don't appear to want to help you.

A brief personal experience was then given to describe what she meant by the use of body language and intimidating language to create an atmosphere that stopped her accessing help.

The following definitions are from four different midwives indicating their understanding of the term horizontal violence.

For me it's about midwives who for some reason, it might be jealousy, I could never work it out what the reason was in my situation, take it upon themselves to judge, be judge and jury on somebody's else's practice and the right they have to be themselves. A more common name for it is bullying in various forms.

To me it means bullying by peers, well by anybody really. But in a work place setting and done covertly or overtly from positions of power usually, and usually as a means of wielding power.

Well first of all I must say it is a new term to me although the problem is an old one which is very familiar to me and the way I see it is that a person is discriminated at the work place, discriminated as a person, or somebody being judgmental to a colleague without a fair reason, that sort of basically is what I understand.

Well it's one of those terms that has really come to the fore within midwifery at any rate, probably over the last eight to ten years, and I think for me anyway, when I first noted what I think is horizontal violence. I think it is the business of people, of other midwives or practitioners who do, or who behave really in a manner, which consciously or unconsciously, undermines the ability of the practitioner against whom it is directed. So that although it's not, not a physical violence, it's often to my mind a subliminal thing that is, it is not always obvious but rather an insidious undermining of the practitioner's practice and philosophy. It's often something that is done almost unconsciously towards another practitioner although of course it can be conscious and it can be quite intentional. But I think from my own experience the worst part of the whole business, is the business of it being done in the nicest possible way.

Common characteristics related to the participants understanding of horizontal violence

Participants' personal definitions appeared to be closely related to their own experience of horizontal violence and the consequent bullying behaviour that they were subjected to.

All participants identified the experience to be related to work or carried out by their peers. While defining their understanding as work related and carried out by peers, participants further identified that the violence was directed at them personally and at their clinical practice. Ten of the twelve midwives believed that horizontal violence was more likely to be of a verbal or emotional nature rather than a physical experience, with several participants referred particularly to bullying behaviour. They referred specifically to mental and emotional bullying tactics. Two participants raised the notion of intent as a central focus of the experience. One participant felt that it could equally be perpetrated 'unconsciously' but irrespective of the way the violence occurred it was just as damaging. Rather more difficult to cope with was the subtle and insidious undermining of another practitioners' practice put aptly by one midwife as 'it being done in the nicest possible way'. Other explanations centred on discriminatory and judgmental tactics, and two participants raised the issue of the violence being carried out from a position of power or as a means of 'wielding power'. Four participants' described being subject to bullying behaviour by midwifery managers in addition to being subject to horizontal violence by their peers.

The experience of horizontal violence

When listening to participants I developed awareness that a growing number of midwives do not stop to consider the potential damage that is caused to both women receiving midwifery care, and their peer midwives when they perpetrate horizontal violence. In order to protect confidentiality and anonymity for the midwives and the areas where the horizontal violence occurred it is not possible to recount verbatim individual stories from each of the participants. The experience of horizontal violence impacted on the emotions of the participants and clearly affected their provision of midwifery care. Participants related how unhappy they felt in their work, about feeling incredibly lonely and isolated, about being angry over their treatment and the behaviour towards them, about the lack of support from both a clinical and personal perspective, about being embarrassed and above all how the impact of tiredness and stress affected their ability to provide good quality care.

A large quantity of data was generated in relation to the experience of horizontal violence and subsequent bullying behaviour that the participants were subject to. It is appropriate to concentrate on the experience because it clearly had a profound effect on these midwives and the way they were able to provide midwifery care. The second study aim, that of the experience of horizontal violence of registered midwives is presented in chapters five and six

Summary

All twelve midwives had a clear idea of what they understood horizontal violence to be, with several of the midwives referring to bullying, aggression, discrimination, undermining of practice and judgmental decisions in their definition. Midwives placed the emphasis for distress on the 'mental' or 'emotional' aspect of the experience and not on the physical, although several acknowledged that it could be physical. Only one participant actually experienced physical violence. The people perceived as responsible for the horizontal violence used body language and tone of voice to convey an aggressive or judgmental attitude, to censure practice, to create doubt in women about the ability of the midwife to practice, and openly criticized and undermined them. None of the participants raised the issue of written matter as a form of violence used against them, although this did surface during the interview of one participant.

In the following three data chapters' categories are presented and verbatim excerpts from the participant interviews supporting the categories are incorporated. The first two data chapter's detail the experience and the consequences of the experience of twelve registered midwives and are titled 'fractured relationships' and 'hanging on: surviving the experience'. The third data chapter, focuses on the effects of the experience of horizontal violence on the provision of midwifery care by midwives, and is titled 'providing care under stress'.

Chapter 5

Fractured Relationships

Supporting women may become a lower priority when midwives feel they continually have to 'watch their backs' (Robinson, 2000, p.143).

Introduction

The experience of horizontal violence of the participants in this study is further intertwined with the consequences of that experience. Fractured relationships describe the state of the relationship between midwives and between midwives and women. The word fractured in the context of this study, gives a picture of a 'cracked', 'broken', 'split' or splintered rift within the relationship.

In this chapter, the first of the main categories, which emerged from analysis of the data obtained from the participants in the study, is introduced. Selected verbatim quotes are presented to support the category and sub-categories identified from the interview transcripts of the midwives who participated in the study. The six sub-categories which together form the structure of the main category of 'fractured relationships' are: 'sabotage of practice relationships', 'communication issues, 'being watched', 'being labeled; lack of support and being treated unfairly'.

In many cases the relationships between midwife and midwife, midwife and woman continued, but were in a less than satisfactory condition. Of particular significance after the experience of horizontal violence, was the relationship between the midwife and the woman when the violence had occurred in front of the woman. After such an experience, midwives perceived when providing midwifery care that there was a lack of trust from the woman, a feeling of negativity about the midwife's level of competency, a feeling that they had 'to be on their best behaviour' and a negation of all the time that had been spent in building up the relationship with the woman during the ante-natal period.

Effective relationships between women and midwives, and between midwives working in self employed or employed situations are central to the provision of safe and appropriate care for women.

Sabotage of practice relationships

In electing to provide continuity of care, the midwife develops a relationship with the woman, becoming familiar with her expectations for her pregnancy and birth, her health status and family support. Undermining of the relationship between the woman and the midwife by another midwife was potentially detrimental to the care the woman received and certainly affected the relationship that the midwives were able to have with the women they were providing midwifery care for. The data demonstrated that where the midwife had suffered horizontal violence in front of the woman it clearly created doubt in the woman about the information they had been given about options of care, the competency and expertise of their midwife and this led to a sense of unease or in some instances a lack of trust in the ability of the midwife to provide care.

Bryar (1995) suggests that the woman ought to be the central person in the development of care, with a right to make informed choices and to obtain care, which she has chosen from suitable and safe options, and in a location that is appropriate to her needs.

Guilliland and Pairman (1995, p.7) define midwifery as being the partnership between the midwife and the woman: “ ..a relationship of ‘sharing’ between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding,” and continuity of caregiver is the essential component to building the midwifery partnership.

For hospital employed midwives there is the added difficulty of attempting to provide care for clients of self-employed midwives who require care interventions or were receiving care post-natally when they had no relationship with the woman. Antagonism was likely to

occur where collegial relationships were less than positive, as evidenced when help was given to a self-employed midwife by a hospital midwife and other staff objected to this.

A participant who had previously worked as a self-employed midwife, and recently changed her type of practice to that of employed midwife, did not differentiate between the employment status of midwives who required help. She was of the opinion that it was important to support any midwife irrespective of the capacity in which she chose to practice in order to provide safe and appropriate care for women.

...But my view was that we are all midwives and even though my friend was working as an independent [self employed] midwife we're there to help each other and there should be no division.

Unfortunately a degree of antagonism has remained between midwives choosing to work in employed situations and giving fragmented care, or self-employed midwives providing continuity of care, and this has implications for the midwifery care provided to women. One reason a midwife may choose to work in an employed position is due to personal commitments that do not allow for an on call capability (Calvert, 1998). Other midwives may consider that working within an institution allows more peer support, guarantees an income or their interest lies in providing midwifery care for women with complex needs.

Hearing a self-employed midwife talk in a disparaging fashion about the care that 'her women' were receiving from a hospital employed midwife led to a feeling of resentment about the attitude and apparent failure of the self-employed midwife to value what the employed midwife was trying to do while carrying a heavy workload.

...They [self-employed midwives] may even think themselves better practitioners because they're doing proper midwifery and I get that feeling that they look down on hospital midwives and their practice. And I was in the

postnatal area not so long ago and I think I had eight women to look after, and you try and help eight women breastfeed all at the same time and look after new [caesarean] sections and stuff, you can't do it and comments were made by a particular independent midwife to her student about how not to do midwifery care, and the appalling care that was provided by the hospital midwife [the participant herself] in looking after her [the independent midwife's] women.

What would have supported the overworked hospital midwife in providing care would have been practical support from her midwifery colleague. This would also have provided a positive learning opportunity for the student midwife, both in a care situation and as a chance to witness positive collegial relations. The participant continued:

... You know if she [the self-employed midwife] had enough time to make some bitchy comment she had enough time to come and help and that would have been more appreciated. Instead it just ends up- [it] rankles you and you begin to resent them [self-employed midwives].

Cummings, in commenting on her reason for resigning from working as a midwife suggests that 'there is low morale...and little sense of work satisfaction, as there is minimal opportunity to give quality care' (Cummings, 1999, p.2 cited in Robotham, 1999, p. 2.), supports the response of the previous participant's difficulty in attempting to provide quality midwifery care without the added stress of a non-supportive colleague.

Another participant who classed herself as a primary care midwife, and used alternate therapies during labour, continued to provide support to women who required transfer into hospital for more specialized help. In order to be able to continue providing midwifery care for these women, the participant was completing the necessary hospital required

competencies. This allowed her to continue providing care with the support of a hospital-employed midwife.

If I have a woman who needs an epidural during labour then I hand over her care but stay on as the midwife support...Initially it was as the support person, but as I was getting ready to go on the epidural register then I could actually do care in conjunction with the hospital midwife. So there were several times, one where I was working in this manner with a hospital midwife, who was one of the bullies and the woman had decided that she wanted me not the [hospital midwife] to birth the baby. The hospital midwife was not having a bar of that and so I just stood aside because I feel it's inappropriate to be discussing those kinds of things in front of a woman.

The support midwife on this occasion was one of the people responsible for episodes of horizontal violence and was completely obstructive in supporting a participant to respect the wishes of the woman. In this instance the participant made a decision to avoid conflict in front of the woman at the time of birth. However on another occasion when the same difference of opinion occurred about who would birth the baby, the participant did not give in.

...Another time I actually stood up in front of the midwife and said, "my client [woman] actually wants me to birth the baby, so I'll birth the baby".

Another participant described how the Charge Midwife constantly questioned her practice. Criticism and blame for 'things going wrong' were always attributed to the midwife even where it was clearly the responsibility of the Doctor.

...And the one in charge of the ward would have been close to [retiring], she had bad legs so she retired early, to the relief, I must say, of everyone in the unit...She constantly questioned your practice and if there was something going wrong she would imply it was your fault not somebody else. If it was a Doctor [who was responsible] it was always your fault, always.

At first the participant felt that she was receiving undue attention because she was from another country but later realized that was not the case.

...She was horrible to everyone, no absolutely everyone. She didn't discriminate I have to say. She was a bitch to everyone, really horrible. And if somebody came from [a large hospital] to help she was really nasty to them. She hated the [large hospital] midwives... They're a big unit, I think she was probably scared of them.

For another participant, the constant undermining of her practice had an effect on both the midwife and the women for whom she was providing care. For the women it created confusion and hesitation about the 'correct way' to parent in conjunction with creating doubt in the ability of the midwife responsible for her care.

I would go in on the Monday [after the weekend off] and find that she [the midwife responsible for the horizontal violence] had contradicted everything that I had said on the Friday.[She] would say to the woman "oh did she tell you that, I wonder why she did that, oh no" so on the Monday the woman would be looking at me oddly, but also

I was talking to the woman and they would tell me what she'd said.

For another participant, being criticized and undermined in front of the woman and her partner for offering a different, but perfectly safe practice, that of the partner cutting the cord, was regarded as interference in the care that was being provided. Undoubtedly, it was a practice that the other midwife did not make use of, identify with or approve of.

...I asked the partner if [he] wanted to clamp the cord and she [the other midwife] was put out by that because apparently that's not done over here and I said to the partner, do you want to clamp the cord, do you want to cut it, and she [the other midwife] thought that was an appalling practice.

Another participant tried to introduce a practice to her midwifery colleagues that would increase the choices for the administration of pain relief to women.

One of the things I tried to do was to introduce PCA [patient controlled analgesia] pumps. Well, it was just, I mean immediately I mentioned it I almost withdrew it in the same breath because of the ruckus...but the mere mention that they would have to learn something new seemed to be unacceptable...they'd worked like this for years and who was I to try and change things.

The suggestion that a new skill would need to be learnt to offer a further choice to women was not seen as acceptable. It seemed irrelevant that the women may benefit from the practice. Midwives whose practice was not based on current research also caused undermining of the relationship of trust between the midwife and the woman.

For one participant this became evident on listening to discussions when visiting women. It was a complete negation of the time that the midwife had spent in working with women in the antenatal period. It was destructive and done with poorly thought out comments and negative remarks that directly undermined the woman's ability to manage the complexity of breastfeeding as indicated by the following excerpt.

...It's the business of a midwife like myself who really wants women to breastfeed their babies and works really hard with them to breastfeed their babies, who has to constantly battle with the old idea [from] people [midwives] who feel that it's perfectly okay for babies to have bottles. And when you get comments from midwives who have been in the institution for something like thirty years and are the same sort of age bracket as myself and they say things like "well do you want to get up at two o'clock in the morning to come and help a woman breastfeed?" Or don't you think she should have a good sleep at night and let the baby have a bottle?" ...Despite the fact that you can do heaps and heaps and heaps with a woman in the antenatal period about breastfeeding there is always that vulnerable tiredness that creeps in which, when they see another professional coming along who says "there there dear it won't make any difference, give the baby a bottle" that they [the health professional] then immediately undermine the relationship/ trust that you have with the woman.

It was often a difference in philosophy and approach to practice by the hospital-employed midwife that was likely to lead to confrontation. One midwife offered the view that where midwives had given little thought to where they stood with their own philosophy and way

of practice they found it difficult to accept variations in practice that were different, though perfectly safe.

...And so the way I provided care was obviously different to how they [hospital midwives] provided care.

Further interference in the relationship occurred when women transferred into hospital for care.

And they did this [attempted interference] in many ways- they did it by undermining your sense of "being with a woman", by knocking loudly on doors, by coming into rooms...There is always a sense of "let's get that baby out", "are you still there" "haven't you delivered yet", comments like that which I see as quite undermining.

The midwife further suggested that while it may not be intentional, there was an inference that if a midwife and a woman having midwifery care provided have come to hospital "you should get a move on". This was typified by the following:

...And what are you doing here if you are not here to get that baby out. So there is a great deal of pressure that comes from the [hospital] midwifery staff. There is also that dreadful business of, "well if you've brought a woman in you can clean up after her" which goes with the hand in glove thing of let's not help out....

The participant offered a view that the employed midwives were reacting to a fear of having been left behind within the institution when other midwives had 'gone out' into self-employed practice by choosing not to provide help. This contributed to pressure on and lack of support for other midwives.

Many of the midwives who endure the experience of horizontal violence, have to carry on providing care for the woman and find that the relationship has become less than whole. For one participant the experience of horizontal violence undermined her belief in her own ability to provide care and made her uncomfortable and unsure of herself, which damaged the relationship, she had previously enjoyed.

... and when I saw her [the woman] in the post-natal period I never felt totally comfortable with her after that. I felt that some of the relationship had been destroyed and I couldn't regain it back.

It is difficult to estimate the damage done to a relationship between a midwife and the woman she is providing care for when elements of doubt are raised over the care that she is or has been providing. Midwifery care is provided for each woman based on an extensive knowledge developed over time in regard to the woman and her social circumstances, her network and health needs, laboratory tests and results and her expectations for the birth and the post partum period.

...I needed to admit a woman who had had an APH [ante-partum hemorrhage] at about 35 weeks, she measured a little bit larger for dates maybe 1-2cms so she had maybe a mild polyhydramnios. She didn't want extra scans so I felt okay with that. I don't know who suggested it in the hospital that she may have twins, and I said to the midwife "she hasn't got twins, a little polyhydramnios yes"...so this particular midwife in front of the woman's father told her she definitely had twins because she had found two heart beats.

The doubt created in the woman and her extended family over the possibility of her having a multiple pregnancy led to a confrontation in the scanning department between

the sonographer and a family member when the scan only revealed one baby. A family member was unwilling to accept the diagnosis because he had uncertainty suggested by the hospital midwife who was certain she had heard two heartbeats. Relatives with little or no medical knowledge would be unaware of the other reasons that a suspicion of a second heartbeat may have occurred. Creating an air of distrust over the original provider's care made it difficult for balanced explanations to be given or accepted as evidenced by the following challenge by the relative, and as conveyed by the participant:

“ ... You've got to find the other baby, the other baby is there, that other midwife told us”.

A participant who was prevented from using the most modern equipment for providing care felt very frustrated with what she perceived as an attempt to influence her practice and impact on the care she could provide. It is a particularly frightening experience for a woman when she notices a decrease in normal baby movements, and may fear that her baby is not alive. Instead of the midwife being able to quickly confirm the condition of the baby by using the best available equipment at that hospital, a cardiotocograph machine with a capability for picking up foetal movements, the use of this equipment was denied as evidenced by the following quote:

I had a woman earlier this year who [telephoned] me because she hadn't felt her baby moving and I arranged to take her up for a CTG [cardiotocograph] and was supposed to go in this very public room with just a curtain around where women go in and out [attending to] their babies and I felt it was totally inappropriate for this woman to have a CTG there. I spoke to one of the CHE [hospital employed] midwives who happened to be a friend of mine, [I] said “look, I need a private [single] room and I need a proper CTG monitor because the one that we're supposed to use, the women have got to push when they

feel fetal movements," the other one actually picks up fetal movements, that was the one I wanted. We got the woman in the room. A CHE midwife of 20-25 years experience came down and was absolutely abusive, and said I couldn't have the machine, that the woman needed to go into the great big room and push the button when she felt the baby move. I said that was inappropriate, she hasn't felt the baby move, this [the most modern machine] is what I need.

Another participant described how a lack of sharing information with her as a new staff member, resulted in her being in a position to provide less than appropriate care for the women she was responsible for.

... They failed to give me the information I needed. I had one day's orientation in a hospital I had never worked in.

This participant offered the view that while midwifery is the same the world over; there are policies and protocols that differ from hospital to hospital, and from country to country. Lack of knowledge of these, or where, or how to access them as a result of a one day orientation, created a degree of vulnerability for the midwife when providing care. It also created a potential risk for the woman. For example,

...Over there every woman [in labour] got Ranitidine [antacid] and they didn't tell me that until I think I was in my third or fourth week. Oh they made me out to be a complete idiot....

For another participant who was new to New Zealand, not adhering to the cultural 'norms' of a unit caused problems. Even when participants were not orientated appropriately, or in some cases where information was deliberately withheld, not maintaining customary practice was a cause of tension.

I remember very distinctly once when I bathed a baby and I don't know, up to today I don't know what I did wrong but again the next day I was called to the Matron's office and she told me that I had shown a woman, from a [small town] how to bath a baby and I was told that...that always babies in the [that] area are bathed a certain way and I was not to come here and introduce new methods and that was how it had to be and I should go and be told by somebody else how it has got to be done.

Over monitoring, or constantly finding fault with any midwife's practice, with no justified reason is bullying. A further unintentional infringement of the cultural norms occurred when the participant first provided midwifery care to a labouring woman.

...The midwives were expected to move aside when the Doctor arrived to deliver the baby, and nobody had ever even pointed that out to me, that that was what was happening in New Zealand. So I didn't step aside when the GP came... and then one of the GP's went to the Matron and complained that I was catching the babies and that was not all right...he would never say anything to me directly. But I was called to the [head of midwifery] and told that that is not on.

This sequence of events had the effect of upsetting the woman and her family, delayed the providing of information that her baby was alive and produced a degree of anxiety that was still present several weeks later when the woman spontaneously laboured. In addition the midwife participant was concerned about the degree of assistance and support that she could expect from her midwifery colleagues if problems arose or if she needed to access care for her clients in the future.

Another participant discussed providing midwifery care within a group practice where the expectation of the women was that they would receive continuity of care. Midwives known to the women would provide care. Whenever possible, one midwife provided midwifery care in labour. Specialized midwifery care was provided for a number of women who had complex medical, foetal or social needs. The participant expressed clearly, the impossible situation of trying to fulfill the expectations of the women for continuity of care when the team was drastically reduced in numbers. The situation was further complicated when a midwife was either off sick or on leave.

... We lost two of our team members fairly early on in the day and those team members were never replaced so my colleague and I had to do [all] the work from then on.

The midwife perceived that there was an apparent unwillingness to advertise and replace the team members who had left. This placed the other team members under unsustainable pressure and contributed to their inability to do their job as shown by the following quote.

... [But] the mission for the team was to provide 24-hour care for women [with] high-risk problems and that had to be abandoned because it was impossible to do that.

The number of hours that the participant could safely provide care for women decreased significantly. An interruption in continuity of care by midwives known to the women then occurred, as other midwives that the women had never met had to provide midwifery care. To enable this process to progress as smoothly as possible communication became a significant matter.

Communication issues

‘Let our voices build not destroy’ (Richardson, 1993, p.5).

Effective communication is fundamental in a profession where it affects the capacity of the practitioner to provide care. Hadikin & O’Driscoll (2000) caution against gossip as a key means of communication and suggest that otherwise ‘little will be changed or taken seriously’ (p.140), unless open and honest communication in a safe environment is encouraged and supported.

A variety of pitch tones and inappropriate language were used in conjunction with non-verbal behaviours such as eyebrow raising and threatening facial expressions to intimidate participants. Deliberate attempts were made to sabotage social conversations, and to interfere in consultations between a consultant and one of the participants with regard to a woman’s care. Communication was used as a weapon in both a public and private setting to control situations, and harass and cause distress to participants. Hadikin & O’Driscoll (2000) reinforce the experiences of the participants of the present study and state ‘Language and non-verbal communication are the media through which female bullying is dispensed’ (p.68).

For a participant who was in a new work situation, her ability to meet and get to know other workers in the area in which she was working was continually stymied by the person responsible for the bullying.

And she did amazingly obvious things like if it was a staff meeting afterwards we'd be talking and having coffee and I'd be chatting to somebody and I'd be feeling really happy that I was managing to have social, friendly words with one of the people at the [health] service and she would come up and join our conversation and then cut me out of it. So she would come and join it and then manage to stand between me and the other person and start talking about

something else and I would be left standing alone. It was awful, it was remarkable, it was just, I mean I can't, I think I couldn't believe it because I couldn't believe that somebody could be purposefully doing that.

The behaviour that the participant describes is entirely in keeping with the relational bullying type described by Randall.

Because women are particularly dependent on having good relationships with co-workers and colleagues, the easiest way to hurt them is to threaten those relationships and exclude the victim from them. Female bullies therefore, would tend to adopt techniques such as social exclusion (Randall, 1997, cited in Hadikin & O'Driscoll, 2000, p. 19).

The participant had gone into her new job feeling proud, happy and full of confidence.

...That somehow I'd put so much on the line going into it [new job] like telling family and friends what a great job it was and how wonderful it was, and telling the people where I left my job, I'd found the greatest job in the world to go to. Having done all that ...I didn't, I couldn't talk to anybody about the fact that I was finding it [the bullying] incredibly difficult, like there was no one....

The participant felt that her usual support network of family, friends and colleagues were not available to her in this situation, as she felt unable to talk about the experience. This feeling of isolation, is supported by Adams (1992, p.34) who says:

Being bullied is an isolating experience. It tends not to be openly discussed in case this poses the risk of further ill treatment. Those who are the prime targets often feel ashamed to discuss it with colleagues because their professional credibility is being called into question.

The use of language with a sneering tone of voice was a tactic used to continue the practice of undermining and was mentioned by several of the midwives in the present study, but is illustrated well by the following quote:

...I'd be talking about doing something and she'd say "oh yeah" [in a tone that conveyed doubt and contempt].

For this participant, the bullying was almost always carried out in front of others, a way guaranteed to cause maximum discomfort and embarrassment for the victim.

It was mostly done with other people, nearly invariably around other people now that I think about it. She wasn't actually, I mean she was abrupt with me, but she only did it publicly.

In one instance a total lack of communication could have had disastrous consequences when a midwife failed to communicate that she was going off the unit.

...I was second on for the [Delivery] suite. The midwife who was first on wasn't busy so I was sending a woman round for a CTG [cardiotocograph], only to find out the midwife had gone to a [function] and I was there on my own with midwives who were not experienced in [Delivery Suite].

The participant was unaware that the Delivery Suite was without any other staff. A second issue was that the participant received no support from her supervisor, the person responsible for ongoing bullying, for a situation that was potentially dangerous; in fact she was laughed at when she raised the issue.

A number of hospitals in New Zealand have separate contracts to provide secondary care and midwives acting, as Lead Maternity Carers (LMC) have to transfer women who develop complications. Many self-employed midwives acting as the LMC will however often remain, or return when notified to provide support to the women. A participant recounts how she organized her time so that she was available to provide support at the time of labour for a woman who had developed complications, and was having medical and midwifery care provided by the hospital team.

...I said I was available and would be at the birth because she'd [the woman] asked me. The hospital midwife, who was doing the late shift, had actually documented it in the notes because the woman had said, "don't forget you've got to call [name of midwife]". Twice, during the time she [the woman] was in labour that night she asked for me and the [hospital] midwife wouldn't call me... So I spoke to the midwife and she said "oh well I forgot who was looking after her" and I said "but she asked you" [to call me].

There seemed to be no excuse given for not carrying out the wishes of the woman receiving care, in relation to calling in her LMC.

A participant, who was an employed midwife from another hospital, had a different perspective on the same issue. She discussed the difficulty of notifying self-employed midwives when labour progressed extremely rapidly and the midwife had expected to

come back to be present for the labour. In this instance the arrangements for calling in the midwife were not documented.

...She [the woman] was in very strong labour so I was there trying to support her through that so what little relationship we had was formed pretty quickly. At that stage she never once asked for her [LMC midwife]. I said to her "do you want us to page her" and she said, "well she's coming at four anyway". We were all taken by surprise by the rapidity of her labour and at that stage the most important thing were her needs, which were for me to stay with her and try and help her through labour.

The labour was rapid and the woman advanced to birthing her baby after fifteen minutes of strong contractions. There was a medical reason to have an obstetrician present at the birth, but although notified he was unable to get there in time. The woman's self-employed midwife arrived after the birth, and was most unhappy that the birth had not gone as expected, that both the baby and the mother had suffered complications and she had not been present, issues that she raised in front of the parents.

So it was a less than satisfactory delivery. She had also sustained nearly a third degree tear so about this time I think the midwife arrived and the obstetrician... and the midwife was not at all pleased that she'd [the woman] had [had] an unpleasant delivery ...and she made that fairly obvious- but at that stage we couldn't do anything about it...

The midwife later raised her concerns about the care in labour in a professional forum, which was a unit meeting, but did not raise her concerns with the participant first.

One participant experienced particular difficulty when attempting to have consultations and conversations. Trying to communicate a particular woman's progress in labour, her concerns about a pregnancy with an obstetrician or even ordinary conversation with family members of the woman were constantly frustrated by interference from other midwives.

If I was discussing one of my clients with an Obstetrician or one of the family, some of the bully midwives would actually interject or take over the conversation so I couldn't have a conversation with anyone. If I needed to talk to the obstetrician I actually had to walk outside the unit with him.

In addition to pointed interference in conversations participants related to a feeling of their practice and themselves as professionals being under constant scrutiny. For one participant this scrutiny also involved aspects of her private life.

The withholding of information [by the person responsible for the horizontal violence] prevented the midwife participant's from "doing their job" effectively, and was a common concern amongst the midwives participating in this study. It resulted in limiting the ability of the midwife to provide appropriate and safe care, and in some instances undermining of the midwifery partnership. For one midwife the withholding of information led to repercussions by being reprimanded by senior staff.

Failure to contact the midwife who had been responsible for the care of a woman during her pregnancy, but whose care in labour was provided by hospital midwifery staff due to complications, potentially endangered the life of the woman. The midwife had been present during the labour in a support role, and later considered that support and information from a known caregiver [herself] may have altered the woman's refusal of medical care.

I went off two or three hours later after the baby was born and the woman had a post partum hemorrhage but nobody

thought to give me a ring to let me know what had happened, and so the woman had refused a blood transfusion. Again I felt that was a time they should have called me in. I knew her better than they did.

The participant discussed another occurrence when she was not notified of a woman's admission to hospital for almost two days. The woman decided to change practitioners as a result of not having seen her Lead Maternity Carer who was the participant.

...And it reminds me of another woman the year before last who had been admitted to hospital with supposed PET [Pre Eclampsia] and she was there nearly two days before I knew she was in hospital. By this time the woman had decided she wanted to change practitioners.

The participant related being told by the hospital midwives that they had tried five or six times to let her know about the woman's admission. The participant used three phones, a cell-phone for work, a home phone and a phone that the home phone could be diverted to. All these phones had the ability to record messages in the message bank. Scrolling back through the message bank revealed no calls had come from the hospital. The inference from the hospital midwife was that the participant was not available by phone, so consequently could not be contacted to provide care.

Another instance where information was withheld prevented a participant from knowing the current whereabouts of a woman for whom she was responsible for providing midwifery care. Current information, which was given to the person responsible for the bullying (to be passed on to the midwife) was withheld, and in one situation used purposefully to discredit the participant.

...And she would bring it [the withheld information] back at a point that was kind of public and I looked like a total idiot.

Accurate information that the participant required would come to her attention by being publicized in the practice meeting, in a manner that inferred the information was common knowledge to everyone. This approach was perceived by the participant to be a deliberate ploy in creating an impression that she was 'useless'. Creating situations that result in people, the participant in this case, looking incompetent is a recognizable tactic of a bully (Hadikin & O'Driscoll, 2000).

Adams (1992) points out that 'getting rid of the competition is a classic survival technique' (p.18), and there is ample evidence of this practice as described in the following quote by the participant.

...Her [the person responsible for the bullying] perception was that she had failed, that it was too much for her [as] she had [reduced her hours] and she couldn't afford the thought of someone else coming in and succeeding.

A further episode of deliberately misleading the participant resulted in the participant always being late for a meeting.

...I seemed to always get the timing of things wrong, ... One example was the Maternity meeting, which I always came late for because I hadn't been told the time it started... I was told the meeting started at nine. But I didn't know that particular meeting started at half past eight, and nobody pointed it out. It was remarkable, and when I realized they all looked at me, like how slow can you be? But in fact I'd

been told that the meeting started at nine, actually I'd been misled.

Being watched

Midwives in this study discussed the practice of other midwives placing them under scrutiny by checking on their practice, using various excuses for banging on doors and coming uninvited into rooms where they were providing midwifery care. The suggestion that they needed to 'get help' for them, the inference being that they could not manage the care or that they didn't know when to call for help as evidenced by the following quote from a participant whose focus in providing midwifery care was disturbed by unnecessary harassment.

I've had midwives standing outside the door waiting for me to ask for the obstetrician because they felt I couldn't actually birth a woman with an epidural safely... Down came the baby, in the mean time I've got the midwife harassing me at the door "do you want me to call the obstetrician, do you want me to call the obstetrician", I'm trying to keep myself calm with a room full of relatives, and a birthing woman while that's going on outside.

For another participant this practice of surveillance was extremely disruptive to her ability to maintain concentration on the care and support that the woman required of her.

...Another one of the little incidences that happens quite often is that when I am with a woman I find people [perpetrators of the violence] knock on the door and barge into the room. Now this has happened more than once and in fact, with some women, it happens two or three times within their labour and I find that that is a very

disconcerting thing because when I am providing care for a woman I am with her totally and I'm talking to her and massaging and making suggestions and we're trying different positions or we're in the bath or whatever we're doing. My care for her should be total and uninterrupted and I find it disconcerting when people come charging into the room.

For another participant there was constancy about the surveillance. As well, there was a feeling of 'being snooped on' and constant pointed interference in, and criticism of, the care that the midwife attempted to provide.

It might not have been a daily occurrence but certainly this person [responsible for the violence], if you were working in the daytime would be around and you always felt that she would be snooping, watching what you were doing, criticizing what you were doing, interfering in the care that you were giving.

The participant attempted to keep away from the person responsible for the violence by requesting duties, changing her rostered duties or working weekends and the unsociable hours of afternoon and night shifts.

For another participant the surveillance happened over a period of time and was connected with both her professional and private life. It was after requesting to view her personal file that the discovery was made. The file even included a reference to a private social function and what she had drunk. The information had been systematically accumulated before the participant was informed that she was no longer wanted in her current role as recounted in the following quote.

...Every conversation I had had with the midwives including phone calls –even an entry about how much I had had to drink at a private function. All this had been documented in my personal file. When I realized what they had been doing I felt physically ill.

Another participant was constantly anxious about going to work at the hospital where she perceived that she experienced constant criticism, ‘a hail of abuse’ and excessive scrutiny of her practice. She also experienced physical symptoms of palpitations and sweaty palms each time she walked into the hospital.

...When I'm working in the hospital scenario I become absolutely exhausted from being hyper- vigilant....

The bullying that she was constantly subjected to caused extreme distress, and resulted in the midwife being unable to concentrate on providing midwifery care.

...It just goes on and on and on, I'm just tired of it...I can't give 120% [to women] when 50% is going towards keeping the midwives off my back.

The same participant gave another account of her practice being excessively scrutinized, unfairly, as she saw it.

...I had gone over for a Caesar, the baby was a bit cold when we came back. I just wrapped it warmly, turned the temperature up in the room and gave the baby to the grandparents to hold to warm up. The midwife documented in the notes that I had done nothing for the low temperature.

The participant was adamant that the care given was appropriate, but later on reading the case notes, found it documented that ‘she had done nothing’ to correct the low temperature of the baby.

...I was exhausted and I felt that what I had done was enough. I'm quite comfortable with parents taking the baby or putting it into bed with the mother to keep it warm.

Lack of support

Another common complaint made by the midwives was a feeling of being unsupported by their colleagues. Whether their colleagues were in employed or self-employed practice was irrelevant. One explanation a midwife in this present study offered for the sense of a lack of support was that support was withheld after midwives had the misfortune to be involved in cases that had less than optimal outcomes.

...If you do end up, and I personally have ended up in front of [Nursing] Council once on a case of my own and involved with other cases, that you are often seen as a bit of a pariah for quite a long time afterwards. It takes a long time to get back any sense of being supported.

The decision of some midwives to withhold support from colleagues created difficulties for participants. These difficulties ranged from a perception of not being liked, a lack of mutual respect for different ways of practice and an apprehension about the assistance that would be forthcoming if help was required in a complex situation. It added to the level of pressure that the midwife was under while endeavoring to provide care.

I used to dwell on it [the lack of support] now I have got past that, it might happen again, I might dwell on it again, but at this stage of the game I feel okay about it.

Another participant described how the lack of support in a very hostile working environment hindered the way that she was able to perform her job.

I was feeling quite distraught about the fact that I'd had these midwives write these complaints, that one of the letters was two months old and [had] never been given to me.

Not being made aware any of these letters of complaint appeared to exacerbate the situation because the participant had no knowledge of nor the opportunity to read or respond to the complaints. The writer of the first letter of complaint receiving no reply wrote a further letter. Two other midwives also wrote letters of complaint. The perception of the participant was that the letters were part of a campaign against her.

The other three [letters] were almost verbatim...they'd obviously colluded and they were spaced five, four days apart.

A participant described being humiliated in a public forum by the person responsible for the bullying. This was a distressing and stressful experience and was intensified by the lack of any support from peers or management.

The [manager] was [there] and did nothing to intervene, or to stop the meeting or anything. I just tried to continue thinking well we've just got to get through this and it came to an end with obviously a very divided unit.

Lack of support from management was an issue for another participant attending a clinical review meeting. This open meeting was the first time that the criticism of the care she had provided was raised.

... [the care she had given] had been criticized, and where we [I] could have defended ourselves [myself], we [I] stood back and let the people [management] who are supposed to be representing us reply on our [my] behalf which they didn't at all.

For another participant the lack of support was attributed to [hospital midwives] feeling left behind in the way they were able to practice, staying within the 'conventional model', and feeling frightened by the speed of change.

... So that they, the people left behind had to in some way, express they're fears or their concerns and in many [ways], they turned that sense of being left behind on to the people who were out in the community working.

A participant considered that withholding support, or giving selected support was a ploy used by some midwives to show disapproval of the way a participant provided care during the labour and birth.

... They [hospital midwives] see the point of not giving you support and encouragement in what you are attempting to do when you support the woman, by making comments and I'm talking specifically about the labouring woman, because in fact when you are in the community the pregnancy care stuff doesn't actually impact on the midwives in the hospital.

For yet another participant, the lack of support was represented by reluctance on the part of the perpetrator who was in a management position to acknowledge the dire staffing situation and do something to rectify it

... Yeah and so she would, she would argue about the need for satisfactory cover and try and make us cope without getting extra people in....

This situation increased the level of stress for one participant, and the degree of risk and consequent liability of the unit that she was responsible for. Equally stressful was the situation for a participant completing a period of sick leave, and returning to work on a part time basis.

I tried to get back to work when I was feeling better but I was always rostered with one or two of the bullies, so it would take me three or four days to get over it [the shift].

She would arrange childcare for the shift that she had been rostered, and then be rung at short notice to say that she wasn't wanted. This created particular trauma for the participant, as she had to cope with the anticipation of going to work and the knowledge of the time that she would take to recover from going and then the shift was cancelled.

... When I was trying to go back to work I would arrange the shift when I could get babysitting for [child] and come home and find at 7 o'clock at night there'd be a message, "we don't want you for this shift in the morning". And then find out that they'd called someone else in to do that shift.

Finding out later that another staff member had actually been called on to work was demoralizing, intimidating and a financial cost to the participant who had arranged paid childcare.

One participant described her distress at watching what she considered to be poor practice, and not being in a position to change or prevent it. She described an incident where she was the second midwife at a birth where the hospital provided the midwifery care in conjunction with a General Practitioner as the Lead Maternity Carer. The birthing woman suffered extensive perineal lacerations that required repair in the main theatre complex.

...I went to see the [midwifery manager] and talked about my concerns and just for a bit of debriefing and her response was to support the actions of the Doctor, that it was necessary to birth the woman that way [flat on her back and pushing without an urge]. So that was probably one of the first times that I had gone to the head of midwifery for midwifery support and not been given any.

Being labeled

Participants in the study referred to the experience of being labeled. This varied from being called a troublemaker, being referred to as the agency midwife, being labeled as 'only a midwife' (the inference being that you were less than satisfactory), being called whingeing and grumpy and being made to feel different because of being from another country or choosing another way of life.

I was labeled along with a few other midwives who had exact or similar experience midwifery wise to myself. We attended a staffing meeting ...at this meeting it was decided that we would be labeled as troublemakers.

Another participant in the study was also given the label of troublemaker. After experiencing difficulties in a previous employment situation she had hoped to start afresh. She tried to support a choice made by a labouring woman not to have a vaginal

examination by the house surgeon. The house surgeon had the attitude that she was the doctor and would decide whether a vaginal examination was performed or not. The house surgeon was unable to understand the concept of informed consent as it applied to women's choice, and suggested that the woman would have consented but for the support of the midwife, here detailed by the participant, quoting the doctor's words.

"... She would have said okay if you [the participant] hadn't been there".

The woman birthed without any problems two pushes later. The house surgeon went off to discuss the 'case' with the registrar who rang some time later to challenge the midwife participant who describes the incident.

I believe you've had some problems with one of the house surgeons?". I said, no not really, she [the house surgeon] wanted to do a vaginal examination when she didn't have informed consent. "What's that mean?" "Well the woman didn't give her consent for the vaginal examination." "Was she compos mentis?" I said she was as compos mentis as anyone can be when she's about to push a baby out. "We encourage house-surgeons to do vaginal examinations". I said but she didn't have consent so it wouldn't have mattered whether you encourage it or not, there was no consent. "We've heard about you", he said, "we know all about you, you're a trouble maker".

The participant was shocked and expressed how she felt:

I just dissolved....

Talking about the incident even now two years later caused a very distressing response. She became extremely upset and recounted that the confrontation with the registrar had caused her to become quite distraught at the time.

...It was like I was just split open really...everything I had tried to leave behind, within two weeks had caught up with me and I would never be effective again. You know the one issue about being there for women and being able to advocate for them, I couldn't even do that....

What this meant for the participant, who was attempting to create a new working situation for herself, was that she could potentially expect difficulty in trying to support and advocate for women if she remained working as a midwife. She felt that 'history' would not be able to be left behind.

...I couldn't sit back and not support women, but in supporting them I would be constantly reminded of my past [previous experience of horizontal violence] and that everyone knew about it...whether they did or not I don't know but in my mind everyone knew that I was a troublemaker....

For another of the participants feeling unsafe when around the bullies led her to exclude herself from their company. She decided to do this in an effort to try and decrease her exposure to episodes of bullying. Her perception was that she was subjected to the bullying because she was labeled as different.

...So I feel perhaps that I'm ostracizing myself because I have nothing in common with the other independent midwives; I don't drink, I don't smoke. I made myself very

conspicuous from the beginning because I'm a vegetarian that in itself brought problems because I eat differently from the rest of them. ...It was like I had a label on myself, I'm [foreign] and different so therefore I'm stupid, I don't know anything.

While being subjected to unnecessary comment for choosing to eat a vegetarian diet may seem minor by itself (Adams, 1992), it attracts more significance when it is one of many reasons for the bullying episodes that the participant had to endure.

The participant continued.

If I arrived two minutes late, I used to ride to work, sometimes if I rode into a head wind then I might be a little bit late so then I'd get the silent treatment. All day no one would speak...Patient allocation would be done and I would get most of the heavier clients and I kept thinking this will pass because I'm the newest person on the block and I am a little bit different. You know I still bleed the same, I still talk the same, I kept thinking, things will get better, it will change.

But it didn't change and the situation never improved for the midwife. Another participant found it difficult to be labeled.

I did take on the issues about my recent grumpiness, which is the Catholic thing to do. This is not me though. I know I am a pleasant and bubbly person, that's how I'm always described, I know that and I found it hard to be labeled grumpy and whingeing....

Being labeled 'the agency midwife led to a participant feeling second class when she chose employment as an agency midwife to fit in with her holiday plans. She felt this affected her 'treatment' within the hospital. Although she was classified as an agency midwife, her contract for the entire time was with one hospital.

... And I was definitely the agency midwife. Throughout the three months I was referred to as the agency midwife.

Even though the participant was a very experienced practitioner and given responsibility equal to her position, this was later withdrawn. In spite of the fact that she had been doing charge duties on both the antenatal and postnatal wards, this abruptly stopped.

... And when I started I was a senior, quite a senior staff member and I was written down on the roster as a senior and treated as a senior and then they realized that if they did that they would have to pay the agency more so they started writing me down as a junior, so that I couldn't be in charge of the antenatal ward or the postnatal ward even though I had been doing it, they suddenly stopped it. It was quite bizarre.

Nevertheless the rate for a senior midwife paid by the agency did not change. Being given mainly night duty by the hospital was another consequence of being an agency midwife, and there was an attitude of 'put up with it' or leave.

... Out of my twelve weeks there, eight were night duty and they wanted to give me more and I was complaining after the fourth week and she said, "well if you don't want them, you can leave, you're only an agency [midwife]...".

For another participant who was proud of being a midwife, and who had a reputation as an experienced health professional before coming to New Zealand, being labeled 'as only a midwife' was insulting.

...And I was introduced to all the people who worked there [small hospital] doctors, midwives, nurses, cleaners so [it] was quite a compact unit and I was introduced as "oh this is [name] she's our midwife, but she's only a midwife" [she was not a registered nurse before becoming a midwife] and it was quite clear that I was put in my place.

For another of the participants being labeled as overly empathetic towards a particular group of women and families was abhorrent. She perceived the inference to be, that she disadvantaged some of the women who came into the unit. She discussed the allegation that she gave preferential treatment to a particular group of women and families. Her interpretation of what she was doing was honouring the Treaty of Waitangi, the founding document of New Zealand. Money was made available to update current outdated facilities to improve the amenities that were available for women and families, and at the same time there was an opportunity to develop extra facilities that would enable care to be provided in a culturally appropriate and acceptable manner.

... I know that I was perceived in the unit as having empathy with Maori and they considered that this was over the top and because I'd worked with Maori for quite a long time I was trying to get them preferential treatment... And we'd never had things like a Whanau room.

The midwife saw attracting criticism while attempting to provide culturally acceptable surroundings and facilities for women and families as unjustified and unfair.

In an attempt to deal with chronic staff shortages and retain existing midwives, a participant supported a scheme where midwives could work in both an employed and limited self-employed practice. This led to being labeled as someone who ‘played favourites’.

...And it was deemed that it was my favoritism that I had picked these midwives [out] and that because I had allowed them to look, actually look after some of my clients and I had mentored them, that that was favoritism and they didn't like that either.

Two participants in the study discussed how the effects of horizontal violence carried on even after they resigned from their jobs where the horizontal violence occurred. One participant perceived that it involved an attempt [by a manager] to block the payment of a salary commensurate with her new position, by false information being given, suggesting that the midwife was unreliable, dishonest and unsuitable for the job:

...She was quite happy that I did the work but she tried to block me receiving the appropriate salary by telling the [clinical leader] that I had left [last job] without giving notice and people hadn't realized that I had left, etc, which was absolute nonsense.

Another participant remains convinced that she was unsuccessful in a job application because of her alleged reputation as a ‘trouble maker’. She was well qualified for the position but did not succeed at the interview (no-one was appointed). In her opinion, her non-appointment was due to the fact that she had acted as an advocate to support women’s choice, and had a reputation as a troublemaker.

...In my mind everyone knew that I was a troublemaker that I'd always be a trouble maker and that I was labeled

as that, which was confirmed when I applied for a [new position] and wasn't appointed.

Being treated unfairly

One participant took eighteen months to get registration as a midwife in New Zealand, although there was no requirement by the Nursing Council for the midwife to complete any further professional development. It took a further number of months before the participant was able to gain employment in her chosen profession. Although there was a shortage of midwifery staff in the city where the participant lived she was unable obtain employment because of a hospital policy of not employing direct entry trained midwives. New Zealand did not have a direct entry midwifery programme until 1992.

...Finally I was able to get registration and then the next hurdle was to find a position. That again was not an easy thing. I was living in [city] and they just full stop would not consider employing a midwife that was direct entry trained at that time although there was quite a shortage of midwives at that time.

The participant continued searching for a position as a midwife and eventually found employment in hospital maternity unit working fulltime night duty as a midwife, in all areas of the unit.

That meant mainly labour and delivery and postnatal care, and that is for me the place where I experienced the first time of horizontal violence... [small town] in my opinion is quite a conservative place in New Zealand, and a lot of people know each other and trained with each other and I perceived them as quite 'clicky' [clique-group].

The participant was never offered any opportunity to participate in any educational development. She felt singled out and subjected to active discriminatory behavior that was most distressing and inequitable. For a considerable period of time she speculated about the ways New Zealand midwives furthered their knowledge. There was no evidence of any opportunity to be present at ongoing education sessions, study days or be advised of future conferences relating to midwifery practice. This situation concerned the participant who was motivated to remain current in her practice. It took a year for her to realise that there were opportunities for ongoing education, but not for her.

I was just never invited to go to any study days or workshops because what happened was the [midwifery manager], she received the invitations to anything that was going on in New Zealand whether it was locally or whether it was further away and she picked the midwives who would attend and I was absolutely not invited, never was. And I found that incredible I found that just, I found that really mean, because I felt totally singled out and excluded in what was going on.

The participant suffered further incidences of being singled out for unfair treatment as she explains:

...And I was only given [an] epaulet, which had one stripe [Junior status] although I had experience of more years, and I was never offered to move up... it was very clearly defined who I was, I was put in my place and that was it and I found that quite hard to take.

She believed that further bias occurred, as a result of her being a direct entry midwife.

...You know I just never got the chance to be with a labouring woman because that was already considered 'higher work' so I was shunted to the post-natal ward. But of course when midwives were on who weren't in the mood to do a delivery, then I was quite happily allowed in the delivery room because I was the one that had to do the work...and I remember being quite tearful in my practice.

One participant who was feeling desperate attempted to get support from her midwifery leader and was greeted with complete disrespect. When trying to explain how bullying was affecting her ability to continue to work, she was laughed at. This was the second time that she had been laughed at in response to her request for professional assistance.

...I needed to talk to the [midwifery manager] about how I was feeling, telling her that I didn't think I could continue working in the unit in the way I'd been working and she laughed...I think my terminology was I'm as flat as a tack and she laughed and said "is this just another [foreign] colloquialism" I said "No, I'm telling you how I'm feeling".

A participant described feeling verbally and physically intimidated when trying to support a woman who needed to undergo a Caesarean Section. It had proved particularly difficult to get an effective epidural, and achieve adequate sedation for the woman. The tension and apprehension of the woman in the anaesthetic room was not helped by the hostile and strident attitude of the person responsible for the bullying behaviour.

...This particular woman [midwife] called down the corridor towards the Caesarean Theatre] several times as to how long we were going to be...it wasn't that they were busy. I thought it was aggressive behaviour. Verbally

aggressive and physically aggressive-I did not feel comfortable with her [the midwife] at all.

The participant described the physical aggression as threatening postures with the midwife advancing towards her in an intimidating manner, and indicated that she felt distinctly uncomfortable with the behaviour.

Another participant was subjected to arguing and yelling in the hospital corridor after a midwifery colleague declined to provide relief cover for the her.

...And so she had an argument with me in the corridor, she was yelling at me....

The participant chose not to respond at that time, but had to continue to provide midwifery care while in a distressed state.

Game Playing and Undermining behaviour were particularly unpleasant aspects of the experience of horizontal violence. Three of the participants believed that there was an orchestrated campaign by the perpetrator/s who actively set out to undermine and discredit them. For one participant, the sudden realization that she had been subject to undermining behaviour by being set up to fail and deliberately misled over practice issues by the midwife she had replaced was very liberating.

...What I later concluded, but it took me about three months to realise, was that the midwife I had taken over from had been undermining me.

Trying to get to grips with a new and demanding job and having to deal with the particularly hostile attitude of a co-worker was unbelievably difficult, in fact almost unmanageable.

...I couldn't even think straight; there was so much information to take on and the fact of feeling such a hostile environment...Yeah it was horrible, but it became clear to me after a couple of months that this midwife didn't like me, but it did take me that long [two months] to realise that she was particularly hostile. What actually happened was that some months down the track [period of six months] other staff [who worked with me]...said to me one day, you know a group of them came to me and said "why do you let her do that to you, don't you realise that she constantly undermines you, she is really trying to damage you, why, why do you let her get away with it?"

The participant had sensed the hostility but had not been aware that it was purposely being orchestrated. Her perception of the situation was that she was becoming more and more inadequate; it had to be her fault. The eventual support of other staff helped her to realise that she was not inadequate, but suffering from a lack of support and constant undermining.

...I think initially they thought I was really stupid, inadequate and a big mistake...And I think maybe it took that long for them actually to realise that there was a theme, that something was going on, that I was kind of constantly being set up...Suddenly I could put a finger on what was going on, that it wasn't cause I had this feeling, why I couldn't get it right ever, and why nobody liked me- it's kind of important to be liked.

For another of the participants the game playing was in regard to difficulty with a hospital staff member being able to contact her. A perfect example of what the participant had to put up with happened while I was in the participant's home and illustrated her frustration, with the often-repeated accusation that she was not available, that she was not contactable and so not able to provide the care needed or make the necessary referral when women needed her.

...I birthed a woman at 4 o'clock on Monday morning. I went up to see her at 9 o'clock –we did all the breastfeeding stuff and the woman was fine. It's now ten to five and I've just had a phone call from the hospital saying they have been trying to phone me all day because the woman had a frontal headache and they said they were phoning a [particular] number and there was no answer but in fact I have been here with a woman until twenty to two. Frances [researcher] has been phoning me on and off since 2 o'clock on my home phone and been able to contact me, and the hospital have just phoned me on my cell- phone and of course you know the cell-phone is always in my pocket, so I am not unavailable. These sorts of games are played all the time....

Another of the participants lacked support in her new position. The midwife, who should have been her main support, used subtle voice tones and disapproving facial expressions to convey a negative impression when asked about the participants' progress.

...I didn't understand at the time [that horizontal violence was going on], and of course when I started she had been in the area a long time, so people would say to her "how's the new midwife going?" And she would say, "I don't really, mmmm, she doesn't seem to kind of get it".

For the previous participant, further deliberate, calculated incidents resulted in her being in situations of acute embarrassment. The person responsible for the bullying would 'save' up issues, for example, lack of knowledge of support services and practice issues and then use these to embarrass the participant at staff meetings. Potential areas of concern would not have been raised or talked about first with the participant.

...I didn't want her to find out things I was doing wrong because I knew she would use them against me. ...Maybe someone who I should have got some baby clothes for cause they didn't have them, and I would suddenly realise that they didn't, even though they had told me that they had. I didn't want her to go there and find out that they hadn't. Because anything that happened she would make so public and she would say to everybody "oh this woman is one of hers and she hasn't even got her any baby clothes".

The lack of what should have been a supportive environment was indeed an actively hostile atmosphere, which led to a diminished opportunity for the participant to acquire the expertise needed to succeed in her new position.

I think it really slowed down my learning really really badly because it made me afraid to ask for help and ask for information because ...usually again I'm someone who just asks freely....

For another participant discrimination resulted in lack of recognition for a new idea. She perceived that there was a lack of acknowledgment for an education programme compiled

by her. The credit for the programme was attributed to the person responsible for the bullying.

...And the whole thing was taken as this person's idea, I found out at a College [of Midwives meeting]...and I felt quite hurt because when you do come up with something that is used and you know it's something novel and you had a good idea and you felt proud of yourself...for somebody else to take the credit is not very fair.

The participant had felt proud of her effort but now felt undervalued, and as Adams (1992) points out 'A manager who takes the credit for somebody else's ideas is likely to make a subordinate feel that their initiative is being undervalued' (p.17).

For other participants it was being diverted from providing midwifery care into completing demeaning and trivial tasks that damaged self-esteem and led to disillusionment with the job.

...She would have us doing tasks that were meaningless...she would have us writing protocols for things that were medical, that were out of the league of a midwife. We would spend hours writing these protocols, thinking hard about them, because it is at the end of the day a learning experience as a midwife to actually have to look at the research but then we would bring protocols to her and she would say "I've changed my mind, I don't want that protocol anymore. But it's kept you busy, hasn't it" ...I became very disillusioned, I wanted to leave, I had serious thoughts about leaving New Zealand again to go back overseas....

Equally unhappy and disillusioned was another participant who was prevented from doing the job for which she had been recruited. She described how various means were used to prevent her doing her job. After commencing employment, she was prevented from completing the hospital required competencies she needed to commence work on the community team. She was required to wait until all other staff had completed a programme of upskilling. What that meant was a period of six months working as a ‘baby sitter’, as independent midwives birthed most of the women. Even showing initiative didn’t work. The participant offered to help out by booking women in ante-natally and received a very positive response from the midwife who was in charge of the team midwives. But when the manager returned from leave a familiar response ensued.

‘oh love, oh kid we don’t want you to do that yet, we don’t know that you’re quite ready to go and do the bookings in”. So whatever I did I couldn’t win. I was stopped from doing all that sort of thing [antenatal bookings]. ... So the things she would ask me to do, or the things that I would get into trouble for would be forgetting to change the date on the allocation board or she would give me a wonderful job to do and that would be to change all the little letters on the phone, you know the direct dial thing. She would say “oh I’ve got a good job for you today”, that would be my job for the day. So I was given demeaning, trivial tasks.

Constant negativity perceived by another participant, contributed to a feeling that it wasn’t worth putting any further effort in, as the standards expected of her were absolutely unachievable. The lack of any positive feedback played a part in the loss of previous motivation, focus and dynamic enthusiasm for the role that the participant previously held.

...I felt there wasn’t any point in doing anything because it was never going to be good enough. I never felt it was

worth doing anything anymore because it was never going to come up to that person's standard.

Struggling to reach unrealistic goals developed into an impossible task and affected the participant to the point that she resigned from her job. She had been hopeful that an open and frank discussion might result in a better understanding of the situation and a change in the person responsible for the bullying that would enable the participant to reconsider her resignation.

I was [hopeful] because for me to resign for this reason hurt me, because I've never resigned for this reason before. The other reasons have been pregnancy, moving house to other areas and emigrating.

Summary

In this chapter, the first of the two data chapters focusing on the experiences and consequences of horizontal violence of twelve registered midwives, I have introduced the main category that became apparent from the data, fractured relationships. The main category is supported by the five sub-categories, 'sabotage of practice relationship', 'communication issues', 'being watched', 'being labeled' and 'marginalizing behaviours'. Relationships that had previously existed before the experience of horizontal violence between the midwife and the woman or between midwives were equally at risk. Experiencing horizontal violence and the subsequent bullying behaviour, particularly when the participant was subjected to the experience in front of the woman for whom she was providing care had particular significance. The relationship that the midwife had previously enjoyed with the woman had the potential to be affected in some way. For one participant the relationship with the woman was broken as she changed her care provider. For others, who carried on being responsible for midwifery care, there were changes within the relationship. These ranged from midwives feeling they had lost the trust of the woman, that they had to be on their 'best behaviour', that their competency levels were

doubted and that all the ante natal preparation spent in building up the relationship with the woman was not valued.

Chapter six discusses the emotional and psychological distress experienced by the midwives as a result of their experience of horizontal violence.

Chapter 6

Hangin' On: Just Trying to Survive

'No one works at their best if they feel hurt, angry, vulnerable and powerless' (The Working Women's Centre, 1997, p.1)

Introduction

Horizontal violence and bullying have a destructive and incapacitating affect on the people who experience it. According to Storey (1999, p.37),

Blows to the outside of the head are physical violence. We call the police and prosecute for assault. But at least as damaging, though there is neither blood nor bruise, are blows to the inside of the head, to the mind and the emotions. That too is a violent assault on another human being.

Three participants suffered ill health that resulted in considerable time off work on sick leave. Another midwife required medication for a period of a year for depression while another recognized that she was clinically depressed took time off work and sought assistance from the hospital Employee Assistance Programme. A fourth midwife recognized that she had experienced the symptoms of clinical depression, but dealt with the experience by resigning her position. Other midwives took positive steps to organize counseling or professional supervision to help them through the experience. The animosity that midwives were subjected to when being bullied was responsible for a number of the respondents developing significant doubt about their ability to continue to practice midwifery in the same way as they were doing at the time they experienced the horizontal violence.

For all the midwives, there was an effect on family and/or personal relationships. Six of the midwives were married. For those who had families, the effect of the experience was both traumatic and unsettling for their family members. The degree of disruption for families varied, but included shifting house, changing schools and living with a parent who was unable to cope with the ordinary household tasks. One family experienced considerable monetary hardship, as the midwife who was off work was the sole income earner for the family.

The other six midwives were single but had the benefit of extensive social support/network systems. These social support/network systems were damaged and not functioning as they had previously. This was in part due to the overwork of the midwives who as a consequence of the horizontal violence were not available for social interaction because of work commitments, or in some circumstances because the midwife was simply too tired, ill or clinically depressed.

All the participants in this present study experienced varying degrees of personal distress as a result of the experience of horizontal violence. For three of the midwives, talking about their experience was very traumatic and brought back much of the reaction that they had experienced at the time. Two midwives cried throughout the interview, while others became upset at intervals throughout the interview. For several of the midwives this was the first time their experiences had been shared with anyone else, and proved to be both distressing, but also part of a healing process.

In this chapter the focus is on the emotional and psychological distress experienced by the participants as a result of the experience of horizontal violence and how that unhappiness was manifested in their behaviour as a coping strategy. Five main sub-categories emerged from the data to support the main category 'hanging on: just trying to survive', and were those of anger and defensiveness, reduced self-esteem, hurt and tearfulness, being separate and trying to cope.

Anger and Defensiveness

Becoming defensive was a strategy some of the midwives used as a coping mechanism to enable them to carry on during the experience of horizontal violence. For some of the midwives however, becoming defensive, although a choice was seen as a self-limiting brake that they chose to put around their sphere of practice for self-protection. Being defensive was a tactic to protect them if the labour did not progress normally. Their concern was the need to justify the decisions they had made and the care that they had provided to practitioners whose views on the choices women were offered and how care that they provided was in opposition.

Some of the midwife participants talked about feeling so angry they were unable to discuss the issues at hand in a rational way and that this had contributed to their inability to 'sort the matter out' at the time. For the participants these responses were seen as either a positive means of protecting themselves or as debilitating or inhibiting to their practice.

For one participant, accepting and trying to ignore the horizontal violence was a means of dealing with her experience. However what the participant was not prepared to accept and what made her angry was when the horizontal violence 'made it difficult for the woman'. She identified this as interference in the care that she was attempting to provide and which resulted in the woman feeling anxious and irritated.

...Unless it becomes truly unpleasant I won't do very much about it, I'll just accept that there are some people who choose to be like that [horizontally violent] and that becomes a difficulty because then I'm seen to be an "old witch" for having spoken up and said "please don't do that" [constant interruptions, undermining of care, negative remarks and pressure to hurry up] and that's fine because I can accept that [it will carry on] but it does make one feel a little bit defensive.

The participant's level of tolerance of the bullying behaviour was reached when she perceived that the actions made life difficult for the woman for whom she was providing care. The act of becoming defensive for this participant meant that she was unwilling to seek help and sought to manage care on her own.

For another participant, a hospital midwife, becoming defensive was as a reaction to a false accusation of not calling the self employed midwife in time for the birth, and a claim by the midwife that not calling her contributed to a less than satisfactory outcome for the woman. The participant who 'felt rushed off her feet' had failed to document her efforts to page the midwife.

...I feel probably a bit defensive and probably will cover my back, which means document everything, conversations that we've had, everything so it is completely clear later.

Becoming angry was a response to a recognized threat to another participant's level of self-confidence and emotional happiness. As a teenager this participant recounted feeling shy, anxious and lacking a belief in her own ability to succeed. As a result a great deal of personal effort over the last fifteen years had been spent in building up her self-respect and confidence in her ability.

...I have been thinking a lot about this lately and I think that I do feel undermined - perhaps on a subconscious level. It is this feeling that then fuels my anger. I have had to work hard over the last fifteen or more years in building up my self esteem and confidence and I resent it when others potentially threaten my emotional well-being.

One participant's reaction to feeling angry stemmed from her growing frustration with being unfairly treated in regard to obtaining midwifery relief for her practice, 'they just

weren't available' and with the hours of having to be available on call. Being on call required the midwife to be contactable by phone or pager and to be available to provide care for women. It also involved providing cover for other midwives in the practice, which was not always reciprocated fairly or in line with the practice policy.

...I guess I got very angry and I began to really hate midwifery and I wanted to get out of it.

Finding herself working in a self protective or defensive way was a means one participant used to deal with the experience of horizontal violence while at the same time becoming familiar with a challenging and demanding new employment position. Working in a defensive manner involved risk for both the midwife and the women for whom she was providing care as meetings and people were avoided, issues of practice were obscured and self-esteem plummeted.

...I think I just felt so confused by it [horizontal violence] I couldn't even think straight. There was so much information to take on and the fact of actually feeling such a hostile environment, I felt like I froze like a rabbit in the headlights. I didn't deal with it very well and I started doing things like dodging meetings and avoiding people and trying not to be obvious, and obscuring things I'd done because I felt like I kind of went into defense mode, that if anyone could see what I was doing they'd find out what an utter failure I was.

Where tension existed between the self-employed and employed midwife in regard to the institution's expectation and interpretation of a specific contract to provide secondary services, difficulty was likely to arise. It appeared that where there was little notice taken of the handover of care and little or no opportunity for the midwives to meet and discuss care there was the likelihood for distrust and misunderstanding to occur. A participant

described with passion her feelings when the care that she had provided was criticized in an open forum and where no support was forthcoming from either her colleagues or her manager.

...I was really angry, really angry that the care that we [employed midwife] had given which was the best in the circumstances presented to us had been criticized [in an open forum] [and we were waiting for something to be said on our behalf and it wasn't] so we [I] felt voiceless and angry that we [I] hadn't actually stood up and said something but we [I] didn't want to rock the boat.

The experience of horizontal violence was intensified for this participant when she found herself in an unsafe environment, an open forum where she felt unsupported by both peers and management, and where she felt powerless to address the issues that had been raised. It resulted in a situation that was left unresolved, and continues to affect the working relationship of the participant with the self-employed midwife.

McMillan (1995), writing in response to a questionnaire survey on workplace bullying, offered a reason for the stance taken by some midwives of maintaining the status quo when he said, 'challenging the bully meant they were branded as troublemakers who upset the boat' (p.40). The previous participant was angry that she had not felt strong enough to challenge the bullying behaviour, on her own behalf, but also disappointed that her peers had not given any support. The reason for the lack of peer support may have been twofold-being branded as a trouble maker or drawing attention to themselves and being a possible recipient of bullying behaviour.

Another participant described how she felt defensive as a result of unwarranted criticism over a birthing choice that she had offered the parents. The senior midwife in an overseas hospital was unable to accept that offering an opportunity for the new father to be an

integral part of the birth process and cut the cord was a safe procedure, and one offered where appropriate, routinely in New Zealand.

... Well I'm not sure that the patient trusted me as much. I mean it's got to impact on how they think you're behaving, what they think your practice is, if you've got senior midwives criticizing you. Yeah so I felt very defensive after that and felt I had to be on my best behaviour with the patient as well, even though you'd got on well you feel very defensive.

The inference that another practitioner's practice is unsafe or suspect unquestionably affected the relationship that the participant and the family she was providing care for had previously enjoyed. It raised the possibility of doubt over the capability of the practitioner.

Reduced Self Esteem

To establish and maintain a positive self-concept, the individual needs to feel worthy, significant to others, successful and approved by others. This leads to feelings of competence and the power to control one's own life and destiny

(Short, Sharman, & Speedy, 1998, p.26).

Feeling good about oneself and having a belief that the work you are doing is considered valuable and worthwhile is fundamental to coping with, and being able to work effectively. Lowered levels of self-esteem impacted on the ability of some of the participants to continue to work effectively and to their capacity.

Two participants who were self employed midwives and who were required to 'hand over' care to midwives employed within the institution felt unimportant and that the information they had to contribute was considered of little consequence. They talked about feeling

unwanted, the atmosphere being hostile and unwelcoming, with no encouragement to stay and support the woman. Prior knowledge they had of the woman, her family and her family circumstances may have contributed to an improved outcome for the woman. It was usual for self-employed midwives to resume the post-natal care when a woman was discharged from the institution; consequently there was a need for them to remain involved.

A participant described how the woman for whom she was the Lead Maternity Carer developed complications during her pregnancy, which necessitated transfer of care to the hospital team. She negotiated with the obstetrician to come in and support the woman and have some involvement with midwifery care when labour was induced. However the participant was unable to tolerate the hostile atmosphere in Delivery Suite, and was given no encouragement to stay and be involved in providing midwifery care. The eventual outcome of the woman's labour was in her view, unacceptable. The relative's perception was that the care that was given was mismanaged and as relayed by the midwife, the issue of pain relief in labour was mismanaged with an epidural being put in as the woman was pushing. The professionals who should have been present at the birth were not, and the woman was distressed and frightened with unknown caregivers.

...I feel that had I been able to stay, had I been made even the least bit welcome, or even supported in my desire to be there, it wouldn't have been such an awful experience for that woman, not quite so unpleasant for her because I mean it was really quite awful.

The participant further elaborated on her reasons for wanting to be included at the birth. She had previously provided midwifery care for other family members and had been in contact with the family over a number of years. Her view was that she was prevented from providing midwifery care that would have impacted positively on the birth experience for the woman.

For another participant prevented from carrying out midwifery care but 'occupied' doing menial tasks there was little satisfaction or purpose in going to work.

But I'm like most people, my self-esteem is tied up in the work I'm doing and if I'm not doing work that I'm proud of....

Prevented from working actively as a midwife in a role for which she had been recruited, and forced to carry out unskilled tasks combined to reduce her self-esteem. Being treated in this way was particularly demeaning for this participant who was an experienced primary care practitioner. Another participant had been very clear about her need to have extra time to orientate to her new position. This did not eventuate. In addition to the lack of orientation were the stresses of feeling 'not liked', being 'out of her depth' and having to work in an atmosphere that was unpleasant and which appeared to be unsupportive:

...I'm always a bit slower to get the hang of things, but I kind of was a little bit [anxious]. It made me very anxious to suddenly realize that actually within about a week or two people were looking at me like I wasn't coming up to scratch.

A difficulty for the participant was working in a situation where she was unaware of why the work seemed so much more difficult than she had expected. A period of three months passed before the participant realized that she had been constantly undermined from the time she started in her job:

...I had this feeling when I came [in] that people looked at me, and were saying things about me...it were very nasty and very unnerving.

And so the difficulty intensified for the participant and affected both her feelings of self-worth, and confidence in her own ability to effectively establish herself in the new role in which she had been employed.

Other participants, who were employed midwives, also demonstrated a lack of belief in the worth of the care that they provided.

...We [employed] midwives have felt second rate and looked down on by our independent colleagues. Not all of them, I mean you can't say all of them, but some of them. They see us as medicalised midwives and doctors' handmaidens and 'that we don't do the job properly'.

For another of the participants, it was the perceived lack of value placed on her skills as an employed midwife and the inference that midwifery care was now going to be provided by a practitioner who was second-rate that contributed to her feeling of lowered self-esteem. This impacted on the ability of the employed midwife taking over the care to form a relationship with the woman.

...The undertones in her [self-employed midwife] voice [and] little digs at the fact that the woman had to be taken over by a hospital [employed] midwife, she had to relinquish care to an inferior provider.

The following two participants dealt with the experience of reduced self-esteem in different ways. One midwife stayed in the situation where she continued to experience frightening and destructive behaviour. On reflection, she was so miserable, felt so alone and believed herself to be such a total failure that she would not be employable elsewhere. A sense of shame about the experience also contributed to a sense of powerlessness to deal with the problem.

But to me the comparison I've made ever since is when I see women in abusive relationships and you say why don't they get out, why don't they get out, why don't they say something and I can't get why I didn't get out and when I look back I should have got out. Nobody should have stayed in that situation and I didn't leave. I can't, I cannot think why, but it was almost like I was so demoralized I believed I had nowhere else to go.

For one participant subjected to horizontal violence her identification with women trapped in an abusive situation was given as a reason for why she felt unable to remove herself and is well described by Hunt & Martin (2001, p. 111)

There is still a widespread belief amongst abused women that domestic violence is still somehow their fault, that some inadequacy in their nature or action has led to the abuse; and, if it is their fault, it becomes something they are ashamed of, and are therefore unlikely to admit or seek help or advice.

Prime targets of horizontal violence are often reluctant, and feel too ashamed to discuss the situation with peers because as Adams (1992, p.34) points out, 'their professional credibility is being called into question'.

Another participant endeavored to come to terms with the abuse in an opposing manner. She made the choice to leave.

My only option was [to leave] I left [a city] behind, I left it behind.

Although leaving her position was the alternative the second participant decided on, she needed and was determined to have a focus. She was undecided at first on whether to study or work, or a combination of both, but her financial circumstances necessitated finding other work.

...I left. I had to work and I was going to do [study], I thought I'd put a brave front on this, I could do my Masters [fulltime] or I could study and do part time [work] but I couldn't work in that community again. They [the perpetrators of the horizontal violence] had systematically destroyed any credibility that I had as a midwife and I no longer had the confidence to stand up. I couldn't stand up to them, I'd lost my confidence as a practitioner, and I just totally lost my confidence in me. I couldn't well I just couldn't do anything. I couldn't. I was useless.

Despite taking a different approach to dealing with the experience, the outcome was not successful for the second midwife. Although she was resolute about 'moving on' both her confidence in herself as a person, and her expertise as a practitioner were shattered.

One of the difficulties is that the person subjected to the horizontal violence begins to believe that 'they must be responsible'. While victims may be aware of what they ought to do, the loss of self-confidence and feelings of self-blame influence their ability to successfully establish themselves again (The Working Women's Centre, 1997; Hadikin & O'Driscoll, 2000).

Being well known in the local community was an added burden for one participant. Every day ventures from the house to continue the activities of life were compounded by meeting women that the midwife had previously birthed and provided care for. Women wanted to stop and chat and this was extremely distressing for the midwife who was constantly reminded of the reality that she was not able to do what she loved best- using her expertise

to provide midwifery care for women. The self-appointed responsibility of 'taking the blame' and 'being seen as unacceptable as a midwife' were almost overwhelming for the participant and impacted on her ability to move ahead in her career.

According to Hadikin & O'Driscoll (2000, p.20)

The psychological effects of bullying can be devastating. It damages confidence in one's self and destroys careers. Victims lose self-esteem, confidence and faith in their ability to do anything.

This is well demonstrated by one participant when she says:

...And that there was no way that I could practice with this burden, this sort of feeling of failure and what a terrible person I must be to have brought this on myself.

Another participant who had grown up with a strong religious upbringing where self blame was the norm, resorted to blaming herself:

...And I thought, well is it me, is it my fault, maybe it is my fault.

For this participant reflecting about the experience of horizontal violence resurfaced the habit of somebody being held responsible [to blame] and taking the blame throughout her childhood years.

The old guilt complex and I did for a while think it is me, it's my fault, this is all coming from me.

Another participant took a considerable period of time to reach the conclusion that the problem of the horizontal violence belonged to the person responsible for carrying it out. It was difficult to actually be aware of what was happening- that undermining was constantly going on in a personal sense and within the work environment.

I think I couldn't believe it because I couldn't believe that somebody could purposefully be doing that.

It was the unexpected support after a period of several months, of a group of fellow workers that helped her to realize that there was a concerted effort by one individual systematically trying to damage her reputation as a midwife.

...Yeah and it became obvious to me that the problem wasn't me it was someone else. It still took me a really long time to deal with it, to actually talk to the person involved about it.

The decision to 'hang in there' was based on two reasons. The positive was fellow workers finally giving unconditional support and acknowledging that the participant was 'actually quite good at what she did'. The participant demonstrated that a negative undercurrent of poor self-esteem remained, that if she left her position she would not be able to obtain any other employment:

Yeah, it was almost, one was the pride that I had to hang in and two, that I would have nowhere to go because I was such a loser.

For another of the participants coping with the effect of the experience on herself, on her practice and witnessing the emotional affect and distress caused to her family further intensified her own misery.

But it's the whole process of all of that, and what's gone on in the hospital has just squashed my confidence in me as a person, as a parent. My daughter said about six months ago she said, 'I liked it better when you were sick, I could get away with more'.

Being unable to work as a result of ill health because of the bullying behaviour, or only able to work part-time hours, created financial hardship for some of the participants and their families and was an added stress.

For the following participant not recognizing the experience as horizontal violence resulted in continually enduring negative remarks, a belittling attitude, constant criticism and a recurring despondency about not ever being able to get it right.

I never felt it was worth doing anything anymore because it was never going to be good enough.

The participant continued talking about how the constant negativity affected her health. For the first time in her life she suffered from feelings of depression and 'I'm not a depressed person'. For her, the feeling uppermost was that there wasn't any point in doing anything anymore in view of the fact that it would never meet expectations.

...I felt like I wasn't getting anywhere. I felt like a hamster in one of those exercise ball things, just going round and round and round and round and never, never really getting anywhere. Never feeling like I don't know, just never feeling like I got anywhere.

Another participant identified that the breaking point for her in continuing on working as a midwife came when she was notified of a complaint against her to the Health and

Disability Commissioner. A hospital investigation into her practice as a result of a complaint had found no cause for concern. However the complaint was referred to the Health and Disability Commissioner by her client.

I was investigated by the Health and Disabilities Commissioner's office, and it just about crushed me.

The participant was convinced that being investigated was a result of constant undermining of the relationship between her client and herself. Constant hounding by the bullies each time that the participant needed to access the hospital to attend to women merely intensified the distress for the midwife.

...I just felt I couldn't go on as a midwife and keep fighting like this.

Previous exposure to the experience of horizontal violence left a participant feeling uncomfortable, unsure of herself and lacking in confidence. When exposed to a further experience the participant dealt with the episode by choosing to ignore it.

...I would crawl back into my shell and not speak up, when that sort of thing [horizontal violence] happens.

Hurt and Tearfulness

One participant, who had considerable experience as a midwife in another country and was proud of her qualifications and the standard of care that she provided, was shocked to find that she was actively blocked from using her skills. She was vitally interested in supporting women's choice and was eager to share her knowledge and previous way of working in her new place of work. In this new work environment there was no interest or support for any practice that was considered different.

...I mean people didn't even want to know what I knew or what I did or how work was like in [foreign country]. They just blocked it off I felt, and that was it. And I felt that hurt me hugely.

The participant expanded on the treatment that she experienced. She was constantly called before the Midwifery Manager to be reprimanded for acts that were considered to be breaches of the hospital culture. Two fundamental errors were not bathing a baby in the correct way, and not moving aside to enable the Doctor who raced in at the last minute, to deliver the baby. The withholding of information by other staff about how the unit functioned contributed to the participant's lack of knowledge and to her embarrassment at her visits to the office of the Midwifery Manager.

...When I used to come home I would get letters from my friends in [foreign country] and they continued where I basically had left and it often reduced me to tears- not so much the situation I was in because I felt quite strongly that I would somehow survive it, I mean the worse they were to me the more my, my sort of will to change the world got stronger....

Being reduced to tears was a response for the previous participant when she received supportive mail from her home country. It accentuated to her how difficult her working situation was, but increased her willpower to survive the experience. She finally made a decision to seek employment at a large city hospital.

For another participant being heckled in a public forum, an education session was acutely embarrassing. Differences of opinion about notification of the meeting and where it had been advertised resulted in intense disagreement and much shouting.

What was particularly hurtful for the midwife was that the notices that she had displayed to advertise meetings and education sessions had either been removed or covered up. Even more upsetting was the realization that her peers had orchestrated the actions.

Several participants described how crying every day became commonplace as they lived through the experience. It varied from happening each time they had to go to work, while they were off sick with other symptoms of stress, or unexpectedly when attacked verbally. For one participant it occurred when she received supportive friendly mail from home, which accentuated how miserable her working conditions were. Another participant related how she felt so upset but was able to 'keep herself together' by frequent breaks and for cigarettes.

One participant was unable to obtain any midwifery relief to help with her excessive workload. She found that she was unable to eat, and coupled with poor sleeping habits developed a tendency for crying on a daily basis.

...And I started crying every day....

Being spoken to in an aggressive and abusive manner when feeling under enormous pressure was the breaking point for one participant who, as she so frankly put it 'lost the plot'. Her distress was heightened over a duty request for a special occasion. Although requested several months in advance the request was denied. She perceived that she was singled out for unfair treatment as all other requested duties by other midwives had been granted, even those requested at a later date.

...As I was looking in the request book the midwife who does the rosters came in and was just so aggressive and abusive and I just lost the plot, I just cried for about two hours.

For a participant who changed from working fulltime to a part-time position in another city the support of the midwife educator was important in getting her through. She shared

part of the story of her experience with the educator but found each day she worked to be traumatic.

... When I [started] work there [in a new job], I started working [part-time]... and I cried, every duty I cried, and there was an educator here and if it wasn't for [her] I wouldn't be here... [she] was really sympathetic and got me through....

A period of recovery time passed for the participant as she adjusted to her new role, and she stopped crying every day. She became more confident, but there were incidents of disagreement over care issues when she again experienced insecurity. This resulted in her feeling alienated and separate from some of her colleagues.

Being separate

A sense of alienation and separation was experienced and endured by individual participants. Working in an unfriendly, sometimes openly hostile environment where colleagues ignored you, subjected you to prejudice, gossip, callous or snide remarks refused support or help, were judgmental or actively sought to sabotage your care, was a factor in escalating the sense of 'being separate'. Furthermore, a perception of being treated badly because you had chosen to move from another country was a further bullying strategy that some of the midwives were subjected to.

Hadikin & O'Driscoll (2000) maintain that not all social exchanges are positive. The outcome of the exchange may be either positive or negative and the result impacts on our psychological being as individuals. They maintain that 'intimidating behaviour is an example of a negative social interaction' (Hadikin & O'Driscoll, 2000, p.1) as it has a destructive effect on the receiver.

For a number of the participants becoming separated from their recognized support structure (family and/or friends) was a source of ongoing anxiety. There were several

reasons why this happened. Prolonged hours of work, inadequate rosters and extended periods of time on call, sleep deprivation and ill health as a result of the horizontal violence, contributed to midwives being deprived of much needed social contact and support.

Short, Sharman & Speedy (1998) in discussing burnout, maintain that nurses [midwives] experiencing exhaustion are likely to feel alienated from their patients [women], colleagues and their jobs. The onset is likely to be insidious, developing with ‘the physical and emotional depletion of the nurse’s resources’ (Short *et al.* 1998, p. 55) and leads to disillusionment with the health service, colleagues and one’s own identity.

A participant, who was in a defacto relationship, was subjected to prejudice as a result of her living arrangements. It was a subject for discussion and speculation amongst the staff.

...Because I also lived with a man at the same time and I wasn't married that was always a bone of contention as well, because they would discuss that and why I wasn't married.

A midwife participant suggests that the large number of midwives leaving hospital practice to commence independent practice may have influenced the apparent increase in horizontal violence from midwives who chose to stay within the institution.

...It seemed to be such a difficulty for the people within the [hospital] system to see midwives moving out of the system like droves of nuns leaving a convent, climbing over the wall and getting away from it all, that the term “have you gone out yet” became almost one of those little tongue in cheek statements.

This participant displayed some sympathy and understanding of the feelings of the midwives who had remained in employed practice when she continued.

...But to move out from what had been the accepted norm is exciting but difficult and for those who stayed within the walls of conventional practice, conventional in New Zealand that is, I think they became almost frightened by what they could see was happening in that they probably felt that we were rushing along at great steam and leaving them behind, their choice of course, so that they, the people left behind had to, in some way, express their fears or their concerns and many times [instances] they turned that sense of being left behind onto the people who were out in the community.

She went on to discuss the manner in which the horizontal violence occurred. She saw it as 'being directed at undermining the ability of the practitioner [herself] to whom it is directed'. It appeared at times to be almost subliminal, not always obvious but rather a steady insidious undermining of the practice and philosophy of the participant.

...But I think the worst part of the whole business is the business of it being done in the nicest possible way.

Her experience led her to believe that at times it appeared to be almost 'unconsciously done' but other instances most definitely intentional.

Another practitioner was oblivious for a number of months of an orchestrated campaign to discredit her.

...But what I wasn't able to accept was that midwives who had been my friends and my colleagues had gone to such extremes in order to discredit me. I had worked with these midwives as practitioners, I had supported them at home

births, we'd worked together clinically and I never imagined that anyone could ever really carry out a campaign of horizontal violence. It was bullying and intimidation to such an extent that was totally beyond my imagination.

The realization of what had taken place was almost beyond belief for this participant and had required a considerable time to come to terms with. Her distress when discussing these events at interview some considerable time later remained incredibly intense. What the participant found particularly frightening retrospectively was her total ignorance of the obvious campaign that had been occurring, and the level of her evident alienation from her peers.

Another participant discussed the 'feeling of alienation or being separated' that she experienced from other practitioners, particularly when she worked within an institution. If her practice differed from what was considered 'the norm', irrespective of the choice made by the woman, then it was likely to be a centre of unwarranted attention. Being alienated from colleagues provided a focus for extra scrutiny.

...[other practitioners] pass on a sense of alienation because what you are doing is different. Although what you are doing may be perfectly acceptable somewhere else it's not always acceptable within that institution so it makes it quite a difficult thing. I feel quite isolated.

On one occasion when the participant wanted to remain to provide support to a woman who she had a special bond with [whose care had been transferred to the hospital], the atmosphere became overtly hostile, the inference being that if she wasn't able to provide midwifery care she had no business being there.

...However the atmosphere became really quite nasty when they [hospital midwives] went on and on about how I couldn't really do anything [for the woman] and what did I think I was doing just coming in and being around when she was in labour, it was awful...

As well as feeling alienated, the participant left feeling guilty that she felt incapable of coping with the hostile environment and remaining to provide midwifery support.

....And I felt so guilty about not having been there just to support her even though I'd sort of explained it...

For another of the participants, the sense of alienation was intensified by her inability to contact women for whose midwifery care she had been responsible. The experience of bullying behaviour brought about a feeling of being totally burnt out, resulting in her feeling unable to face the women. Previously, a highlight of her job had been the close contact with women and families. There was as a consequence no ability to bring the relationship to an end.

...I was actually unable to have anything to do with those women. I was intending to ring them all in my holidays when I was feeling better but I was unable to, and absolutely unable to have any more to do with it totally, I was really burnt out.

Another participant demonstrated the consequences of alienation in two ways. She worked independently in a community setting and felt alone, unsupported, isolated and alienated from colleagues. The situation did not improve for her when she worked within the institution as she felt the midwives there were hostile to her

Somehow the combination of being out in the community and every time I went into any of the places where there were other kinds of midwives [employed] I didn't feel like I could talk to them because I felt they were against me, I was very unhappy in my work.

Being alienated from her social support network was particularly significant for another participant. Friends were extremely important to her. As a result of the bullying experience lack of social support was a primary cause of dissatisfaction, the result of which was her inability to be available for social support and occasions. In addition the lack of social interaction was responsible for her beginning to hate midwifery, and was certainly central to her intention to leave her job:

...I was just trying to survive, like sleeping and eating and working that was all I was doing. My friends were getting pretty pissed off that I wasn't available. Here I was going into this marvelous independent [self-employed] practice and it meant they saw nothing of me.

Other participants also recounted being too tired, lacking motivation or generally feeling unwell which impacted on their capacity to participate in their normal physical, educational and social interests. People who have been exposed to bullying frequently experience a loss of self-confidence and self-esteem and are often convinced that they are to blame for the bullying. It leads to increased rates of sick leave, reduced effectiveness in the provision of care and increased costs for organizations that may have increased staff turnover (The Working Women's Centre of SA Inc, 1997), and compromises effective care for women when midwives suffer stress related ill health as a result of being bullied (Hadikin & O'Driscoll, 2000).

Trying to cope

The participants in this study described a broad range of symptoms that they experienced. These varied amongst the midwives but included feeling stressed, burnt out, lacking in energy and motivation, feeling tired, worn out from hyper-vigilance, frazzled, not coping with the job, and a fear of coming to work. Poor sleeping patterns, and an inadequate diet, which included severe weight loss for two participants, were two other concerning issues. For one midwife, walking into the hospital caused palpitations and sweating. Four participants required long term sick leave. All of the participants in the study suffered from tiredness but attributed the cause to different reasons. Overwork was a prime cause, in particular where midwives were unable to get adequate relief from midwifery colleagues. One participant made a conscious decision to work on her days off to 'protect herself' from constant undermining by her colleague who was responsible for relieving her.

One participant attributed her continual feelings of tiredness to 'fighting' the conflict and being unable to sleep properly. An added stressful issue for one of the midwives was exhaustion from being hyper-vigilant, a state she considered herself to be perpetually in when she worked within the institution. She expressed it as spending one hundred percent plus of her energy in trying to protect herself from the bullying. Another said her self care was abysmal culminating in weight loss as she was unable to eat.

The following account demonstrates clearly how one midwife's self care was compromised.

... But the care of myself was abysmal. I had no energy to cook properly, to give myself good nutritious meals. Diving into my bed at every opportunity for sleep on my days off. By the end of that year I realized that I'd become clinically depressed. I was unable to clean my house, go out with friends; I used to dread the telephone ringing in case it was somebody ringing from work.

Warland (2000) argues for the importance of midwives and other health workers providing good self-care to prevent burnout and it is clearly evident that for this midwife this did not happen.

One of the participants who read through this draft chapter to check the appropriateness of excerpts from her interview text in specified categories identified with the above excerpt. She was shocked to recognize that quite possibly she may have been experiencing clinical depression at the time of her experience of horizontal violence. She identified with many of the symptoms detailed by another of the participants, and although she had acknowledged herself as being severely stressed, she had not considered the possibility of a medical condition. She had dealt with the situation by leaving her position.

For another participant, meeting up with the midwives who were responsible for the horizontal violence was a constant reminder of the experience. This coupled with the fact of not having the strength to carry on with tertiary study and having to take medication for depression, contributed to one participant suffering extreme weariness.

...I was so tired...I would just go home and go to bed; I'd spend every day in bed. I could get out of bed and come to work and do my [rostered] days [each] week and then I'd go home and I'd spend the rest of my time in bed. I didn't do any housework or anything.

One participant described how constantly feeling ill all the time affected her whole life, her health and her marriage. Feeling constantly nervous and sick prevented the participant from eating and contributed to constant headaches.

...I was ill all the time, I felt ill all the time, I couldn't eat, I felt so undervalued and I had lots of headaches, don't get me wrong I still have them.

She declared that she had previously suffered from migraine headaches but these had previously been infrequent and responded well to treatment.

Another midwife needed long term sick leave to recuperate from illness brought on she believes, as a result of constant bullying.

...I was off [off sick] two to three months. And I couldn't walk the length of that corridor from here to the toilet. Sometimes I thought I was dying, I wasn't aware that I could feel like this.

When the midwife was well enough to return to work she experienced unpleasant physical symptoms:

Every time I walked into the hospital, I'd have palpitations, my hands would sweat....

These physical symptoms were exacerbated by the knowledge that every rostered duty worked she would be on with one of the bullies and 'so it would take me three or four days to get over it [the duty]' as the bullying behaviour continued.

Another of the participants related feeling so devastated after being spoken to in what she perceived to be an intimidating and insulting manner that she took sick leave to attempt to recover her composure before making any long term decisions about her future.

And so I went home and, I was feeling pretty awful, in actual fact I took a few days off the next week, to try and recover from it.

Some employed midwives made a deliberate decision to work the unsocial hours of night duty and afternoon duty to avoid having to work alongside the person responsible for the violence. One self-employed midwife chose to work on her days off rather than let the relieving midwife provide care for the women on her books in order to protect herself from persistent undermining of her practice. These actions resulted in participants having a restricted social life, and led to feelings of anger and resentment of their work as a midwife and about an absence of their 'normal' social support system. Another midwife describes being penalized by having to work ten ten-hour in length night shifts after asking for one special duty request over a three-month period. Another participant describes arriving to start a new job and being told that she had two weeks of night duty, and there was no negotiation. The lack of adequate relief, holiday relief, sick cover or educational opportunities for midwives who were case loading, was particularly difficult.

One midwife who was subjected to the experience of horizontal violence and consequent bullying tactics for more than a year, and who had extensive working experience as a nurse within the mental health service, feared that she was going to suffer a nervous breakdown. She recounted the experience with some anger at the position that she found herself in, and the consequences for her career.

...The episode [of horizontal violence] that I remember went on over a period of a year, and the effect on my practice was that eventually I thought I was going to have a nervous breakdown.

She resigned instead, took time to heal herself, sought counselling and returned to work on a part-time basis in another position. A further problem that she experienced while on sick leave before resigning was being continually hassled at home by her manager. The inference was that she had neglected to hand over care of the women for whom she could no longer provide care. Although ill, the participant had meticulously documented all the necessary information for the relieving midwives. The participant considered that she was being harassed.

Midwives described the potential dangers of trying to ‘do all the work’. One participant described her reason for overworking as a way of protecting herself from further bullying.

...So I tried to take on more and more and more so I ended up feeling overworked, and stressed and tired and I would work on my days off, we had days off but I would sneak out and do the visits because I didn't want other people to do them and then find out that I had been doing them inadequately. So if there was a weekend I was meant to be off I would say to the midwife who was hostile, I don't have any visits for you to do, and then I would go and do them so she couldn't... .

Another participant expressed with some sadness and anger, the sheer impossibility of an inadequate number of midwives trying to carry out a full caseload when team members who resigned were not replaced. This was particularly evident when one of the remaining midwives went on leave:

...It made me very very tired, so I found it a big struggle to be on call and to be able to function, sixteen-hour labour hauls were just absolute hell, but I had to do them... .

Other midwives referred to unfair rostering, as a cause of resentment and distress. For one of the participants it was particularly upsetting, as she perceived the non-granting of the request to be uncaring, deliberate, and a continuation of the bullying behaviour that she was subject to.

I put in a request in my first week at the hospital for our anniversary [with four months notice]. The only request that I'd put in and when the roster came out I was actually

working. So I went to the midwife who does the rostering and she said if I wanted it off I would have to work night duty and finish that morning.

The midwife was affected by the preferential treatment given to other staff, and the pointed hostile treatment that she perceived that she received. Unable to see a way to remedy the situation, and feeling considerably apprehensive and stressed she felt unable to contemplate a full or long-term future in that institution as she recalls:

All the time my stress levels were running really high...I never went back fulltime in that unit...and in the end I just decided that I couldn't continue like this.

In order to take some care of herself she sought counseling, and made a decision to change her way of working, by returning to self-employed practice.

For another of the participants, the bullying did not stop when she resigned from her position and transferred to another area of work. She experienced continual problems with getting adequate staff for the area that she became responsible for and would experience repeated arguments about the need for satisfactory cover. Her perception was that she was held responsible for being unable to cope, and that made it very difficult to ask for help

Yeah and so she would argue about the need for satisfactory cover and try and make us cope without getting extra people in....

According to Hadikin & O'Driscoll (2000),

Bullying is often adopted as a gagging technique. In a department where staff are often bullied, and or being bullied, genuine concerns about staffing levels and/or

patient care can be effectively trivialized and sneered at (p. 26).

Seven of the twelve midwives resigned the jobs they held at the time of the horizontal violence as a means of trying to leave the experience behind. One midwife suffered constructive dismissal.

The following excerpt from a participant typifies the despondency of the midwives, where, resigning became the only viable option.

...I actually resigned, because I just felt no matter what, I couldn't carry on working in that position anymore, I couldn't see a way forward.

Summary

People who have been exposed to bullying frequently experience a loss of self-confidence and self esteem and are often convinced that they are to blame for the bullying. It leads to increased rates of sick leave, reduced effectiveness in the provision of care and increased costs for organizations who may have increased staff turnover (The Working Women's Centre of SA Inc, 1997). As a result of the experience of horizontal violence and subsequent bullying behaviour emotional and psychological effects were experienced by all the midwives in the present study and were distressing for them. The severity of the occurrence varied between midwives, but appeared related to the severity and extent of the incidence of the horizontal violence and consequent bullying behaviour.

In this chapter the main category, *hanging on: just trying to survive* has been supported by the five sub-categories those of, 'anger and defensiveness', 'reduced self-esteem', 'hurt and tearfulness' 'being separate' and 'trying to cope'. The subcategories are illustrated with participant's verbatim data.

Chapter Seven details the effects of the experience of horizontal violence on the provision of midwifery care by midwives, and how provision of that care for women was placed at risk.

Chapter 7

Providing Care under Stress: Creating Risk

Good staff relationships are essential for effective care (Symon, 1998).

Introduction

For midwives in this study ‘providing care under stress: creating risk’ was a consequence of the experience of horizontal violence. Providing midwifery care in situations that created risk developed as a result of the horizontal violence the midwives experienced, and affected the care that they were able to provide for the women for whom they were responsible. Midwives exposed themselves to situations of risk by intentionally practicing in isolation without the support of colleagues, as a form of self-protection from further opportunity for bullying, or unintentionally as a result of their unhappiness and isolation. As a result of their experience of horizontal violence, the midwives ability to talk with colleagues, discuss issues of concern with peers, refer for consultations, or ask for help was diminished, or on many instances non-existent and consequently compromised their ability to provide effective midwifery care.

In this chapter I discuss the main category, Providing care under stress: Creating risk and the five sub categories that emerged from the data and which together form the structure of the main category. The five sub categories are: Risk Creating for the Woman and the Midwife; Being isolated out; Trying to survive; Being undermined and finally Feeling Guilty.

Verbatim data were selected to illustrate the category and sub categories identified. The data show that elements of the categories presented in the two previous data chapters on the experience of horizontal violence by registered midwives cannot be separated from the effects of that experience on the provision of midwifery care. Some excerpts used in this chapter may be the same as those used to describe the experience of horizontal violence but the emphasis will be on their relevance to the provision of midwifery care.

Risk Creating for the Woman and the Midwife

One consequence of the fracturing of the relationships between midwives referred to in Chapter Four, resulted in a number of midwives providing midwifery care in isolation. Isolation in this instance meant that the midwives practiced without the support or assistance of colleagues and affected both employed and self-employed midwives. This created potential risks for both the woman and the midwife. For the midwife, these potential risks included their being prevented from using the most appropriate equipment, the lack of any opportunity for further study, a perception of not being liked, being treated 'like a pariah', having support withheld, a distinct lack of support particularly where the midwife was exhausted and constant undermining of the participant's practice. Two participants had a concern that the women they provided care for would be 'got at' (treated poorly) or unfairly treated in view of the fact that midwife was disliked or poorly thought of. Where the participants practiced without the support of colleagues and consequently felt unable to refer or consult, seek advice, obtain relief when exhausted, these situations potentially constituted a threat to the continued well-being of women and babies.

Colleagues acting as judge and jury on a midwife's practice without accurate knowledge of the details of the case when there had been an untoward outcome created a threat to safe practice by withholding adequate support or backup. Equally, where peers held on to preconceived ideas about the competence level of a practitioner, this constituted risk when support was withheld.

One participant's experience led her to believe that support from employed midwives was conditional on having had nothing go wrong in her practice.

If you do end up in front of Council [Nursing Council of New Zealand] as I did, once on a case of my own and involved with other cases, that you are often seen as a bit of a pariah for quite a long time afterwards. It takes a long

time to get back any sense of being supported... by other midwives.

Midwives are autonomous practitioners and as such are required to be accountable for their practice. However as Symon (1998) points out, there is a view that should a midwife be involved in a complaint or litigation 'then she would receive no support from colleagues at all' (Symon, 1998, p.97).

For another participant, the death of a baby after a birth caused opposition when she was appointed to a hospital midwifery position. Other midwives were unhappy with the prospect of the participant acting in a clinical midwifery role. At issue was the fact that she had supported a woman's decision about her preferred place of birth.

... One of the things that had happened... was a home birth and the baby actually died, and it was the only baby that I had ever lost... ...And given that this woman had had a previous caesarian section should I have actually birthed her at home at all... one midwife came to me and said that other midwives were talking openly about the circumstances around which the baby had died.

For another midwife getting a negative response when asking for help led to her working on her own.

If I feel that the [person] who I've asked has not been helpful, willingly helpful and [I've] felt [I am] supported by them, then I'm inclined not to ask for help and just do my own thing.

Another example of situations in which there is a perceived lack of support in spite of the midwife being extremely tired after providing midwifery care at a long drawn-out labour and birth is provided by the following quote.

There is also that dreadful business of, well if you've brought a woman in [from a planned homebirth] you can clean up after her, goes with the hand and glove thing of let's not help out.

Potentially these practice circumstances where support is withheld create risk for the woman. How the employed midwife chose to be involved in helping with the care of the woman or in supporting the self-employed midwife was crucial to the well-being of the midwives and in view of available support, that lessened or increased the potential risk for the woman.

For another participant the lack of a formal structure for the group practice she joined was a factor that impinged on getting support or relief from her group. The formation of the group was an extremely loose arrangement. The group existed theoretically to comply with a provision of the contract needed by each midwife to access the facilities of the local maternity hospital to have midwifery backup available.

...In this group there was nothing [no formal support structure] like that. You just joined the group full stop. So there was nothing, no expectations of what any of the people in the group expected was ever discussed.

Two participants talked of the risks that they felt they would be putting their clients in when they went to the hospital to birth. This, they felt was a direct result of the horizontal violence that they had experienced. Their main focus of concern was safety for the woman in her birthing experience.

One participant said:

...The opportunity for them to get at me [further harass me] through the women was a possibility, therefore I wouldn't put them at risk.

As a result of this probability, this participant felt that her work choices were restricted. Her overriding concern was that the women for whom she would be responsible would not be safe if she resumed self-employed practice. The midwife made a deliberate decision to work in another city as an employed midwife.

A second participant gave an account of how she was prevented from using the most suitable monitor and room for her client's needs. The woman had not felt her baby moving. The area set aside for monitoring was screened off, part of a large communally used room and highly inappropriate for a woman who may not have a live baby. The monitor the midwife wanted to use automatically picked up and recorded movements by the baby, whereas the monitor the midwife was required to use did not, and relied on the woman to push the button when she felt the baby move.

Stipulating that the midwife was not allowed to use the most appropriate equipment is an example of how a woman can be put at risk, or treated insensitively as a means of attacking the midwife and consequently creating risk and negatively influencing the care the woman received.

These are the sorts of things that have been happening to my clients. If it wasn't directly [aimed] at me it was through my clients at me. I've spoken with several other midwives who have all said 'our clients would never be treated like that'. I feel that I was actually putting women at risk by them having me as their midwife.

The objectionable and abusive way in which the midwife was spoken to led to a potential risk situation for the woman. The woman wanted to leave the hospital without the midwifery care that she required as reported by the midwife:

'I'm so sorry for getting you into trouble, I'll leave'.

For both these midwives the decision was made not to go back into self-employed practice, as they were not prepared to take the risk of having the care and safety of the women for whom they provided care compromised. Furthermore it was necessary for them to consider the degree of compromise to their ability to practice safely, for as Kirkham (2000) states, 'midwives also want to feel safe and able in their work' (p.227).

Both midwives returned to practice as hospital employed midwives. As a result of the experience of horizontal violence, one midwife described a resultant lack of confidence that influenced her ability to be woman focused in her practice. Circumstances that required her to advocate for, and support choices for care that women made became difficult. The following excerpt gives an example of her dilemma.

The only problems I have are things, and I haven't said anything to anybody but I was looking after a woman, I was helping her organize her birth plan,[and] she didn't want her membranes ruptured. The house surgeon came in and said "we have to rupture your membranes" and I said, "the woman's asked not to have them ruptured", she was having an induction and chugging along quite nicely. She [the house surgeon] reported to the registrar and he came in and said "I understand you don't want your membranes ruptured but my boss will be very angry with me if I don't rupture your membranes and you don't want me to be in trouble with my boss do you, so are you okay to do your membranes now?" She said "yes".

The participant stood by and felt absolutely distraught about her seeming inability to advocate to support the choice the woman had made when the Doctor was manipulating the woman. She linked her experience of horizontal violence at her previous workplace with her inability to advocate effectively for women at her new employment location. She was passionate about informed choice and consent and had previously been accused of giving ‘women too much information’, too much information being seen as a fault.

Being isolated Out.

Midwives who felt that they were not accepted or supported by colleagues, who felt that they were unfairly judged when their practice was considered to be ‘different’, who were unable to practice according to their own philosophy felt lonely and isolated. Feeling unable to communicate safely with peers was a situation that led to isolation in practice and the creation of risk for both the midwife participant and for the women.

Isolation occurred in two ways, as a result of the experience but was also used as a form of self-preservation by some participants in an effort to safeguard them against further exposure to horizontal violence.

...So I just try to slip in and out. I very rarely sit in the office. I sit in another room across from that. So I feel perhaps that I am ostracizing myself.

Talking about the experience of horizontal violence was particularly traumatic for one of the participants. She recalled how lonely and isolated she felt at the time, and how the experience incapacitated her by affecting her ability to be able to ask for help personally and professionally. Furthermore, because the participant felt so insecure, she was unable and unwilling to discuss the hostile situation that she found herself in with anyone at all.

It [the bullying] made me [feel] very isolated and it [the experience of horizontal violence] was incredibly isolating as well.

The loneliness and isolation that a person subject to the experience of being bullied feels is difficult to fully identify with and understand for those who have not been subjected to the experience and is well illustrated by Adams (1992), when she says:

Being bullied is an isolating experience. It tends not to be openly discussed in case this poses the risk of further ill treatment. Those who are the prime targets often feel ashamed to discuss it with colleagues because their professional credibility is being called into question

(Adams, 1992, p.34).

For another participant, being isolated in practice lessened the choices that were available to women for whom she was caring and impacted on the care she provided. This participant felt unable to consult with, or discuss other care options with peers or request relief for a break. In this instance the participant felt unable to communicate effectively with her colleagues and felt that she would have provided better care with the benefit of a short break, or if she had discussed with peers the advantage of using the birth pool.

And she was requesting an epidural and because I was in the hospital I feel I can't talk to 80% of the midwives. I work mostly on my own, and I feel if I'd been able to go out and just talk to the other midwives and gather my thoughts cause it had been quite a long birth for me as well... But I've found that when I'm working in the hospital scenario I become absolutely exhausted from being hyper vigilant about crossing everything twice, [double

checking] dotting all the i's twice, having eyes in the back of my head, because whatever I say is misconstrued.

Even more distressing for this participant was the silent treatment dispensed when she was slightly late for a duty, defined as a few minutes –no one spoke to her for the rest of the day. It appeared she was being punished for being late.

Patient allocation would be done and I would get most of the heavier clients.

For another participant, silence, as a result of fear of asking for information about the vast complexities encountered in a new job, was a response that she used to protect herself. The type of response that had been forthcoming by the person responsible for the bullying, that of showing the questioner up as inadequate, taught the participant that it was not safe to ask for information.

I think firstly it really slowed down my learning really, really badly because it made me afraid to ask for help and ask for information because...I'm someone who just asks freely. But at the beginning when I started asking for information I could see this look on people's faces, like concerned that I was inadequate. It took me a very short time to start trying not to ask for help. I had this feeling that when I came to the hospital, to practice meetings and to the homes of women that people looked at me, and were saying things about me-it was very nasty and very unnerving and it meant that when I felt like I wasn't coping with things I felt like I didn't have anyone to talk to because if I asked for help from the hospital or the [practice] I worked in, I was confirming I was inadequate.

The midwife was aware that she was being treated badly, but did not realize that, at the time she was targeted, and that one person was deliberately undermining her.

I'd gone in with a lot of unfounded confidence but it got knocked out of me within moments of being in the job. What I later concluded, but it took me about three months to realize it, was that the midwife I had taken over from had been undermining me.

This situation led to anxiety about her ability to 'ever do the job', a sense of isolation and involvement in preventable risky situations, for example not consulting, referring or obtaining suitable relief and support. To further protect herself the participant became extremely wary in her interactions with her colleagues. In fact this behaviour created further potential risk for both the participant and the women for whom she provided care. Choosing not to attend meetings resulted in her lacking relevant and possibly significant information with regard to women's care, a lack of opportunity to discuss issues that were concerning her, and potentially provided opportunity for the person behind the bullying to legitimize her behaviour.

...I started doing things like dodging meetings and avoiding people and trying not to be obvious, and obscuring things I'd done because I felt like I kind of went into defense mode, that if anyone could see what I was doing they'd find out what an utter failure I was.

For another participant continuing doubt exists about whether working in an isolated way contributed in any way to a stillbirth. The participant is left with a nagging doubt that if she had been able to work collaboratively and in a supportive midwifery group, events may have been different. The lack of a supportive environment and the way that the participant was feeling made it impossible for her to ask for help after the event. This

intensified her distress. Not only did she feel she couldn't ask for help within her group, she also felt she couldn't ask other midwifery colleagues for help and support.

I don't know but sometimes I wonder whether the events leading up to the stillbirth came about in some ways because I had become I was working very independently and in an isolated way and I wonder if I had been working more closely with people at that point whether that event may not have occurred...And in fact what I felt strongly was, that [what] I had learnt was that I had to carry on and make judgments for myself even though I was uncertain and so I don't know that and I would hate to try and blame that [stillbirth] on the person [responsible for the horizontal violence] because I don't, I don't [know].

Before the stillbirth occurred the midwife had been slowly recovering confidence in her ability to provide quality midwifery care. Her confidence was, as she described 'knocked out of me again' when the stillbirth happened. Even though the person responsible for the bullying resigned, the midwife still felt hesitant and uncertain about asking for help and support.

But I didn't use the support I needed then. I didn't use the support had at the hospital or the support [that was available elsewhere] and I think I didn't use them because it [the safety of asking for help] still felt really fragile and tentative.

Participants appeared to underestimate the effect the horizontal violence had on their health, and on their ability to provide safe midwifery care.

Trying to survive

The experience of horizontal violence impacted on the emotions of the participants and clearly affected their provision of care. Participants related how unhappy they felt in their work, about feeling incredibly lonely and isolated, about being angry over their treatment and the behaviour towards them, about the lack of support, about being embarrassed and above all how the impact of tiredness and stress affected their ability to provide good quality care.

One participant described how trying to provide midwifery care was compromised by the lack of support she received from midwives in her group. For this participant, the midwifery group practice in which she worked had a relief system that ensured that the midwife had an occasional rostered day off after being on call for a weekend. Although at first agreeing to provide relief a midwife then changed her mind and declined to provide the midwifery support and relief that the participant required.

...And so she had an argument with me in the corridor, she was yelling at me. I wasn't arguing back in the corridor. So I was very upset about that and made the decision right then that I was leaving the group, which looking back I had probably been toying with that decision for the previous year. I decided that was the last straw and I knew, I knew that I needed that day off if I was going to keep myself together, and of course I didn't get the day off and I didn't keep myself together, and I was pretty brassed about that ...I think that it really upset me, so of course I was all upset at work, which isn't the most pleasant thing anyway and knowing that you have to pull yourself together to look after this woman, it is really difficult when you're that upset...

The impact of the episode was twofold. The participant was an unhappy, angry and tired midwife who did not get the relief that she expected and needed, and made a decision to leave her practice group. That same midwife had to attempt to carry on providing midwifery care in a manner that did not disadvantage the woman.

... I guess I found I had to really make sure I didn't let the woman know I was pretty pissed off at being there because I wasn't happy about being there....

A practitioner who had to continue to provide midwifery care, and maintain a 'front' when providing the care when relief was denied, experienced particular personal difficulty. It required an immense amount of effort and energy to make sure that the woman was not aware of her desire to be 'anywhere but there [the labour ward]'.

You'd kind of pull yourself together to go in and see the woman and you'd get in there and do whatever you had to do and this woman was on Synto [Syntocinon] so in fact I did have to go in there regularly and she was on the CTG [cardiotocograph] and da da... then you'd come out and be all upset again, then you'd have to pull yourself together and you'd go in again....

A participant described how lack of relief in one area of practice compromised the care she was able to provide to other women for whom she was responsible.

I didn't [provide care] that's why there were great problems because I was just not available.

Another participant related how she kept increasing her workload to prove she was 'doing her share' in an attempt to try and prove that she was up to the job. Coupled with this she

worked on her days off and the combination of this and her heavy workload greatly increased her level of stress and tiredness.

I think I was very unhappy in my work and I think that affected how I dealt with the women- it did affect the care...it made me take on more than I was capable of handling. That was one thing and lots of time[s] when I should have referred and consulted, not with obstetricians, not at that level so much, but with colleagues, I should have asked people, I didn't and that was potentially dangerous. It made me take on too much altogether, because I was so conscious of trying to do all the work, being seen to do my share and not being seen to be inadequate, so I tried to take on more and more so I ended [up] feeling very overworked and stressed and tired and I would work on my days off.

Another participant associated her extreme tiredness with a lack of support from a group member who was reluctant to return to work after having time off.

...[she]wasn't prepared to start work as soon as she got back which I thought was a bit rank given that I had carried the group and was just about dead anyway.

She elaborates more fully on this by saying:

I had two women in labour at the same time and I called [on] two midwifery colleagues actually to come and give me a hand and they wouldn't come and I think it's at that point that I decided that I'd had a guts full of this thanks, and if they weren't prepared to help me out I made the

decision to leave the group very soon after that... yeah, they just weren't supportive... I was very angry and also very upset and at that point because I had been doing extra work [for colleagues] I was just trying to survive, like sleeping and eating and working. That's all I was doing. I guess I got very angry and I began to really hate midwifery, and I wanted to get out of it.

Overwork, feeling exhausted, significant health issues, lack of support and relief, constant stress, lack of access to conferences or study days in order to update knowledge, interference in the provision of care and being prevented from providing care, were factors that affected the care that participants in the study said they were able provide.

Being unsupported in their efforts to change poor midwifery practices or to gain encouragement and support for new practices was distinctly discouraging to a number of the participants in the present study. Two participants were, on occasions prevented from working in a midwifery role but were kept occupied with demeaning trivial non-midwifery jobs. Withholding information or the transfer of deliberately false information prevented some participants from giving quality care. In one circumstance a participant was prevented from having the opportunity to provide midwifery care, because of false information given to women about her practice status by another midwife.

Being undermined

Undermining with regard to issues of practice included belittling remarks, questioning of competency and failure to appreciate effort surfaced in the interviews with more than one participant.

The lack of orientation and support when new to an area, or commencing work in an unfamiliar area led to 'being set up to get it wrong'.

They never gave me enough information, like at the hospital I am familiar with we give Ranitidine [antacid] to a potential Caesar. Over there [overseas country where bullying occurred] every woman got Ranitidine and they didn't tell me that until I think I was in my third or fourth week. Oh they made me out to be a complete idiot...they didn't tell me about other things. They were only small things, general things but they made me out to be a complete wally [fool]. I said to one "well you come and have one day's orientation and then come and work somewhere you've never worked before with people you don't know and see how you go".

A participant described how women who were actively seeking to engage her services as a midwife, were prevented from contacting her by being given false information about her availability from a midwifery colleague. This included women for whom the participant had provided midwifery care in previous pregnancies.

...When I actually returned to self-employed practice [some time later] my former midwifery partner was still out there working as she had been right through and I found that women were apparently contacting her trying to get hold of me so that I could look after them for their pregnancy and she would tell them that I wasn't available, that I wasn't out in practice and of course the women would eventually come into the hospital [in labour] and quite often I would be there and they'd see me and, kind of like, the truth would be revealed.

Deliberate withholding of significant information, that is the new address of a client, had two consequences. It prevented the participant from providing midwifery care for her

client, and also placed the woman at risk. Passing on the relevant information in a way that was likely to cause the most embarrassment and distress to the participant was another deliberate ploy.

...And I'd say "I don't know where she's gone, I can't find her" and she [the person responsible for the horizontal violence] would say, "oh yeah she's just around the corner at [an address]. Like she always knew more about my women than I did and I'd find out later that someone had given her that message to tell me the address but she hadn't passed it on.

A participant was purposefully misled about the dates and times for meetings, classes and appointments which caused her to turn up late, not appear at all or arrive on the wrong day.

...I seemed to always get the timing of things wrong. There would be appointments made but the timings were wrong, there would be antenatal classes, which I would think were on the wrong day. One example was a [weekly] meeting I always came late for because I had been given the wrong time.

Missing meetings and antenatal classes resulted in the midwife not having current information about the women for whom she was responsible. Not arriving at the appointed time to carry out antenatal bookings or visits was a potential risk for women, and where it happened on more than one occasion lessened the chance for the midwife to get to know the woman.

So, not only did I get the sense of people thinking I wasn't coming up to scratch, but also I was not coming up to

scratch for myself...Even some of my clients were making comments about my lack of knowledge...

For one participant the experience of constantly being the one 'picked on' to go and help in another area was a common occurrence. Being required to move caused constant interruptions to the care that she was endeavoring to provide. It was embarrassing to be constantly explaining to women that 'she had to go' again. The constant moving to help out was very disruptive to her provision of quality care.

...if you [were] required in another department because they're busy, you are asked to go and help out, like we are here really [current employment] but it was always me, I was always the one who went even on my last day they sent me...On my last day I was the one that was told to go and help out in delivery even though there were other people there [with less work to do], a fact I resented.

What the midwife resented was her perception that she was being bullied, by always being the midwife made to move. While she acknowledged that there is a need to help out in busy areas, interrupting the care that she was attempting to give by being constantly shifted, prevented her efforts to provide quality care, limited her job satisfaction and meant women received inconsistent care.

Casting doubt on another practitioner's ability to provide care was detrimental to a participant trying to establish a relationship with a woman. In one example the hospital consultant had assumed responsibility for care from the self-employed midwife who had been the Lead Maternity Carer. Midwifery care was now the responsibility of the hospital employed midwife. The self-employed midwife was negative and unhelpful during her handover of care.

...And the undertones in her voice [and] little digs at the fact that the woman had to be taken over by a hospital midwife, she had to relinquish care to an inferior provider....

The outcome of this unsupportive transfer of care, carried out in front of the woman and her partner, was that a longer period of time was needed for the employed midwife to form a relationship with the woman. As a result the woman became extremely anxious.

... It took me a long time, much longer than I thought it should have... to establish a relationship or partnership with the woman. After all I thought we're not here to fight over patients [women], we are here to look after them.

For another participant blatant interference in the care she was trying to provide led to a decrease in the woman's confidence in her own ability to parent. Conflicting advice given by different practitioners is unhelpful to women who are tired and adjusting to being a mother.

...I would go in [after days off] and find she had contradicted everything I had said. She would say to the woman "oh did she tell you that, I wonder why she did that, oh no" so on the Monday the woman would be looking at me oddly.

By the time the participant had been working in her new role for several months she had established a rapport with the women for whom she was providing care. Later, those women repeated the relieving midwife's conversation.

The participant continued:

...So then I would go to her and say, "Why did you tell her that? If you think what I did was wrong come to me. You know this is a woman who is really unconfident. She doesn't need us to be squabbling through her. If you're not happy with my practice come and tell me".

For another of the participants it was interference in the way that she provided care that caused a problem particularly as she received no guidance on 'how it [bathing a baby] should be done'. Complete intolerance for new ideas or different but wholly safe ways of practice contributed to an oppressive work atmosphere.

I bathed a baby and up to today I don't know what I did wrong. I was called to the midwifery manager's office and told that I had shown a [small town] woman how to bath a baby, and I was told that babies in that area are bathed in a certain way and I was not to come here and introduce new methods, "and that was how it was to be".

For another participant, (a hospital midwife working in an extremely busy post-natal area) doing her utmost to provide appropriate care for a significant number of women and babies was made more difficult by inappropriate remarks made by another midwife. The participant related how she considered that she was doing the best she could allowing for the shortage of staff and the number of women and babies that she was responsible for. Trying to allocate time appropriate to each woman's needs was difficult, but she considered that her allocation of time and care was matched to the women's needs. The participant considered that the self-employed midwife, who criticized the care that she perceived her women were receiving, made her job even more difficult.

...I mean how can you look after eight people [women]. You can't, really, not properly...and I know if I am not providing good care and if I've got eight women I know

I'm not providing good care. But they're getting as good a care as they're going to get from anyone else... and you try and help eight women breastfeed all at the same time and look after new [caesarean] sections and stuff. You can't do it.

For another participant it was a husband who raised the issue of his wife's care being compromised by the action of the midwife responsible for the incident of horizontal violence. He hadn't shown any reaction at the time because of his concern about his wife, but had raised the issue with the participant during the post-natal time while his wife was in the ward.

...But in the postnatal period at home he talked to me about it and said how unhappy he'd been with the treatment that he felt was coming [my way], not in the caesarean theatre but outside of the [caesarean theatre]. He felt it impinged on his wife's care, the midwife's behaviour [towards me].

The participant felt that the couple was dissatisfied by the fact that she had not been assertive enough in her response to the midwife. It led to awareness that she had been unable to be an effective advocate for the woman for whom she provided care.

I don't feel I was always truly the woman's advocate in those times [when horizontal violence occurred]. I would crawl back into my shell and not speak up when that sort of thing happened.

For another participant deliberate and unprofessional undermining of the midwife-client relationship occurred when she re-entered self-employed practice.

...I decided to go into independent practice and build up another practice again. And that was fine until they all started to have their babies and I had to start going back into the hospital again. The [manager] would say to [the women] in front of me, "now is [participant] treating you well, now you be sure to come and let us know if you're not getting what you need"

Using a derisory tone, speaking in the third person, putting a person down at every chance, and casting doubt about their practice are deliberate bullying tactics and are both intimidating and undermining. Hadikin & O'Driscoll (2000) maintain that 'if these ploys are used in the presence of mothers then the reputation of the whole profession can suffer' (p. 95).

Another participant related how a lack of relief and support impacted on the care that she was able to provide. In this instance it impacted on the midwife being available to provide continuity of midwifery care for women.

...And what happened was because I had so many women and such a short space of time, I would do the labour care and she [another practitioner] would pick up the postnatal visits, which isn't optimal at all, and I had no idea how many women were due so it was trial by fire really.

The care provided was complicated by a lack of input into the antenatal care, and lack of information about the history of the women for whom care was to be provided. Trying to provide 'good' care when rushing between two rooms was a challenge, and resulted from a lack of relief.

I mean ideally I would [provide continuity of care], like there were two women so ideally they would have had a midwife each, so I guess yes it did affect their care. But I still think they didn't get bad care because I was able to whizz between the two rooms. It was me that was frazzled...Because I was trying to provide good care so therefore I was back and forward, back and forward to both of them, trying to provide that good care. So, yeah, it was me that suffered.

Other participants described instances of interference in the provision of the care. The following participant suffered interference and constant criticism when trying to provide woman focused care.

She [person responsible] didn't take the time to listen to concerns [about care issues] and practiced pointed interference [in my care]. She would constantly criticize my practice.

Aggressive behaviour towards the participant, and an insistence on hurrying for no apparent reason led to the woman feeling miserable and 'on edge' and the midwife feeling exhausted as she spent her energy trying to support the woman.

It took me a lot of reassurance and a lot of energy to reassure her, that we didn't need to rush [her choice over care] and I felt totally exhausted by the end of it- it impacted on how I could concentrate on providing care.

Another midwife also relates about the 'hurry factor'- how when she was the midwife at a birth in her local hospital there was always a sense of urgency to get the baby out and she recalls it being negative and undermining to her practice of midwifery. There was an

implied sense of a need 'to get a move on', which created a great deal of unnecessary pressure, as described in the following quote:

There is always a sense of "let's get that baby out, are you still there, haven't you delivered yet", comments like that, which come from other midwives and which I see as quite undermining and which are quite negative.

Interference in the establishment of breastfeeding and a lack of support for what the participant was trying to achieve proved extremely frustrating.

When women want to breastfeed this is so often undermined by others whose ideas may differ vastly...a midwife like myself who really wants women to breastfeed their babies and works really hard with them to breastfeed their babies, who constantly has to battle with the old ideas from people [other midwives] who feel that it is perfectly okay for babies to have bottles...and they say things like "well do you want to get up at two o'clock in the morning and come and help a woman breastfeed?" or "don't you think she [the mother] should have a good sleep at night and let the baby have a bottle?".

Undermining the participant's practice and negating all the work the participant had accomplished in the antenatal period was extremely disheartening, as was the following comment when the mother is feeling vulnerable and tired.

"There there dear, it won't make any difference, give the baby a bottle".

Another participant related how the withholding of information led to her feeling undermined and uninformed. She felt this might have affected the care that she provided by interfering in her concentration as she worried about the undermining while she was providing midwifery care. Not focusing on the care being provided was a potential cause of risk.

It may well have because I felt a bit uncomfortable, because I may have gone to thinking of what was happening [experience of being undermined] and not really concentrating on what I was doing.

One participant detailed how she was prevented from working in the area where she had had the most experience. Her belief was that this was because she was a direct entry midwife from another country.

...But when certain midwives were on I was just not allowed to work in the Delivery Suite. I mean that was the first thing, you know I just never got the chance to be with a labouring woman because that was considered higher work, so I was shunted to the postnatal ward.

For another participant, who was employed by the hospital, providing care for women at short notice who were not known to her, influenced the care she could provide. A lack of knowledge of previous labours, and of the woman's complex social and medical needs led to a less than optimum experience for the woman and the midwife. The woman had an exceptionally rapid labour. There was no time to call the self-employed midwife who was expecting to be present for support. This gave rise to an accusation that she had not been called 'on purpose' and led to her voicing her displeasure in front of the woman and her partner, the story recounted as follows by the participant:

The midwife arrived after the delivery and was not at all pleased that she [the woman] had an unpleasant delivery [rapid and with some complications] and she made that fairly obvious-but at that stage [the time of birth] we couldn't do anything about it. She [the midwife] sort of came in and stated, "I had requested to be called" and " I had requested to be here" "Oh well it's all over, I didn't know any of this was happening".

The case was discussed at an open forum some time later and used to highlight the fact that the difficulties may have been avoided if the primary Lead Maternity Carer had been present. There had been no previous attempt to discuss the labour complications, or why the self-employed midwife had not been notified.

The participant continued:

For a long time we employed midwives have felt second rate and looked down on by our independent colleagues. Not all of them, you can't say all of them, but some of them. They see us as medicalised midwives and doctors' handmaidens and "that we don't do the job properly".

Not mutually respecting the skills that each midwife, employed or self-employed has to offer leads to misunderstandings and it could be argued may contribute to poorer outcomes for women. Ongoing disagreement about the need to handover women's care, the way that handover is completed and the improper use of communication channels are issues that further complicate the change of care giver.

Feeling Guilty

Participants talked about feeling guilty over poor treatment that they perceived was experienced by women either when they were prevented from providing the care, or in the way women were treated as people. The participants discussed their own feelings of guilt over poor outcomes, and about 'being there' with little or no motivation for providing woman-focused care. Participants experienced the greatest concern when they felt unable to do anything, or felt unable to act as an advocate for the woman.

A participant who practiced as a self-employed midwife, describes a situation where a woman she was providing midwifery care for developed some complications and was admitted to the ante-natal ward for rest. It was agreed in a conversation with the obstetrician that the midwife would be present as the support person for the labour. The woman was transferred to the delivery suite for induction three days later. When she went to give care to the woman during the labour, the midwife found the atmosphere so hostile that she felt unable to stay. This was because she wasn't made welcome. She was spoken to in a most offensive manner and the point emphasized over and over that she 'couldn't really do anything'

...And what did I think I was doing just coming in and being around when she was in labour. It was awful...The woman was actually transferred to secondary care and I came in to be her support when she was in labour and I'd indicated that I'd like to be there to provide the care and to catch the baby and I wasn't asking for any fiscal reward for these endeavors but I wanted to be there. I'd been the midwife in that family for her mother and for this girl for some years and I wanted to be there specifically and the midwife that was on was so unpleasant about my being

there, that I felt that it was impossible for me to stay on. It really was impossible. I explained to the woman that I wouldn't be able to stay and I left the hospital- it would have been more difficult to stay.

The participant continued:

... Which was really quite awful and in fact what happened was that the whole birthing thing for that woman was just ghastly and I felt very guilty about having not been there just to support her, even though I'd sort of explained it, so yeah that's a difficulty.

What would have been beneficial for the care of the woman would have been an environment that was inclusive of the self employed midwife and recognized what she could contribute to the best possible outcome for the woman. Her prior information about the woman and her circumstances, both social and medical, may possibly have influenced the birth experience and outcome for the woman. It is appropriate and perfectly possible to facilitate inclusion of the original Lead Maternity Carer where this is the wish of the woman.

Another participant dwelt on the fact, that a woman for whom she provided care, and of whom she had little prior knowledge, had a third degree tear of her perineum at the birth of her baby. The circumstances of the birth were well managed despite the midwife having no prior knowledge of the woman, her complex medical history, and her previous rapid labours. In spite of this the participant felt a sense of guilt.

I felt awful about the third degree tear... but I did not have time to do an episiotomy -it was all so quick.

A sense of unreality about what was happening prevented one participant from taking a stand on the following incident that she describes:

And they also did things like, there was one room that was the postnatal ward and, not all midwives did that but some of them did. When certain midwives came on you knew there was a lot of work to be done with shifting beds and they just separated the married mothers from the not married mothers. They shifted them on one side of the room and the ones that weren't married went into the other sort of corner of the room. For me sometimes I couldn't believe, I knew it wasn't right you know I knew it wasn't right but sometimes I couldn't believe that this was really happening.

As she talked about this incident at the interview she pointed towards her heart and said almost tearfully “*I knew in my heart it wasn't right*”.

Another participant felt guilty about her inability to relate well to the women for whom she was responsible. A lack of motivation and concentration at work prevented her from providing woman-centred midwifery care. This she felt was a result of feeling incredibly anxious about her work situation, and the possibility of having to work alongside the person responsible for the horizontal violence that she had previously been subject to. She felt let down over her expectations of what her midwifery role would entail, and the terms of her employment contract. Because of financial commitments she felt trapped in her job and not in a position to seek other employment.

I was in a situation where I couldn't change for financial reasons. So it had the effect of making me very anxious at work, unable to relate well to the women.

For another participant the trauma of the ongoing experience of horizontal violence affected her level of tiredness, and her ability to be able to provide the type of care to women, that was a characteristic of the service that she worked in.

Well as I said it [the horizontal violence] made me very tired, so I found it a big struggle to be on call, and to be able to function. Sixteen-hour labour hauls were just absolute hell but I had to do them.

She felt at the time that her care of the women was 'fine', but that her self-care was abysmal. She self diagnosed clinical depression, and felt that retrospectively the experience of horizontal violence did affect the way she was able to provide care:

It just, possibly unless I'm absolutely a golden angel it probably did [affect the care of women]. I used to feel that I worked to the very best of my capacity and it was a huge sacrifice, the whole episode was a huge sacrifice to myself.

It was simply not possible for the participant to continue to provide continuity of midwifery care for women without adequate backup:

Whilst I worked to the best of my capacity in what I did, we stopped doing the continuity of care... Yes the mission for the [practice] was to provide 24-hour care for women with [complicated] pregnancies and that had to be abandoned because it was impossible to do that. Yeah so we had to abandon the promise that we'd made to look after these women in labour and that was a huge disappointment to those women because they came to us with the expectation that they would have us in labour and they had trusted us and we weren't there, and so they were looked after by

strangers in the end... And also my care [while on sick leave] was compromised because I was unable to actually ring up those women and say good bye. I could not work any more ... I was actually unable to have anything to do with those women.

When women were booked in the possibility was discussed that they may not get the 'primary midwife' but the expectation for this service was that the woman would know the midwife who would provide her care in labour. A sense of 'abandoning the promise' made to women and not fulfilling the 'trust' the women placed in the midwife to provide a known caregiver weighed heavily and was an ongoing cause of concern to the participant and impacted on her ability to recover.

As a result of her experience of perceived horizontal violence the participant was unable to actually 'close' her care or explain to the women about her inability to carry on. She felt unable to even explain to women the arrangements she had put in place to ensure that midwifery care was available.

Summary

In this chapter I considered the effects on the provision of midwifery care by midwives who had experienced horizontal violence under the main category, Providing Care under Stress: Creating Risk. The sub categories that emerged to support the main category were, Risk creating for the Woman and the Midwife, Being isolated out, Trying to Survive, Being Undermined and Feeling Guilty. The twelve midwives involved in the study, gave numerous examples of the way that the experience of horizontal violence had influenced the care they provided. In addition, ways in which some of the midwives were prevented from providing care, or inhibited from practicing according to their own philosophy are detailed.

Chapter Eight presents a discussion of the data findings presented in the Chapters four to seven.

Chapter 8

Discussion, conclusion and implications

Introduction

In the preceding four chapters I have presented the findings supported by verbatim data from the participants to illustrate their definition of horizontal violence. The two main categories related to the experience and consequences of horizontal violence, that of 'fractured relationships' and 'hanging on: just trying to survive', and the main category illustrating the effect on the provision of care by midwives, 'providing care under stress: creating risk' are also presented.

The findings detailing the experience and consequences of horizontal violence have elements of categories that cannot be separated from findings that illustrate the effect of the experience on the provision of midwifery care by the midwives. In each data chapter the emphasis has been placed where the relevance of the illustration seems most appropriate.

It is important to highlight the fact that the incidence of horizontal violence and consequent bullying behaviour in this study was not simply between employed and self-employed midwives but occurred between midwives irrespective of the area in which they preferred to practise.

In this chapter the categories in relation to the aims of the research are discussed. The chapter concludes with the implications for practice, research, education and management that are central to the findings of this study. Limitations of the study are also addressed.

Definition of horizontal violence

This study has been about the experience of horizontal violence as experienced by twelve midwives and the effects of that experience on their provision of midwifery care. The participants were asked at the outset to give their definition of the term horizontal violence. The findings from the first of the data chapters confirm that participants clearly understood the term, and each definition appeared closely related to their personal experience of horizontal violence. Although a definition of horizontal violence was included with the information sent to each intending participant not all had read it. Those who had, indicated that the definition confirmed their view but did not shape it.

The twelve participants identified common characteristics of their understanding of horizontal violence as being work related, perpetrated by peers and/or by a manager. The participants understanding is similar to characteristics that are identified by Thomas-Peter, 1997, The Working Women's Centre SA Inc. 1999 and Wilson, 2000) and of an emotional or verbal nature rather than a physical assault which is consistent with the literature by Farrell, (1997) and Hadikin & O'Driscoll (2000). Some midwives referred to subtle and insidious undermining of their practice by the use of sneering speech, social isolation and the use of body language to cause intimidation which is comparable with Adams (1992) and Hadikin & O'Driscoll, (2000). Several midwives raised the notion of intent as central to their experience (Randall, 1997; Blanton *et al*, 1998; Hadikin & O'Driscoll 2000) and a number of the midwives referred specifically to bullying behaviour (Adams, 1992; Randall, 1997; Spurgeon, 1997; Beck, 2000).

The experience of horizontal violence affected participants' ability to provide quality care for women. They spoke about being lonely and isolated in their work (Adams, 1992) about the lack of support both clinically and personally and the detrimental health effects they suffered (Adams, 1992; Field, 1996). The experience and resultant consequences of the experience are described more fully in the following section.

Fractured relationships

The second of the data chapters supported the main category 'fractured relationships', and appeared to identify the state of the relationship between midwives and between midwives and women as a result of the experience of horizontal violence. In many cases the relationship between midwives, and between the midwife and the woman continued but was drastically altered and impacted negatively on the care that could be provided. The changed nature of the relationship between the midwife and the woman was particularly significant when the horizontal violence had occurred in front of the woman. Here midwives sensed from women, a lack of trust and feelings of doubt about their level of competency to provide care as a result of the undermining of the relationship. The midwives consequently seemed to perceive that women were confused and uncertain about the right way to provide care for their baby. Where a changeover of caregiver was considered necessary (handover to secondary/tertiary care) and relationships between midwives were antagonistic, self-employed midwives also experienced a feeling of negation of all the relationship building that had occurred with the women during the antenatal period.

A number of employed midwives giving fragmented care related feeling undervalued by their colleagues who provided continuity of care. Central to a number of incidences of horizontal violence were differences in the philosophical approach to care that midwives held. Where midwives had given little thought to a research basis for the way they practiced they appeared to have difficulty accepting variations in the practices of other midwives, and this led to conflict. A reason put forward for incidents of horizontal violence was the departure of numbers of midwives from hospital midwifery practice that occurred when midwifery regained independence as a profession in New Zealand in 1990. Tension developed between midwives based around issues of payment, choice of practice setting and the perceived degree of autonomy the self-employed midwives have in their work setting (Hunter, 2000).

Hanging on: just trying to survive

Participants in this study experienced emotional, and/or psychological distress and/or physical ill health consistent with the literature by Adams (1992) and Field (1996). The significance of the effects appeared directly related to the severity and extent of the experience experienced by the midwives.

Equally significant in this study were the effects on family and/or personal relationships. Social and support systems were damaged and impacted on the midwives' ability to cope with the experience are supported by Quine (1999) and Bakker et al (1996). In order to cope midwives resorted to 'becoming defensive' within their practice in order to protect themselves, although this was seen as a self-limiting brake. Alternatively, they became 'angry' when the horizontal violence impacted on the care being provided to women, their practice was criticized unjustly, when emotional health was threatened, or when midwifery relief was denied.

Working in a defensive manner resulted in significant risk for the women and the midwife when meetings were avoided, peer support was not sought and issues of practice were obscured. Reduced self-esteem among the participants was a significant factor and impacted negatively on the ability of some of the participants to work effectively and to their capacity. They felt undervalued, were prevented from providing midwifery care but were occupied doing menial tasks, and were consistently undermined while providing care. Several of the participants 'took the blame' for the horizontal violence which is consistent with the literature (The Working Women's Centre, 1997; Hadikin & O'Driscoll, 2000).

Feeling hurt and becoming tearful were the responses of several participants. Several described crying every day as they struggled to live through the experience. Another participant only managed 'to keep it together' by having frequent cigarette breaks. Participants gave an impression of feeling separate and alienated by having to work in unfriendly, at times openly hostile environments where they were the subject of gossip or

ignored, were refused support, where their practice was undermined or judged unfairly, or where on occasions they were singled out for unfair treatment or subjected to prejudice.

Several participants felt separated from their normal support system as a result of overwork, ill health, sleep deprivation and extended periods on call. Although trying to cope four midwives suffered ill health that required time off work, while all experienced a number of the following symptoms: feeling stressed or burnt out, lacking energy and motivation, feeling tired, worn out from being hyper-vigilant, frazzled, feeling unable to cope with the job and for one midwife, a fear of coming to work. As well, poor sleeping patterns and severe weight loss affected two participants. The experience of horizontal violence resulted in eight of the twelve midwives changing the positions they held at the time of the incident, seven resigning and one suffering constructive dismissal. These health effects had an impact on the care they provided or wanted to provide thus increasing risk for themselves as well as their clients. The impact is discussed in the following section in relation to relevant literature.

Providing care under stress: creating risk

Practising in isolation without the support of colleagues either intentionally to protect themselves from further bullying, or unintentionally as a result of their unhappiness and isolation, exposed both women and midwives to situations of potential risk. The risk was a direct effect of the midwife experiencing horizontal violence and impacted on her ability to discuss areas of concern with colleagues or refer for consultations when they were unsure. Failure to request help, or situations where help and support was denied or provided conditionally, further compromised the capacity of the midwife to provide effective and safe midwifery care and lessened choices for women. Risk was also a factor where midwives considered that if they continued to work in a self-employed capacity the women they were providing care for would be disadvantaged when they went to hospital to birth. One participant was prevented from using the most appropriate equipment available and considered that her practice was put at risk. Participants related that they lost

confidence in their ability and were unable to advocate and support women's choice particularly where intervention was promoted.

Participants, who felt that they were not accepted or supported by colleagues because they practiced differently, felt lonely and isolated. Some practitioners were unable to communicate safely or effectively with peers. Tingle (1997) suggests that poor communication leads to an increase in complaints and litigation, a hypothesis that could be tested in a future study. The lack of communication also contributed to isolation in practice, consistent with literature by Adams (1992) and Hadikin & O'Driscoll, 2000) and to preventable risk situations. By not attending meetings a participant lacked relevant and current information, and for some participants being denied access to ongoing education also contributed to a lack of current knowledge in regard to midwifery care. Aslam, (1999) reminds us that 'information is essential if risks and opportunities are to be successfully identified' (p.43). Remaining isolated from peers was a deliberate action by some of the midwives as they attempted to shield themselves from further bullying. Being bullied was an isolating and embarrassing experience and several midwives found they were unable to discuss the experience with anyone at all. Being ridiculed when asking for information necessary in a new job quickly taught one participant that it was unsafe to ask for help.

Lack of midwifery relief and support resulted in midwives, who were tired, stressed, overworked, unhappy and angry, but who had to maintain 'a front', and carry on providing care for women. Suffering from significant health issues, constant stress, being prevented from updating skills and knowledge, interference in or being prevented from providing midwifery care were factors that affected the care that participants were able to provide. A lack of orientation to a new job and environment, withholding of information, and constant interruptions when providing care resulted in inconsistent care being provided to women by the midwife participants.

Being undermined in regard to issues of practice or competency, in particular where this occurred in front of the woman was damaging to participants attempting to form a relationship with women, and caused unnecessary anxiety for women. A lack of mutual

respect for the skills and knowledge each midwife has to offer especially where there is a need to transfer to another care provider may compromise women's care and create risk. Participants discussed feeling guilty over perceived poor treatment that women received, or self-guilt when the midwife felt unable to act as the woman's advocate or remain to provide care.

Much of the literature about risk management in midwifery relates to the care that women are offered or receive, and is aimed at minimizing or reducing adverse outcomes for women and babies (Aslam, 1999; Thomas, 1999; Royal College of Midwives, 2000). Risk management may be described as an approach aimed at identifying and reducing both the likelihood of error occurring and the impact of error when it does occur.

Williams (1997) emphasizes that midwives need to be proactive about risk management. She raises the concept of direct risks 'categorised as those inherent to a particular pregnancy' (p.58). The idea of indirect risk that relates to issues around staffing levels, resources, communication, the practice of individual midwives, friction and the risk to women and midwives where midwives are tired through lack of sleep. From this study the lack of support could also be considered to constitute an indirect risk.

Responsibility of Employers

Although midwives in this study practiced either in a self-employed or employed capacity, a number of the incidences of horizontal violence and bullying behaviour occurred within institutions. It therefore seemed appropriate to consider the responsibility of employers concerning employees and workplaces. The evidence obtained in this study indicated that bullying behaviour was not simply between employed and self-employed midwives but involved midwives who were self-employed and worked in partnerships or groups.

Bullying seems to occur more often in areas that have a definite chain of command, 'where you do as you are told and that's it' (Field, 2001 cited in Dempster, p.7). Field (2001) also contends that there are occupations with perceived higher levels of bullying,

namely education, the hospitality industry and emergency and medical nursing. A lack of understanding of what constitutes horizontal violence and bullying behaviour may offer an explanation for why the behaviour continues. One senior nursing manager's understanding of what constitutes bullying confirms a lack of knowledge. She considers there is not a bullying problem among her staff, but that horizontal violence defined by her as 'seniors expecting too much of new graduates is widespread' (Johnston, 2000, p. A3); that is, bullying behaviour. All staff have the right to expect to be treated with respect, and acknowledged as intelligent, capable and worthy of fair treatment according to Caldwell (1996), who is a director of midwifery services and midwife supervisor.

In Britain two senior midwives have been dismissed as a result of a yearlong investigation into allegations of bullying and harassment, while seven other staff members have been required to complete additional training, with five midwives being issued with written warnings (Hall, 2001) in relation to allegations of bullying.

Employers have a responsibility to protect employees from violent behaviour, which must be considered in the same way as any workplace hazard (Rowbotham, 1996). In New Zealand, The Health and Safety in Employment Act 1992 (New Zealand Government, 1992) passed by the New Zealand Parliament, protects the 'health and safety of employees, and other people at work or affected by the work of other people' (p. 2). Where I practise as a midwife, a stated policy to manage aggression, violence and security emergencies has been initiated:

To provide a safe working environment for staff and patients of [site] via prevention, early detection and effective management of incidents and post incident sequelae of aggression, violence or security emergencies (Berry, 2000, p.1).

Covered under this policy are incidents that involve verbal, physical and/or psychological abuse. Both the Act and the policy remind employees of their responsibility to make

certain that their actions or inactions do not cause harm to either themselves or anyone else within the work environment as staff are all responsible for their own behaviour. For the policy to be effective, the issue of horizontal violence and bullying must be acknowledged, staff must feel listened to and supported, and complaints must be investigated. Bullying is a form of violence that employers have a responsibility to stop.

Limitations of this Study

This research has been a small qualitative study undertaken with twelve participants within a 250-mile radius of one major New Zealand city. The findings revealed as a result of this study while important, cannot without further study be confirmed as the experience of a large proportion of New Zealand midwives, therefore this study is unable to be generalized to the remainder of the New Zealand midwifery workforce.

A further limitation of the study is acknowledged in recognition of the fact that the participants are a self-selected group; all considered that they had experienced horizontal violence and consequent bullying behaviour, and may therefore be seen to be a biased group.

Further constraints in relation to the size of the study were due to the time limitations required by the university for the completion of a masters thesis.

The term horizontal violence narrows the subject down and may well prevent further exploration of the wider picture of workplace violence within the midwifery workforce.

An exploration of oppression in terms of being an explanation or excuse for horizontal violence, or the results of that phenomenon, recognizable, as bullying behaviour has not been undertaken.

Acknowledgement

The researcher acknowledges that the people held responsible for the bullying and horizontal violence that is the subject of this study, have had no opportunity to answer the accusation. It is likely that the issue has never been raised with them, as a number of the participants taking part in the study indicated that this was the first time they had felt safe enough to disclose and discuss the experience. My interest was in the experience of the horizontal violence as the participants perceived it, and so no effort was made to validate the stories with the perpetrators or other witnesses. The midwives stories were accepted as they were told.

Implications for Practice

In this study eight of the twelve midwives left the midwifery position they were in when they were subjected to the experience of horizontal violence and consequent bullying behaviour. Through my experience of conducting this small research study I am of the view that:

- Horizontal violence and bullying behaviour in the clinical setting create significant risk factors for women and midwives.
- Policies and procedures that comprehensively address the issue of horizontal violence and workplace bullying must be in all facilities in which midwives provide care and women give birth.
- Midwives in independent practice working in groups need to document a commitment to zero tolerance of horizontal violence within their group, practices.
- The possibility of women not wanting to enter or remain in the profession of midwifery must be acknowledged, as must the impact on midwifery care for women if that situation arises.

Implications for Midwifery Education

Workforce planning is required to determine the number of midwives necessary for midwives to work with sustainable workloads that afford women continuity of care but acknowledge that the majority of midwives are women and part of extended family relationships with other commitments. Midwives in the study irrespective of the area in which they chose to practise were overworked. In addition:

- Communication skills coaching ought to be recognized as an essential component of a midwifery education programme.
- Assertiveness training must be included within any midwifery education programme.
- An education programme that aims to increase the level of awareness of horizontal violence and bullying behaviour should be mandatory within any midwifery education syllabus.
- Reporting of any horizontal violence as a student midwife to a mentor or peer is to be encouraged.

Implications for Future Research

This study was of necessity only a small sample of the current New Zealand midwifery workforce therefore:

- A study about the experience of midwives of horizontal violence and bullying behaviour that considers, and is representative of, a larger section of the New Zealand midwifery workforce is necessary.
- A replication in New Zealand, of the quantitative survey sent to a randomly selected cross-section of Royal College of Midwives members and carried out by

the Royal College of Midwives in Great Britain would be useful to determine the extent of horizontal violence and bullying within the midwifery workforce (Hadikin & O'Driscoll, 2000).

- A study is necessary to determine whether there is any evidence that women who are receiving midwifery care are bullied.
- A study within hospital facilities to assess the current knowledge base and possible extent of employees with regard to the issues of horizontal violence and bullying behaviour could be undertaken.
- A study is necessary to test the hypothesis that 'poor communication leads to an increase in litigation and complaints'.
- A study that looks specifically at the effects of horizontal violence on the provision of midwifery care and the potential risks that result for women, babies and midwives.

Implications for management

The responsibility for maintaining a safe working environment rests with management. Risk management is a course of action for identifying, assessing and evaluating risks, which will adversely affect the safety, quality and delivery of safe and effective health care.

- Development of, and enforcement of a policy that indicates a zero tolerance of horizontal violence or bullying behaviour for all staff.

Conclusion

Horizontal violence that resulted in bullying behaviour was an important issue for the midwives in this study. Midwives who took part in this study were personally and professionally affected by the experience of horizontal violence and consequent bullying behaviour. There was an important effect on the relationship between midwives, between midwives and women and on the provision of care for women with some of those effects lasting a considerable time.

Horizontal violence and consequent bullying behaviours are costly to employers and the midwifery profession. Practicing in isolation causes potential risk to midwifery care for women as a result of the midwives coping strategy to survive the experience. This study, although small has shown that the experience affects midwives, women and families and friends and associates of the midwife being bullied.

People perceive the world around them differently and are influenced by factors and circumstances that cause situations to be unique (Siddiqui, 1999), how else do we explain gestures and swearing that some may find offensive or threatening, and which for other people are a normal everyday way of expressing themselves (Rowbotham, 1996).

Researching this subject heightened my awareness of the language, tone of voice and everyday behaviour that I used in conversation and work interactions with peers. It made me acutely aware of the need for fair and transparent policies with regard to the management of disciplinary procedures and the importance of treating people fairly and equitably. As well it has increased my awareness of the need to acknowledge and deal promptly with any situation where interaction has been less than ideal.

A deliberate decision by midwives to improve their attitude towards any interaction with users of our unit has impacted positively on the atmosphere we work in. We have made an extra effort to 'consider the other' in our daily communication and in our working relationship with peers and this behaviour has contributed to a safer environment for midwives and birthing women.

It is time for change. Time for each of us to examine our behaviour and our aspirations: to ask ourselves whether we are part of the problem or part of the solution

Hastie, 1995, p.8.

Postscript

'That's just crap-absolute crap-it's just a new vogue way of not being able to correct people'. This was one remark I received when asked about the subject of my study. The *raison d'être* for this study was to listen to the story brought by each participant to the interview. My interest lay in their perception of the experience they had endured and the effect that experience had on the midwifery care they were able to provide.

I acknowledge the complexity of the feelings I experienced when listening to participants talking about their experiences, an overwhelming sense of sadness that midwives subjected one another to bullying behaviour was foremost. I felt uneasy at the beginning of the study, around whether the topic would be considered real, of interest and if midwives would be prepared to take part. I was not prepared for the impact that listening to and replaying tapes and reading and re-reading the transcripts would have. I was in tears while listening to some of the more harrowing of the stories on tape and found that I had difficulty sleeping if I worked on my thesis late into the evening.

Carrying out the interviews was a very humbling experience. It was a privilege to be trusted with the information from the participants who in some cases had not previously disclosed or discussed the experience with anyone else. The participants appeared to be at ease with me and were willing to share their experiences despite the emotions that surfaced in varying degrees for nearly all the participants.

Issues including a family death, personal ill health, a partner out of work, a lack of self confidence in midwifery skills, low self esteem, taking on new jobs/roles and a perception of not being liked may have impacted on and intensified the experience of horizontal violence for some of the participants in this study. Other issues that may have contributed to or exacerbated the bullying, included non-advertisement of vacancies and paying increased rates of pay and allowances to certain staff, but not to others.

Talking about this research project on one occasion caused me to be subjected to an experience of horizontal violence. As well as a result of carrying out this research project I have also been accused of being responsible for horizontal violence in relation to an incident that happened eight years ago and of which I was unaware. I have endeavored to deal with both these incidents in a way that facilitated resolution and healing for all involved.

In spite of the challenges that arose for the participants as a result of carrying out this research project, no participant regretted taking part in the study. Although a small study I believe it raises the problem of horizontal violence and consequent bullying behaviour that may be affecting the working life of other midwives and consequently adversely affecting midwifery care for women.

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Appendix A

Advertisement Midwifery Research

ADVERTISEMENT:

MIDWIFERY RESEARCH

I am a registered midwife carrying out research as part of the requirement for my Masters degree in midwifery at Massey University, Palmerston North. I am currently employed as the Team Leader in Delivery Suite at Wellington Women's Hospital.

The aim of this study is to explore one factor that may inhibit good collegial relations within the midwifery profession in New Zealand, that of horizontal violence. The working title of the proposed research is: The effects of the experience of horizontal violence on the provision of midwifery care by (a number) of midwives practicing in New Zealand.

Blanton, Lybecker & Spring (1998) define horizontal violence as ...harmful behaviour, via attitudes, actions, words, and other behaviors that is directed to us by another colleague. Horizontal violence controls, humiliates, denigrates or injures the dignity of another. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights (p. 1).

I would like to explore this topic by conducting one or two semi-structured interviews with each participant. These interviews will be audio taped. Ethical approval for this study has been granted by the Wellington Ethics Committee, Manawatu Whanganui Ethics Committee and the Massey University Ethics Committee

If you would like more information about this proposed research or are interested in participating, please telephone me at either of the numbers below.

Frances McIver: 043855999, pager: 6850(daytime) or 025-2486867.

Appendix B

Information sheet for midwives

APPENDIX B

INFORMATION SHEET FOR MIDWIVES

THE EFFECTS OF THE EXPERIENCE OF HORIZONTAL VIOLENCE ON THE PROVISION OF MIDWIFERY CARE BY MIDWIVES.

My name is Frances McIver. I may be contacted by ringing 04-3855999, pager no. 6850 or 025-2486867. I am conducting a research project to produce a thesis as part of the Masters of Arts (Midwifery) at Massey University, Palmerston North. I am currently employed as the Team Leader in Delivery Suite at Wellington Women's Hospital.

My research supervisor is: Dr. Cheryl Benn, who may be contacted at the School of Health Sciences, at Massey University, Phone: 06 3505799 x 2543.

This proposed study has been granted ethical approval to proceed by the following Ethics Committee's, Massey University, Wellington and Manawatu Whanganui.

This study is being conducted to explore one factor that may inhibit good collegial relations within the midwifery profession in New Zealand. I wish to explore the experience of horizontal violence of midwives practicing in New Zealand and the effects of that experience on their provision of midwifery care. I wish to interview midwives who are employed within a maternity unit, and independent midwives who have access contracts to their local maternity unit, who have any experience of horizontal violence within the midwifery profession.

Blanton, Lybecker & Spring (1998) define horizontal violence as

...harmful behaviour, via attitudes, actions words, and other behaviors that is directed towards us by another colleague. Horizontal violence controls, humiliates, denigrates or injures the dignity of another. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights (p. 1).

You are invited to participate in this study. If you agree you will be expected to participate in two one to two hour audio-taped interviews. You will be invited to select a pseudonym to ensure that your name will not be linked to the data. The transcriber will sign a confidentiality agreement. My research supervisor and possibly my examiners will have access to the tapes and typed transcripts but will only be

aware of the pseudonym and not your real name. After the first interview has been completed and subsequently transcribed and the initial data analysis carried out, I will, with your permission arrange a second interview to discuss the transcript and any other questions that have arisen after the first interview after which further data analysis will occur. You will be given an opportunity to review the transcript of your interview and to amend or remove any details or information that you do not wish to have included

I will write a report of the findings, which will be assessed by my supervisor and two examiners. The findings of the report may be published in professional journals, and may be presented at conferences. A summary of the findings will be made available to you. A copy of the completed thesis will be available in the Massey University Library.

As a participant you have the right:

- To decline to participate;
- To refuse to answer any particular questions and to have the audio tape turned off at your request;
- To withdraw from the study and have all data destroyed before you return the transcript to the researcher for analysis
- To ask any questions about the study at any time during participation;
- To provide information on the understanding that your name or other identifying information will not be used unless you give permission to the researcher;
- To be given access to a summary of the findings of the study when it is completed;

If you are interested in being a participant in this study, please contact me on the telephone number provided. I will send you a consent form, which we will sign prior to the commencement of the first interview.

Thank you for considering this invitation,
Yours sincerely,

Frances McIver
RGON, RM, ADN, BN, Masters of Arts (Midwifery) student, Massey University.

Appendix C

Consent Form

APPENDIX C

CONSENT FORM.

THE EFFECTS OF THE EXPERIENCE OF HORIZONTAL VIOLENCE ON THE PROVISION OF MIDWIFERY CARE BY MIDWIVES.

Consent Form:

I have read the information sheet about this study. Questions I have asked, have been answered to my satisfaction by Frances McIver. As a participant I have the right :

- To decline to participate;
- To refuse to answer any particular questions and to have the audio tape turned off at my request;
- To withdraw from the study and have all data destroyed before the transcript is returned to the researcher for analysis;
- To ask any questions about the study at any time during participation;
- To provide information on the understanding that my name or other identifying information will not be used unless I give my permission to the researcher;
- To be given access to a summary of the findings of the study when it is completed;

I understand that my participation is voluntary and may require up to two hours of my time on at least two separate occasions. I am aware that my identity will remain confidential and information gathered will be securely stored. I am also aware that the researcher will use the services of a transcriber but that she will be bound by a confidentiality agreement.

Should issues arise that may cause me to become uneasy or distressed, I am at liberty to contact the researcher, Frances McIver, her supervisor Dr. Cheryl Benn or the Ethics Committee at Massey University, Wellington Ethics Committee or the Manawatu- Whanganui Ethics Committee on: 06 356773.

I agree to participate in this study under the conditions set out in the information sheet.

I agree to have the interview audiotaped: yes / no.

Name of participant:

Name of Researcher:

Signature of participant:

Signature of Researcher:

Appendix D

Confidentiality agreement form for the transcribing typist

APPENDIX D

CONFIDENTIALITY AGREEMENT FORM FOR THE
TRANSCRIBING TYPIST.THE EFFECTS OF THE EXPERIENCE OF HORIZONTAL
VIOLENCE ON THE PROVISION OF MIDWIFERY CARE
BY MIDWIVES.

I.....of.....agree not to divulge any information that I may become aware of in the course of my employment while transcribing audio-tapes for Frances Kathleen Melver. I will not keep any copies of the audiotapes, transcripts or computer discs or any of the data on the hard drive of my computer. I also agree to store the audiotapes, transcripts and discs securely while they are in my possession.

Name of transcriber:

Name of witness:

Signature of transcriber:

Signature of witness:

Date:

Appendix E

Ethic committee approval letters

Massey University Human Ethics Committee
Room 2.02, Main Building, Turitea
http://www.massey.ac.nz/~muhec

Telephone: 64 6 350 5249
Fax: 64 6 350 5622
Email: S.V.Rumball@massey.ac.nz



Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

27 June 2000

Ms Frances K McIver
PG Student
Health Sciences
TURITEA

Dear Frances

**Re: Human Ethics PN Protocol – 00/74
The effects of the experience of horizontal violence on the provision of
midwifery care by midwives**

Thank you for the above protocol that was received and considered by the Massey University Human Ethics Committee: Palmerston North at their meeting held on Tuesday 13 June 2000.

The protocol was unconditionally approved with the following suggestion:

Consent Form

- bullet point Participants statement of rights for increased clarity.

The ethics of the protocol are approved.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Human Ethics Committee for further consideration and approval.

Yours sincerely

A handwritten signature in cursive script that reads "Sylvia Rumball".

Professor Sylvia V Rumball, Chair
Massey University Human Ethics Committee: Palmerston North

cc Associate Professor Cheryl A Benn
Health Sciences
TURITEA

Wellington Ethics Committee

Room 425, Fourth Floor
Community & Support Services
Wellington Hospital
Private Bag 7902
Wellington South
Phone (04) 385 5999 ext. 5185
Fax (04) 385 5840
Email: sharonmc@wec.org.nz

19 July 2000

Our Ref: 00/07/081

Please include the reference number and study title in all correspondence.

Ms Frances McIver
12 Marina Grove
LOWER HUTT

Dear Frances

00/07/081 The effects of the experience of horizontal violence on the provision of midwifery care by midwives

The above study was considered by the Wellington Ethics Committee at its meeting of 11 July 2000.

The discussion of the Committee centred on the term "horizontal violence". For most of the Committee this was a new term, although the Chair had discussed it with some nurses and it appears that it is a term that is understood by both nurses and midwives. The Committee was anxious to be reassured that midwives would know what was meant by the term "horizontal violence" as it could be interpreted as a somewhat pejorative or emotional term. However we have been reassured on this issue.

In the information sheet however you should omit the title "13 Appendix A Information for intending participants."

The Committee also wished to commend you for the very sensitive way in which you inform participants about their rights, especially with respect to participation, reviewing transcripts and tapes and any rights of withdrawal.

Ethical approval for this study is granted by the Chairperson under delegated authority from the Wellington Ethics Committee. It is a condition of Ethics Committee approval that you provide a brief progress report no later than July 2001 and at the completion of the study a copy of any report/publication for the Committee's records. Please notify the Committee if the study is abandoned or changed in any way.

We hope your research goes well.

Yours sincerely



 Sharron Cole
CHAIRPERSON

20th July 2000

Manawatu Whanganui Ethics Committee

Ms Frances McIver
12 Marina Grove
LOWER HUTT

C/- Palmerston North Hospital
P.O. Box 5203
Palmerston North
Phone/Fax (06) 356 7773
Email: mwethics@xtra.co.nz

Dear Ms McIver,

THE EFFECTS OF THE EXPERIENCE OF HORIZONTAL VIOLENCE ON THE PROVISION OF MIDWIFERY CARE BY MIDWIVES

REGISTER: 32/00

The above application for ethical approval was reviewed at the committee's meeting on 17th July 2000. The committee raised the following concerns and have made a number of requests for amendments.

1. The term "horizontal violence" may not be familiar to all participants. A definition of horizontal violence should appear in the information sheet. The first question in the study should also ask at the outset "what do you understand by the term "horizontal violence". Participants' understanding of the term may have a significant bearing on the answers they provide.
2. The limitation of a self selected sample should be acknowledged in the study report.
3. Point 4.1 - Study Design. Consent for the audiotaping must be obtained from the participants prior to proceeding - this must be clearly provided for in the consent form.
4. The issue of confidentiality was of some concern - both confidentiality in terms of specific incidents which may be discussed during the interview and the need for support people to maintain confidentiality. Both issues need to be stressed to participants prior to the interview commencing.
5. A statement in relation to Ethics Committee approval should appear in the information sheet in order that participants are aware that the study has been approved.

Your response to the above points will be fast tracked when received.

Yours sincerely,



Jenny Maher
Chairperson

c.c. Wellington Ethics Committee
c.c. Dr. Cheryl Benn, Supervisor, Massey University

Manawatu Whanganui Ethics Committee

C/- Palmerston North Hospital
P.O. Box 5203
Palmerston North
Phone/Fax (06) 356 7773
Email: mwethics@xtra.co.nz

9th August 2000

Ms Frances McIver
12 Marina Grove
LOWER HUTT

Dear Ms McIver

**THE EFFECTS OF THE EXPERIENCE OF HORIZONTAL VIOLENCE ON
THE PROVISION OF MIDWIFERY CARE BY MIDWIVES
ETHICS REGISTER: 32/00**

Thank you for the prompt response in relation to queries raised by the committee.

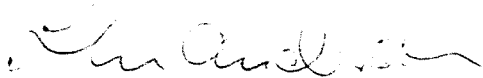
I am pleased to advise you that the Manawatu-Whanganui Ethics Committee gives full ethical approval for your study to commence in the Manawatu-Whanganui area, subject to a yes/no option on the Consent Form in relation to audiotaping.

The Ethics Committee makes decisions on ethical issues only. Please note, this ethical approval for the Manawatu-Whanganui area is for the period of the study only.

Ethical approval is conditional upon the Ethics Committee receiving a final report at the completion of the study and a copy of any publications. Your final report will be due by March 2002.

Please notify us if your study is abandoned or the protocol is changed in any way.

Yours faithfully,



Jenny Maher
Chairperson

c.c. Dr. Cheryl Benn, Supervisor, Massey University.