Author: E. Dietsch, P. Shackleton, C. Davies, M. Alston and M. McLeod
Title: "You can drop dead: Midwives bullying women
Journal: Women and Birth
ISSN: 1871-5192
Year: 2009
Volume: 23
Issue: 2
Pages: 53-59

Abstract: SummaryBackgroundThis paper describes how women experienced what came to be labelled as "bullying by a small number of midwives when they were evacuated from their rural and remote areas of NSW, Australia to a maternity unit to birth.Research questionWhat is the experience of women who are required to travel away from their NSW rural/remote communities to birth?Participants and methodsForty-two participants together with a number of their partners/support people were interviewed indepth for this qualitative, exploratory study. Upon thematic analysis of the transcribed interviews, an unexpected finding was that four participants (plus one partner) described experiences which were interpreted as bullying, by a small number of midwives working with them. Women identifying as Aboriginal were especially likely to share stories of midwifery bullying.Results, discussion and conclusionEmotional and cultural safety of women must be a prime consideration of midwives. Strategies to reverse power differentials between midwives and women are urgently required to eradicate bullying by any midwife.

Author Address: edietsch@csu.edu.au
pshackleton@csu.edu.au
cdavies@csu.edu.au
malston@csu.edu.au
URL: http://dx.doi.org/10.1016/j.wombi.2009.07.002
http://researchoutput.csu.edu.au/R/-?func=dbin-jump-full&object_id=12077&local_base=GEN01-CSU01
http://unilinc20.unilinc.edu.au:80/F/?func=direct&doc_number=001563809&local_base=L25XX

CRO Number: 12077

Dietsch, E., Shackleton, P., Davies, C., Alston, M. & McLeod, M. (in press). 'You can drop dead': Midwives bullying women'. *Women and Birth,* DOI: 10.1016/j.wombi.2009.07.002

'*You can drop dead*': Midwives bullying women

Sticks and stones may break your bones, but

words can break your spirit[1]

She left here bright and happy and looking

forward to the future, and came back like an

old woman, like a broken woman (Henry,

partner of Jemma)

Abstract:

Background: This paper describes how women experienced what came to be labelled as 'bullying' by a small number of midwives when they were evacuated from their rural and remote areas of NSW, Australia to a maternity unit to birth.

Research question: What is the experience of women who are required to travel away from their NSW rural/remote communities to birth?

Participants and methods: Forty-two participants together with a number of their partners/support people were interviewed indepth for this qualitative, exploratory study. Upon thematic analysis of the transcribed interviews, an unexpected finding was that four participants (plus one partner) described experiences which were interpreted as bullying, by a small number of midwives working with them. Women identifying as Aboriginal were especially likely to share stories of midwifery bullying.

Results, discussion and conclusion: Emotional and cultural safety of women must be a prime consideration of midwives. Strategies to reverse power differentials between midwives and women are urgently required to eradicate bullying by any midwife.

Keywords: Bullying; Midwifery; Aboriginal women; Power; Abuse

Total words: **5,023**

Introduction and background:

This paper reports on a very unexpected finding from a larger research study which explored forty-two women's experiences of having to move away from their rural and remote communities in NSW, Australia to birth. When sharing their experiences in the larger study, five (four women and one partner) of those interviewed described incidents which they reported as uncaring, cold, callous, abusive and aggressive behaviour by a small number of midwives. During the process of thematic analysis this behaviour was identified and labelled by the authors as bullying and this interpretation was confirmed through member checking. Bullying behaviour was reported to have occurred in more than one maternity unit and was not limited to either the urban or rural/regional area. Four of those who spoke of bullying midwifery behaviour in the larger study identified as Aboriginal. One participant who is quoted in this paper (Vicki) did not identify as Aboriginal. Sally, an Aboriginal midwife, was present as a support person at the time of some interviews. Although Sally was not a participant who had left her rural and remote community to birth, her words were transcribed verbatim and included as data. Jemma's story will be used as an indepth case study to illustrate the negative impact of midwifery bullying. Recommendations are made to help ensure bullying of women is eradicated and midwives are enabled to provide emotionally safe and culturally secure care for women.

Literature review:

Bullying is a universal phenomenon but there is no universally accepted definition.[2] The definition of bullying used in this paper has been inferred from the data and relates to midwifery behaviour that is perceived as uncaring, cold, callous, threatening, abusive and/or aggressive; the midwife, in a position of authority, abuses and exerts power over the woman who is in the more vulnerable position. Bullying is the antithesis to woman-centred care and the midwifery partnership deemed as an integral part of the *National Competency Standards for the Registered Midwife*.[3] Most attempts to define bullying in the literature assert or imply that the bullier intends to physically or psychologically hurt

the victim.[4] However, Jolliffe and Farrington[5] focus on the feelings of the target of the bullying. They argue that the bullying may or may not be deliberately intended to hurt the other person but what the perpetrator demonstrates is an acute lack of empathy. If there is no intentionality, the perpetrator is either unable or unwilling to understand the emotions of the person they are bullying.[5] Whatever the intent, the victim of bullying will always feel oppressed by the more powerful perpetrator.[2] The intent of the midwives who bullied women in this study is unknown. What is known is that the midwives were in positions of power, with the women expressing feelings of oppression. These feelings were exacerbated by repeated vexatious, unwanted and provocative comments.

For more than a decade, the practice of midwives bullying each other in the workplace has been extensively documented in the literature.[6-10] In her doctoral thesis, Gillen[11] reported that bullying is not only a reality in midwifery, it is culturally accepted. Bullying of midwifery students by registered midwives has also been reported both overseas and in Australia.[12,13]

Previous research has addressed women's fear of obstetricians' demeanour and the strategies women can use to reduce that fear.[14] An extensive search of the literature found no research specifically looking at bullying, harassment and abuse of women by midwives, but Eliasson, Kainz and von Post[15] reported that almost half the women in their study perceived the behaviour and actions of midwives as humiliating. Women in this Swedish study described how they felt ignored by midwives; they believed that midwives held them in contempt, treated them carelessly and did not believe them or blamed them for whatever was happening at the time. Midwives' treatment of women in this way has the potential to lead to long term post traumatic stress disorder.[16,17,18] Magill-Cuerden[19] argued that a midwife's actions are never forgotten by women and the significance women attach to negative events in childbirth intensifies and increases over time.[20]

Participants and Methods:

The study was funded by the Nurses and Midwives Board of NSW. Participants self-selected and were recruited following media coverage of the study and consequent promotion by the Country Women's Association of Australia. Women who had been forced to travel at least one hour from their

rural and remote communities to birth in the previous two years were eligible to participate in the study. Forty-two participants (six of whom identified as Aboriginal) were interviewed in 2007 and 2008 from all over rural and remote NSW. Several participants had a partner, friend or family member present at the time of the interview.

The indepth interviews were conversational in style. As part of the consent process, potential participants were informed that they would be asked to share information in response to two prompts. The first related to their pregnancy and birthing experience and the second prompt related to their experience of leaving their home community to birth. No participant was asked to share experiences of being bullied as this had not been previously considered a possibility by the research team. It was only after incidents had been spontaneously shared by participants, that interviewers explored these experiences in more depth. All interviews were transcribed verbatim, and as mentioned earlier, thematically analysed by members of the research team and then offered to participants for verification (member checking). This reflective and consensual process ensured the trustworthiness of the data.

Ethical considerations:

The larger study informing this paper received Charles Sturt University ethics committee approval (2006/307). Safeguards were built into the design of the project to minimise the risks of harm and burden to participants. These safeguards included the giving of information about the nature, advantages and potential disadvantages of the project so that informed choice could be exercised. Written consent was obtained and copies of the consent form and information sheet were given to each participant. In keeping with the feminist principles underpinning the study, participants were advised that they could seek information from the researcher or ask their own questions at any time during or after the interview. Participants were given control of the tape-recorder and the process, knowing they had the right not to proceed at any stage of the interview, turn off the recording and/or withdraw from the project at any time. Post-interview debriefing and the offer of further information and/or counselling was offered to all participants. Participants chose the venue for the interview. All

identifying data were changed to protect anonymity and confidentiality on the transcribed interview scripts.

Data analysis was initially attended by individual research team members and themes identified. This individual thematic analysis was followed by paired research team member analysis and only those themes which were agreed on by consensus were considered as part of the findings. Regular, monthly meetings by the research team involved in the larger project allowed for review of the consensually agreed themes and deliberations on how best to report such findings. Research team meetings were the mechanism which enabled an audit trail of the qualitative data and its review to be established.

The participants' allegations of what came to be interpreted as bullying, by some midwives, were completely unexpected and unsolicited. However, once bullying was identified, the research team decided it would be unethical not to publish these claims. The ramifications of reporting the data were discussed at length during research team meetings to decide how best to publish the serious allegations against a small group of midwives.

The research team was acutely aware of the ethical dilemma which had evolved. At no time did any participant identify a midwife who engaged in bullying, nor was this information sought by the interviewer. The reported bullying was clearly in breach of all midwifery professional codes of conduct and competency standards and should have been reported to midwifery professional regulating bodies. However, the participants were assured at the time they gave their informed consent that no town, maternity unit, health professional or person would ever be identified by their participation in the study. Research team members believed that coercing participants to identify the alleged bulliers or make a complaint or have a complaint made on their behalf was not in keeping with the ethical principles that guided the study. At the time of the interviews when incidents of bullying were reported, the interviewer(s) explained their rights to the participants and the process by which a complaint could be made to the NSW Health Department Complaints Unit and/or any maternity unit involved and/or the Nurses and Midwives Board of NSW. A health professional who

could support them and advocate for them during the complaints process was also identified at the time of interview.

Findings:

The core definition of bullying emerged from data analysis and subsequent member checking. It relates to a midwife, in a position of authority, abusing and exerting power over a woman through uncaring, cold, callous, threatening, abusive and/or aggressive behaviour. This behaviour which came to be labelled as bullying was not perceived as unusual but as part of an endemic culture of negativity:

> *And it wasn't just one nurse* [sic] … *They come down and they was swearing in my face* (Sarah).

> *I was disgusted. … just being rude and stuff, and not wanting to help you and things like that … Oh that was shocking* (Henry, partner of Jemma).

This lack of midwifery care and compassion surprised Henry:

> *I honestly thought a hospital, a maternity ward, I thought it would be full of caring, wonderful people* (Henry).

Already feeling alone and in a foreign environment, some participants, especially those who identified as being Aboriginal, felt further alienated by the midwives:

> *Like …* [the midwives] *were looking at me like I'm dumb and stuff … they didn't believe I was in labour. So I just really … on my own, I was just crying and, you know? I just didn't know what to do, and I can be very timid when they come about you, you can get real timid and they kind of put it over you and stuff. That's what I felt* (Kerry).

Kerry described feeling intimidated:

> *Yeah, there was aggression towards me, especially when I first went in, in labour … and so I was very timid. … I'm not one to let someone run over me, but there I was really, yeah. I just went into a shell …* [the midwife] *got stroppier* (Kerry).

Sarah pleaded with the midwives to allow her partner to be with her:

> *Then they induced me … I told them I was getting contractions and I was in labour, and they wouldn't believe me. They said, 'No you're not, you're smiling. You don't look like a woman in labour.' Because I was walking around and, when I'm in labour, until the very end, you can't really tell because I'm very quiet and if I'm in pain I'll just stand there and I won't really make much racket about it. And they wouldn't believe me, and I was just … I went back into my room and I was just crying, and they wouldn't let my husband come up. But I just ended up ringing him and I said, 'No, just come up … I know I'm in labour, don't worry about what they say.' And then someone rung up the hospital, once I'd rung him crying, and complained and then they finally did something about it. And they took me down to the labour ward and I was like four centimetres dilated … yeah, I found that really distressing, because the fact that they just wouldn't believe me* (Sarah).

Sally, the Aboriginal midwife, reiterated other occasions when she had observed Aboriginal women not being believed that they were labouring:

> *Aboriginal lady … birthing … and non-Aboriginal lady birthing … bet your life, the midwife is actually in with the non-Aboriginal girl. … I've experienced that recently, quite recently, on a number of occasions, where a doctor and a midwife has been with a non-Aboriginal girl while the Aboriginal girl has been left in a labouring ward on her own, waiting for someone to come in … I've also had women, Aboriginal women, on the ward labouring and they haven't been believed, that these girls have been having pains … No, these girls haven't been believed, that they are in labour. They've just been left on the ward. Given a handover in the morning shift, it's been stated that these girls have kept other members in a four bedroom ward awake all night …* [a vaginal examination is done and] *eight centimetres and bulging forewaters … And she told me, 'They haven't believed me all night'* (Sally).

Sally described her observations of how some midwives discouraged women from breastfeeding:

> … [midwives] *they stand over the girl … physically, yes. They actually invade the girl's private space. The tone, the tone and manner is always aggressive. … Aboriginal girls, if they're going to be reprimanded that they're not doing it right by a non-Aboriginal white fella, they immediately get their back up. So they'll go for an easier alternative while they're in hospital, they'll go to artificial feeding. They'll go out and get a couple of bottles. They don't want to be judged … it's disempowering … It's like their rights have been taken away from them* (Sally).

Kerry and Vicki went on to describe how their wishes to breastfeed their babies were negated:

> *They didn't ask me until I got back to* [local hospital], *they asked me if I wanted to breastfeed and I said, 'Yeah, I'll try it.' … At* [other hospital] *they were just giving me the bottles, so I had to give him bottles … and when I got back to* [local hospital] *the doctor asked me, 'Do you want to try breastfeeding?' I said, 'Yeah.' And because my Mum used to be a nurse, she helped me put him on* (Kerry).

> *I was pushing them. I wanted to breastfeed. They were trying to bottle all the time. I said, 'No, I'm breastfeeding'* (Vicki).

The participants perceived that some midwives used their judgment as to whether or not bonding had taken place. Threats of authority caused Jemma to fear that her baby would be taken from her and as a consequence felt she had no choice but to sleep, sitting up in a chair, beside her well baby's cot in the nursery:

> *Sat up, night and day, sitting in a chair next to the baby …* [the midwife said] *'Don't you care about your baby?' and 'I'm going to tell the doctor about …' … Threatening … all the time. Just filthy, filthy attitude* (Jemma).

Henry added:

> *I'm saying, 'When can* [Jemma] *go home? When can she go home?' And they said, 'Well, when she proves that she's bonded with the baby' … 'Oh, she's not bonding with the baby.' That's what they're all saying, 'She's not bonding with the baby'* (Henry).

Bullying by midwives towards new mothers was not limited to the Aboriginal participants in this study. However, on many occasions the bullying described by participants was racist in nature:

> *Like, one of the midwives said … 'Oh, we have a lot of trouble with black girls from* [town]*.' That was out of her own lips. That was to my face. … I don't believe they treat whites the same. I can't believe they would* (Jemma).

Sally confirmed their reports when she said:

> *I have seen and spoken to Aboriginal young girls, especially … they feel judged … stereotyped … They're not doing it the right way … In the hospital, they're in a totally different environment. It … disempowers them. … they don't have rights. They're spoken down to … It's actually degrading to actually see some of the midwives speak to our girls. … They're given direction … authoritative direction, without consulting with the young girls. The girls are not openly involved in a conversation. They're actually given directions … These girls do have rights, but they get in the system, that's all taken away from them … It's like the authority figures – the nurses, the midwives, have to have this control* (Sally).

Kerry described how Aboriginal and non-Aboriginal women were treated differently at one hospital:

> *I personally noticed it. Just the general way that they went about things with white women. I had a white woman next to me in my room, and she … would come and check up on her, just check up on her for no reason. 'Are you okay? Do you need help, assistance, rah, rah?' And I mean, I saw other young black girls there that were being treated worse than me* (Kerry).

Kerry also described her fear when she 'escaped' from the hospital:

> *Loss of freedom: I actually ended up running away from the hospital. They wouldn't let me go but I just took him and went … I suppose because it was like my freedom was taken away, in a sense, in the hospital, over my own child. Do you know what I mean? I couldn't do, they wouldn't even let me stinking bath him, and he'd been in there for four days and every day I'm there going, 'Can I bath him?' And other midwives are going, 'How come you haven't bathed him?' … And I'd say, 'Because other ones wouldn't let me.' And they're like, you know? I just, my freedom was taken away over my child, and I hated it. Yeah, I couldn't just, you know? And that's what I hated the most.*
>
> *And so I just grabbed him and I said ' … pack the car, we're going to head off.' So we just, I just ran down the steps and went. I was so scared though, it was like I was stealing someone's baby … Yeah. I was really scared* (Kerry).

It is not surprising that a recurring theme related to the Aboriginal women's fear of the midwives and, as Sally said:

> *Fear of the nurses* [sic] *yeah. I mean … so many times that the nurses* [sic] *have their own attitudes and, you know, their beliefs. They're not welcoming, by any means … midwives actually* (Sally).

Case study: Jemma

To illustrate the extent of bullying described by some of the participants, Jemma's story is provided as a case study. Jemma was a young Aboriginal woman from a small town. She was transferred with a severe urinary tract infection by Air Ambulance to a hospital, at term. She travelled alone and was extremely frightened. Her partner, Henry was unable to be with her due to there being no room in the aeroplane and then extenuating circumstances prevented him from being with Jemma and their baby until the eight day following her Caesarean section. The Caesarean was attended at midnight on the night she was admitted to the hospital. Jemma's baby was reportedly well but nevertheless was admitted to the Special Care Nursery and stayed there for the duration of Jemma's hospitalisation.

Less than eight hours after her Caesarean section and with a severe urinary tract infection, Jemma was informed that she would need to go to the nursery to feed her well baby. It is acknowledged that early mobilisation is advantageous for the woman following surgery. However, the nursery was estimated to be over 100 metres away and Jemma, though desperate to see her baby, was not offered a wheelchair or any assistance. In keeping with manual handling and 'no lift' policies, the midwife did not physically assist Jemma out of bed, nor did she offer verbal support or education on how best to support herself as she attempted to get out of bed:

> *And they were just cold and callous. They refused to help … they absolutely refused. They said, 'Pull yourself up by that handle.' And, I mean, if you've got a stomach wound, there's no way that you can pull yourself up* (Jemma).

Jemma is short in stature and the foot stool that could have been of assistance was out of sight, under the bed:

> *All they'd do is come up and say, 'Your baby's crying. Get out of bed and go down and feed her.' Right from the start. This is the morning after a major operation* (Jemma).

Following this incident and repeatedly in the days to follow, the midwives reported to Jemma that they were concerned that she was not bonding with her baby, who remained in the nursery. She was never advised why her well baby had to stay in the nursery but she surmised it was due to the midwives' concerns.

Jemma's partner said:

> [Jemma] *was so scared and so frightened because they were threatening her with DoCS* [Department of Community Services] *all the time* (Henry).

This was not a one-off threat but continued throughout her hospital stay. For the last three days of her admission in the hospital, Jemma was so frightened of the midwives and their threat to report her to DoCS that, as mentioned earlier, she slept in a chair beside her well baby's cot in the nursery.

Jemma remained in the hospital and her only support was the Aboriginal Health Worker who came in occasionally to see her. Henry, her partner, described the scene:

> *It was obvious that she cared, otherwise she'd be lying in bed and telling everyone to go away. She was making every effort. She was sitting up at night in a chair next to the … baby in the nursery … sitting up in the chair … nights and nights … She didn't dare go to bed because she couldn't get there, because if she was late, if the baby was crying … that* [midwife] *would come up and say, 'Oh, I had to feed your baby. You don't care, do you?' That's the sort of thing she was saying. 'I had to feed your baby'* (Henry).

Exhausted from sleep deprivation, in terror that her baby would be taken from her and in agony from an untreated severe urinary tract infection, Jemma pleaded with the midwives to be allowed to go home. She reported their response:

> *All the time they're saying, 'You go. Go on, you go.' … 'You can drop dead in the car park, but the baby stays here. We won't come and help you.' … 'You can drop dead and your baby can stay here.' And I said, 'Baby not staying neither, baby coming with me'* (Jemma).

Henry had no transport or means of travelling over four hours to the hospital, to be with Jemma and their baby daughter. He was contacted by the Aboriginal Health Worker who advised him to come to the hospital immediately as she was concerned that Jemma's baby would be taken by DoCS and she was powerless to stop them:

> [Aboriginal Health Worker] *she was very concerned. She was the one that rung me up and said, 'You better come down'* (Henry).

On arrival at the hospital, Jemma's partner went looking for her and eventually found her being verbally abused in a public place by one of the midwives:

> *And then that woman* [midwife] *walked over, and they were sort of half behind that pillar and I was walking down the corridor and this woman was in her face, screaming at her. She was saying, 'Did you feed, did you bath the baby? I don't believe you. You're lying to me. Did you*

> *bath the baby?' And she was screaming at her. And I got closer, and I couldn't believe that it was Jemma and this woman was just over her, just yelling, literally yelling at her. … in front of everyone … She was absolutely shocking. But she was the worst, but they were all terrible.*
>
> *And all the abuse was terrible. Terrible. Jemma was like a broken woman … She left here bright and happy and looking forward to the future, and came back like an old woman, like a broken woman. That's what she was like. I really think it scarred her. I think it's really brutal, it's shocking. It's disgusting, the way they were treating her. I don't know what she was like the day after the baby, but after eight days she was, she couldn't walk, she couldn't do anything, so, I don't know, I can't imagine what she went through for the first couple of days … Oh, that was shocking. It was like they were, it was designed to break* [my wife] *and take the baby* (Henry).

Jemma believed the midwives were accusing her of not caring for her baby and Henry added:

> *She used to sit in there, night and day … sleep in there, next to the baby, just so as soon as* [the baby] *cried, she could give her a bottle, so this woman wouldn't be screaming at her and yelling at her* (Henry).

During the eight days Jemma spent at the hospital, she received no treatment for the urinary tract infection. It was not until she returned home to the small town hospital on Day 8 postpartum, that she was admitted for three days of intravenous antibiotic treatment and her pain and urinary tract infection eventually resolved.

Discussion:

Compared with the non-Indigenous population, perinatal mortality rates are up to five times higher and the percentage of low birth weight babies are double in the Indigenous population.[21,22,23] There is evidence equating maternal stress and anxiety with both prematurity and low birth weight babies;[24,25] stressors imposed by a medicalised obstetric system and experienced by Aboriginal women during pregnancy, labour and birthing need urgent consideration.[26]

Sonn and Fisher[27] argue that oppressive social systems (such as the maternity services described) and enforced interaction with a dominant culture lead to the loss of individual and community cultural identity. This in turn disrupts the healthy development of self and community and results in increasing family and community dysfunction, poverty and violence, as well as an increased maternal and neonatal morbidity and mortality rate.[28]

Pregnancy, labour, birth and parenting are powerful and culturally embedded. From the beginning of time, women and the midwives who supported them have known it to be so. However, with the increasing medicalisation of pregnancy and birth, the power is shifting more and more away from the woman herself and directed towards the system and the professionals who govern how and where a woman should birth.[29]

The larger study informing this paper exposed the negative impact of medical dominance and the commercially vested interests of medical practitioners on childbearing women living in rural and remote NSW. However, the above narratives demonstrate that the abuse of power is not limited to the medical profession but women are being bullied by some midwives caring for them in referral maternity units. This study found that a culture that causes midwives to fear each other is also a culture that instils fear in women when relating to bullying midwives. A taboo which refuses to identify bullying of women by midwives appears to exist and it demands urgent exposure to ensure women's emotional and cultural safety.

The small number of participants and the nature of the methodology used in this study does not allow for the generalisation of findings. However, it alerts the reader to the possibility of midwifery bullying of the women who are meant to be supported. Further qualitative research is needed to increase understanding of this aspect of some midwives' practice and the culture which allows bullying to continue. Mixed methods research is also needed to ascertain the extent and impact of bullying perpetrated against women by midwives.

A limitation of the study is that only the women's voices were heard. The research design did not allow for the midwives to have a right of reply. According to the participants' descriptions, the

behaviour of some of the midwives did not meet the *National Competency Standards for the Midwife*[3] and they did not practise in accordance with the professional *Code of Ethics for Midwives in Australia*.[30]

Recommendations:

The *Code of Ethics*[30] clearly states 'Midwives value respect and kindness for self and others' (Value Statement 2). However, midwifery education and practice are skewed in the direction of technical competence and away from valuing human kindness and compassion.[30] This imbalance requires redressing as a matter of urgency so that kindness, empathy, cooperation, encouragement and a willingness to share knowledge in a respectful way are as highly valued as ensuring physical safety.[30,31] All midwives must be accountable for their own actions/inactions in keeping with the *National Competency Standards for the Midwife* which address the issues of power imbalances and bullying.[3] Bullying behaviour is both unsafe and unacceptable. Midwives need to appraise and address the impact of power relations in their practice. This means acting to eliminate harassment, victimisation and bullying.[3] All midwives have a responsibility to identify bullying, unkindness, lack of empathy or compassion as unacceptable in themselves and their peers. They need to be encouraged to take their concerns to management for immediate remedial action, so that bullying midwives are given an opportunity to change their behaviour. Anti-bullying policies need to be written and communicated to all midwives and rigorously enforced in all maternity units. Managers, senior clinicians and academics need to role model behaviour and strategies that work to eliminate the negative impact of power imbalances and convey the desired characteristics of the midwife.[31-33]

Conclusion:

Emotional safety for women accessing midwifery services needs to be as highly valued as physical safety. Participants in this study exposed a previously hidden form of abuse, that is, midwives bullying women. The bullying behaviour of what is believed to be a very small minority of midwives requires further research to determine its extent and impact. More importantly, it requires immediate redress and the recommendations outlined in this paper need to be adopted as a matter of urgency if

women's safety is to be assured. This paper has focused on, but has not been limited to, experiences of Aboriginal women who felt abused and bullied by midwives. Recommendations made to meet the needs of women identifying as Aboriginal will benefit all women, especially those living in rural and remote communities.

Acknowledgments:

The Nurses and Midwives Board of NSW provided financial support to enable this study to take place. We also wish to thank the women who gave so much of their time and themselves in sharing their stories so courageously with us.

References:

1. Viga G, Comer D. Sticks and stones may break your bones, but words can break your spirit: Bullying in the workplace. *Journal of Business Ethics* 2005;**58**(1–3):101–9.

2. Baldry A, Farrington D. Effectiveness of programs to prevent school bullying. *Victims & Offenders* 2007;**2**:183–204.

3. ANMC. *National competency standards for the midwife*. Australian Nursing and Midwifery Council; 2006.

4. Bonafons C, Jehel L, Hirigoyen M, Coroller-Bequet A. Clarifying the concept of bullying. *Encephale-Revue de Psychiatrie Clinique Biologique et Therapeutique* 2008;**34**(4):419–26.

5. Joliffe D, Farrington D. Examining the relationship between low empathy and bullying. *Aggressive Behavior* 2006;**32**:540–50.

6. Hurrell S. Workplace bullying in the NHS. *British Journal of Midwifery* 2008;**16**(1):59.

7. Kirkham M. Traumatised midwives. *Association for Improvements in Maternity Services* Journal 2007;**19**(1). http://www.aims.org.uk/Journal/vo19no1/traumatisedMidwives.htm (accessed on 23 May 2009).

8. Keeling J, Quigley J, Roberts T. Bullying in the workplace: what it is and how to deal with it. *British Journal of Midwifery* 2006;**14**(10):616–21.

9. Gould D. Leaving midwifery: bullying by stealth. *British Journal of Midwifery* 2004;**12**(5):282.

10. Leap N. Making sense of horizontal violence in midwifery. *British Journal of Midwifery* 1997;**7**(3):160–3.

11. Gillen P. The nature and manifestations of bullying in the workplace. Doctoral Thesis, Belfast: University of Ulster; 2007.

12. Ford J. The dark underbelly of midwifery: a student perspective. *Midwifery Matters* 2008;**118**:20–1.

13 Leap N, Barclay L, Sheehan A. Results of the Australian midwifery action project: education survey. *Australian Midwifery* 2003;**16**(3):6–11.

14. Beddoe A, Lee K. Mind-body interventions during pregnancy. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 2008;**37**(2):165–75.

15. Eliasson M, Kainz G, von Post I. Uncaring Midwives. *Nursing Ethics* 2008;**15**(4):500–11.

16. Wijma K, Soderquist J, Wijba B. Post-traumatic stress disorder after childbirth: a cross-sectional study. *Journal of Anxiety Disorders* 1997;**11**:587–97.

17. Waldenstrom U. Women's memory of childbirth at two months and one year after the birth. *Birth* 2003;**30**(4):248–54.

18. Dietsch E, Davies C. The nocebo effect for women in waiting. *Collegian* 2007;**14**(3):9–14.

19. Magill-Cuerden J. Remembering the midwife. *British Journal of Midwifery* 2007;**15**(9):534.

20. Simkin P. Just another day in a woman's life? Part II: nature and consistency of women's long term memories of their first birth experiences. *Birth* 1992;**19**:64–8.

21. Trewin D, Madden R. *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples.* Canberra: ABS & AIHW; 2005.

22. Hancock H. Low birth weight in Aboriginal babies: a need for rethinking Aboriginal women's pregnancies and birthing. *Women & Birth* 2007;**20**:77–80.

23. Laws P, Sullivan E. *Australia's mothers and babies 2003*. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 16); 2005

24. Arias E, MacDorman M, Strobino D, Guyer B. Annual summary of vital statistics – 2002. *Pediatrics* 2003;**112**:1215–30.

25. Orr S, Reiter J, Blazer D, James S. Maternal prenatal pregnancy-related anxiety and spontaneous preterm birth in Baltimore, Maryland. *Psychosomatic Medicine* 2007;**69**:566–70.

26. Kildea S. Risky business: contested knowledge over safe birthing services for Aboriginal women. *Health Sociology Review* 2006;**15**(4):387–96.

27. Sonn C, Fisher A. Sense of community: community resilient responses to oppression and change. *Journal of Community Psychology* 1998;**28**(5):457–72.

28. *Birth Rites*. (video recording) Sydney: JAG Films; 2002.

29. Wagner, M. Birth and power. In: Savage W, editor. *Birth and* power. London: Middlesex University Press; 2007.

30. ANMC, ACM & ANF. *Code of ethics for midwives in Australia*. Australian Nursing and Midwifery Council; 2008.

31. Gould D. Taught to be kind. *British Journal of Midwifery* 2008;**16**(7):430.

32. Smith M. How to stop the bullies. *Kai Tiaki Nursing New Zealand* 2008;**14**(9):4.

33. Snow T. Poor management exacerbates harassment and bullying at work. *Nursing Standard* 2008;**23**(10):7.