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**TRAUMA, RELATIONAL TRUST AND THE
EFFECTS ON THE MIDWIFE**

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Abstract

This qualitative thesis uses a method of narrative research to explore the effects of a traumatic practice experience on the 16 midwives interviewed for this project. It is an investigation of relationships at play influenced by power games and their consequences creating conflict. The issues of partnership and autonomous midwifery practice are the key drivers that make New Zealand midwives more likely to be blamed and their competence in practice challenged. Partnership negates domination for collaboration and as a result challenges the beliefs of the dominant groups of medicine and management. Midwives questioned why when they had coped with similar situations in the past was this incident ‘the straw that broke the camels back’. The investigation uncovers that the trauma experienced was prolonged due to a breakdown of relational trust in organisations, management, colleagues, women and self. The breach of trust altered the meaning of the traumatic event for the midwives which impacted on their personal and professional identities creating biographical disruption and exacerbating the initial stress reaction. Loss of personal and professional identities elicited grief which in most cases was disenfranchised and therefore not supported. Grief associated with maternal death was supported. As a result of the increase of emotional stress some of the midwives suffered illness such as anxiety, post traumatic stress disorder and chronic back pain implying that the aetiology of the disease could be emotions. These illnesses experienced by the midwives contributed to workforce attrition.

Midwifery has an oral history whereby relationships are built and experiences shared, making narrative research an ideal method for this personal topic. The analysis of the study data draws upon the narrative concepts of Margaret Somers (1994), Arthur Frank (2005) and Davis and Harre (1990) and Bourdieu (1982) *theory of economic practice* to facilitate an understanding of the effects of these traumatic practice experiences for the midwife participants. Midwives in New Zealand are legally required to provide care to childbearing women using a partnership model of care based on trust and mutual respect (MCNZ,2004). Consideration was given to the influence of the model on the effects experienced by

the midwives. Substantive chapters explore the effects of biographical disruption, grief, support, violence in the workplace, destroyed relationships and disrupted lives, trust and dysfunctional organisations.

In the text gathered from this study I have developed two theoretical models; one explains how the trauma is exacerbated rather than supported; the other outlines the effects of the trauma. The study adds to the literature by providing evidence that biographical disruption occurring as a result of a traumatic practice experience can lead to a chronic illness. My research has addressed gaps in midwifery, biographical disruption, grief, workplace violence and trauma literature.

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Chapter One

We are all personalities that grow and develop as a result of our experiences, relationships, thought, and emotions. We are the sum total of all the parts that go into making a life (Axline, 1990, p.194).

Introduction

A qualitative methodology using a narrative research method was implemented to explore the effects of a traumatic practice experience on the midwife. The study demonstrates that midwives like other health professionals such as ambulance personnel experience similar physiological and psychological effects from the traumatic practice experience. I anticipated the cause of the trauma would be the result of the initial traumatic experiences however the findings from the current study indicate that the trauma episode was exacerbated by a breach of relational trust. The breakdown of trust was not restricted to people involved in the actual traumatic event, it emerged from managers, health professionals, women and others associated with the event, destroying relationships and disrupting lives.

Midwives working in partnership with women seek to negate domination and subordination of traditional patient/health practitioner relationships and as a result challenged the beliefs of the dominant group. The challenging of the habitus of medicine by midwives in New Zealand often places midwives in a vulnerable position. Partnership and autonomous midwifery practice, it is argued, are the key drivers that make New Zealand midwives more likely to be blamed for poor outcomes and their competence in practice challenged.

The current study has demonstrated that the long term relationship that develops between the woman and the Lead Maternity Carer (LMC)¹ midwife when working within the partnership model can at times be problematic. Relational problems

¹ For the purpose of this study the terms Lead Maternity Carer (LMC) and core midwife are used. A LMC is described by the Midwifery Employee Representative & Advisory service (MERAS, 2009) as a registered midwife who has been selected by a woman to provide maternity care. A core midwife, is a registered midwife who is employed to work shifts within either a community maternity unit or an obstetric hospital (MERAS, 2009).

arose because of boundary issues, organisational structures or conflicting paradigms of care that instigated a breach of relational trust exacerbating the initial traumatic practice experience for the midwife. Feelings of vulnerability occurred when trusting relationships were breached and the midwife's competence was questioned. The socio-political environment in which the partnership occurs is influenced by the economic health reforms which resulted in the organisational and clinical managers failing to provide a safe supportive working environment.

Midwives who participated in this study witnessed unethical practices such as abuse of women, were exposed to violence or bullying from colleagues and managers and were let down by women for whom they provided care. Managers failed to take the midwives' concerns seriously when issues regarding staff shortages or skill mix were reported. Practitioners believed formal complaint procedures were punitive, they felt let down by health organisations, their business colleagues and their professional body all of whom failed to provide a positive environment of response. Consequently midwives' lost confidence and trust in their own competencies illustrating another breakdown of trust. As a result of these traumatic experiences midwives personal and professional identities were challenged creating biographical disruption. The disruption exacerbated the initial stress reaction associated with the traumatic event which for some midwives led to a chronic illness demonstrating that emotions can be the aetiology of disease.

Assumptions of the study

Prior to embarking on the study I considered that dealing with critical incidents is a component of midwifery practice and in most instances, apart from the initial stress experienced, the midwife suffers no further effects. Sometimes the stress of the event continued but in practice I noticed there was very little support for the midwife unless provided by her own colleagues or family. Further debriefing sessions tended to be destructive rather than constructive. Therefore an assumption of the current study was that midwives suffer from traumatic practice experiences

and are expected to continue as if nothing has happened or the experiences have not affected them either physiologically or psychologically. It must be acknowledged that not all midwives involved in a traumatic practice experience will suffer biographical disruption neither will these traumatic events impact on their relationships.

Another presumption of mine was that the lead maternity midwife (LMC), who develops a long term relationship with the woman, is more at risk of complaints from women about her practice than the core (hospital) midwife.

Aim of the Study

The aim of this study was to explore the effects of a traumatic practice experience on the midwifery practitioner.

Objectives of the study

- By the use of stories, develop an understanding of the effects of a traumatic practice event on the health of the midwife and on her personal life.
- Determine how the midwife managed the effects of such an experience/experiences and the impact the experience may have had on the midwife's practice.
- Explore the similarities and differences between the experiences of LMC and core midwives
- Identify barriers to support for midwives following traumatic events.

Background to the Study

I first became interested in midwives' experiences of trauma when working as a LMC midwife in New Zealand in the 1990s. Personal experiences and those of my colleagues of the effects of traumatic experiences encouraged me to present a paper

at the International Confederation of Midwives Congress in Austria in 2002 about this topic. The presentation received positive feedback from many midwives who were present. In this paper I recommended that research be undertaken to ensure correct debriefing procedures and assistance for midwives were implemented. Later as an employed midwife I was exposed to trauma of a different kind in the hospital setting, the trauma was that of symbolic violence from a manager. In November 2005 I enrolled in doctoral studies and decided to take up the research challenge to explore the effects of a traumatic practice experience on the midwife.

The study of traumatic events and their effect on human beings is not new; it can be traced back to Egypt and the early medical scripts of 1900 BC (Morrissette, 2004). Interest in psychological factors and the development of physical symptoms began to be recognised following the First World War when the concept of combat stress was developed (Ritchie, Schneider, Bradley & Forsten, 2008; Herman, 2006). Acute combat stress tends to refer to the initial reaction of the person to trauma whereas Post Traumatic Stress Disorder (PTSD) is ongoing (Herman, 2006; Boss, 2006; Morrissette, 2004; Shives & Isaacs, 2002). Following a traumatic event most people will suffer acute stress but not everyone develops PTSD (Lukey & Tepe, 2008; Boss, 2006). Boss (2006) suggests that trauma occurs unexpectedly, and is unpreventable which accounts for victims being stunned and their defense mechanisms failing. Lukey and Tepe (2008) argue that negative psychiatric outcomes, in relation to trauma and stress, are determined by the degree of vulnerability within a population as opposed to resilience which supports a positive outcome. Initially it was believed by the medical profession that personnel who suffered a form of psychological trauma following a traumatic event must have some pre-existing psychological condition; it is now recognised that is not correct (Morrissette, 2004). However, one must not completely rule out the fact that in some people a pre-existing condition will exist (Morrissette, 2004). The environment was also disregarded in the diagnosis of trauma hence anxiety was masked and the physical symptoms were identified as organic conditions. Once the impact of the environment on the traumatic experience became recognised the

reaction was considered as a normal human response for the victim (Weisaeth, 2006).

Historically, the victim has always been the focus of the trauma and the resulting effects on the caregiver have received little attention. Expectations were that caregivers would cope with traumatic events and not display any signs of emotional reaction such as shock, grief or denial (Morrissette, 2004; Maher, 1999; Taylor, 1983). However, following the New York September 11 Twin Tower terrorist attack, the public attitude changed and the emotional response to caregivers has become one of support, compassion, understanding and worldwide acknowledgment (Morrissette, 2004). Morrissette (2004) refers to “the ripple effect” whereby in relation to the victim’s significant others are also affected. Remer and Ferguson (1998) discuss the consequences for those who are indirectly involved in a trauma and refer to them as the secondary victims. The secondary victim in the current study may be the midwife but could be those who are close to her, for example, her husband, partner or children. By acknowledging the impact of the trauma on the caregiver the notion that caregivers are protected in some magic way from feeling the effects of the trauma is negated (Morrissette, 2004; Maher, 1999).

The modern concept of traumatology has moved from the original specialty of surgery to incorporate the individual’s perception of any traumatic event and the subsequent consequences (Figley, 2006; Summerfield, 1995). Some areas which have been researched in relation to trauma have been the circumstances and consequences of rape (Holmstrom & Burgess, 1983), victims of incest (Herman, 2006), survivors of the holocaust (Danieli, 2006), the effects on health professionals (psychologists) dealing with victims of trauma (Camerlengo, 2002), firemen (Maher, 1999) and the police (Figley, 2006).

The focus of the current study is on the effects of a traumatic practice experience on the midwife. The role of the midwife as the Lead Maternity Carer (LMC) is specific

to New Zealand and no published evidence exists about the effect that a traumatic incident may have on the midwife working as either a LMC or core midwife in New Zealand.

A traumatic practice experience

A traumatic event is described as unpleasant and may be due to injury, violence or emotional shock. It usually occurs suddenly and without warning (Figley, 2006; Levi, 2005; Sykes, 1978), is often dangerous and emotionally overpowering. There may be no or very little time to prepare for the event (Figley, 2006); examples in midwifery include a postpartum haemorrhage, cord prolapse or uterine rupture. There is a feeling of loss of personal control which leads to fear (Weisaeth, 2006). The event is unique to each individual as a result of personal history, their culture and perception of self (Brown, 2008). As a consequence of a stressful situation the body responds with activation of the fight and flight system with its subsequent physiological and psychological effects. The midwife will cope with the emergency situation and provide initial care and support for the woman and her family (Devenk & Dykes, 2001). It is after the event that the midwife experiences the reaction to the situation which according to Kleber (1995) can be exacerbated by the meaning of the event for the individual.

If the traumatic situation is not resolved it can lead to long term physiological or psychological consequences such as chronic back pain or PTSD (Stables, 1999; Shives & Isaacs, 2002; Weisaeth, 2002; Morrisette, 2004). Traumatic events do not have to occur as a result of a major disaster; they are those events which carry the risk of creating a major stress reaction (Gamble & Cready, 2007). Evidence suggests that traumatic childbirth experiences can cause acute stress or PTSD in the childbearing woman (Nilsson & Lindgren, 2009; Gamble, Creedy, Moyle, 2004; Ayers & Pickering, 2001; Creedy, Shochet & Horsfall, 2000; Soet, Black, & Dilorio, 2003; Green, Coupland & Kitzinger, 1998; Menge, 1996) but what effect do these situations have on the midwife who is providing care to the woman? The

published research available has as its focus on the emotional effects of the midwife-woman relationship (Hunter, Berg, Lundgren, Olafsdottir & Kirkham, 2008; Hunter, 2005; Hunter, 2001). Emotions can be invoked or provoked by trauma as by relationships.

Herman (2006) whose work has focused on the interchange of the psychology of human relationships and the social dynamics of power suggests that individuals are developed or destroyed by relationships of dominance and subordination. People are forced to accept these relationships that are perpetuated by violence; the violence is often socially invisible especially when oppressive relationships are socially condoned (Herman, 2006). The dominance of the doctor in the hospital environment is a result of the organisational structure (Turner, 1995) and therefore their behaviour is accepted, in many cases without question. Gender is another issue that impacts on midwifery practice for institutions are dominated by male power (Tully & Mortlock, 2005; Turner, 1995). Therefore doctors, both male and female, influence midwifery projects and, as some of the narratives in the current study have demonstrated, prevent autonomous practice and create stress for both the core and LMC midwives.

I will now introduce an overview of the recent history of midwifery in New Zealand. The history provides an understanding of some of the political issues that underpin the narratives in the study.

History of Midwifery in New Zealand since 1990

The training of midwives and the regulation of midwifery began in New Zealand with the passing of the Midwives Act of 1904 which led to the control of midwifery by medicine. Medically-orientated fragmented care dominated the childbearing scene almost without question until the late 1980s when the homebirth movement, women's groups, and the newly formed College of Midwives, with the support of the Minister of Health, Helen Clark, pressured the government into passing the

1990 Amendment to the Nurses Act. The act repealed the section requiring midwives to provide care under the supervision of a doctor. This legislative change enabled midwifery to regain its independence from medicine (Guilliland & Pairman, 2010; Cooper, 1998; Papps & Olssen, 1997). It also enabled the midwives to receive the same fee for service as the doctor thus placing the midwife in direct competition with the general practitioner for the provision of primary maternity services.

Further negotiations occurred in 1993 between the Ministry of Health, New Zealand College of Midwives (NZCOM) and the NZ Medical Association in relation to payment for service and the opportunity for the woman to elect her preferred practitioner. Consequently the concept of the Lead Maternity Carer (LMC) was introduced into Section 51 of the Health and Disability Act, 1993 together with the issues of partnership, choice, informed consent and control (Engel, 2000; Daellenbach & Thorpe, 2007). The Health and Disability Commissioner Act (1994) was passed to protect the rights of the consumer. The Consumers' Code of Rights (1996) was established that developed a complaints mechanism which provided a formal avenue for the woman to question the competence of health professionals. The Primary Health Care Strategies (MoH, 2001) focused on health professionals in all fields working in teams rather than the doctor being the main provider of care. The shift to team work occurred as a result of Treasury reviewing the anti-competitive restrictions on practice and recommending rivalry between health professionals could be more efficient and meet consumer needs (Tully & Mortlock, 2005; Surtees, 2003). Due to the midwives' position in the market environment in the 21st century competition in some areas not only occurs between midwife and doctor but between midwife and midwife (Surtees, 2003). Although the provision of autonomous midwifery care by both core and LMC midwives was made possible in 1990 it was not until the passing of the Health Practitioners Competence Assurance Act (2003) that midwifery practice, education and registration became independent of nursing control. In September 2004 the newly appointed Midwifery Council took over the

regulatory functions for the midwifery profession. The New Zealand College of Midwives is the professional body for midwives. Formed in 1989 the college is responsible for the development and maintenance of professional standards and has been instrumental in aiding midwifery to achieve the status of a profession (Midwifery Standards Review (NZCOM, 2007); Code of Ethics and Standards for Practice, (NZCOM, 2005); Guilliland & Pairman, 2010).

The professional midwife

It is suggested that a profession is identified by a method of speaking, a discourse that is connected to the wider social world and is influenced by history and culture. Therefore a discourse influences a person's values and beliefs and marginalises others (Dew & Davis, 2005). Today midwives are professional people with specialist knowledge of the topic in which they study and are therefore viewed as experts in their field (Pairman & Donnellan-Fernandez, 2006; Tully & Mortlock, 2005; Wilkins, 2000). Professionalism of this form tends to relate to the objective or scientific paradigm rather than that of the subjective or social paradigm (Wilkins, 2000; Pairman & Donnellan-Fernandez, 2006). An objective of the scientific paradigm involves special knowledge and skills and thus the role of the professional who relates to such a paradigm is one of dominance.

Wilkins (2000) argues a dominant professional relationship inhibits people from taking into account the "human relationships, emotions, and biographical experiences as integral parts of midwifery practice" (p. 29). Tully and Mortlock (2005) discuss a new form of professionalism introduced by Stacey (1992) which is a democratic professional model based on partnership. This model provides an avenue for professions such as nursing, midwifery and social work to achieve autonomy (Tully & Mortlock, 2005). Pairman and Donnellan-Fernandez (2006) propose a new style of professionalism in midwifery which comprises reflective practice, interdependent decision processes, supportive teamwork, collective

learning and engagement which incorporates biographical experiences, emotions and human relationships.

The New Zealand Midwifery Partnership model with its emphasis on collaboration between midwife and woman (Tracy & Millar, 2006; Tully & Mortlock, 2005; NZCOM, 2005; Surtees, 2003; Pairman, 1998) constitutes the concepts proposed in the new professionalism. The partnership model although initially not research based was adopted by many midwives in New Zealand (Calvert, 1998). In order to make the model research based Pairman (1998) explored the relationship between six LMC midwives and six women during the childbirth experience using the partnership model. From the findings of the study additional concepts were added to the original model proposed by Guilliland and Pairman (1995) to demonstrate emancipation of the midwife and empowerment of the woman (see Appendix A). These added concepts illustrate that midwives contribute more than their midwifery skills and knowledge to the relationship (Pairman & McAra-Couper, 2006). The study also acknowledges that both parties bring their own cultural values and beliefs to the relationship which should be respected. Recognition of the impact of the health system and the maternity services was also added (Pairman & McAra-Couper, 2006).

Trust is an important factor in the midwife-woman relationship (Calvert, 1998) and develops over time (Pairman, 1998; Calvert, 1998; Fleming, 1995). In her Grounded Theory study of the decision making in the midwife-woman relationship Calvert (1998) found women in her study used the term “friend” when discussing their midwife. The women felt in control of their pregnancy and trusted their midwife to provide them with information to make informed choices in order to achieve a positive outcome for their baby. The issue of friendship is reinforced by Pairman (1998) who found the relationship was described by both women and midwives to be one of ‘friendship’ and ‘partnership’. Due to the short timeframe of working in partnership with the woman core midwives must be aware that as a trusting relationship has not been articulated the balance of power in the

relationship will be different (Guilliland & Pairman, 2010). Pairman (1998) views the role of the core midwife as the link between the woman and her midwife when extra support is required and the woman requires hospitalisation. The partnership in this situation is between the core midwife and the LMC midwife (Pairman & McAra-Couper, 2006) both of whom are autonomous practitioners. A similar link occurs between the core midwife and the LMC doctor.

Working in partnership with the woman requires collaboration and mutual respect (Pairman, 1998; Calvert, 1998; Fleming, 1995) as opposed to domination and subordination as exhibited by some health practitioners (Thachuk, 2009; Wagner, 1994). The current study identified that when practicing within the partnership model of midwifery care, in an environment of power and control, the midwife-woman relationship becomes highly visible and open to criticism.

Midwives nurture women through childbirth and into motherhood. The association with such an intimate and life changing event, means that midwives may blur the boundaries between friendship and professionalism. The friendship that develops as a result of working in partnership with the woman can, as a consequence of boundary issues, make the midwife vulnerable and according to Reamer (2001) can increase the risk of being hurt and/or subjected to litigation.

Boundary issues leading to violence in the relationship

Boundary issues occur as a result of health personnel experiencing actual or potential conflict between their professional duties and personal relationships. Dual relationships develop when a health professional engages in a friendship relationship with a client or colleague while continuing to provide professional care. These relationships within professional practice may lead to boundary violation or boundary crossing (MCNZ, 2010) and can be problematic and harmful (Reamer, 2001). Boundary violation refers to issues that create a conflict of interest and impact on the professional's decision making thus placing the client at risk.

Examples include sexual relationships and fraudulent behaviour (MCNZ, 2010; Reamer, 2001). Boundary crossing which involves bending the rules rather than breaking them may not be unethical and could be therapeutic. Accepting an invitation to have a meal or discussing personal issues with the client illustrates boundary crossing and may occur in some midwife-woman relationships. By self-disclosing issues to a client a closer link may develop with the practitioner but it can also make the client lose confidence in the health professional's practice (Reamer, 2001).

Boundary problems may arise as a result of the practitioner's own emotional need that may stem from environmental or personal distress, which can be interrelated (Reamer, 2001). The life of a LMC midwife can be very lonely and, coupled with the long and often unsociable hours, can add to personal stress. Developing a friendship with a client may assist the emotional needs of the midwife by providing the support required and is an example of boundary crossing. However, not all professional relationships develop as a result of the personal needs of the practitioner rather the emotional relationship is purely a wish of the practitioner to maintain a trusting, shared relationship during the caring phase (Reamer, 2001). By examining the professional Code of Conduct (MCNZ, 2010) a midwife can ascertain if their actions in the relationship have breached the Code and are of concern.

Autonomous midwifery practice

According to Collins (2006) autonomy indicates self-governing and independence. In health care in New Zealand the concept of autonomy implies independence not only for professionals but also for consumers which enables the individual to make decisions in relation to their care and for these choices to be respected by the practitioners (Guilliland & Pairman, 2010; Thachuk, 2009; Anderson & Pelvin, 2006; Surtees, 2003; Fleming, 2002). Autonomy in health care is a result of the

public's desire to be involved in their treatment and is linked to the concept of informed choice (Thachuk, 2009; Anderson & Pelvin, 2006; Surtees, 2003).

Thachuk (2009) suggests that the midwifery partnership model of care is an ideal relationship based on autonomy for women within the health care system. The midwifery model, by the provision of relevant information, enables the woman to have choice in her care and to accept or refuse treatment whereas the medical model tends to use the term informed consent which facilitates the exchange of information but carries a subtle difference. Consent implies agreeing to or complying with the information provided and suggestions made. This subtle difference demonstrates the power relations present in decision making (Thachuk, 2009) between the models of midwifery and medical care. Thus autonomy for midwives enables autonomy for women.

Autonomy in midwifery practice requires the practitioner to provide information to the woman that is relevant, objective, accurate and culturally suitable to enable her to make an informed choice (Thachuk, 2009; Fleming, 2002). In order to provide current information to the woman the midwife has a responsibility to maintain her own professional development (Thachuk, 2009; MCNZ, 2004). In New Zealand anecdotal evidence suggests that the focus of the midwife's professional development is influenced by her philosophy of practice, her professional obligation to provide evidence - based information to women (MCNZ, 2010) as well as the organisational policy requirements. This is understandable if, as Clarke (1995) in her discussion of midwives in the UK suggests, most midwives view their role in relation to the policies, procedures and protocols of the organisation, which are influenced by medicine and management, rather than autonomy of midwifery practice. In New Zealand it is suggested that the practice of the midwife is influenced by such medically orientated organisational guidelines (Skinner, 2006). These guidelines prevent the midwife from working autonomously consequently creating conflict and stress as the midwife's professional status is challenged.

Medical dominance is defined as having three components; firstly, strategies that enable the medical profession to have control of the situation, secondly occupational autonomy within the medical profession and lastly supreme occupational power over interconnected groups (Turner, 1995). According to Turner (1995) medical dominance in relation to allied health professionals is defined by three aspects which are subordination, limitation and exclusion. Subordination prevents independence and autonomy as the behaviour of the subordinate group is controlled by the doctor (Tully & Mortlock, 2005; Turner, 1995). Limitations are restricted areas of practice. In New Zealand the *Guidelines for Consultation with obstetric and related medical services* requirements to be used in conjunction with the Primary Maternity Notice (2007) of the NZ Public Health and Disability Act (2000) are an example of such a limitation. The way these guidelines are imposed in some institutions limits competition between practitioners to the advantage of the dominant group, namely the medical profession. For example implementing policies of mandatory handover of care by LMC midwives for women with certain conditions (Vasen, 2009). Finally, exclusion refers to denying registration of competing health professionals thus preventing them from providing a legitimate form of care (Turner, 1995) which is now not applicable in New Zealand as the midwifery profession is no longer controlled by the medical or nursing professions.

The three factors of subordination, limitation and exclusion, inhibit the autonomy of midwifery practice as doctors, due to their position in the field of maternity care attempt to control childbirth. Doctors use their symbolic power in an endeavour to oppress both the woman and the midwife. To be oppressed is to be dominated, criticised and bullied by a person or a group of people who perceive they are superior to the oppressed group (Roberts, 1983). Therefore in an attempt to succeed the oppressed take on the values and beliefs of the dominant group in the hope that it will give them power and control (Calvert, 2001; Duffy, 1995; Roberts, 1983). Control by the dominant group of the midwife stems from the historical background of midwifery and its relationship with nursing (Tully & Mortlock

2005). The behaviour exhibited by the subordinate midwife is what Bourdieu (1991) refers to as dispositions that are a part of the midwives habitus. Autonomy challenges these dispositions which constitute part of the field of midwifery therefore creating conflict between midwifery practitioners. The conflict creates counterproductive behaviours which consist of intentional acts that are contrary to the organisational interests or those of its employees (Penney & Spector, 2008; Mark, Matinko, Gundlach & Douglas, 2002; Sackett, 2002). Counterproductive behaviours occur in dysfunctional organisations and are considered to arise from changes in the organisational structures (Langan-Fox, Cooper & Klimoski, 2007) which in health was a move to competitive based organisations (Hyde & Cooper, 2001) and in New Zealand the introduction of autonomous midwifery practice. I suggest that by challenging the values and belief of those working in the field of maternity institutions creates vulnerability and exposes the midwives who accept this autonomous role to attack and the accompanying emotional distress.

Stress associated with autonomous midwifery practice

The reintroduction of the autonomous midwifery practitioner involved the changing of professional practices and social relations that were the foundation of midwifery (Pairman & Donnellan-Fernandez, 2006; Tully & Mortlock, 2005; Calvert, 2002). These marked changes involved the LMC midwife being able to work in partnership with women providing continuity of carer to childbearing women (Calvert, 2002; Fleming, 1995). The ability to provide continuity of care to women resulted in some core midwives, who provide fragmented care, feeling undervalued (McIver, 2002). These professional practice changes also threatened the dominant medical model of care subjecting some midwives to criticism that was unjustified as was evident in the current study.

Stress is cited as one of the main reason why midwives in New Zealand are leaving the workforce (MCNZ, 2009). The increase in birth rate over the last few years (MCNZ, 2008; Weil, 2008) plus the increase in women with medical conditions,

for example heart disorders, obesity and diabetes (MCNZ, 2008), becoming pregnant and requiring complex care also impact on the staffing situation and increase the work of the midwife. As a result of midwives taking on the role of the LMC (DHBNZ, 2009; MCNZ, 2009; Tully & Mortlock, 2005) the number of midwives available to work in hospitals is reduced. Staffing levels in some hospitals are less than desirable (Ferguson, 2009; DHBNZ, 2008; MCNZ, 2008) and in some instances can be affected by poor skill mix (Ferguson, 2009; MCNZ, 2008). An analysis of the New Zealand Midwifery Workforce (DHBNZ, 2009) has recommended strategies to increase the number of midwives and also aid in stemming the attrition rate. The MCNZ Workforce Report (2010) indicates an increase in the number of midwives requesting annual practicing certificates during 2009. However, anecdotal evidence still suggests that the current workplace environment remains stressful.

In summary the Midwifery Partnership model is a practice model for midwives in New Zealand that enables a reciprocal relationship between the woman and the midwife to develop based on mutual respect and shared meaning (Pairman, 1998; Fleming 1995). The model assists the midwife to provide a professional service to the childbearing woman that enables empowerment and emancipation for both parties (Guilliland & Pairman, 2010; Pairman & McAra-Couper, 2006). The friendship that develops from the midwifery partnership can create boundary issues increasing the potential for litigation for the LMC midwife. Autonomy in midwifery practice can be inhibited as a result of the domination that occurs in an oppressive health organisation. Core midwives working in partnership with the LMC are perceived by some LMC midwives to be less likely to receive complaints from women against their practice. Finally the growth of midwives providing a continuity of carer service to women since 1990 has reduced the number of midwives available to work in the hospital. In addition to this factor the increased number of women with complex care issues requiring core midwifery care also produces workforce issues (MCNZ, 2009) which create vulnerability and stress for midwives in New Zealand.

Overview of the study

Chapter One introduces the background to the study which includes a brief overview of trauma and the rationale for this research. To understand the relationship between the midwife and other health professionals involved in the maternity services in New Zealand a brief of history of midwifery since 1990, the role of the professional midwife, boundary issues and the introduction of autonomous midwifery practice is provided. The aim and objectives of this research and a brief outline of the focus of each chapter is provided.

In Chapter Two, the literature that was critically reviewed related to the emotional effects of midwifery practice on the midwife, violence, bullying and issues of control in the workplace. The chapter shows there is a comprehensive body of literature taking cognisance of traumatic experiences of other health professionals who have been exposed to trauma, but research on trauma in midwifery practice tended to be obscured in the midwifery literature. However, a large body of published knowledge exists on the impact of a traumatic birthing experience on the woman. The articles in the review were read prior to the commencement of the data collection therefore the findings chapters contain further literature on the themes identified in the narratives and other topics.

Chapter Three contains an outline of the philosophical underpinnings of narrative methodology and the method of narrative research implemented in the current study. The analysis of the study draws upon the four dimensions of narrativity: ontological, public, meta-narrativity and conceptual narrativity from the work of Somers (1994). The stories of the 16 participants were analysed for their content and form based on identity and ontology (Phibbs, 2008; Somers, 1994). Bourdieu's (1982) Theory of Economic Practice with its concepts of fields, habitus and symbolic power were drawn upon to demonstrate the impact of the dominant groups on midwifery practice. Frank's (2005) dialogical research that involves monologue, the unfinished person and perpetual generation were used to demonstrate the significance of the stories of trauma that was generated from the

narratives. Davis and Harre's (1990) concept of positioning was employed to draw attention to the dynamic aspects of encounters.

The substantive chapters in this thesis all describe traumatic events and the effects of the trauma experienced by the midwives. They demonstrated how the effects of the initial traumatic experience are exacerbated by a breakdown of relational trust. Chapter Four contains two stories of the whistleblower and of the advocate who challenge the boundaries, rules and regulations of hierarchies of institutions without any thought about the repercussions. In this chapter I argue that the power and control attributed to health institutions and the hierarchy within impacted on the traumatic practice experiences of the midwives in the current study. The concept of risk is discussed and the women's compliance expected even in situations that result in the practitioner failing to exercise a duty of care. As a consequence of the deficit in a duty of care the importance of informed consent is deliberated. Controlling actions of those in hierarchical positions, if unchallenged, force the midwife to conform to the rules and regulations of the institute rather than encouraging professional and clinical judgement. Bourdieu's (1982) theory of economic practice and Foucault's (1978) ideas of a disciplinary society are drawn upon to demonstrate how control is produced and maintained in the maternity units discussed in the narratives.

In Chapter Five Bury's (1982) ideas on biographical disruption which focus on chronic illness have been discussed together with the concepts of coping, strategy and style. I have threaded these concepts throughout the analysis of the midwives narratives to provide clarity to their stories.

The midwives' stories in chapter six illustrate how trauma, loss and grief that occur in the workplace go unrecognised unless associated with the death of a mother or baby. In order to understand the failure to acknowledge the grief experienced by the midwives I introduce Doka's (2002) concept of disenfranchised grief and Thompson's (2009) ideas of grief in the workplace. The concept and methods of

support such as risk management and psychological debriefing sessions together with the importance of professional supervision are addressed. Breaches of relational trust are threaded throughout the chapter.

Chapter Seven highlights the importance of relationships and the impact on the midwife. I argue that the increase in violence against midwives occurred due to the political changes in the maternity system that changed the role of midwife from the doctor's handmaiden to that of autonomous practitioner. These political changes are the key drivers that form the basis for the demonisation of the midwife in New Zealand. In order to understand the concept of demonisation I have drawn upon the works of Stewart and Strathern (2004). The chapter also contains what I have referred to as the trilogy of violence model.

In Chapter Eight two immigrant midwives tell their stories of traumatic practice experiences and the torment that they were subjected to as a result of the events. The violence was subtle and hidden. Therefore studies on violence in the workplace Bentley et al (2009) Barton (2005) and Clarke (2005) are used to support the argument together with Bourdieu's (1982) theory of economic of practice. Consideration is given to the different management styles and the role of the manager as a perpetrator of the violence (Keeling, Quigley & Robert, 2006).

I suggest in chapter nine that counterproductive behaviours that occur in dysfunctional organisations breach relationships of trust that alter the meaning of the traumatic event for the midwife. In order to support my argument I have drawn upon several researchers who have investigated the concepts of trust (Crepaz, 2009; Brownlie & Howsen, 2008; Cook & Stepanikova, 2008; Calnan & Rowe, 2008; Parr & Davidson, 2008; Goudge & Gilson, 2005; Russell, 2005; Reina & Reina, 1999), dysfunctional organisations (Langan-Fox, Cooper & Klimoski, 2007; Worrall, Cooper & Mather, 2007; Hyde & Cooper, 2001; Reason, 2000) and counterproductive behaviours (Penney & Spector, 2008; Mark, Matinko, Gundlach & Douglas, 2002; Sackett, 2002). The chapter concludes with the effects of a

traumatic practice experience and a trauma model developed from the common threads that run through the data analysis.

Chapter Ten reviews the main findings of the study and sums up the arguments that have developed from the findings. A discussion on the complexities of a traumatic practice experience and its effects on the midwife serve as an overview of the main theoretical and contextual ideas within the thesis. This is followed by an examination of breaches of relational trust an argument which is central to this thesis. As this thesis emerges from an applied discipline, an overview of ideas for easing or eliminating the effects of a traumatic practice experience on the midwife is provided. The chapter ends with the limitations of the study and questions that refer to education, practice and research.

Chapter Two: Exploring the Literature.

Understanding grows from personal experience that enables a person to see and feel in ways so varied and so full of changeable meanings that one's self awareness is the determining factor.

(Axline, 1990, p15).

Introduction

In the previous chapter I introduced the role of the professional midwife in New Zealand and my rationale for embarking on this study. To justify the need to explore the effects of a traumatic practice experience on the midwife and the suitability of the research design I undertook a literature search using the databases Medline, CINAHL, MIDIRS, Google Scholar, Psycinfo as well as the ICM Congress Proceedings and the Internet using the key words “Midwives”, “trauma” or “Post traumatic stress disorder”, “Midwife- Trauma- Birth-Midwifery practice”, “Midwifery –PTSD” “Midwife - emotions”. The search was limited to those articles written in English and published in the timeframe 1986 to 2006. Two articles were found but their focus was on the trauma associated with maternal or neonatal death only. Assistance was also sought from Massey University Library staff but no further articles were obtained. Publications (articles and books) in relation to midwifery trauma are scant. The identified and accessible papers focused mainly on problem solving when faced with a critical incident (Devenek & Dykes, 2001), the experience of emotions in the workplace (Hunter, 2005), maternal death (Mander, 2001), bullying (Hastie, 2007; Curtis, Ball & Kirkham, 2006) and horizontal violence (McIver, 2002). An article by Guidera (2005), discussed later in this chapter, has been superseded in 2009 (McCool, Guidera, Stenson & Dauphinee) by the final article of her research and confirms my findings that research in the field of midwifery trauma is scant. An editorial by Zeldenstein (1995) discussed the importance of breaking the silence around the midwife's unresolved grief when involved in a neonatal death and suggests that midwives do not receive sufficient emotional support following such incidents. The lack of information on the midwife's experience of trauma is particularly significant, as since the 1990 Amendment to the Nurses Act, an increase of in the NZ media of

negative press in relation to the provision of midwifery care following a traumatic practice event appears to have become prolific (www.stuff.co.nz).

In this chapter trauma is explored using the literature from the pioneers in general trauma (Figley, 2006; Herman, 2006, 1981; Daniels, 1984). These experts argue that trauma has a wider social context and the person's ability to cope is influenced by their cultural background and the environment of response (Kleber, Figley & Gersons, 1995). The chapter continues with a critical review of the literature in relation to traumatic experiences of women, midwives, nurses and other carers such as the police. Due to midwives in New Zealand working in partnership with women I have drawn on the literature about the women's traumatic childbirth experiences. Attention is given to issues that prevented or lessened the effects of a traumatic experience for the person under study, for example talking about and reflecting on the event, in order to see if the midwives stories were influenced by these factors. The main argument in this chapter is that attention has not been given to the effects of traumatic practice experiences on midwives due to the common belief that health professionals are not affected by the trauma they witness (Morissette, 2004) consequently they are expected to carry on as if nothing had happened.

Trauma a general area of exploration

According to pioneers in the field of Traumatology, Kleber, Figley and Gersons (1995), trauma that affects an individual has a wider context. How the person interprets and copes with the event is influenced by their cultural background in ways that will be approved and supported by their environment. The effects of war, loss, disaster, bereavement and violence can only be understood by considering the particular situations in specific societies (Kleber et al, 1995). These arguments suggest that the causes of traumatic practice events experienced by midwives in New Zealand may not be transferable to midwives in other countries who are influenced by different systems and power relations.

The initial works of Raphael (1975) considered bereavement, which is a loss or a death (Collins, 2006), as a stressor in relation to life events. She developed a framework from her study to assist in the understanding of both normal and pathological reactions to bereavement and concluded that as a disaster stressor, bereavement can deeply affect mental health and social outcomes. It can be extrapolated, therefore, that bereavement is not a normal part of midwifery practice. Should an unfortunate event like a maternal or neonatal death occur then the midwife could experience mental health issues. The psychological aftermath of bereavement could be a result of not talking or not having the opportunity to talk about the situation. Raphael (1981) coined the term 'personal disaster' to describe stressful and catastrophic events in people's lives and posits that due to the intensity and shock involved the incident is often viewed as a disaster by the individual. These events where the individual has little control and involve change in status or transformation of role, often as a result of loss of a trusting relationship, increase the individual's susceptibility to psychological impairment. Lack of social support also exacerbates the person's psychological risk. As a result of providing care and consolation, caregivers are also subjected to distress and like the victim experience the intensity of the disaster. Debriefing is therefore an important support system.

Danieli (1984) focusing on the origins, meaning and aftermath of the conspiracy of silence in relation to holocaust victims and their families found that it was not that these victims did not want to talk rather it was people they came into contact with, including professionals, who did not want to listen. Failing to listen created further trauma for the victims hence the conspiracy of silence was a result of secondary trauma caused by the therapists. In their report to Danieli the therapists admitted failing to listen to their patients. In view of this finding the need for the researcher to listen to the stories of the participants justifies the importance of choosing a design such as narrative research that enables listening to occur.

In the second part of the study Danieli (1984) interviewed 61 psychotherapists who had worked with at least two survivors of the holocaust, to examine the emotional

responses experienced by the therapists as a result of working with this group of clients. She recorded the countertransference themes of guilt, rage, dread and shame. Guilt, associated with not having experienced these atrocities, was a major factor which prevented the therapist from setting boundaries and asking questions for fear of upsetting the patients. Rage was experienced as a result of being overwhelmed by the stories. Dread occurred as they shared the nightmares of the survivors. Shame was related to the disgust felt by the therapists in relation to the incidents relayed by the clients and resulted in the therapist using defensive manoeuvres such as changing the subject thus preventing the survivors relating their stories.

The importance of listening to stories is supported by Herman (2006, 1981) in her work and research as a psychiatrist. She found that listening to women who told their stories of being victims of incest, led to the lifting of shame and despair demonstrating the positive effects of therapy. As a result of her study Herman (2006, 1981) posits that violence is often socially invisible and suggests that research into trauma should consider the interaction between the social forces of power and relationships which is discussed in detail in Chapter seven of this study. She developed the concept of complex Post Traumatic Stress Disorder (PTSD) in order to describe the pathological reaction that occurs from prolonged exposure to violence (Herman, 2006). However, it is not just the event that triggers the PTSD but also the environmental response such as lack of psychological and social support and disbelief by the listener that the events related could have happened that exacerbates the problem (Kleber et al, 1995). The works of Daniels (1984), Herman (1981) and Kleber et al (1995) all stress the importance of listening to the victim of the trauma to enable healing to occur. A traumatologist Charles Figley (2002) suggests that one of the results of globalization is the breakdown of village life and the support that was provided to victims of trauma. He also suggests that societies have developed an increased tolerance toward violence and in order to cope with the physical and psychological effects associated with trauma and violence supportive therapies are required.

I have cited the above studies to demonstrate the impact of trauma on the individual in a wider social context. The studies suggest that people suffer physiological and psychological effects as a result of trauma (Figley, 2002; Kleber et al, 1995; Daniels, 1984; Herman, 1981; Raphael, 1975). Telling the story to a therapist may have a positive effect but can also create a negative reaction in the therapist (Daniels, 1984; Herman, 1981). It would appear that the environmental response plays a significant part in recovery (Kleber et al, 1995). One thing that is evident from the literature is that people suffer from the impact of trauma whether experienced personally, as a witness to the event or as a listener to the stories related and therefore require support or access to other means of coping with trauma.

Overview of carers as victims of trauma

Due to the lack of published information relating to traumatic practice experiences of the midwife evidence from other types of carers was sought. Police, firemen and paramedics are exposed to many types of trauma on a daily basis whereas general practitioners (GPs) and most nurses and midwives are not. Literature on childbearing women is included for the women's experiences may be a part of the trauma experienced by the midwives. Women as carers are also expected to carry on caring and coping regardless of the circumstances.

Women's experiences of childbirth

Several studies have been published in relation to women's experiences of childbirth and the impact on their physical and emotional health and have concluded that control is an important aspect in their psychological well-being (Gamble et al, 2004; Ayers & Pickering, 2001; Creedy, Shochet & Horsfall, 2000; Soet, Black, & Dilorio, 2003). Green, Coupland and Kitzinger (1998) in their prospective study in the UK of 825 women's expectations and experiences of childbirth demonstrated that the provision of information and feelings of control

were associated with a positive psychological outcome. The study also found that even minor interventions such as a pubic shave, an enema or lack of continuity of care and unsupportive staff created negative psychological outcomes. This study supports the suggestion by Devenek and Dykes (2001) that being in control is an important issue in preventing or lessening the traumatic experience.

Beck (2004) used a descriptive phenomenological research design to investigate mothers' experiences of a traumatic birth. The purposeful sample of 40 women was gained from Australia (n=6), New Zealand (n=23), the United Kingdom (n= 3) and the United States (n=8). The data was analysed using Colaizzi's (1978) seven steps of data analysis. Beck found that trauma may occur from any phase of childbearing. Four themes emerged from the data, 1) that the women wanted to feel cared for; 2) they wanted to be talked to and have things explained and not be neglected; 3) they perceived that their trust in relation to safe care had been broken and 4) that the safe arrival of a baby overrode the emotional impact of this achievement on the mother.

Beck (2004) suggests that some of the women's trauma is a result of a stillbirth or neonatal death however, she does not appear to have considered their reactions as part of a normal process associated with loss and grief which occurs even in the absence of childbirth. Her study stresses the importance of debriefing following a childbirth experience particularly when birth plans are not achieved. Despite more than 50% of the participants in Beck's study being from New Zealand the study does not state if the women received LMC or core midwifery care. The support provided by having developed a long term relationship with a midwife could influence the outcome for some women.

The importance of debriefing with the midwife present at the birth was an outcome finding of a qualitative study undertaken in England by Hammett (1997) who used focus groups to explore midwives' experiences of debriefing women following childbirth. She cites two definitions for debriefing, the first is the military explanation as described by Samter, Fitzgerald and Bradaway (1993) as 'procedure

of extracting facts, comments or recommendations concerning a previous assignment or experience' (Hamment. p.136). Alternatively she cites Parkinson's (1993) definition as 'debriefing provides a structured method of talking through the experience and feelings of those involved'. The second explanation was portrayed by the midwives for when they provided explanations for actions undertaken. They highlighted their understanding of debriefing as a means of achieving a positive psychological outcome for the woman. In order to debrief the midwife requires communication skills, empathy, knowledge and self-awareness. The need for midwives to receive training for debriefing and psychological support was recommended.

Considering the psychological impact of trauma a qualitative study to determine the mothers' experience of anniversary birth trauma was undertaken by Beck (2006). Thirty seven participants were recruited from a charitable trust in New Zealand named Trauma and Birth Stress (TABS). Four themes were identified from the data; it was an agonizing time (the childbirth experience), a celebration of rape not birth, a fragile state and subsequent anniversaries. The study found that the women's quality of life decreased during the period surrounding the anniversary. Due to the invisibility of anniversary birth trauma Beck introduced the term 'failure to rescue', a term originally used by surgeons when a complication arose resulting in the death of a patient. Although the anniversary of a traumatic event may not involve a death but emotional and physical suffering, it still impacts on the women's feelings and their attitudes toward their children. The study does not state the type of birth experienced or the midwifery support provided which may have influenced the women's experiences. The study recommends that providers of health care should screen women who suffered birth trauma for symptoms of Post Traumatic Stress Disorder (PTSD). There appears to be no literature that identifies whether midwives suffer from PTSD or anniversary grief after a traumatic practice experience.

According to Seng, Low, Ben-Ami and Liberzon (2005) post traumatic stress disorder affects 12% of women in the United States of America and therefore could influence childbearing. The authors undertook a pilot study of 25 primigravid women with symptoms of PTSD to generate preliminary data for a future prospective longitudinal study. The research was to ascertain 1) if PTSD altered the woman's basal cortisol levels and 2) if the mothers' symptoms of PTSD influenced the perinatal outcome as evident on the Optimality Index Score (Murphy & Fullerton, 2001). Data was collected using telephone interviews, case records and swabs for salivary cortisol levels. Although this was a small pilot sample and therefore cannot be generalized to the childbearing population, the results demonstrated that women with partial or full PTSD had lower basal salivary cortisol levels and worse overall perinatal outcomes. This finding therefore justified the need for a full study. Confirmation of these results by a larger study could highlight the need for pregnancy-specific interventions for people with PTSD to be incorporated into maternity care.

No studies were identified that consider the influence of the practitioners' PTSD on perinatal outcomes. Assessing midwives for PTSD is not one of the objectives of the current study, however, it must be considered that the presence of this condition has the potential to impact on midwifery care provided.

A small number of studies that demonstrate the impact of traumatic birth experiences on women has been considered. In the following section consideration is given to the literature which explores the impact of trauma on midwives, emergency workers and others who provide healthcare.

Midwives as carers

A search of the literature found no articles specifically on the effects of a traumatic practice events experienced by the midwife. However, two studies (Guidera, 2005; Mander, 2001) were found that relate to maternal and/or neonatal death. Guidera

(2005) undertook a collaborative study, based in the USA that related to the effects of poor maternal and/or fetal outcome on the midwife. No definition is given for 'poor outcome'. The aim of the study was to gather both personal and professional information from midwives working in developing and developed countries about their experiences of dealing with poor outcomes. A Critical Incident Stress framework was developed by the researcher and used in an attempt to understand practitioners' reactions following the event.

The data was collected in four phases from five different continents. Phase one focused on gaining information from midwifery leaders and educators in the US about the kind of support that should be available for midwives who have experienced a poor birth outcome. In phase two 12 USA midwives and 19 international midwives who had experienced a poor birth outcome for mother or baby between 2002 and 2004 were interviewed. The results of phase two only were presented in the article. Midwives interviewed reported signs of stress as sleep disturbances, grief, guilt, appetite loss, and flashbacks. The response to the incident was clearly culturally related; midwives working in the developing world were anxious about issues such as loss of income, public exposure, loss of license, prevention of the event and inability to practice. Those midwives working in developed countries were concerned with issues of litigation, emotional support, recovery from the event and future employment. The experiences of midwives in the developed countries support the anecdotal evidence available in New Zealand in relation to midwifery practice events that there is a lack emotional support for midwives (Calvert, I., 2002).

Although the article by Guidera (2005) considers the experience of a poor outcome for the midwife it does not tell the story from the midwife's perspective. However, an exploratory phenomenological study by Mander (2001) undertaken in the UK does consider the meaning for the midwife when caring for a pregnant woman who died. Thirty two participants who met the criteria were enrolled into round one of the study and interviewed by telephone, letter or email. In round two of the study

three experienced midwives from the initial group plus four midwives with no experience of maternal death were interviewed. Involving midwives with no experience of the topic was undertaken in order to compare their views with the views of the experienced midwives. Four themes emerged from the data namely 'images intruding', 'identifying with the mother', 'encountering death' and 'being prepared'. The findings demonstrated that the midwife's experience is similar to that experienced by emergency personnel attending a large scale disaster (Mander, 2001) such as a train crash. A limitation of the study is the small number of midwives interviewed with no experience of maternal death. The study provides a basis for comparing the impact of a maternal death on the midwife however it does not include other events that the midwife may also determine as traumatic.

Using an ethnographic approach Hunter (2005) explored how a range of midwifery students and midwives in Britain experienced and managed emotions in their workplace. Negotiating relationships was influenced by the practice environment and was viewed as a key issue in creating emotional work. Although the midwives were able to describe how they managed their emotions in order to function on a professional basis the researcher was surprised to find that the origins of the emotions stemmed from the co-existence of different philosophies of midwifery practice. These differences occurred between midwives with different lengths of experience thus creating disharmony amongst practitioners. The conflict results from what Bourdieu (1991) refers to as their position in the field and the accompanying value associated with clinical experience that is identified with this position. The implication of Hunter's (2005) study for midwifery practice is that it demonstrates workplace bullying exists and is a factor in workplace attrition. The study also illustrated that midwives who do not have a lot of practice experience become subservient to the senior staff in order to survive. Hunter's research focused on the emotions experienced by hospital staff in everyday midwifery practice and did not consider the impact of midwifery practice on the emotions of midwives working in the community. In considering how midwives manage emotions it was acknowledged that emotional impact on the individual can create

trauma (Herman, 1986) but the effects of traumatic practice events were not a primary consideration of Hunter's (2005) study.

Hastie (2007) reinforces the issue of workplace bullying or horizontal violence referred to by Hunter (2005) as a cause of stress and believes that it is endemic in the Australian workplace. In Britain a quantitative study by Curtis, et al (2006) reported that a minority (2 %) of midwives leaving the profession cited their reason as bullying. From the 1155 (54%) questionnaires returned thirty three percent of midwives had been exposed to bullying (Curtis et al, 2006).

McIver (2002), in her qualitative study in New Zealand, explored twelve midwives' experiences of horizontal violence and the effects of these experiences on midwifery care. She demonstrated that the participants recognized the bullying as work related. Bullying behaviour was continually repeated by peers and managers and was in the form of emotional and verbal abuse rather than physical assault. Some of the violence was subtle and took the form of isolation or sneering speech; several midwives believed that it was intentional. Participants in McIver's study were either affected by the behaviour of other employees towards them or by what they witnessed and perceived as incompetent practice by other practitioners. This qualitative study of twelve participants, derived from one area of New Zealand, is small and as such the results cannot be applied to the general midwifery workforce within New Zealand. McIver's study does not focus on traumatic practice events neither do those of Hunter (2005) and Curtis et al, (2006). However, what those studies do demonstrate is how the environment of response can have a negative effect on practitioners and increase workforce attrition.

The articles discussed so far related to the possible repercussions of a traumatic event for the midwife, emotions in midwifery and the environment of response. Using a phenomenological method Devenek and Dykes (2001) explored the use of problem solving when the midwife is faced with a critical incident in the absence of a doctor. Seven midwives participated in their study which took place in a labour

ward in Sweden. The data were collected using the critical incident method. Each midwife was asked to relate a specific experience where she had been faced with a critical incident while alone and had to make important decisions very rapidly. The results demonstrated that the power to make decisions and experience were seen as key factors in the midwives' ability to solve problems, which was viewed as multifaceted, when a critical incident occurs. Part of the event was listening and trusting the woman, using knowledge and intuition, assessing and identifying a problem, concentration, respect and being in control of the situation. Consideration was not given to the effects of the event on the midwife and the midwives' perceptions of the event were not sought. Devenek and Dykes' (2001) study of the link between feeling in control and the provision of good care is supported by that of Schmitz, Neumann and Oppermann (2000). A convenience sample of 361 German staff nurses participated in their study which examined the impact of work related stress and the degree of locus of control associated with burnout. The study concluded that feeling in control was a major factor in the prevention of burnout.

With the exception of the research by McIver (2002) the studies presented above were not undertaken in New Zealand and therefore do not represent the New Zealand midwifery practice context. The issue of workplace bullying is present in the midwifery literature (Hastie, 2007; Hunter, 2005; McIver, 2002) and is a cause of stress (Hunter, 2005; Ball & Cready, 2006) and of midwives leaving the profession (Curtis et al, 2006; McIver, 2002). The importance of feeling in control was viewed as a positive factor in the prevention of trauma (Devenek & Dykes, 2001; Schmitz, Neumann & Oppermann, 2000) and is a factor worth considering in relation to traumatic events. As the above literature on trauma in midwifery is scant male dominated professions, such as the police and firefighters, is discussed in order to ascertain the effects of trauma experienced by these professions.

Police and Firefighters

A study to investigate the effects on the police involved with the Bradford football club fire disaster was undertaken by Duckworth (1986) who argues that the helping

personnel are the 'forgotten victims' of disaster. One month following the event a health screening questionnaire and a letter regarding the study was sent to all police who were involved. Two hundred and thirty four (59%) of the 399 personnel involved were recruited into the study. The participants had all completed the health screening questionnaire which assessed their need for counselling. They were allocated to groups of 'likely non-cases', likely cases and likely serious cases' according to the individual scores on the questionnaire. Thirty five 'likely cases' were found and were offered counselling; twenty accepted. Twenty 'serious cases' were also offered counselling of which only thirteen accepted. One non-likely case requested counseling and was offered the service. The treatment given was tailored to the themes which emerged from the questionnaires and were; performance guilt, reconstruction anxiety, generalized irritability, focused resentment and motivational changes. The participants completed a health questionnaire at one month and nine months following treatment. The results indicated recovery occurred during this period of time. The study demonstrates the importance of psychological debriefing and ongoing support following a traumatic incident. The participants were supporters of the football club and knew some of victims who died. The study does not indicate if these variables were taken into consideration and regarded as responsible for the increased suffering experienced by some of the participants.

The importance of support in aiding recovery from a traumatic event involving members of the police force was also found in a study in New Zealand by Stephens and Long (2000). The support provided by supervisors and peers was to buffer the physical and psychological effects of trauma. Questionnaires were sent to one thousand police in one geographical area of New Zealand. The return rate was 52% (n = 527) with an equal distribution of age, gender and length of service. The findings demonstrated a positive prediction of traumatic events creating physical and psychological symptoms. The prediction that higher social support would buffer the effects of trauma was only supported for some forms of communication, for example, the ease with which the person was able to talk was positive for reducing symptoms. Discussing personal issues not related to work tended to

increase the symptoms of PTSD. Negative work issues with supervisors created further problems. Three policemen suffering symptoms or affected by PTSD were excluded from the study for these health reasons. A limitation of the study is people with PTSD who received support were not assessed for trauma or the effect of treatment. Support from trained peers with communication skills that reinforces the workplace custom of non-disclosure are suggested to assist in recovery. The policy of non-disclosure of individual stories is to protect the larger group from experiencing the effects of the trauma. The study confirmed that the participants suffered physical and psychological effects as a result of the trauma. The focus of the study was on the support provided by peers and supervisors and not on the total effects of the traumatic event as narrated by the individual and the social issues involved.

Maher (1999) in her exploration of critical incident stress debriefing within the New Zealand Fire Service disputes the old belief that emergency personnel should be used to coping with tragedy and supports the suggestion by Duckworth (1986) that emergency workers are the forgotten victims of disaster. She suggests that professionals dealing with emergency situations experience personal pain and suffering as a result of the incident. They do not become used to tragedies experienced by others as is commonly believed and neither do other health professionals as the following study indicates.

Following the Omagh bombing that occurred in Ireland in 1998 a study was undertaken by Lucy, Firth-Cozen, Midgley and Burges (2002) to explore the levels of PTSD in different staff groups in the local hospitals. Questionnaires were sent to every employed staff member (n=3500) both professionals and non professionals. The response rate was 35% (n =1235) which included responses from nurses, doctors, administration staff, domestics and laboratory staff. The results demonstrated that health workers are not immune to the traumatic experiences they witness. Staff who had experienced previous trauma and those staff members that witnessed the trauma, whether on or off duty, had the greatest number of symptoms

of PTSD. Being able to help in a practical way reduced the number of symptoms in staff and could explain the low rates of symptoms in the doctors. The study concluded that only a small proportion of people requested help or support and they tended to be participants with higher PTSD symptoms. It was suggested that the failure to seek help could be attributed to the myth that health professionals are strong and do not suffer as a result of the trauma they deal with. The findings suggest that by not seeking help the participants place themselves at greater risk of severe deeply rooted symptoms. These studies confirm the need for support for victims of trauma, even if they do not request support. As a result of the low response rate of some groups of health workers the results cannot be generalized to specific groups. The article does not state if midwives were involved in this survey however they could have been grouped under 'nurses'.

Nurses

In a commentary regarding grief Picton (2007) argues that emergency nurses are expected to disregard the impact traumatic events have on them and accept that participating in emergency situations is a part of their job. The result is they suffer flashbacks, sleepless nights, grieving, failure, guilt and anger. She suggests that the emotions they experience are part of the grieving process and should not be denied. Neither should the emergency nurses be considered inadequate for expressing their emotions; rather it should be accepted as part of their maturity. Picton (2007) considers that it takes a wise, mature person to care for themselves as well as others. Emotions were an important aspect of a qualitative study in Northern Ireland by McCreight (2004) who investigated the personal experiences of fourteen nursing staff in gynaecological wards caring for parents experiencing a pregnancy loss. She found that the nurses acknowledge, through a process of reflection, that there is a cost to caring. Words used to describe their feelings were trauma, hurt, pressure and the need for a break. Empathy was viewed as an important construct of professional decision making in relation to caring and understanding the emotional needs of the parents. McCreight (2004) concluded that emotions can be

viewed as a valid resource for professionals when incorporated into the origins of the situation, in this case dealing with the grieving parents. In view of this conclusion the recommendation is that nursing education policies acknowledge the importance of managed emotions.

The use of crying as an emotional coping mechanism for nurses was investigated by Pongruengphant and Tyson (2000). Questionnaires were sent to 200 nurses in Bangkok and other areas of Thailand requesting the nurses to rate their degree of occupational stress, job satisfaction and crying, which may indicate fear, joy, pain or grief (Collins, 2006), as a means of coping. Crying was found not to have an effect when dealing with the stress of caring for the dying. However, a correlation between job satisfaction and crying did exist. It was found that nurses who enjoyed their job were less likely to cry than those who were unhappy at work. It must be acknowledged that in Thailand culture plays a part in the restraining of emotions (Pongruengphant & Tyson, 2000) and individuals are encouraged to hold back their feelings. If emotions are held back long term the situation can create physical and psychological problems (McCreight, 2004). The cultural attitude towards crying as a coping mechanism in New Zealand could differ from that of Thailand. The study did not address the reason why some nurses were unhappy in their job.

Nurses' perceptions of critical incidents were studied by O'Connor and Jeavons (2003) to determine what type of incidents nurses elected as critical and whether demographic factors such as age and qualifications impacted the experience. A survey research design was used for the collection of data from full time registered nurses working in a 750 bed teaching hospital in Australia. Nurse managers and clinical nurse specialists were included in the sample as part of their employment required clinical practice. Clinical Events Questionnaires were sent to 574 nurses with a response rate of 28%. Due to the poor response rate personal contact was made by the researcher and a notice was mailed to those who had not completed the questionnaire. These actions resulted in a 40% response rate which is consistent with other studies reviewed. The questionnaires were sent out at Christmas

therefore the poor response rate was further attributed to the time of year. The data were analysed using the Statistical Package for Social Sciences (SPSS). The results showed that sexual abuse of a child and death of a child were rated the most stressful critical events. Fifty eight percent of the sample had experienced a critical incident within the last year; the most stressful and frequent was an emergency such as a cardiac or respiratory arrest followed by multiple events in a short period. Violence from patients or their families was identified as a critical event by 12% of the participants however when reports of violence from staff members were added the figure increased to 19%. No difference amongst the participants was found in relation to age or qualifications. Feelings of grief were ranked lower by male nurses as compared with female nurses. Grief was also a concern amongst senior personnel and the authors suggest this could be the result of observing the impact on their staff of witnessing death.

The limitations of the study are the small sample size which contained a few male nurses reflecting the nursing demographic. Another factor was a possibility of the responses being from nurses with a special interest in critical incidents thus creating a bias. Although the focus of this quantitative study was on what nurses believed constituted a critical incident, the study findings suggest that these critical incidents can cause stress and grief for the practitioner. Therefore these findings would support the assumption of the current study that a traumatic practice event may affect the midwife.

Paramedics

An exploratory study which contrasted and tested the predictive value of reverse-buffering of social support and the information processing model of PTSD was undertaken by Lowery and Stokes (2005). Reverse-buffering was defined as “when the presence of social support does not function to enhance coping abilities but acts to strengthen the relationship between an occupational stressor and individual strains” (p.171). Surveys were sent to seventy four student paramedics with a return

rate of 54% (n=42). The forty two responding (n=42) student paramedics, 35 male and 7 female, were from all three years of the course. The study concluded that dysfunctional peer support following a traumatic event contributes to the negative attitudes towards expression of emotions in student paramedics and interferes with the recovery process. The sample size in the study was small and from one area of Australia therefore cannot be generalized to the entire population of Australian paramedics. The students' previous experiences of exposure to trauma or their coping strategies were not addressed. The study supports the work of McIver (2002) who found that the horizontal violence from colleagues can contribute to employment stress.

General Practitioners

Baker, Schaufeli, Sixma, Bosveld and Van Dierendonck (2000) undertook a five year longitudinal study of 207 general practitioners in the Netherlands to test a process model of burnout. The study demonstrated that demanding patient contact produced a lack of reciprocity in the GP-patient relationship. The researchers suggest that according to equity theory individuals judge their relationships according to what they put in as opposed to what they get out. Historically people expect a relationship of reciprocity therefore participating in a relationship that is unreciprocated creates distress. The harder the person tries to improve the relationship the greater the distress. The authors questioned if the GP-patient relationship is out of balance as the relationship should be one of giving and receiving care. The study demonstrated that many GPs believed that what they put into the relationship was not reciprocated. Many patients were aggressive, threatening, demanding and did not comply with treatment. Dealing with non reciprocal relationships can lead to emotional distress and burnout.

In an attempt to cope with their emotional state, GPs distanced themselves from the patients. The study found that this action of distancing can create threatening and demanding behaviours from patients. The study also demonstrated that it was not

the demands of the patients that created the stress but the breakdown of the relationship. Emotional exhaustion can lead to depersonalization which influences the practitioner's feelings of competence. In Holland the working environment could be different from New Zealand where many doctors tend to work in groups and share caseloads; these factors could influence the outcome if a similar study was undertaken in New Zealand.

The study did not explain if the GPs experienced loss and grief as a result of the breakdown in relationships or indicate the support systems available to assist the practitioners. The long term relationships experienced by the GPs are similar to the relationship that develops between the woman and the LMC midwife which is based on a partnership of trust (Pairman, 2000). Anecdotal evidence from midwives in New Zealand suggests the midwife-woman relationship is not always reciprocal and can lead to distress for both parties.

Psychologists

In an attempt to understand the psychological effects of a traumatic event on caregivers, Eidelson, D'Alessio, and Eidelson (2003) studied the experience of psychologists who were involved in the events of September 11, 2001 at the World Trade Centre in New York. The findings from their survey data demonstrated both positive and negative effects. The participants experienced a positive effect in being able to assist clients but negative outcomes were experienced due to feelings of inadequacy and helplessness as a result of the vast amount of suffering they observed. The meaning and the significance of the event for the individual and the disruption or potential disruption of the psychologists' biographies is now considered an important factor aiding recovery (Brown, 1989).

The impact on all professionals, not just psychologists, from listening to disturbing stories was considered by Salston and Figley (2003) in the literature review for their research paper. The paper explored the effects of secondary traumatic stress

on people working with survivors of victimization. Salston and Figley (2003) found the terms compassion fatigue, burnout, vicarious traumatization (VC) and traumatic countertransference were very similar to secondary traumatic stress (STS). Vicarious traumatization and compassion fatigue are a direct result of being exposed to traumatic experiences as is STS. However, STS can also affect the significant others in the life of the person exposed to the trauma. Salston and Figley suggest that professionals working with clients traumatized by criminal victimization are at risk themselves of becoming stressed. It is therefore important that they instigate self-care. Helping survivors of trauma, demonstrating empathy and being exposed to the stories of others' traumatic events are underlying factors which may precipitate secondary traumatic stress. Further information from the study suggested that a professional with a history of trauma may be at greater risk of exposure to secondary traumatic stress than a person with no past traumatic history. The researchers argue that educators involved in the training of therapists, knowing that the therapists are at risk of developing STS, are morally required to ensure that students are made aware of this risk factor. Educators should include strategies in their programmes to assist with the prevention of STS.

Overview of the effects of trauma

It is apparent from the literature reviewed that individuals can suffer physical and/or psychological effects from being exposed to trauma (Beck, 2004; Devenek & Dykes, 2001; Stephens & Long, 2000; Schmitz et al, 2000). Control is an important factor in the degree of psychological trauma experienced (Beck, 2004; Devenek & Dykes, 2001; Schmitz et al, 2000). Trauma can lead to post traumatic stress disorder which, for the women in Beck's study, affects the mother-baby relationship (Beck, 2004).

When involved in a poor birth outcome midwives reported symptoms of PTSD, they feared litigation and effects of litigation on future employment (Guidera, 2005). Conflicting paradigms of care was the cause of stress for some midwives

creating emotional issues resulting from workplace bullying (Hunter, 2005). Bullying or horizontal violence particularly from managers, colleagues (McIver, 2002) and patients (Baker, et al, 2000) created trauma (McIver, 2002; Baker, et al, 2000) which was exacerbated in an environment of negative response (Hunter, 2005; McIver, 2002; Curtis et al, 2006). Dysfunctional peer support contributes to negative attitudes toward the expression of emotions and interferes with recovery (Lowery & Stokes, 2005). Emotions are a valid source of expression of feelings however, when held back over a long period of time can lead to physical and psychological conditions (McCreight, 2004).

Studies indicate that professionals do not become used to tragedies experienced by others (Lucy et al, 2002; Maher, 1999). Feeling helpless as a result of witnessing a vast amount of suffering has a negative outcome; helping victims ensures positive effects (Eidelson et al, 2003). Accepting the trauma of others as part of one's job disregards the personal effects of the trauma thus denying the right to grieve (Picton, 2007). Female nurses had a greater risk of experiencing grief following a critical incident compared to male nurses. Grief was also experienced by managers observing the grief experienced by the staff (O'Connor & Jeavons, 2003).

The literature critiqued above in relation to caregivers demonstrated that an important factor in recovery is establishing meaning from the event and for the disruption experienced (Brown, 1989). Receiving psychological support (Guidera, 2005) from colleagues (Stephens & Long, 2000) and psychological debriefing aids recovery following trauma (Stephens & Long, 2000; Duckworth, 1986). Therapists, caregivers, friends and family are at risk of secondary traumatic stress as a result of listening to trauma stories (Salston & Figley, 2003). Debriefing of postpartum women by the midwife involved in her care aids in the reduction of psychological trauma for the woman (Beck, 2004; Hammett, 1997). Providing the midwife with the skills to debrief women following birth is recommended (Hammett, 1997). The effects of long term GP-patient relationships (Baker et al, 2000) is discussed. Only one study (McIver, 2002) was undertaken in relation to the New Zealand maternity

system and considered the effects of bullying on the midwife. The suggestion by Lucy, et al (2002) that studies into the effects of trauma on health workers is rare, aligns with the result of the literature search for the current study.

When reading the literature on trauma the importance of preparation and talking about the incident became apparent therefore the midwifery literature was reviewed to ascertain its reference to talking and the possible impact of the research design on the participants.

Talking

The International Society for Traumatic Stress Studies (ISTSS, 2005) indicates the importance of staying connected to friends and family and taking care of basic needs in the aftermath of traumatic events. This form of help is referred to by Raphael and Wooding (2004) as “psychological first aid” a term developed by Raphael and involves ensuring survival as well as comfort and support. Psychological first aid is not to be confused with psychological debriefing (Raphael & Wooding, 2004) which is a formal process involving a discussion that focuses on the traumatic event. The psychological session is undertaken by individuals who have been professionally trained in the field (CISM, 2010; ISTSS, 2005; Raphael & Wooding, 2004) and implemented for those at risk of developing chronic post traumatic stress disorder (NICE, 2006). These debriefing sessions for personnel dealing with trauma could instigate healing (Raphael, 2006; Hart & Warren, 1997). Risk management debriefing is another situation where the event is discussed however the focus of these sessions is on the quality of care provided (Atwood & Macken, 2005) rather than the psychological wellbeing of the practitioner.

A conference discussion by Penwell (2002) from the USA outlines the issue of midwives coping in stressful situations and suggests midwives should accept that birth is not always a happy event but sometimes involves tragedy and grief. The

key to long term emotional survival is to develop coping strategies to prevent issues such as PTSD and enable the midwife to maintain the role of helper and healer.

Chesney (1996), in an attempt to encourage practitioners in England to link theory to practice, suggests that sharing midwifery practice incidents by means of reflection in a supportive environment is vital in the prevention of stress-related illness. Burgum and Bridge (1997) demonstrated how skills of reflection and critical thinking can be developed by using critical incidents or events that occur in everyday practice in the education of both qualified and student midwives in Australia. A personal incident is considered both for personal meaning, and the social context in which it occurred. The process of reflection assists the individual to withhold judgement until all aspects of the event have been considered. In their discussion of different types of reflection and methods of application Rich and Parker (1995) acknowledge the importance of reflection in midwifery education in an attempt to close the theory-practice gap. The authors stress the necessity for lecturers and students to be thoroughly prepared to participate in these reflective sessions as they test competence and can identify ineffective responses to situations. Failure to participate in this preparation can be counterproductive, leading to student disaffection or psychological issues.

Laing (2000), considering the role of reflective practice for midwives dealing with bereaved parents supports the suggestion by Rich and Parker (1995) that the midwife must be prepared to recognise reflection may highlight effective or ineffective responses to the situation. Reflection also assists in the prevention of ongoing stress (Laing, 2000). The suggestion of the use of reflective practice could be a means of helping midwives cope with traumatic practice experiences. In New Zealand reflecting on practice is part of the Midwifery Standards Review process for every practitioner. A special review is sometimes requested following a critical incident and could be classed as a form of debriefing. Reflection on practice is also a requirement of the Midwifery Council of New Zealand portfolio criteria (MCNZ, 2008) for recertification.

It would appear from the literature that we know very little about the physiological or psychological effects of a traumatic practice experience on the midwife. No published research on the impact of trauma on the midwife in relation to the midwife woman- relationship exists. Due to the lack of evidence on the effects of traumatic practice events on the midwife in New Zealand this research will address these gaps in the literature. A qualitative methodology was used in the current study as recommended by Raphael (2006) who suggests that qualitative research methods should be considered in order to answer questions and develop plans aimed at the prevention of adverse mental health issues in relation to trauma.

Summary

Various texts related to trauma have been examined in this chapter and have shown that trauma does affect individuals exposed to or witnessing trauma as well as therapists and significant others. None of these studies, however, specifically offers an in depth investigation into the effects of a traumatic practice experience on the midwife or the impact of the midwife-woman relationship on these events. The current study will address these gaps. The following chapter introduces the methodology and method that was used for the current study.

Chapter Three: Methodology and method

It is important that you tell this story in language that midwives and the public can understand. I want you to tell my story as it is and not break it down into little pieces that does not tell people how it was and still is for me. (Portia)

Introduction

Stories are a part of social life through which experiences, personal feelings or prejudices can be located through narrativity (Phibbs, 2008; Somers, 1994). Narrativity is being aware of the meaning of the events within a story in connection to relationships that occur in a specific place and at a specific time (Somers, 1994). As a result of these connecting relationships people's identities are constantly changing. Identities are never complete; they alter as a result of specific social relationships that are influenced by the environment and the historical context in which they occur (Phibbs, 2008; Frank, 2005; Somers, 1994). Somers (1994) uses the term *emplotment* to enable the researcher to understand the historical context of the narrative and the way identities are located in networks that are interrelated and are concurrently "personal, local and global" (Phibbs, 2008, p.59).

This chapter focuses on placing the effects of a traumatic practice experience within a critical narrative framework related to midwifery. Using an eclectic approach to data analysis I have developed a template based on the concepts of narrativity (Somers, 1994) dialogical listening (Frank, 2002) symbolic violence (Bourdieu, 1991) and positioning (Davis & Harre, 1990) and applied this template to the analysis of each interview. The four interrelated concepts of narrativity outlined by Somers (1994) are used to frame the analysis of the narratives of 16 midwives who participated in this study. Ontological, public, meta-narrativity and conceptual narrativity (Somers, 1994) provide the basis for considering the social conditions that influence the stories and impact on the participants' identities. Frank's (2005) ideas of dialogical listening enable the researcher to connect to the participant and the other voices in the story allowing truth and meaning to be

generated. By telling their story the participant reflects on the incident which provides an opportunity for the person to change and grow from the experience (Frank, 2005). Bourdieu's (1982, 1991) theory of economic practice with its focus on the economic value placed on symbolic power which enables hierarchical structures within institutions and their influence on relationships to be maintained, is considered. Davis and Harre's (1990) arguments about the discursive positioning of selves which enable the interpersonal relationships within ontological and public narratives to be explored (Phibbs, 2008) are also employed. The chapter concludes with an overview of how the analysis was undertaken.

Narrative Research

Use of the narrative research method has increased in popularity over the past two decades (Riessman, 2008; Sparkes, 2005; Rankin, 2002; Murray 2000; Lieblich, Tuval-Mashiach & Zilber, 1998) and has focused on individual life experiences and the influences of the social context (Murray, 2000) on experiences, both of which affect an individual's concept of identity. According to Chase (2003), in the qualitative research paradigm narrative research has two major principles; the first is how the person interprets, reflects upon and communicates the meaning of their experiences. The second is that all narratives are influenced by the social system in which they evolve. The importance for the researcher is the combining of these two principles (Chase, 2003). The use of narratives also enables the researcher to develop research questions that focus on actual life events (Frank, 2005; Loyttyneimi, 2005; Marvasti, 2004; Chase, 2003; Ellis & Berger, 2003). Therefore, in this thesis I not only look at the midwives' personal accounts of the dramatic or traumatic practice experience but also the social, political and institutional structures that influence midwifery practice in New Zealand.

Stories are used as a form of communication to understand the social order. The ways in which stories have been recorded have changed over time from initial annual reports of dates and events, followed by chronicles which demonstrate

connections to events, and finally to stories that contain a plot (Rankin, 2002; Czarniawska, 2004). A plot is part of the story that disturbs the status quo. Throughout the story plots provide culturally orientated insight into the lives of individuals as well as the impact of the wider social structures on the situation (Phibbs, 2008; Chase, 2003; Sclater, 2004; Czarniawska, 2004, Roberts, 2002; Somers, 1994). The content or plot and how it came to exist or take shape, the form of the narrative represents a section of the person's life story shaping and constructing the story teller's reality thus suggesting that story telling is part of human existence (Rankin, 2002; Sparkes, 2005; Lieblich et al, 1998). Developing a narrative requires the participant to construct a retrospective view of an event which sometimes assists the individual to understand the action and consequences on themselves and others thus bringing meaning to the situation. The link between story, meaning and identity explains why narrative is sometimes referred to as a developmental discourse (Dauite & Fine, 2003). Developmental discourses occur due to the reflective nature of the narrative method and the recognition of an associated social theory (Frank, 2005; Marvasti, 2004) such as Pierre Bourdieu's concepts in his theory of economics of practice. In order to trace tensions between different groups Bourdieu (1991) introduced the concepts of field, habitus and capital which could be economic, social, cultural and symbolic and perceived as power.

The researcher may focus on the content, structure, functions or context of a narrative at the same time recognising that all of these components are interrelated (Marvasti, 2004). Verbal accounts of events by participants provide the researcher with data that are deeply involved in the process and content of the entire activity (Barbour, 2008; Blaikie, 2000; Gorman & Clayton, 1997) and its impact on the person's identity (Rankin, 2002; Somers, 1994). The researcher in the narrative method locates different actors within each narrative and then tries to situate the data in the context of the social setting in which the experience occurred (Phibbs, 2008; Frank, 2005; Chase, 2003; Marvasti, 2004; Somers, 1994). Links between

biographical details of the narrator and issues in the environment, that impact on the individual, are also considered (Chase, 2003).

Multiple readings of the story are required to understand the different stories told by the other people involved in the narratives (Chase, 2003). The interview transcripts may be affected by the interactions of the narrator and the researcher, which is why it is important not to focus everything on the first reading but to repeat the reading and listen to the voices in the story (Frank, 2005). Consideration must also be given to the influence of other actors on the outcome of the story.

In his discussions on narrative method Frank (2004) recommends that the start of any research story should be interesting and entice the reader to read on. The body of the research must describe what the concern was for the participants thus enabling the reader to envisage these concerns as their own which makes the story convincing. Producing the feeling of connectedness between the reader and the participant is “the prerequisite – and not simply a prerequisite – of good story telling” (Frank, 2004, p.433). The feeling of connectedness enables the reader to be concerned about the outcome for the narrators.

When documenting his illness experience Frank (2004) highlighted the gaps between what people do and what they say and argues the gap is a source of powerlessness for it contains an explanation of what constitutes the truth. The gap replaces the simplistic view of the truth with a distinctive appreciation of the social structures and cultural practices that impact on the story. In his story, Frank closed the gap by writing what people cannot say. He draws upon the work of Lement (1993) who suggested “What is inarticulate cannot be protested and changed” (cited in Frank, 2004, p.437) therefore narrative researchers have a responsibility to fill the gaps bringing understanding and empowerment to the narrator (Chase, 2003). It was my responsibility as the researcher and the participant’s advocate (a concept coined by Frank, 2005) to include in my interpretation of the narratives the

presence of workplace bullying occurring in dysfunctional organizations. Giving voice to marginalised people highlights the way in which individuals may be exploited through forms of power and control arising from institutional rules (Chase, 2003) that support the values and beliefs of the dominant group. The dominant groups in health care in the current research are management and the medical profession.

In narrative research it is often surmised that either the story or the storyteller are the objects for analysis. I would suggest that the purpose of the study and the method of interpretation used determines the focus of the analysis, whether structural (syntax and semiotics) that uses verbal skills to explore the experience (Labov, 1972; Wiles, Rosenberg & Kearns, 2005), thematic (linguistic) analysis to understand how individuals construct their identities and create meaning (Riessman, 2008) or narratology (dialogical research) that analyses the stories in the social context in which they occurred.

In the current research I wish to explore the effects of a traumatic practice experience on the midwife therefore it is necessary to analyse the story to determine the impact on the storyteller. Loyttyneimi (2005) would argue that by internalising the story the concept of subjectivity is developed and continues to develop throughout the process of knowing. The gap between subject and object is lessened as the researcher internalises the words of the participants, shared intrinsic meanings develop which provide understanding (Loyttyneimi, 2005). Consequently the researcher becomes the narrator of the story as he or she relates it through the words of the participant as well as their own (Frank, 2004; Chase, 2003; Loyttyneimi, 2005; Quellette, 2003). The method of analysis that has been adopted in the current study draws on the works of Arthur Frank (2005) and his dialogical approach (Narratology).

Dialogical Research (Narratology)

Dialogical research stems from the works of the Russian philosopher Mikhail Bakhtin (Riessman, 2008; Frank, 2005; Marchenkova, 2005; Rankin, 2002) who considered dialogue as a universal means of communication within cultures and individual human experience. The self in dialogue is a changing being; truth is generated from dialogue and not from the mind of an individual person. Language is the consequence of dialogue but it is also a central component of it (Marchenkova, 2005). Dialogue creates relations which are built on the concept of identity of self and others. For Bakhtin the dialogical method is based on describing communications between equal participants. I interpret this to imply that as a researcher the midwives will tell their personal stories of trauma however commonalities will be identified from these data that are present in all or most of the stories. The sharing of cultures of experience enables mutual enhancement which leads to greater understanding rather than simulating or replacing one's own cultural experiences with those of another. By this act of understanding reciprocal enhancement and change can occur (Marchenkova, 2005).

Rankin (2002) suggests that from birth individuals are part of a story; as a result people learn to think and act simultaneously. People talk to themselves and are both the object and subject of this conversation. Individuals are the main characters in their own stories and the secondary characters in others. Rankin suggests that by connecting with others self-reflection and self-consciousness are made possible. Identity in this situation is not just the achievement of one's personal potential nor the putting aside of stories, but the understanding of the relationship of how this personal potential is influenced by the time, place and the circumstances in which they live, brought to realisation by the process of dialogue (Phibbs, 2008; Franks, 2005; Rankin, 2002). This method of interpretation enables the researcher to focus on how individuals in the course of their activities of daily living manage the social realities of their environment (Frank, 2005; Marvasti, 2004).

The dialogical process is the method of choice for this study as by analysing the stories in their social context the narrator and the readers of their story become aware of the social circumstances that impacted on the event. This awareness then enables the narrator to reflect on the situation and understand the basis of their insecurities (Frank, 2004). The dialogical method of research provides a model which, by the process of story telling, will enable the significance of the situation for the individual to be identified (Frank, 2002). Within this thesis I want to develop a stronger focus on contextual relationality including the way that local narratives are constructed in relation to non-local processes, hence the work of Somers (1994) which considers the four dimensions of narrativity, was drawn upon.

Four Dimensions of Narrativity

Margaret Somers (1994) in her discussion on the reconfiguration of identity states that older forms of narrative research were based on representation where roles were clearly defined and controlled. In contrast the new method of narrative research is based on the concepts of social epistemology and social ontology. Somers' narrative methodology enables the concepts of time, space and relationality which influence a person's identity to be considered. Space implies the network of relationships that structure our world (Jacobs, Munro & Adams, 1995). These relationships may be political, geographical, social or embodied (Phibbs, 2008). Embodied space is the space that surrounds the body and alters according to a person's sex as well as their cultural values and beliefs (Phibbs, 2008). The narrative researcher cannot separate time and space (Phibbs, 2008) for they are combined within a parameter called the space-time continuum (Hawking, 1996). Time and space destabilise narratives through making them transient and unrepeatable (Somers, 1994). Therefore if the researcher introduces the destabilizing concepts of time and space they will attempt to identify the social structures present in the place that the narrative occurred which impact on the identity of the participant (Somers, 1994). A midwife's identity, social knowledge and expectations influence the story that she tells. The connectivity of parts creates

episodes within the narrative and through a process of emplotment, which introduces history into the relationship, enables an understanding of the current event. Phibbs (2008) suggests that applying Somers' concepts of narrativity to narrative analysis provides a new template for individuals involved in narrative research to use in their analysis of stories. In the current study the story is analysed for its content and form based on the concepts of identity and ontology as outlined in Somers (1994).

The ontological aspect of the narrative describes the speaker in relation to their values and beliefs and is influenced by the community or group in which the narrator is involved. Narratives are also private and exclusive. They explain who we are and as a result can influence our actions or behaviour in given situations. Ontological narratives develop events into experience and can influence immediate or evolutionary change. Ontological narratives are crafted in relation to public narratives which can also be thought of as stereotypes (Somers, 1994).

The public dimension of narratives includes traditional ideas about identity that transcend the individual person and includes the family, the organisation, government and cultural beliefs (Somers, 1994) that impact on the story. The public dimension contains the concepts required of all narratives: drama, plot, explanation, and selective criteria which, in my thesis are seen in the traumatic practice events narrated. The public dimension of the narrative considers the image of midwifery, for example, in contemporary New Zealand midwives are understood as professional people with a degree level qualification, who work in partnership with the woman and her family throughout the childbearing experience (Pairman, 1998). However, I contend that the public image of the midwife is still tainted by the historical concept of the midwife as the doctor's handmaiden.

Metanarrativity is the effect of the "master narratives" (Somers, 1994, p. 619) (industrialization, capitalism, communism) from history that influence contemporary social theories today. Metanarratives impact on the social forces

which are comprised of market and institutional practices as well as organisational constraints. Market practices within midwifery in New Zealand are influenced by the 1990 Amendment to the Nurses Act and the introduction of autonomous midwifery practice. Another factor is the neoliberal reforms which focus on economy and individualism (Bourdieu, 1998a). Institutional practices within health care stem from protocols which condone the power of the management, the medical profession and the dominance of the medical model (Guilliland & Pairman, 2010). Organisational constraints on midwives are associated with the economy, scope of practice, Health Practitioners Competence Assurance Act (2003), Midwifery Council requirements for recertification and Guidelines for Consultation appended to Sections 88 of the NZ Public Health and Disability Act (2000).

Conceptual narrativity refers to the social theories (see page 88) that are used in the analysis of stories that enable the researcher to situate the narrative in relation to social life and practices and their influence on the participants. Conceptual narrativity contains two central concepts, narrative identity and relational setting which involve time, place and space. As a consequence the researcher is able to consider the ontological and public aspects of the narrative as well as the social forces involved. The result is that conceptual narrativity produces the ideas and findings that are acquired from narrative analysis as the plot is portrayed through the researcher tracing a network of relationships that connect to the plot (Somers, 1994). From the information gained by this process of emplotment the researcher constructs their interpretation of the narrative. To me this implies that as a researcher I stand alongside the midwives who have suffered the trauma and narrate my interpretation of their stories.

With the change in the focus of the narrative advocates of the interpretive method are now claiming that social life comprises of stories and that narrative is part of our social existence. If life itself is a story then interpretation of narrative research creates a story from within a story (Andrews, 2004; Franks, 2005; Somers, 1994).

In order to demonstrate the concept of story within a story Franks draws upon the theory of dialogical listening as portrayed by the Russian Philosopher Mikhail Bakhtin.

Dialogical Listening

According to Frank (2005) Bakhtin's Theory of 'Dialogical Listening' is a means of communication which permits the researcher to connect and describe identities between participants that enable truths to be generated. Story telling allows the participant to reflect on the incident enabling the person to change and grow from the experience (Frank, 2005). Dialogical listening involves the concepts of the unfinalised person, monologue and perpetual generation which include subjective meaning within the story and the socio-political context between social classes that result over time.

Monologue or finalised person are things that cannot be changed in the story, they involve having the final word about someone or something and occur in situations such as exam results, medical diagnosis and titles such as registered midwife or medical practitioner. According to Frank (2005) it is disturbing that young individuals who hold a professional title are instructed to use finalising words to or about those with whom they come in contact. Consequently those who are finalised expect this behaviour as a part of the social norms which retain the status of the profession in society. The social norms explain some of the actions undertaken and maintained in hierarchical health institutions.

The unfinalised person implies that the storyteller is influenced by other characters that have been involved in their life history. This is an ongoing process whereby every voice looks forward to and acts in response to other voices in the story. In order for the researcher to hear these other voices multiple readings of the story are required (Chase, 2003). The subject's position is sought, how they interpret the situation, the various meanings and complications involved and how

the storyteller links together the different stories within the narrative. The narrative link includes biographical information coupled with the environmental constraints and resources that provide an interpretation of the story as perceived by the storyteller (Chase, 2003; Holstein & Gubrium, 2000). The implication is that other figures or actors in the story, for example the birthing woman and her husband, also influence the midwife's story as do objects (Latour, 2005) such as forms of documentation, institutional routines and policies. The midwife's interpretation of these interactions in her story is her choice. The researcher hears these stories but leaves the storyteller to accept or reject the researcher's responses (Frank, 2005) which in the current study would be the analysis chapters. In dialogue unlike monologue neither party has the last word about the other (Frank, 2005).

Perpetual generation refers to alternative stories that could be created from the other actors in the story as well as the research. Researchers have a responsibility as to how their participants' stories are represented in their work. Research stories go out into the world and create new stories as people read and relate their own interpretation of the stories. The other actors in the original story relate their explanation of the event thus producing other variations of the story. Reading other peoples experiences may also bring to mind similar personal experiences that the reader may also use to understand renarrate and enhance the story (Frank, 2005).

Narrative analysis, using the principle of "perpetual generation", illustrates how one story will produce another story thus the outcome of the research is never final. The stories portrayed within narrative research are often ones of conflict or struggle and therefore may generate common themes. These themes or commonalities are used as beginnings and not, as in other methods of qualitative research as finalising descriptions. These commonalities symbolise the struggles and emotions experienced by the participants as interpreted by the researcher and represented in the research findings. The research report is a continuous dialogue between the researcher and the narrator that occurred in a certain time and space and not a final report of representation. It should echo to the readers of the research the shared

knowledge each has of the other which in turn enables the reader of the research to express their own thoughts and opinions (Frank, 2005; Loyttyniemi, 2005). In the current research perpetual generation occurred due to the presence of others within the stories as well as the researcher's analysis of the stories within the thesis and the presentation of some of these stories at conferences.

The organisational influence on the midwives' stories requires consideration therefore Pierre Bourdieu's theory of economic practice, as discussed below, was drawn upon to assist in the analysis.

Theory of Economic Practice – Pierre Bourdieu

Bourdieu's theory of economic practice focuses on the relationship between the individual and society and how power in the form of capital is used to shape these relationships (Bourdieu, 1982; 1991). Bourdieu (1992) introduces a connection between subjectivism or personal feelings and objectivism which is the ideas and morals of the organisation that have a subtle impact on the primary experience that is not directly understood. He suggests a wide division between subjectivism and objectivism exists and uses social and economic logic as an example of these oppositions. Social logic has as its primary focus equity whereas economic logic which is the basis of neo-liberalism, posits competition and promising efficiency thus demonstrating a return to individualism (Bourdieu, 1998). He explains this individualism as *a self-fulfilling prophecy* that undermines the philosophical underpinnings of the welfare state which posits a collective responsibility to issues such as health, industrial accidents and poverty. Individualism reduces costs and enables victim blaming to occur (Bourdieu, 1998). In his theory Bourdieu (1982, 1998) tends to bypass these roles of oppositions and suggests that a move to the middle of these two paradigms of subjectivity and objectivity is required.

The polarisation between the objective and subjective paradigms appears to suggest that the constraining social and institutional structures cause individuals to struggle

and implies that change can only occur when people are liberated from these structures (Behague, Kanhonou, Filippi, et al, 2008; Bourdieu, 1992). To capture and understand these harsh and subtle differences in which structural modifications are started, an approach that considers the relationship of structure to individuals as both restricting and empowering is required. Pierre Bourdieu has attempted to achieve this aim by his empirical work of the theory of economic practice in concepts of fields, habitus and capital which are outlined below (Bourdieu, 1998; 1991).

Social space or field contains groups of people who are distributed according to their capital which for Bourdieu is found in an economy of power located in practice. He contends that capital is more than economic value and includes social, cultural and symbolic capital all of which can lead to domination and subordination (Bourdieu, 1991; 1982). Economic capital describes financial resources. Social capital refers to lineage (Bourdieu, 2001) and reflects the use of capital within the family unit thus creating business alliances and social networks (Bourdieu, 1998a). Cultural capital incorporates social background, qualifications and career. Symbolic capital is anything that is perceived by individuals in the field to have value or power for example integrity, honour, the law or an expensive house (Bourdieu, 1998; 1991; 1982). Capital is content-specific therefore it may be necessary for individuals not only to transfer but to alter their capital in order for it to retain value in a new field (Behague et al, 2008; Bourdieu, 1998; 1998a; 1991; Calhoun, 1993)

Bourdieu (1998; 1991) views the social world as a multi-dimensional space, comprised of autonomous fields in which people occupy positions which are determined by the number of different forms of capital they possess. The most important thing about fields is that they allow one form of capital to be converted to another, for example cultural capital in the form of qualifications traded for economic capital in the form of income. Different levels of qualifications, for example those held by doctors and nurses, create unequal distribution of capital and

therefore influence the power attributed to individuals and groups (Bourdieu, 1991) creating tension within the field.

The field not only contains social forces that are imposed on individuals but also creates an environment where individuals contrive and fight over processes depending on their position in the structure thus maintaining or altering the status quo (Bourdieu, 1998). Bourdieu refers to these non-violent contested relations as symbolic power which is usually collectively legitimized and therefore invisible. Recognising or misrecognising forms of symbolic power occurs on the basis of shared philosophical beliefs (Calhoun, 1993; Bourdieu, 1998). For example the power attributed to the midwifery manager and the belief of her staff that she is entitled to use this power as part of her role illustrates recognition of symbolic power. The example explains why those that benefit the least from these hierarchical relations of power, which are socially constructed, acknowledge its presence but fail to see the impact it has on them, a failure which occurs as a result of their habitus.

The habitus is a set of dispositions that encourage people to act or react in a certain way in a particular field of social forces. They provide people with a presupposed understanding of other people's experiences and how these understandings assume knowledge of the social world (Lash, 1993; Bourdieu, 1991). Bourdieu (1991) suggests that dispositions are formulated from the symbolic systems of art, science, religion and language which he refers to as 'structuring structures' that form part of the objective world. They are symbols of the past influenced by myths and symbolic power embedded within the beliefs that constitute a normal way of behaving (Bourdieu, 1998; 1991). The habitus is responsible for the subconscious actions of individuals, such as the way someone speaks or their accent, as well as being reflective of the social conditions in which they exist. A person's habitus is also influenced by their continuous interaction with their environment and various other social fields and as a result these interactions influence the practices and perceptions of the individual and the group (Bourdieu, 1989; 1998) thus

constructing structures which form the basis of social categories. These symbolic or mental structures can lead to domination for they constitute reality and the meaning of the social world. Bourdieu (1991) refers to these taken for granted core values and beliefs articulated in fields as doxa as they constitute rhetorics of common sense which are equated with consensus. He suggests that this ideological power enables symbolic violence to contribute to political violence identified as a form of domination whereby doxic beliefs and practices within a particular health field tend to reflect *the point of view of the dominant* (Bourdieu, 1998). He suggests the best example of political doxa is the symbolic violence used against women (Bourdieu, 1991) by unintentional acts such as discrimination or exclusion from positions of power (Bourdieu, 2001).

Krais (1993) in her discussion of gender issues states that in modern capitalist societies women's behaviour is viewed as weak, women are viewed as inferior to men, therefore the work they do is of less value than that of men. These features are fragments of an androcentric society that creates a gender and class issue which leads to dominance, oppression and exploitation (Bourdieu, 2001). Bourdieu (2001) uses this taxonomy of male and female to explain how this division of labour between the genders is culturally constructed and as such appears to represent the natural order of the world. Therefore beliefs, such as gender issues are embedded in the habitus and as a consequence kept alive in institutions, which helps to explain the subordinate position and lack of capital attributed to midwives in hierarchical maternity departments.

Symbolic violence is defined as “violence which is exercised on a social agent with his or her complicity” (Bourdieu, 1992 p 167). This prereflexive assumption or doxic practice is derived from the cognitive beliefs stemming from the structures of the field and is the foundation of domination and politics (Bourdieu, 1991). The actions of the dominant are often friendly and subtle as they unconsciously carry out the beliefs dictated by their particular habitus (Bourdieu, 1989) that they happen to occupy. An example of symbolic violence in the maternity field is the acceptance

of the superior role of the doctor over that of the core midwife despite the midwife's right to autonomous practice. Narratives from midwives who participated in this research provide examples of how midwives may comply with these organisational rules without question. However, denying the core midwives the right to practice autonomously makes them feel devalued compared to their LMC counterparts (McIver, 2002) and creates conflict within midwifery.

It is sometimes necessary to use symbolic violence against symbolic violence to alter the "circle of belief" (Brubaker, 1993, p. 217). Reflecting on the early days of autonomous midwifery practice in New Zealand provides me with an example of 'breaking the circle' through the use of symbolic violence. The actions of midwives, who worked with women alongside doctors sharing the LMC role, enabled some childbearing women to see the practice of a midwife. Observing the skills of the midwife and the different service provided to the childbearing woman opposed to the service provided by the doctor changed some doxic practices within the field. One of the changes that occurred as a result of this subtle process was the increase of women requesting midwife only services.

Calhoun et al (1993) criticised Bourdieu's theory as focusing on the way societies recreate themselves and how the social structures inhibit individual action rather than developing methods of changing the shape or character of the organisation producing the services. Wacquant (1992) argues that Bourdieu's theory constitutes a reflective sociology developed in order to understand and engage in strategies against symbolic violence. He contends that Bourdieu extends an invitation to think beyond his theory (Wacquant, 1992). Angus, Kontos, Duck, Mc Keever & Poland (2005) suggest that to enhance Bourdieu's theory researchers should consider the biographical events in a person's life that may assist in altering the character of the organisation as well the individual social positions. Other studies (Lizardo, 2004; Crossley, 2003) have made clear that crisis creates inventive or imaginative ways of practicing, which are socially constructed and have the ability to tone down the power structures within a field (Behague, et al, 2008). Bourdieu (1992) suggests the

best tool we have to critique domination is science and the use of research mechanisms that implement reflection.

I contend that Bourdieu's theory of economic practice which considers fields, habitus, capital and doxa fits logically with Somers' (1994) concepts of ontological, public, meta and conceptual narrativity found in her network approach to the construction of identity as used in this study. Both theories focus on the historical background and economy that influences the identity and behaviours of the individual or groups. Consequently by uncovering the underlying social structures that influence and maintain social relationship both the participant and I were able to reflect on the situation and bring comprehension as to how relationships shift over time and space. The use of Frank's (2005) ideas of dialogical listening enabled the researcher to identify the underlying structures and describe the meaning of the event for the participants.

Another factor that influences a story and is used in this study is that of conversational positioning. Understanding that the position people assign, or are assigned to, influence courses of events, shape narratives of self and impact on their personal and professional identities (Phibbs, 2008; Riessman, 2008).

Positioning

The concept of positioning was developed by Davis and Harre (1990) who explored how the story teller was positioned in the story by his/her self and others involved in the story. How the storyteller positions others in their narrative is also considered. The concept of positioning suggests a connection between the participant and the social world in which they are involved (Phibbs, 2008; Marvasti, 2004; Sclater, 2004; Riessman, 2003; Davis & Harre, 1990) and could influence the rationale for this positioning. For example a midwife may resist being positioned as 'unsafe' or incompetent by her colleagues and seek strategies to address this such as challenging the assumptions of colleagues and/or requesting a

formal review of an incident. Social positioning demonstrates how the meaning of the event impacts on an individual's identity (Riessman, 2002) which can lead to a breach of relational trust for the midwife.

Phibbs (2008) in her article on gender identity argues that it is not just language but also bodies and spaces that influence the way in which people are positioned. She contends that geographical space contains interconnections between political and economic power relations that are simultaneously national and international. An example of 'global and local' (Phibbs, 2008) change that influenced the maternity units in the current study would be the international swing from monolithic structures to consumer based services (Upton, 1991). The impact of this structural change affects places which tend to be more localized and contain social relations that alter over time. The alteration of these social relationships influences the meanings that are associated with place (Phibbs, 2008). Consequently identities change and affect how people involved are positioned within a given place (Phibbs, 2008). The 1990 Amendment to the Nurses Act and the introduction of autonomous midwifery practice altered the position of the midwife from the doctor's handmaiden to that of an autonomous practitioner and illustrates how corporeal identities, spaces and places influence positioning.

In summary, in the current study Frank's (2005) ideas of dialogical listening enables the meaning for the individual and the social-political context in which the event occurs to be considered. Somers (1994) four concepts of narrativity are drawn upon in order to analyse the narratives of the 16 midwives who participated in this study. These concepts ontological, public conceptual and metanarrativity provide a framework for considering the social conditions that influence the stories. Bourdieu's (1991) concepts of field, habitus and doxa provide an explanation of how power invested in these four concepts of narrativity impacts on the midwives stories. Davis and Harre's (1990) concept of positioning enabled the researcher to understand the influence of the social world on how the midwife was viewed by

herself and others in the story. The ideas provided by the above researchers are evident in the methods section that follows.

Researching the effects of a traumatic practice experience on the midwife: The method

Narrative research was chosen as the method for this study as it encourages the participants to story the event as they perceived it, describe the situation and the actions of actors and the influence of technological objects in the story. Narrative research has the ability to reconstruct the meaning of the event for the narrator potentially leading to reconstruction of their personal and professional identities (Willig & Stainton-Rogers, 2008; Marvasti, 2004; Chamberlayne, 1999). The following section of the chapter describes the recruitment of midwives into the current study. The method of data collection and analysis are provided together with the judgment or standard to ensure the credibility of the research and the ethical and legal considerations involved. The area of practice for the midwife at the time of the event and the initial interview are introduced. The impact on the researcher is also discussed as well as the means for the dissemination of the results.

Participant Recruitment

Midwives were invited to participate in the study if they self-identified as having experienced a traumatic practice experience. The incident must have occurred since the 1990 Amendment to the Nurses Act which enabled midwives to work as autonomous practitioners. Ethical approval for the research was sought and gained from the Massey University Ethics Committee before the midwives were enrolled into the study (see Appendix C).

In an attempt to contact midwives who met the criteria for participation in the current study I requested that a general information sheet (see Appendix D) entitled “Dramatic or Traumatic Practice Experiences” be attached to the New Zealand College of Midwives, Wellington Regional Newsletter to inform midwives of the research. The term dramatic was removed from the data following the initial interview. This occurred as none of the midwives described the events they narrated as dramatic; rather they referred to them as dramatic. The information sheet provided a telephone number where I could be contacted. Prior to the publication of the newsletter nine midwives who were aware of the pending study had already contacted me requesting to participate in the study. As a result of the publication of the regional NZCOM Newsletter three midwives requested further information and then decided to participate in the study. Two other midwives were referred by an obstetrician, from another area of New Zealand; the obstetrician was aware of the study and felt that it could be therapeutic for the midwives to participate. Following a conference presentation in September 2007 outlining the methodology to be used, two midwives contacted me for further information before agreeing to participate. The number of participants recruited into the study was 16. The location of the participants ranged from the top of the South Island to as far north as Auckland.

Once an expression of interest was received I contacted the participant to make an appointment and informed them verbally about the nature of the research and the likely input in time and energy expected from each midwife. At the initial interview the participants were again provided with the written information sheet which reinforced the verbal information and they then signed the consent form prior to the interview commencing. They were also informed that it is important participants are aware that during the analysis of the data the personal meaning of the trauma will be sought and produced in an account of a life story (Kazmierska, 2004). My interpretation of the meaning of the event for the individual midwife was discussed at the second interview and participants were made aware that it was part of the findings and would be included in the write up of the thesis.

The midwives recruited could practice either as a core midwife in a hospital or they could work as a LMC providing total care for women throughout the childbirth experience. At the time of the traumatic event occurring five of the participants were working as core midwives and eleven worked as Lead Maternity Carers. By incorporating both core and LMC midwives into the study a range of positions available within the midwifery workforce in New Zealand is represented.

Narrative interviews for data collection

I chose the interactive interview method for my study as it is used for topics that are private and personal; as a consequence it requires strict attention to ethical issues in order to prevent the participant's reputation falling into disrepute (Ellis & Berger, 2003). Interviews conducted for this research also offered the opportunity for self-reflection for both the participant and the listener. The interviewer in the interactive interviewing situation must have the ability to understand the narrator's feelings, as if they were experiencing them, as well as demonstrating respect for the narrator's emotive state. This is in contrast to that of the empirical paradigm where personal feelings are bypassed (Ellis & Berger, 2003; Fleming, 1995). Researchers who use the interactive method do so in order to make a contribution to the participant and the community (Ellis & Berger, 2003). In the current research it is the hope of the participants and the researcher that the midwifery community will benefit from the findings of this study. The interactive method also enables the researcher to be a *story facilitator* interested in the meaning the event has for the person as well as the social structures that affect this meaning (Wengraf, 2003). Therefore the research questions are broad to encourage the person to focus on their perception of the experience and how it affected them. The story relayed demonstrates to the researcher how the participant has internalized the event (Chase, 2003).

One interactive interview method used in narrative research is the Biographical Narrative Interview Method (BNIM) which comprises of two interviews and three

subsessions. In interview one subsession one the researcher asks the participant a single question that will enable them to relay the story that incorporates the experience under investigation. The researcher does not interrupt the participant during the narration of their story (Wengraf, 2003; Campbell-Breen & Poland, 2006). The first two subsessions occur at the first interview usually with a short break between sessions. In subsession two, interview one, the researcher discusses with the participants any issues that require clarification. The third subsession interview two occurs about a week or two later when the researcher has undertaken a primary analysis of the results from subsessions one and two. In order to maximize the effectiveness of this method it is important that the role of the researcher is outlined and maintained.

In the current study the method used for the collection of the data was an adapted form of the BNIM. The data collection commenced with an initial face to face interview which was recorded using an audiotape. My role as the researcher and not counsellor or advisor was outlined to the participants and maintained during the interviews. Due to the sensitivity of the data collected at the first interview the tape was stopped in some interviews at the participant's request. Once the participant felt composed they would then direct the researcher to restart the tape recording. All participants completed the recordings of their narrative.

The research question is usually unstructured in order to ascertain the meaning the event has for the participants. The interviewee then decides the format in which they will relate their personal experience which is unique to each individual (Riessman, 2008; Loyttyneimi, 2005; Frank, 2005; Marvasti, 2004). A single question intended to produce a narrative does not allow for researcher participation. The researcher may provide reassurance in the form of non-directional support, but changing or expansion of the research question is not permitted (Wengraf, 2003).

In interview one subsession one the participants were asked to tell their story using the following unstructured research question:

Would you like to tell me about your background, your country of origin, how you decided to become a midwife as well as your dramatic or traumatic practice experience and how you perceive this event?

I listened and noted emotions that occurred and recorded them later. Due to the sensitivity of the data it was not possible to have a gap between subsessions one and two during interview one as recommended by Wengraf (2003) and Campbell-Breen and Poland (2006). Therefore, directly following the completion of the narrative relayed during subsession one I asked for some clarification or extension of certain issues discussed by the participant. The tape recorder was again used for this process. Once I left the participants a self-debriefing occurred where I reflected on the story and the behaviour of the participant. I then recorded the non-verbal communications into my field notes. The participants in most cases displayed some form of emotion. The degree of the emotion depended on their health status and on the level of repair of their identities following the traumatic practice incident.

Interactive interviews can have liberating effects and for the researcher discussing a topic of mutual interest can heighten their self-awareness (Marvasti, 2004). For some of the midwives in this study the interview was the first time they had been able to discuss the traumatic practice event and they verbalized having found the interview liberating which supports the current literature (Raphael, 2006; ISTSS, 2005; Laing, 2000). I felt empathy for the participants and anger toward those who had abused them. However, it was by listening to their stories that the realisation of the greater impact of these events became apparent. All of the interviews provided an insight into contextual ideas that led to the development of the trauma model of commonalities across stories provided in chapter nine. Interview two occurred about seven months later to confirm the cause of the trauma for each midwife. The interview also contained questions that focused on the common threads derived

from the analysis of the data (see Appendix F). Two of the LMC midwives did not respond to the phone calls and therefore did not participate in interview two.

It must be acknowledged that failing to have a break between sub-session one and two of interview one did not give the participants time to reflect on their stories and could have impacted on the transcribed analysis. Another consideration that could have influenced the data collection and interpretation was not having undertaken all of the second interviews on a face to face basis.

The audiotapes are viewed as the primary documents (See section on informed consent for storage and confidentiality issues). The transcription of the audiotapes into text involves the opinion of the researcher (Neergaard, 2007) as they present their interpretation of the story (Frank, 2004). For example when a midwife has been deemed as incompetent by another actor in the story through considering the different paradigms of care involved I may have challenged this decision and advocated for the competence of the midwife as is evident in the story of Judy in Chapter Four. The researcher's personal and cultural values and beliefs affect the way they interpret and develop research (Denzin & Lincoln, 2008). To become effective as a researcher one must understand these influences and adopt a position where prejudice does not distort the findings (Daiute & Fine, 2003).

Transcription

The first five tape recordings were transcribed by a typist however due to the problem of getting the tapes to and from the typist I decided to transcribe the remaining eleven tape recordings myself. I edited all of the transcripts before sending them to each individual midwife for comment, prior to the second interview. The midwives were asked to sign the Authority for the Release of Tape Transcripts form (see Appendix E) and return it with the transcript in the stamped addressed envelope that I provided. This form confirmed that the midwife had the opportunity to read the transcript of the interview and agreed that the edited

transcript and extracts from the audiotape could be used by the researcher in reports and publications arising from the research. All sixteen forms were returned by the midwives together with the transcripts acknowledging agreement.

Analysis of the Data

The analysis of the narratives gathered for the current study draws upon the four dimensions of narrativity: ontological, public, metanarrativity and conceptual narrativity from the works of Somers (1994). Each story was analysed for its content and form based on identity and ontology (Somers, 1994). Frank's (2005) dialogical research and his concepts of the unfinalised person, monologue and perpetual generation were also used in the analysis. As the topic developed it became evident that the issue of power and control were influential factors, therefore Bourdieu's (1991) theory of economic practice was drawn upon to demonstrate the organisation's influence and relations of power that impacted on the midwives' stories. The concept of positioning (Davis & Harre, 2003) explored how the story-teller was positioned in the story by herself and others. Additional theorist specific to the focus of each substantive chapter and cited on page 88 were also used

I developed a template based on the concepts cited by the above researchers for the analysis of each interview. The resulting template is unique to each story. Figure 1 is an example of a template for analysis that was derived from Caroline story, who was the first midwife to participate in the study.

Theoretical concepts	Example
Positioning	Competent /incompetent midwife Safe/unsafe
Actors	Woman, husband, core midwife, G.P.obstetrician grandparents
Objects/technologies	Documentation, CTG tracing, institutional routines
Time (comes with the story)	2007, 41+3days gestation
Space	Here and there – Regions of the North Island. Places of birth, such as maternity units.
Embodiment	Pregnancy, contractions, birth
Identity	Professional person, LMC, caring midwife
Formal support networks	Request for review of incident
Informal support networks	Neo-natal nurse, consultant, midwifery partner
Power	Obstetrician, G.P. Grandparents
Symbolic Violence	Colonized.
Silencing	Ostracized from the group
Us – them	Core midwife versus LMC midwife
Tension – release	PPH / Bleeding stopped. Baby dying/baby lived
Binary opposition	Medical/midwifery paradigms of care Autonomy-oppression

Fig 1 Template for Data Analysis.

As I used the Biographical Narrative Interview Method (BNIM), which in the first interview requires very little if any verbal interaction with the narrator, my voice in most instances was not a part of the transcript. From the content and form of the story I developed a text, which provided me with the personal and professional identities of the participants situated within a socio-political context (Frank, 2004; Czarniawska, 2004; Lieblich et al, 1998). I undertook multiple readings of the individual midwives transcripts and although each person's trauma was specific to them common threads did emerge and form the basis of interview two. These

threads led to the formation of a trauma theory model which appears on page 275 and forms the basis of the substantive chapters.

In interview two I ask the midwives to confirm the commonalities comprising the trauma theory model. The interview was structured (see Appendix F for an example of interview two questions) yet personalised as the meaning of the event for the individual was discussed. The second interview, subsession three, occurred approximately seven months after the initial interview. Two of the interviews were face to face the other twelve were by phone. All of the interviews were audiotaped. The data from these interviews was used to clarify the meaning of the event for the participant, support the common threads derived from the original data and assist with the study recommendations.

In interview two the midwives confirmed that my analysis of the cause of their trauma as a breach of relational trust was correct although the concept of relational trust was not used at this stage. The findings from the other questions derived from the common threads that ran through the midwives' stories and addressed in interview two are threaded through the substantive chapters, for example questions in relation to support appear in Chapter six. Once the analysis was completed I made the decision about the stories that would illustrate the key concepts of each chapter. Mertle's narrative in Chapter five, for example, was used to demonstrate how the traumatic practice event created a biological disruption in her life resulting from a breach of relational trust leading to a chronic illness. A final tier of analysis came from additional theoretical perspectives that are specific to the concepts in each substantive chapter.

Credibility and Trustworthiness

In this study using the Biographical Narrative Interview Method (BNIM) stories that were told to me were unrehearsed therefore I had no influence over the content or form of the story. On occasions due to the emotional state of the participant it

was necessary to switch off the tape until the participant composed herself. Support was provided but the narrative was not discussed. At the end of the first interview I would repeat issues to the participant for clarification. This enabled the participant to reflect on the story she had just relayed thus verifying the account as accurate. The participants also had their transcripts returned for verification of authenticity prior to the analysis of the narratives. In interview two I discussed with each participant my analysis of what caused the trauma for confirmation of the findings. Common threads such as loss, grief, impact on identity, support, violence and relationship were present across the 16 interviews demonstrating a consistency between narratives. The occurrence of these common threads was supported by the literature and verified by the participants at the second interview. In this research intercoder reliability was achieved by my supervisors' involvement in the reading of the stories and the subsequent development of the transcript analysis templates to ensure they agreed with my interpretation. Presentation to groups of midwives of some of the stories and my analysis thereof has also occurred and the feedback confirmed the credibility of the findings.

Researchers have a responsibility to their participants and the readers of the findings to ensure that their research is an accurate representation of the topic under study (Bradshaw & Stratford, 2005). Riessman (2008) talks about 'situated truth' and suggests the credibility of a research project should be assessed from the environment in which it took place and the cultural factors that surround it. She discusses trustworthiness in relation to narrative research and suggests that some researchers may achieve credibility by a critique of the analysis of the data whereas others may consider the trustworthiness of the data in this case the narrated stories. Hiles and Cermak (2008) suggest that the most important component of critical evaluation is the transferability of the method used thus ensuring auditability by clearly outlining the processes undertaken.

Some researchers (Reinharz, 1992, Cook & Fanow, 1996 & Roberts, 1981 cited in Ellis & Berger, 2003) suggest it is impossible to have value-free research and recommend that the researcher and the participant should co-exist as active participants in an environment pervaded with “issues of power, emotionality and interpersonal processes” (Ellis & Berger, 2003, p.159). A trusting partnership between the researcher and the participant reduces the power in the relationship, encourages mutual respect thus enabling a dialogue to occur rather than formal questioning (Ellis & Berger, 2003). The method of interviewing and the question asked enable this to occur.

Dissemination of the research

Following a conference presentation in New Zealand (2007) outlining the proposed research I received support from several other midwives who heard the presentation and believed that the topic needed to be explored. A conference in Australia (2007) confirmed the need for support for midwives following dramatic or traumatic practice events. At the NZ conference presentation (2007) it became apparent that the pathway for complaints (see Appendix F) against midwives and the availability of assistance from NZCOM were not widely known. In 2008 the lawyer for NZCOM produced a booklet called *Unexpected Outcomes* that outlines the complaints process and the assistance available.

An overview of three of the stories was presented at another conference in Dunedin in 2008 as well as at two NZCOM regional meetings that same year and the common threads were confirmed by the audience. Some of the midwives present suggested that I write a book to enable people to understand that being a midwife is more than being present at the birth of a perfect baby. Listening to a presentation of one of the narratives and the analysis at a conference in 2009 was very emotional for some people but again the discussion that followed confirmed the need for the study. The same presentation was given at an NZCOM Wellington regional meeting in May 2010 and one participant present confirmed the need to talk in a

safe environment and that being part of the research had helped her heal. A midwifery manager present recognizing 'bullying behaviour' in her workplace, asked me to discuss actions she could implement to eradicate bullying from her unit. Another midwife stated that by participating in the research it had helped her to develop a support group in the Wellington area for midwives. I attended the initial meeting of the support group and suggested they should seek some education/training and also develop a means to protect themselves from vicarious traumatisation. They have had the education but believe that supporting each other will be sufficient protection against the effects they may experience. Feedback from a presentation at a midwifery conference in September 2010 confirmed the need for education on the elimination of violence and workshops on how to understand workplace trauma and its effects. Positive feedback and the importance of this research for the profession were also received from a conference in Brisbane in October 2010, ICM in South Africa and New Plymouth in August 2011.

Ethical considerations

This research was undertaken with regard to the requirements of the following legislation. The Human Rights Act 1993 which requires that the participants are fully informed of the study. All participants were informed verbally and in writing (see information sheet Appendix D) about the nature of the research. If after reading the information they still wished to be part of the study consent to participate in the research (see Appendix H) was obtained by me at the initial interview prior to the commencement. The participants were informed that they could contact me for further information regarding the study or that they had the right to withdraw from the study at anytime and no explanation would be required.

Attention was also given to the Health and Disability Commissioners Code of Rights (1996) which requires the researcher to ensure the participants are aware of the Right to Privacy; The Right not to be Harmed; The Right to Self-Determination and the Right to Full Disclosure was considered. The researcher is also

professionally bound to abide by the professional codes of the New Zealand College of Midwives. Code of Ethics and Standards for Practice

Participants were assured in the information sheet and at the first interview that confidentiality and anonymity would be maintained. All interview material was coded using pseudonyms and kept on a password protected laptop, used only for the purpose of this research. The tapes and transcripts were kept in a locked cabinet in my study. No one other than me has had access to the tapes and notes with the exception of the first five tapes. These tapes were transcribed by a typist who signed a confidentiality agreement. In the thesis personal details that may identify individual midwives who participated in this study have been changed. For example the names of the participants have been changed with the exception of two midwives who requested that pseudonyms were not used and their wishes have been respected. The country of origin for all overseas midwives has been omitted as has the name of the local area or District Health Board where the event took place. This was done in an attempt to protect the identity of the participants as well as other employees or women and their families that may have been involved. These actions of maintaining anonymity in published documents arising from research acknowledges that midwifery is a small community where providing countries of origin and local areas could enable other actors in the story to be identified. All data from the study will be kept for 5 years and destroyed or archived according to the Massey University requirements. Participants were offered the opportunity to have their audiotapes returned to them; none have requested this option.

Potential harm to researcher

The concept of vicarious traumatisation which occurs as a result of witnessing or listening to another's trauma (Morrisette, 2004; Figley, 2002) was considered by the members of the confirmation committee for doctoral studies with the School of Health Sciences at Massey University, Palmerston North in May 2007. The availability of counseling for me, the researcher was sought before this study was

accepted by the department. Concern was expressed that I could be seen as a counsellor, therefore it was made clear to the participants at the initial contact and at interview one that I was there as a researcher. Collecting the data was distressing but not problematic. Listening to the psychological and physical effects experienced by the participants was very moving and created for me feelings of compassion and helplessness. The main problems for me arose when transcribing, interpreting and analysing the data which required multiple readings of the transcripts. Identifying the hidden political agendas by reading other studies that confirmed the violence and power struggles in the health arena and the lack of support was another source of stress. Finally the belief from colleagues that the findings from this study will help provide support for future midwives to be prepared and supported when subjected to these events became somewhat overwhelming. To continue with the emotional support for the researcher, during this timeframe, was too expensive and therefore did not occur following the completion of the initial data collection.

The effect on the researcher when dealing with sensitive topics is an area that remains under researched (Dunn, 1991; Paterson, Gregory & Thorne, 1999; Gilbert, 2002; Rager, 2005; Lalor, Begley & Devane, 2006). The involvement of the researcher with the participants increases the stress levels of the researcher but also strengthens the connections between them (Rager, 2005) and was my experience in the current study. Rager argues that the increase in stress occurs as the researcher is the instrument through which the data is collected and analysed, consequently is involved with the participants at both a cognitive and emotional level. Disclosing the impact of a qualitative study on the research team is often not discussed in order to protect their feelings of vulnerability (Lalor et al, 2006) however, support for the research team is an area that requires further development (Dunn, 1991; Rager, 2005; Lalor et al, 2006; Sword, 1999).

Potential harm to participants

From the start of the study it was recognised that discussing a traumatic practice event could possibly disturb the psychological wellbeing of the participants. Therefore information was sought in relation to counseling that could be made available to the participants if required. No participant required a referral to an agency for emotional support. During sub-session two of the initial interview it was necessary to clarify certain issues that were causing distress with some midwives. The distress was usually in relation to questions over the midwife's competence or her being subjected to horizontal violence in the workplace. These discussions were initiated at the midwives' request and I felt if not dealt with had the potential to cause harm to the midwife. One distressed LMC midwife provided case notes of a woman who had experienced a long second stage of labour and where the core staff believed the midwife had not acted appropriately. In discussing this issue with the midwife and viewing the case notes it was evident that the horizontal violence directed at the midwife was a direct result of different philosophies of care. This knowledge confirmed for the midwife that she was not at fault.

New Zealand is a small country therefore it must be acknowledged that participant's stories or parts of their stories could be recognised by others involved in the narratives. In order to maintain confidentiality pseudonyms were used.

Benefits to participants

It soon became apparent that the midwives shared my interest in the topic and the need to find a process to help, prevent or protect others from similar experiences was paramount. This reciprocity enabled a relationship of mutual trust to develop which was rewarding but stressful. Yet it is this trust and the sharing of their individual stories that has encouraged me to complete this project. Knowing that for many I have been the first person that has really listened to their story and acknowledged their distress or listened without making destructive comments. Following interview one Bobby left a message on my answer phone stating that

participating in the research had enabled her to talk about the issue which had initiated the healing process for her. The importance of talking about the incident is a recommendation of the ISTSS (2005) and supported by the traumatologists Herman (2006) and Rapheal, (2006). The following are some of the comments received from participants in interview two as a result of participating in this study:

It was good to talk to someone who was out of the unit. Who was non-judgmental. (Emma)

Yes it was helpful. I could read through and make sure that what I had said was what I wanted to say. It was really helpful. (Susan)

I was pretty messy when you came. I felt it was very helpful to read it over and see what I had said. (Janet)

Having it written down and talking about it helped a great deal. (Anita)

It was good seeing stuff written down because it also validates it. (Portia)

Yes very, very, nice, somebody that wanted to listen. When the email came up I thought yes I would like to do that I would like to talk about it. In the research you know that you can talk openly and honestly about it. (Margaret)

I have heard many different stories and learnt from all of these practitioners but the thing that has haunted me, yet has been an inspiration to continue, was an email I received from a participant who was present at a conference where I outlined the research method and some of the findings. The email read “Thank you for believing our stories”. To Susan, the participant I will be eternally grateful for my reaction was, ‘My god, how could anyone not believe you’. I hope this thesis portrays to the readers the torment these dramatic and traumatic events can produce in the lives of midwives and those who have chosen to support them.

Overview of how the analysis was undertaken

When I embarked on the current study both my supervisors and I expected the traumatic stories to be mainly those of obstetric emergencies. Although they are part of the stories, the strong focus on relationships and violence whether between

midwife/doctor, midwife/midwife, midwife/manager, midwife/woman came as a surprise to us all. Frank (2004) discusses the concept of action and incongruity within research. This means that in the study there is a difference between what people would expect to be present in the story and what is actually there. The incongruity is what creates the tension in the narrative which in the current study was a breach of relational trust.

Midwife participants requested that their stories be told verbatim to enable the reader to get an impression of the impact of their dramatic or traumatic practice event. Telling the story using the direct words of the participants is supported by Frank (2005) who also recommends that researchers using the narrative approach write up the findings as the participants' advocate; I have attempted to achieve this. It would be impossible to incorporate the full 16 stories into this thesis therefore the six analysis chapters contain a least one story supported by extracts from other stories to illustrate shared themes.

The ideas of the main theorist Somers (1994) Frank (2005) and Davis and Harre (1990) used in the current study are threaded throughout chapter four to nine which are the substantive chapters. Each chapter has as its primary focus one of the common threads seen in the model on page 269 but may portray other issues specific to the narratives in that chapter. To complement or expand on the main theoretical ideas each chapter includes researchers whose work has centered on the topic specific to that chapter.

In Chapter Four I have drawn upon Foucault's (1978) development of disciplinary power as outlined in his theory of governmentality to demonstrate how individuals conform to social norms and expectations. Foucault's ideas of deconstruction also provide a basis for the critique and explanation of hierarchical organisational structures that influence midwifery practice.

Chapter Five illustrates Bury's (1982) ideas about biographical disruption, usually associated with chronic illness, and are drawn upon to understand the lifestyle changes described by participants and how individuals activate methods to cope with the disruption caused as a result of their traumatic practice event.

Doka's (2002) concept of disenfranchised grief was used in Chapter Six to demonstrate how workplace grief in most cases does not receive the support and acknowledgement required. Chapter Seven draws upon the Partnership model (Guilliland & Pairman, 1994) in order to demonstrate the relationship that develops between the woman and the midwife. Stewart and Strathern's (2004) ideas of rumour and gossip that have the ability to create conflict and Thompson's (2009) work on violence in the workforce are also acknowledged to understand the negative relationships that are present in the stories. I have developed a model illustrated in Chapter Seven demonstrating the outcome of rumour and gossip often arising from different paradigms of care. Studies on workplace violence by Mace, (2010), Bentley, et al (2009) Clarke (2005) and Barton (2005) have been used in Chapter Eight to demonstrate how individuals are treated or may behave when power struggles arise.

Chapter Nine: Calnan and Rowe (2008) ideas of trust and Langan-Fox, Cooper and Klimoski's (2007) concept of dysfunctional organisations are used to illustrate how counterproductive behaviours are exhibited and can lead to breaches of relational trust.

Summary

In this chapter the theoretical underpinnings of the chosen methodology and method that emerge from poststructuralist thinking, used in this current study, have been presented. Sixteen participants, a combination of core and LMC midwives from various areas of New Zealand, enrolled in the study. The data were collected using a biographical narrative interview method and analysed for its content and

form using the template on page 75. When writing the thesis I have not changed the participant's story but protected the honesty and intricacy of the personal meanings and attempted to try and link the data together in the context of the social setting in which it occurred (Frank, 2005; Marvasti, 2004). The stories portrayed are ones of conflict or struggle and therefore have generated commonalities or themes. These commonalities associated with the midwives' traumatic practice experience have been used as beginnings and not as in other methods of qualitative research as finalizing descriptions. The common themes symbolize the individual struggles and emotions experienced by the participants as interpreted by the researcher. They were confirmed in interview two by the participants.

It has been suggested that a narrative research thesis is a continuous dialogue between the researcher and the participants who come together in a particular time and space (Frank, 2005; Loyttyemi, 2005). It should echo to the readers of the research the shared knowledge each has of the other which in turn enables the reader to also echo their sentiments (Frank, 2005). By engaging with each other the report is not passive but reactive and could assist the narrator to make changes in their life. In the following six chapters I relate stories from midwives who participated in the study together with my analysis and interpretation of the stories thus creating a story within a story.

Chapter Four: The whistleblower, the advocate, and the forces against change

The past is no longer out of date.

(Serres & Latour, 1995).

Introduction

Whistleblowers and advocates challenge the boundaries, rules and regulations of hierarchies within maternity health care institutions in order to work in partnership with women and ensure the women receive best practice care. Despite health reforms which encourage collaboration between practitioners and choice of care for clients the maintenance of hierarchical structures within the health institutions accessed by participant midwives in this study is evident. In this chapter I argue that the power and control present in health institutions serve the good of the dominant group and influence the organisational boundaries found within these institutions impacting on the midwives' traumatic practice experiences. The overarching effect is a breach of relational trust that altered the meaning of the event for the midwives as they challenged organisational and professional boundaries.

Routine practices in the provision of midwifery care are linked to the unconscious behaviours of the core midwifery habitus which is dominated by the medical and management structures within the organisations. Bourdieu's (1982) theory of economic practice and Foucault's (1978) ideas about the disciplinary society are drawn upon to demonstrate how control is produced and maintained in the maternity units discussed within the narratives in this chapter.

The stories tell of two courageous midwives who, like the women they cared for, were disempowered by the dominant groups of management and medicine. The first story is from Susie, a core midwife, who was assaulted, abused and undermined by the obstetricians within the rural hospital where she worked. Her

narrative portrays the actions of a whistleblower and documents the repercussions of her actions on Susie's health and lifestyle. The second story is from Judy who practices as a LMC and is an ardent advocate for women's choice in childbirth. Judy's story demonstrates how she was positioned as unsafe and her actions of care prevented. The prevention of care resulted from different understandings of safety and risk as interpreted by the midwifery and medical paradigms of care.

The incident spoken of in Susie's story as with Judy's narrative occurred in 1995, five years after the 1990 Amendment to the Nurses Act and the early days of autonomous midwifery practice in New Zealand. The legislative change challenged the habitus within maternity hospitals consequently both Judy and Susie and the women they cared for were caught up in the struggle as actors tried to reposition themselves within the field of maternity care.

Susie: The Whistleblower

I remembered the help that Joan Donley gave me when I wanted to birth my babies so I really wanted to help women to do the same.²

Susie has extensive experience in midwifery working in both a primary birthing unit and as a LMC; she has also practiced for several years in the Middle East. The incident that Susie narrates occurred when she went to work in a rural hospital in New Zealand where staff appeared to be disempowered by the medical team. Susie stated:

When I began work at the hospital I noticed the staff were very disempowered. The doctors would come in and they would literally shout to people at the door. Very soon I asked them for a meeting and we established a code of conduct. This put me out of favour with the GPs and the obstetricians.

I had two or three incidents of working with a particular obstetrician and I realised that working with him was going to be very difficult. When I tried to speak to him about my concerns he just told me it was my problem. After a few months I started to see a pattern in the behaviour of this man. I looked back through the case records. I enquired from the staff what his history was and what his behaviours were. I was looking after this obstetrician's women and two serious incidents occurred. I started having nightmares, and honestly if I knew this man was on call I would be in fear and

² Joan Donley, RM, OBE; 1916-2005. Official founder of the NZCOM

trepidation. It affected my whole way of practicing. I got no support from the staff; in fact they became very fearful and made it clear where their priorities lay.

I sent in a couple of incident forms as I was not happy with the way that women were being treated by some doctors. These incident forms came back to me unsigned; when I rang the supervisor his reply was 'This is just your opinion'. I was told by the supervisor that if this obstetrician leaves, the hospital will close down as a large amount of the funding to keep this rural hospital going was coming from the complex maternity care. The situation got steadily worse. Then I started recording in the clinical notes. One of the offending GPs read it and came in and confronted me saying that I was playing a very dangerous game and that I would lose my job. I asked him if he was threatening me and that I really was not interested. Losing my job paled into insignificance as to what I was witnessing. I had five complaints in all up against me and then I realised for this to happen that these men must be talking together among themselves. I went up and faced these complaints that were unsubstantiated.

A young Maori woman came in for induction. When she was one centimetre dilated in the early stages of labour, without any pain relief, the obstetrician wanted to apply a fetal scalp electrode. Now this young woman was open to his suggestions. She trusted him, but as the VE continued she shouted 'Stop stop' and she started screaming and she was literally climbing up the back of the bed as he continued and ignored her cries. He did not stop until he had applied the fetal scalp electrode. I was so traumatized I was speechless actually. I had to continuously monitor her and I put the syntocinon infusion up. Further down the track he said he was taking her for a Caesar and I asked "Why?" and this was in the office and he grabbed both of my wrists. He is a tall man, and he said "I am sick of you" and he dragged me out of the office and tried to drag me down the hall and said "I am taking you to the manager". Halfway down the hall I pulled my arms off very very strongly and said "Take your hands off me" and it was at that point that he realized what he had done and walked off in the other direction. I then went straight to the manager myself and said that I was going to lay a complaint as to what had happened and that I was calling myself off duty.

That started a whole chain of events which led to my alienation as a midwife on the staff. I was called up for meetings. The hospital arranged a meeting with the head of the New Zealand Obstetricians' Society and the New Zealand College of Midwives' regional representative to examine my practice. In the meantime while I was still working the Occupational Health and Safety people came in and had to make sure that he, the obstetrician, was not on call the same days that I was there. I became very unpopular. At the same time the women were having meetings in the community and sixteen complaints came pouring in from the women about him. I rang the office of the Health and Disability Commissioner and they informed me that if I had five cases where the behaviour was consistent then I had something to go on. I managed to do that and then the disciplinary procedures started.

The fear of litigation was terrible, terrible. I thought I would be struck off because I realised that they can turn any sort of care into negligence or that I was sticking my neck out way above my job description. I was meeting with women in a clandestine way in the community gathering the information. There was no support anywhere really. I rang the College of Midwives and wanted to talk to the lawyer. I do not think they realized how severe the situation was. I got very little help from the College.

There was no help in terms of facing charges that were coming at me. I had to find my own lawyer who advised me that I had to trust and let it go and be happy with the outcome or otherwise it would destroy me as a person. Once I had sent my letter with my complaints into Health and Disability I was to forget about it and really literally do just that because I think it was about two years before the interviews that brought this all out came. That is what I did and when I had to go and tell the stories again then I lived it all again and in fact that time was a very healing time two years down the track. The lawyer was right I just had to let it go and look forward to another life in midwifery and that was distressing in itself. I have to say at this point in time there will be no looking back.

The outcome was the doctor was reprimanded by the Health and Disability Commissioner; he had to have his practice supervised and compensation was paid to some of the women. I felt it was a no win situation so I left the hospital as did another midwife who had witnessed his behaviour. The newspapers got hold of the situation and they wanted to publish the story. My husband was against that; looking back I realise that I was very much in a controlling marriage as well. I regret not getting that desire of what was happening out into the public eye, because I believe the outcome for the women would have been a lot more satisfying. However, it is a no win situation and I guess it has in a way confirmed or cemented, should I say, my resolve to assist women to birth their babies with the faith resting clearly within themselves.

The effects were devastating; we moved and settled in another town and my confidence was just so low. I really had to take it very carefully probably for about two years. Luckily the other hospital that I transferred myself to the obstetricians had a very good relationship with the midwives and it was a very kindly place. According to the trauma that I witnessed personally I do believe that this incident cost me my marriage and changed my whole life in terms of my relationships with all the staff and people around me. It left me having flashbacks at night and just being afraid of being on my own at home which I have never been; I am a very independent person. I realized that I suffered the symptoms of Post Traumatic Stress Disorder but we did not realize that is what they were at the time. I really want to help women to find power with each birth and to encourage the women to have faith in themselves.

The incidences of assault and battery that Susie relates took place in New Zealand in the late 1990s more than ten years after the Cervical Cancer Enquiry otherwise known as the Unfortunate Experiment (Coney, 1988) that occurred in Auckland, yet the incidents are similar. In the Unfortunate Experiment consent to participate in the research was not obtained and informed choice in relation to treatment was not offered to the women in the study (Coney, 1988). Parents were unaware that experimental tests were being performed on their newborn babies as no consent was obtained, and finally, nurses were aware that these activities were occurring yet complied with the doctors' orders (Coney, 1988). The mothers and babies involved in the Unfortunate Experiment were the victims of assault and battery as were the

women of the families that Susie represented in her narrative. It is suggested that the culture of the hospital today could be influenced by the fact that many of today's doctors trained under the direction of the medical team at the National Women's Hospital, the site of the enquiry, hence these out-dated attitudes and practices would have taken some time to be eliminated (Phibbs, 2001). The superior position of the doctors in Susie's narrative and the women's acceptance of their subordinate position relate to ideas that are associated with the old form of professionalism based on power and control (Dew & Davis, 2005). Professionalism of this kind does not include human relationships and emotions (Wilkins, 2000) which are an integral part of the partnership model (Guilliland & Pairman, 2010) practiced by Susie.

The threatening behaviour of the medical staff, as recounted by Susie, demonstrated resistance to the dispositions within their habitus being challenged. An expectation of compliance, by staff and women, to the dominant behaviour of the medical staff indicates the existence of a hierarchical system with all its power and control (Currie & Suhomlinova, 2006) present within this hospital. The elevated status of the doctor developed as a result of technology and the economic capital attributed to it but has also occurred as a result of the doctor's social origins together with the social ties and cultural capital in the form of knowledge that accompanies this position (Smith, 2005; Kirkham, 1996; Bourdieu, 1991). Cultural capital is viewed by Bourdieu (1991) as a part of the wider habitus and therefore forms an image of the social position of those who belong, in this case the image of the doctor. Within this habitus a ranking of different positions occurs with emphasis placed on those who gain the most social, cultural and economic capital (Bourdieu, 1991). The New Zealand health system is controlled through access to technical power. Consequently power is attributed to the specialists who implement the technology (Skinner, 2006; Fleming, 1995) thus demonstrating the link between cultural and symbolic capital and power (Bourdieu, 1989) as Susie's narrative illustrates.

Midwifery, by contrast, with its focus on birth as a normal life event advocates very little use of technology. As a consequence it does not have the symbolic capital associated with access to and control of technology or the power of the medical profession within the organisation. It is also a feminist profession whose knowledge base is construed as inferior to that of medicine (Smith, 2005; Turner, 1995). As a result midwives are expected to defer to the rules and regulations of the institution that are influenced by those in power. Individuals, like Susie, who challenge the system, are viewed as deviants who lack professionalism as well as femininity (Ehrenreich & English, 1973). Despite the autonomy attributed to midwifery in New Zealand, the knowledge acquired via an undergraduate degree, and the break from the control of the Nursing Council of New Zealand midwives are still viewed as inferior to their medical counterparts (Skinner, 2006). The expectation to conform to the rules of the dominant group was evidenced when the doctor informed Susie that by documenting her concerns in the women's case notes she was playing a dangerous game and could lose her job. The doctor's expectations of conformity demonstrate how hierarchical practices that constitute power and control persisted within health institutions.

Being exposed to the threatening behaviour of this doctor when Susie was informed she was playing a dangerous game is bullying but may not be perceived as such by the doctor. Could it be that due to the autonomy now accredited to the midwife his overt policing of boundaries is because he considers them to be fragile and in need of reinforcing? Symbolic boundaries are a method of conveying order within the social environment and as a consequence of their rigidity protect authority. The strengthening of boundaries results from the way the structured positions of medicine, midwifery and management interrelate in ways that are influenced by different types of capital that operate in this setting. Organisational boundaries are used by social actors to categorise people, practices and objects and often create a struggle as to what is the truth (Watkins, 2006).

I propose that in Susie's narrative what constitutes the truth is influenced by the person's philosophy of care and is evident in the binary oppositions of medicine and midwifery. According to Levi-Strauss (1963) binary oppositions provide meaning or value to units of language and are believed to develop and organize human thought and culture. In this polarization one end of the system is privileged over the other, such as male over female (Smith, 2005; Derrida, 1976; Levi-Strauss, 1963) or obstetrician over the midwife. The obstetrician and his value of rational thought is privileged over that of the midwife whose focus is one of subjective thought. This privileged position creates or sustains a hierarchy (Smith, 2005; Prasad, 2007) within the institution. Therefore truth for the obstetrician in Susie's narrative was the right to power and control of the birth process. Truth for Susie was empowerment of women and collaboration between health professionals.

Derrida (1976), whose work emerged from the structuralist tradition of Levi-Strauss (1963), discusses these relationships of difference arguing that meanings are not static but are continually being produced and influenced by the environment in which they are used. He suggests that meaning should include what is absent as well as what is present such as historical and socially specific issues that change over time (Derrida, 1976; Smith, 2005; Glendinning & Eaglestone, 2008). Weedon (2004; 1999), drawing on the works of Derrida, suggests that deconstruction of binary oppositions has identified that they are not indications of a natural order but different topics developed within specific historical conditions. The implications of Derrida's work suggest that when deconstructing binary oppositions within the stories of the midwives that are presented in this study, the history of the midwife as the doctor's handmaiden, the introduction of the autonomous midwifery practitioner and their influences on boundary issues and current doctor-midwife relationships should be considered.

Lack of attention to ethical issues, such as the doctors' abuse of women, by the management in Susie's narrative demonstrates the strengthening of boundaries within the field of the hospital. Management's actions of returning the incident

forms to Susie unsigned without any discussion demonstrates their support of the dominant group. Their acceptance of the behaviour of the medical staff towards women and midwives and their actions reflect the social conditions that exist within the institution (Behague, Kanhonou, Filippi, Legonou & Ronsmans, 2008; Fineman, 2008; Bourdieu, 1982) and explain the management's negative attitude towards Susie. Watkins (2006) recommends that organisational boundaries should be more relaxed and easily adjusted in order to pave the way for advancement of new ideas. The introduction of fluid boundaries would assist the new system of collaboration and partnership in health care to develop and produce an environment of mutual respect which was not present in the hospital where Susie was employed. It must be acknowledged that Susie's story occurred in 1995 not long after the introduction of autonomous midwifery practice. Anecdotal evidence suggests that collaboration between practitioners in some institutions in New Zealand does exist.

Susie's actions of challenging professional boundaries were tackled by the medical profession through these unsubstantiated claims made against her competence in practice. Lack of support from colleagues indicates that they had come to accept the situation of power and control, exhibited by the doctors and were reluctant to change. Kirkham (2000) suggests that as a result of midwifery being dominated at the beginning of the 20th century by medicine and more recently by management, the values and beliefs of these power-holders have been adopted by many midwives. Adopting the values and beliefs of those in power constitutes the behaviour of an oppressed group. In this setting the oppression of midwifery by the medical profession is a socially constructed historical element of the wider medical habitus. Consequently midwifery leaders, instead of adhering to the values and traditional beliefs of their own professional group, assume those of the power holders (Kirkham, 2000). This explanation could account for management's treatment of Susie as well as the lack of support from her colleagues as she remains true to her own values and beliefs of empowering women and refuses to conform to the demands of those in power

Foucault (1978) refers to these expectations of conforming to the rules and regulations of the organisation as disciplinary power that arises from governmentality. Morality, economy and politics form the basis of governmentality which demonstrates how the power of government and technology are connected and influence the state, the market and everyday life. Governmentality considers the historical background relating to how problems and techniques (technologies of power and technologies of self) are formulated (Nadesan, 2008; Lemke, 2000; Foucault, 1979; Foucault, 1978). Technologies of self include self-control that involves organising behaviours for the benefit of the self, family and society (Foucault, 1978; Lemke, 2000). Foucault views 'technologies of power' as the means used to create good behaviour by linking technologies of domination to technologies of self which enables the distinction between power and domination (Foucault, 1978). Power in this sense is considered a guide to ensure good behaviour (Lemke, 2000).

The hospital discussed in Susie's narrative is a small hospital which, without the presence of an obstetrician, would fail to meet the accreditation requirements and would be downsized to a primary birthing unit (MoH, 2003). In this situation, based on political and economic factors, it would appear management have linked the technologies of power to technologies of self and impressed upon the staff the importance of retaining the obstetrician. Maintaining his position was necessary because of the status and economic capital that he contributed to the hospital. In this situation little consideration appears to have been given to the obstetrician's clinical skills therefore ignoring the moral concept associated with governmentality (Foucault, 1978). Fear of losing their employment and the impact this would have on their families created good behaviour amongst some of the midwives and provides another motive for the lack of collegial support for Susie. Support for Susie from her colleagues would not only mean challenging management and the social norms of the institution but could also lead to the closure of the unit.

Financial self interest combined with fear ensures compliance and reflects the lack of social, economic, symbolic and cultural power held by the midwives within the institution. Employees, by conforming to the requirements of an institution, believe that they relinquish accountability and therefore place all the responsibility onto the management team thus denying their part in the actions that have occurred (Millgram, 1963; Martin, 2006; 2007). According to Herman (2006) hierarchical relationships are oppressive, socially justified and accepted; fear abounds and collegial support is inhibited (Fineman, 2008). Lack of support from colleagues demonstrates how power and domination in institutions create a docile individual who conforms to the request made and which is perceived as good behaviour (Foucault, 1978). By ignoring the moral aspects related to the obstetricians behaviour and succumbing to the requests of management the behaviour of Susie's colleagues could be perceived as cowardice by Susie.

Due to overt or covert means of social control individuals, from early life, identify with positions in their environment and as a result develop identities. Disciplinary power is responsible for different types of citizens that evolve from internalizing what is considered to be characteristic of the modern subject. As a result of constantly surveilling oneself in relation to disciplinary power the psychological state of the individual is conscious and permanently visible (Nedesan 2008; Lemke, 2000; Foucault, 1978). Foucault (1978) argues that disciplinary power contains a number of aspects associated with technology such as regulations, monitoring and surveillance. Disciplinary power provides methods of training that continually alter thoughts and behaviour patterns and operates mainly through institutes like hospitals and schools (Smith, 2005; Lemke, 2000). As a result of applying his concept of disciplinary power to behaviours of individuals in prisons, medical institutions and mental health hospitals Foucault (1978) posits that we now have a disciplinary society. He suggests that individuals conform to the performance of power; consequently power becomes productive creating good behaviour and could explain why Susie's colleagues adhered to the requests of the dominant group.

Autonomy threatens disciplinary power as it challenges the values and beliefs of the dominant group. Midwifery autonomy for example enables the midwife to focus her practice on the midwifery model of care as opposed to conforming to the medical model of care as was the expectation prior to the 1990 Amendment to the Nurses Act. Foucault (1978) argues that in relationships of power and knowledge resistance is an essential component of power, as is conformity. These actions of resistance or conformity to power demonstrate that individuals act in relation to the social norms that are a part of their daily custom. Occasionally one may take precedence over the other depending on the situation. The desire for a certain identity that is considered useful to the individual and society encourages people to conform. Compliance is a subtle way of ensuring appropriate ways of acting or interacting in a given situation (Woods, 2007; Smith, 2005; Lemke, 2000; Foucault, 1998). Complying with the doctor's expectations was not an option for Susie as she valued her autonomy and the provision of best practice care.

Susie's actions as a midwife have demonstrated the value that she places on a duty of care which in the case of the young Maori woman was to give consent for a Caesarean Section. Consent is granting to someone the permission to do something they would not have the right to do without your permission (New Zealand Health Council, 1989). Informed consent implies that sufficient information is provided to the person to enable a reasonable decision to be made (New Zealand Health Council, 1989). When discussing a duty of care in relation to midwives caring for women experiencing a mental health problem Philips (2007) suggests that there are four elements to informed consent:

- Information on which to make a decision
- Comprehension of the information
- Competence to make a decision
- Absence of pressure or coercion.

The right of informed consent grew out of the Nazi War Trials which led to the production of the Nuremberg code (1947) and the Declaration of Helsinki (1964). The underlying principle is that a person's bodily integrity should be protected from unauthorised touching or invasion. In New Zealand health practitioners have a legal requirement (H & D C Act, 1994) and a professional requirement³ to provide their clients with sufficient information regarding their medical condition and the procedure to be undertaken. Following the provision of this information consent must be obtained from the person before the practitioner carries out the procedure discussed. Failure to do this can lead to a charge of assault or battery.

Assault is:

- Intentional or threatened use of force against someone (crime); can also be an intentional or reckless act that causes someone to fear harm (tort).

Assault only requires intent not actual contact.

Battery is:

- Intentional or negligent application of physical force without consent

(Philips, 2007).

A 'duty of care' is a legal requirement that practitioners' actions or omissions do not harm someone else (NZNO, 2008) and is also a part of the Midwifery Council of New Zealand's Competencies for Entry to the Register of Midwives (2004), the Midwifery Code of Conduct (2010) and the Standards for Midwifery Practice (NZCOM, 2008). The Standards require the midwife to ensure the woman is provided with sufficient information to make an informed choice (NZCOM, 2008) in relation to the care received.

The action of the obstetrician, by refusing to stop applying the fetal scalp electrode when requested by the woman, was battery and his intention to perform a caesarean section without informed consent was that of assault. The physical force used against Susie when she questioned the obstetrician's intent was also one of battery.

³ New Zealand College of Midwives (NZCOM) is the professional body for midwives and incorporates informed consent into the Standards for practice (NZCOM, 2008).

By his actions, this doctor failed to provide a reasonable duty of care to the woman and was therefore negligent. His actions also betrayed the relational trust the woman and Susie had in him to provide a good standard of care. When assaulting the young Maori woman and expecting acceptance of his behaviour by the staff, the obstetrician demonstrated that cultural and economic capital can be converted into social capital that enables individuals to mobilise their social ties to their own advantage (Smith, 2005).

Susie's collection of evidence to prove a case against the obstetrician demonstrates her determination to ensure that he was made accountable for his actions. It also illustrates the case of a 'whistleblower' who is a person who tries to prevent harm to others by working initially within the boundaries of the organisation to try and solve the situation (Marcia, Miceli, Near & Dworkin, 2008; Vanderkerckhove, 2006; Alford, 2001; Balk, 1996). Susie did this by establishing a code of conduct and sending incident forms to the manager. However, the whistleblower also has sufficient information to seek other channels of assistance if required and occurred, as Susie narrated when she complained to the Health and Disability Commissioner. By challenging the organisational rules of an institution whistleblowers place themselves at risk of being accused of insubordination and being threatened with dismissal (Marcia et al, 2008; Vanderkerckhove, 2006; Alford, 2001; Balk, 1996) and occurred for Susie when the obstetrician informed her she was playing a dangerous game. By adhering to their own moral values and beliefs the whistleblower steps outside the organisation's moral order illustrating a lack of coherence within the system to the cultural norms and expectations (Alford, 2001; Balk, 1996). Susie demonstrates this incoherence by questioning the obstetrician's decision to perform a caesarean section without gaining informed consent from the woman.

Whistleblowers are seen to have the long-term interests of the organisation at heart and are in many instances viewed by the media and the public as heroes (Manning, 2009; Bather & Kelly, 2005; Balk, 1996). As whistleblowers they know the sins of

the organisation however, rather than expose the situation, admit fault and correct the policies, the organisation attacks the whistleblower whose sole purpose is to protect the moral values of the profession and safeguard the public (Bather & Kelly, 2005; Balk, 1996). The organisation's methods of attack against Susie were the incident forms being ignored by management, doctors complaining about her practice, being unable to work when a certain obstetrician was on duty and being silenced by her colleagues. The majority of whistleblowers lose their employment and/or are prevented from getting other positions (Bather & Kelly, 2005; Alford, 2001). This means they may lose their lifestyle, their families, may become depressed and in order to cope with the situation some turn to alcohol (Bather & Kelly, 2005; Alford, 2001; Clark, 1997; Miethe, 1999; Balk, 1996). Hunt (1995) suggests that employees wishing to express their concerns in relation to standards must be aware of the sudden change of attitude, defensiveness or ignorant behaviour that will be displayed by those in authority. Gooderham (2009) states that "whistleblowing is still hazardous to whistleblowers" (p.1) and argues that those in official positions should recognise the risks taken by these people.

Whistleblowers, like Susie, deserve protection against organisational retaliations as they disclose information in the interests of the public (Vandekerckhove, 2006). When someone is exposing incompetent practice or illegal behaviour in health care it is absurd that the person should be punished. Failure not to expose harm is what people should fear (McClusky, 2009). The dichotomy that results between the public's right to know and the organisation's right to loyalty creates conflict especially in the development of whistleblowing policies. The stakeholders and shareholders are part of the public as are the non-governmental organisations; they all have a right to know the failings of the organisation and many present day managers are recognising this fact (Vanderkerckhove, 2006; Baten & Kelly, 2005).

Hunt (1995) argues that the issue of the whistleblower has developed as a result of a failure of the 'separation of power' of professional and managerial ethics. Professional ethics is aimed at the protection of the public and the respect for their

autonomy. Managerial ethics refers to the protection of information vital to the success and profit of the business. The protection of these proprietary rights would appear to provide managers with the power to relinquish ethical responsibility in order to maximize profit (Bather & Kelly, 2005; Hunt, 1995). An underlying factor here is the power and prestige that the obstetrician brings to the hospital which are vital to the success of the business. The women and midwives such as Susie do not have such power and prestige. Yet both medical and midwifery practitioners are vital if there is to be any type of maternity service.

Managerial corruption can only occur when subordinates routinely accept its presence (Balk, 1996). The inaction of Susie's colleagues to the behaviour of management suggests they have internalised the concept of disciplinary power (Foucault, 1978) by obeying authority and cooperating with the medical team. (Woods, 2007; Smith, 2005). However Balk (1996) suggests the reason subordinates remain quiescent is a result of witnessing the treatment inflicted on the whistleblower which could also account for the lack of support Susie received from her colleagues. Patel (2009) supports Balk's explanation for the silence of colleagues and questions why the National Health Service in the UK does not provide an environment that reinforces the actions of the whistleblower. He claims that to be disadvantaged by performing a morally good act places the practitioner in a no win situation and creates an ethical dilemma. Although I agree with Patel's statement from a moral perspective I have to support Susie's actions and therefore ask "How ethical is it to do nothing?"

Blowing the whistle on incompetent practice threatens the functions of the institution and demonstrates how Susie as the whistleblower is a threat to the management of the maternity unit. Baten and Kelly (2005) propose that corporate social responsibility is adopted by management and that issues of incompetent practice are investigated which should result in no further need for the whistleblower. Alternatively Gooderham (2009) suggests what is needed is that whistleblowers should receive statutory protection, more support from regulatory

bodies, and a cultural change that encourages whistleblowing. These recommendations were made after the events narrated by Susie took place; the legislation protecting the whistleblower was not in statute at the time. Susie's story occurred in the 1990s prior to the introduction of the Protective Disclosures Act (PD) 2000 that protects workers like Susie in the public sector. Despite the changes in legislation relating to the protection of the whistleblower in New Zealand, organisations, as a result of their hierarchical system, still protect those with specialised labour in accordance with the supply and demand of their knowledge and skills (Marcia et al, 2008).

The following stories by Dobson (1997) and Lenzar (2004), like Susie's, demonstrate the issues of managerial power versus professional ethics and indicate the importance these practitioners place on their duty of care. They also explain why the story of the whistleblower, from a management perspective, is one of disloyalty. Dr Sian Caiach was thanked by the Audit Commission for drawing to their attention a situation in relation to private practice at a hospital in South Wales. Despite the report finding in favour of Dr Caiach, she has not been able to work for ten months and is still reported by the hospital as being on maternity leave (Dobson, 2009).

Unfair treatment by the organisation is exemplified in the case of Dr Kruszewski, a psychiatrist in the USA, who uncovered the use of off-label medication and serious abuse and death of the mentally ill at the Pennsylvania Department of Public Health. He accused the organisation of allowing political influences and the drug companies to dominate prescribing rather than the use of good practice guidelines. His employment was terminated as a result (Lenzar, 2004). In her narrative Susie was also trying to expose substandard care provided to childbearing women.

The support Susie received from the community when collecting evidence against the practice of the obstetrician demonstrated the women's disapproval of the status quo within the institution and recognition of the need for change. The provision of

support also represents the trust they had in the midwife to help them resolve the issues about improper care by a member of the medical staff. The culture of the hospital is embedded within a form of disciplinary power (Foucault, 1978) in which consumer compliance is expected and the right of choice is removed from the women. Informed choice and control as set out in health legislation (Health and Disability Commissioners Act, 1994), was missing. In order to alter the situation the women, supported by the midwife, decide to take action against the culture of power and control in this institution. Susie's story demonstrates partnership in action as both midwife and women share their experiences, exercise their autonomy and strive for best practice care.

Susie's narrative demonstrates how the power and control present in hierarchical health institutions impacts on organisational boundaries and creates a docile individual which was not the case with Susie who refused to conform. Challenging the behaviour of the obstetrician demonstrated Susie's compassion for a young Maori woman and her trust in her own values and beliefs; there was no thought of recompense. In their discussion on emotional support Dass and Gorman (1985) suggest that "Caring is a reflex" (p. 5) an innate reaction that feels normal and results in an unselfish relationship. Susie's actions were those of solidarity for not only was she working in partnership with the woman she was also her advocate. It is these issues that provide the platform for Susie to challenge the customs of the organisation. Susie, from her subjective position sees the obstetrician as controlling this woman's birth experience. The obstetrician, from his objective stance, ignores the issue of control raised by Susie and endeavours to make clear the organisation's rules which support his superior position in the field. These positional rules influence the woman's experience of childbirth in ways that may not be immediately apparent to others. Consequently as a result of witnessing abusive treatment of women and midwives Susie takes on the role of the whistleblower and suffers the repercussions of this action.

Susie experienced the effects of vicarious traumatisation (Morrissette, 2004) however, she had to carry on with her role as a core midwife. In order to provide safe and effective care she had to suppress her own feelings and continue working as if she had not been personally affected thus creating further stress. Stress and suppression of feeling can lead to powerlessness which implies feeling helpless and vulnerable (Herman, 2006). The result of powerlessness can lead to PTSD which may occur as a consequence of witnessing the long term effects of threats to physical integrity which in Susie's situation was witnessing the abuse of women by the obstetrician. In order for recovery to occur an environment of empowerment is required (Herman, 2006). The decision to leave her place of employment and take up work in another town provided Susie with an environment conducive to the road to recovery.

Once the whistleblower is no longer a part of the institution little thought is given to these people, their concerns or the impact on their identity. The following quote by Alford (2001. ix) explains the need for understanding the experience of the whistleblower if people are to acknowledge the importance of maintaining moral values. "I think we will not understand what is happening in our society until we listen to the tears, the screams, the pain, and the horror of those who have crossed a boundary they did not know even exists". It is my perception that initially Susie did not know the boundary she was about to cross when she sent those incident forms to the manager. However, when she states that losing her job became insignificant compared with the behaviour she was witnessing I suspect that is when she became aware of the potential consequences to her as she continued with her quest for moral justice.

In this narrative multiple breaches of relational trust have occurred for both the woman and Susie. Susie's trust in the obstetrician was destroyed when he failed to provide best practice care to women irrespective of their status or ethnicity. She was also disappointed that he did not respect the midwives with whom he worked. Failure to acknowledge the woman's request to stop when she withdrew her

permission for a VE was another breach of trust. Neither Susie nor the woman expected to be abused by the obstetrician let alone his actions accepted by management. Management failed to meet their duty of care by their acceptance of his behaviour illustrating a lack of obligation towards their responsibilities. Susie was also disappointed in the response of the hospital staff to her actions of resistance as she refused to conform to the requests of the manager and the obstetrician. Failure to receive support from her professional body was another expectation that created disillusionment for Susie. The performance of this midwife suggests she is an intelligent, caring woman and an ardent advocate of the human rights of women in the community in which she lived. The following are the final words from Susie's story:

There are no heroes in a story like this and I believe that the midwife is a change agent and if you are to be a midwife you have to be a political animal. We are changing the face of relationships as we know it by helping women to become strong and powerful and reclaiming their right, their power to birth their babies as they wish and also reclaiming ownership of their own doubts. In actual fact I think it has a significant effect on communities throughout the whole world. That when there are well women, there are well babies, and there are well communities. Where women are upheld and the communities thrive I am certain that we will see an end to war. So I see this as a worthy cause and one fraught with struggle.

Susie's story is that of a courageous woman with exceptional qualities who led a challenge against what she perceived to be incompetent medical practice. She was an advocate for the women of the community as she challenged the institutional preference for power and control over that of competence and informed choice. In my opinion these qualities make Susie the hero of her story.

Susie's suggestion that midwives need to be political animals is substantiated in the following narrative told by Judy as she challenges a system that considers her actions of supporting a woman's requested birthing position as evidence of incompetence. The narrative demonstrates the conflicting demands on the midwife when she is required to work in partnership with a woman, the first competence

requirement of the Midwifery Council of NZ Competencies for Entry to the Register (2004), but also expected to adhere to the policies and protocols of the institution.

Judy: The Advocate

I have a very firm belief in woman's ability to birth normally and naturally. In order to be able to do that women need to be in an environment that is safe, trusting, loving, secure and respectful.

Judy trained under the auspices of the medical or technocratic model of care (Wagner, 1994) and, as legally required at that time, under The Nurses Act (1971) she followed the orders of the medical profession. As a result of her experience and the social changes that have occurred in New Zealand over the last 20 years, Judy is now entrenched in the midwifery model of care which means working in partnership with the women who request her professional services. Judy's story provides an example of conflict occurring between the midwife and the obstetrician as a result of different philosophies of care.

Practicing the way I do means that you tend to be coming up against that interface between the medical and midwifery model a lot. I think my passion for my job comes not from any religious beliefs but from humanistic values. I am very committed to women and their families. This particular incident is about a woman that I had looked after previously who had a homebirth for her first baby which went really well. Jan had a history of depression which had never been treated. Perhaps an emotional fragility. They are an intelligent couple who knew exactly what they wanted and contacted me this pregnancy for midwifery care. At about 36-37 weeks gestation I discovered the fetus was in the breech position. We had to go through all this whole process of 'Oh God what do we do now?' This was probably not going to be a homebirth unless they particularly wanted one because I felt it was safer to do a breech in a hospital. We did a scan to ensure the baby was in the correct position and not too large. I consulted with an obstetrician who saw Jan and supported a vaginal birth. These were the days before the breech trial and the development of Section 88 and the risk guideline therefore the hospital was still doing breech births. He advised that the obstetrician on call should be contacted when the birth was imminent.

When labour was established we went to the hospital, the lights were dimmed and I had another midwifery colleague with me who was confident with breech birthing. Jan had been in the bath and she was currently standing and we had taken the mattress off the bed so it was not looking much like a labour room at the time. Jan was breathing this baby down; she was not even pushing and we could just see the bum starting to

appear, it was beautiful. Jan was so calm and so serene and it was just beautiful. At this point I rang the obstetrician to inform him of the situation and requested his presence at the birth but unfortunately it was not one that was comfortable with vaginal breech births. The obstetrician arrived and gave orders, to "Get that woman onto the bed on her back, how could you possibly birth this baby standing up". It is interesting how you work, really, you kind of withdraw and you have to do what you have to do.

He wanted her into lithotomy, so she goes up into lithotomy. The breech is just coming down beautifully and he wants to do an episiotomy. Jan put her hand over her vulval area and said 'Please respect my body' which was really powerful that she could say that. Yes it is amazing that a woman can do that. He did a managed breech birth, the baby was fine. He said that this baby's head was stuck and he applied forceps to the after coming head but in actual fact it was because he never waited. He managed the whole process, he never allowed the breech to hang. There was no hands off the breech. After that whole incident I thought I would never advise any woman to have a vaginal breech birth if they were going to have an obstetrician present because I did not think it was safe, I thought he made it very unsafe for the baby and the mother. After the birth the obstetrician calmed down a bit but he was unpleasant and continuing to say what terrible people we were. Well what a terrible person I was really and how dangerous it had all been. I suppose by the same token what a wonderful warrior he was which means saving the situation.

After the birth the obstetrician wrote a letter of complaint to the board of the obstetric unit and they made a very concerted effort to get rid of me. The communications went on for months; they wrote to me legally. Then they called a special meeting with the Human Resource people. This meeting was like a court, a Kangaroo court; I thought I am going to be taken out and summarily shot. Because that is what it felt like, there were all these people and then there was me and my midwifery colleagues who were told they were not allowed to say anything. The questions were shot at me by the manager. They did not get my access agreement; they certainly scared me sufficiently to think they might. At that time I was the major bread winner in our family and it would have had bad implications if they had done that. They threatened, they bullied, they did everything they could to try and get me into submission and get me either to stop practicing or comply with the medical model and that was the hospital in cahoots with the obstetrician. Pretty sick really, there was very little midwifery support within the hospital. I suspect if it happened again to-day it would be exactly the same.

At the debriefing session there was another one of the obstetricians present and he was renowned for shouting and roaring at you when you went to debrief. What happened? I was shouted at and told how stupid I was so it was not constructive at all.

The obstetrician that was present at the birth certainly continued to watch my every move and commented by writing letters to the obstetric department to try and get rid of me which made life a little bit difficult if you had to consult with him, if he was on call. I think we need to have professional respect, if I needed to have someone there I would not hesitate to call him but unfortunately the respect was not mutual. This continual complaining led to a Special Review being undertaken by the New Zealand College of Midwives and this was very affirming. Unfortunately the hospital was not so happy with the outcome.

Horizontal violence is very much alive and kicking, was, has been and still is in many ways in that if your practice is seen to be outside what they consider to be normal, practicing in the midwifery model is not seen to be OK these days. The core midwives tend to treat you, not that well, really, and they never support you and I would never expect them to support me. On the other hand having worked in a hospital for four years I understand that that is the environment they have to work in and live in and they have to be able to get by so it is very difficult to be standing up in that environment when you are the only one standing up.

Emotionally I was incredibly flat. I am actually quite strong but I think what has happened over the years, I think it has chipped away and that nasty little man has kept chipping away at my armour. I am a bit more crumbly than I used to be and I think the fact that it is still there and I can still weep about it yeah it is very powerful stuff.

Violence in a symbolic form is hidden and maintained by unauthorised cooperation (Herman, 2006) which, in Judy's story, was between the obstetrician and the service manager. The meeting initiated by the obstetrician was referred to by Judy as a "Kangaroo Court" as she perceived that the meeting was set up by management with the sole aim of disciplining her practice. Processes of conflict, accusation, trial and outcome are based on judicial proceedings (Stewart & Strathern, 2004) and are the steps that Judy felt she was subjected to. The actions of the service manager, in her role as the judge, can hardly be viewed as impartial as she silences Judy's midwifery colleagues who were there to provide emotional support and acknowledge Judy's midwifery competencies in practice. The binary opposition of talk versus silence demonstrates that social norms and values are closely linked to speech (Tannen & Saville-Troike, 1985) which is apparent at Judy's perceived "trial". The power exercised by the management and the obstetrician, supported by the representative from the Human Resource Department, exhibits an environment enveloped in hierarchical structures resulting from organisational and professional boundaries. Due to their positions in the field, the symbolic violence (Bourdieu, 1982) that Judy was subjected to at this meeting would have been perceived by these actors as their right of command.

The environment in the institution discussed in Judy's narrative is pervaded with symbolic power (Bourdieu, 1982) derived from the doctor's and management's position in the field. Challenging Judy's competence to practice and attempting to

remove her access agreement demonstrates how acts of subordination and violence can destroy individuals. The access agreement is of value to Judy as it enables her to provide midwifery care to women in the hospital; without it she would not be able to practice in the area and thus maintain her family's lifestyle. The management team and the obstetrician gave little thought to the consequences their actions would have on Judy's health, the impact on her family or her continued practice as a midwife. The narrative also illustrates how the management and medical staff failed to acknowledge the woman's legal right to control her own birth process supported by her caregiver of choice. By neglecting the woman's choice in childbirth the management and the doctor failed to meet their duty of care. Their actions constitute a breach of trust not only in the personnel involved but in a system that disempowers women and midwives rather than enabling informed choice and control.

Judy is an ardent believer in women's rights and advocates for her women while still remaining within the boundaries of safety. The safety issue was confirmed at the Special Standards Review meeting which measured Judy's practice against the NZCOM (2008) midwifery standards for practice. Safety and risk can be viewed as binary oppositions; how one views these concepts will depend on the paradigm that governs one's practice. In the medical model of childbirth which is problem orientated, situations are viewed as risky and full of danger. Intervention which is usually based on scientific truth is believed to be required to aid a safe outcome (Wagner, 1994). The midwifery model has its focus on health solutions rather than problems. Regular assessment of the woman to ensure everything is progressing normally guarantees safety and minimises risk (Wagner, 1994). In these opposing paradigms different interpretations of risk are apparent therefore it is not surprising that conflict will occur (Skinner, 2006; Mythen, 2004; Stapleton, 1997; Wagner, 1994).

Beck (2009) suggests that the meaning of risk has altered, for in today's society fatalism and compensation have been replaced by risk and prevention. Historically

risk was linked to danger; today risk is associated with uncertainty and probability. It is futuristic for it concerns what may happen and not what is happening (Beck, 1992; Lupton, 1999; Mythen, 2004) therefore in this futuristic context risk is the desire for control of predictable outcomes (Mythen, 2004). The obstetrician in Judy's story demonstrates this futuristic concept of risk by taking control of the situation and demanding Jan is placed in the lithotomy position. His actions of managing a breech birth demonstrate that as a consequence of risk management now focusing on a negative outcome the intervention rate is increased (Skinner, 2006; Mythen, 2004; Lupton, 1999). Practitioners' fear of litigation also increases the use of intervention and creates anxiety (Skinner, 2006; Walsh, El-Nemer & Downe, 2004; Smythe, 1998).

It is argued by Beck (2000) that risk is a type of institutional reflexivity which in sociological terms implies a reaction to a situation that arouses anxiety or fear that is active and not passive. Institutional reflexivity contains two contradictory emotions, one which is risk and the other fear; fear as to who will take responsibility for the outcome (Beck, 2000). In Judy's story the fear of having to take responsibility for a negative outcome and possibly face litigation could be the reason for the actions of the obstetrician despite the evidence that there is an increased risk to women when interventions occur (Skinner, 2006; Walsh, et al, 2004). Fear of a negative outcome could also account for the subservience of Jan when ordered by the obstetrician to get on the bed.

In stressful situations personal anxiety and lack of experience may influence decision making (Stapleton, 1997) which may not involve logical thought. The situation the obstetrician in Judy's story found himself in, where the woman was standing to birth a breech baby, placed him outside his comfort zone. His reaction relates to the medical paradigm where, according to Wagner (1994), birth is only normal in retrospect. He was unable to accept that things were normal; that the woman, supported by the midwives, was in control and the fetus was safe. In a qualitative study by Calvert (1998) safety of the baby was found to be the primary

focus of women therefore if women are encouraged to understand risk in terms of safety of the baby prevention of risk will be the overriding concern above any other issue (Calvert, 1998; Stapleton, 1997). Despite following the messages from her own body during labour and standing to give birth, supported by Judy and her midwifery colleague Jan's primary focus is the safety of her baby. The safety issue could account for her adhering to the demands of the obstetrician and climbing on to the bed rather than continuing in her chosen position for birth.

Behague et al (2008) suggest that doctors tend to blame women for poor birth outcomes; in order to avoid conflict women are inclined to focus on survival. By remaining silent and complying with the medical orders Jan could be demonstrating the use of subservient behaviour in order to survive. However, by preventing the obstetrician from performing an episiotomy Jan demands some choice and control of her birth experience. According to Cole (2009) the power attributed to doctors is provided to the profession for the common good of society. The power used by this obstetrician does not, in my opinion, work for the common good of society as expected as his actions do not reflect a democratic process. Neither do his actions demonstrate informed choice and respect for difference as required in the Code of Health and Disability Services Consumers' Rights (1996). What his actions do represent is his perception of risk associated with his role in the organisational field and the power acquired from the social, cultural and economic capital attributed to this role. The power attached to the obstetrician's role confirm the ideas of Tullock and Lupton (2003) that in a risk society experiential knowledge is denied and power as danger can only be decided or regulated by experts. The concept of the expert forces consumers of health care to gain information in relation to risk from those with the knowledge and subsequent power which in Jan's case was the obstetrician.

Judy's story demonstrates how the midwife's role can be contradictory, from one of being 'with woman' to one of 'following the doctor's orders' when asked to change the position of the birthing woman. The compliance demonstrated by Judy and her

colleagues is a result of ‘technologies of power’ which link domination to the self and create good behaviour (Foucault, 1978). The actions of Judy and her colleagues is not unusual as in an oppressive environment subordinates tend to conform to the requests of a senior person who has cultural capital and institutional power (Currie & Suhomlinova, 2006; Bourdieu, 1991). The senior person in this case was the obstetrician who, upon entering the room, demanded that the woman get on the bed. He failed to provide the woman with information to make an informed decision regarding her position for birthing. Rather he followed the paternalistic model of decision making that is associated with the old professionalism and used coercive behaviour to ensure the birth was managed his way. By failing to gain informed consent it could be stated that he assaulted the woman and undermined the midwife who was following the advice acquired at a previous obstetric consultation. The consultation had occurred in the antenatal period when Judy’s examination revealed that the fetus was in a breech presentation. The consultation and subsequent plan would be documented in Jan’s records. By ignoring the plan of action provided by his colleague at that consultation, the delivery obstetrician showed little respect for his colleague, the midwife or the woman.

The Medical Council has developed a policy in relation to behaviour that threatens clinical respect in the maternity sector. The policy of the disruptive doctor applies to all sectors of medical practice (Cole, 2009). Now that the policy of the disruptive doctor is in place individuals like Susie and Judy are enabled to challenge the abusive behaviour of the doctors such as those in their stories.

The obstetrician’s actions in Judy’s narrative indicate that he gave little thought to the emotional impact his disempowering command could have on the woman. His focus was purely on his technical management of the birth and his right, by virtue of his position in the field, to ensure that the birth was managed to conform to his manner of practice. How can Judy empower women under her care when, as a midwife, she is disempowered? A vicious circle is created as “disempowered midwives disempower women” (Kirkham, 2000, p. 232). An oppressed group does

not have the opportunity to acquire skills to enable them to teach these skills of empowerment to others (Kirkham, 2000). How are midwives to meet the mandatory requirements and work in partnership with women, offering choice and control of their birth experience (MCNZ, 2004) if these choices are to be removed by members of the medical profession? Failure of the doctor to comply with the requests on this woman's birth plan is another example of the organisational forces that allow the dominance of the medical profession to continue inhibiting the alternative midwifery service delivery and retaining a class system. Judy's actions to support this woman in her request for a vaginal breech birth, demonstrate her firm belief in a woman's choice in childbirth. The actions of the delivery obstetrician derived from his learned values of control rather than informed consent created a breach of trust for the woman and Judy. The breach of trust occurred as, having adhered to the *Guidelines for Consultation with obstetric and related medical services* (2000), both Judy and Jan expected the obstetrician to adhere to the birth plan formulated with one of his colleagues as part of this process.

Judy understands that the lack of support that she received from the hospital staff, although disappointing, is a result of her practicing in the midwifery model of care. The core midwives work in a hierarchical environment where the expectation is that they will obey the orders of senior personnel. Therefore as a group they exhibit disciplinary power and conform to what is expected of them rather than challenge the medical and management teams' behaviour. To support Judy and challenge the authority they may be labeled as disobedient and therefore could be subjected to possible disciplinary action (Alford, 2001).

According to Martin (2007) "Unfortunately there is nothing more obstructive to 'woman-centered care' than disinterested authority combined with the midwife's buffering effects of denying responsibility" (p.1). In Judy's situation neither the obstetrician nor the senior management team were interested in the rights of the woman. Neither did they show respect for Judy's right to practice in the midwifery model of care and comply with the NZCOM Standards for Midwifery Practice

(2008). The buffering effects of the core midwifery staff were displayed by not supporting Judy's right to practice in the midwifery model of care. In this site of struggle the management and medical teams strive to maintain the status quo whereas the midwife advocates for a change for the birthing women of the community. All participants believe in their actions and the resulting consequences. In the environment present in a field such as this the conflict arises from the different values and beliefs of the participants (Bourdieu, 1991) exacerbated by legislation which introduced independent midwifery. These values and beliefs stem from the paradigm in which these health professional practice and illustrate the implications of binary oppositions.

The incident disrupted Judy's biography as her trust in the system was broken and her professional identity was challenged. As Judy related this birthing scene to me it was obvious that she still suffers emotional distress when talking about the situation thus demonstrating the long term impact these events can have on the individual. Perhaps the continuation of this distress for Judy could have been averted if the debriefing session had been constructive rather than destructive. If she had been given the opportunity to state the rationale for her actions and respect for the midwifery paradigm had been acknowledged by the obstetrician and management, Judy would have felt supported, safe and competent in an environment of trust and mutual respect. However she was subjected to power and control which included the boundaries and regulations in the field that work against collaboration or partnership and led to breaches of trust. Failure of the system to be receptive to woman centered care is the primary source of mistrust experienced by Judy.

Judy and Susie's stories demonstrate how binary oppositions such as the medical and midwifery models of care maintain hierarchical practice (Smith, 2005; Levi-Strauss, 1963) within institutions and how these dualisms serve the interests of the dominant group. Both Susie and Judy were subjected to power and control by management and doctors as a result of exercising their autonomy and working in

partnership with the women for whom they provided care. By working within the midwifery model of care and empowering the women these two midwives challenged the values and beliefs of the habitus which resulted in conflict within the workplace. Susie's and Judy's stories confirm the words of Serres and Latour (1995) that the past is no longer out of date as the narratives demonstrate the hierarchical health system based on knowledge, economy and class is still active as in the 1990s. Evidence of these hierarchical institutional practices are present in the other narratives in the current study; the content of which were experienced in the 21st century.

Summary

The midwives' stories of the whistleblower and the advocate challenge the boundaries of hierarchical organisations by supporting women's choice in childbirth. Both midwives expected and advocated for collaboration and respect between professionals and women yet their trust in the system and the professionals to provide an environment conducive to women centered care was breached. Failure of the obstetricians to provide a duty of care to women as perceived by the midwives is an example of the mistrust the midwives witnessed. It was evident that the fear that occurs in hierarchical institutions led to poor channels of communication and prevented the words of the whistleblower and advocate from being heard. The narratives also illustrate how autonomy threatens the power and control of the dominant group and is a key driver involved in situations of conflict in this thesis. Conflict created a disruption of the midwives' biography therefore the concept of biographical disruption is discussed in the following chapter.

Chapter Five: Traumatic Practice Events Leading to Biographical Disruption.

Every minute that I was awake I thought about her and the baby, I dreamt about it. At one point I thought never a day would go by when I did not think about her but as time went on perhaps a day then a week and so it is. Time did heal. (Rose)

Introduction

The stories of the whistleblower and the advocate presented in the previous chapter demonstrate how organisational structures, coupled with attempts to maintain power and control by the doctors as identified by the participants, combined to create a form of biographical disruption in the lives of the two midwives. Biographical disruption is an alteration in an individual's identity that impacts on their self confidence (Bury, 1982). In this chapter I explore the effects of a traumatic practice experience on the midwife and argue that the initial trauma and its associated physiological and psychological effects were exacerbated by a breach of trust leading to biographical disruption. Breach of trust is identified as a key theme by participants in the current study for it impacted on the meaning of the event, thus affecting the midwives' personal and professional identities. The alteration in their identities created biographical disruption in their lives which, for some, led to a chronic illness. The midwives associated the increased emotional responses that resulted from the biographical disruption with the chronic illness. This illustrates Williams' (2000) suggestion that emotions are central to the aetiology of disease.

Biographical disruption as the cause of the chronic illness differs from Bury's (1991) work which indicates that the chronic illness led to the biographical disruption. The evidence derived from the current study extends the concept of biographical disruption from the illness literature to events experienced in professional practice. The extension makes an original contribution to the literature. The following section introduces the initial stress reaction associated with trauma, provides a brief overview of biographical disruption and the method of repair followed by one of the participants' stories. The meaning of the event, the

associated emotions and the physiological and psychological long term effects of the traumatic event are discussed to demonstrate how the impact of trauma and the subsequent biographical disruption can lead to a chronic illness.

Initial stress reaction to trauma

A traumatic experience is something that is described as unpleasant and may be due to injury, violence or emotional shock (Sykes, 1978; Levi, 2005). The General Adaptation Syndrome (GAS) is a theory developed by Hans Selye in the 1940s which suggests that the body responds to exposure to a stressful experience by the instigation of the fight and flight reaction. The fight and flight reaction is a method of style (Bury, 1982) as it instigates a bodily change in the form of reaction. The process of this reaction has three stages, alarm, resistance and exhaustion. In the initial phase the body responds by activating the sympathetic nervous system with an increase in pulse rate and respirations, the skin becomes cold and clammy and the pupils dilate a condition that most people will have been subjected to as a normal reaction to a stressor of any kind. The reactions to phases two and three are more insidious and not recognised by the individual until body function is affected in some way (Shives & Isaacs, 2002; Stables, 1999, Blattner, 1981).

Caroline explains the initial and subsequent physical symptoms she experienced following the effects of dealing with a sick neonate:

I went home my stomach churning. You don't want to eat, you feel as if you are going to vomit. All the time your mind is just constantly going over and over the situation. What could I have done differently? I couldn't sleep because all I would do was churn it over and over in my head. (Crying) The thing that amazes me is how long it lasts. It is one and half years down the track and when I am talking to you I still cry about it.

Caroline displays the physical symptoms of acute stress and the long term emotional impact this practice event had on her due to having her professional identity being challenged by colleagues which led to biographical disruption.

The findings from the current study demonstrate that all of the midwives were affected by the initial phase of the GAS. However it was the breach of trust as Caroline has indicated which created biographical disruption that led to phases two and three of the reaction and is discussed later in the chapter.

Biographical Disruption.

Bury (1982), a medical sociologist who researched the effect that chronic illness has on the individual suggests that the illness causes a physical impact on the body that alters the person's sense of identity and affects their self confidence. It was while conducting this research that he developed the term 'biographical disruption' which describes the above sequence of events. Bury states that biographical disruption has three components, firstly the normal events of daily living and the meanings that surround them are changed. Secondly the person is required to evaluate their profile which may have an influence on their self-concept and thirdly the person responds to the disruption by trying to activate means to live with the disruption. The disfigurement and immobility that accompanied the chronic disease altered the person's sense of identity and affected their self confidence. The implication therefore is that a biographical disruption is also a form of social disruption. Although the three aspects of biographical disruption of change, evaluation and activation were stimulated by an illness they also may be attributed to health professionals' experience of traumatic practice events as is evident in the following narrative by Mertle.

To assist with the lack of control associated with a chronic illness Bury (1991) offered a method of biographical repair. Bury (1991) suggests that people use three concepts coping, strategy and style to help them adapt to chronic illness and repair their biography. He posits these terms have been used synonymously or combined and proposes that to draw attention to the different aspects of the illness experience these concepts be classified separately. Bury (1991) indicates that coping involves valuing oneself and the meaning of one's existence despite the disruption. Strategy, in contrast to coping, is the actions people undertake when faced with an illness and

not their attitude that develops in relation to the disease. He suggests that strategy in this situation involves the setting of realistic goals and the effective use of resources in order to achieve favourable outcomes. These strategies will change over time as the disruption alters. Style involves how the individual reacts to the disease and focusses on aspects of the disease or the treatments involved. Style includes cultural practices that people associate with their illness or treatments and any personal changes such as body disfigurement or the different ways that illness presents (Bury, 1991).

According to Bury (1991) he found the concepts of coping, strategy and style difficult to understand. Drawing on words used in his discussion of biographical repair I have attempted to avoid confusion by applying the following meaning to the three concepts when analysing the midwives methods of repair valuing (coping), action (strategy) and reaction (style).

Mertle

A month of Hell. I am out there in no man's land

Mertle entered midwifery to achieve her vision of assisting women to have a birth experience that suited their individual needs. For the six years prior to her traumatic practice experience she had been part of a midwifery rural group practice that offered women the opportunity to birth either at home or in a primary birthing unit. The group also transfer and care for women in a tertiary hospital if required. Mertle views pregnancy as a normal life event and bases her philosophy of midwifery around holistic practice and a partnership of trust and mutual respect between the woman, her family and the midwife.

Mertle's traumatic practice experience is multifactorial in that, during one month of practice, she experienced three traumatic practice events and was also the subject of a complaint. These issues not only caused biographical disruption but led to a chronic illness which prevented Mertle from working.

Mertle: Disruptive event - discrimination

Jessie was nearly forty weeks gestation with a baby that was extremely high in the pelvis. I did not think the baby would descend so I asked for a second opinion from the obstetric team. Jessie was convinced, by the team, to have a trial of labour. She was booked for an induction that was very straight forward. She progressed to second stage and after one and a half hours of no descent I requested a review by the registrar. I was told to keep pushing on even though at the height of a push there was no sign of descent of the baby's head. At the two hour mark I went out for another opinion and the same registrar came and said to 'Keep going as the unit is extremely busy'. At the three hour mark I asked for the consultant to come in and give me his opinion. He came in and said "This woman needs to have a Caesarean section and get that baby out." In Caesar theatre at that time, there were two crash Caesars where the mother and baby were ill. Our baby's tracing was well within the compounds of normal, so we were asked to wait in the queue.

At three and a half hours I asked the consultant if we could get another team in and go over to main theatre. He made the call that that was inappropriate, that the baby's tracing was absolutely fine. So we waited and the family got extremely anxious and were very annoyed, mainly the extended family, to the extent that in the last hour a colleague went in and sat with the family because I felt I could not go in anymore. I felt the family did not believe me because nobody was coming to our assistance. At six hours and five minutes the baby was finally born by Caesarean section. The neonate had had an absolutely perfect reassuring CTG tracing all the way through labour but the Apgar Scores were 9, 6 and at the five minute mark 4. Subsequently the baby developed respiratory problems and was taken to the neonatal unit where he became extremely jaundiced and stayed for two weeks.

The following day I saw the consultant in delivery suite and I asked him if there was anything we could have done differently because I am extremely upset about the situation. He said "No not really, yes I guess I could have brought another team in but really financially it did not really warrant that because the CTG tracing was fine." I then asked "If this had been a private patient of yours would this have happened?" He said "No". I was furious, absolutely furious. I left and went and debriefed the birthing experience with the mother. Three weeks later the woman developed a pulmonary embolism and was rushed back into hospital where she remained for five days. I have no doubt that it was a direct result of the 6 hour 5 min. second stage. I lost faith in the obstetrician for ignoring the protocol.

The next day when I went in and saw that obstetrician I had a huge panic attack then and suffered them probably for about six weeks after. I would often break into a very hot sweat when I was working down in the delivery unit. I did note that when the mother or baby was at risk I did not feel well supported particularly if a certain registrar was on duty. I did not feel safe with asking for his assessment because I did not trust him. I would suffer panic attacks from that, and just a general nervousness going in there. I reacted with the old pendulum where my boundaries were at a certain stage beforehand; my boundaries are tighter now because I do not trust the system because the system let me down. There was no debriefing session what so ever, apart from the very quick conversation I had with the obstetrician the following day.

The outcome was good; both the mother and the baby are healthy. The couple decided that they will have no more children; they will not risk her life. They perceive that it would not have come about had she not had such a long second stage. Another reason is the effects on the baby of jaundice and the apnoeic attack due to the stress of the birth. The experience was very traumatic for them; their comment to me was "They could see that I was asking for help." We were damned lucky that mother or baby didn't die, in my opinion and I have to say if that had happened that would have destroyed me completely and I would have walked away from midwifery regardless.

Mertle's story illustrates how biographical disruption is a breakdown in the "orderly sequence of facts" (Williams, 1984) causing an alteration in the normal progression of daily life (Williams, 1984; Bury, 1982). The labour situation was stressful for the woman, the midwife and the family coupled with a less than ideal outcome for the newborn. Mertle coped with the situation by providing quality care to this woman and worked within the Standards for Midwifery Practice (NZCOM, 2008). She requested help when it was obvious the situation was outside her Scope of Practice and continued to support the woman and her family throughout the experience. The decisions made by the registrar did not address Mertle's concerns therefore she demonstrated her autonomy by contacting the obstetrician directly. She positions herself as a competent and caring midwife yet she perceives the family positioned her as uncaring during the long second stage. They were anxious and concerned about the couple as well as the unborn baby. The family's reaction is a normal response to a stressful situation when time is of the essence; on reflection they realised that this wait was outside Mertle's control. The strategy of debriefing that Mertle held with the woman gave her an opportunity to explain the reason for the delay of the lower segment caesarean section (LSCS). Debriefing with the woman and her family also reduces the chances of a complaint against the practitioner if they believe their concerns are listened to (Atwood & Macken, 2002).

The doctors' strategy was to finalise the woman and her baby's conditions as being safe. They chose to ignore the hospital policy in relation to the length of second stage of labour and the obstetrician chose to focus on the budget rather than the safety of the mother and her fetus. The decision to wait was not based on a total

assessment of Jessica but on one CTG tracing which itself is not diagnostic of fetal wellbeing. This was a trial of labour; the length of the second stage and the drugs used for the induction, which are known to increase the risk of jaundice in the neonate (Banister, 1997; Jordon, 2002), do not appear to have been taken into consideration by the medical team. The physiological symptoms, such as jaundice experienced by the baby can create hypoglycaemia (Stables, 1999) and the possibility of the respiratory problems which occurred in this situation. By his actions the obstetrician failed in his duty of care to this family as he harmed the woman and the neonate. Mertle believes that the outcome for the baby was a result of the long wait for delivery and is substantiated in the following case study. In their audit into managerial and institutional factors that influence the quality of obstetric care Behague et al (2008) cite the case of a woman waiting nine hours for an emergency caesarean section following the decision that it was necessary. The case notes state that as a result the baby could suffer long term neurological problems.

Mertle's story confirms Bury's (1991) suggestion there is a link between social class, social practice and style as illustrated by the obstetrician not calling in a second obstetric team to perform a caesarean section on a woman under Mertle's care. Style (reaction) is demonstrated by Mertle in the form of frustration at the realisation that not only has the obstetrician exercised his power over her but also over the woman who she views as a victim of discrimination. In this situation the obstetrician is using his position in the field and the power that accompanies it (Bourdieu, 1982), to focus on resources. His position also enables his expertise to be traded for capital in the form of access to resources which would be available without question to his private patients. As a consequence of the obstetrician stating "this baby needs to come out" Mertle views the woman's situation as an emergency. Therefore she believes the obstetrician had a moral duty to call in another team regardless of her client's status of being under the public system. The actions of the obstetrician can also be an underhand way, despite the woman's right to choose her LMC, of adhering to 'determinants' or 'rules' of his profession

(Bourdieu, 1982). These rules demonstrate the boundaries between medicine and midwifery as the obstetrician controls the access to resources.

Trust was important to Mertle; discriminatory practice was not what she expected from a doctor who she believed should be objective and make his clinical decisions on the information before him. Mertle feels let down by the obstetrician's discriminatory action towards this woman yet the strategy she adopts toward him when in practice is to respect his position within the habitus. Feeling let down yet behaving in a professional manner demonstrates Bury's (1982) idea that there is a balance between the body's internal effects, what one thinks and feels, as a result of illness, or in Mertle's case as a result of a traumatic practice event, and external reality which is what is seen by others. The panic attacks described by Mertle signify mild anxiety (Shivers & Isaacs, 2002) and would not have been openly visible to the obstetrician. Bury (1982) argues that a disequilibrium between these internal and external realities occurs when the person realises that their normal life pattern has to be altered. The change in life pattern for Mertle is the loss of trust in the professional relationship she thought she had with the obstetrician exhibited in the form of panic attacks (style). Similarly to a chronic illness where the long term effects are uncertain (Bury, 1982) Mertle is unable to predict if the obstetrician will discriminate against women she provides care for in the future.

In his theory of Wellbeing, which focuses on positive psychology, Seligman (2011) suggests that the purpose of meaning is to do something in life that is valuable and worthwhile. Being a LMC midwife and providing evidenced based care to women were valuable and worthwhile components of Mertle's life. The discriminatory action of the obstetrician and the possibility of being placed in a similar situation again altered the meaning of LMC midwifery practice for Mertle. The purpose of Mertle embarking on a midwifery career was to enable her to support women to achieve a good childbirth experience. However in this situation she positions herself as having failed this woman as a result of circumstances beyond her control. The change in meaning aroused negative emotions that affected Mertle's wellbeing

In this maternity unit Mertle did not feel well supported consequently the strategy she undertook in order to feel safe was to tighten her professional boundaries and not have as much trust in the obstetrician or registrar. Style in the form of bodily changes (Bury, 1982) was evident for Mertle by an increase in stress levels that enabled her to cope with the lack of control. Stress creates feelings of vulnerability (Shives & Isaacs, 2002) which in Mertle's case occurred from a lack of trust in the obstetrician, the registrar and the system to ensure safe and effective care for all women.

Mertle's narrative indicates that the hospital did not use risk management debriefing as a form of quality improvement by requiring the obstetrician to account for his decision to expose the woman and her baby to a six hour second stage. Mertle would have been able to present her case which would have exposed the failure of the obstetric team to adhere to the policies and procedures of the organisation. It is likely failure to adhere to these policies may have resulted in the adverse outcome for the mother and baby. Although a debriefing session would not have changed the outcome for this woman it may have empowered Mertle as her voice would have been heard. She could have been reassured that systems and processes could be put in place that would mean that such trauma would not happen again to anyone else. Feeling supported by the organisation may have prevented or lessened the impact of the traumatising event for Mertle and assisted in the reconstruction of her identity. However, the debriefing did not occur, consequently, Mertle did not receive the support that may have helped her to repair her biography.

Breaches of trust occurred in Mertle's narrative when the registrar neglected to listen to her concerns in relation to the failure of descent of the presenting part. His focus was purely on the busyness of the unit rather than the safety of the woman and her baby. Bury (1991) suggests that the meaning of the event is associated with the consequences and significance for the individual. The consequence of the event in Mertle's narrative was that the woman and the baby appear to have suffered as a

result of the delay in the caesarean section. The significance was that the obstetrician discriminated against the woman. The obstetrician's actions altered the meaning of the traumatic practice experience for Mertle from one of trauma to one of mistrust. The breach of trust created a biographical disruption that exacerbated the physical and psychological symptoms experienced by Mertle. Mertle's narrative also demonstrates that the meaning of the event and the context in which the event occurs are interwoven (Bury, 1982).

Mertle's Disruptive event - congenital abnormalities

A week later, Mary, another woman that I was the LMC for, had an extremely traumatic hospital birthing experience with her first baby. A 36 hour labour with a new midwife whom the woman, Mary, felt did not listen to her. The couple used alternative therapies and had refused to have a scan or blood tests during the first pregnancy. Mary this time round decided she wanted all the routine screening tests in the hope that she would avoid what happened in labour previously. She went into spontaneous labour and baby Michael was born with Apgars of 9 and 10. Despite the normal scan results the baby was born with no ears and had no ear openings. He died three months later.

The shock for the parents and the midwife when the happy birthing experience was shattered by the realisation that all was not well was devastating. However, the tests performed were screening tests and provide information about risk of an abnormality occurring therefore uncertainty always exists. This was another traumatic practice experience for Mertle yet in order to carry on caring for June, Mertle's strategy was not to acknowledge her distress which was increased due to lack of support.

I had some colleagues to talk to about it but really I had no backup or support. I felt hugely vulnerable. I find there is actually nothing out there for the midwives. I feel incredibly sad; the College is there for the woman and the Resolutions committee is there for the woman but what is there for the midwife? There is nothing there for the midwife.

The lack of support provided to Mertle confirms Morrissette's (2004) suggestion that the public image of the health professional is that they are not affected by the trauma they are exposed to and as a consequence will not have a problem carrying on with their daily practice. The problem with this attitude is that it fails to recognise the effects of stress on the individual and the potential for Post Traumatic Stress Disorder to occur (Morrissette, 2004; Maher, 1999). Uncertainty of outcome

is again highlighted in the following event as Mertle was to be exposed to even more stress.

Mertle's Disruptive Event – neonatal deaths

The same week another woman contacted me in labour. I had looked after her during her third pregnancy where the baby died seventeen days following birth. The baby had been born with a syndrome that had not been picked up until after birth. In 2006 Jean went on to conceive twins and I arranged for some checks at the beginning of her pregnancy to see if these babies could have that syndrome. She was informed there was no chance of these babies being born with this syndrome, a one off scenario. Jean went into labour at 7 months, I was not able to be at the labour and birth but my colleague was present. I cared for the family postpartum and during this time both babies were diagnosed with the same syndrome that the other baby had died of. These babies have just died, one died five weeks ago and one three weeks ago (2007).

The narrative highlights the role of the midwife as a support person for the woman and her family not only in the provision of routine care but also in times of uncertainty and distress. The woman's trust in her midwife and expectations of support add further responsibility and increased Mertle's stress. Again her strategy was to suppress her own feelings in order to cope with the situation. The final incident is one of a complaint coupled with the lack of support Mertle believed that she received from the NZCOM Resolutions committee (see p.131) and NZCOM central office. The lack of support experienced by Mertle exacerbated the emotions associated with biographical disruption and contributed to her long term emotional stress and chronic illness.

Mertle's Disruptive event – A complaint

I met this woman at 30 weeks gestation, she was a client of a colleague of mine who, for personal reasons had to change practice and move. The woman was unable to find another midwife at such short notice so I agreed to be her LMC. I was unable to attend her birth and arranged for my second midwife to attend. The complaint occurred as the couple were unhappy about their birth experience and felt hugely traumatized because I was not there. We had a meeting and it was very confrontational so I left.

I would have to say that if I could have and I could have afforded to do so, I would have walked away from midwifery at that stage because I was hugely traumatized by it all. I am not usually vulnerable but I could see no safety networks, no safety nets whatsoever. So that was my November.

I debriefed with a colleague, I tried to debrief with a group colleague but it was an extremely busy time and we were in a small practice and therefore it was dealt with sometime after that. I debriefed with my family and my mum who is actually a counselor and colleague. I have since spoken to one of the more senior midwives and she said to me “Why don’t you have some supervision in relation to this?” The big thing for me was one, having the energy and the clarity to find a supervisor and the other thing was the cost. There was nobody there that I could ring and go to for help.

The row with the couple went to the Resolutions Committee in my local area and that has not been resolved. When the midwife that was involved in the process rang me I said ‘Look I think I should consult a lawyer because he is extremely angry and he is very, very abusive.’ “Oh no I think you are over reacting about it.” Then when she dealt with this man she rang back and said “O god I see what you mean, he was absolutely abusive and completely off the track with what was going on, and brought in all sort of issues that you had nothing to do with.” The Resolutions Committee is part of the New Zealand College of Midwives’ processes; this midwife knew how upset I was because I was crying on the phone when I was talking with her. Not once have I had a follow up call from her or the committee. Yes we can deal with things on a peer group basis but peers don’t have the counseling skills to help. If something goes wrong where am I supposed to go?

Although I had contacted the college there is no one in the New Zealand College of Midwives that I could ring and get life skills, advanced life skills to get through this. Neither was there anybody there to go “What can we do for you? Is there anything that we can do?” I worked for fifteen years in the corporate sector where I was involved in human resources and also in the managerial field mainly to do with IT and I can say I have never worked anywhere where I have felt so totally unsupported. They are not there unless something goes to HDC (Health and Disability Commissioner) where you need their lawyer. I felt withdrawn from the midwifery community and dealt with the trauma of all of this within my family, especially my mother who is a counsellor. I talked about it so that I could overcome it.

If I had felt cared for and supported and cherished through all of this by my midwifery community then I have no doubt that I would be feeling differently about midwifery now and I would just carry on being a LMC but as it is I don’t want to because I am too vulnerable. I am out there in no man’s land and no safety nets so I don’t know necessarily if I will ever go back to LMC work again. When I am well enough I will work as a core midwife and see how it goes.

The narrative demonstrates how relationships within the midwifery partnership can change and how complaints are instigated which increase the fear of investigation of the midwife’s practice. Mertle was unable to attend the birth of the woman who made the complaint however she met her contractual obligations by arranging for her practice partner to provide the care. It is not surprising that Mertle’s style was to feel betrayed by the woman when at the resolution meeting she refused to listen to Mertle’s rationale for not attending the birth. Consequently the strategy that

Mertle used to cope was to walk away. The couple's complaint to the Resolutions committee was outside Mertle's control and resulted in emotional stress (style). According to Shives and Isaacs (2002) emotional stress may occur due to feelings of betrayal of trust and disempowerment which was the situation Mertle was faced with.

Anecdotal evidence suggests non-attendance at birth may occur when the midwife is either with another woman, recovering from a long birth or is having a day off. According to Mertle these practice rules were outlined to the woman when she agreed to become her LMC. It is understandable that the woman was disappointed, firstly losing her initial midwife, and after having developed a partnership of trust with Mertle, finds she is unable to attend her birth. However this is a reality that does occur. Normally not attending a birth is an issue of safety which the woman may not have considered. It is also a downside of the Midwifery Partnership model as some women become possessive of "her midwife" and due to the trusting relationship believes that her birth experience would have been different if Mertle had been present. The belief creates underlying grief issues for the woman and the subsequent 'if only Mertle had been present things would have been different' thus attaching blame to the carer. The strategy of attaching blame to the caregiver enables the woman to remove the perceived blame from herself thus implementing a style attached to grieving that helps the woman to repair her identity and cope with the situation. The narrative demonstrates dependency on and the expectations some women have of the midwife when she practices as a LMC. The impact Mertle may have made if present at the birth is unknown. What is known however is that professional relationships can increase the risk of litigation (Reamer, 2001) which is evident in this story when the woman contacted the Resolutions Committee.

The Resolutions Committee is a voluntary service run by each local branch of the New Zealand College of Midwives where women can seek advice about issues regarding their care. The committee acts as a mediator to try and resolve the situation and reduce the potential for complaint. Initially the committee may just

hear the woman's issues or complaint. The consumer may request that the midwife not be informed that they have contacted the Resolutions Committee. If the woman refuses to discuss the issues with the midwife or continues to refuse to hear the midwife's point of view then other options are offered, for example the case is referred to the Health and Disability Commissioner informal advocacy service, and the College has no further involvement (NZCOM, 2008). It would have been more prudent if a call back to Mertle from the midwife involved in the Resolutions Committee, offering emotional support, had occurred. Especially as initially she had accused Mertle of over reacting to the fear of a formal complaint investigation but later acknowledged her concerns. Failure of the midwifery member of the Resolutions Committee to support Mertle through the complaint is another breach of relational trust.

Mertle was correct in stating that there is no funded emotional support for the self-employed midwife unless a complaint has been made. At the time of the telling of this narrative (July, 2007) there was no leaflet providing information to midwives from NZCOM of the availability of support, legal or otherwise. The lack of information is surprising as the Midwifery Code of Ethics (NZCOM, 2005) requires midwives to nurture and support each other in their professional roles. One would therefore have expected support systems to be in place other than to check with the NZCOM lawyer one's entitlement to assistance.

Mertle positions herself as a safe practitioner and in all four cases she used the midwifery decision points (NZCOM, 2008) and the Guidelines for Consultation as required by the Primary Maternity Notice (2007) of the New Zealand Public Health & Disability Act (2000). Despite Mertle's actions she believed that medical technologies, the hospital and health system together with the NZ College of Midwives let her down. The disappointment was attributed to lack of policy and protocol adherence for the length of second stage of labour, discriminatory practice on behalf of the obstetrician, failure to emphasise to the woman that screening tests are not diagnostic, the unrealistic expectations of the public about the availability of

the LMC and finally the lack of support and understanding from her professional body. Mertle's distress and loss of confidence in the hospital procedures is understandable as her philosophy and her faith in the health system have been challenged. Her story demonstrates the power attributed to the doctor by the organisation and the impact this power can have on the woman, the fetus/neonate and the midwife.

It is imperative that Mertle's emotional health is attended to in order for her to continue effectively with her roles as a mother, a daughter, a caring new partner and that of a midwife. Bury (1982) suggests that how an individual copes with disease, or in the midwives' case the traumatic practice event, is dependent on their social networks particularly the support of a good friend. Informal support was provided by Mertle's mother. Formal support could have assisted Mertle to deal with the emotional impact of her biographical disruption and enable her to reconstruct her identity as a competent, trusting midwife. There was no formal support for Mertle, no opportunity to discuss the issue with the obstetrician on a risk management basis. She was also financially trapped and unable to access support of her own choosing. Coupled with all of this was the fear of a complaints investigation and the added stress that accompanies that fear. To be able to counsel someone through stress is a skill that requires training and is not part of the scope of practice of the midwife. Training in psychological debriefing is time consuming and costly (Hawkins & Shohet, 2000) and not feasible for every midwife to undertake, neither should they be expected to. According to Hawkins and Schohet (2000) the troubled practitioner requires support, a listening ear and reassurance which are provided in a safe environment in which she may relive the situation with all its emotional components. The process of reflection should bring about understanding and growth (Hawkins & Shohet, 2000; Taylor, 2000) resulting in a reconstruction (Williams, 1984) or repair (Bury, 1982) of her identity.

Mertle has not been able to work as a midwife for 11 months due to a chronic illness resulting from the biographical disruption that she experienced as a result of

these traumatic experiences. She has had to reconstruct her biography by activating strategies to cope with both the incidents and her illness. She has also had to deal with grieving for her midwifery practice and what the future held for her as a midwife. The decision to give up LMC midwifery practice and work as a core midwife was a result of biographical anticipation (Williams, 2000), determined by the uncertainty of similar situations occurring again if she remained working as a LMC. The lack of support available, even within the hospital system and the stress the first case created caused Mertle to consider leaving the midwifery workforce altogether. Mertle's narrative demonstrates how the meaning of the event can exacerbate the traumatic experience by affecting a person's identities as well as impacting on workforce attrition.

Leaving midwifery practice or changing their mode of practice was evident in a phenomenological study by Mander (2004) who examined the experience of midwives dealing with a maternal death. Mander also suggests that as a result of the midwives not separating their personal and professional lives the emotions experienced at the time of the maternal death reappeared when personal issues such as childbirth occurred.

It is a normal part of midwifery clinical practice to be exposed to traumatic practice events (Penwell, 2002; Hammett, 1997) and therefore such exposure could be considered biographical anticipation (Williams, 2000). In many circumstances this does happen but why does the experience of a specific event appear to impact so greatly on some midwives. The current study has demonstrated that it was the meaning of the event, which involved a breach of relational trust that impacted on the midwives' personal and professional identities and exacerbated the initial stress associated with the traumatic event.

Meaning making and the need for preparation to cope with trauma

Meaning making enables individuals to understand themselves, where they belong and their relations to other people. In other words meaning making constitutes a

person's personal identity (Saleeby, 2001; Roberts, 2000) which incorporates the event experienced and the impact on their life story (Mander, 2004; Arciero & Guidano, 2002). Meaning making in relation to personal identity is a combination of culture, relationships, interest, needs, experience and personal ingenuity which influence how a person views the world. Identities are constantly constructed and reconstructed as a result of cultural influences (White, 2008; Fuhrer, 2004; Mander, 2004). The cultural influence on their identity for some of the midwives in the current study was the breach of trust in individuals, groups and systems that they related to or were associated with autonomous midwifery practitioners.

Moving from a personal level, constructing the story can also demonstrate the social issues involved (Neimeyer & Rasking, 2002). I suggest that part of the difficulty in finding meaning for some of the midwives in this study occurred because of the organisational structures which, according to Bourdieu (1982) are a part of the habitus and are often invisible in the everyday workplace. Such organisational structures focus on competitive based productivity (Fineman, Sims & Gabriel, 2006; Hyde & Cooper, 2001) and could in Mertle's story account for the obstetrician's failure to call in a second obstetric team thus privileging cost over safety. Understanding the meaning of the event is vital in order to adjust to the situation and enable healing to occur (Davis, 2002; Neimeyer & Rasking, 2002; Bray, Less, Smith & York, 2000). It is therefore important that strategies to help the midwife understand the meaning of the event and reduce the emotional impact of the disruption are identified and implemented.

All of the midwives in this study suffered the symptoms of acute stress immediately following the event and eleven experienced long term stress. In order to uncover the meaning of the event and reconstruct their identities five of these midwives received psychological counselling, two of whom were required to pay for the counseling themselves. One received counselling from a family member who is a trained counselor. One midwife had a session paid for by the DHB; another had three sessions paid by her employer but was required to pay the remaining visits

herself. The latter required counselling on a weekly basis for approximately five months. Some of the remaining midwives would have liked counseling but for financial reasons were unable to access this service as Mertle explains:

Going yourself for emotional help is a huge financial cost. Until a year ago I was a single mum and I did not have that extra funding to spend just on me. I was trying to cope with a mortgage and bringing up two children.

The midwives felt their employers should have provided an environment of response conducive to their health needs. When they didn't these midwives believed their stress was exacerbated by their employers failing to meet their expectation. The fourteen midwives that responded to the second interview felt that counselling should be available for all midwives as part of their employment contract. Bobby describes what she feels should be available:

Someone to go to, not necessarily outside the midwifery profession, but someone totally unconnected to the hospital. Perhaps someone like you Irene who has been there, done that and can understand the issues and has a bit of counseling knowledge as well. What I have found incredibly helpful was to have the opportunity, at the right time to suit me, to talk about it, in a non-judgmental environment. Someone who can open the flood gates but asks the right question and be there.

According to the Diagnostic and Statistical Manual of Mental Health Disorders (DSM -V, 2000) PTSD is:

the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death or injury experienced by a family member or other close relative (p. 424).

The condition may have an acute, chronic or delayed onset. Some people will experience symptoms of stress immediately following the traumatic event which may last for a few days or even weeks. Should these symptoms of acute stress disorder persist longer than four weeks then the diagnosis becomes Post Traumatic Stress Disorder (PTSD). Depending on the length of the trauma and the degree of severity the risk of the symptoms of PTSD developing are increased. If this

condition is not resolved within three months of the event then the acute condition becomes chronic and may persist for many years or even a lifetime. Delayed onset occurs when symptoms of PTSD appear six months after the traumatic event (Shives & Isaacs, 2002). Wendy explains her experience:

I had all the symptoms of PTSD, not sleeping, the reliving over and over the guilt, the what “if’s” the “if only”. Even now as I pass the hall where the funeral was held I get flashbacks to the time of the incident.

It is evident from Mertle’s story and those of other participants in the study that midwives are not sufficiently prepared to cope with emotional trauma experienced from horizontal or linear violence and/or a breach of relational trust. No workshops or support systems are freely available to enable this to happen. The lack of preparation of midwives to cope in emotional situations is supported by Chan, et al (2007) in their study that focuses on midwives’ attitudes toward perinatal bereavement. McCreight (2004) who investigated the personal experiences of fourteen nursing staff in gynaecological wards caring for parents experiencing a pregnancy loss also found that nurses were unprepared to cope with the emotional effects of this aspect of their role. Mertle’s commitment to assist women to achieve the birth experience that suited their individual needs, supports the findings by Hunter (2005) who, exploring the emotional effects of the midwife–client relationship, found that the relationship can be the source of the emotional stress. She also established that midwives are not given preparation to cope with the emotional component of practice.

The disruptive effects of emotions and the need for repair

The emotions experienced by the midwives in the current study occurred as a result of their moral values and beliefs being challenged and provides evidence of the need for a supportive environment for midwives. These emotional effects on the midwives contributed to their ability or inability to cope with their midwifery practice and their activities of daily living. The emotional effects impacted on their physiological and psychological health status and depleted their resilience. The

midwives had to engage in biographical work to make sense of the situation in order to recover their spoilt identities. Biographical work is discussed by Corbin and Strauss (1987) who argue that a biography consists of the self, time and body. Self refers to the person's conception of their identity, body being the means of communicating the changes in action or appearance, and biographical time meaning past, present and future. They link these three concepts together under the term biographical body conception chain (BBC chain). The authors suggest that everything that occurs in life revolves around this chain therefore when a biographical disruption is experienced all three concepts are affected. Once this chain is disrupted the individual must start the process of repair which Corbin and Strauss (1987) refer to as 'biographical work'. The concept of biographical work reflects the works of Bury (1982) and Williams (1984) both of whom suggest that the person must instigate methods to cope with the disruption. The following excerpts from the midwives' narratives demonstrate BBC inaction.

I am at the stage where I say "Do I stay in or do I change my profession" and I am seriously looking at that at the moment. If I need to do something to feel well supported in a healthy environment then that is what I will do and I will just walk away. (Mertle).

The whole episode provided for me a cut off point from my independent practice. Certainly I feel I could never, ever take up independent practice work again. I have been asked several times to do locums for people and just do not have the confidence. I am very comfortable in the hospital sharing the responsibility but I would never take on LMC work myself again. (Wendy).

My interpretation of the BBC in relation to these excerpts is currently Mertle is considering leaving the midwifery workforce (time) and finding employment (self) in a healthy environment where she will feel supported (body). Wendy describes leaving LMC practice (time) and cannot identify with being self-employed (self) due to lack of confidence (body). The excerpts also demonstrate how the emotional experience for the midwives can impact on their work choices and their relationship to midwifery in the future.

Disruption of a biography can be associated with two types of emotions, those emotions that develop from commitments or motives for example providing safe midwifery care. The second type of emotion that disrupts a biography is emotions that affect daily activities such as feelings of self-worth (Williams, 2000), as that experienced by Wendy:

The experience gave me paranoid feelings that I was useless as a midwife.

Emotions are considered to be messages people receive from themselves concerning what they see, expect to see and how they deal with it (Stryker, 2004). Kathleen, a midwifery coordinator and one of the core midwives who participated in the current study demonstrates these issues as she believes that the cause of her emotional state was due to a system that allows junior midwives to work in teams without the support of experienced staff. Kathleen was called to an emergency situation by a LMC for a suspected shoulder dystocia. On her arrival she found the midwives were just standing watching for progress of birth instead of doing what she would expect and attempting to cope with the emergency situation. Kathleen believes the cause of her trauma was:

What I perceived unsafe midwifery practice. Yes grossly unsafe practice. They hadn't done anything to help the woman. It annoyed me to go in there blind. I just felt sorry for them really in relation to the woman and her family. All this time I was shaking because I was really angry with those midwives. I guess for a long time after that event I did not want to stay in delivery suite anymore because it was not the first time I had been called to something like this in the birthing unit and that worried me. Was it because I did not feel clinically competent or confident or was it because I can't tolerate people who do not follow what I think is the correct procedure.

I debriefed with the midwives about the case as my perception was that I had gone in there like something shot out of a gun and ordered everybody around and shrieked at people whereas the feedback they gave me was not that at all. They saw someone come in and take control of the situation.

Debriefing the case was therapeutic for Kathleen as her negative perception of her behaviour during the event was considered differently by others present in the social environment. They perceived Kathleen's actions as a confident practitioner who took positive actions. Conditions such as anxiety, distress or a general sense of

doubt are indicators of an emotionally stressed state (Turner, 2007; 2004) and were exhibited by Kathleen in her narrative. Hunter (2001) suggests that the practice of midwifery creates high levels of emotional work for practitioners that go unnoticed and is evident in the current study.

In her qualitative study that explored the experiences of midwifery coordinators in three tertiary delivery units in New Zealand Ferguson (2009) suggests that midwives work in an environment that is high in emotion. In order to provide quality care to the women the coordinator midwives used a stylist method of coping by suppressing their feelings often to the detriment of their own health. These midwives are leaders, they are unafraid to speak out; they advocate for women and their colleagues. Ferguson (2009) asks the question “Is there a breaking point? (p.180). Some of the negative changes in midwifery practice that Kathleen has witnessed over the last few years have created for her a breaking point. As a result of evaluating the situation and the effect it had on her personally she has activated means to cope; her strategy to assist with the reduction of stress was by leaving the midwifery workforce. Kathleen explains the emotions (style) she experienced by participating in the study “*It made me anxious again, it brought it all back.*” These feelings expressed by Kathleen resulted from her participation in the study and were not echoed by the other participants

The dynamics of emotion enable the researcher to connect the ontological, meta and conceptual narrativity levels of a social process (Turner, 2004). Kathleen’s story demonstrates how these social processes as well as expectation states can influence a person’s emotional state. The Midwifery Council of New Zealand has defined the competencies for entry to the register of midwives. All midwives who qualify are deemed competent to practice and are able to work as either a core or community based LMC midwife. Kathleen expected the midwives to be competent but their actions did not bear this out. At the micro level Kathleen’s experience makes her believe support in a tertiary institution is required for newly registered practitioners. The events relayed in this narrative took place before the introduction

of the new graduate mentorship programme (Midwifery First Year of Practice programme, MFYP) which effectively enables provision of support for new graduate midwives in their role (NZCOM, 2009).

Turner (2007) discusses 'expectation states' and their effect on emotions and suggests that they are more than 'status and power' as researchers in the field of psychology suggest. He recognises the importance of these concepts but proposes that whenever individuals enter into a situation they do so with some form of expectation other than status and power. Initially this encounter may be heralded by anxiety or shyness that are 'mild negative emotions' (Turner, p.83) which disappear once these expectation states are assured. These mild negative emotions resulting from expectations occur daily and have no effect on the individual. However if these 'expectation states' are not sanctioned then negative arousal of emotions leading to bodily disturbance can occur. The traumatic events experienced by the midwives in this study prevented the 'expectation states' associated with relational trust of these health professionals being met, thus creating a negative arousal with all its possible consequences. An example is evident in the narrative relayed by Mertle when initially the obstetrician said the baby was distressed and arranged a caesarean section. Mild emotions such as fear were experienced by Mertle as she waited for this to occur. Finding out the next day that the doctor failed to meet her expectations of treating all women and carers as equal was a breach of trust and the catalyst to biographical disruption for Mertle. The other cases added to the disruption which led to a chronic illness. Eleven months after the event Mertle states:

I have no doubt in my mind that the stress and trauma caused from this one month has had a large part to play in my time off. Still to this day, while I absolutely love being a midwife and believe in what I am doing I still feel hugely vulnerable and I am leaving midwifery practice as an independent practitioner because of it.

In the current study the midwives values and beliefs were challenged creating feelings of vulnerability. The degree of emotional hurt as a result of relational trust could explain why some midwives suffered more severe physiological and

psychological effects than others and reinforces Williams (2000) suggestion that the biographical disruption and its emotional effects can be the aetiology of the chronic illness. In addition the midwives received no or very little support to cope with the emotional impact of the event(s) consequently the physiological and psychological changes associated with the trauma were increased. The lack of support and the absence of opportunity for funded counselling are discussed further in Chapter Six.

Biographical disruption leading to chronic illness

Stress is how a person responds to a high degree of pressure and is therefore subjective and individual. The pressure may be from the social environment or from the person's understanding or expectations of themselves and others. The inclusion of the impact of the social environment, which incorporates issues of loss and conflict, into the concept of stress and the potential for a subsequent mental illness suggest that stress and distress are symptoms of social processes (Stanley & Burrows, 2005; Thompson, 2002, Bury, 1991; Blattner, 1981). The social process and cultural practices will influence the style adopted by the individual (Bury, 1991) as Janet's story outlines.

Janet experienced biographical disruption and describes herself as having 'had a bad run'. Within a few weeks, she dealt with a woman who experienced a postpartum haemorrhage. Participated in the resuscitation of a neonate. The neonate required assistance because of an avulsed cord from a velamentous insertion. She cared for a woman who experienced a cord prolapse, another woman who birthed twins at 28 weeks gestation and finally a woman who experienced a stillbirth. These incidents collectively caused a breakdown in Janet's belief in birth being a normal life event. She lost trust in her lecturers who had instilled this concept into her as a student. The breach of trust exacerbated the stress Janet had already experienced from dealing with an avulsed cord and the resuscitation of the baby and created a biographical disruption in Janet's life. The emotions resulting from this experience plus the other events elicited for Janet style in the form of PTSD.

I had about 4 births and then the fifth birth I freaked out right as the baby was being born I suddenly got really panicky. I have actually gone on medication, can't sleep, turning over and over all the time. Thinking I do not want to do the births, just the postnatal.

The symptoms described by Janet, feeling as if the event was recurring, insomnia, labile emotions and hyper-vigilance are some of the symptoms associated with PTSD (Shives & Isaacs, 2002). Janet explains how she coped with the disruption by valuing herself and the strategies she undertook to repair her biography:

My focus was the women but now I am concerned about me. I have actually gone on medication, can't sleep, turning over and over all the time. You can't function if you can't sleep. I keep thinking I do not want to do the births, just the postnatal, you are so responsible, and it is just all on. I am concerned that I can't take something else now that I have had quite a few traumatic things. If I had another one I think I would be seriously in trouble. I mean for me to go on medication I am already in serious trouble. I look dreadful. I look years older. I can't be there 24 hours 7 days a week but that's what the women expect, they do expect that.

The stress of the incidents had an impact on Janet but the ongoing demands to care for the families created further stress accentuating the demands of the partnership between herself and the woman. Janet is aware that as a LMC she is meeting her practice requirements to the detriment of her own health. The strategy she considered to enable her to rectify the situation was to change her practice. During this time Janet's father-in-law died which added further stress and grief to the situation.

Janet's narrative supports the suggestion by Stanley and Burrows (2005) that some forms of employment subject the person to higher degrees of stress especially when long hours and shift work are involved. According to Perkins (1997) evidence suggests that midwives are subjected to stress on a day to day basis and from personal observation these day to day stressors may not have a negative effect on the individual. They could however be a precursor to a negative stress response when a traumatic event occurs. Emma explains her feelings about being a rural Lead Maternity Carer and the stress involved which concurs with Janet's views regarding the expectations women have of midwives:

I think the women feel disappointed if we are not there. They wonder if the person who is looking after them is giving them the same care. I find being a LMC is a lifestyle; it is not just a job, twenty-four hours 7 days a week the job is with you

The demands of the women were not what the midwives expected in a midwife-woman partnership. They presumed the women would respect the need of the LMC midwife for regular time off. Failure of individuals to have their expectations met creates negative emotions which can contribute to the development of a chronic illness (Turner, 2007) as experienced by Janet and Emma.

Although Emma's story appears in chapter 7 the focus is different as are the excerpts of her narrative. The traumatic experience for Emma was multi-factorial again depicting the demands sometimes experienced by the LMC. Within one week she was involved in caring for a woman with an intrauterine death; a neonate that required readmission and died two days later; a woman who had a long labour followed by a major postpartum haemorrhage; a baby diagnosed with a congenital condition and poor life expectancy; and being subject to horizontal violence as a result of her care of a woman in labour. In the middle of all of this Emma, who was in the early weeks of pregnancy herself, experienced a miscarriage.

It was the next Monday morning I had a primeup for induction. I came to this woman with no heart in midwifery anymore. I was hoping and wishing she would have a caesarean which is not the way I practice. I believe pregnancy and birth are a normal life event, I am not one that goes for caesareans but I wanted this woman to have a caesarean because I wanted to wash my hands of midwifery. I was waiting for the next horrible thing to happen and I guess I suppose feeling hopeless and feeling I am not a good midwife. Also just what was going on in my life, losing my baby, I didn't take time for my grief. It was one of the midwives on the ward and I still thank her to this day, she came up and told me to go home. She said you can't deal with this and then sent me home. I felt guilty I had let this woman down, but I didn't feel I had anything to give, I felt empty.

I went through a lot of stress at this time, I suffered a lot of sleep deprivation, not able to sleep and not really interested in eating meals. I ate just junk food, a lot of junk food comfort food. I think the tiredness and sleep deprivation was the big thing. My GP put me on anti depressants which I fought for a while, I don't know why because I couldn't manage on my own. I became really anti social not wanting even my friends to come and visit me. The phone would ring, my heart would sink and I would feel sick in the stomach because I didn't want to talk to anybody. I would say to my partner I am not in, I'm asleep or in the bath and he would pass me the phone. I used to lock myself in the house and I wouldn't go to

the shops anymore. I dreaded seeing anybody. I had to learn to face people. I needed help. I have been going for counselling, Employee Assistance Programme (EAP), for the last three and a half months.

Emma's biographical disruption is not only due to the practice experiences but the grief associated with having a miscarriage herself. These personal and professional childbirth experiences challenged Emma's trust in her philosophical views of childbirth being a normal life event. The challenge to her accepted understanding of childbirth created emotional responses that resulted in biographical disruption and PTSD thus highlighting that emotions can be the aetiology of the disease

Emma's identities as a midwife and woman, changed as she believes that she let this woman down and also failed to carry her own baby to term. She has had problems communicating with people which would have inhibited support. It was fortunate that the core midwife informed her of the Employee Assistance Programme which she accessed as part of her strategy to repair her biography. Levi (2005) cites Selye's theory and suggests that stress can be positive or negative depending on the individual's sense of control over the situation. Stressors such as role conflict or excessive demands coupled with a loss of control create both physiological and emotional reactions as well as behavioural changes. Emma exhibited behavioural changes when she stopped communicating with people. If a person's coping mechanisms are exhausted, not present or not instigated as a result of the trauma then the result of these and the reactions can lead to suicide attempts, hypertension, stroke, heart attack and even death (Levi, 2005). The number of stressful situations Emma was faced with in one week plus the grief of her miscarriage would suggest that her coping mechanisms were exhausted which resulted in the exacerbation of her physiological and psychological symptoms. Emma's story highlights the need to consider the suggestion by Williams (2000) that people should contemplate "the contradictory demands of the social roles in modern society" (p. 52) that lead to disruption in daily living and which can ultimately lead to illness.

Rose discusses the psychological effects she experienced following the induction of a woman's labour because of a stillbirth and the woman's subsequent death due to a ruptured uterus. These events were unexpected and Rose was powerless to assist the woman:

It is all coming back to me; as I talk I can bring myself back to the minute and the day and then to the night. I remember driving home in rush hour traffic and just thinking. 'I don't care if I die, I don't care. I could just drive my car off the motorway that would be the best thing (Sorry I knew I would cry). Of course that was going to be the end of my midwifery career because I had done the worst thing in the entire world I'd killed the baby and killed the mother. That's how I felt, I used to say that a lot "I killed her" and people used to say 'Stop saying that Rose, but that it is what I believed. You could have done anything to me; you could have come and struck me down dead, you know, that is what I deserved. I can never not eat, I can be on death's door and I can eat. I completely went off my food, I didn't sleep for a long time I would take myself back to that evening and I still can you know, eleven years on and I can still go back to that night. I really didn't know much about PTSD but I remember having the flashback and all of the symptoms. I would burst into tears at the drop of a hat. I couldn't talk about the event without bawling my eyes out but I wanted to talk about it all the time. Now I can look back and say yes I did go through PTSD at that point. I felt suicidal. People kept saying 'It will get better in time". But every minute that I was awake I thought about her and the baby, I dreamt about it. At one point I thought never a day would go by when I did not think about her but as time went on perhaps a day then a week and so it is. Time did heal.

Despite providing exemplary care blaming herself for this woman's unfortunate death demonstrates Rose associates her competence with the outcome. Rose received counselling following the event and it is unfortunate that the diagnosis of PTSD was not initially considered as a potential problem. Kolb (2006) recommends health professionals, when examining personnel who have been exposed to trauma, should consider PTSD in order to initiate treatment in the acute phase in an attempt to prevent the disease from becoming chronic. The body's unconscious actions of anxiety, loss of appetite, difficulty in sleeping and flashbacks confirm a disruption and would support Rose's personal diagnosis of having had PTSD. Blaming herself is a part of the grief process (Doka, 2002). Talking about the issue to the counselor in order to accommodate the tragic event demonstrates a strategy instigated by Rose to assist with the reconstruction of her biography. The narrative also suggests

biographical disruption may be the cause of the chronic illness rather than the other way around.

Williams (2000) argues biographical disruption was introduced for chronic illness, which in most cases is a developmental issue associated with adulthood; therefore he questions whether it is a disruption of the biography or a shift in the continuity of life. In this context biographical disruption is a suitable term indicating a shift, however slight or gradual, from a normal healthy status to one of illness. Considering traumatic experiences being part of normal midwifery practice and reflecting on this gradual development of a disruption as presented by Williams (2000) deliberation was given to biographical disruptions in midwifery practice being part of an accumulative process. The accumulated effects of trauma as a result of several practice issues occurring in a short time frame are demonstrated in the stories of Mertle, Emma and Janet discussed in this chapter.

Another study that supports the concept of disruption occurring in the absence of a chronic illness is that by Wilson (2007) who, using a biographical disruption framework, examined the role of motherhood and how identity may be influenced by moral and existential threats when the mother is HIV positive. Wilson (2007) concluded that although the women in her study had a diagnosis of HIV they were not ill yet this alteration in identity involved both biographical disruption and a subsequent biographical reinforcement. None of the midwives in the current study had a chronic illness prior to the dramatic or traumatic practice event. As a result of the emotional effects associated with the disruption some of the participants developed a chronic condition such as back problems, anxiety or PTSD.

The stories have illustrated how the initial physiological and psychological effects of the trauma have been exacerbated by a breach of relational trust. The breach of trust occurred as the midwives' expectation or needs, for example the provision of emotional support by management, were not met. In the current study, due to the disruption experienced as a result of the traumatic practice event, some of the

midwives coped by carrying on caring for women, setting realistic goals and attempting to accommodate the incident into their activities of daily living. Others lost trust in themselves or developed strategies such as looking after themselves, giving up midwifery practice or changing their mode of practice in order to cope. Some recognised the stress they were experiencing and requested or accessed support. However, they felt let down by organisations that they trusted to have strategies in place to provide funded support. Others, in the face of adversity have remained silent as a result of their position in the field thus exhibiting a style of active denial.

Summary

In this chapter the literature on biographical disruption which has its focus on chronic illness (Bury, 1982) has been discussed together with the concepts of coping, strategy and style. The stories have demonstrated how the meaning of the traumatic event impacted on the midwives' personal and professional identities creating biographical disruption that for some led to a chronic illness. Biographical disruption as the cause of the chronic illness differs from Bury's (1991) work which illustrates the chronic illness led to biographical disruption. The increase of emotions experienced by the midwives as a result of the disruption confirms the suggestion by Williams (2000) that the biographical disruption and its emotional attachments can be the aetiology of the chronic illness. The current study has also shown that midwives are not given the preparation needed to cope with the emotional impact of trauma especially when caused by death, violence and/or breaches of relational trust. Loss of personal and professional identities caused grief for the midwives and are discussed in the chapter that follows.

Chapter Six: Trauma, Loss and Grief in the Workplace

“There is a cost to caring” (Figley, 1995, p.1).

Introduction

Trauma and its effects can occur anywhere (Vickers, 2009; Thompson, 2009; Figley, 2006; Raphael, 2006) and in a safe workplace environment the understanding of loss, grief and trauma should be considered part of valuing the employee and be a part of maintaining their wellbeing (Vickers, 2009; Thompson, 2009; Eyetsemitan, 1998). The literature on management and human resources neglects the issues of trauma, loss and grief in the workplace which is disturbing and concerning for the cost of ignoring these issues is immense (Vickers, 2009; Thompson, 2009; Eyetsemitan, 1998). Grief impacts on health (Vickers, 2009; Thompson, 2009; Doka, 2002; Worden, 2002; Eyetsemitan, 1998; Worden, 1989). It is estimated that grief costs organisations millions of dollars yet many institutions fail to acknowledge its presence (Vickers, 2009; Thompson, 2009, Eyetsemitan, 1998) or their part in its occurrence (Vickers, 2009). Where it is acknowledged, the focus is on the traditional ideas of grief in relation to a death and then only when someone very close has died (Vickers, 2009; Doka, 2008, 2002). In this chapter I consider that trauma, loss and grief in the workplace in most cases goes unnoticed therefore support is not forthcoming. Maternal death, which is sanctioned by society as a legitimate reason for experiencing grief, was part of two of the midwives’ narratives. Their grief was acknowledged and emotional and practical help was provided to the midwives. Failure of management to acknowledge the workplace as a source of distress is apparent in a number of the midwives’ narratives and was not what the midwives expected. The participants’ narratives highlight how the emotional stress associated with grief was exacerbated by the lack of support. The chapter concludes with suggestions from the midwives about the various forms of support they felt would have helped them to reconstruct their biography.

The following story told by Margaret provides an example of workplace grief. The story demonstrates how the loss of a midwife-woman relationship and the subsequent grief is not recognised therefore formal support is not available.

Margaret

There couldn't have been a better midwife to have been there; if it hadn't have been you that baby may not have made it.

Margaret developed a relationship with Mary from her first and current pregnancy both of which had been uneventful. During labour Mary started having convulsions, proceeded to bleed and required a hysterectomy. Following recovery she was left with the mental age of a two year old:

I had support from colleagues but I found it difficult not being involved in the hospital debriefing. The father took the baby home on about day two or three so I visited him for five weeks at home as you would for a normal postnatal visit. Seemed weird, I didn't have a fundus or breasts to check.

Margaret was emotionally distressed because of the loss of a longstanding midwife-woman relationship with Mary. However, as a health professional she is expected to suppress her feelings and continue providing postnatal care (Morrisette, 2004) to the neonate and family. No consideration was given to her personal experience of the trauma and the loss of her relationship with this woman. Employees or in Margaret's case contractors who are viewed as normal healthy people are expected by management not to experience suffering as a result of critical incidents (Vickers, 2009). Expecting Margaret to hide her emotions is what Eyetsemitan (1998) refers to as "stifled grief" a term he suggested following his survey of 145 participants of organisational responses to grief. He concluded that management's understanding of the emotional impact of grief on employees is lacking and as a result workers were expected to leave their feelings at the door. The grief Margaret felt and continued to feel following this experience was not acknowledged. This created a breach of trust in management for failing to provide a supportive environment conducive to recovery. It could be argued that it is unreasonable to expect an

organisation to provide support to contractors. However the organisation does have a duty of care to provide a safe working environment which implies caring for the emotional health of all personnel. Therefore in my opinion when someone is experiencing trauma, loss and grief as a result of issues in the workplace discrimination between practitioners should not occur.

Doka (2002) developed the term disenfranchised grief which occurs in situations where the loss is not “openly acknowledged, socially validated or publicly observed” (Doka, 2002, p.5) therefore the survivors of the loss are not granted the right to grieve. Lack of a right to grieve occurs because the grieving norms of society distinguish between family relationships and what is perceived by society as insignificant losses which include death by suicide (Vickers, 2009; Thompson, 2009; Doka, 2002; 1989; Eyetsemitan, 1998), adoption, miscarriage or the loss of a trusting relationship (Doka, 2002; Gilbert, 2002) as in Margaret’s story. The situation for the LMC midwife not only results in the loss of a trusting relationship but may involve financial loss which complicates the grief already present. Both the loss of a relationship and the loss of financial status may be precluded by management and friends as part of the emotional support required to cope with the associated grief.

Margaret’s grief is a result of trauma and loss. Raphael (2006) has demonstrated a link between grief/bereavement and stressors following a traumatic event that can affect the mental health and social outcomes for the individual. She suggests that traumatic stress is a reaction to a threat on one’s life whereas grief is related to loss; both issues interrelate and affect mental health. Thompson (2009) and Vickers (2009) support Raphael’s (2006) suggestion that grief is a psychological response to loss and recommend that it should not be treated as an illness. Gilbert (2002) posits that grief is more than a psychological response to loss and occurs due to the insecurity that results from the destruction of a meaningful relationship. Margaret’s narrative exemplifies this claim as the grief she experienced stemmed not only from

the loss of a midwife-woman relationship but from a breach of trust in management who failed to acknowledge her traumatic experience.

Another issue for Margaret that may have eased her grief was to have been part of the debriefing session that occurred.

I was the key person but they didn't want to involve me; I was not a member of the organisation. I would have liked to have been a part of it.

Being present would have enabled her to discuss the care she had provided during the emergency and receive feedback that her care met the standards for midwifery practice. Not requesting Margaret's attendance at the debriefing sessions denotes management's lack of respect and understanding of the impact of trauma, loss and grief on the practitioner or the need to ensure that all practitioners are involved in processes that ensure quality and safety in the maternity services. According to Erikson, Foy and Larson (2004) the impact on the caregiver, who is involved in the incident and not a bystander, is the same as for the victim when recorded on the Impact of Event Scale (IES) at 2 weeks and 4 months after the event. A supportive environment of response is known to promote positive mental health or at least do no harm (Raphael, 2006). Sharing the experience is also viewed as an important step in the healing process (Laing, 2000; Hoff, 1989) and was expressed by some of the midwives in the current study. The provision of psychological support was not offered to Margaret nor was she given the opportunity to share her experience at the debriefing session.

Margaret's narrative has illustrated the effects of the 'grieving rules' (Doka, 2002) or expectations of the habitus in relation to trauma, loss and grief in the field of maternity care. The narrative illustrates how disenfranchised grief experienced by the practitioner is not publicly acknowledged or given the same rite of passage by employers as those whose grief is associated with death. The following story by Wendy confirms the view that people who experience disenfranchised grief do not receive the support required to cope with the traumatic practice experience. In

addition it illustrates how personal issues can impact on an individual's coping mechanism in times of trauma.

Wendy

I felt I had no right to grieve; it was not my loss it was hers

Wendy has been practising as a lead maternity carer midwife for ten years. Over the last three years Wendy has been involved in two minor traumatic events with which she did not cope very well and attributes this to issues within her personal life which involved her daughter experiencing a long illness. She believes she became depleted of serotonin as a result and these issues were antecedents to the major event. She felt that she was sensitized to a pending issue.

Wendy was the LMC for Karin whom she had cared for in her previous pregnancy. As a consequence she was aware that Karin had a history of mental illness and had been on medications since her pregnancy five years earlier. Therefore Wendy had referred her to the Mental Health team for advice and support if required during birth and the postnatal period. Between 34 and 36 weeks gestation Karin contacted Wendy four times citing reduced fetal movements as a concern. Each time she was assessed by Wendy a CTG recording was undertaken. All were reassuring as was a follow up call the next day. Wendy believes that this woman had an intuitive feeling that something was wrong but had difficulty expressing it.

I have done a bit reading around this and apparently some women just know there is a problem with the baby. In retrospect maybe a scan might have been a good idea but all four traces were reassuring, the baby was moving appropriately and Karin was reassured so I left it.

At 36 weeks gestation Karin informed Wendy the baby had not moved that day; Wendy's assessment revealed a fetal heart rate of 240 beats per minute. A subsequent scan demonstrated the fetus had an enlarged heart, abnormal heart structures and reduced liquor volume. The anatomy scan at 20 weeks had shown no fetal abnormalities. As Wendy did not state what medication the psychiatrist had

prescribed for Karin it is not possible to ascertain if it had the potential to be teratogenic. A caesarean section was advised and occurred two hours later due to the number of emergencies that required immediate attention. Wendy explains:

The obstetrician did not expect this baby to be alive. The two hours we waited in one of those tiny windowless rooms was terrible, it was a very hard time sitting with her. The hospital staff were great. Finally a little girl was delivered and she lived for about 20 minutes as the cardiac abnormalities were incompatible with life. The couple were Jehovah's Witness which made a huge difference for them to be able to cope with this. They had wonderful support from their church, they had a belief system in place and they strongly believed that they will see their baby again, which must be a great comfort.

After the birth I felt utterly exhausted, drained, and guilty. Karin was my last case as a LMC as I was getting ready to wrap up my practice and have a holiday. This experience gave me paranoid feelings that I was useless as a midwife. I had kept a whole box of thank you cards from previous clients and I had comfort from reading through those. I would just delve in and take a handful and know that I had helped a lot of women through difficult times and I was probably an OK midwife. I was able to talk about it to colleagues, my husband, the student midwife we had in our group and each time I talked about it, it became easier. I was able to talk to the psychiatrist involved with the maternal mental health team. He actually came to the funeral with me and I thought that was great of him to provide that sort of support to both Karin and myself.

The person I felt most angry with was her GP, probably inappropriate anger, but I needed to direct it at someone. We had been colleagues for years sharing maternity caseloads when he was an obstetric GP. He had looked after Karin for up to 12 weeks and had not talked about a NT(Nuchal translucency) scan which may or may not have shown some fetal abnormalities certainly the 20 week scan didn't. He didn't contact me afterwards and I just felt a bit let down really. I do wonder now if that is part of his judgment in some sort of horizontal violent way. I have seen him several times since but he has never broached the subject. A phone call from him I think would have made a great difference to me from someone who was not involved in the maternity care at that stage but who knew both Karin and me. I would have felt quite comforted knowing that he did not hold any blame.

I visited Karin several times in hospital and at home. I visited her once after the funeral. It was extremely difficult. The little boy kept asking me where the baby was and kept looking in my maternity bag because that is where he thought the baby would be. I felt that I could not help Karin very much because I was still grieving myself and yet I felt I had no right to grieve; it was not my loss it was hers. I felt just so guilty that I felt that I could not go back and see her again. Sometimes when I get near her house I feel I could call but one day, one day I will. Part of my not calling in on her was that I did not want her to perceive that I had something to hide that I had missed something and perhaps felt guilty that I needed to be visiting her again, obviously not justified but that is how I felt.

It is interesting to me how these antecedent factors came into place. Had I been able to deal with, particularly my daughter's illness in a different way I might have been able to cope with this incident with Karin in a different way. Maybe in a less traumatic way but to me, because I was depleted and not coping with things very well, it made this all that much worse. I do not know how you get around that. We all have things going on in our lives but to have trained qualified people to talk things through with, it helps. To me this incident I had all those symptoms of PTSD afterwards, not sleeping, the reliving over and over, the guilt, the "what if's", the "if only" and triggers. I found the funeral very traumatic and even now as I pass the hall where the funeral was held I get flashbacks to the time. It was a real defining experience for me. I am very, very happy now working as a core midwife and I would never go back to independent practice. I enjoy the hospital. It is great.

Wendy is now working in a primary birthing unit as the sole charge midwife having decided to end her practice as a LMC prior to this practice event. Wendy positions herself as having failed this woman and her baby yet her actions suggest she has worked in partnership with the woman and provided quality care throughout, based on the Standards for Midwifery Practice (NZCOM, 2008). She responded to Karin's calls when she perceived the baby was not moving and provided ongoing support to the woman between these incidents. She referred appropriately and despite her personal grief supported this family in their time of need. The NT scan referred to by Wendy is a nuchal translucency scan performed between 11-14 weeks gestation and is a screening test for Down's Syndrome (Tracy, 2006). There was no indication for a scan prior to the 20week gestation anatomy ultrasound scan that screens for structural abnormalities (Travy, 2006) and Wendy has no need to reproach herself. Rather she should focus on the positive actions she took by giving the parents a short time with their daughter to welcome her into the world, touch her, talk to her and say goodbye, which according to Trulsson and Radestad (2004) assist healing in the grieving process. It is understandable that Wendy had difficulty trying to cope with the little boy who was looking in her bag for the baby as she was still trying to come to terms with the loss herself and the guilt that she felt. Wendy does not state if she discussed with the parents the little boy's need for help to understand the situation.

Wendy attended the funeral service which is another means of assisting a positive recovery from grief as not only does it validate the life of the person, it also strengthens the links between the survivors and aids in the reduction of the symptoms of loss (Thompson, 2009; Worden, 2002; Walsh-Burke 2006). Although the funeral was very traumatic the emotional support that Wendy received from the psychiatrist was provided unconditionally and helped her through the initial period of distress. Implementing strategies to talk about the situation, as Wendy did, should help the person to find meaning and ease their reactions (Neimeyer, 2002; Worden, 1989). Given time and support the majority of individuals will adjust to the situation and the pain and behaviours experienced as a result of the emotional effects of the loss will diminish (Walsh-Burke, 2006) as they reconstruct their identities.

Wendy's statement *I felt I had no right to grieve; it was not my loss it was hers* confirms Doka's (1989) thinking that death is socially validated only when it involves a close family member. Wendy affords no grieving value to the carer in the midwife-woman partnership therefore is unable to openly acknowledge her feelings. By not acknowledging her grief experience Wendy denies herself any offer of support that could have been available.

The meaning of this event for Wendy was that she questioned her professional identity in relation to her competency for not having performed an earlier scan. Consequently she experienced feelings of guilt. She felt let down by the GP whom she trusted and valued as a colleague. She also struggled to come to terms with the ill health of her daughter which was another biographical disruption in her life creating stress and grief. Evidence suggests that caregivers who are subjected to psychological distress prior to the death of the patient have an increased risk of greater distress following the death (Kelly, et al,1999) which appears to be the situation with Wendy. Feelings of guilt and the questions of 'what if' and 'if only' are common and normal reactions to grief. Although they are often irrational (Thompson, 2009; Doka, 2002) and create psychological conflict within individuals

(Rubin, Malkinson & Witztum (2008) the feelings of guilt will lessen with discussion of the situation. Doka (2008) suggests that in situations of disenfranchised grief feelings or emotions of anger, guilt and powerlessness are intensified. If the anger in grief is not handled correctly it can be directed at others thus blaming them for the death which the mourner defines as preventable (Stroebe, Hannson, Schut & Stroebe 2008; Doka, 2002; Wolden, 1989). The anger directed at the GP by Wendy for not contacting her following the death of the baby, although she recognises it as irrational, is an example of an anger/grief reaction. In order for recovery to occur Wendy needs to consider the social and cultural factors that influence her reaction to the traumatic event.

Stroebe and Schut (2002) developed a model that considers the social and cultural aspects of grief. This model contains a concurrent process approach to grief reactions, namely loss orientation and restoration orientation. Loss orientation involves anger, denial, sadness, and crying whereas restoration orientation refers to attempts to recover from the loss and reconstruct one's life. The Dual Process Model (Stroebe & Schut, 2002) suggests that following a loss people move between these two phases with the loss orientation predominating during the initial loss and then gradually restoration orientation will predominate.

A theory by Neimeyer (2002), a leading figure in the importance of finding meaning in bereavement (Nadeau, 2008), is the Meaning Construction Theory. This theory could have been used to assist Wendy to understand the grief associated with the loss of her client's baby and the illness of her daughter. The theory suggests that the individual has to make sense of the loss, ask why it happened and decide what life means to them then reconstruct their life to fit the current situation (Neimeyer, 2002). Vickers (2009) in her exploration of the impact of redundancy on the individual reported that the participants' experiences of grief appeared to occur in phased sequence. From these findings she developed a four phase model using the terms 'something changed, loss commenced, loss confirmed and afterwards'. The Meaning Construction Theory (Neimeyer, 2002), loss orientation and restoration

orientation (Stroebe & Schut, 2002) and the four phase model by Vickers (2009) are similar to the works of Bury (1982) on biographical disruption. These models all focus on a change in life's circumstances and the need to evaluate and restore life to as near normal as possible, having incorporated the change into activities of daily living. Consequentially these theories move away from the "narrow, psychological reductionism" (Thompson, 2002, p.11) views that have been associated with grief.

Wendy acknowledges she had all of the symptoms of PTSD as a result of her trauma and associated grief but does not infer if her doctor made a definitive diagnosis of PTSD or related the PTSD to her grief. Worden (2002) states that a psychiatrist colleague of his estimated that 10-15% of individual's access health care for physical or psychological reasons but health professionals fail to recognise that these conditions are a result of an underlying grief issue. The failure to recognise underlying grief issues is reinforced by Walsh-Burke (2006) who found some clients who presented with anxiety or depression had issues of actual or symbolic unresolved grief. Symbolic grief like disenfranchised grief occurs due to a loss not necessarily associated with death and often the need to grieve is not socially validated (Vickers, 2009; Gilbert, 1996; Worden, 2002; Doka, 2002; Eytsemitan, 1998). It is therefore important that health care professionals are aware of the effects of loss and grief and the subsequent consequences (Vickers, 2009; Thompson, 2009; Raphael, 2006; Worden, 2002) for themselves as well as their clients. It is equally important that organisations recognise the impact grief has on the employee as well as the workplace environment (Doka, 2002; Eytsemitan, 1998).

It is interesting that both the woman and the midwife had an innate feeling that something was not quite right during the pregnancy. Evidence suggests that many women do get a premonition that there may be a problem with the fetus (Trulsson & Radestad, 2004). The intuitive feelings experienced by Wendy and Karin demonstrate how subjective knowledge can prove to be superior to that of the

objective scientific knowledge which was provided by the scan results. Intuition is linked to thoughts and emotions (Plessner, Betsch & Betsch, 2008). Guilt is a negative emotion associated with grief and can arise when an event is evaluated as relevant to one's concerns (Zeelenberg, Nelissen & Pieters, 2008). Being concerned for not having performed an earlier scan could account for Wendy's guilt. By Wendy and the woman acknowledging their innate feelings they may have subconsciously prepared themselves for the adverse outcome which may have eased the grief that occurs.

In order to recover from grief associated with loss it is important that the person feels well supported. Wendy did receive support from many sources including professional help however this was not the experience of several of the midwives in the current study. Organisations were perceived by the midwives as failing in their duty of care to provide a safe working environment. Consequently the midwives felt let down by the managers who breached the trust the midwives attributed to their position in the field which they believed should involve valuing the employee and maintaining their wellbeing (Vickers, 2009; Thompson, 2009; Eytsemitan, 1998).

Wendy's story illustrates the impact of workplace loss on the LMC as a result of the longterm relationship that develops. The following story demonstrates how workforce issues such as safe staffing in terms of numbers and skill mix can subject the practitioner to disenfranchised grief and influence the workplace attrition.

Anita

I felt a lot of grief, I felt as if my life had died.

Anita is a very experienced midwife having worked in several countries before moving to New Zealand. She practised midwifery in this country for 25 years before she experienced the traumatic practice event that led to her decision to

relinquish her career as a midwife. Anita's belief in midwifery is based on the midwifery model of care.

During my midwifery career I have worked in stressful situations, been very busy and always seemed to cope with it. I also had the backing of my colleagues. I have always felt I have given 110% of my time to the person that I have been looking after. Recently the staffing situation has been very minimal and you had to work with unsafe staffing conditions which I did complain of from time to time. On this particular occasion I was looking after a woman who was having twins, IVF babies. I also had two or three other unit women to look after. The postnatal ward was very busy and there was no help from anywhere. I was asked to help and run the ward unit as well as look after the women in delivery suite. The unit was extremely busy; there was one other core midwife on with me.

The woman with the twins labour was progressing well but I noted some early decelerations were present on the CTG tracing. The consultant said to keep an eye on the monitoring and inform him of any changes. I gave the woman an epidural top up and she seemed quite comfortable. Due to the other responsibilities that I had as the senior midwife in the unit I wasn't able to give the woman my full attention. I had to go out of the room on several occasions therefore I couldn't monitor her or the twins as well as I thought I should have been able to do. The mother ended up having a caesarean section due to the presence of some late decelerations on the CTG tracing. The second twin had to be resuscitated and he was subsequently transferred to a Level 3 neonatal unit.

About three days later we had a debriefing and they just said that perhaps I should have contacted the consultant earlier. It wasn't a debriefing for me it was a debriefing for management.

I was deeply distressed by this situation. I thought that this baby could have died because of my lack of attention. This really upset me. I had never ever been in that situation before and it really scared the hell out of me. On the afternoon shift the next day I was working in the same conditions again. Over the years I had tried to bring to the attention of senior management the issue of unsafe staffing levels. I thought I can't go on with it any longer. I was putting myself and my clients at risk. I went home after that duty and said that I wasn't going to do midwifery again and I haven't.

I felt a lot of grief, I felt as if my life had died. Some of the staff were supportive of me; some of the staff were not. I always wanted to be a midwife. I felt it was my career which had just ended so tragically and there was no choice. I have really missed it ever since. I have got another job but midwifery is my first love and it has been just like a death. I have grieved over the loss of my midwifery practice. On reflection everything was really out of my control. The high patient ratio of high risk clients to staff meant there was nothing that I could have done differently.

Anita was a safe and competent midwife who positioned herself as hard working and very capable of working under pressure. The workload that Anita was expected to carry was extremely heavy and did not enable her to provide one to one midwifery care to any of the women especially the woman with the twin pregnancy. It also challenged her values and belief system of providing 110% care to women. Failure of senior management to address the unsafe staffing issues demonstrates how they use their symbolic power by ignoring the requests of the worker thus creating what could be regarded as a breach of trust. Anita trusted her superiors to address situations of unsafe staffing when they were brought to their attention but they did not do so.

In New Zealand it is a woman's legal right to have a midwife care for her during her childbirth experience (Primary Maternity Service Notice 2007, NZPH & D Act, 2000). All midwives in New Zealand are encouraged to work within the Partnership Model (NZCOM, 2008) and whenever possible to provide care to women on a one to one basis within the birthing unit (NZCOM, 2008). Evidence suggests that continuity of carer throughout pregnancy and birth ensures a better outcome for the mother and the baby (Pairman & McAra-Cooper, 2006; Sandall, 2004; Page, 1996; Waldenstrom, 1996; Flint, 1991). The provision of this type of care is especially important for high risk women whose main reason for hospitalization is the 'risk' attributed to their condition. They therefore require vigilant observation to ensure that if the risk becomes reality urgent action is undertaken. Because of shift work the core midwifery staff, provide care that may be fragmented (McIver, 2000) however they should be available to remain with the woman during labour and birth for the period they are on duty. Unfortunately this is not always possible as Anita explained when she had to leave her woman to provide midwifery care in other parts of the unit.

The staff shortage issue is one that the New Zealand Ministry of Health has been working hard to improve. In 2005 the New Zealand Nurses Association, Midwifery Employee Representative & Advisory Service (MERAS) and the District Health

Boards united in an attempt to rectify the staffing situation nationwide (MoH, 2006). It must be acknowledged that there is regional variability in staffing shortages (MoH, 2006). In order to retain and attract people into the sector substantial pay increases and Primary Health Care Scholarships were some of the initiatives implemented for nurses and midwives (MoH, 2006). The work to improve staff ratio and skill mix is ongoing. The stress experienced by some practitioners as a result of these shortages continues and contributes to the increase in the attrition of midwives from the workforce (MCNZ, 2008). Consideration must be given to the impact of the Rural Midwifery Recruitment and Retention Service (RMRRS) which enables midwives to practice away from their local area thus having the potential to deplete staff in that area. From personal experience another factor that impacts on midwifery shortages in units is the budget restraints that prevent managers from employing above the number of salaries allocated even through this number may not be sufficient to provide best practice care.

Anita's traumatic event demonstrates the difference in roles between the core and the LMC midwife. Anecdotal evidence suggests that if the LMC is occupied with a birthing woman and requests help she does so from another member of her group or a member of the core staff. She may receive the odd call from a woman but most women understand that the midwife cannot leave a woman in labour and are content to ring the second person on call. The LMC is rarely responsible for other women and certainly not responsible for other parts of the unit. The core midwife does not always have this privilege of providing one to one care as Anita has explained. The inability to provide best practice care created grief for Anita that went unrecognised.

Anita did not state whether the CTG changes which occurred for the woman expecting twins, could be attributed to the procedure when she gave the epidural top up. On reflection it is easy for Anita to see that the first twin was compromised and could have been so for a greater timeframe than the three hours stated but one acts on the information available at the time. From personal experience it is not

always easy to monitor a twin pregnancy even with modern equipment. Another interesting factor is that everyone, including Anita, is focussing on the CTG, a screening tool, which without other information has no diagnostic value. Why have the experts present at the debriefing session not recognised that? Is the debriefing session as Anita suggests purely an exercise in keeping with the Risk Management policies? If so then to blame someone for not having time to monitor a woman correctly without considering the staffing issue is futile. It would have been to more avail if Anita had been listened to and the focus had reverted to the underlying cause which was the staff shortage, a system issue. Anita lost her trust in management as they failed to recognise the concerns she brought to their attention and failed to acknowledge they had a duty of care to provide a safe working environment. Failure of Anita's expectation states (Turner, 2007) being acknowledged aroused negative emotions of fear and sadness (Turner, 2007) for her.

Anita suffered the effects of emotional stress as a result of her involvement over the years with traumatic events combined with staff shortages that prevented her from providing what she perceived as 'good care'. Larson (1987) suggests certain traits such as emotional over involvement, feelings of inadequacy and a desire to leave the profession, are portrayed by individuals suffering from secondary trauma. These traits are certainly displayed by Anita and are the direct result of her empathic involvement with childbearing women. For the sake of her own health Anita's coping strategy was to make the decision to leave. She believed she had no choice. Engle (1961) argues the effect of loss is the same as experiencing physiological trauma. He suggests that grief causes an alteration in the normal physiological balance of the body and, like healing, a period of time is required for mourning (cited in Worden, 1989). Thompson (2002) posits that when an event occurs that our normal coping mechanism is unable to deal with, an alteration in the homeostatic balance of the body occurs. The homeostatic disturbance caused by grief can lead to physical and psychological conditions as Anita has explained:

I used to cry a lot. I had lost all my self confidence. I thought I was no good as a nurse, no good as a midwife. I felt as though I had let the profession down, I was worthless, no good to anybody.

Under the circumstances Anita provided the best care possible but this did not equate with her personal standard of care therefore it challenged her values and belief system. In her opinion she was at fault. Anita experienced a loss of her normal professional standard of providing safe care to women which impacted on her professional identity creating biographical disruption. Blaming oneself is a normal part of the grief cycle and is not based on reasoned thought (Worden, 1989). Had Anita's concerns about the unsafe practice environment been discussed with her and the staff shortages addressed by management then these actions may have lessened and helped remove Anita's self-reproach. Leaving midwifery was a huge loss in Anita's life and it is little wonder that she feels as if she had died. The loss of her career was sudden and traumatic and resulted in disenfranchised grief which goes unrecognised.

Anita's reflection on the event demonstrates her recognition that she is not at fault. She was very composed while telling me the initial part of the story however when it came to the traumatic incident there were lots of tears. I had to stop the tape several times and it was obvious to me that this incident still had a big impact on Anita's life. As part of the recovery process she now moves between the phases of loss orientation and loss reconstruction concepts of the Dual Process Model of Grief (Stroebe & Schut, 2002) discussed earlier in the chapter. She is very happy in her role as a nurse but the abrupt and traumatic ending to a much loved midwifery career led to disenfranchised grief with all its emotional and adverse consequences. Her narrative also illustrates loss and grief associated with employment is not validated and therefore not supported.

Grief can resemble depression with symptoms such as loss of appetite, weight loss, and sleeplessness. The difference between grief and depression is that it is uncommon to find a loss of self-esteem with an uncomplicated grief reaction (Thompson, 2009; Worden, 2002; Worden, 1989; APA, DSM III, 1980). It is not

uncommon to experience depression as a result of a traumatic event (Thompson, 2009). If the grief-induced anger is not handled correctly it can be directed at others thus blaming them for the death (Mikulincer & Shaver, 2008; Stroebe, et al, 2008; Doka, 2002; Worden, 1989). The mourner's motive, however irrational, is that if blame can be attributed then the death could have been prevented (Worden, 1989). The need to attribute blame could account for why some women shock the practitioner by complaining to the Health and Disability Commissioner about a birth situation that at the time of the event was not an issue. According to Portia:

Yes we all know that if you get an unexpected outcome the women turn. We know that it is historical.

Margaret supports Portia's statement when she states:

I remember a shoulder dystocia, we had rescued a baby from the brink of death, but a year later the mother comes back to me and blames me for things "Why didn't you do, this, why didn't you do that?"

These irrational actions by the woman associated with grief demonstrate another means by which trust between the midwife and the woman can be destroyed. To help individuals overcome guilt Thompson (2009) recommends that supportive people assist the sufferer to make the transition from thoughts of guilt to thoughts of regret. Failure of management to acknowledge Anita's concerns in relation to safe staffing, Margaret's loss of relationship with her client and the lack of contact from the GP experienced by Wendy demonstrate breaches of trust experienced by these midwives. These breaches of trust exacerbated their traumatic practice experience. The stories also illustrate how those who experienced disenfranchised grief did not receive the support they required

Support

The midwives narratives showed the importance they place on the need for support particularly emotional support following a traumatic practice event. In this section I discuss the relevance of support and provide an overview of different types of support such as emotional support, risk management debriefing, psychological

debriefing and professional supervision and their relevance to a traumatic practice experience as Anita explains:

I did have a lot of support at that particular time from my husband and family. When I decided to leave my job my family supported me even though it was a great financial loss. They realised that emotionally I had just had it and had come to the end of my career as a midwife.

To feel supported and cared for is a basic human need especially in times of stress and/or trauma. Lack of support can exacerbate the problem creating further stress and lead to chronic health problems (Needham, 2003) as the current study has demonstrated. Although formal support in the shape of psychological debriefing sessions may be required, initially equally as important is informal support (Parkes, 2008) to assist the person to deal with the event and as a means of improving the person's self esteem (Semmer, McGrath & Beehr, 2005). Informal support can consist of providing reassurance, explanations or sharing experiences over a cup of coffee. Demonstrating public support for the midwife or a hand on a shoulder letting her know you care may be all that is required in order for the midwife to reconstruct her life. Emotional support can be provided by friends, colleagues, family or the church but the primary focus must be to promote the individual's self-worth (Thompson, 2009; Morgan, 2002).

Rose received the following support:

I went for a walk and my next door neighbour, nothing to do with midwifery, was driving past and he stopped me and he said 'O Rose how are you' I said 'I have had a terrible night, oh, it's awful.' It was 8 in the morning and you know he was lovely and continued to be lovely afterwards.

The support provided to Rose by her neighbour was unconditional and demonstrates his understanding of the need to be cared for in times of workplace distress. Social support is the support that one person receives from another and evidence suggests that it is a crucial factor in dealing with health issues (Semmer, et al, 2005; Sumi, 2004; Stroebe & Schut, 2002; Kirkham, 1996; Morrison & Bernard, 1991.) and is firmly situated in all cultures (Bruhn, 2005). The ability to provide emotional support depends very much on the interpersonal skills of the supporter

(Bernard, 1990). Heron (1989; 1999) believes that interpersonal skills are greatly influenced by one's values and belief system, how individuals see themselves in the world, their confidence levels and sense of self-worth. Rose explains how when the midwifery community became aware of the death of both a mother and baby, she received support from midwives she did not even know:

There were many people that were helping me at that point. They were absolutely terrific and I remember getting cards coming to delivery suite. I mean they did not know who I was but they said to the midwife that was involved with that woman' and it would be from other midwives saying, "Keep going, have courage" and that was lovely. I got flowers from various groups of midwives. That was amazing.

The response from the midwifery community demonstrates how close and caring a proportion of the midwifery profession can be when an adverse event occurs.

Susan explains the support she received following a maternal death:

I was incredibly supported by my midwifery practice colleagues. They came round almost instantaneously and took my pager for the day. The hospital staff were absolutely amazingly kind and the neonatal unit were awesome. The obstetric team that were on that night were incredible. My husband was absolutely brilliant and I think that is probably one of the big things that got me through.

Both Susan and Rose's stories highlight the importance people place on providing support following a death and the subsequent grief associated with it.

Page (1995) found that working as a midwife in a small team, which provided one to one midwifery care, although extremely satisfying, became difficult when an adverse outcome occurred. The difficulty arose due to the relationship which had developed between the midwife and the family. However, the advantage of working in a group is the support provided by team colleagues both professionally and personally (Kirkham & Stapleton, 2000; Page, 1995).

Janet explains her experience of support:

All my team came in to offer support because the word had got out that the woman had actually had a neonatal death as the Apgar Scores were 1, 0, 1.

Several of the participants in the current study did not get the support they expected from their colleagues, management or professional body. A reason for this could be the expectation that the midwife will be able to carry on despite the trauma (Schott, 1996; Taylor, 2000). However, the majority of loss and grief experienced was disenfranchised grief (Thompson, 2009; Doka, 2008, 2002, 1989; Eyetsemitan, 1998) therefore no or very little support was elicited. The evidence from the current study confirms the findings of Kirkham and Stapleton (2000), who from their ethnographic study in England that requested 168 midwives to reflect on their practice concluded that the midwives' support needs were not met by colleagues or supervisors of midwifery. In relation to midwives in New Zealand Emma states:

Midwives need something. There is nothing there to support them emotionally.

Lack of Support

Responses to loss are influenced by cultural values and different levels of status in society and the resources that accompany the status or position (Vickers, 2009; Thompson, 2009; Davis, 2005) within the field (Bourdieu, 1991). They play a major role not only in the occurrence of trauma but also in the response to healing (Thompson, 2009; Needham, 2003; Davis, 2002). Organisations expected the midwife to cope with her work irrespective of the emotional difficulties that she may be experiencing or the impact of trauma on her identity. As a result some of the midwives lost their confidence and were unable to work and/or gave up midwifery practice. The lack of information regarding accessing the Employee Assistance Programme highlighted the dearth of understanding of workplace grief and produced in the midwives feelings of mistrust in the organisations. Mertle expressed concern about the lack of access to information:

I think the fact that we do not know about EAP is wrong.

A reason for this lack of information could result from a tendency in western society to celebrate emotional events such as weddings and birthdays but the emotions which accompany loss are seen as something that should be avoided (Morgan, 2002; Thompson, 2002). The result is that the support required is not

always available for the victims of loss and as a consequence decisions resulting from loss often occur in isolation (Thompson, 2002). Caroline was faced with this situation as she explains:

I'm trying to just keep my normal life going, trying to provide midwifery care to other women and it was a very busy time. I do not think there was anybody in this place that I work who actually knew what was going in my life or even my heart.

Suppression of feelings is an example of stifled grief (Eyetsemitan, 1998) that is not only present but expected in the workplace. An alternative view point is that by suppressing her feelings Caroline suggests that she is being cared for elsewhere and exhibits what is described by the American sociologist Arlie Hochschild (1983, p. 57) as “feeling rules”. These feeling rules are private acts of emotion that influence behaviour. They guide emotional work by deciding how much if any emotional exchange will be required or provided. Caroline’s narrative suggests that she is a strong person able to carry on even in the face of adversity. As a result the impression she portrays to her midwifery practice colleagues suggests that she is coping therefore she is denied the support needed to deal with the consequences of the traumatic event.

Rose experiences a breach of trust in her relationship with her midwifery partner when she failed to provide the support Rose required when dealing with a maternal and fetal death.

Interesting enough it changed how I viewed her forever. I still view her as my lost past midwifery partner, for she was irritated at having to come in yet I had been up for hours and hours. I asked her if she could just go and see to the baby. It needs washing, wrapping up and putting in the little box. “Oh I couldn’t go in there by myself; oh no it freaks me out seeing dead babies.” I ended up having to support her through her distress and actually go in there and help. Then she said “Can I go home?” and I thought I cannot believe that this is going on; this is one of the people that I work with. Later that morning we had a sort of practice get together and she said to me “Ah well Rose I will cover you until midnight tonight and then you’ll be back on call.” I was just in total shock that I just couldn’t argue.

The support or lack of support which Rose’s midwifery partner provided to her could be an example of what Dass and Gorman (1985) refer to as “professional

warmth” which they suggest is a survival strategy instigated by carers who witness the suffering of others on a daily basis. Like pity it enables the practitioner to maintain a distance from the sufferer. Many professionals believe that it is inappropriate to get involved therefore their behaviour displays an individual who is cool, calm and impersonal (Dass & Gorman, 1985). Hochschild (1983) argues that not becoming involved is a normative behaviour expected by the organisation which he alludes to as ‘feeling rules’. Alternatively is this midwife so entrenched in her own values and beliefs that the public image of the ‘caring midwife’ or professional issue of a working partnership and support for colleagues holds no or very little value for her?

Dass and Gorman (1985) posit that when we rush to someone’s aid without thinking about it this is part of an innate process that stems from having trust in ourselves and others. It happens without effort and both parties feel reassured by it; this is unity. However as we grapple with the binary oppositions of kindness or unhelpfulness, sacrificing or protecting the self we wrestle with doubt. According to Bruhn (2005) and Dass & Gorman (1985) it makes one feel good to help people; although the reasons to hesitate could be complex as they are influenced by conditioning and custom. Conditioning and custom are two of the factors which influence a person’s identity, relationships with people and self-worth and can direct people’s thoughts to the model of the separate self. The model of the separate self creates an environment where people avoid unpleasant situations rather than confront them. Rose’s colleague chose to retain her separateness and as a consequence betrayed the trust Rose had in her as part of their working relationship. In contrast, despite her trauma and her personal need for support, Rose demonstrates her commitment to what is referred to as unity (Dass & Gorman, 1985) by supporting her practice partner in providing end of life care for the baby.

Some of the midwives in the current study felt they received no support from their professional body.

The legal advisor did not get back to me. I needed someone from my professional body to say something to me. I felt very isolated. I thought I am really going to lose my practising certificate.
(Caroline)

There was no support anywhere really. I rang the College of Midwives and wanted to talk to the lawyer but I don't think they realized how severe the situation was. I got very little help from the College. I felt that because I was a staff midwife that this was the reason sitting behind that and even to this day I have to say I regard the College with a little bit of caution. I am not sure that I would be supported again; I still have that fear. I am very pleased to hear that this research is being done. It gives me great heart.
(Susie)

I felt hugely let down by Midwifery, by the College my professional body. I spoke to two people who have contact with National office, in Christchurch. I had no response from either of them. Yes we can deal with things on a peer group basis and within my own little group but they don't have the skills to help me, where am I supposed to go? They are not there to pick me up and support me at all unless it goes somewhere and you do something wrong. The Council is there for the woman and the Resolutions Committee is there for the woman but what is there for the midwife? There is nothing there for the midwife; that is a huge sadness now that midwives are leaving because of burnout or stress. We do not care for our own.
(Mertle)

Everything is there for the women. I think the College could do more for the midwife really. Not everybody goes to litigation.
(Emma)

One of the things I found quite difficult was the lack of support I got from the College of Midwives. I know it is all about privacy but I really felt quite alone from that professional point of view. I just found that there was very little support apart from them saying that I could have three sessions with a psychologist or a counsellor that was really the only input that I had. I was the one that used to contact the lawyer to say "Is anything happening?" I haven't heard from you for months. She would say "Now who are you again?" I know that she would have heaps of cases and that she was not full time, but I actually felt here you were coping with this massive, massive incident, and you are invisible apart from the people that were around you. Nor did I feel that they understood legally how devastating and destroying the event is for a midwife. At the same time I got the feeling that you just had to move on but really you just wanted someone constantly to say 'It is OK and that they are there for you'. But I never got that at all from the College.
(Susan).

I remember ringing up the College and it was December and people were on holiday. I couldn't get anyone to talk to me about what to do. I finally managed to talk to someone who said "Oh well you can probably expect the police to come and knock on your door and you might be arrested" "What!" It was like oh my god we are going down another route that I hadn't considered, part of that was traumatic. That was to do with the coroner's case; the case was not heard until a year later.
(Rose)

The perceived lack of support destroyed the faith these midwives had in their professional body to help them in their time of need. They trusted the organisation to provide a more personal approach, emotional support and information about the availability of help from EAP as well as feedback on claims against their practice and direction as how to proceed. The loss of trust in their professional body exacerbated the effects of the traumatic experience.

Trust is engendered by emotional commitment and support (Mollering, 2008) which these midwives perceive that the College failed to provide thus making them feel vulnerable. Vulnerability has the potential to create health issues (Cook & Stepanikova, 2008) and has been demonstrated in some of the midwives' stories in the current study. Active listening and nonverbal expressions of caring and empathy are important (Cook & Stepanikova, 2008) and these are the kinds of support that the participating midwives believed were not provided by NZCOM. While some of the midwives felt unsupported Portia stated she they received good support as did Rose once she spoke to the lawyer:

The lawyer who was at the College then was involved and she was fantastic. (Rose)

The midwifery advisor was good and the current lawyer was absolutely exceptional. She would check my letter for Health and Disability and then she would send me a thing saying it had gone. I wanted reassurance, and I received it. (Portia)

According to the Midwifery Advisor of the NZCOM (Conference discussion, 2007) the College offers counselling support for its members at the discretion of their Legal Advisor. The advisor did not clarify if this recommendation was based on emotional requirements, potential for a disciplinary or enquiry process or litigation at the time of enquiry. Discussion with other members of the College from several areas of New Zealand made me aware that the availability of counselling services is not common knowledge among the NZCOM membership neither does it guarantee that all members who require this service will be granted it. The criteria for

accessing counselling appear to be if practice complaints are a potential problem. Many members experience trauma that will not be affected by a complaint therefore the criteria for accessing such counselling from NZCOM may disadvantage these midwives.

Thompson (2009) suggests that organisations have a duty of care to provide support for all members or employees experiencing emotional issues. He recommends that Health and Safety assessments should not deal only with physical effects but should also consider trauma, loss and grief that create psychological issues. The Midwifery Employer Representation and Advisory Service (MERAS) is the Trade Union section of the professional body for core midwives in NZ. The MERAS Meca has negotiated three paid EAP sessions from the DHB's as a part of the core midwives employment contract. However this is not always easily accessible as Anita explains:

I was offered EAP but when I tried to contact them the people were not available.

Conversations at a conference in 2007 suggested that in some areas the clinical manager made the decision as to who received EAP service providing evidence of employees' lack of understanding of their employment contractual rights. Some midwives felt they could not ask the manager for these sessions; others were placed in a difficult situation as the manager may have been the perpetrator of the violence and trauma.

Social networks play an important part in the dissemination of information (Cook & Stepanikova, 2008) and research demonstrates that these networks are the primary channel through which this information is distributed (Kawachi & Berkman, 2000). The midwifery professional network, until recently, has failed to distribute this information about the EAP services available to midwives. Also the primary focus of the provision of EAP available from NZCOM still appears to be for those midwives who require help for potential case review issues (NZCOM, 2008).

When I met Susan for interview two she stated the following:

The college has now put out a leaflet “What to do with an unfortunate outcome.” I really do not think that that booklet says what to do when something really bad happens. It doesn’t say what to do in the middle of the night or weekend so even now I do not think that they have got it.

The booklet referred to by Susan is known as “Unexpected Outcome” and has been developed by the legal advisor for NZCOM (2008). The booklet is comprehensive and clearly outlines the process to follow if an unexpected outcome occurs and the possible legal advice which may be required. The booklet outlines the different forums where the midwife could be held accountable. The ability to access Employee Assistance Programmes is also discussed. The legal advisor recommends that help or support is sought from colleagues. This booklet was not available for the midwives who participated in the current study but it should be of assistance to current practising midwives.

In interview two of this study all but one of the fourteen participating midwives stated that ongoing emotional support from colleagues was not what they would prefer as their main form of support, due in some cases, to relationship issues. It must also be noted that not all colleagues were willing to provide initial or ongoing support as has been narrated by Rose earlier in this chapter.

Midwives perceived support needs

In order for midwives to cope with the other factors in their lives as well as continuing in practice it is imperative that they are supported and their emotional health is attended to thus enabling them to continue to manage their other roles effectively. In interview two I discussed with the midwives the type of support they appeared to have received and what kind of formal support they felt should be available. The interview was structured (See Appendix F for example of questionnaire) yet personalised as the meaning of the event for the individual was discussed. The options suggested for formal support were derived from the analysis

of the midwives' narratives and were risk management debriefing, psychological debriefing or professional supervision. Of the 14 midwives who participated in interview two the general consensus was that risk management debriefing on its own although important for management, does not provide the support required by the midwives following a traumatic practice experience. Although the importance of psychological debriefing from a mental health worker was acknowledged professional supervision from someone with knowledge of midwifery, preferably from outside of the area, was viewed as paramount to lessening the trauma. It was suggested that professional supervision should be part of the midwife's employment contract for the employed midwife and MoH contract for the self-employed midwife.

The current study has demonstrated the importance of emotional support for the midwife. An expert in the field of traumatology, Beverly Raphael (2006) in her report following the 1974 Darwin cyclone, recommended the presence of a mental health worker as part of the response team. The grief counsellor Dunfee (2004) recommends that following traumatic events psychological support should be forthcoming and that clinical guidelines should ensure that assistance from mental health personnel is readily available. The provision of psychological support is reinforced by Walsh-Burke (2006) who also suggests that professional development programmes should be available for all staff to ensure that they are prepared to deal with situations of trauma and loss. A form of support that some midwives experienced and found helpful was psychological debriefing. The same was not always found with risk management debriefing.

Risk management debriefing

Risk management debriefing is a method of quality control to enable those practitioners involved in a traumatic event to focus on the concern and, without attaching blame, discuss how things could have been performed differently. These risk management sessions are to ensure a better outcome should the same situation occur again (Atwood & Macken, 2002). The emotional needs of the health worker

do not appear to be taken into consideration in these debriefing sessions. The attitude of management which fails to recognise the needs of the health worker in times of stress is inconsistent with an organisation that exists to care (Thompson, 2002). These following narrative excerpts support the anecdotal information that some debriefing sessions can be destructive rather than constructive as Judy and Emma explain:

Oh no it was not about constructive criticism or improving practice, oh no none of that. I was shouted at and told how stupid I was by the obstetrician so it was not constructive at all. (Judy)

I requested a debriefing session but when it was held it was a risk management issue. The only comment was that the obstetrician felt that an epidural should have been inserted earlier despite my informing them that I had tried but the anaesthetist was busy and unable to undertake that procedure. (Emma)

In order to ensure the support available is of value the providers of the support must not in anyway reproach the person for their actions during the traumatic event (Semmer, et al, 2005). As Emma experienced reproach she viewed the debriefing sessions negatively. In her situation the debriefing panel did not hear what was said as they recommended she undertake action that she has previously stated she was unable to do thus shaming and blaming her. Failure of the manager to recognise Emma's concerns and acknowledge that the inability to obtain an epidural was a systems fault has created a loss of trust in management for Emma.

Several midwives found that they had to initiate the debriefing which again was focused on risk management. Although Caroline stated she needed to debrief because of how she was feeling, the emotional aspects were not considered as Caroline explains:

I went to see the consultant and I said "I am feeling so awful about this I have to have a debrief." He agreed but of course it was a typical risk management debrief. I was informed that I should have called an obstetrician sooner.

Such actions demonstrate that the prime considerations of management are the risks to the organisation rather than the emotional health of the practitioners involved. Dass and Gorman (1985) suggest that emotions no longer contain deeply rooted morals that elicit loyalty to the organisation but rather short lived beliefs influenced

by the marketing media and exist with no real value or worth. Emotions are considered to inhibit the smooth running of the organisation and should not be displayed at work (Deery & Kirkham, 2007). Inhibiting the emotional behaviour of the employee ensures emotions are controlled by the organisation and are in line with what is expected of an employee as part of the habitus. Ignoring Caroline's emotions is a method of control but it also demonstrates the organisation's lack of understanding of trauma in the workplace, the associated grief and the need for psychological debriefing.

Psychological Debriefing

A method that is found to be useful for stress management is psychological debriefing. Psychological debriefing or early intervention is considered the first aid for acute psychological stress. Psychological debriefing does not cure or prevent PTSD; nor does it suggest that everyone involved in the traumatic events will suffer from the disorder. Its value lies in the provision of a structured process which enables the individuals to talk about the issues, a process known to aid a speedy recovery rather than develop a stress-related disorder (Parkes, 2008; Kinchin, 2007; Devilly, Gist & Cotton, 2006; Raphael, 2006; Cooper, 2005; Laing, 2000; Chesney, 1996; Rich & Parker, 1995; Hoff, 1989).

Psychological debriefing sessions should be provided by correctly trained individuals who may be (Parkes, 2008; Atwood & Macken, 2001) from within the organisation or from without (Kinchin, 2007). The advantage of having an internal debriefer is that the person is familiar with the functions of the organisation and it is usually more cost effective for management than using an outside facilitator; however issues of professionalism and confidentiality could be jeopardized (Kinchin, 2007). The preference of most trauma victims is to debrief with someone from outside of the organisation (Kinchin, 2007). Wendy provides her thoughts:

I would like someone like the researcher with a midwifery background and knowledge of PTSD to listen. It would be worth paying for and traveling to. Someone in the midwifery community; someone that you could ring and say this is

what has happened and they would respond with no judgments, you know in a really supportive manner.

I think it would be valuable to have someone to go to who is totally unconnected, not necessarily outside the midwifery profession but someone totally unconnected to the hospital. In a non judgmental environment. Perhaps someone like you Irene who has been there, done that can understand the issues but has a little bit of counseling knowledge as well. Someone who can open the flood gates but asks the right question and be there.
(Bobby)

Emma found participating in the research to be a form of debriefing as she explains:

It was good to talk to someone who was out of the unit, who was nonjudgmental.

An individual debriefing session was only readily available for one midwife in the current study. In relation to group debriefing Kinchin (2007) stresses that all practitioners involved in the incident should be present at the debriefing session. On-lookers should be excluded as should senior management (Kinchin, 2007). Group debriefing was available for two of the midwives in the current study.

Two of the midwives, Susan and Rose, both of whom were involved in a maternal death received a group debriefing. Susan explains how her organisation provided a positive debriefing session.

The debriefing session was with the intensive care staff and the obstetrician. I was quite anxious about that but it was really good. It was really lovely to meet the nurses that looked after this woman prior to her death and I felt really good about hearing what they had to say.

The psychological debriefing session appears to have been constructive for Susan as she received the support of the other health professionals involved in the woman's care and was positioned as a safe and competent practitioner. An organisation that functions in this way demonstrates the importance that management places on their most valuable resource, the human being (Thompson, 2009). Rose also told of a positive debriefing experience:

One of the things that was good, and I was interested when I heard your presentation the other day and I was remembering back to the time when the hospital gathered all the people that were involved to a meeting. They had some of the mental health staff and did a sort of debrief, not a clinical debrief but an

emotional debrief because everybody was in shock, the staff in delivery suite and everybody. That was really good. Then the hospital offered three counselling sessions to anyone who had been involved. I was not employed by them but I still got it.

The support and care received by Susan and Rose illustrates the institutions understanding of the need for support associated with staff dealing with death. In contrast the lack of support provided to Margaret discussed earlier in the chapter, illustrates the organisation's lack of understanding of disenfranchised grief

Disputes arise as to when and if these psychological debriefing sessions should occur. According to the Cochrane Database of Systematic Reviews (2009) no current evidence is available to suggest the validity of single session individual psychological debriefing. If they are used it is currently accepted that this process should occur within 72 hours of the traumatic event (Mitchell & Everly, 2001; Devilly et al, 2006; Kinchin, 2007). Thompson (2009) disputes the idea of a timeframe for debriefing and suggests that psychological debriefing can cause distress by "opening up old wounds" (p.98). Therefore it is imperative that it is used when the time is right for the individual with trained personnel rather than there being a blanket organisational policy that states when psychological debriefing will occur (Thompson, 2009). The suggestion that single psychological debriefing sessions should not be practiced routinely is supported by the National Institute for Health and Clinical Excellence (NICE, 2006, undated 2011). Bonnano (2004) also challenges the blanket policy of debriefing in relation to trauma and loss. He suggests that studies that support debriefing have used victims of trauma and loss as their participants. These people required help; yet offering this support to individuals experiencing a normal reaction to trauma pathologises the natural resilience process. The idea of the right time and the right person for debriefing is supported by Bobby:

I don't know if talking at the time would have helped me. Someone to talk to when I was ready.

Bisson (2003) acknowledges the lack of justification to carry on providing routine single-session intervention following trauma but suggests that the emotional needs of the victims need to be catered for. He proposes that researchers should identify methods that individuals have found useful.

Given the controversy surrounding psychological debriefing sessions in the second interviews I asked the midwives what type of support they felt would have met their requirements to aid recovery from the traumatic event. The importance of psychological debriefing from a mental health worker was acknowledged as useful. However, talking with someone with knowledge of midwifery, preferably not attached to the workplace was viewed as paramount to lessening the trauma as was ongoing professional supervision.

Professional Supervision

Supervision is a voluntary interaction between the supervisor and the person receiving the supervision with the aim of assisting the latter to effectively help people (Fergusson, 2009; Weils, 2008; Brodie, 2007; Hawkins & Shohet, 2000; Raeve, 1998). It involves the provision of a safe environment where the midwife can reflect on her practice and personal wellbeing (Symthe & Young, 2008; Weils, 2008; Brodie, 2007; Hawkins & Shohet, 2000). Professional supervision by qualified personnel is a method of providing non-judgemental support in relation to the ethical decisions made by the health professional whether based on moral or professional grounds (Raeve, 1998). It can assist in preserving the person's integrity by providing an environment where guilt associated with grief can be removed.

The main functions of professional supervision is considered to be educative (formative), supportive (restorative) and managerial (normative) (Hawkins & Shohet, 2006, 2000; Proctor, 2001). However, Proctor (2001) argues that supervision is a means of helping professionals to cope with the daily stressors they experience and contends that the restorative function should take precedent over the

normative or informative aspects. She indicates that if the practitioner does not feel supported and refreshed how can they cope with the managerial or educational components of their role. I content that the normative and formative components of supervision (Procter, 2001) are requirements of the Midwifery Council of New Zealand's (MCNZ) recertification programme what is lacking is the restorative function.

Professional supervision replaces the term clinical supervision and differs from mentoring in that it not only encourages the professional development of the practitioner but also maintains the principles of the client/practitioner relationship (Vallance & Harker, 2009). However the terms clinical and professional supervision have been used and viewed by some midwives in the current research as interchangeable.

Kathleen explains her experience:

I think one of the things that helped me enormously was the professional supervision on a monthly basis provided by the organisation in my coordinator role. I just told my manager that I needed it more often to deal with what I thought was a traumatic occurrence for me.

Many midwives struggle with the word supervision as Margaret explains:

Supervision no. Only because the word supervision makes me think I have done something wrong.

The issue of incompetence that is associated with the term supervision could be related to the mandatory requirements for supervision for midwives in the United Kingdom (Brodie, 2007; Duerden, 2002) or as a result of the legislative requirements surrounding the term clinical supervision in relation to midwifery practice in New Zealand. In New Zealand Section, 22 (3) (a) of the HPCA Act (2003) outlines supervision in relation to a practitioner's scope of practice. The midwife in this situation is practising under supervision as directed by the Midwifery Council of New Zealand (MCNZ) as a result of her performance. The focus of this form of supervision is on competency and not on coping with the

stressors of the everyday work environment. In this respect it is easy to understand the confusion surrounding the use of the term 'supervision'.

Feedback following a conference presentation of part of this study in November 2008 (SAANZ, 2008) suggested that due to the cost of formal professional supervision it should not be sought by midwives but that collegial support from within the midwifery groups should be obtained. Midwifery is a female dominated profession and suggestions of providing care to each other rather than seeking suitably qualified individuals to provide the supervision is a powerful means of maintaining the dominant values and beliefs of the habitus, an action that sustains oppression (Schott, 1996). Although part of the midwifery scope of practice is that midwives will support one another support in this context does not imply psychological debriefing or professional supervision both of which requires special training. In the current research most of the midwives chose to receive professional supervision from someone with knowledge of the maternity system but not attached to their workplace. McIver (2002) in her New Zealand study that focused on horizontal violence, found that people preferred to go outside of the institution for support due to the bullying that was part of the working environment.

It is a reality that part of a midwife's practice experience is that of being exposed to traumatic situations therefore in order to survive midwives must be prepared to cope with tragedy and grief (Penwell, 2002; Taylor, 2000), recognise that violence is present in the workforce and work toward its elimination (Thompson, 2009; Raphael, 2006). To achieve this aim an environment of caring and compassion (Penwell, 2002) with psychological debriefing sessions and ongoing support is required (Thompson, 2009; Kinchin, 2007; Figley, 2006; Raphael, 2006). Brown (2008) suggests that victims of trauma, and this includes health professionals suffering vicarious traumatisation, hesitate to seek help for issues they believe they should be able to cope with. To seek help suggests personal and professional failure (Schott, 1996). Therefore systems such as psychological debriefing or professional supervision that are empowering and suited to the needs of the individual should be

implemented (Brown, 2008) as a part of the organisational structure. Mertle explains her thoughts on supervision:

Professional supervision from someone with midwifery knowledge for these events is a must and I think NZCOM should offer it and notify midwives that it is available.

The voices of the midwives who have participated in the current study illustrate the importance they place on the need for support to assist them to cope with the grief associated with their traumatic practice experience and to ensure their mental wellbeing.

Summary

The chapter illustrates how loss and grief in the workplace experienced by some of the midwives in the current study involved in a maternal death received support from the managers, colleagues, friends and family. This was contrary to the loss and disenfranchised grief experienced by the other midwives. Consequently the midwives felt let down by the managers who failed in their duty of care to provide a safe supportive working environment that incorporated the midwives' emotional needs. A deficit of emotional support was perceived by the midwives as a breach of trust in management, the people they expected to help and support them in times of trauma and grief.

When asked what type of support the midwives felt should be available from the organisation the midwives stressed the importance of psychological debriefing from a mental health worker. Professional supervision from someone with knowledge of midwifery, preferably from outside of the workplace, was viewed as paramount to lessening the trauma. It was suggested that professional supervision should be part of the midwife's employment contract. Self-employed midwives would have to negotiated with the MoH that professional supervision be incorporated into the LMC package. Professional supervision may also help the midwife understand how relationships are disrupted and destroyed.

Chapter Seven: Destroyed relationships – Disrupted lives

I know what it is like to be gang raped but that was nothing compared to the unexpected violence I experienced from my colleagues. (Field notes, 2007).

Introduction

Relationships and violence are a key issue identified in this research and contributed to the midwives' traumatic practice experiences. The current study provides evidence that symbolic violence is a part of the institutional culture of midwifery in New Zealand often arising from conflicting paradigms of care. The symbolic violence occurred between midwives, midwife and manager, midwife and doctor, midwife and the women and her family. Symbolic violence (Bourdieu, 1982) comprises of rumor, gossip and negative non-verbal communications that destroy relationships and disrupt lives. I argue that the changes in the health service as a result of the health reforms (Upton, 1991) led to legislative changes that enabled the midwife to practice as autonomous self-employed practitioner. Philosophical differences in practice between self-employed midwives, doctors and some core midwives combined with staff shortages have exacerbated the presence of symbolic violence in the workforce. These political changes are key drivers that form the basis of the demonisation of the midwife in New Zealand in the 21st century and are discussed further on page 191 of this chapter. The study also suggests that issues of psychological trauma are politically driven because, when the social problems involved are considered, trauma tended to occur as a result of oppression (Herman, 2006).

Violence or bullying from women, other midwives, management or medical staff was present in all but one of the sixteen stories told by the participants in the current study. This chapter commences with one of the stories of bullying and a rationale for the increase of these violent behaviours amongst midwives. Arising from the analysis of the sixteen midwives stories I have developed a model titled the 'trilogy of violence' which provides an explanation of how the violence occurs

and creates harm for the midwife. The story that follows the discussion of the model illustrates the impact of these harming effects on the practitioner. The final story by Susan indicates positive relationships even in the face of a terrible outcome. It exhibits the provision of collaborative care between the midwife and the medical team to a woman and her family which, signals compassion from practitioners (Thachuk, 2009). The narrative demonstrates how a midwife can, as a result of grief, harm herself by challenging her own competence, consequently disrupting her own life due to a relationship destroyed by death.

Relationships between the midwife and the woman which do not end neatly are not what is expected in an ideal midwifery partnership model of care and may cause distress for the midwife. In order to understand the significance of the relationship between the woman and the midwife the role of the professional midwife as well as boundary issues have been outlined in Chapter One.

Bobby

Truly, it was awful I was actually still shaking the next day

Florence selected Bobby as her LMC as she had been highly recommended by another woman. Despite her heavy caseload that month Bobby agreed to care for her. During the antenatal period it became obvious that they had different philosophies of childbirth. Although this was Florence's first pregnancy she believed that she could not birth vaginally and requested a caesarean section. The request was declined by the obstetric team as there was no physical reason for the caesarean section to occur. However, due to Florence developing gestational diabetes Bobby was able to arrange for an induction of labour for her. The traumatic event took place during the induction as Bobby explains:

Florence did not cope well with labour and neither did her family because she started screaming and I mean screaming. The husband left the room, the mother dissolved into tears and it was left to me to deal with her. I was hoping to get an epidural for Florence as early as 2 centimetres dilated but the anaesthetist couldn't get the cannula in, possibly due to the fact that she is a big woman. He walked out of the room in disgust leaving me with this screaming woman. I

actually gave her a very large dose of pethidine and phenergan which took the edge off her pain but Florence was angry that I hadn't got her an epidural. She had good limbs. I can tell you she was kicking me and screaming so loudly that everyone was saying "What is going on with your woman?" I just said she was distressed. The obstetrician on call actually came down to see her and got somebody else to try and get the epidural in who succeeded. By which time my nerves were in a mess and quite honestly I could have easily done what the husband did, walk out of the room. I have never known a family less supportive. They had absolutely no way of dealing with what she was actually going through.

I wasn't handling it too well now for, of course, I had been with her for hours. When she was fully dilated she started to scream again. The Obstetric Registrar examined her and said he would do a caesarean section. I visited her the next day and everything was fine. The following day the core staff informed me that she didn't want me to be her midwife anymore. At the time I just thought that is fine and then I started thinking instead of opting out of the situation why didn't she just tell me why she didn't want me anymore.

The traumatic thing about this for me was it is an unresolved situation due to what I perceive is Florence's perception of her birth experience. When I drive past the house I still think about it; I never had a chance to explain myself. Equally she has never had a chance to explain herself. I know she didn't like the pain but she actually traumatised her husband, her mother and her midwife. It was awful; I was actually shaking the next day from that.

For about a week afterwards you would hear one of the staff make a comment "Did you hear that woman the other day. It was disgusting and the midwife wasn't doing anything about it." I was thinking "If only you knew." I did explain to a lot of people "If you knew what I had gone through in that room there is no way that you would say that." Again it is somebody commenting on your practice, it is inappropriate. Midwives have to be very careful about making a statement about someone else's care.

The reason why I am talking to you now is recently at a Mental Health Workshop I was listening to one of the presentations; it was almost like a repeat. I know it wasn't me, but it was almost like a repeat of what potentially could have happened with this particular client. When I heard the speaker maligning her client's midwife it actually made me really angry because I thought she is maligning the midwife and that midwife has got no come back here. I don't know if my woman has rubbished me to the whole community. God knows. Is there a history of trauma in the family? There must be something that gave her this terrible fear. She obviously has got unresolved issues but so have I. That is why it is good to tell my story to you now.

Being informed her services were not wanted following a very stressful labour disturbed Bobby. She had never had this request from anyone before neither had she had to deal with such a distraught woman. Bobby exhibited what Laing (1959) refers to as the true and the false self; by pretending to her colleagues that she was

not bothered by this woman's action she presented her false self whereas to her true self she acknowledged she was hurt. The hurt was a result of grieving for the loss of the midwife-woman relationship, her personal and professional identities which were affected by the incident and what was actually and potentially being said about her. The significance of this incident for Bobby was that she is viewed by the woman and some of the staff as uncaring because she let the woman's behaviour get out of control. Being unable to control Florence in order to insert an epidural also explains why the anaesthetist left the room in disgust.

Control is part of the medical model of care (Wagner, 1994; Hunt & Symonds, 1995) which uses pain relief as a method of restraining women during childbirth (Yerby, 2000). One of the most powerful methods of pain control during labour was Twilight Sleep. It was used in the early 20th century and consisted of a combination of scopolamine and morphine. Twilight sleep not only controlled the woman's pain but blurred her memory of the event (Squire, 2000; Mander, 1998; Tew, 1990) making a woman a passive recipient of care. Although the woman is aware of her environment when an epidural is used for pain relief in childbirth (Yerby, 2000) her labour is still under the control of the medical team (Tew, 1990). These controlling forms of pain relief are part of oppressed group behaviour where the social norms (Roberts, 2000) are those of the dominant group. By functioning under the philosophy of the medical model the core midwives in Bobbie's story have internalised the social norms of the dominant group within the field of maternity care. The core midwives' actions explain why they perceive it as important to control the woman's behaviour in labour and also demonstrate how conflicting paradigms of care create rumour, gossip and silencing.

I am unsure of Florence's ethnic origin however the controlling of her behaviour by Bobby which was expected by the core midwifery staff suggests no consideration was given by the core staff to the way women of different ethnic groups may behave in labour. Some ethnic groups use traditional methods of pain relief to cope with pain. Support is provided to the woman whose conduct may be vocal or stoic (Leap

& Vague, 2006; Priya, 1992). Traditional methods of pain relief such as support or herbal substances which are used in the midwifery model of care challenge the values and beliefs of the habitus and create conflict which is evidenced in the behaviour of the core midwifery staff toward Bobby. Bobby believes the symbolic violence that she was subjected to by the core staff was unnecessary. The exposure to violence impacts on her feelings of self worth as the core midwifery group, rather than discuss the woman's situation with Bobby, have chosen to isolate her and discuss the woman's situation and her midwife with each other. Their behaviour could, as Hunter (2004) suggests, be a result of a different philosophy of care rather than a wilful attempt to destroy the practitioner.

Bobby is silenced as she is unable to discuss the birthing experience with the woman. The silencing created an unresolved situation for her that led to emotional trauma. Part of Bobby's recovery process was to accept that she was faithful to the relationship she had with Florence and remained with her despite wanting to walk out of the room as Florence's husband had. Bobby's situation is recalled for her when at the mental health workshop the speaker inferred a condition experienced by one of her clients to be a result of midwifery care. The accusation is based on the woman's perception of the events as interpreted by the speaker. The midwife was not included in this conversation effectively silencing her and demonstrating how partial information can create suspicion, blame and exacerbate the harm experienced by the midwife.

Bobby's story demonstrates some of the pressure and conflict faced by the Lead Maternity Carer midwife as she struggles with long working hours and her loyalty to her clients. It also illustrates the impact of violence on the midwife arising from rumour and gossip.

Violence in the Workplace

No workplace is totally void of violence and aggression (Thompson, 2009) yet it continues to occur in organisations as the corporate structures allow it to happen by remaining silent and being inactive (Needham, 2003). It is suggested that horizontal

or linear violence, bullying or mobbing is perpetrated by peers or management (Sperry and Duffy, 2009); McIver, 2002; Calvert, 2001) and consists of harassment, spreading rumours, emotional or verbal abuse rather than physical abuse (Hogh, Sharipova & Borg, 2008; Hansen, Hogh, Persson, Karlson, Garde & Orbaek, 2006; Needham, 2003) and occurs more frequently in human service work where the majority of employees are female (Bentley et al, 2009; Hogh et al, 2008). Actions such as isolation, manipulating information and abusive working conditions coupled with professional discredit and devaluing professionals may also be present (Escartin, Rodriguez-Carballeira, Zapi, Porrúa & Martin-Pena, 2009). Sperry and Duffy (2009) use the analogy of an accident victim to recommend the use of the word victim for the person being bullied, their rationale being “Victimization and injury precede recovery and survivorship” (p.434). Needham (2003) suggests the word ‘target’ replace the word ‘victim’ as the bully targets those who are emotionally intelligent and good at what they do. In my opinion the participants in the current study were both the target and the victim of the abuse. For example Bobby was targeted by the core staff and experienced both physical symptoms in the form of shaking and unresolved psychological effects that were eased somewhat by participating in the current study.

In their qualitative study of twelve professional women in Britain, Lewis and Orford (2005) investigated the social processes involved in workplace bullying and found that participants had difficulty recognising workplace bullying and often accepted responsibility for the breakdown in relationships which impacted on their self confidence. Failure to recognise the presence of bullying is due to the vagueness of the bullying behaviour as well as the subtle and gradual development of the process (Sperry & Duffy, 2009). According to Lewis and Orford (2005) as the bullying escalates confusion develops for the victims as do physical and mental health problems. The participants did not initially attribute their health issues to bullying consequently this enabled the organisation to support the self blame thus instigating another form of victimisation. These researchers cite an example of two health professionals who were postpartum and accepted the suggestion by

management that difficulties at work occurred as a result of postnatal depression. Once the participants interviewed for this study recognised this abuse of power by management they found it difficult to maintain their commitment to the organisation. Anita narrated how her repeated requests for better staffing levels were constantly ignored by management; she recognised this as management abuse consequently no longer felt committed to continue to work within the organisation.

I said that I wasn't going to do midwifery again and I haven't.

Workplace bullying is a major occupational stressor which is growing in strength throughout the industrialised world yet is often hidden or under reported (Sperry & Duffy, 2009; Escartin et al, 2009; Brousse et al, 2008; Hamilton, Newman, Delville & Deville, 2008; Lewis & Orford, 2005; Needham, 2003). Smythe (2002) refers to 'everyday practice violence' and suggests that it is part of the social norms of the maternity environment in New Zealand. She posits that it may only be viewed as violence by the person who is receiving it which could suggest this is the reason the staff do not challenge its presence. The horizontal violence exhibited by the staff in Bobby's narrative could be an example of everyday practice violence. The core staff discussing Bobby's practice may not envisage the discussion to impact on her personal and professional identities. I suggest the purpose of the core staff discussing Bobby's practice was because they expected her to acknowledge that her care was inappropriate and then alter her practice to fit with these core midwives' philosophy of care.

A collaborative study between researchers in New Zealand and the United Kingdom noted that in the health sector bullying was viewed as endemic. Aggressive behaviour tended to be linked to inappropriate responses under pressure rather than repeated bullying (Bentley et al, 2009) and could account for one reason why violence is part of the social norms of the maternity units in New Zealand (Smythe, 2002) where staffing issues occur (MCNZ, 2009). Job strain associated with workplace bullying was demonstrated as a source of acute pain (Saastamoinen, Laaksonen, Leino-Arjas & Lahelma, 2009) amongst a group of middle-aged municipal employees from several occupations in Helsinki. Chronic

pain associated with job strain and organisational injustice was found amongst participants in the current study. Mertle explains the effects of chronic pain associated with an exceptionally high rate of critical incidents coupled with organisational injustice in the form of discrimination by the obstetrician.

It has had a huge impact on me and my family in the fact that I have not been able to work for five months due to a back problem. I have no doubt in my mind that the stress and trauma caused from this one month has had a large part to play in my time off now.

Workforce bullying can have severe mental health repercussions, triggering serious and persistent mental health disorders (Brousse, et al, 2008) and was responsible for some of the midwives in the current study suffering anxiety or PTSD. Sperry and Duffy (2009) cited depression, anxiety disorders and PTSD as the most common health problems documented as resulting from workplace trauma, bullying or mobbing. They describe mobbing as “Nonsexual harassment of a coworker by a group of other workers or members of an organisation designed to secure the removal from the organisation of the one who is targeted” (p.433). The term mobbing was developed by Leyman (1996) who estimated that 15% of people who committed suicide had been subjected to workplace bullying within six months of the event. Hastie (1995) cites the case of a new graduate midwife who committed suicide as a result of the horizontally violent behaviour she was exposed to in the maternity unit where she was employed. Isolating the individual from normal social networks present in the workplace is a common activity and creates loneliness (Sperry & Duffy, 2009; Escartin, et al, 2009; Hansen et al, 2006; Lewis & Orford, 2005; McIver, 2002). Fellow workers witness the mobbing of the victim and as a result relationships collapse, peers increase their distance from the victim (Sperry & Duffy, 2009) and a cloak of silence develops. A common sense view would suggest that the victim of the mobbing would be supported by colleagues and co-workers who challenge management to ensure justice prevail. Unfortunately this does not occur and the victim loses the social networks from within the organisation that have previously been their means of support (Sperry & Duffy, 2009). The loss of

social networks was demonstrated in Caroline's narrative when she was ostracized by her midwifery colleagues and the medical staff while attending a study day.

I kept thinking what is the matter why won't they talk to me? I discovered it was because they thought I was the worst midwife having caused this baby long term disabilities because I had not picked up on what was going on early enough.

Emotions associated with violence may lead to feelings of insecurity that impact on the person's ability to function effectively in the workplace (Thompson, 2009; Lindberg, Christensson & Ohrling, 2005) creating an unsafe environment for the women and babies (McIver, 2002). Insecurity plays a significant part in the reaction to trauma (Vickers, 2009; Thompson, 2009). The findings from the current research suggest that feelings of insecurity created harm for some of the midwives who gave up practice, practiced defensively or altered their style of practice from LMC to core or visa versa, thus creating workforce issues. Mertle explains her feelings of insecurity following her traumatic events:

If I felt supported I would carry on as an LMC but as it is I don't want to because I am too vulnerable. I am out there in no man's land and no safety nets I don't know if I will ever go back to LMC work again.

Management's inaction following Anita's request to improve staffing levels and failure of the maternity service to provide support for Mertle destroyed the trust these midwives had in the maternity system and provides insight into how these breaches of trust disrupted their lives.

The increase of violence in midwifery

I contend that there are two reasons for the apparent increase in violence in the midwifery workforce over the last twenty years (Keeling, Quigley & Roberts, 2006). Firstly the changes within the organisational structure resulting from the introduction of the health reforms that focus on the business model of economy (Upton, 1991) have led to short postnatal stays for women and staffing issues for the midwifery workforce. The women requiring longer postnatal stays are high risk women who have developed obstetric complications or women with conditions such as cardiac disease that, as a result of advances in medical sciences, are now

able to consider pregnancy. Caring for these women places added strain on an already depleted workforce (MCNZ, 2009). The impact of these organisational and social changes leading to a malfunctioning system and counter productive behaviours is discussed in chapter nine.

Change can require individuals to discard old values, beliefs and practices for new and challenging enterprises. These changes make the past seem safe and secure and the future uncertain (Hope-Hailey, Farndale & Kelliher, 2010) resulting in fear and suspicion leading to demonisation (Stewart & Strathern, 2004) that arises from conflict. When a person is demonised the tendency is for the instigator to blame them for their problem/s in order to free themselves of blame. The demonisor thinks the person is different from them and views the person in a negative light (Alon & Omer, 2006; Stewart & Strathern, 2004) which occurs when paradigms of care are in conflict. The demonisation of the midwife is a relic of the witch hunts of centuries past where the 'wise woman' or 'the midwife' was seen as a threat to those in power. The witch hunts did not arise from the peasant population but were instigated acts of terrorism on behalf of the ruling class (Stewart & Strathern, 2004; Ehrenreich & English, 1973). Rumours were spread by those threatened by the actions of the 'witches' which led to gossip within the general population. Accusations occurred followed by trials and punishment, usually by execution (Stewart & Strathern, 2004). The specific purpose of the trials was to identify the 'evil wrongdoer' and remove them from society thus supposedly making society respectable, trustworthy and law abiding (Stewart & Strathern, 2004).

The process of the witch hunts commenced with an historical change that occurred within the church and significantly influenced people lives. The change resulted in midwives' use of herbs and potions being viewed as works of the devil rather than magic or medicine. Consequently this minor change in social perspective resulted in women being prevented from seeking midwifery care (Stewart & Strathern, 2004). According to Ehrenreich and English (1973) the witch hunts were one of the first struggles led by men to suppress women as healers. Coinciding with these

trials in Europe was the development of the new male medical profession sponsored by the ruling class. Consequently the medical fraternity supported the persecutors of the witches thus excluding women from independent healing roles. The witch hunts have had a tarnishing effect on midwives and women healers ever since (Ehrenreich & English, 1973).

I contend that the historical change that led to the demonisation of the midwife in the current study was the 1990 Amendment to the Nurses Act and the introduction of the midwife as an autonomous practitioner. The legislation enabled the midwife to stand alongside the doctor and offer women an alternative form of care that incorporated partnership and empowerment. Midwifery autonomy threatened the power of the dominant group and created a division between the core and the LMC midwife as a result of an oppressive hospital environment that inhibits the autonomy of the core midwife.

The narratives in the current study tell of acts of oppression that occurred as a result of power relations and social control. From analysing the narratives I have derived the term 'harming' in order to understand how subtle acts of violence often arising from conflicting paradigms of care, impact on the midwife. The source of these acts of violence and the channels of complaint that can lead to destroyed relationships and disrupted lives are surrounded by silence. Harming was experienced by the participants as a result of what I refer to as a trilogy of violence which comprises of rumour, gossip and silencing both within midwifery and between midwives and other health professionals. These harming actions by practitioners and/or women led to an escalation of complaint submissions often unknown to the midwife who was the focus of the submission. These harming actions were viewed as a breach of relational trust by the midwife and exacerbated the emotional impact of the trauma experienced.

The Spiral of Complaints

I suggest when an adverse event/ incident occurs the medical professionals close rank and support one another, whereas in midwifery the midwife is often not supported but becomes the subject of abuse. According to Alonzo and Aiken, (2004) “flaming” is a term used to describe the hostile and insulting interactions that can occur between internet users for the purpose of irritating or offending someone. It occurs due to misunderstanding, a perception of unfairness and frustration. The interactions go backwards and forwards but there is no face to face contact. Hostility in midwifery occurs for similar reasons to flaming but there is personal contact. As a result the midwife may be subjected to verbal abuse; alternatively there may be no personal communication and a cloak of silence develops.

Harming, which can mean injure, abuse, damage, hurt, ill-treatment, spoil or wound (Collins, 2006), can commence from a subtle and hidden basis. Midwives, in some instances without realising their actions, gang up against a person and create a cloak of silence that causes harm. The silencing involves staring at the midwife, discussing issues concerning her but not talking directly to her. The clandestine non-verbal communications from the gang ensure the midwife is aware she is the subject of malicious gossip. Gossip creates suspicion, leading to accusation and possibly trial and punishment (Stewart & Strathern, 2004). In midwifery, complaints leading to punishment can occur at three levels; professional, organisational and governmental (See Appendix G). Information in relation to the accusation spirals up through the channels of complaint; initially, the subject of the complaint may be unaware of its occurrence. For example:

They talk about me behind my back. Incidences get back to management and it is all misconstrued. (Lillie)

A problem for me was not knowing that the woman had contacted the College of Midwives' Resolutions committee. (Portia).

Although these complaints may not be substantiated the midwife's practice is still scrutinized. I suggest that irrespective of whether the perpetrator is another

midwife, a manager, a doctor or a woman and/or her family the process of these hidden harming actions is the same. The midwife experiences a loss of trust in the relationship as the accusations alter her personal and professional identities creating biographical disruption. The subsequent grief exacerbates the stress and leads to chronic physical or psychological conditions making emotions the aetiology of the disease. The complaints also led to destroyed relationships and disrupted the lives of those involved.

The current study has demonstrated that ‘harming’ for some of the participating midwives occurred as a result of conflicting paradigms of care: rumour, gossip and silencing which led to accusations and complaints.

Conflicting paradigms

Conflict within relationships was present in fifteen of the midwives’ narratives in the current study. The source of the tension stemmed mainly from cultural and historical ideas present in the philosophical underpinnings of the medical and midwifery paradigms of care. The focus of the medical model is based on technology and birth is normal in retrospect (Wagner, 1994; Martin, 1989) whereas the Midwifery Partnership model views the woman in context and birth as a normal life event (Guilliland & Pairman, 2010).

In the current study tension was created as practitioners both medical and midwifery, functioning under the medical model argued the outcome of the traumatic event would have been different if the woman’s care had been based on the medical model.

If your practice is seen to be outside what they consider to be normal, practicing in the midwifery model is not seen to be OK.

(Judy)

You could walk into the office and hear people saying you wouldn’t have had someone pushing for 2 hours.

(Emma)

The issue of safe practice was considered in an ethnographic study by Kennedy and Lyndon (2008) who explored the relationships between midwives and nurses in a busy teaching hospital in California. Tension existed between the two groups due to different philosophical views that created a marked discrepancy in the practitioners' understanding of what comprised safe care. An example of conflicting paradigms of care and practitioners' understanding of safety is provided in Emma's narrative when tension arose as to the appropriate length of time for a safe second stage of labour.

Shallow (2001) in her qualitative study that considered midwives' views of competence and confidence in the workplace in England concluded that competence reflects the midwife's philosophy as well as the setting in which practice occurs. Midwives who practiced mainly in the community, tended to focus on the midwifery model of care, which has an emphasis on holistic care and working with women. In contrast midwives, who worked mainly in the hospital setting, viewed technocratic birthing skills as the primary indicators of competence. Hospital midwives were expected to be able to function in all areas of practice dealing with both normal and high risk women; rotation of staff enables the midwife to be used effectively as opposed to providing effective midwifery care (Shallow, 2001) thus demonstrating the organisational influence on the midwife.

The current study supports the finding by Shallow (2001) that competence and confidence reflect the midwife's philosophy as well as the setting in which she works. However, I argue that the behaviour of the midwives also occurs as a result of midwifery autonomy being influenced by the dispositions present in the field of maternity care.

Midwifery autonomy threatens medical dominance as autonomy removes total control from the dominant group (Turner, 1995). However, core midwives still have to adhere to the policies and protocols of the organisation which are strongly influenced by the medical paradigm of care (Hunter, 2001; Shallow, 2001). In the current study abiding by hospital policies inhibited core midwives from practicing

autonomously and ensured the beliefs of the dominant group in the hospital maternity field prevailed. An oppressive hospital environment that hindered the autonomy of midwifery created a division between the core and the LMC midwife. Evidence suggests that disharmony amongst midwifery practitioners as a result of conflicting ideologies creates tension and conflict between them as they struggle to retain their midwifery skills in an environment where the medical model dominates (Hunter, 2001; Shallow, 2001). The midwife using her midwifery skills over that of medical technology, was often positioned as incompetent (Hunter, 2004) as Emma's narrative on the following page identifies.

The midwives in the current study were also subjected to medical and managerial ideologies as well as women's expectations which, when not met, created anger, grief and tension in the relationship leading to horizontal violence or bullying being experienced by the midwife. The violence instigated a breach of relational trust for the midwife arousing emotional effects that created harm for the practitioner, destroying relationships and disrupting lives. To demonstrate how conflict in midwifery is generated and managed the three concepts that constitute the trilogy of violence are briefly outlined. Examples from the midwives' stories are threaded throughout the sections.

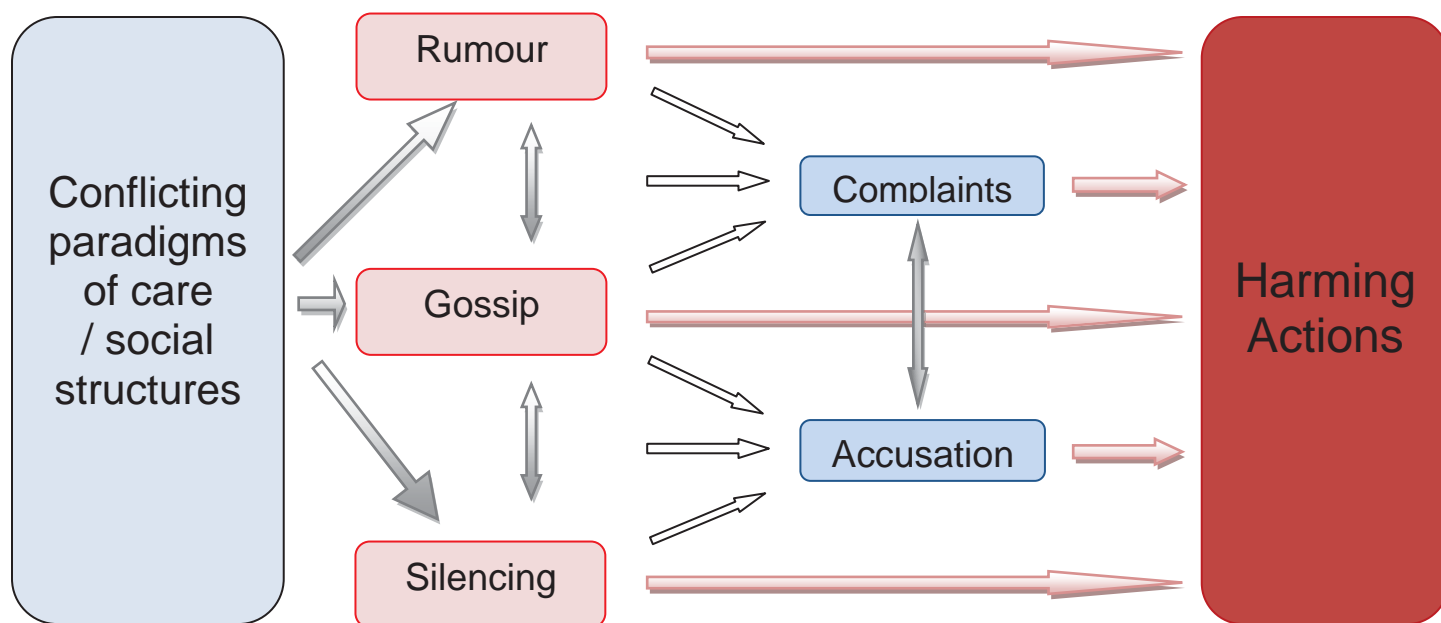


Figure 3: Trilogy of violence and its consequences for health professionals

Rumour and Gossip

Rumour and gossip from which fear and uncertainties surface are part of communication systems in all societies. Gossip or idle talk is a feature of human behaviour; talking about people is a social function (Stewart & Strathern, 2004; Tebbutt, 1995; Bergman, 1993). It establishes a field for political and moral debate thus playing a significant role in the development of social values (Peters, Kashima & Clarke, 2008; Stewart & Strathern, 2004; Tebbut, 1995). Stewart and Strathern (2004) suggest that gossip is polarised; at one end of the pole it can be positive talk and at the other it can be a means of “hostility and disruption” (p. 202) where it is used against others and as a method of self gain. Legalized gossip according to Marshall (1964) is a form of evaluation and is non-destructive. It is used in academic institutes and employment interviews to award grades or positions. These internal politics can have a greater influence over the appointment or grade than the

academic achievement of the person ((Marshall, 1964). In risk management debriefing sessions where outcomes are discussed in a non-destructive manner, the gossip would be classed as legalized gossip. Talking behind people's back is malicious gossip and is the root of violence within institutions. The following narrative by Emma provides an example of gossip present in the maternity workplace.

Emma

I was waiting for the next horrible thing to happen and I guess I suppose feeling hopeless and feeling I am not a good midwife.

The traumatic experience for Emma was multifactorial but the issue that still causes her great distress is the case of the woman who experienced a postpartum haemorrhage and the subsequent treatment Emma received from her colleagues. This was the woman's first pregnancy, the labour was long, and as the anaesthetist was attending an emergency no epidural service was available. After half an hour of second stage Emma called the obstetrician for assistance as there was no descent of the presenting part; the baby was born approximately 90 minutes later. Two hours postpartum, before leaving the hospital, Emma went to see the woman again and found she was bleeding. She dealt with the postpartum haemorrhage but in the days that followed Emma experienced the following:

There was a lot of the gossip that went on in the ward from other midwives that made the situation even worse. You could walk into the office and hear people saying "You wouldn't have someone pushing for 2 hours." I had long talks with my second midwife with regard to what did I do wrong at the birth that I could have changed. She said "You did everything right and the woman wasn't actually pushing for two hours." I did ask quite a few times just for a peer review on my case of PPH to see if there was anything different I could have done that could have prevented the incident. Instead you just get the gossip that goes around and certain people saying maybe in this situation you should have tried this.

No acknowledgement was given to Emma for the care she provided to the woman when she had the PPH. Rather Emma was exposed to harming by the actions of her colleagues and isolated from the group. Had a peer review session been granted to

Emma and these core midwives presented the outcome of their discussions in a non-destructive manner, this legalised gossip would have enabled Emma to argue her view from the perspective of the alternative paradigm. A debriefing session did not occur; Emma was the victim of malicious gossip which was the root of symbolic violence within the institution.

Stewart and Strathern (2004) discuss the relationship between witchcraft and sorcery and rumor and gossip, and suggest that accusations arise in response to interpersonal and social tensions and are influenced by the historical background. In Emma's situation the historical background of the core midwifery group is that of the medical model of care which still has a great influence on core midwifery practice at the institution involved. The midwives she worked with found the midwifery partnership model difficult to accept therefore this shaped the gossip and subsequent conflict or symbolic violence that Emma was exposed to. Rumours and gossip are people's attempts to create what they perceive to be the truth of a situation based on their philosophy or understanding of the situation thus providing them with the facts to judge others. Judgement may be non-malicious but when malicious violence develops, demonstrating that cohesion and conflict coexist, this intensifies the struggles that occur as part of life (Stewart & Strathern, 2004).

A major concern that arises from the gossip is that it sends out different messages in relation to the women's care and the safety of the maternity services to other health professionals in New Zealand as well as women in the community. As a consequence of the conflict the midwife may get accused of unsafe practice which can instigate the spiral of complaint. The violence from the hospital staff is a result of different philosophies of care and, according to the MoH (2009), Kennedy and Lyndon (2008) and Hunter (2004), creates clinical disrespect and negative relationships as is apparent in Emma's narrative when the core midwifery staff talked behind her back in relation to care she provided. She trusted the core staff to support her midwifery philosophy of care; their failure to do so created a breach of relational trust for Emma with all its emotional consequences.

I went through a lot of stress at this time: I suffered a lot of sleep deprivation.

The conflicting paradigms of care seem to be the catalyst for the rumour and gossip and the subsequent violence Emma experienced. Many of the stories in this study demonstrate that rumour and gossip were hidden or subtle and involved silencing.

Silencing

It is suggested that if a victim remains silent and does not respond to violence then the observers also remain silent (Cohen, 2002). Yet this very silence may camouflage discontent and injustice felt by the victim. By the victim hiding their feelings it prevents those in the public arena from being aware of the situation. Silence as objection is used in situations of dominance and subordination where risk is attached to challenging the situation. In these circumstances it becomes difficult to distinguish between silence as a threat as opposed to silence as genuine acceptance. Witnesses, whether direct witnesses, those who are actually present when the incident occurs, or indirect witnesses, those who become aware of the situation by talking with others, are faced with agreeing to the commands of the instigator of the harming or abiding by the principle of moral justice (Needham, 2003; Cohen, 2002). The following story by Caroline provides an example of silence as objection.

Caroline

It was just so awful to deal with because you know you can't deal with it because nobody is actually speaking to me.

Caroline tells of being subjected to symbolic violence from midwifery and medical staff following the birth of a neurologically impaired neonate that led to destroyed relationships. The silencing occurred firstly in the NNU and then delivery suite:

The neonatal staff, when I went in, looked at me with suspicion. You are at fault and it was just that sort of atmosphere, you are to blame for what has happened to this baby. That was just so awful to deal with because you know you can't deal with it because nobody is actually speaking to me. All they are doing is looking at you

The thing that just hit me like a sledge hammer was the looks from the other midwives and medical staff in delivery suite. I kept thinking "What is going on here? What do they know about the case?" I found out that they had taken the woman's notes and they'd passed them around and read them then made their decision that I had failed to provide the best care possible. The story goes "She ought to know how to do these things and what to do and look what a failure she has been." This was going round and different people had made judgments on the record keeping, had made judgments on the care that my second midwife and I had provided.

Caroline was again exposed to symbolic violence when she attended a study day with some midwives and doctors from the maternity department. She was ostracized, and discovered later on the first day that it was because of the way they felt about her actions with the case, actions that she took as a result of her midwifery philosophy of care. At the evening social event Caroline challenged these inferences of incompetence and suggested that when something happens you make the decisions and bear the consequences; errors do occur. As a result she is acknowledged as a competent practitioner. Silencing, rumour and gossip resulting in suspicion that occurs because of conflicting paradigms of care are evident in Caroline's story. The story also demonstrates a breach of trust between Caroline and the core midwives and medical staff present in the unit.

In an oppressive environment, abiding by the principles of moral justice can be difficult as it may mean challenging those in power. It also means challenging the customs of the habitus as was demonstrated in the narratives of Emma and Caroline as in their respective hierarchical institutions these midwives challenged the dominant model of maternity care. Agreeing with the instigator occurs when people are uncertain of their right to intervene. Alternatively fear of being the only one in the crowd to disagree creates hesitancy. Inaction results even in the face of injustice (Sperry & Duffy, 2009; Needham, 2003; Cohen, 2002). The risk for the victim and the witnesses of complaining against injustices is often too high a risk to take therefore silence dominates. Silence may also be a result of ignorance of the injustice occurring. Mechanisms of justice such as meeting with the HR department and the union are attempts on behalf of management to mask the unjust actions of the organisation (Cohen, 2002). Silent collusion used by institutions is part of

oppression, as is rumour and gossip and is entrenched in situations where paradigms are in conflict.

The midwives in the current study were also subjected to medical and managerial ideologies as well as women's expectations which, when not met, created anger, grief and tension in the relationship leading to horizontal violence or bullying being experienced by the midwife. The form of symbolic violence instigated a breach of relational trust for the midwife arousing emotional effects that created harm for the practitioner, destroying relationships and disrupting lives.

The following story illustrates how rumour and gossip arising from different paradigms of care destroyed the midwife-woman relationship and initiated a complaint process. The midwife had no right of redress and therefore was silenced.

Portia

I wanted to participate in this research because I want people to understand that the trauma does not have to come from a stillbirth or a postpartum haemorrhage but from violence in the workplace.

Portia was contacted by a woman experiencing her first pregnancy, requesting her to be her lead maternity carer. Portia explains the relationship she had with the woman and the subsequent traumatic event:

We had a real good relationship; we got on really well. The visits lasted over an hour and occurred on Saturday morning to enable her husband to be there. When I went on holiday to Australia our relationship was so good she gave me books to read. She rang me a few times during the pregnancy about odds and sods but nothing dramatic.

She rang me one Sunday morning about 0200 hours and said to me "I feel unwell, I have been vomiting and I have got pain." In my head I thought she's got fulminating pre-eclampsia. I advised her to go immediately into delivery suite. My diagnosis was correct and she was sectioned about 0800 hours. The baby was 36 weeks gestation but was fine. Her blood picture changed from the time she came in to the time she went to theatre, so really she was developing haemolysis, elevated liver enzymes and low platelets (HELLP) before she delivered. She developed renal failure; she got worse on the third and fourth days. She then proceeded to get better which is what most people with HELLP do. People on the staff were saying to her "Oh you need to be in ICU you should not really be here; you've got renal failure. Of course her mother was getting quite agitated because she had talked to people on another ward who said she should be in a tertiary hospital.

She was in hospital for about 10 days but she was never sick enough to go to intensive care. On discharge she went to special care and roomed in where I looked after her. I had visited her every day in hospital although I did not have to because she was under secondary care, but I wanted to know what was going on. The baby was good, putting on weight, fully breast feeding. I visited her at home; everything was good until the third week of the postnatal period when she went to have her follow up consult with a physician. The physician wound her up totally, absolutely slammed the care that she had got and that instigated what became a huge process of complaint from this woman and her family.

During my third week visits I knew something had changed, something was different. However she was happy to have my care until 45 days when I discharged her. When I received my evaluation form back from her from NZCOM this was my first indication that there was a problem. The NZCOM recommended that I bring my Standards Review forward.

This woman had gone to the Midwifery Resolutions Committee because she wanted the case brought up at my review in order for dissatisfaction to be relayed to me and that was fine. She did not want it taken any further. I had a Midwifery Standards Review to talk about the case and the people at the review were absolutely fantastic. I went saying how I was just so perturbed about what the woman said. She was absolutely lying and I found that very difficult that I had no right of reply. My whole practice had been called into question. I felt that my practice changed; I had stopped trusting women.

The same time that she contacted the Resolutions Committee she had written this huge letter about me which contained seventeen complaints. She had also written a huge complaint about the hospital. I was called into a meeting with the clinical manager and the service manager but they were very casual and the fact that they were casual worried me. Their focus was the hospital staff and not me. They planned to have an external review and suggested that I may be happy to be part of that process. The external review cleared me but I still had no right of reply. No one had asked me yet for my opinion of what had happened.

The next thing I get an ACC letter in the post and immediately your heart sinks because it has private and confidential. Then I received a letter from Health and Disability and at that point I just thought I am going to be deregistered. The woman had gone to the Health and Disability Advocacy Service, which is her right and they had suggested that she make a formal complaint to Health and Disability. I cannot believe that this had come up again. I had been through five complaint processes. I sent the letter to the Health and Disability and eventually I heard back that there was no case. So for the first time I felt vindicated and it was such a relief I went home, had a bottle of wine and I had the best sleep that I have had in 18 months. I am still not convinced that it is finished for me. I guess the only other thing the woman can do now, because she is not happy with the Health and Disability outcome, would be for her to take out a Civil case. It all sounds very trite when you talk about it but is not trite it was 18 months of stress for me.

It transpired that during the time I was doing her antenatal care she was going to her GP and her sister who worked in a health organisation and she was having blood tests and blood pressure checks and there was no documentation at all of

any of that. I knew nothing of this and I was angry when I found out. As far as confidence or loss of confidence in midwifery practice goes, I lost having as much trust in women and I was very wary with women for a long time.

Portia's narrative suggests that despite seeking alternative antenatal checks from her sister and GP the initial midwife-woman relationship based, on trust and mutual respect, was positive. The advice Portia provided to the woman to go to hospital immediately, coupled with her assessment and referral process on admission to delivery suite were not to be faulted. The damage to this relationship seems to have occurred in the postpartum period where this woman has sensed a tension between caregivers. The tension occurred as core midwifery staff, demonstrating their lack of knowledge of HELLP syndrome which is a variant of pre-eclampsia (pre-eclampsia foundation.org, 2011), believed the woman should be cared for in ICU. Staff in another part of the hospital, who again would have limited, if any, knowledge of HELLP syndrome, were exacerbating the conflict by suggesting the woman should be in a tertiary hospital. Added to this conflict were the uncomplimentary comments made by the renal physician thus increasing anxiety and tension for the woman and her family.

Tension between health professionals occur often as a result of conflicting ideologies (MoH, 2009; Kennedy & Lyndon, 2008; Hunter, 2005) which in this story is the dispute as to the appropriate place for the provision of postpartum care for a woman suffering from HELLP syndrome. The question of appropriateness of care received was also highlighted by the physician. His comments could be viewed as a deliberate act of symbolic violence wielded on behalf of those in power to demonise the midwife who dares to challenge the beliefs of the habitus by providing LMC services.

Portia's story illustrates how a trusting midwife-woman relationship is destroyed as a result of workplace rumour and gossip resulting from conflicting paradigms of care. Portia provided support for the woman through the entire process which included her hospital stay and even when she sensed a change in the relationship. As a result of the complaints made against her practice by the woman Portia lost

trust in the woman and her family, the physician, the core midwifery staff and the clinical manager.

The dissonance created by conflicting opinions which were expressed when the woman was in the delivery suite should have been rectified by the clinical manager in a discussion with the staff regarding this woman's care. The clinical midwifery manager did not call a case conference which would have included the woman, her family, LMC, core midwifery staff, obstetricians and the physician to discuss the woman's condition and the appropriate treatment required. Case conferences are a venue where clarity of roles should be incorporated (Edmonds & Baker, 1997); they also provide the family with memories of shared professional relationships with mutual respect and trust in each other's judgments (Damos, Leventhal & Dinter, 2005). By giving the woman and her family the opportunity to understand the situation and express their concerns demonstrates compassion and communication, both of which are known to reduce the risk of malpractice suits (Atwood & Macken, 2005). In Portia's situation a case conference would have enabled her expertise and competence in this emergency situation to be acknowledged by the obstetric team. The case conference held while the woman was in the maternity unit may well have acted as a form of mediation and prevented the subsequent complaints instigated by the woman. Informing the staff of the rationale for the plan of care may have suppressed the gossip and sustained the midwife-woman relationship.

According to the Primary Maternity Notice (2007) of the New Zealand Public Health & Disability Act (2000) it is the LMC's responsibility to provide care before, during and following birth. The legislation enables a GP or midwife who is not the LMC to provide care in an emergency situation only. The checks provided by the GP were not in an emergency situation therefore the GP breached the legislation. He could, with the woman's permission, have officially adopted the role of the LMC in the antenatal period but the LMC must be notified and the transfer of care documentation completed. The transfer of care did not occur, yet his actions have gone without redress. The woman's sister is a health professional and had no

legal right to provide antenatal care to her sister. Her actions have also gone unchallenged. Portia indicates in her narrative that she was hurt by these clandestine meetings the woman had with her sister and the GP. Non-disclosure thus silenced the midwife as the woman did not inform Portia of these visits despite appearing friendly toward her. The woman's actions breached the trust Portia believed had developed in their relationship and this has influenced her trust in the relationships she has developed with women since then.

Portia implies that the actions of the GP and the woman's sister are hardly moral actions and do not, in her opinion, reflect the collegial trusting behavior expected of a health professional. They do however demonstrate that their actions, and those of the core midwifery staff and the staff in the health facility where the woman's mother worked, occurred as a result of conflicting paradigms of care and lack of knowledge of HELLP syndrome. The philosophy of the habitus (Bourdieu, 1982) that surrounds the core midwifery staff in this situation, as well as the health professional influence from within the family, is based on the medical or technocratic model of care. The medical model "is a powerful agent of social control, shaping and channeling individual values, beliefs, and behaviours" (Davis-Floyd, 1994, p.1125). It removes the right of autonomy from the midwife and eliminates choice (Thachuk, 2009; Fleming, 1998; Wagner, 1994). It is little wonder that when the perceived severe complications arose the Intensive Care Unit, together with its technology, would be the place of choice for those practitioners.

Portia's story demonstrates the harming effect experienced by a practitioner when her professional integrity and competence are questioned. The narrative also illustrates how boundary violation in the form of a dual relationship of professional and friend can increase the practitioner's risk of litigation. Portia's narrative suggests midwives should be aware of the organisational and political issues that impact on the midwife-woman relationship (Lundgren & Berg, 2007). Political issues relating to the development of the midwife/LMC in the field of maternity care challenged the dispositions within the medical habitus. The challenge to the habitus could explain the GP's actions of providing unauthorized antenatal care to

the woman in Portia's narrative as he strives to retain access to resources within the field of maternity care. Midwives should also be conscious of the impact family and friends may have on decision making and their influence on power relations within the midwife-woman relationship (Thachuk, 2009). Lack of understanding of the autonomy of midwifery as opposed to obstetric nursing could be the reason why the relative, who has a health background, provided antenatal care together with the GP and encouraged the woman to conceal these meetings from Portia.

Relationship issues and violence are present in the workforce and create loss and grief for the employee (Thompson, 2009). Thompson (2009) suggests that more harm can be experienced by the victims of trauma from the psychological and social effects of violence in the workplace than from physical harm. Hunter, Berg, Lundgren, Olafsdottir and Kirkham (2008) in their discussion of relationships view maternity care as a tapestry and the threads that bind it together are the human relationships within the service. These relationships, particularly at the macro level, are often responsible for the quality of care provided yet despite the evidence to support the importance of the midwife-woman relationship these relationships are rarely acknowledged as an issue in policy making (Hunter, et al, 2008). The Midwifery Council of New Zealand, the New Zealand College of Midwives, and Primary Maternity Notice (2007) of the New Zealand Public Health & Disability Act (2000) clearly stress the importance of a partnership between the woman and her caregiver yet there appears to be a breakdown of communication or miscommunication within institutions and in relationships as Portia's story demonstrates. Failure of communication can impact on the quality of the care provided and lead to possible safety issues for the woman (Kennedy & Lyndon, 2008) and potential litigation or case review for the health practitioner (Atwood & Macken, 2002) as occurred for Portia.

Portia's story demonstrates how the midwife-woman relationship can change and impact upon the midwife. The woman's right to complain is set out in the legislation and is something that the consumers of midwifery services have come to

expect (Surtees, 2003). Evidence from some of the midwives' stories in the current study suggests that 'there is nothing out there for the midwife and that everything is there for the woman' (Emma, 2007; Mertle, 2007). When one considers the avenues of complaint open to this woman and the lack of redress for Portia, her narrative clearly supports this claim. One has to ask, where the power is in the partnership, when the midwife is continually denied her right to freedom of speech. The woman referred to in Portia's narrative has never had to account for her accusations nor her action of accessing care without advising her LMC. Unless Portia chooses to take legal action for the stress incurred as a result of the woman's accusations the woman will not be required to be accountable for her actions. Despite providing excellent care Portia was subjected to having her practice scrutinized by a number of agencies for example Accident Compensation Corporation, which created a traumatic situation for her as the narrative which is reproduced in the following section portrays.

Harming as a result of the Accident Compensation Corporation (ACC) complaint process

The ACC provides comprehensive, no-fault personal injury cover for all residents of and visitors to New Zealand (ACC, 2008). It is an avenue where a woman can request financial help for treatment for issues arising as a result of the childbirth experience. Individuals cannot sue for personal injury in New Zealand but they can apply to ACC for exemplary damages in order to get some financial or supportive help (ACC, 2008). The case is examined by a panel of experts using, among other things, the practitioner's case notes. If fault is suspected then ACC can, if they deem it necessary, refer the practitioner to the Health and Disability Commissioner, or in the case of a midwife, they may also choose the Midwifery Council of New Zealand as a source of referral.

ACC creates a status difference between children whose impairments are the result of medical misadventure and those impairments that result from natural

circumstances (ACC, 2008). Parents bring cases against health practitioners in order to get financial and rehabilitative resources for their child. Resources are much more difficult to secure for parents of children whose disability results from natural circumstances providing an incentive for some parents to bring a case of medical misadventure to the Corporation.

Caroline explains how her relationship with the woman was disrupted when after the six week postpartum period the woman visited her GP. The GP felt the couple should apply for compensation for the injury to the baby. He is reported to have said to the woman

Your midwife is to blame for this. You have to get ACC to provide help and support for you.

The GP blaming the midwife for the poor outcome of a neonate without being present at the birth is an example of gossip which destroyed the trust the woman had in the midwife but also the trust the midwife had in the GP.

These claims of medical misadventure can be very stressful as Caroline describes:

When I got the letter from ACC my heart sank and all the emotions started all over again and this was a good, probably four to six months, down the track. You are starting to recover and getting back to normal and it brings it all back again. You start going through what did I do wrong. How could I have done it differently?

I told them everything that I could, I provided them with all the documentation, and I waited with baited breath to hear the outcome. I heard nothing for six weeks from anybody and finally, I called the woman "Have you heard anything from ACC?" Oh yes I got a letter saying they could not find any error or misadventure and they would not be giving me any financial support." I experienced two emotions, real sadness for them for they needed that financial help but at the same time total relief for me. I rang ACC and said "What is the process? I was the midwife who provided information about this claim in terms of my practice but I have received no feedback." "Oh no, it is not our practice to provide feedback only to let her (the woman) know what the outcome is." That was very hard because you are waiting to hear when the sword is going to fall on your head. It just hung over my head constantly.

Rose and Portia support the words of Caroline:

*It went on for five years until it was settled. Every time you go to the letter box and you see ACC on the envelope your whole heart just turns over.
(Rose)*

I got an ACC letter and immediately your heart sinks. The woman was going for money for the trauma she had experienced and they wanted access to all my notes. I was waiting for a letter from ACC that stated either I was cleared or they had a problem. Eventually I rang ACC and was informed that I would not hear anything. All this time I had been waiting, really stressed and not sleeping.

(Portia)

ACC came into effect in 1974 and in order for compensation to be granted fault on the part of the practitioner was sought. Although finding practitioner fault is no longer the case the fear of a possible referral to another agency exacerbates the stress created by the traumatic event. Some participants have suggested that in an attempt to reduce the stress experienced by the midwife as a result of not being informed of the outcome of the review ACC should be approached at a strategic level to alter this process. Following a discussion with the team leader of the Maternity Section at ACC I was informed it is not possible to inform practitioners of the outcome. The practitioner may contact the department at any time and will be informed if the situation has been resolved. Some participants' narratives confirmed that these claims can affect the midwife's confidence, disrupting their lives and impacting on future relationships with childbearing women.

The excerpts from three of the midwives' stories outline the harming effects of ACC investigations. Although the midwife in the following story was not affected by ACC it tells how her life was disrupted as a result of destroyed trusting midwife-woman relationships. The story also highlights the midwife's fear of having her practice scrutinized in a formal process.

Trust and disrupted lives

The following narrative portrays how a good midwife-woman relationship can end suddenly after a traumatic practice experience leaving a midwife grieving and doubting her actions and abilities as a result of guilt. Grief resulting from death is a dominant feature in this narrative however I have included it in this chapter as the story demonstrates the hurt and the disruption experienced by the midwife as a

result of a destroyed relationship. Like other stories in the chapter it also includes fear of the outcome of having your practice questioned by an official process. This is the only narrative in the current study where the midwife experienced harm but not as a result of the trilogy of violence. The harm Susan experienced arose from a loss of trust in her own competence which is a normal reaction to the grief she experienced after the death of Tui.

Susan

I felt like it was the aftermath of a tsunami

Susan practices as a homebirth midwife where her philosophy includes that of a woman-midwife partnership. The dominance of the medical profession asserting power and taking control is absent from the homebirth scene and the woman takes control of the situation as she trusts her body to safely birth the baby. The homebirth setting equates well with Susan's current philosophy of professional midwifery practice as she states:

My philosophy now is more about trusting, keeping your hands away, letting women discover themselves and really helping to let them see that they are big enough, strong enough to make their way through their pregnancies and birth. That there is time for intervention but mostly it is good just to let things take their place in their own time.

Susan's story is about a woman named Tui whom she had cared for during two previous pregnancies. The traumatic event took place following Tui's third pregnancy which had progressed normally until approximately 24 hours postpartum when Tui complained of backache. She described the pain as the same as that experienced from a back injury she sustained while playing netball and which had been successfully treated by an osteopath. Susan undertook a complete assessment of Tui and, demonstrating the partnership that this woman and midwife shared, Susan discussed with Tui and her family her care options for either a medical or osteopath referral. The latter was chosen due to the woman's previous experience.

Susan then prescribed Voltaren and made an appointment with an osteopath for Tui. She continues with the story:

I rang Tui later in the day and asked how things were going. Her mother said "She is in bed, she is very tired but the back pain is a little bit better". Something was niggling me, I felt uneasy, I knew something was not quite right. At lunch time that day I did take a full blood count and a swab because I was just not quite sure whether I was missing something. The blood result came back fine; obviously the swab wasn't going to come back for a while.

That evening her mother rang and said that Tui was bleeding more heavily. She actually hadn't passed urine for about eight hours as at lunch time I had been unable to get an MSU because she had just been to the toilet. I rang the consultant on call who said "Bring her up to the hospital; she may have some renal retention".

When I got to the house I could see that she was in trouble. She was in shock, she was blue around her lips, her nail beds were blue. I just didn't even call the ambulance. I bundled her into my car and rushed up to the hospital. I don't know why I didn't call an ambulance; I thought I could get there quicker. I got up to the hospital and I think I knew she was going to die. I called the obstetrician; they were doing an emergency Caesar so I started putting an I.V. in, taking bloods, inserted a catheter but got no urine back. By the time the house surgeon came down to help all the blood samples we took just kept on haemolysing, it was a terrible picture. We couldn't get any idea about what was happening with her platelets or clotting factors and other issues in disseminated intravascular coagulation (DIC). We started antibiotics and by that time the consultant arrived. She was transferred to ICU with a suspected septicaemia and DIC.

Approximately 3 o'clock in the morning I remember waking up terrified having realised that this woman was going to die. About that time, as I did a debriefing, that was the time that she got severe pulmonary oedema and needed to be intubated and she died at 0630 hours, almost 72 hours after her baby was born. I got a call about half past seven in the morning from the consultant to say that she had died. It's terror, just terror and it's your worst nightmare come true. I remember thinking how am I going to survive this and also knowing that a beautiful girl had died leaving three wee babies and a husband. The impact on me was amazingly deep and widespread. It wasn't just a practice thing; it was like spiritually I felt let down by God. I felt really alone even though I had lots of colleagues. I felt I had let the family down, I hadn't seen what I needed to see. Every part of me felt like I had been put through the wringer and then just left out to dry. I don't even know how I got through the next six months.

It is amazing how much you could do on so little sleep; I didn't really get stressed that I wasn't sleeping. I figured that was what had to happen and if I could get a couple of hours a night I was o.k. I was feeling really numb and I hated that feeling. I didn't want to feel numb. I wanted to be able to feel the grief of the loss for the family and for me and the fear that I had within me. Other times I knew I

would get this release of tears, I liked that much better I liked being able to express the feelings inside me. That cycle is not as frequent as it used to be. I went to see a psychologist; she really reassured me how I was feeling was normal that I wasn't going nutty. I kept a sort of a diary I was just so traumatised. I had no idea how I was going to work through it. Over the months you get some other problem and you pop this issue away; you get things sorted out enough to be able to cope. I think you realise that the pain gets put in a box and put a lid on it and every now and then when you are on your own you take the lid off and have a cry and then put the lid back on. I think that is the only way that you manage; you can't keep revisiting it all the time. You only do it when you feel safe and you are on your own.

When I first heard that she had died of course I had that overwhelming feeling of grief and guilt. I felt so much for her family but obviously underneath I was terrified that I had done something wrong and that I would be facing a court case. I have just heard recently that there was to be no Coroner's case and obviously a little bit of relief but bizarrely enough part of me was like I felt that I needed to be purged from my guilt and that the Coroner's case might have helped to do that. Now I don't have to face that and I don't have to think about that anymore.

When I think about the particular day when Tui was admitted to hospital I guess that is the only day that I think of every other day. All that day she complained of lower back pain there was something inside me saying something is not right here. I feel that if I had rung an obstetrician and said that she had lower back pain not kidney pain not even sacral pain as such but buttock pain he probably would have said don't be silly you are wasting my time. In a way I wish I had, because then I could put that to rest in my head. I could say that I did do everything; that is the only thing that I really wish I had changed. I wish that I had not chosen an osteopath but chosen a G.P. I have gone over the events in my head so many times I couldn't count.

Susan's story demonstrates the role of the midwife as the Lead Maternity Carer working in partnership with the woman and her family throughout the childbirth experience. It incorporates the concept of intuition, an innate form of knowledge (Belenky, 1997) that guided Susan's actions as she provided vigilant care to Tui. Susan suffered the physical effects of trauma as well as the psychological effects; this is not surprising due to the abnormal amount of pressure she has been subjected to throughout this experience. The stressed state caused Susan to position herself as incompetent as she relived this trauma and its consequences.

Despite the normal results of the assessment and the blood tests Susan's intuition was telling her that things were not normal therefore she was not surprised when

she was contacted by Tui's mother a few hours following her daily visit. Upon arrival at Tui's house Susan was faced with an emergency situation as she realised that Tui was extremely ill and in shock and decided to transfer this woman to hospital in her own car. Some would say she should have waited for the ambulance in case Tui's condition deteriorated whilst in the car. Others would admire her courage to drive with a sick mother beside her. On arrival at the hospital she strived to save Tui's life. Susan utilized her knowledge and skills which she has acquired through experience and demonstrated her ability to work autonomously until assistance arrived. The scene shows how things can change so rapidly from the normal birthing situation to a traumatic practice event despite the practice experience of the midwife and her provision of vigilant care.

During the night Susan was awoken by her intuitive self, the inner sense, that something is not right. No practitioner wants this sort of outcome for anyone whether they are familiar with the family or not. Although maternal death is rare in New Zealand (PMMRC, 2009) it happens and often when least expected. The important thing is that the practitioner is vigilant and when things start to change, acts accordingly as Susan did. The phone call Susan received from the obstetrician demonstrated his respect for Susan as the LMC as well as her being part of the emergency team. She is positioned as a professional, caring midwife despite the doubts she may have had about her own ability.

Traumatic events are the aspect of midwifery that many lay people do not see unless involved in such a situation. Childbirth is supposed to be a time of happiness and the celebration of a new life. Despite having worked in a third world country where maternal death is very common Susan is extremely traumatised by this situation as she tries to find fault with her care. Danieli (1984) refers to 'survivor guilt' as a powerful defense mechanism used in experiences of utter helplessness. It serves as an unconscious attempt to reverse the effects of helplessness; guilt means there was a choice as Susan explains:

the guilt of watching what was happening and feeling responsible for not picking up on something, that's the main feeling.

The attribution of blame, however irrational, is associated with a belief that the death could have been prevented (Worden, 1989; Danieli, 1984). Survivor guilt maintains loyalty through guilt and suffering (Danieli, 1984). Susan's care was supported by the medical team therefore the blame she experienced was self-inflicted and part of the grief associated with loss. She punishes herself by wanting to feel the grief and not the numbness that helps to ease her pain. The reaction she experienced is common in these circumstances but the degree of disturbance depends very much on the individual, the severity of the event and the emotional signs involved (Brown, 1989). The pain associated with grief and loss is described as the worst pain ever (Walsh-Burke, 2006) and Susan recognises this when she uses the analogy of the *tsunami* to describe her feelings:

I felt like it was the aftermath of a tsunami and I think that was a really good description of how I felt. I felt like I was overwhelmed by what was left behind. I did not know how I was going to get through it.

In order for the feelings attached to survivor guilt to change, individuals need to concentrate on what they did accomplish rather than on what they perceive they did not do (Worden, 1989). For example when Tui complained of backache a full assessment was undertaken by Susan, laboratory investigations were performed and anti-inflammatory drugs prescribed. She did not make the decision to go to an osteopath; this was a joint decision between the woman, her family and the midwife demonstrating a true midwife-woman partnership.

It is a legal requirement in New Zealand that any sudden or unexplained death is reported to the Coroner for a case review (Ministry of Justice, 2009; NZCOM, 2008) and this was the reason for the referral of this case to the Coroner. It is understandable that Susan experiences fear of litigation as she strives to convince herself she acted appropriately. Fear of litigation amongst midwives is common following such events (Hall & Taylor, 2004). Consequently if the midwife fears litigation, feels vulnerable and questions her ability this can impact on the relationship she develops with women (Hall & Taylor, 2004) in the future.

However, when there was no case to answer Susan experienced relief and disappointment as she considers the case might have purged her of her guilt.

Susan experienced a deep sense of loss because she had developed a trusting relationship with Tui. Her life has been disrupted therefore she must now mourn the loss of a midwife-woman relationship as well as her loss of confidence in herself as a competent practitioner. According to Neimeyer (2002) people need to understand loss and reconstruct their lives in order to cope with their activities of daily living. It takes time to achieve these tasks (Walsh-Burke, 2006; Worden, 1989) as Susan has recognised. According to the psychiatrist, Engle (1961), experiencing a loss is similar to physiological trauma in that the equilibrium of the body is affected. Just as a wound requires time to heal the mourner requires time for their body to return to its normal state (Engle, 1969). Given support, people will recover (Walsh-Burke, 2006). Unfortunately there was no ongoing formal support network available for Susan to help her through this recovery phase unless she chose to pay for a continuation of the professional help which was initially provided free of charge, an issue discussed in chapter six. Figley and Kleber (1995) posits that grief has an impact not only on the person involved but also on their significant others as well as the community. The effect on the community in Susan's case is that the area where she worked has lost a confident experienced homebirth midwife.

Susan outlines how time also changed her behaviour in relation to the loss. Susan stopped discussing this incident with people. In so doing she was self-silencing, as she felt that she could no longer be the centre of attention. Her story was no longer acceptable in the world of stories as, according to Frank (2005), self-silencing occurs as time has elapsed and individuals imagine that others now expect them to move on. According to Beverly Raphael (2006) "Experience has demonstrated that trauma, loss and grief may be horrific but they may also bring out the best qualities in people: altruism, courage, maturation, and hope" (p.160). The traumatic event experienced by Susan which suddenly ended a relationship, was horrific for her and she still suffers some of the effects however one cannot help but position her as

altruistic and courageous. When I met Susan at the second interview she had returned to LMC practice but was uncertain how long she would stay as she was finding practice very difficult. She expressed the following:

Some of the barriers are within yourself. You are so traumatized that you can't think what to do. You were caught in a lost world, you were so desperate you wanted to work your way through the trauma but at the same time you did not want to explain yourself to people.

This traumatic experience outlined by Susan demonstrates the long term harming consequences for the midwife when a relationship is suddenly destroyed. Susan was not subjected to violent behaviour from others but to grief and the associated insecurity that occurs when a relationship is suddenly ended (Gilbert, 2002). Her view of herself as a competent trustworthy midwife was altered by Tui's death and exacerbated by the trauma. Self-silencing, her loss of confidence in her competence as a midwife, the physiological and psychological effects she suffered, blaming herself for not sending Tui to a GP and having the case referred to the Coroner's Court all contributed to a disrupted life.

Summary

In this chapter I have demonstrated how the changes in the health service as a result of the introduction of the business model coupled with the legislative change that enables the midwife to be autonomous and self-employed have exacerbated forms of symbolic violence in the workforce. These political changes are key drivers and form the basis for the demonisation of the midwife in New Zealand in the 21st century. The midwives' stories illustrate that symbolic violence is a part of the institutional culture of midwifery in New Zealand and comprises of rumour, gossip and negative non-verbal communications. A model titled the 'trilogy of violence' developed from the analysis of the stories of the 16 participants in the study provides an explanation of how the violence occurs and creates harm for the midwife. The harm was often a result of breaches of trust that exacerbated the physiological and psychological effects experienced resulting from the traumatic event thus destroying relationships and disrupting the life of the midwives. The last

story in this chapter, which is not associated with violence, illustrates how grief associated with the loss of a midwife-woman relationship can create fear and harm for the practitioner thus disrupting her life. The following chapter illustrates how symbolic violence is often subtle and hidden.

Chapter Eight: The hidden side of trauma

We all feel or have felt the distress and the isolation. Ultimately, I believe, there is no solution to the problem. All of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all, inherent in the relationship. (Hilfike, 1998, p.207)

Introduction

This chapter contains the stories of two midwives who tell of a traumatic practice experience and the hidden torment they experienced as a result of the event. Both midwives were new immigrants to New Zealand and both of the events involved an interpretation of a cardiotocography (CTG tracing). In this chapter I demonstrate how the violence associated with trauma in the workplace is often subtle and hidden. I acknowledge the claims of Kleber, Figley, and Gersons (1995) that those who are subjected to workplace violence may be the most vulnerable and use new immigrants as an example. Bourdieu's (1982) theory of economic practice is drawn upon to illustrate how power can be used to the advantage of the dominant group when an error in the interpretation of a CTG tracing occurs. In the narratives of these two immigrant midwives who contributed to this thesis the clinical issues that led to the torment were not the primary cause of the trauma. Both midwives were subjected to violence or bullying and both participants suggest that this behaviour is part of the New Zealand culture. Their suggestions reinforce the current literature that demonstrated violence or bullying is present in the workplace in general (Mace, 2010; Bentley et al, 2009; Barton, 2005 & Clarke, 2005) and in hierarchical health organisations in New Zealand (Mace, 2010; Bentley et al.2009).

The first story from Louise, a core midwife, demonstrates linear violence as she is positioned as unsafe by her clinical manager. Louise is silenced by the organisational management and denied the right to freedom of speech, a basic human right. Louise outlines how she coped with the biographical disruption resulting from this traumatic experience by rethinking her profile and making

changes in her life. The second story is also from a core midwife, Lillie, who positions herself as a marginalized disempowered bystander in a fetal death that she considers was potentially avoidable. Her narrative explains the changes she made, not only personally but within the unit, to build resilience and assist her to cope with the biographical disruption that she experienced. Trusting other people, especially health professionals, was a concern identified by both midwives but particularly Lillie, who at the second interview was still unsure as to whom she could trust in New Zealand.

Louise

It was a very distressing time. I cannot believe the career that I had worked on for more than fifteen years could end so abruptly without a warning.

I first met Louise not long after her arrival in New Zealand from a developing country. Louise's mother died in childbirth when Louise was 9 years old and this was the influencing factor for her entry into the midwifery profession. Being the eldest child in her family she was required to take on the mother role but continued with her education to ensure that she was able to embark on her chosen career. Unlike New Zealand it is a requirement in Louise's country of origin that one graduates as a nurse before entering midwifery; she completed this requirement then followed her ambition. Her reason for immigrating to New Zealand was for a better way of life for herself and her family. Although she came alone, the salary which she received from working as a midwife enabled her to send money back to her father to improve the standard of living for her siblings.

Louise has vast experience as a midwife having worked in areas where there was no medical support available. Therefore she is used to working autonomously and dealing with emergency situations. Her philosophy is that birthing and breastfeeding are normal life events which women have the ability to do unaided. The cultural differences of the midwifery profession in her country of birth to those of New Zealand challenged Louise's professional identity. She was used to

supervising the traditional birth attendant, caring for women experiencing a normal birth whilst dealing with a large caseload of high risk women herself. Good clinical skills, knowledge and use of modern technology combined with the ability to deal with emergency situations in a calm manner are part of her professional identity. These requirements were a result of the social structure of the area where she was employed and influenced her working environment. The challenge for Louise on coming to NZ was learning to work as part of a hospital team providing woman centered care to the woman and her family. According to Ibarra (2001) role change affects a person's professional identity which will have to be reconstructed in order to cope with the new requirements (Chreim, Williams, Djokoto-Asem & Janz, 2003). Knowledge of the New Zealand health system, the legislation and the social context of the workplace are part of the requirements for overseas midwives to gain entry to the NZ Registrar of Midwives (MCNZ, 2004) and these requirements assisted Louise to cope with the alterations in her professional identity.

In order to complete the competency requirements for registration Louise accepted a position in a hospital which was prepared to provide the practical experience necessary. When she gained her midwifery registration the manager of the unit was happy to offer her a permanent position. The traumatic event occurred a few months later following the appointment of a new midwifery manager.

Louise admitted a woman who had arrived at the unit stating that she was bleeding. The woman was expecting her third baby and Louise assessed the bleeding to be a 'show'. She felt the baby was small for its gestational age but was happy with the CTG recording and notified the LMC of her findings. The woman was sent home and arrived back in hospital eight hours later in labour. Louise had no further contact with the woman as she was not on duty when the woman returned. She enquired after her the next day and was informed that the admission CTG was reassuring, meconium stained liquor was present during labour and when the baby was born it was small, required resuscitation and was transferred to the Special Care Baby Unit.

Approximately one month later the midwifery educator was requested by the manager to comment on the CTG undertaken by Louise. To support her assessment the educator accessed the woman's clinical records and as a consequence of her assessment recommended that Louise receive support and education. The manager did not communicate these findings to Louise therefore this education did not occur. A month later another expert midwife was requested by the manager to comment on the same tracing and her recommendations matched those of the educator who had been on leave since the original assessment. Louise was not aware of any of this process even when she was informed by the manager that she had to attend a debriefing session. Failure of the manager to relay her concerns to Louise demonstrates abuse of the power attributed to her role. This abuse of power is a form of symbolic violence and breaches the trust that Louise attributes to someone in such a position.

Louise continues with her story:

The debriefing happened two months after the event which is unusual. There was no documentation; nothing was said about my CTG. It was how to improve things because the baby was resuscitated at birth and the paediatric doctor that came to assess the baby did not know where things were in the unit. He did not know what to do until a paediatrician came and took the baby to SCU. Following this review one of my colleagues advised me to contact the union; I took her advice although I could not really understand why.

I never knew about the manager's concerns until about two months after the birth when she called me into her office and told me what she had done. I asked her what I should do? She said I had to go for education with the midwifery educator and I will not be allowed to work in the delivery unit until the educator is satisfied that I am OK to work in delivery suite. So I agreed to that. The education never occurred. After another week I received a letter stating serious allegations against me concerning the care of that woman.

A meeting was called by the manager to discuss the issue and she said that a midwifery expert would be present, someone from the Human Resource Department and my union representative. When we arrived at the meeting there was no midwifery expert. It was not until later that I learnt that they were advised that their presence was not required. At the meeting the manager just read a letter telling me that my employment was terminated. Well, I was shocked and so was the support person from the New Zealand Nurses Organisation (NZNO) because we were not expecting that.

I could not believe it. My whole life has ended due to this traumatic experience. I felt very humiliated, I couldn't talk, I was thinking of so many things. I am the eldest of my family, the bread winner. My father is retired and the younger children are still at school. I have been sending money home to help him. Where will I get the money? I was also told that a letter had been sent to the Midwifery Council. Does this mean I will not be able to get a job? The worst thing that could happen was that I would lose my practicing certificate for good. It was really shocking and when I got home I had to move out from where I was staying. I had to go and live with a friend because I couldn't afford the rent. It was horrible that is all I can say.

I could not sleep; I never had a good sleep. I was always thinking what to do; so many things were going on in my head. I couldn't eat; I felt sick. Sometimes I would go out for a walk and just get lost in my thoughts. I just cannot understand why she would do this. It was a very distressing time. I cannot believe the career that I had worked on for more than fifteen years could end so abruptly without a warning.

I was lucky that I got support from the friends that I had made in New Zealand because I do not have any family here. I received support from the NZNO but very little support from my midwifery colleagues. I was very surprised the way my colleagues treated me. Very few of them called to see how I was feeling especially those of whom I was very close to. When we were on duty we would laugh and have a joke together, and do things, sometimes go out. Even the midwifery manager was friendly before she took up her current position as manager. I never heard from them and it was very shocking. It was very hard.

The NZNO representative requested a mediation meeting with the manager and prior to the meeting he had the trace assessed by an expert midwife who I knew was also a lawyer. She recommended the same as the two expert midwives that I should attend an education session to demonstrate my competency in this area. She also commented that she could not understand why the manager had ignored the two expert midwifery reports. The union representative asked me what I wanted as compensation and I asked to have my job restored. I wanted them to pay for the humiliation they had caused me, to apologise to me. The mediation meeting was unsuccessful.

The case was then taken from the NZNO representative and given to one of their lawyers. The lawyer gave me the options of going back to mediation or go to the court. If I went to court I would have to wait for a year for the first hearing and there would be a lot of media and people involved. I had no job, I was really stressed. Waiting for another year to go to the court would add more stress so I decided to go for the mediation option again.

The hospital reconsidered and they offered me compensation but refused to reinstate me. I was asked not to talk about the situation because it was confidential and I had to sign a letter to this effect. I knew most of my colleagues knew because following the debriefing their attitude towards me changed; everybody kept looking at me. They sat around talking and I knew they all knew that the manager was not happy with me. It really affected me that I was asked not to talk about it.

The Midwifery Council investigated the case and found no problem. I then gained a position in a primary birthing unit. Over the years I have worked in so many places before coming to New Zealand, I was very confident with what I did and the way I practiced. Since this incident I am a little bit self conscious. Whenever I care for women I am a little apprehensive, I keep asking myself "Am I doing the right thing? Is this the right way to do it?" I try not to get into trouble, it is really holding me back but with time (big sigh) things will sort out soon enough. Life is hard I know because my mum died in childbirth when I was nine and growing up not having anyone to call a mother, being the eldest and looking after the younger ones, life was, although very difficult, it was fine in those days.

The story demonstrates how Louise had been totally disempowered through being finalised as unsafe to practice. Her trust in the manager, her colleagues and the organisation, to be treated fairly had been eroded. Her sense of self, her social identity as the eldest and the key provider for the family as well as her professional identity were threatened by the actions of managers within this health organisation. The narrative demonstrates the subtle and hidden actions of the manager by seeking advice regarding the CTG tracing without first expressing her concerns to Louise.

The role of the researcher in narrative research is that of a facilitator, interpreter (Murray, 2007; Chase, 2003; Josselson, Lieblich & McAdams, 2003) and advocate (Frank, 2005) and as in the midwife/woman partnership (Guilliland & Pairman, 1995) the researcher and participant share an experience within a relationship of trust. Part of this relationship is uncovering the underlying structure or behaviours that impact on the narrative which are referred to as the gaps in the story (Chase, 2003; Frank, 2004). Finding these gaps means the researcher cannot be neutral however the outcome for the participant should help to clarify the event and enable closure (Frank, 2005). In Louise's narrative I suggest that these gaps are a combination of the organisational structures, management behaviour and symbolic power. They constitute the hidden side of trauma which according to Kleber, et al, (1995) is the political context in which the trauma occurs; political, refers to power relationships and social control all of which influenced the outcome of Louise's story. Social control is based on symbolic power which comprises of two elements firstly the possession of symbolic capital gained through qualifications or material things that carry prestige and secondly the authority to manipulate the groups as a

result of the power that accompanies this position (Bourdieu, 1989). The clinical midwifery manager used the symbolic capital attached to her qualifications and the power of her position to convince the service manager and the HR manager that Louise was incompetent. In this political field of dominance, people like Louise are affected by two components, namely powerlessness and disruption (Figley & Kleber, 1995). Louise was subjected to both of these elements by the actions of the clinical manager who terminated her employment.

The long timeframe from the adverse event to the risk management debriefing session, failure to communicate concerns about the interpretation of the CTG tracing to Louise, ignoring the advice of the expert midwives and not arranging the recommended education coupled with sending a letter of allegation to the Midwifery Council without first investigating concerns about Louise suggests ineffective management. Factors that influence the effectiveness of a manager are the job requirements, the senior manager's expectations, the subordinate's expectations, the manager's past experiences, own expectations, their personality and the climate of the organisation (Fineman, 2008; Morgan & La Monica, 1994). Louise's narrative suggests that the working environment in the maternity unit is one of oppression as staff are expected to comply with the power and control requirements exhibited by the the manager. An oppressive environment coupled with the managers inexperience could have inhibited an effective management style and altered the manager's obstructive behaviour toward Louise. Consideration must be given to the possible failure of the organisation to provide adequate training and support for the manager in her new role.

Although I am not qualified to confirm the diagnosis considering the writings of Clarke (2005) the manager's actions towards Louise could also be attributed to that of an occupational psychopath. It is estimated that 1 in 300 adult males and 1 in 200 females in the workforce are affected by this condition (Clarke, 2005). Clarke (2005) describes the characteristics of an occupational psychopath as including superficial charm, being unreliable, untruthful and insincere, lacking in shame or

remorse, rapidly becoming bored and intolerant toward people. Consequently the behaviour of the occupational psychopath is unpredictable and their emotions shallow. Shallow emotions enable them to adapt to a situation thus detracting the attention from an issue that could prove negative towards them (Clarke, 2005). In Louise's narrative by focusing on the CTG tracing the manager draws the attention away from the lack of resuscitation skills of the paediatric doctor or her own inadequacies as a manager. The deficit of skills in relation to neonatal resuscitation could reflect the lack of orientation provided by the manager to the doctor. Occupational psychopaths have no feelings of guilt in relation to their actions and give little thought to the consequences of their bullying and manipulative behaviour. By creating conflict between workers they gain more power and control which is the reason for their existence (Clarke, 2005). The manager in Louise's story appears unconcerned about her actions toward Louise or the effect of her actions on Louise's lifestyle.

The description of the occupational psychopath is similar to the definition of a workplace bully, developed by the Workplace Bullying and Trauma Institute (WBTI) who suggest that bullies "knowingly, deliberately and persistently" (Needham, 2003, p.23) target their victims. Constantly focusing on the CTG tracing combined with the long time it took to address the issues and even bring them to Louise's attention, could be interpreted as the manager knowingly, deliberating and persistently targeting Louise. In order to explore the differences between the core and the LMC midwife in interview two I asked Louise if she felt she would have been treated differently by the manager if she had been a LMC. Louise replied:

No I don't think so because she just wanted rid of me.

Louise's response to my question suggests that she felt that she was deliberately targeted by the manager. Her narrative supports Fineman's (2008) arguments that prejudice and discrimination may thrive in such an oppressive environment.

According to Neeham (2003) bullying is a precursor to work related stress. In midwifery frequently the perpetrator of the bullying is the manager who is in the position to misuse the power or authority attributed by the organisation to that role (Keeling et al, 2006). Mace (2010) refers to workplace bullying as ‘the silent epidemic’. In New Zealand bullying associated with professional groups differs in that the bully is driven by an addiction to control therefore the bully targets those who are strong or successful (Barton, 2005). Success in Louise’s case could be attributed to gaining midwifery registration in New Zealand, being offered a permanent position on the staff coupled with her overseas experience making her a competent and confident midwife. Louise provided her explanation for the manager’s behaviour:

I do not really know why she behaved in this way but in my case the manager was not experienced.

Louise’s reply suggests that her competence may have challenged the manager’s position in the field of the maternity unit. Needham (2003) indicates that the targets of the bully refuse to be subservient; they are emotionally intelligent, competent and have the ability to maintain good relationships. Competent practice and strong collegial relationships are also present in Louise’s narrative until she was ostracised by her colleagues following the debriefing session.

The manager’s actions in Louise’s story reflect the autocratic management style found in hierarchical organisation combined with a lack of management skills. The reaction of the manager to a CTG tracing was powerful and negative and in my experience not the normal response attributed to the misinterpretation of a CTG tracing. The clinical manager is the leader of the unit therefore the dispositions or subconscious actions attached to her position reflect the social conditions of the working environment. The actions of the clinical manager in this narrative provides evidence of how symbolic violence is often subtle and unassuming (Mathias, 2009) and demonstrates the use of the power attached to symbolic capital resulting from her position in the field (Bourdieu, 1982). The manager’s actions also suggest that she gave little thought to the emotional impact on Louise of

terminating her employment. When a person undertakes an act of any kind it is with the soul purpose of achieving or altering something. According to Sartre (cited in Warnock, 1965) this is the “power of negation”. The person is aware of the situation and its consequences, they are conscious of the act they are performing as the result is to achieve their motive (Bourdieu, 1982; Warnock, 1965). Louise’s has suggested the motive of the manager appeared to be the removal of Louise from her team; the interpretation of the CTG tracing after the event was the excuse to do so. In this situation the manager demonstrated a total disregard for Louise’s basic human rights to be innocent until proven guilty. The manager was however, legally required to notify the Midwifery Council (HPCA ACT, 2003) of her concerns relating to Louise’s competence to practice.

The disempowerment of Louise by the clinical manager and the human resource department manager led to further stress and anger associated with grief.

I was asked not to talk about the situation because it was confidential and I had to sign a letter to this effect .It made me angry because I could not go back to my colleagues and say I have done nothing wrong. It was very stressful the way I was treated. I was concerned that I would lose my practicing certificate. I started to look at doing nursing.

Louise is silenced by the institution and her right to freedom of speech denied. Acts of dominance and subordination destroy individuals as they are involuntarily subjected to acts of violence and the effects of terror (Herman, 2006) as Louise’s story has suggested through her use of terms such as “shocked”, ‘humiliated’ and ‘stressed’ in her narrative. Clarke (2005) asks how are people to understand and help tackle unfair treatment if victims fail to tell their stories of bullying. Although Louise was prevented from telling her story to her colleagues she has participated in this research to help midwives understand her experience.

Louise is an immigrant to New Zealand therefore consideration must be given to the manager’s actions being a consequence of lack of tolerance for cultural diversity. It is not uncommon for individuals to be abused in organisations as a result of racial prejudice leading to discrimination and oppression (Thompson,

2006). A collaborative study between New Zealand and the United Kingdom found that part-time or immigrant workers were at greater risk of abuse due to their lower power status within the organisation (Bentley et al, 2009). The action of the manager to dismiss Louise without giving her an opportunity to defend herself coupled with getting her to sign a confidential agreement not to discuss the issue demonstrates bullying and is a violation of human rights.

The New Zealand Human Rights Act (1993) prohibits racial or sexual harassment but does not prohibit workplace bullying. Similar to many countries New Zealand does not have a legal definition of workplace bullying (Fitzgibbon, 2006) consequently, in this country employees must make their claims under the Employment Relations Act (2000), using the heading ‘unjustifiable disadvantage’ or ‘unjustifiable dismissal’. The claim is then focused around failure to provide a duty of trust and confidence by the management or a duty to provide a safe environment for the individual. Claims cannot be made under the personal grievance Section 103 of the Employment Act as bullying is not defined in the definition of grievance (Fitzgibbon, 2006). The introduction in 2003 of the Amendment to the Health and Safety Act 1992 enabled work related stress as a result of bullying to be assessed. Claims related to stress and bullying were able to be heard due to the terms physical or mental harm being included in the definition of harm (Fitzgibbon, 2006). Louise could have made a case under the Health and Safety Act (1992) or the Employment Relations Act, however due to the stress she was experiencing she chose not to take the case to court.

Human rights issues cannot be viewed only in relation to the abuser for the implications are much broader. It is argued that indifference, which is the lack of attention to the suffering of those around you, is a part of social relationships and that human rights are the methods by which these situations may be addressed (Cohen, 2002; Tester, 2002). However the social conditions in which these abusive situations develop often prevent human rights from being recognised and support being provided. A dualism occurs between moral action and lack of care due to

minimising or ignoring the situation (Cohen, 2002; Tester, 2002). The silence of Louise's colleagues in response to the manager's actions although disappointing could have occurred as a result of ignorance of the situation, fear of being subjected to similar treatment (Keeling et al, 2006); Kornfield, 1995) or as a result of their position in the field and the doxic practices (Bourdieu, 1982) that accompany that position. Doxic practices are the taken for granted actions within a field that are considered necessary to gain a position in the social hierarchy (Bourdieu, 1982).

A silent reaction to injustice can also be a result of the battle (Cohen, 2002) between protecting or sacrificing the self (Dass & Gorman, 1985). To confront these abusive situations Louise's colleagues would have had to listen to her, understand the position she was in, and work with her to try and rectify the injustices. In a hierarchical environment listening to Louise and confronting the manager is difficult to do unless the listener is in a more senior position or the midwife is confident and has trust in herself and others. The union representative, who is in the position to challenge the organisation, requested a mediation meeting which as Louise stated was unsuccessful. The second mediation meeting involved an NZNO lawyer and the potential for media coverage could have threatened the hospital's image and may explain why the management chose to reconsider the situation and offer compensation. The actions of management in response to the NZNO lawyer's demands could also be attributed to the lawyer's position in the field and the power that accompanies that position.

Louise should never have been subjected to bullying behaviour by the manager and one must question why the Human Resource Department allowed this discriminatory act to occur. If action had to be taken the normal moral process would have been to suspend the employee on full salary pending investigation. These actions would have avoided the financial problems that occurred for Louise. It would have provided Louise an opportunity to speak about and expose the actions of the manager who failed to accept the recommendations of the expert midwives. According to Clarke (2005) in most organisations Human Resource Departments try and make the problem disappear by not responding appropriately,

supporting the management or suggesting that conflict is an unfortunate part of life (Clarke, 2005). The support of the manager's actions by the human resource manager, without any forum for discussion with the employee, indicates that the actions of this human resource department were inadequate and dismissive (Clarke 2005) and did not meet Louise's expectations of their role. This form of response signifies a traditional organisational HR department which is mainly administrative and focuses on issues such as recruitment and retention. In today's value-based organisations the role of these departments is to function as a change agent by directing the values of the organisation onto employees and providing professional development networks (Hoag & Cooper, 2006). These networks create an environment that encourages loyalty to the organisation and loyalty to the employee. In these organisations where HR see their role as supporting professional development the relationships are of equal value and dependent on trust and trustworthiness (Hoag & Cooper, 2006). The relationship with HR experienced by Louise in this traditional hierarchical environment was one of risk management involving punitive disciplinary practices.

The Midwifery Council of New Zealand investigated the complaint against Louise made by the manager and found no case to answer. Louise was thereby finalised as safe to practice. Part of the Midwifery Code of Ethics includes the practitioner's responsibility to her professional colleagues:

- a) Midwives support and sustain each other in their professional roles and actively nurture their own and others' sense of self-worth (NZCOM, 2008, p. 13).

The clinical manager is a midwife yet Louise's narrative suggests that the manager did not nurture her or care about her self-worth. Failing to address her concern about Louise's competency with Louise demonstrates devious behaviour and provides evidence that the clinical manager has not adhered to the Code of Ethics. The service manager and the manager from the human resources department

condoned the behaviour of the clinical manager by their silent acceptance of her actions. By condoning the clinical manager's actions, these managers share equal guilt in depriving Louise of her basic human rights and may explain why Louise lost faith in the system.

Louise was positioned as incompetent by her manager. The accusation of incompetence challenged her self worth and her professional identity as it altered the meaning of the event for Louise. She was denied the opportunity to accept the recommendations of the other professionals involved and access the education and support which she had agreed to. Louise had to relinquish her role as a midwife from this organisation instantly which further impacted on her self confidence. No consideration was given to the effect this disempowerment may have on the health of the midwife. She had to learn to survive in a new country with no job and no income. It is understandable that she felt betrayed by the manager and a system that allowed bullying behaviour to occur.

Louise could rationalise why life was hard in her earlier years, which led to her becoming a kind and trusting person influenced by her religious background. The manager's behaviour challenged Louise's trust and belief in people thus initiating a chain of events that created a biographical disruption in her life. According to Bloom (1996) moving beyond the emotions and the effect on one's personal identity should bring about new meaning. In interview two Louise appeared to have reconstructed her identity bringing new meaning to the situation:

I decided to move on with my life I have got a new job and the people there are very supportive.

Research suggests that New Zealand has one of the highest rates of bullying in the developed world especially in the health and educational sector (Bentley et al, 2009). The current study strongly supports bullying being a part of the health culture in New Zealand.

In the following story Lillie, like Louise, was also a new immigrant to New Zealand an experience which in itself creates a biographical disruption. Her story also demonstrates how a CTG tracing was used to disempower her and advantage the dominant group in the unit.

Lillie

I felt like my voice had gone as a midwife.

The role of the midwife as the primary health professional for childbirth is part of Lillie's identity. Born in a developing country her childhood memories revolve around the birth of her siblings and the relationship and confidence her mother had in Irene her midwife. Lillie left school and trained to be a nurse and then a midwife. She loved babies and working in delivery suite, where she stayed for some years and became the manager of the birthing unit. Lillie goes on to explain what influenced her to leave the hospital environment and practice as a homebirth midwife in her homeland; she outlines her expertise:

My philosophy of midwifery is forever changing. Initially it was how important clinical skills were. Now I firmly believe that midwifery needs to be woman centered; the woman needs to drive the birth. It is her birth, it is her baby. I also believe in normal physiological birth and if left well alone the body knows what to do. I also know as a midwife, a skilled professional is sometimes required to help and step in when I know things are not going along the physiological sense and sometimes they don't. They just follow a different path. In the late 80s early 90s there were all those sweeping changes worldwide; women were saying they no longer wanted childbirth as it was. Many women came to me to be their attendant at a homebirth. I don't think I would have done homebirths if it had not been for the women who pressurised me. I was sure of my skills as a midwife, and that was a very important factor for me.

Lillie positions herself as a safe homebirth midwife working in partnership with women and providing total midwifery care. The above excerpt from Lillie's story demonstrates her understanding of the social issues surrounding the changes in midwifery worldwide as well as informing the readers of her knowledge and expertise in the field of midwifery practice. These "sweeping changes" she discusses were brought about by the Safe Motherhood Initiative (1987) and its

commitment to reduce maternal mortality and morbidity worldwide by the year 2000. One of the changes was to increase the role of the midwife as an autonomous practitioner, particularly in third world countries (Kensington, 1993).

In New Zealand the Safe Motherhood Initiative plus the economic reforms of the 1980s which focused on the reduction of public spending, the introduction of competition for health services and the restructuring of government funding agencies opened the doors for midwives and women to unite and influence legislative change (Engle, 2000). The result was the 1990 Amendment to the Nurses Act which gave midwives the right to practise independently of the medical profession. It was this legislative change that was one of the factors that influenced Lillie to leave her place of birth and settle in NZ.

In order to fulfil the Nursing Council of New Zealand's requirements to meet the competencies for practice I worked at a level two maternity unit as part of the core team. I needed to see how midwifery worked here. I needed to kind of understand different cultures I was coming into contact with here as well because part of being a midwife is getting to understand where your client is coming from. I had no basic understanding and therefore decided to stay and work as a core midwife.

Lillie outlines her competence to practice safely in New Zealand through discussing her childbirth philosophy and how it is relative to time, place and her professional identity. The following story demonstrates how social structures in New Zealand and the power of the obstetrician impacted on Lillie's identity and her sense of trust thus altering her resilience. Loss of resilience influenced the meaning of the situation for Lillie from one of a competent midwife to doubting her own knowledge and skills as a result of the doctor's untrustworthy behaviour.

A woman phoned delivery suite one evening concerned about reduced fetal movements. She was thirty two weeks pregnant with her second child. I advised her to come to the hospital and following my initial assessment I contacted the Lead Maternity Carer (LMC) responsible for her care. Ensuring the woman was placed in the correct position and not one which could compromise the tracing, I undertook a CTG recording. I was concerned about the results of this assessment tool (CTG tracing) which in my opinion was non-reassuring. Another factor was the baby had not moved during the 40 minute assessment period and I believed that urgent action was required.

The couple obviously realized that I was not taking things very lightly. "What is going on?" "I am concerned about this baby there has been no movement now for 35 minutes. I will consult with the obstetrician on call while we are waiting for your LMC to arrive".

The consultant came into the unit with this client's LMC, a GP, and the consultant said "What is the matter Lillie?" "I am a little concerned" and I explained to him my findings. "The baby's absolutely fine" he said. The obstetrician, the LMC and I all went in to see the woman. The LMC said "Oh baby's fine. I will see you on Tuesday in my rooms". I followed them out and I said "I am most unhappy about this tracing" "No, no, no baby is fine". "I am not happy about it and I want you to sign the tracing please." so the LMC signed it and I documented that a consultant was called and present.

The following morning the woman phoned the unit complaining of reduced fetal movements and was readmitted for assessment but the fetus was found to have died. Although distressed about the situation the couple accepted the outcome as fate. For me this was a tragedy that may have been avoided if I had not been disempowered. I still feel angry toward those health practitioners involved.

The woman was offered the opportunity for an induction or a Caesarean section. A decision to perform an Elective Caesarean was made. I cared for the woman pre-operatively and in the postnatal period but I was disappointed at the treatment I received from the LMC. At no stage did that LMC speak to me about what happened even though I went down to theatre with them. Later he said "It's a shame" and I said "Indeed not, it is a tragedy". I think about it often and keep thinking if I was actually in my own country, where I feel more secure of my place than in New Zealand, I would take them both to the cleaner. Not in terms of the law but when I called both of them I would not have backed down. But being the LMC with the power well what does one do?

We were in theatre and this couple's baby as I said had died. The theatre nurse kept checking on the resuscitation crib, the lights, getting the oxygen ready, leaving the suction on and warming everything up. I kept turning it off and saying "No the baby's dead". The nurse said "We always do it for every baby and you may not turn the resus crib off." I said "Actually this baby has died." "No that does not make any difference" she said, loud enough so this couple could hear." I looked at her, turned my back on the couple, and said "Don't you dare turn that resus crib on again." She looked at me as if I was stupid and appeared to be thinking why would you not want a resus crib on for a dead baby?

We had the so called debriefing meeting about the tracing because I felt very strongly that it had been mismanaged. The head consultant sat down at the table took the tracing out and said 'Lillie you have written baseline of the tracing 162 actually if you look at it very closely it is 157.' "What difference does that make? Actually the baby has died." "Well I agree with the LMC the tracing is fine". The debrief was anything but supportive, it was a waste of time.

I found the experience very humiliating. In the meeting, in terms of my own professionalism, I had no credibility in their eyes. I was laughed at and made to feel that I really did not know what I was talking about: that I had blown

everything out of proportion. The main impact that scenario had on me was the loss of confidence that I had in myself. I had always prided myself in keeping my knowledge up to date and rely heavily on my own clinical skills and suddenly I think “How could I possibly make such a mistake” and I just completely lost my confidence.

I suddenly did not want to give my opinion on things. I backed away from comments on tracings. It made me doubt myself and I kept thinking of what other mistakes I had possibly made and make women have unnecessary sections because I was not happy with fetal tracings. I used to start crying sometimes because I felt so helpless. I felt like my voice had gone as a midwife. Emotionally that is what happened and I kept on smoking which was my key factor whether stressed or not. I also suffered from lack of sleep. I think what happened to this couple and their baby was swept under the carpet and not really spoken about.

All was kept hush, hush. There was not any formal support or acknowledgement of what that tracing was really like. I had already formed a relationship with the educator where I was working and did discuss it with her on an informal basis which I found helpful. I started saying what I thought in the unit instead of running around trying to please everyone.

The obstetrician and the LMC dismissed Lillie’s call for help and implicitly position her as incompetent by insisting that the baby was fine. The positioning challenged Lillie’s professional identity as her knowledge and expertise are not recognised by the doctors. Lillie questioned this dilemma, created by these practitioners insisting that all is normal with the CTG tracing, by stepping outside the professional norms of subordination expected in this organisation and requested the LMC to sign the CTG tracing. Signing the tracing is objective evidence that he has viewed and interpreted the tracing. Lillie continued to exercise her autonomy by documenting her findings and action in the woman’s case notes. The case notes are a legal requirement (HDC, Act 2000) and documenting her actions of her interpretation of the CTG tracing provides evidence of opposite view points in relation to the woman’s care. The scenario demonstrates a hegemonic act on behalf of the medical practitioners and Lillie’s refusal to accept their ideological dominance and unethical behaviour as she advocated for the woman and her baby.

Despite the legislative changes which enabled all midwives to practice autonomously many doctors still view themselves as superior to the midwife (Skinner, 2006). These actions are part of dispositions within the field which

subconsciously influence people to behave in certain ways. They reflect the social conditions of the time and place, and the way people believe they are positioned within the fields in which they interact (Bourdieu, 1991; 1982). The public narrative of the doctor in New Zealand is that they have a greater knowledge base than the midwife and their word is often accepted without challenge. When Lillie contacted the obstetrician for his expert advice it was his responsibility to listen in a professional manner to all involved in the care. However, in the situation described above a three way discussion between the two doctors, the midwife and the woman did not occur. What did occur was collaboration between the GP and the obstetrician opposing the midwife's concerns. The Primary Maternity Notice (2007) of the Public Health and Disability Act 2000 attributes all the care and responsibility to the Lead Maternity Carer but does not remove a duty of care from others involved with the woman, which in this case are Lillie and the obstetrician.

In this traumatic narrative Lillie has experienced an ethical and moral dilemma which challenged both her personal and professional identities and caused her much distress. She was involved in a moral dilemma where not only were her values and beliefs questioned but also her professional Code of Ethics and her trust in the doctors. As a midwife she is accountable for her actions to herself, the woman and to the profession. She is responsible to ensure that the woman is not placed at risk by actions or omissions on the part of any health professional (NZCOM, 2008). In this situation the woman was not placed at risk but by ignoring Lillie's concerns these health professionals placed the fetus at risk. In New Zealand the fetus has no rights therefore there is no legal case to be answered by those who ignored Lillie's advice but for Lillie a moral dilemma has occurred. According to Johnstone (1996) a moral dilemma involves choice and in some instances competing moral duties. Lillie had a choice to advise the woman to request a second opinion from another consultant or to accept the advice from the consultant and the LMC that the CTG tracing was not a cause for concern. Advising the couple to obtain a second opinion would be a difficult course of action as the couple had faith in the expertise of the LMC who supported the advice of the obstetrician. Lillie made her choice; however the health professionals were unfamiliar with her expertise. She now regrets her

decision to remain silent. Johnstone (1996) suggests it is normal for the person to regret the decision they took following an issue involving conflicting duties. Lillie's narrative also demonstrates how a CTG tracing linked to other documents (medical documentation) and actors (the two doctors) influence the outcome of the narrative.

Lillie was new to her position as a core midwife and was caught up in a system entrenched with power relations particularly between midwives and obstetricians. The LMC holds total responsibility for the woman and if concerned for her safety is required to consult with an obstetrician (Primary Maternity Notice, 2007, of the New Zealand Public Health & Disability Act 2000). Lillie did all that was required of her as a core midwife and as with all midwives, is responsible and accountable for her own actions (NZCOM, 2008); however what do you do if, as in this case, your actions are ignored? Lillie does not identify with this culture of care that enables a form of medical dominance which disempowers the midwife. She is used to practicing autonomously, being trusted and listened to and having her knowledge and clinical expertise respected. In her opinion the safety of the woman is paramount, not the power of the medical team. She struggles to find her place in this hospital system that appears rife with symbolic violence which in Lillie's situation was hidden by laughter and a subtle accusation of incompetence as she explains:

I was laughed at and made to feel that I really did not know what I was talking about.

It is apparent that midwives are dominated in this institution by the medical profession's status in the organisational structure and the power attributed to that position. Despite having professional autonomy Lillie's story demonstrates how some midwives in New Zealand are still oppressed by the structures within the organisation and the use of cultural capital within this field. Lillie is not used to being oppressed; she is used to working in an environment that enabled her to be a part of a multidisciplinary team that supported autonomy. She struggles to come to terms with her position as a core midwife which, differs considerably from that of

the one she held in her country of origin. Lillie wishes to be part of a multidisciplinary team similar to the one she left in her own country.

Another incident that Lillie experienced while in theatre demonstrates a failure on behalf of the nurse to understand the position of the woman and her husband. It also outlines the nurse's lack of autonomy and her adherence to the rules of the organisation her actions, which according to Bourdieu's (1991; 1982) theory, supports her position in the habitus. Lillie positions the nurse as uncaring whereas the nurse positions Lillie as authoritative and not understanding the rules of the organisation. The philosophy of care of both practitioners was being challenged in that Lillie's primary focus is that of the woman whereas the nurse has her focus on the correct preparation of the theatre which is part of the institutional routine. This scene is a tense situation for all concerned and requires an understanding not only of the personal feelings of the individuals but of the morals and values of the organisation.

The concept of fields outlines the underlying social conditions that influence the actions of the nurse and the midwife. In the field or space of the operating theatre, the nurse is exerting symbolic power over the midwife as she views this as her territory therefore she expects compliance from Lillie. Lillie however does not belong to this field and refuses to comply. Failure to comply demonstrates Lillie's strength and ability to initially recover quickly from the stress associated with the fetal death she was exposed to providing evidence of her resilience (Ritchie et al, 2008). However, as the stress continued Lillie's resilience was soon to wane.

Lillie was distressed by the situation and the loss of a baby so she requested a debriefing session to discuss the outcome. A CTG tracing is interpreted using a number of specific parameters; the baseline is only one factor involved in the interpretation. The obstetrician made no reference to the other parameters such as decelerations or the number of accelerations in a given timeframe. His interpretation of the baseline figures as 157 reduces the number of beats per minute

and it places the CTG baseline recording within the realms of normal (normal being 110-160bpm). His actions also undermine Lillie's expertise as well as altering her trust in him. The debriefing session was destructive as opposed to constructive. Lillie was made to feel incompetent rather than feeling supported and having her expertise acknowledged. The session was representative of a clinical audit or sentinel event inquiry which would be part of the hospital's risk management programme (QIC, 2009; Calvert, 2001). To be ridiculed in such a way is not part of the quality control process either. In Lillie's narrative focusing on the baseline CTG tracing draws the attention away from questions regarding the competencies of the LMC and the obstetrician. What it does demonstrate is that by focusing on Lillie the response to the emergency situation was ignored thus relinquishing the dominant group from any form of responsibility.

The scenario clearly demonstrates the vertical violent behaviour of the medical practitioners and their apparent superiority. Lillie's narrative illustrates how the hierarchical position of the doctor is socially situated as is that of the clinical manager whose position also carries symbolic power. In failing to provide support to Lillie at the debriefing session and by not challenging the medical team to consider the assessment of the CTG tracing, the clinical manager clearly demonstrates her acceptance of the behaviour of these medical practitioners. She also expected the staff to accept the symbolic power that comes with her position within the organisation and to comply with her decisions. Again Lillie's personal and professional values and beliefs are challenged and she lost trust in the medical team, the clinical manager, the hospital system and confidence in herself as a result of this symbolic violence. She had been finalised as unable to interpret the assessment tool, yet if we look at the situation through Lillie's eyes she appears to position the medical team as incompetent and unsafe when she states:

I believe that this situation had been mismanaged.

Lillie felt vulnerable and suffered both physiological and psychological effects that are not uncommon in these circumstances. However the degree of emotional disturbance depends very much on the individual, the severity of the event and the

emotional signs involved (Semmer, et al, 2005; Doka, 2002; Brown, 1989) which for Lillie were crying, being unable to sleep and loss of confidence. In this incident Lillie's personal integrity and self worth were threatened. Her trust in the medical profession to act in the best interests of the woman as well as her professional judgment had been placed in jeopardy causing Lillie to question her knowledge and ability. The distress created by the medical profession by not acting in a way that Lillie perceived was not in the best interests of the woman created symptoms of anxiety for Lillie.

Emotionally this affected me, I lost my confidence. I used to start crying sometimes because I felt so helpless I felt like my voice had gone as a midwife. I kept on smoking. I also suffered from lack of sleep. I think what happened to this couple and their baby was swept under the carpet and not really spoken about. All kept hush hush quiet there was not any formal support or acknowledge of what that tracing was really like.

Throughout this event Lillie received very little support or recognition of her role from those with whom she worked. To challenge the manager and the medical team on behalf of a colleague is to alter the status quo and to do this one must have a strong sense of self-worth and the ability to recognise that speaking up could have devastating consequences for the individual within the organisation (Tester, 2002; Cohen, 2002). As a result of the whole situation Lillie withdrew from discussions with the staff on other issues thus isolating herself which can also exacerbate the effect of a traumatic event. Failure to resolve this situation could have long term relationship effects leading to destructive consequences (Wilson & Drozdek, 2004) for Lillie's health and her working relationships as her story has demonstrated. The inability to discuss this situation freely could be the reason why Lillie still holds this woman's loss.

The meaning of this situation for Lillie is that she has been deemed incompetent and her professional identity challenged. The loss of professional identity created a breach of trust in the doctors and manager for Lillie and created biographical disruption in her life. The effect of a traumatic practice event has caused loss, grief and stress related issues for her which could result in a chronic illness if not

rectified (Williams, 2000). Lillie explains her feelings nine months later at interview two:

If I had been the LMC midwife she would have been sectioned. As the LMC midwife I would not have tolerated the behaviour of the obstetrician. There were no processes in place to provide formal support; I did not know what was available. I got informal support from the educator. Because I was so new I did not know who I could trust. Trust was a huge thing but I trusted the educator. I have always had implicit trust in what she has done. What kept me going was my belief in normal birth and the fact that I knew that my interpretation of that CTG was correct. Smoking kept me going and I had to survive in NZ. I liked getting the transcript back so that I could read through it; I need to read to understand things so that worked well for me.

The one good thing I have had implemented is the opportunity for individuals to have access to a mental health worker for a debriefing session or the normal risk management debriefing session. I think midwifery professional supervision should also be available.

I have become far more assertive in telling people what I think. I do not mess around now. I am very keen that midwives are taught they can be assertive in their knowledge. The longer I stay in New Zealand I think bullying is part of the culture here. I can deal with confrontation but what I can't deal with is when people go in the tea room and say those things behind my back. It seems to be that people do not confront here. I do not know if it is a cultural thing or if it only belongs to where I work. All the time I have been here I still do not know who I can trust and who I can't. It makes my life quite difficult. I am not culturally comfortable. I had never come across the term bullying, violence etc at work until I came here. I don't know who I can trust. Information gets back to management and it is all misconstrued.

Lillie is able to draw upon her experience of working in another country to reflect upon the organisational culture that she has encountered in New Zealand. Lillie considers the cultural significance of lack of confrontation to explain the reasons for the horizontal violence she was subjected to. The suggestion by Lillie that midwives need assertiveness training supports the request made by Mertle in Chapter Five that workshops be implemented to assist practitioners cope with the violence perpetrated by workplace bullies.

Notations from my field notes gave me the impression that Lillie is still sad, angry and disappointed as a result of this event even more so now that there is no evidence to support her story as she explains:

She became pregnant again and I had to access her previous records only to find that the CTG tracing is now missing from this woman's notes.

The missing CTG tracing can no longer be linked to the medical or midwifery documentation leaving the outcome of the story unresolved for Lillie.

In order to continue to work in this environment and cope with the stress associated with her biographical disruption Lillie has had to rethink her profile. Finding someone to trust is very difficult for her. The opposite to trust is betrayal which can contribute to a traumatic experience by clouding thinking, reducing motivation, work output and reducing the capacity to trust people (Reina & Reina, 1999) which Lillie experienced. However, the strategy she activated to reconstruct her identity was to become more assertive and encourage and support others to do the same. She encouraged the clinical manager to offer the staff the opportunity to have a mental health worker present at a debriefing session to ensure their emotional needs were cared for. This is a positive outcome of the disruption Lillie experienced and provides her with a different focus.

According to Heagerty (1997) the history of midwifery has resulted in some midwives being the willing handmaidens of science. Unlike other professions midwives have failed to achieve autonomy and control of midwifery (Crabtree, 2004) due to the obstruction and rivalry created by the male dominated medical profession (Fleming, 1998; Heagerty, 1997). I would argue that in New Zealand since the passing of the HPCA Act (2003) the decisions at a strategic level regarding the profession of midwifery are made by midwives. However I support Heagerty's (1997) view that midwifery practice in health institutions is still to a large extent, influenced by the rivalry with the dominant medical group. Many of the stories in this study have demonstrated this rivalry and dominance and these issues are apparent in Lillie's story as her interpretation of the CTG tracing is laughed at and reinterpreted by the doctors. The medical domination of midwifery stems from the past; the new phenomenon that influences and can dominate the profession is management (Worrall, et al, 2007; Kirkham & Perkins, 1997) and this is evident in the story told by Louise in which the manager ignoring the advice of

others positioned Louise as incompetent. Negative feedback from management can be difficult to handle and inhibits employees caring for others (Kirkham & Perkins, 1997). It also impacts on the employee's professional identity creating loss, grief and stress and as Lillie suggests a breakdown in relational trust which appears to be intensified when one is an immigrant thus exacerbating the trauma experience.

The Immigrants – Louise and Lillie

Louise and Lillie's stories illustrate issues of violence that were subtle and hidden and occurred as a result of their position in the field. They were both new immigrants to New Zealand. Moving to a new country creates a biographical disruption in the life of the person for, according to Brown (2008), even voluntary immigration and the most positive experience and outcome of dislocation bring about disturbance.

Louise came to New Zealand for a better way of life and Lillie's decision was to enable her to work as an autonomous practitioner in a country where the legislation enabled this to occur. Yet both of these midwives were subjected to behaviour that was detrimental to their objectives. Despite change in immigration over the years from involuntary (slave trafficking) to voluntary movement with applicants requiring certain knowledge and skills for entry into countries (Brown, 2008), immigrants are still greeted with hostility (Brown, 2008; Infante & Lamond, 2003). Being an immigrant means that the person is different from the bodily norm within that environment which, particularly if they are non-white and a woman, makes them highly visible (Puwar, 2004). The presence, although small, of these individuals can be perceived as a territorial threat altering the institutional scenery by invading a space that some people may believe is not rightly theirs. Moral panic is created as it is believed that standards will be lowered which creates over-surveillance of the activities of women or coloured employees in order to prevent losing masculinity and/or whiteness within the organisation (Puwar, 2004). The immigrants are viewed with suspicion therefore they have to work harder than non-

immigrants, men and Europeans to display competencies and thus be accepted. Louise was accused of incompetent practice following a mis-interpretation of one assessment tool confirming Puwar's (2004) suggestion that when one is the centre of attention small discrepancies are noticed and exaggerated thus increasing the risk of immigrants being labelled as incompetent.

Becoming accepted into an organisation requires endorsement from someone that is part of, and trusted, by the dominant groups as a result of sharing the same philosophy of existence (Puwar, 2004). I see this endorsement as a part of the role of the midwifery clinical manager influenced by her commitment to the midwifery Code of Ethics (NZCOM, 2008). However due to their position in the field of maternity care and the symbolic power attributed to that position the clinical managers in the stories narrated by Louise and Lillie do not appear to have endorsed these midwives as competent registered midwives. Rather their actions appear to have made the issues of race visible, an action that is supposedly resisted within the professions especially as professions view themselves as treating everyone fairly (Puwar, 2004). The belief of treating everyone equally makes it difficult for outsiders to contest the assumptions of the habitus. Consequently the immigrants develop strategies aimed at survival, part of these strategies is that they remain silent and focus on their work (Puwar, 2004). This is what Lillie did when the obstetrician and the doctor ignored her concerns about a non-reassuring trace.

Louise lost her social networks, had her skills challenged and questioned her self-confidence. Although the immigrants of to-day have an option to return home (Brown, 2008) returning to her country of origin was not an option as Louise explained. Therefore to overcome the traumatic event and succeed in New Zealand she had to reconstruct her biography and regain her resilience. In their research into the adaptation of Latino immigrants into America Infante and Lamont (2003) suggest that it is the core categories of resilience as described by Grotberg (2003), inner strength, social skills and social networks that enabled immigrants to focus on social adjustment and succeed in their new country. It is these same characteristics

that encouraged the participants to emigrate (Infante & Lamont, 2003). Louise had the inner strength, the skills and the support to adapt to her new country and her story confirms that she trusted both the manager and the system to help her succeed. However, following the traumatic event and the loss of her social networks, she found it difficult to carry on in the face of adversity.

When people lose something they tend to gain something in return (Thompson, 2009). Giving up life in their respective countries created a loss for Louise and Lillie. Coming to New Zealand for a better way of life and practising as an autonomous midwife was to be the gain. Initially this did not occur and they were subjected to hostile treatment as immigrants. Louise commented in interview two that she felt the manager was threatened by her expertise; by challenging the doctor's interpretation of the CTG tracing, Lillie's expertise appears to have threatened the doctors in her story. The actions of the manager and the doctors were hidden acts of violence. These two midwives were subjected to actions that caused feelings of guilt and shame as they lost respect and honour from management, colleagues, and medical staff, a loss that was not justified. Loss of respect can lead to loss of confidence and self-worth (Thompson, 2009) which was apparent in both of these stories.

Summary

The stories of Lillie and Louise demonstrate that hierarchical health institution that support oppression and enable symbolic violence to occur are present in the hospitals of the NZ Health system. Their stories confirm the literature that bullying is part of the NZ health culture. The violence was subtle and hidden as those in power did not question the actions of the clinical manager or the medical staff involved in these stories. The narratives revealed how a CTG interpretation may be used to the advantage of those in power and influence the outcome and the meaning of the event for the midwives. Louise and Lillie were immigrants to New Zealand; they experienced a violation of their human rights and bullying from management and doctors which neither were used to or expected to occur in a developed country. Their trust in the health system, the management and the medical

profession was eroded. The stories illustrate the extent to which a breach of relational trust affects the individual and how the individual can accommodate this experience into their activities of daily living and grow in confidence. The concept of relational trust is discussed further in the following chapter.

Chapter Nine: Trust and Dysfunctional Organisations

I think we should talk about our trauma, remove this cloak of silence. Appreciate each others positions, do not blame people. I know people say you should not talk about it for fear of litigation but in a safe, secure environment it would help.
(Rose)

Introduction

Midwives have asked me why when they have dealt with similar situations in the past does one incident become ‘the straw that broke the camel’s back’ exacerbating the stress associated with the initial traumatic experience. From analysing the narratives of the 16 midwives interviewed for this study I have come to the conclusion that trauma associated with these specific situations is exacerbated by a breach of relational trust that impacted on the midwives’ personal and professional identities resulting in biographical disruption. In many cases the breach of trust was a result of counterproductive behaviours that occur in dysfunctional organisations. According to Worrall, et al (2007) dysfunctional health organisations are a result of structural changes within the organisation which have moved away from the professional model of administration to one of competitive based productivity. In New Zealand these structural changes include changes to the health system in the 1990s where through a process of reform midwives working as community based midwives were made to compete against one another. It is not so much the midwives who were competing but the system that was restructured to reduce costs through promoting competition between providers for services. From the midwives’ narratives it would appear that these structural changes also led to reduced staffing levels and heavier workloads for practitioners. Midwives felt neglected by management as they perceived that management failed to listen to their concerns. Feelings of neglect create counterproductive behaviours such as violence or bullying. Sometimes a breakdown in the woman-midwife relationship occurred as a result of counterproductive behaviours exhibited by other health professionals causing the woman to lose trust in the midwife. Threaded throughout the chapter are excerpts from the stories of the sixteen midwives that participated in the current study relating their perception of a breach of relational trust. The

chapter concludes with the effects of a traumatic practice experience on the midwife and the trauma model developed from the common threads from the midwives' stories.

Trust in Health Care

Trust or lack of trust in managers, colleagues, doctors or women and their families was experienced by all of the midwives in the current study. Trust is central to all relationships and is necessary to enable individuals to carry out their daily tasks within an organisation. In environments where leaders have a high degree of trust in their employees, people feel safe and perform beyond expectations (Crepaz, 2008; Reina & Reina, 1999). When a traumatic experience occurs those involved trust the organisation to provide support as part of the taken for granted culture embedded within the institution. Trust in management applies to both core and LMC midwives. In this section I argue that breaches of trust by managers, women and colleagues created feelings of betrayal for the midwives involved. The betrayal of trust impacted on their personal and professional identities increasing the stress associated with the traumatic event and eliciting grief.

Interest in the concept of trust by research academics and in public debate has increased over the last few years yet it remains a concept that is difficult to define and investigate (Brownlie, 2008; Brownlie & Howson, 2008; Cook & Stepanikova, 2008; Parr & Davison, 2008; Calnan & Rowe, 2008; Luzio, 2006; Goudge & Gilson, 2005). The increased interest in trust in health care is attributed to the portrayal of trust as a diminishing article of trade due to globalization and social change (Calnan & Rowe, 2008). Trust in professionals such as lawyers, clergy and doctors has always been interconnected yet the image of the professional has been eroded with the increase in negligence and malpractice suits against lawyers and doctors. The words of management and politicians are constantly in doubt and trust in public institutions is in question (Mayer, 2007; Evetts, 2006).

There are two levels of trust identified within the literature (Cook & Stepanikova, 2008; Luzio, 2006; Riewpaiboon, Chuengsatiansup, Gilson & Tangcharoensathien 2005; Gilson, 2003); one is impersonal and relates to the structure of the organisation and the other interpersonal; and is associated with relationships. Breaches of trust occurred for the midwives in the current study at both levels and are discussed separately. I acknowledge that interpersonal and impersonal issues of trust can be interrelated as some of the midwives' narratives illustrate.

Impersonal trust

Diminishing trust within health services occurs as a result of the redistribution of power as a consequence of neo-liberal or economic reforms which introduced new forms of clinical governance and increased accountability. The introduction of clinical governance into health care reduced the amount of power attributed to the medical profession. Prior to the redistribution of power authority was based on professional status, resource control and coordinative competence. This ensured the dominant position of the medical personnel (Calnan & Rowe, 2008). The demise of the professional model of power occurred as a result of the growth of consumerism, the introduction of entrepreneurial values into the public arena and exposure of nefarious professional activities within the media (Calnan & Rowe, 2008). In the new governance arena accountability and performance indicators work to reduce risk and improve clinical outcomes (Calnan & Rowe, 2008; Worrall, et al, 2007).

The midwives expected management to listen to their concerns and be accountable for systems errors but this did not occur. Rather the midwives in the current study were shamed, blamed and accused of incompetent practice in debriefing sessions. Shaming and blaming the midwife and not acknowledging a systems fault is a method of demonisation as the manager places all the responsibility of the problem on the staff member. The midwife's trust in the management to provide a safe work environment where actions or omissions of staff do not cause harm (Philips, 2007), did not occur for Judy as she explains:

At the debriefing I was shouted at and told how stupid I was by the obstetrician. It was not constructive at all.

At the debriefing the obstetrician's unprofessional behaviour was not challenged by the midwifery manager and could be attributed to his position in the field. The manager's actions illustrate McIver's (2002) suggestion that management in health institutions are often complacent about dealing with the perpetrators of violence. Lack of support from the clinical management and a professional colleague ensures that the power to control remains with the obstetrician signifying that clinical governance is not functioning effectively in this maternity unit. Failure of the manager to provide support to Judy who was following the woman's birthplan developed in conjunction with another obstetrician demonstrates a betrayal of relational trust.

Impersonal trust implies that the organisations have the ability to provide quality care to the patients accessing the services (Brownlie, Greene & Howson, 2008; Calnan & Rowe, 2008; Riewpaiboon, et al, 2005; Russell, 2005; Gilson, 2003; Laschinger, Finegan, Sharmian & Casier, 2000) and are trusted to do so by the staff and the public. Workforce issues relating to staff shortages and skill mix issues were apparent in the following excerpts from Anita and Kathleen's narratives which demonstrate violations of impersonal trust as the organisations compromise the provision of midwifery care.

I had tried to bring to the attention of senior management the unsafe staffing levels and I thought I can't go on with it any longer. I was putting myself and my clients at risk.
(Anita)

I did not want to stay in delivery suite anymore because it was not the first time I had been called to something in the birthing unit due to the absence of a senior mentor.
(Kathleen)

Emma explains how neglect of employees by managers, which she perceives occurred as a result of the lack of money, led to bullying.

A lack of staff creates a lot of horizontal violence. We have a new LMC and another midwife that needs help which is causing friction. That is a management problem; there are not enough staff to provide support. Yes there is a midwifery shortage but management are just not employing. It is all about money, management, budget and making money. It doesn't matter if you kill the worker.

Judy confirms Emma's concerns of the presence of horizontal violence.

Horizontal violence is very much alive and kicking, was, has been and still is in many ways. The core midwives tend to treat you, (the LMC) not that well, really, and they never support you and I would never expect them to support me

Excerpts from Anita, Kathleen's Emma and Judy's narratives have demonstrated how the midwives lost trust in the organisational management as they failed to provide an environment conducive to safe care. Emma's comments suggest that the unsafe environment appears to be linked to the introduction of the economic reforms. The introduction of entrepreneurial values and their impact on trust is demonstrated in a predictive, non experimental design study by Laschinger et al (2000) to assess the link between empowerment and organisational trust amongst 412 staff nurses in Canada. Laschinger et al's findings suggest that organisational environments that promote the empowerment of staff by trusting them to use their expert knowledge are essential for the maintenance of trust. The indirect influence of trust impacts on organisational outputs in a positive way and should be considered an important factor in today's working environment. Working in an environment without trust can be difficult (Laschinger, et al 2000) as Anita found when she trusted the managers to provide adequate staffing levels to ensure midwives could provide safe care to women.

Only when trust has been violated does its importance become apparent as a moral imperative within an organisation (Crepaz, 2008). Both Anita and Kathleen gave up midwifery practice as a result of their trust in management being eroded. The actions of these two midwives, instigated by a breach of trust in management, created a hazard by depleting staffing levels even further. The stories in this section demonstrate that midwives should be cognisant of the influence of organisational structures on their practice. Another concept of trust that impacted on the midwives stories was interpersonal trust.

Interpersonal trust

Interpersonal or relational trust (Cook & Stepanikova, 2008) is associated with relationships (Gilson, 2006; Riewpaiboon et al, 2005) and is considered to be the trust a person has in someone who is perceived as worthy of their trust (Cook & Stepanikova, 2008). Interpersonal trust is context specific (Goudge & Gilson, 2005) and can be further subdivided into communication and competence. Communication comprises of face to face interactions which demonstrate the use of listening skills and concern for the individual (Russell, 2005; Riewpaiboon, et al, 2005; Goudge & Gilson, 2005; Calnan & Rowe, 2008), whereas competence is the knowledge and skills of the care provider (Russell, 2005; Riewpaiboon et al, 2005; Goudge & Gilson, 2005; Calnan & Rowe, 2008). In the current study there are numerous examples of relational trust: women trusted the midwives to be competent and capable of providing a good standard of midwifery care. Midwives trusted the doctors and their midwifery colleagues to collaborate with them and ensure a positive outcome for the woman and her baby. The midwives trusted the women to be honest and maintain their side of the partnership. However these relationships of trust did not always happen thus creating various breaches of interpersonal trust between doctors and midwives, managers and midwives, midwives and midwives and women and midwives.

Derived from the theoretical literature Gilson (2006) has identified three costs to trust. The first relates to morally unworthy acts associated with a shared identity that involves a large amount of trust within the group and with Mafia being cited as an example.

The second is the abuse of power due to an imbalanced relationship and may result in domination or exploitation. Mertle's narratives in chapter five demonstrate domination and exploitation of Mertle and the woman when the obstetrician failed to call in a second obstetric team to perform a caesarean section on Mertle's client. The domination was confirmed the next day when he stated he would not have made a woman wait six hours for a caesarean section if he had been her LMC.

The third cost to trust is the vulnerability of some people and the impact on their livelihood. The stories of Lillie and Louise about CTG interpretations presented in chapter eight demonstrate imbalanced relationships and vulnerability due to the position of management and doctors within the organisation. Both midwives were new immigrants to New Zealand and trusted they would be helped to adjust to their new country and working environment by colleagues and managers.

According to Cook and Stepanikova (2008) trust is part of social relations that can bring about positive social outcomes. A positive social outcome occurred in Susie's story in chapter four when the women in the community trusted her to challenge the behaviour of a certain obstetrician toward young Maori women. The outcome of this complaint required the obstetrician to be supervised in practice for a certain time. Cook and Stepanikova (2008) suggest that trust is especially important in situations that have the potential for vulnerability or exploitation. Vulnerability and exploitation of a woman was also evident in Susie's narrative as she explains:

This young woman trusted the obstetrician but as the VE continued she shouted 'Stop stop'. She started screaming and she was literally climbing up the back of the bed as he continued and ignored her cries. He did not stop until he had applied the fetal scalp electrode. I was so traumatized I was speechless actually.

This abuse by the obstetrician is also a result of an imbalanced relationship (Gilson, 2006) due to his position in the field of the maternity unit. The story demonstrates that the social outcome can also be negative as the woman and midwife lost trust in the obstetrician.

Caroline also experienced a betrayal of trust relating to the honesty of a medical colleague. Caroline was caring for a woman undergoing a prostaglandin induction and was concerned about the change in the CTG tracing from one that was reassuring to non-reassuring. She consulted with the core midwife and the registrar who assured her that there was no need for concern. Caroline trusted in the registrar's competence attributed to his position in the field. She did not get the registrar to sign the trace or document his findings in the woman's case notes. The baby was born white, floppy and required resuscitation. When questioned about the

CTG tracing the registrar denied his part in the assessment. Narrating her story Caroline expressed her feelings in relation to the breach of trust by the registrar's lack of accountability.

What I still struggle with is that the registrar did not own the fact that he had said the tracing was OK. He actually just pulled right back and didn't say he was involved in any way with this because there was no documentation to that effect. He had not signed the trace and so there was nothing to say he had been associated with it. That was quite hard, knowing that he was not going to stand by me as a colleague, even as a medical colleague in saying "You know I did say to you just keep going".

Like all of the stories in this study, Caroline expresses the hurt and despair that accompanies a traumatic practice experience even eighteen months after the event. Her trust in the registrar is destroyed as he remains silent, effectively denying his part in the care of this woman. Caroline goes on to state that while her trust was destroyed it did make her ensure that in the future she would document all consultation however minor demonstrating a positive outcome.

Mertle experienced a similar situation to Caroline when trying to advocate for a caesarean section for the woman for whom she was providing care.

The registrar was fairly new and often very flippant with his comments. 'She's a primip she has only been pushing for two hours even with an induction and synto'. I replied that 'There is nothing on view even at the height of a push' and he said 'Well you know she is only a primip'. When we got to the six hour stage he had gone off call. I did see him later on and one of his comments was "Mertle did you say it the way it should have been said because obviously I did not hear". I disagree with his comments as I have had no problems with communications in the past or since this event. I also lost faith in the obstetrician for ignoring the protocol and letting the woman have a six hour second stage of labour.

Mertle's narrative provides evidence of a registrar's lack of competence coupled with his failure to accept responsibility for his clinical inadequacies. Lack of accountability causes Mertle to lose trust in the relationship she thought she had with him as well as in his competence to practice.

Mertle also lost trust in a hospital system that enabled those in power to ignore the protocols. At interview two I asked Mertle if she had lost trust in her ability as a homebirth practitioner.

No I did not and the reason why was because there is myself and my colleague and we have practiced for six years now. She's my left hand and I'm her right hand. I just know if any emergency arose that we would just deal with it because we had been in scenarios like undiagnosed breech births in a primary unit. We are rural midwives, we have dealt with PPH's we have dealt with APH's and we have resuscitated babies so I felt confident in what I could achieve. I felt that where my areas of weakness were my colleague could counterbalance that so no, I had no problems outside of the hospital system.

Mertle's comments demonstrate a trusting relationship where both midwives have confidence in each other's skills and knowledge and accept responsibility and accountability for their actions. According to Pullon (2008) relationships of trust demonstrating collaborative practice between doctors and nurses are the key to the effective delivery of best practice care. In her qualitative study which explored the relationships between nurses and doctors in a primary care setting in New Zealand Pullon (2008) found that where practitioners demonstrated competence mutual respect developed. The respect stemmed from the nurse and doctor having an understanding of each others' professional identities which enabled interpersonal trust to occur. Interpersonal trust between health professionals does not always occur (Pullon, 2008) as is evident in Judy's encounter with the obstetrician when he failed to accept her competence in dealing with vaginal breech births. Another example of lack of interpersonal trust was evident in the story told by Wendy about the GP with whom she worked closely and who did not contact her following the death of a baby:

He didn't contact me after the baby died. I felt let down really.

Wendy's interpersonal issue was relating to lack of communication whereas the interpersonal issues of Lillie and Judy were a result of competence stemming from different paradigms of care. Weedon's (2004) concept of cultural diversity suggests that rather than opposing one another doctors, midwives and managers, irrespective of the practice disciplinary should respect each other's philosophical differences.

Respect and collaboration should occur in order to provide quality care for the pregnant woman in a non-threatening environment based on trust and respect. Susan's story of a maternal death in chapter seven demonstrates practitioners respect for each other's philosophies and teamwork as all strive to save the life of a woman. Susan explains:

I called the obstetrician. but the team were doing an emergency caesar so I started putting an I.V., did bloods, put a catheter in. By that time the house surgeon came down to help and we started antibiotics. When the consultant came up she was transferred to ICU with a suspected septicaemia and DIC.

Trust is considered to be a social action in situations where a risk or future uncertainty is involved and decisions are required. However, in some circumstances the results of the action may outweigh the advantage of the action (Luzio, 2006). Susie's experience as a whistleblower, discussed in chapter four, raised her trust in the organisation to support her actions to improve care for birthing women but this did not occur. Instead she was abused and bullied by the obstetrician, ostracised by the midwifery community and felt she had no other choice but to relinquish her position as a midwife in the hospital. Confidence and certainty are essential components of trust therefore violation of trust has a greater significance for those who are vulnerable and in lower positions of power (Laschinger et al, 2000) such as Susie.

Part of the relationship between professionals and clients involves a degree of trust which is not always present in non-professional relationships however this trusting relationship may be destroyed by the action of others (Luzio, 2006). Trust from the woman versus mistrust from relatives created stress for Janet:

I did not fear litigation because I knew that it was nothing to do with my practice it was one of those really rare things a venomous insertion. People who were there at the time see you making every effort to do the best you can. It's actually people coming from outside, the aunts or mother-in-law, people that weren't even there. They are the ones that jump up and down and say shoot the midwife. There is a lot of that out there.

Janet's excerpt demonstrates that trusting relationships make a person vulnerable to the actions of people not involved in the relationship. The people who were passing

judgement on Janet's competencies were family members who were not part of the relationship and not present at the birth of the baby. These people were basing their comments on their own perceptions of what should have occurred and not on fact.

Vulnerability through being subjected to the actions of others is also demonstrated in Portia's narrative when unbeknown to her the woman, influenced by her family, had further antenatal visits and tests provided by her GP and sister, a registered nurse. Following the termination of the midwifery relationship the woman made accusations of incompetent practice against Portia:

It transpired that during the time I was doing her antenatal care she was going to her GP and her sister who worked in a health organisation and she was having blood tests and blood pressure checks and there was no documentation at all of any of that. I knew nothing of this and I was kind of angry when I found out.

Portia felt disappointed by the woman actions of accessing care behind her back as she believed they had a good midwife-woman relationship built on trust. Portia explains how her experience of betrayal of trust damaged her relationship with other pregnant women:

I lost having as much trust in women and I was very wary with women for a long time.

Betrayal of relational trust destroyed the heart of the midwife-woman relationship for Portia and some of the other midwives in the current study. Loss of trust in people for whom the practitioner cares is common when caused by a traumatic event (James, 1997) creating pain which differed in intensity depending on the severity of the incident experienced by the midwife. Bobby's story in chapter seven explains how she experienced pain when the woman informed the core staff she no longer required Bobby's services. Although it is uncertain as to why the woman did not want Bobby involved in her care the situation suggests interpersonal trust with caregivers requires consideration.

Trusting your caregivers

Trust is considered to be a fundamental factor in the provision of health care (Calnan & Rowe, 2008; Pairman & McAra-Couper, 2006) as it lowers social involvement on behalf of the client as they trust the health professional to help them overcome the problem and refer them to the necessary agencies if required. As a result of this belief the trustor is also provided with a sense of security (Calnan & Rowe, 2008). Trust involves believing the person is honest, sincere and will not intentionally do you any harm (Russell, 2005). Luzio (2006) suggests that client trust is impersonal trust based on two factors; one is that professional relationships have a specific function. Two is the trustworthiness attributed by society to the institution and members of specific profession therein. The professional behaviour expected in the consultation process promotes client trust in the professional and the institution (Luzio, 2006). Ill health creates a vulnerable state for the patient who in most cases trusts the competence of the health professionals and the organisation involved in his or her care (Brownlie et al, 2008; Goudge & Gilson, 2005).

In the current study trust in the midwife-woman relationship is demonstrated in Susan's story in chapter seven who after having cared for Tui in her previous pregnancies was requested to provide care in Tui's third pregnancy. The family also trusted Susan to cope in the emergency situation she was presented with when she took Tui to hospital. In his research which explored how patient-provider relationships and trust influenced treatment decisions in two low income areas of Colombo, Russell (2005) defines trust in health care as "user confidence that the health worker, and the system which they represent, works for the best interests of the patient and has the technical and personal competencies to do so" (p.1398). Confidence in the health worker is supported by Calvert (1998) in her grounded theory study that explored the way decisions were made in the midwife-woman relationship. She found the women trusted their midwife to support actions that would lead to the birth of a healthy baby which implies that the women also developed a trust in the knowledge of the midwives. Fleming (1995) found that trust occurred as the midwife-woman relationship developed and attributed this

development to the relationship being one of reciprocity rather than power. In her study that refined the midwifery partnership model of care Pairman (1998) suggests that unique to the midwifery profession, as opposed to other health professionals involved in maternity care, is the ability to build a trusting relationship with the woman over a defined period. An example of a relationship of reciprocity was apparent in Chapter Six when Wendy answered the woman's calls for help when she could not feel her baby moving. The woman trusted Wendy's assessment that all was well. Despite the reassuring CTG tracing the baby was born with a severe congenital heart condition yet no blame was attributed to the midwife by the woman.

Trust within the midwife-woman partnership may support information sharing and assist with decision making. In this relationship the respect that each has for the other enables both midwife and woman to expose their vulnerabilities (Pairman & McAra-Couper, 2006). The exposure of vulnerability within the midwife-woman partnership was evident in the story of Rose when a woman with a history of a previous stillbirth dismisses Rose's thoughts of incompetence by insisting Rose care for her in labour. The feelings of incompetence were a result of Rose having just cared for a woman who had died in childbirth the previous day as she states:

I cannot look after you because I am not competent to look after you. The woman said to me "There is no other midwife I want other than you." and that was like gob smacking, you know. I said "No you have not heard what I have said". She replied "There is no other midwife I want other than you".

Susan also cared for a woman who had died during childbirth; trust in her competence was expressed by a friend of the deceased:

The terrible part about it was that Tui's best friend was also pregnant and I was looking after her. She broke her waters the night Tui died. This woman wanted me to look after her which I thought was absolutely wonderful and really brave of her. I, in a way, felt so overwhelmed with grief but at the same time I wanted to honour that girl's request for me to look after her.

The actions of these two women toward Rose and Susan demonstrate the two underlying components of trust "the willingness to be vulnerable in a situation of

risk and confident positive expectations” (Dietz, Gillespie & Chao, 2010, p.3). The women were aware of the maternal deaths but insisted on being cared for by their respective midwives therefore positioning these midwives as safe practitioners. The women recognized the midwives vulnerability and extended support and trust. The women’s actions demonstrate not only a trusting relationship but also an understanding that things can go wrong unexpectedly in childbirth and that a satisfactory solution to the situation does not necessarily involve casting blame on a practitioner. The importance of supporting the midwife in her time of need and requesting her expertise during labour and birth was paramount for these childbearing women. The support provided by the women to Rose and Susan is specific to the experience of the self-employed midwife and would be unlikely to occur for the core staff. The women who access the hospital services receive care from a number of different midwives (McIver, 2002) and are usually unaware of the events that occur for midwives with whom they have no prior relationship. Rose and Susan’s stories also demonstrate the public expectation that practitioners will carry on providing care regardless of the circumstances (Morrissette, 2004) especially when a relationship of trust has been established.

Excerpts from stories have provided examples of violations of trust that occurred for the midwives in the current study from doctors, managers, midwives and women and their families. The stories demonstrate that midwives should be conversant with political and organisational influences such as the dominance of the medical profession as well as the neoliberal reforms on the midwife-woman relationship. Midwives should also be conscious of the impact family and social contacts have on the woman’s decisions that influence her care. Failure of management to ensure a safe working environment implies a dysfunctional organisation and was evident in the midwives’ narratives.

Dysfunctional Workplace/Organisations

In this section I argue dysfunctional health organisations resulting from structural changes that introduced competitiveness-based productivity into health care are

responsible for reduced staffing levels and skill mix. These malfunctioning systems also failed to implement policies that enabled autonomous midwifery practice to occur. Reduced staffing levels and failure to incorporate autonomous midwifery practice into policies contributed to destructive debriefing sessions. These destructive debriefing sessions focused on blaming the individual rather than considering a fault within the organisation thus breaching the trust between midwife and management and exacerbating the effects of the traumatic practice experience.

Dysfunctional organisations are a result of malfunctioning systems, unethical behaviour, loss of trust, bullying, organisational deviance, personality disorders and mismanagement (Langan-Fox et al, 2007). It is suggested that dysfunctional organisations that impact on individuals are a result of changes within the organisational structures such as the move to competitiveness-based productivity (Hyde & Cooper, 2001). In public hospitals competitive-based productivity meant shifting control of care from the health professional to the manager, intensified monitoring of staff in order to improve quality of care and reduce costs. Closing wards, reducing staff or using unskilled staff are cost saving measures. Closing wards would be frowned upon by the public therefore the only option left to management, as a result of the organisational changes, is the reduction of labour costs (Worrall et al, 2007). In the hospital environment staffing levels may be reduced resulting in heavier workloads for those who remain and whose performance is also monitored (Worrall et al, 2007). In the maternity sector in New Zealand one of the spin offs of the introduction of the midwife as the LMC meant that there was a potential to reduce labour costs. The LMC is contracted to the Ministry of Health thus shifting the financial costs for primary midwifery services out of the DHB. Secondly the introduction of the midwife LMC is in accordance with the government's recommendations for appropriate community based services that were cost effective (MoH, 2001; Engle, 2000; MoH, 1996). The LMC midwife provides a community based service to childbearing women which includes the provision of postnatal care. The provision of postnatal care makes it possible to

reduce the timeframe for hospital postnatal stays for women thus again bringing down facility costs.

The change in the system from professional to managerial control and failure of management to listen to the concerns from some members of the midwifery profession in relation to reduced staffing levels were evident as Anita explains:

Recently the staffing situation has been very minimal and you had to work with unsafe staffing conditions which I did complain of from time to time. On this particular occasion I was looking after a woman who was having twins, IVF babies. I also had two or three other unit women to look after. The postnatal ward was very busy and there was no help from anywhere. I was asked to help and run the ward unit as well as look after the women in delivery suite. The unit was extremely busy; there was one other core midwife on with me.

The organisation has a responsibility to the midwife to ensure she has the resources to meet her professional obligations (MoH, 2009). When this does not occur the midwife may be positioned or position herself as incompetent. Anita was concerned that her inability to continually remain with a woman in labour with a twin pregnancy would show her up as being incompetent. Yet looking beyond the individual, it is the system that is at fault as there was minimal staff on duty.

Blaming the employee rather than listening to their concerns is a form of neglect. The negative consequences of employee neglect were illustrated in a study by Gill, Sypher and Sypher, (2009) who over a four month period examined the relationship between civility and trust in an information technology (IT) workplace. The study found that the organisation's move to a competitive-based model altered the relationships between worker and manager who previously valued the employee's wellbeing. The negative consequences associated with employee neglect was reduced commitment and loyalty, decreased morale, high staff turnover, workers refusing to help others and simultaneously participating in destructive communication practices (Gill, Sypher, & Sypher, 2009). These destructive communicating actions of incivility demean, demoralise and degrade others threatening communities, democracy and the trust required for both. The actions are not always subtle and unintentional however the less intense levels of rudeness

were associated with employee's low levels of interpersonal and organisational trust that became more destructive overtime (Gill et al, 2009).

The issue of employee neglect is present in a study by Worrall, et al (2007) in the UK that assessed the scale and complexity of organisational change and the managers' view on this change. The study found that in the public sector lower motivation, poor morale and heightened concern about employee well-being were issues relayed by the manager participants. The managers also believed that absence, sickness, the level of industrial action and staff turnover were all a result of these organisational changes designed to enable the public sector to be run on free market principles (Worrall et al 2007). The midwives narratives in the current study suggest that governmental changes associated with competitive-based productivity was the catalyst for the reduction of staffing levels and skill mix within the maternity units. These structural changes were also the precursor for the midwives' workplace stress and led to a loss of trust in management.

Anita and Emma lost trust in management as they failed to address their concerns in relation to safe staffing levels. According to Mohr and Batalden (2002) dysfunctional health organisations lack effective communication systems between the organisation and the clinical microsystems of which maternity is one. Communications failure leads to human error which can be dealt with in one of two ways (Reason, 2000). One approach concentrates on the blaming and shaming of the individual while the second employs a systems approach which concentrates on the working environment and implementation of strategies to reduce or avert errors (Reason, 2000). Understanding the 'vulnerable systems syndrome' (Reason, Carthey & Leval, 2001) is essential for the improvement of adverse events and ultimately patient care. The pathologies associated with this syndrome, "blame, denial and the pursuit of the wrong kind of excellence" (Reason, et al, 2001, p.21) are present to some extent in all organisations and are associated with the individual approach. By blaming the individuals and trying to change behaviours the organisational management believes that it has improved patient care thus denying

its own responsibility. Using the systems approach managers accept that errors are part of a system not a single cause and make global changes that will achieve both safety and financial goals (Reason, et al, 2001).

An example of an individual approach occurred at a debriefing session when Emma was blamed for not getting the woman an epidural despite having informed those present at the debriefing session that her request for an epidural was denied as no anaesthetist was available. Using a systems approach the group would have acknowledged Emma's situation and considered why the anaesthetist was not available. The management would then look at strategies to ensure this did not happen again. Such an approach to Emma's situation would make her feel valued and listened to by management and ease the stress of the situation.

Lillie provides an example of shaming and blaming behaviour that resulted in her feeling unsupported. Lillie states:

The debriefing was anything but supportive. It was a waste of time

In health institutions the individual approach to debriefing dominates and inhibits the growth of safer healthcare (Reason, 2000). In their prospective cohort study in two tertiary hospitals in America, Leape, Bates and Cullen (1995) investigated systems failures underlying the causes of potential and adverse drug events; 334 errors were detected as the cause of 264 adverse drug events. The finding showed 16 major systems failures. The first seven failures (29% of the 334 errors) were associated with impaired access to information. The remaining nine failures were associated with management issues such as safe staffing levels and job allocation. The study demonstrated that an individualised approach to identifying and addressing error has little effect when hospital systems are also at fault.

Maintaining employee trust during times of organisational change is important. Change can also require individuals to relinquish old values and beliefs and adopt new ones. These changes make the past seem safe and secure and the future

uncertain (Hope-Hailey et al, 2010). Midwives in New Zealand have not only had to deal with the organisational changes within maternity departments as hospitals moved toward competitive-based models but also to the legislative changes surrounding midwifery practice. The 1990 Amendment to the Nurses Act which introduced autonomous practice coupled with the HPCA Act(2003) resulting in the establishment of the Midwifery Council and the subsequent introduction of the Recertification programme and requirements that surround this Act have created enormous changes for midwives.

These changes altered the identity of the midwife from the doctor's handmaiden to an independent practitioner thus creating a situation in which biographical disruption may occur. The current study illustrates how some organisations neglected the midwife by failing to support her to make these changes thus creating tension between external requirements and internal restraints. Inhibiting the right of the core midwives to practice autonomously created stress and according to McIver (2002) made some midwives feel devalued and others believed their practice was not current. Feeling stressed and devalued creates a loss of trust in the system and are signs of a dysfunctional organisation (Langan-Fox et al, 2007).

The current study links governmental changes in the distribution of the economy within health institutions and the legislative changes that enabled autonomous midwifery practice to workplace stress. The stress resulted from communication issues at debriefing sessions, poor skill mix and staff shortages. Failure of management to implement strategies to cope with the change of the professional role of the midwife was another source of stress that caused midwives to lose trust in management. Loss of trust in management could be a precursor to counterproductive behaviours such as bullying.

Counterproductive behaviour

In this section I argue that counterproductive behaviours, such as workplace bullying, were experienced by the participants in the current study and created

feeling of mistrust. Counterproductive behaviour refers to an intentional act by an employee that is contrary to the interest of the organisation or its employees (Penney & Spector, 2008; Mark, Matinko, Gundlach & Douglas, 2002; Sackett, 2002) thus disregarding the values and rules of the organisation and society in general (Mark et al, 2002). These actions involve damage to property, possession or evidence of use of alcohol or drugs, poor attendance, poor performance, inappropriate verbal actions or inappropriate physical actions. Counter productive behaviours also include misuse of time and information (Penney & Spector, 2008; Mark et al 2002; Sackett, 2002) revenge and blame characteristics (Penney & Spector, 2008; Mark et al, 2002), mobbing, bullying and employee abuse (Penney & Spector, 2008). An example of employee abuse occurred in Louise's narrative when her employment was terminated as a result of misinterpreting a CTG tracing as discussed in chapter eight. However in Louise's narrative the manager failed to communicate her concerns about the CTG tracing to Louise as she explains:

I never knew about the managers concerns until about two months after the event when she called me into her office and told me what she had done.

The key to a trusting working environment is for the manager to display openness and transparency which is not always easy to do. They should recognise that despite the best planning possible people make mistakes and learn to distinguish between mistakes and botchups. Botchups occur due to lack of planning whereas mistakes are not intentional and therefore are acceptable as they indicate research and planning for a safe outcome (Reason, 2000). Individuals can learn from mistakes which is the purpose of a risk debriefing session following a traumatic event. Communicating her concerns to Louise about the CTG tracing would have instigated respect and trust from Louise for the manager however this did not occur.

Moods influence behaviour. Individuals in a negative mood will focus on negative events and overestimate their future occurrence; those in a positive mood will do the opposite (Penney & Spector, 2008). The influence of moods on behaviour was demonstrated by Anandakumar, Pitsis and Clegg, (2007) who found that the manager's negative moods resulted in counterproductive behaviours that created

fear and stress for the staff of a neonatal unit in Australia. The implications of personality influencing counterproductive behaviour (Mark et al, 2002) could account for the demonisation of Louise by the manager whose behaviour is representative of an occupational psychopath (Clarke, 2005) or workplace bully (Needham, 2003). Characteristics, both internal (guilt and shame) and external (anger/frustration) and the style of the attribution of an individual play a large role in the development and demonstration of counterproductive behaviour in organisations (Mark et al, (2002). Moods influence behaviours as they affect information processing. Consideration must also be given to the impact of institutional changes within organisations that influence the manager's mood due to a lack of control which inhibits managers from meeting requests to improve staffing levels.

Negative responses by core staff to LMC midwives in the current study resulted in the midwife feeling lonely and isolated creating negative emotional effects. Losing confidence in one's skills as a result of bullying was apparent when Lillie's assessment of a non-reassuring CTG tracing was challenged and laughed at by the obstetrician and the LMC. Consequently the pregnant woman was sent home:

Emotionally this affected me, I lost my confidence, and I suddenly did not want to give my opinion on things I back away from comments on tracings. It made me doubt myself and I kept thinking of what other possible mistakes I had possibly made and make women have unnecessary sections because I was not happy with fetal tracings.

Noting the need to focus on a shift of behaviour overtime in connection with workplace deviance throughout South Eastern USA, Judge, Scott and Ilies (2006) demonstrated that most of the changes in deviant behaviour were within the individual and influenced by their state of mind and job satisfaction. The inferior position perceived by some core midwives (McIver, 2002) could be another reason to account for the anger they exhibit and the frustration they feel toward LMC midwives. Anita explains how heavy case loads reduced her job satisfaction:

I have always felt I have given 110% of my time to the person that I have been looking after. On this particular occasion I was looking after a woman who was having twins IVF babies and the unit was extremely busy, there was another core

midwife on with me, I had two or three other unit woman in delivery suite to look after. The post natal ward was very busy and there was no help from anywhere. I was asked to help and run the ward unit as well as look after this woman with twins. At the end of the shift I felt I cannot go on like this any longer.

Anita gave up midwifery practice as a result of what she sees as abuse by management failing to provide a safe working environment. Abuse of employees by management is a counterproductive behaviour (Penney & Spector, 2008) that creates stress and impacts on the worker's job satisfaction.

Working in birthing areas is routinely stressful for staff (Anandakumar et al, 2007) added to this stress are the general workforce issues that exacerbate its presence as Anita's story has portrayed. Stress that accompanies job dissatisfaction is due to a lack of resources defined as time, knowledge, money, personal characteristics and support (Hobfoll, 1998). Absenteeism and staff turnover are means of individuals coping with the actual or potential loss of resources and are strategies to prevent depression (Brough, O'Driscoll & Kalliath, 2009). Lack of job satisfaction, absenteeism, poor job performance and staff turnover influence the maintenance of long term organisational goals (Brough et al, 2009) and ignore the functions of the organisation. Anita's decision to leave the midwifery workforce reduced staffing levels even further potentially impacting on the running of the organisation.

Counterproductive behaviours affecting the health of the employee is illustrated in Caroline's narrative showing the misuse of information by staff the day after the birth of a neonate under her care. The baby had been successfully resuscitated but subsequently developed seizures. Caroline's care is scrutinised by her colleagues as she explains:

I was in delivery suite looking for the clinical director when it just hit me like a sledge hammer, the looks from the other midwives and medical staff in delivery suite. I kept thinking what is going on here? What do they know about the case? I found out that they had taken the woman's notes and they'd passed them around and read everything in the notes and they made their decision that I had failed to provide the best care possible. Different people made judgments on the record keeping and on the care that my second midwife and I had provided. I went home stomach churning, you don't want to eat you feel as if you are going to vomit, all the time your mind is just constantly going over and over the situation. What

could I have done differently? What did I do wrong? The incident did not make me stop practicing it made me scared in practice. Every time I have to do an induction, especially for a post term post dates baby, I go into delivery suite and I relive what I went through that time and the fear rises in my chest. I think I do not want that to happen again.

Caroline's story provides an example of how the bullying may be instigated by rumour, gossip and unprofessional behaviour associated with the resuscitation of a newborn baby. A breach of interpersonal trust is associated with competence and communication (Goudge & Gilson, 2005) and for Caroline resulted from conflicting paradigms of care between practitioners. Caroline's fear associated with caring for women having an induction demonstrates how counterproductive behaviours can impact on the workforce.

Loss of trust in the system and in an obstetrician is present in Suzie's story. Suzie challenged the bullying actions of the obstetrician toward a young Maori woman and suffered the consequences.

That started a whole chain of events which lead to my alienation as a midwife on the staff. When I was working the Occupational Health and Safety people came to make sure that the obstetrician, was not on call. The effects were devastating. We moved and settled in another town. This incident cost me my marriage. I lost my confidence and suffered the symptoms of Post Traumatic Stress disorder.

Margaret discusses her experience with a staff member when a woman under her care was admitted to ICU due to a postpartum haemorrhage

"I don't know who let this happen to her but they never should have let it happen" I said actually I was her midwife and I was there when it happened and if you want to know there wasn't anything that anybody could have done to predict it or stop it happening.

Bobby's story demonstrates how counterproductive behaviours that occurred in another part of the organisation can impact on the image of midwifery.

At a Mental Health Workshop recently one of the presentations was on the woman's point of view of the midwife that cared for her. When I heard the speaker maligning her client's midwife it actually made me really angry because I thought she is maligning the midwife and that midwife has got no come back here.

These inappropriate verbal actions alter the image of the midwife and create fear and uncertainty in those present about the care that midwives provide and also the

midwife's ability to provide care. Accusations against midwifery practice created from rumour and gossip demonstrate how conflict is generated between professionals and creates stress and a loss of trust.

Part of the expectations of the midwifery habitus is that midwives will support one another and respect each other's differences (Guilliland & Pairman, 2010; NZCOM, 2008). The findings from the current study demonstrate that this does not always occur and that violence toward midwives is both apparent and distressing. Emma experienced rumour and gossip containing accusation of incompetent practice following what was perceived as a long second stage. Accusations of incompetence occurred as a result of conflicting paradigms of care in relation to the management of the second stage of labour. Being accused of incompetent practice was stressful for Emma and caused her to doubt her clinical ability:

I had long talks with the second midwife present at the birth. "What did I do wrong at the birth I could have changed?" and she said "You did everything right.

Both professionals and consumers trust organisations to provide an environment that is safe and conducive to good care; unethical behaviours identified by participants include bullying, human rights issues, physical abuse, rumour, gossip and silencing. These behaviours challenged the professional and personal identities of staff, create a negative working environment and depict dysfunctional organisations with all their failings. There are several means by which organisations may prevent or reduce counterproductive behaviour however a comprehensive discussion of this literature is outside the scope of this thesis. Recommendations to reduce the hostility that accompanies workplace dysfunction includes fair supervision of staff that is interpersonal and respectful (Judge et al, 2006) and would certainly be an asset in reducing trauma in the midwifery workplace.

The narratives in this study have illustrated how these health organisations have failed to meet their contractual requirements to provide an environment in which

consumers can receive safe and competent care. A safe health care environment not only means adequate equipment and sufficient staffing but one that is free of violence (Langan-Fox et al, 2007). The adverse events discussed by the midwives in this research such as the misinterpretation of a CTG recording or the perceived inadequate resuscitation of a neonate were not intentional acts of unsafe practice yet subjecting the midwives involved to shaming and blaming debriefing sessions indicates otherwise.

An environment of subservience, control and blaming that creates fear is not a healthy environment and needs to be replaced. The new environment should be one where employees respect management because threats and promises have been replaced by celebration, recognition and rewards (Needham, 2003). In the case of a traumatic practice experience the reward would be a safe working environment, support of management and colleagues, listening to the midwife's narrative and providing psychological debriefing and/or professional supervision. A positive environment of relational trust could retain the personal and professional identities of the midwife and prevent adverse health issues and workplace attrition.

The effects of a traumatic practice experience

The study has identified that it was the meaning of the event that impacted on the midwife's personal and professional identities creating biographical disruption. The disruption exacerbated the initial physiological and psychological reactions associated with adapting to stressors. Loss of identities created grief which in most instances was disenfranchised grief and as a consequence very little if any support was available. Consequently, lack of support increasing the physical and psychological symptoms already experienced. Debriefing sessions were destructive rather than constructive indicating counterproductive behaviours that are present in dysfunctional organisations. The underlying meaning of the event, or the gap in the story, for the participants was a breach of relational trust. These breaches of trust further exacerbated the stress reactions and led to chronic conditions such as PTSD,

anxiety and chronic back pain. Consequently midwives changed their mode of practice or gave up midwifery practice altogether.

A trauma model for midwifery practice derived from the commonalities originating from the data collected for the study is diagrammed below. The commonalities symbolize the individual struggles and emotions experienced by the participants as interpreted by the researcher. These commonalities have been threaded through the substantive chapters (four to nine), discussed individually and illustrated using the words of the participants. While the model was developed from the narratives of the participants in this study it could be applicable to any situation that creates a disruption in a person's life.

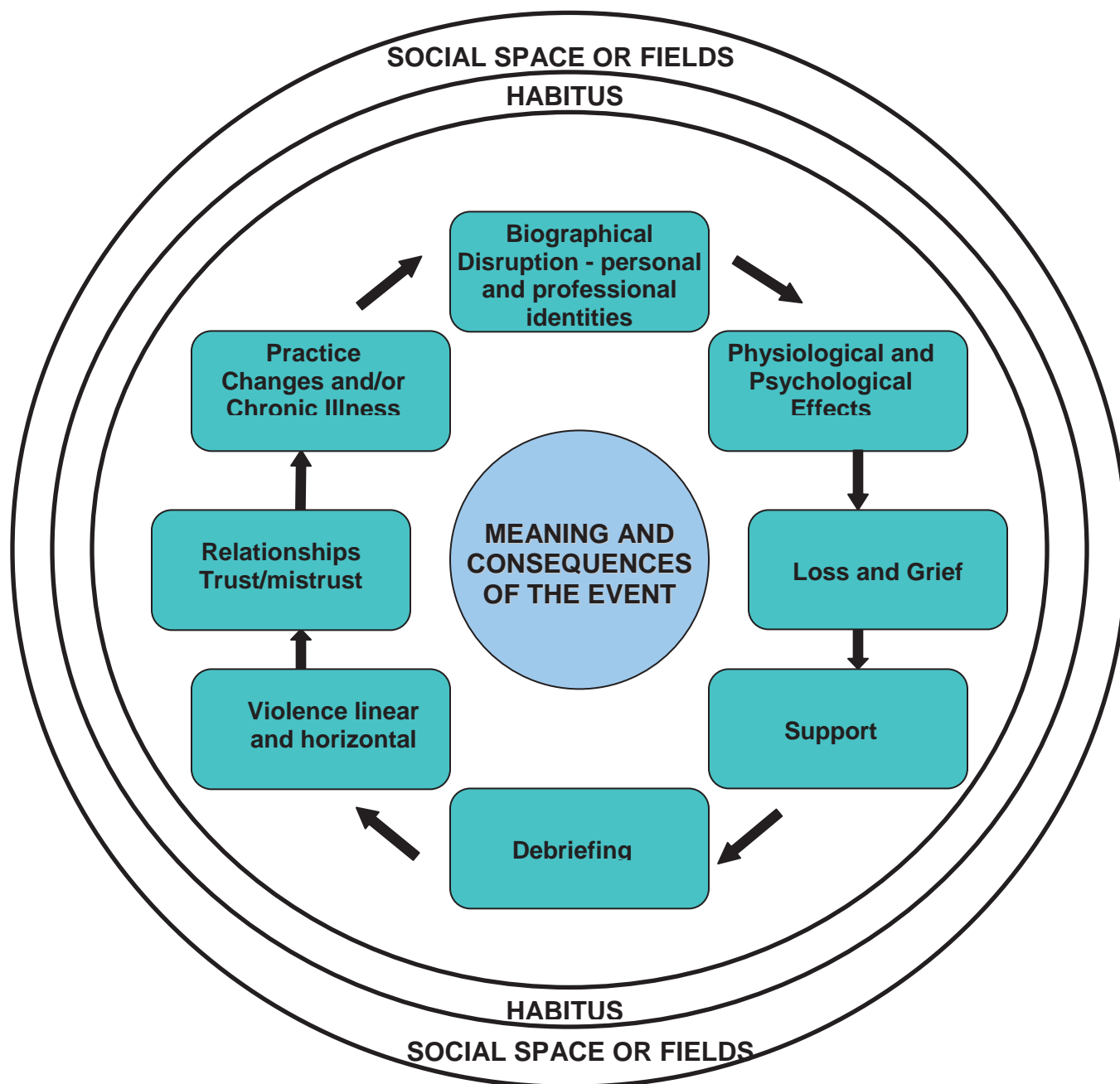


Fig 2. Trauma model - The Effects of a Dramatic or Traumatic Practice Experience on the midwife

Summary

The chapter illustrates how dysfunctional health organisations and the counterproductive behaviours therein, have contributed to the midwives' traumatic practice experience. The loss of relational trust occurred as organisational management failed to meet their contractual requirements of providing an environment that is free of violence and in which consumers can receive safe and competent care. The participants felt the managers were more focused on their budget than the emotional requirements of the staff. Although the behaviours of these managers cannot be condoned they can be explained as resulting from changes within the organisational structure leading to practices that are counterproductive to the health of the staff and the safety of the organisation. Lack of understanding of these changes by midwives led to counterproductive behaviours as did conflicting paradigms of care. Midwives were subjected to violence and abuse from managers, doctors, midwifery colleagues and women that were not warranted consequently the midwives lost trust in the system and/or the abuser. Loss of trust was the major factor that exacerbated the stress associated with the initial trauma and was the straw that broke the camel's back. A trauma model has been developed from these common threads and is presented on page 273. Suggestions as to how some of these counterproductive behaviours may be rectified and recommendations for further research are provided in the following chapter.

Chapter Ten: The effects of a traumatic practice experience, recommendations and conclusion.

I want to say how much I really believe in the research topic; it has been going on for years but it has been under reported. It is only now with this research that we are starting to look ahead. It's not just about the road to recovery it is what you are left with. You do feel that you have lived it. (Susan)

Introduction

Narrative methodology has been an ideal approach to explore the effects of a traumatic practice experience on the midwife. The eclectic narrative method used adds a new dimension to midwifery practice research in New Zealand. The method has enabled the midwives to tell their stories in a safe environment and in some cases the interview instigated the healing process. Using a modified biographical narrative interview method was beneficial in that in interview two I was able to confirm with the participants that the trauma was exacerbated due to a breach of relational trust creating biographical disruption. The threads or commonalities that run through the thesis were also discussed.

The study has achieved the aim of the research which was to explore the effects of a traumatic practice experience on the midwifery practitioner. The substantive chapters (4 to 9) focused on the commonalities derived from the data analysis and illustrated in the trauma model on page 275. The research findings support the advice of the experts in traumatology (Weisaeth, 2006; Kleber, et al, 1995, Herman, 1981 & Daniels, 1984) that it is not the trauma that exacerbates the physiological and psychological effects rather the impact of the social structures involved and the environment of response. These factors account for how the 16 midwives have coped with similar experiences without any effect and indicate how on the occasion narrated the experience was “the straw that broke the camel’s back”.

This chapter reviews the main findings of the study and sums up the arguments that have been developed. A discussion of the complexities of a traumatic practice experience and the effects on the midwife serve as an overview of the main

theoretical and contextual ideas within the thesis. This is followed by an examination of relational trust which is a thread that is central to this thesis; relational trust when breached, destroyed relationships and disrupted lives. The chapter ends with the limitations of the study, suggestions for education, practice and further research.

The effects of a traumatic practice experience

The study, underpinned by the narrative concepts of Somers (1994), Frank (2005), Davis and Harre (1990) and Bourdieu's (1982) theory of economic practice, identified that the issues of partnership and autonomous midwifery practice are key drivers of conflict that make New Zealand midwives more likely to be blamed for unfortunate outcomes and challenge their competence in midwifery practice. The blaming of the midwife results from structural changes that have occurred since the 1990 Amendment to the Nurses Act and the introduction of the autonomous midwifery practitioner. Becoming an autonomous practitioner alters the midwifery habitus by changing the requirement for the midwife to work under the direction of a doctor. Midwives working in partnership with women attempt to substitute domination for collaboration and as a result challenges the beliefs of the dominant groups of medicine and management within health care settings.

The 16 midwives in this study told diverse stories incorporating issues of human rights and maternal death. Forms of symbolic violence and bullying are key factors in all but one of the stories but the overarching theme was that the trauma was exacerbated by a breach of relational trust in organisations, management, colleagues, women and in themselves. The breach of trust altered the meaning of the event for the midwife and impacted on her personal and professional identities creating biographical disruption. Loss of identities led to feelings of vulnerability incurring loss of confidence in knowledge and skills as the midwife questioned her own actions. For some loss of trust in their own competence resulted in practice changes or leaving the midwifery workforce.

In order to illustrate how the midwives attempted to cope with the disruption Bury's (1991) ideas of biographical repair have been outlined. Biographical repair contains the concepts of coping, strategy and style which I have interpreted to mean valuing (coping), action (strategy) and reaction (style). For example Mertle was disappointed in the obstetrician's discriminatory action toward a woman for whom she was the LMC (valuing herself). She stopped trusting him (action) but suffered mild panic attacks (reaction) whenever she had an interaction with him.

In the current study, irrespective of the perpetrator of the breach of trust, the environment of response demonstrated failure to recognise the midwives' grief resulting from the biographical disruption and failure to ensure their support needs were met. The lack of support further increased the stress response. Grief associated with maternal deaths was supported. Disenfranchised grief, such as that associated with the loss of identities, is awarded very little if any support (Doka, 2002). The grief and emotional distress connected with the disruption caused some midwives to develop a chronic illness such as backache, anxiety or PTSD. None of the midwives suffered a chronic illness prior to the disruption therefore verifying Turner's (2007) suggestion that emotions may be related to the aetiology of the disease. The study adds a new dimension to the literature on biographical disruption as it illustrates that disruption may not be a result of a chronic illness as demonstrated by Bury (1982) rather from a traumatic practice experience associated with a breach of relational trust and its consequences.

Risk management debriefing sessions focused on shaming and blaming the practitioners and were destructive rather than constructive. Psychological debriefing sessions were only available for the two midwives involved in a maternal death and were offered at the time of the event. A deficit regarding information on and how to access Employee Assistance Programmes (EAP) was evident.

The study has also illustrated that symbolic violence is prevalent through the maternity institutions discussed in the midwives' narratives. Symbolic violence is the violence applied to and in most incidences accepted by a person due to their inferior social position in the field. This ideological power contributes to political violence and is the basis of domination as it enables the beliefs and practices of a particular health field to reflect the views of the dominant group (Bourdieu, 1991). The belief of some that they have the right to perpetrate the violence is due to the cultural, economic and social value held by the bearers of the dominant position. The forms of symbolic violence identified in the current study occurred between doctors and midwives, managers and midwives, core midwives and LMCs and women, midwives and their families. The subtle way in which most of this violence occurred contributed to the breach of relational trust experienced by the participants.

The final words of Susan cited at the start of the chapter are echoed in the stories of other midwives who participated in this research. They have lived with the traumatic experience which destroyed relationships and disrupted their biographies. In the text gathered from these stories I have developed two theoretical models; one explains how the trauma is exacerbated rather than supported (Chapter Seven); the other outlines the effects of the trauma (Chapter Nine) that stemmed from breaches of relational trust.

An overview of relational trust

The study has identified a breach of relational trust as exacerbating or prolonging the initial physiological or psychological symptoms experienced as a result of the traumatic practice event. The perpetrators of this breach of relational trust were organisational and clinical managers, colleagues both medical and midwifery, women and their families.

Organisational breaches of trust

It was evident from the study that hierarchical structures within the health organisations that midwives accessed were being maintained despite the new health reforms which encourage collaboration between practitioners and women. The actions of those in power in these maternity units confirm Bourdieu's (1982) ideas that symbolic power, control and hierarchical relationships are influenced by social and economic capital attributed to individuals' roles within the institution. The effects of these hierarchical institutions are manifested in the experiences and targeting of midwives in this oppressive environment. Those midwives who resisted rather than conformed to the requests of the institution had to cope with the medical practitioners and their associated power games. What drives these midwives to resist is their respect for the woman's choice, their faith in the partnership model of midwifery practice and their right to autonomy. Midwifery autonomy was the key driver in the current study that threatened the dominant groups of management and medicine. Autonomy enabled the midwives to provide safe care based on the midwifery model of partnership, choice and informed consent as opposed to the dominant medical model of care with its focus upon power and control. Hospital policies and protocols tend to follow the risk management concerns of management and medicine rather than incorporating the holistic approach that is more characteristic of the midwifery model. By omitting the midwifery model of care into these policies and protocols the autonomy of some midwives was inhibited as they had to follow the orders instigated by the dominant groups of management and medicine.

The midwives trusted the organisation to implement policies that enabled autonomous midwifery practice to occur. Removing the midwife's right of autonomy is a breach of relational trust and was evident in Judy's (p.107) narrative in Chapter Four. Despite adhering to the Guidelines for Consultation with Obstetric and Related Specialist Medical Services which are referred to in the Primary Maternity Services Notice (2007), and subsequent recommendation Judy was prevented from supporting a woman to have an unassisted vaginal breech birth. The

delivery obstetrician, by his interpretation of the guidelines, chose to control the birth his way thus preventing movement within professional boundaries that would demonstrate respect for the paradigms of care of other professional groups.

Another factor in the study was that midwives and women trusted the organisation to meet their duty of care and provide an environment conducive to safe practice. However due to the neoliberal reforms and their focus on economy core midwives were expected to carry high caseloads of women and work in areas where the skill mix was inadequate. These deficits of staffing led to an unsafe environment creating stress for the participants as they were constantly required to compromise their practice. Anita (p.159) felt betrayed by the hospital management for not heeding her concerns in relation to safe staffing levels whereas Kathleen's (p. 138) concerns were related to skill mix. The betrayal of trust by management was the direct cause of these two midwives leaving the midwifery workforce. Failure of management to listen demonstrates how the social structures inhibit individual actions rather than developing methods that alter the character of the organisation (Calhoun, 1993). These unsafe environments also subjected birthing women to risk thus challenging the myth that the safest place to birth is a hospital.

Management breaches of trust

Following a traumatic practice experience the midwives trusted the management to provide an environment of response conducive to positive mental health. This implied the provision of support systems, acknowledging disenfranchised grief, listening to the person and a non-violent environment. However, for most of the midwives this did not occur. Evidence of rumour and gossip is rife throughout the midwives' narratives. Psychological debriefing sessions were rarely available and a deficit of knowledge in relation to obtaining access to Employee Assistance Programmes was apparent. Risk management debriefing sessions were destructive rather than constructive and favoured those in power. Doctors were not requested to be accountable for their actions; the midwife was blamed for situations that arose due to organisational deficits. For example, Emma was told that she should have

arranged an epidural for the woman when she had previously informed the group that she had been unable to do this as no anaesthetist was available. Such debriefing sessions demonstrate what Bourdieu (1982) refers to as a field or a site of struggle where individuals seek to maintain or alter their form of capital depending on their aim. Bourdieu (1982) believes that social fields comprise of and are shaped by relations of power which is evident in the way debriefing sessions described by participants were controlled by management and the doctors and was also obvious in the treatment of whistleblower.

In chapter four two stories are used to illustrate the impact of the medical profession and health management on midwives and their practice. The whistleblower (Susie, p.89) and the advocate (Judy, p.107) are not part of this system as they challenge the control entrenched in these institutions. The stories of Lillie (p.230) and Louise (p.218) in Chapter eight, both of whom are immigrants to New Zealand, highlight two practitioners who trusted the organisation to provide a safe working environment to enable them to adjust to their new country. However, they were subjected to feelings of guilt and shame as Lillie was silenced by doctors and Louise by the manager, both midwives had their expertise ignored. In contrast Kathleen's (p.178) stress associated with a lack of skilled personnel was supported by management and her ongoing professional supervision visits were increased demonstrating a positive environment of response. It must be acknowledged that Kathleen was in a junior management position which could account for the difference in response that was provided.

Collegial breaches of trust

Collegial trust was evident in Susan's (p.211) narrative as it demonstrates the provision of collaborative care between the midwife and the medical team displaying trust, support and compassion in a positive institutional environment of response. Another positive example of collegial trust was experienced by Judy when her colleagues supported her at the management meeting despite being

silenced by the hierarchy and denied the opportunity to contribute to the discussions.

Fifteen of the stories in the current study demonstrate breaches of trust influenced by counterproductive behaviours exhibited in dysfunctional organisations. In the midwives' narratives the conflict stemmed from the cultural and historical ideas present in the philosophical underpinnings of the medical and midwifery models of care (Martin, 1989) which influence the ideas of each habitus. The on call obstetrician prevented Judy from assisting a woman to have a vaginal breech birth which demonstrates conflicting paradigms of care. Rumour and gossip instigated by colleagues, both medical and midwifery, positioned the midwife as incompetent and was unjustified as demonstrated in Caroline's (p.202) narrative when staff discussed the care she provided to a compromised neonate without involving her. Workplace violence expressed in the form of silencing (Escartin, et al, 2009) or verbal abuse (Hogh, et al, 2008) perpetrated by peers and management was experienced by Emma (p.196) in relation to the care she provided to a woman during the second stage of labour. Midwives found it difficult to understand why they were exposed to this type of behaviour from midwifery colleagues. This was especially true of Louise (p.223) who as a new immigrant had trusted her fellow midwives and considered them friends.

Women and breaches of trust

Trust and respect are key factors in the reciprocal relationship that develops between the woman and the midwife within the midwifery partnership model of care (Guilliland & Pairman, 2010). This relationship of reciprocity was demonstrated by the two women who requested that Susan and Rose (p.164) continue to provide midwifery care to them despite being aware that these midwives had just been involved in a maternal death. Both women trusted in the competence of their LMC despite the midwife's feeling of incompetence and guilt. Another example of relational trust was experienced by Susie (p.92) when the

women of the community provided support for her fight to get the hospital management to address the behaviour of a particular obstetrician.

Despite such examples of good communication and trust a number of examples surfaced in the narratives that demonstrated partnership that was not based on open communication. One such event occurred when a woman accessed antenatal care without informing Portia (p.202) she had done so. Bobby (p.182) experienced another example of poor communication when she was dismissed as a woman's midwife without being given the opportunity for discussion. In these relationships the women have disempowered their midwives demonstrating a breakdown of equality and a breach of relational trust. It must be acknowledged that the women's actions could be associated with the grief that occurred as a result of an adverse outcome or the birth not meeting the woman's planned expectations.

Information from the study demonstrates that the trusting relationship that develops between the woman and the LMC midwife makes the midwife potentially more vulnerable to complaints against her practice. One core midwife who provides fragmented care suggested that lack of a long term relationship with a woman reduced the risk of complaints against core midwives. It would be interesting to compare the short term relationship of the nurses in hospital accident and emergency rooms to those of nurses who provide palliative care and consider these relationships of difference. Does the long term relationship make the nurse more vulnerable to complaints against her practice?

Limitations of the study

In this thesis a narrative research method of analysis was applied to the stories of a traumatic practice experience derived from the interviews of the sixteen participating midwives. Although the participants represent both core and LMC midwives from various areas of New Zealand, due to the small number of participants the findings are not generalizable. Rather the thesis brings to the fore relationship issues located in a social context relevant to space, time and place. As a

result the thesis requires the application of critical thought to social situations stemming from different philosophical underpinnings of care coupled with organisational practices resulting from economic reforms. The credibility of the thesis is enhanced by the inclusion of the midwives' narratives that provides a variety of individual realities. Nevertheless, there are other issues within the research that are considered limitations.

The participants in this research were not of Maori or Pacific Island descent but reflect the dominant ethnic group in midwifery. The Midwifery Council Workforce Ethnicity Statistics for 2009 (MCNZ, 2009) confirm that New Zealand Maori represent 4.6% of midwifery practitioners; Pacific Islanders 1.2% and NZ European, British, Irish and other Europeans 84.3%. Information regarding the study was sent to midwives from all ethnicities via the NZCOM regional newsletter but no response was received from Maori or Pacific Island groups. Information from these different ethnic groups may provide different strategies that helped the midwives cope with their traumatic practice experiences.

As this study used a dialogical method of narrative research to explore the effects of a traumatic practice experience on the midwife the stories from the perspective of the other characters in the narratives have not been addressed. Portraying the stories from the perspective of the managers, doctors, nurses, other midwives or women would provide a more balanced perspective of the event. However, these players were not the focus of this research.

Midwives in the current study have discussed the impact of their traumatic practice event on significant others who provided support. In this study the midwife was either the victim of the trauma, a witness to the trauma, or both. Therefore by witnessing her distress an impact on the midwife's family, friends and colleagues is inevitable. As I wished to explore the effects of a traumatic practice experience on the midwife considering the impact on significant others was beyond the scope of this study.

Two of the midwives' stories occurred over ten years ago and the remainder within 5 to 7 years therefore changes in the process of risk management investigations with a focus on systems issues could subsequently have been implemented within the settings in which the trauma took place.

Implications for practice, education and research

The findings have a number of implications for midwifery practice, education and research. It is evident that traumatic events can have a negative effect on the midwife. In order to reduce the stress the requirement for an environment of positive response needs to be addressed. As this is a qualitative research study I cannot make specific prediction as to what will prevent or reduce the effects of a traumatic practice experience. However, the findings from this study provide opportunities for reflection on and consideration of issues that need to be addressed in workplaces.

Violence -- As the researcher I have been exposed to the depth of the problems that result from a breach of relational trust and the impact on the participants' mental health which may not be apparent to observers in practice. I contend it is not only the responsibility of the health institutions or the midwife's professional body but also of the individual midwife to ensure the reduction and elimination of violence in the workplace. In order to help midwives understand the effects of traumatic practice events and the violence that surrounds them the following is proposed:

- Workshops should be made available to assist midwives to understand how violence in the workplace is established. A discussion involving a breach of relational trust, biographical disruption, collaboration and team work and respect for each other's philosophy of practice should be incorporated. What constitutes the violence, the implications for the individual and for organisations should also be deliberated. The workshops should stress the importance of all midwives accepting responsibility to eliminate violence by

refusing to tolerate or participate in malicious rumour and gossip. Initially these workshops should be a compulsory requirement of the recertification programme. The workshops should be implemented by the providers of the recertification programmes and led by an educator/facilitator with an in depth knowledge of grief.

- Managers should instigate zero tolerance policies toward violence in their work areas.
- Occupational health units should meet their duty of care in relation to workplace bullying by ensuring these zero tolerance policies are implemented and the Employee Assistance Programme (EAP) is visible and easily accessible by all employees.

Grief – It is evident from listening to the midwives narratives that disenfranchised grief is not acknowledged and therefore support is not forthcoming. The importance of the environment of response should be stressed.

- In order to assist midwives to sustain their practice workshops should be available preparing them to coping with trauma and grief in the workplace. The workshops should include the different types of grief, the importance of support and the different types of support available. The concept of resilience should also be discussed.
- **Support** -- The findings from this study have demonstrated that midwives require informal support from family, friends and colleagues and formal support such as psychological debriefing and professional supervision from experienced peers. The importance of professional supervision for midwives has been stressed by other researchers and educators in New Zealand (Ferguson, 2009; Lennox, Skinner & Foureur, 2008; Smythe & Young, 2008; Weils, 2008). A model for midwifery in New Zealand should be developed which incorporates the requirements of the recertification programme in order to enable this formal support to occur:

- NZCOM should be approached to access funding for professional supervision for all midwives. To support this claim evidence from this study should be provided to the Safe Staffing/Healthy Workforce Unit (2008) informing them of the need for emotional support for midwives in order to reduce the workforce attrition rate.
- I strongly recommend that MERAS members request a remit for professional supervision to be a part of the employment agreement for core midwives.
- Psychological debriefing sessions should be available when the midwife is ready and should be offered by a midwife preferably trained in this field or a trained therapist with knowledge of the maternity system. In order for this to occur formal training for midwives to undertake this task should be made available.

Debriefing --The study acknowledges the significance of risk management debriefing however:

- Managers should ensure that risk management debriefing sessions are constructive and focus on the system and not just the individual. By removing the ‘shaming and blaming’ aspect surrounding these debriefing sessions the managers are providing an aspect of a safe working environment. Managers should inform midwives of the purpose of the debriefing session (risk management or psychological) prior to attendance.

Further research

- The number of participants in the current study is small and may not be sufficient to convince the Minister of Health to invest in emotional support for midwives. To achieve this end I suggest that a quantitative national survey should be undertaken to ascertain if midwives think emotional support is required following a traumatic practice experience and what type of support midwives perceives should be available.

- A further study aimed specifically at Maori and Pacific Island midwives' experiences of traumatic practice events should be considered.
- A study exploring the effects on significant others while observing, living and working with a midwife who has suffered the effects of a traumatic practice experience should be undertaken.

Conclusion

A narrative method of research has been used in this study to explore the effects of a traumatic practice experience on the 16 midwife participants. Given the lack of attention perceived to be paid to trauma in relation to midwifery practice this study is invaluable, not only in identifying that a problem does exist, but also by demonstrating that the trauma was exacerbated by a breach of relational trust. The participants' stories have drawn attention to the effect of counterproductive behaviours that occur in dysfunctional organisations resulting from organisational structural changes as well as conflicting paradigms of care. The need for a positive environment of response that involves relational trust, collegial support, zero tolerance of horizontal violence or bullying, constructive risk management debriefing sessions and psychological support provided at the right time for the midwife should be paramount. Midwives are a small workforce with a responsibility that carries a duty of care for the health of the future generations. Midwives also carry a responsibility to their colleagues and therefore should refuse to tolerate malicious rumour and gossip. Midwives have a choice between ensuring that their colleagues are supported through these traumatic practice events or alternatively, accepting the consequences of the effect of workplace attrition on the work environment.

I believe the midwifery profession has a responsibility to honour the narratives of the sixteen midwives who have trusted me with their stories through taking seriously the issues related to trust identified in these stories. It is the hope of the participants as well as mine that by sharing their traumatic practice experiences

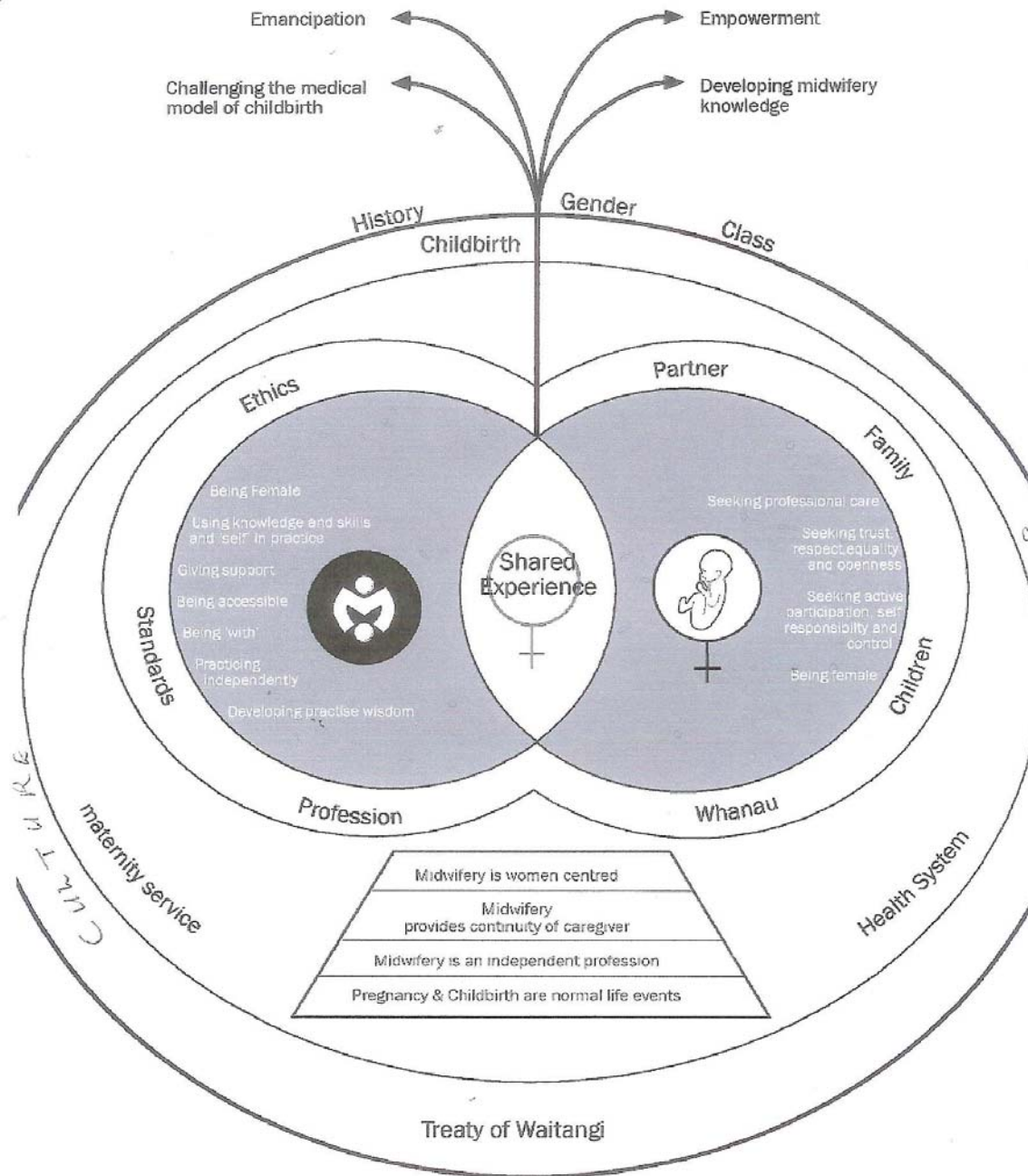
within the midwifery community the outcome will be the provision of collegial and psychological support and a behavioural change that aims to eliminate violence toward our midwifery colleagues in the future.

List of appendices

A	Midwifery Partnership Model
B	Template for Analysis
C	Ethics Approval
D	General Information sheet
E	Authority for the release of tapes
F	Questions for interview two
G	Pathway for Complaints women's business
H	Participants consent form

Appendix A

Midwifery Partnership model



Appendix B

Template for Data Analysis

Positioning	Competent midwife, incompetent midwife Safe/unsafe
Actors	Woman, Husband, Core midwife, G.P.
Actants (non-human things that impact upon the story)	Documentation, CTG tracing, institutional routines
Time (comes with the story)	2007, 41+3days
Space	Here and there – Regions of the North Island
Embodiment	Corporeality, pregnancy,, contractions, birth
Identity	Professional person, LMC, caring midwife
Formal support networks	Request for review of incident
Informal support networks	Neo-natal nurse, consultant, her 2 nd
Power	Obstetrician, G.P.Grandparents
Symbolic Violence	Colonized.
Silencing	Ostracized from the group
Us – them / Judgments	Core versus LMC/ Incompetent
Tension – release	PPH / Bleeding stopped. Baby dying/baby lived
Binary opposition	Language, metaphors used

Appendix C Ethic approval



Massey University

6 June 2007

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Dear Irene

Re: **HEC: Southern A Application – 07/21**
The effect of a dramatic or traumatic practice experience on the midwife

Thank you for your letter dated 22 May 2007.

On behalf of the Massey University Human Ethics Committee: Southern A, I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor John O'Neill, Chair
Massey University Human Ethics Committee: Southern A

cc A/Prof Cheryl Benn
School of Health Sciences
PN351

Dr Suzanne Phibbs
School of Health Sciences
PN351

Professor Carol McVeigh, HoS
School of Health Sciences
WELLINGTON

Appendix D

Massey Letterhead

The Effects of a Dramatic or Traumatic Practice experience on the midwife.

Information Sheet.

Introduction.

My name is Irene Calvert. I am a midwife and a student enrolled in the Doctor of Philosophy (Midwifery) Degree at Massey University. This qualitative research project that I am undertaking will evaluate the effects of a dramatic or traumatic practice experience on the midwife.

I wish to recruit approximately 10-20 midwives for this study. Please consider participating in this research if you meet the following criteria :

- You are a registered midwife with experience of a Dramatic or Traumatic Practice Experience that has had some impact on her life.
- This incident must have occurred since the 1990 Amendment to the Nurses Act and the introduction of the midwife as an autonomous practitioner.
- You are not involved in a review of the case by The Midwifery Council of New Zealand, The Health and Disability Commissioner, Criminal Court Proceedings or the Accident Compensation Committee. (The reason that I am unable to interview midwives that may be involved with any of the above bodies is that the tapes or transcripts could be called as evidence).

If you agree to participate in this study you will be expected to:

1. Be personally interviewed by the researcher where you will be asked to describe how you became a midwife, discuss your dramatic or traumatic practice experience and how you perceive this event. The interview will be tape recorded and will be transcribed by the researcher or a transcriber. At the end of the interview the researcher will reflect on the information provided and may then ask you questions in order to clarify or extend issues that you have discussed. The timeframe for this interview is expected to be approximately two hours in length.
2. Following the transcribing of the audiotape interview the researcher will contact you for a further interview. This interview may be either face to face or via the telephone.

Confidentiality.

Every effort will be made to maintain confidentiality throughout the research project to the level accepted by law. The data gathered from you for this study will be treated in the strictest confidence. Your name or any other identifying details will not appear on any documents. The only people that will know you are participating in this research will be yourself and the researcher, unless you choose to tell colleagues, friends or family. However, should any participant disclose any practice issue that may indicate to the researcher that she/he is unsafe to practice then the researcher has a professional responsibility to notify the Midwifery Council of the concern.

Participant's Rights.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time until the analysis of the data is completed;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;

- be given access to a summary of the findings when it is concluded.

I hope to commence the data collection in May 07 and be completed by July 08

Benefits of the Research

While any benefits arising from this study may not affect your past experiences of dramatic or traumatic practice events, they may affect you and your colleagues in the future. Telling your story may also have some therapeutic benefit for you.

Effects on the Participants

The telling of your story could evoke an emotional response. Should this occur I will consult with you about stopping the tape and/or ending the interview and depending on the situation recommend an appropriate avenue for assistance. (The Employee Assistance Program is available without charge for the core midwife but a charge for the self employed midwife could be incurred.).

Reimbursement

In recognition of your time and to cover any expenses incurred a \$20-00 petrol voucher will be given as a koha to each participant.

Results.

On completion of the research, the data will be held for a period of the time (5 years) as stipulated by the requirements of Massey University, they will then be destroyed. If you wish to receive a summary of the research findings they will be made available to you. A copy will be sent to the address provided by you at the completion of the second interview.

A thesis for examination and at least one article for publication will be produced from this research. Aspects from this study may also be presented at conferences.

If you wish to participate in this study please contact me on

Phone 021-0563292.or email Suec@xtra.co.nz

If you have any concerns about this study you may contact one of my supervisors:

Assoc. Professor Cheryl Benn

School of Health Sciences

Massey University

Palmerston North

06-350-5799 x 2543

Email – C.A.Benn@massey.ac.nz

Dr. Suzanne Phibbs

School of Health Sciences

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06-350-5799 x 2319

S.R.Phibbs@massey.ac.nz

Approval

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 07/21. If you have any concerns about the conduct of this research, please contact Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 8771, email humanethicsoutha@massey.ac.nz.

Thank You

Irene Calvert.

Letterhead

16, Olliver Grove
Waikanae Beach
6010

Research into the Effects of a Dramatic or Traumatic Practice experience on the midwife.

Appendix E

Massey Letterhead.

The Effects of a Dramatic or Traumatic Practice Experience on the Midwife.

AUTHORITY FOR THE RELEASE OF TAPE TRANSCRIPTS

This form will be held for a period of five (5) years

I confirm that I have had the opportunity to read and amend the transcript of the interview/s conducted with me.

I agree that the edited transcript and extracts from this may be used by the researcher, Irene Calvert in reports and publications arising from the research.

Signature:

.....

Date:

.....

Full Name - printed

.....

Appendix F

Second Interview (Subsession three) BNIM

The purpose of the second interview, subsession 3 may require the researcher to consider:

- Questions derived from subsession one and two
- Questions arising from the research objectives

The following themes have been derived from the initial data - support – effect on the midwife – violence – debriefing – leaving or altering midwifery practice. I should like to ask questions on the following issues:

Question One – Support

- Were there any barriers to you getting support?
- If you received no support what type of support would you have liked to receive?
- Do you think NZCOM could have helped with this support?

Question two – Violence

- Violence can be from managers, doctors, colleagues and women.
- How do you think we can help to reduce this issue?

Question three - Debriefing

- What type of debriefing if any would you like to see introduced in to practice?
- Risk management
- With Colleagues
- Mental health worker
- Mental health worker with midwifery supervision
- Supervision

(Clarification of the above will be provided as part of the interview).

Question four

Did you find talking and reading about your experience of any help?

Question five

What kept you going throughout this experience?

Question six

Do you envisage the traumatic event would have been any different if you had been a core/LMC midwife?

Question Seven

Some candidates indicated they may leave or change their form of midwifery practice.

The following question applies to these candidates.

- Have you left or changed your method of midwifery practice?

All of these questions may not apply to you or may need to be arranged to fit your story.

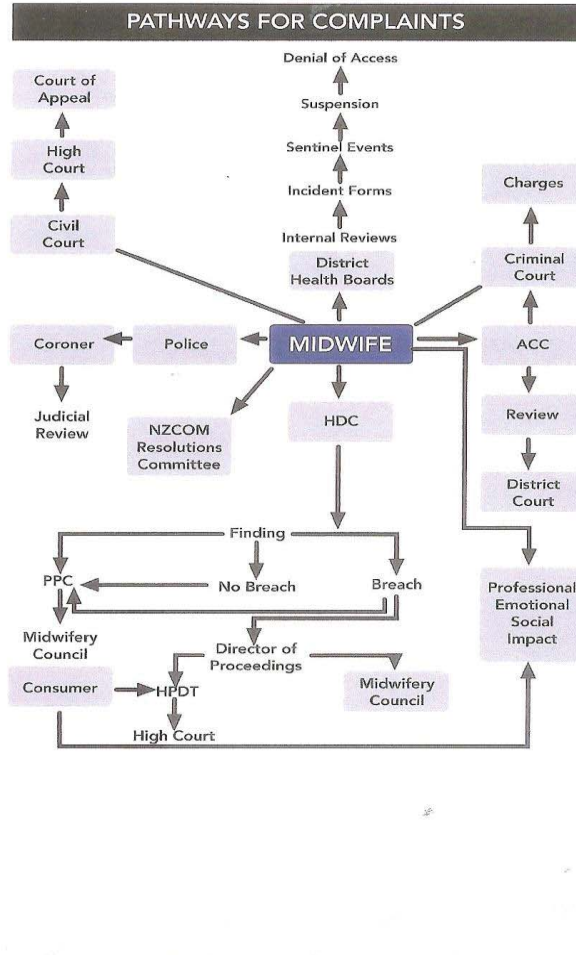
Irene Calvert

Doctoral Candidate/Researcher

Appendix G

Pathway of complaints for women (Guilliland & Pairman, 2010)

Appendix (iv)



Appendix H

Letterhead

Participant Consent Form.

The Effects of a Dramatic or Traumatic Practice

Experience on the Midwife.

This form will be held for a period of five (5) years

I have read this consent form and the information sheet and have had the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at anytime.

- I agree to the interview being audio taped.
- I wish/ do not wish (delete one) to have my tapes returned to me.

**I AGREE TO TAKE PART IN THIS STUDY UNDER THE CONDITIONS SET
OUT IN THE INFORMATION SHEET.**

Signed. _____ Midwife/participant). / / (date)

Full name –printed _____

Signed. _____ (Investigator). / / date

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