"I'm just a number, I'm not a person, I'm just a servant to the system": introducing a new conceptual framework to understand bullying in NHS midwifery

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Declaration

I confirm that the work submitted is my own and that appropriate credit has been given where reference has been made to the work of others

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Abstract

Workplace bullying in NHS midwifery has persisted for decades, despite research and interventions designed to eliminate it. This thesis explores the persistence of the bullying, by reconceptualising the phenomenon and the traditional approaches taken to addressing it. I question the merit of utilising the dominant modes of understanding bullying whereby it is considered primarily interpersonal or is labelled as an outcome of workplace stress. In seeking to understand the impact of employment structures and embedded workplace practices, I advocate for the Depersonalised Bullying conceptual framework. This approach can unveil the hidden mechanisms that inform how the midwifery profession is positioned with regard to workplace bullying. These ideas formed the basis of the forty-seven semi-structured interviews conducted with NHS midwives. Reflexive Thematic Analysis was used to explore midwife subjectivities and the sense of being bullied within the particular paradigm of NHS midwifery. In these conversations, the expected topics of womancentredness and wishing to avoid causing harm emerged strongly, while I discovered the strength of feeling the interviewees had for their midwife identity. By reconceptualising bullying as depersonalised, I am able to reveal the sense of insecurity and confusion experienced by midwives who work within the current framework of maternity services. Recommendations are for research which will lead to a better critical understanding of the midwifery profession within the context of the structures of employment.

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Chapter One: Introduction

Bullying in NHS midwifery has been acknowledged as a complex and long-standing

problem, but it continues despite considerable effort to eliminate it. Bullying and

harassment policies have long been in circulation throughout the NHS (NHS

Resolution, 2018), however do not appear to be having much impact. Almost 20% of

NHS employees reported in the 2022 National NHS Staff survey that they had

"personally experienced harassment, bullying or abuse at work from other

colleagues" in the twelve months prior (NHS Survey Co-Ordination Centre, 2023).

This figure rises to 26% for the occupational group of midwives, further

demonstrating that it is problem far from being solved.

1.1 Bullying in NHS midwifery

The theoretical teaching of midwifery philosophy and its application in real-world

clinical practice suffers from a discrepancy. Divergence between the exemplar and

the practical reality is acknowledged within the profession, and may be measured by

comparing education training materials with inspection audits such as Care Quality

Commission (CQC) reports (Tingle, 2021). This is an appropriate route to take in the

pursuit of optimal patient outcomes in a health care service. However, obscured

within this approach is recognition of the role of personal expectations of the care givers themselves.

In the context of midwives leaving the beleaguered National Health Service in increasing numbers (Barker, 2016), the persistence of the troubling phenomenon of workplace bullying has justifiably concerned senior healthcare people. The Royal College of Midwives (RCM) reported in 2021 that 57% of midwives in England, and 75% of midwives in Scotland may be intending to leave (RCM, 2021). The reasons given are dishearteningly similar to those from a seminal study conducted fifteen years before—'Why Midwives Leave' from Curtis et al., (2006d)—which also cited bullying, staff shortages, poor mental health, burnout, high workload and feeling unvalued, as key reasons for departure (Moncrieff et al., 2023). Bullying in the maternity workplace has also been noted as having a negative effect on the service users by impacting safety and impairing the women's confidence in the profession (Capper et al., 2021). This further underlines the urgency with which bullying in midwifery should be managed.

The traditional approach taken to researching bullying in midwifery is in keeping with bullying research undertaken across most fields of employment. Commonly, researchers rely upon the use of surveys and interviews to learn more about employees who report being bullied. It is common practice to uncover antecedents to bullying which may then be revealed to have their basis in personality, intolerance, or professional jealousy. Often, organisations will be described as weak and ineffectual in their management of poor behaviour. Workplace structures which

apply excessive pressure upon stressed employees are also thought to foster bullying behaviour. Within this context, bullying behaviour is defined as a response to workplace strain, and the targets as victims of a poor behavioural choice made by the bully.

Within each of these approaches, a definition of what constitutes bullying is not firmly established, and appears to rely upon a target's own sense of *having been bullied*. Further, while targets could often describe the bullying event and the negative impact it had, perpetrators would rarely admit to committing the act. Ambiguity in the definition of bullying is further reinforced by the common finding that perpetrators may even express shock that the behaviour was considered bullying at all. Perpetrator perspective is in fact rarely sought in the study of workplace bullying. On the few occasions when bullies have been approached for their assessment of the situation, researchers have been led back to the question of intentionality.

1.2 Research Questions

In this thesis, I focus on three main research questions:

- i- By which routes do midwives feel bullied at work?
- ii- How does this impact midwives' feelings about their job?
- iii- What does this mean for the profession?

Inspiration for this line of enquiry originated in my personal and professional experience, however, is easily contextualised within the much wider, and more established, discourses regarding workplace bullying in general (e.g. Einarsen, 1999; Hoel and Cooper, 2001; Leymann, 1996) and well-publicised concern for the midwifery workforce (e.g. Leap, 1997; Pezaro et al, 2017). The theoretical approaches taken for the project arose from acknowledgement that bullying in midwifery unquestionably poses a real and quantifiable problem. Alongside this foundational element, I brought a first-hand, but imprecisely grasped, understanding that there is a generalised discord within the profession, and in the NHS in general. Factors contributing to this seemed myriad and nuanced. In order to better understand this, a qualitative approach to research was required.

The relationship between professional midwives and their structures of employment are constantly evolving and being reconstituted. Midwives inhabit a unique position within the changing landscape of maternity healthcare, and as the moving parts of their professional lives shift around them, the theme of bullying has survived. While the literature on both professional midwifery and workplace bullying is extensive and detailed, the concepts tend to be treated in isolation. Discussion around the interrelationships of the two have been sparse. Reframing these concepts allows an original perspective.

Additionally, and further demonstrating the urgency of the matter, staff shortages in maternity services have been implicated in a number of high-profile safety investigations undertaken in response to deaths or injury of mothers or babies

(Knight et al., 2021). This has resulted in a renewed focus on staff retention in the NHS. With awareness that definitions of bullying contain an intrinsic vagueness, the research interview questions were formulated to represent a 'wide net'. The aim was to encourage the midwives to talk about themselves in their career, and to situate themselves with regards to general feeling of pressure. The following interview questions suited this aim:

- How long have you been a midwife? And why did you become one?
- Is the job what you thought it would be?
- Do you think you are well-suited to the role?
- Can you tell me about your experiences of feeling under pressure at work?
- What would your advice be for those starting midwife training?

The questions were posed in semi-structured interviews in which flexibility for detour was allowed. However, at a minimum these particular questions were always asked. Forty-seven female midwives were interviewed, virtually, during the Summer and Autumn of 2020, and each one was encouraged to construct their experiences in as much detail as they wished. Experiences and events of all kind were discussed, including their sense of how this had impacted their career and personal lives. Data were analysed only after completion of all interviews, and Braun and Clarke's Reflexive Thematic Analysis (2006) was used. This enabled identification of shared patterns of meaning across the dataset, and commonalities among the stories were quickly recognised.

Setting

The NHS provides an important research setting in this thesis. The midwifery profession was chosen as a specific area of investigation due to my own experience in, and familiarity with, the field. This limits my analysis to this particular field which, while similar to other groups employed within the NHS, is distinct in some ways. Midwives tend to work with people who are not ill. A visit to see the midwife is often a happy event, which is not the case with other NHS professions. There is also a dualistic approach to things, holistic normal and technocratic interventionist. Like nurses, midwives will very often work alongside physicians, and will require their input. Midwifery is uniquely autonomous though, at least on paper. However, this research also represents a useful exemplar for the caring professions more broadly.

1.3 Summary of key findings and contributions

The findings of this thesis contribute to the midwifery bullying question in two main ways: identification of the numerous ways midwives feel demoralised and hurt by the contemporary maternity system, and, the aspects of their professional identity and philosophy which they feel conflict with their work environment. Contributions are therefore made illuminating the hitherto obscured aspects of working life that cause midwives to feel bullied, explaining also the ineffectiveness of current antibullying strategies.

1.4 Structure of the thesis

The thesis is structured as follows:

Chapter Two: offers a detailed background of the profession of midwifery. Information in this chapter is framed around elements pertaining to the midwifery profession, the National Health Service, society in general, and maternity care issues in particular. The content of this chapter provides for the reader a more richly illustrated portrait of how the midwifery profession and general maternity issues operate, and have operated, within the NHS, and within society.

Chapter Three: combines a traditional literature review with my argument for imposing a novel conceptual lens upon the topic under question. The chapter begins by outlining the main current conceptualisations of bullying, as defined within the extant literature. Discussion of the literature as it relates to bullying in the NHS, and then in midwifery, follows. The related topics of professionalisation, organisational goals and midwifery philosophy are considered next. The chapter concludes with discussion of how the depersonalised conceptualisation of bullying might be applied to midwifery.

Chapter Four: describes the methods and methodological approach undertaken in the thesis. Positionality and the impact of insider status are emphasised in this section, on account of my background as a midwife. Following this, the details of research methods and data analysis methods are given attention.

Chapter Five: is the first chapter to convey empirical findings and provides a foundation for the two empirical chapters that follow. In this chapter I argue that the impact of depersonalised bullying is overwhelmingly negative. It causes harm to the midwives, the pregnant and birthing women, as well as to the profession of midwifery itself. The findings of this chapter provide understanding of the broad consequences of depersonalised bullying in the maternity workplace.

Chapter Six: in this empirical chapter I argue that the structures and processes of depersonalised bullying cause the maternity workplace to resemble a conveyor belt. This chapter illustrates the mechanisms through which depersonalised bullying impacts the women and midwives. The conveyor belt metaphor is particularly antithetical to midwifery ways of working as it implies standardised, uniform, mechanised workplace behaviour. The midwives felt that this conflicted with midwifery principles, and were frustrated and troubled at having to work this way.

Chapter Seven: provides the third and final empirical chapter in which I argue that depersonalised bullying in the maternity care workplace has such an impact on the midwifery workforce that they are forced to question their professional identity. The midwife identity is profoundly valued by those who hold it, to the extent that some midwives consider losing it to be almost inconceivable.

Chapter Eight: is the concluding chapter and restates the core findings while making recommendations and suggestions for future research. Primarily, I propose that in

order to maintain an adequately sized midwifery workforce, the structures and processes of the organisation of employment must be scrutinised in relation to the professional philosophy of the employees. Finally, recommendations for future research are made.

Chapter Two: Background

The purpose of this chapter is to provide context for the working life of an NHS

midwife. It is intended as a descriptive chapter to give greater depth of

understanding regarding the profession of midwifery, the NHS and the field of

maternity matters more broadly. This will be presented in two sections: the first will

discuss the profession of midwifery and its relation to the NHS. Section Two attends

to the arena of maternity issues and also introduces the idea that midwifery is often

considered to be a values-based profession; that is, a profession which people enter

due to a value system which incorporates the "art of caring".

Structure of the chapter

The chapter begins with a review of the practice of midwifery and the National Health

Service (NHS). While midwifery only became legally recognised as a profession at the

start of the twentieth century, the practice of supporting pregnant and birthing

women clearly pre-dates this. Factors relating to this are briefly outlined in section

2.1. Following this, I present factors relating to the midwifery workforce, the

conception of the NHS, increased reliance on clinical guidelines, and the working

structures of the midwifery profession. This will reveal some of the operational and

practical realities of life as a midwife in the UK. In section 2.2 a broader overview is

given, relating to the position of maternity care within society today. This section presents the sometimes contrasting paradigms of healthcare which symbolise modern maternity care, and then presents useful background information on how the increased use of technology has impacted the profession. Following this, the evolution of maternal requirements is discussed and pertinent changes in the demographic composition of the United Kingdom are described. Finally, the public reputation of midwives is briefly outlined, and discussion of a values-based approach to healthcare is presented.

Section 2.1: Midwifery and The National Health Service

2.1.1 History

Throughout history, birthing women have often had a supporter present for the duration of labour and birth, and into the postpartum period. Ancient Egypt, ancient Greece and the Roman Empire documented the presence of midwives among their populations (Donnison, 1988). The Middle Ages saw midwifery develop as one part of the skillset of female healers of the time, and also oversaw the origin of the title of 'midwife', with an etymological basis of 'mid' - Middle English for 'with' - and 'wif', meaning 'woman' (Donnison, 1988). Though the role has undergone many progressive changes, it has always been a role inhabited by individuals (usually, but not always, women) who wish to care for those going through pregnancy and

childbirth. Other historical milestones in midwifery include the introduction of forceps in the 16th century, the creation of midwifery manuals in the 17th and 18th centuries, and the medicalisation of birth and professionalisation of midwifery in the 20th century. All of these factors have contributed to the modern NHS and to midwifery as a profession in many ways.

Prior to the twentieth century, hospital birth was fairly uncommon in the UK and childbirth usually took place within the female domestic arena of the family, local community or church parish (Heagerty, 1996; McIntosh, 2013). The midwives who assisted at these births would not have been professionally trained, but would have possibly undergone informal apprenticeships and relied on reputation in order to secure clients (McIntosh, 2013). Meanwhile, in this era, in England, home was the safest place to give birth (with a midwife or staff member from the Royal Maternity Charity (RMC) attending). Until the 1880s, hospital birth carried a ten times greater risk of mortality compared with an RMC attended homebirth. This was due mainly to excessive levels of puerperal sepsis in hospitals, caused, many believe, by "arrogant doctors", whose "impatience led to an orgy of hazardous interference" (Loudon, 2000). The dramatic fall in maternal mortality rates occurred from about 1936 with the introduction of antimicrobials, and later, antibiotics (Loudon, 2000). In the following decades, the rate of maternal mortality continued to drop with the introduction of blood transfusion, better clinical care, better education of care providers, increasing application of antenatal care, and better nutritional supplements (Loudon, 2000).

The Midwives Act of 1902 had the explicit aim of ensuring the regulation and inspection of midwives (Heagerty, 1996) as a way of achieving a trained and disciplined workforce. However, it was the 1936 Midwives Act which finally succeeded in establishing midwifery as a salaried and regulated profession. The largely working-class body of midwives found themselves subject to 'occupational demarcation' (Witz, 1992) as stipulated by the medical profession. In the following decades, the number of midwives employed by the hospitals grew rapidly, until the formation of the NHS in 1948 oversaw a unifying of the employing hospitals (Kirkham, 1999).

2.1.2 Workforce trends

The state of the NHS workforce is under constant review (The King's Fund, 2023) and midwife numbers have been under scrutiny for several years now. The Royal College of Midwives (RCM) reports that the full-time equivalent (FTE) number has grown from around nineteen thousand in 2010, to around twenty-two and a half thousand at the end of 2022 (RCM, 2023). Figure 1 from NHS Digital illustrates this trend. It is also the case that midwifery remains a popular university degree, with several thousand starting the course every year (Health Education England, 2022). The RCM describe their concern, however, that this is not translating to a similarly sized increase in the workforce each year. The unexpectedly low levels of growth—and reduction—are only partly explained by the natural rate of retirement (RCM, 2023).

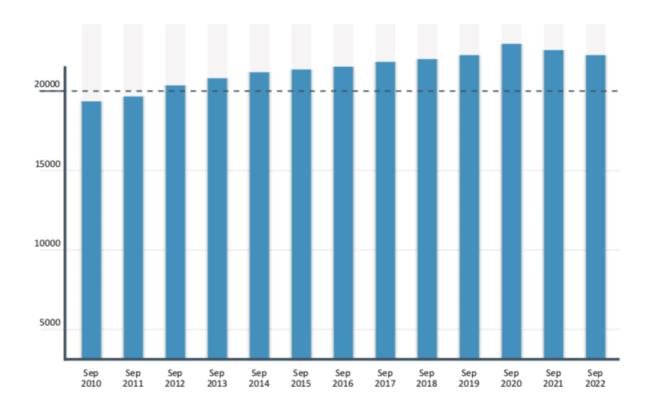


Figure 1. Annual change in midwifery workforce (FTE) (Source: NHS Digital)

The lack of growth is thought to be due to "the NHS not retaining older, experienced staff" (RCM, 2023, p. 14). The increased rate of attrition is attributed to a shortage of flexible working opportunities, lack of support for learning and development, poor workplace cultures and unacceptable behaviour in the workplace (RCM, 2023). Meanwhile, there has been a concomitant rise in patients presenting with more complex health conditions than ever before (RCM and RCOG, 2016) resulting in a workforce under ever-increasing pressure.

Workforce numbers are often reported in terms of the deficit, but can be unclear on the calculations upon which recommendations are made, which can lead to great variety in the reported figures. In 2011 the midwife shortage was said to be 4,700

(Press Association, 2011) falling to 3,500 in 2017 (McKinney, 2017). In 2022 an improved shortage of only 2000 is reported (MIDIRS, 2022). The RCM have cautioned, however, that staff numbers do not tell the whole story. The rising number of complex births, plus challenges including substance abuse and obesity, are also placing a strain on the existing midwifery workforce, which itself is comprised of an ageing workforce. Currently, a third of the workforce is aged in their 50s or 60s (RCM, 2017)—a fact which the Royal College of Midwives describes as a "gathering storm" necessitating urgent replacement of the older, typically more experienced workforce, but in time for them to build up their level of experience before their older colleagues leave the profession (RCM, 2017). As part of the NHS People Plan, a National Retention Programme was launched in April 2020 (NHS Employers, 2020). From this foundation the NMC and National Retention Programme have produced the Nursing and Midwifery Retention Self-Assessment Toolkit (NHS England, 2022). However, data regarding the success of these endeavours remains difficult to uncover at this point.

2.1.3 The NHS

The National Health Service has been described as an institution and a resource, as well as an emblem of wider and deeper social beliefs (Bivins, 2017). It has a special place in the hearts of the public (Parkin, 2009). Presently, most midwives in the UK work in the NHS, which has grown into a huge, complex, evolving organisation. When

it was founded in 1948, the NHS was supported by around 144,000 staff. It has now grown to around 1.5 million employees, making it the largest employer in the United Kingdom (NHS England, 2022).

The period after the Second World War heralded a reshaping of health-care systems across Europe, and an era of generating reforms that emphasised the responsibility of the state for providing healthcare (Benoit et al., 2005). At this time the NHS operated a tripartite health system comprised of hospital services, community services and family practitioner services, with midwives working mostly within the first two of these. In 1974 the NHS implemented significant structural and administrative reform and united these three separate arms of the health system into one integrated care provision service (Jones and Jenkins, 2008). This repositioned the previously relatively autonomous community midwives to within the hierarchical structures of hospitals, where midwifery practice was already constantly and tightly controlled (Kirkham, 1999).

2.1.4 Clinical governance and the commodification of healthcare

The 1980s saw a profound shift in health service delivery including the introduction of internal markets, as the NHS underwent the changes imposed by the Conservatives' long-term programme of 'rolling back the state' (Flynn, 1992). Policies which were designed to extend managerial control over medical professionals led to the application of increasingly bureaucratic and managerial control structures upon

a system which had formerly been dominated by the autonomous caring professions (Flynn, 1992). By the 1990s the question of healthcare quality had come to the forefront of consideration for NHS organisations, and a system of clinical governance was introduced. The aim was to develop an environment of excellence with the organisational capability to deliver high quality, accountable, patient focused healthcare (Donaldson and Gray, 1998; Nicholls et al., 2000).

Since this time, governance and clinical guidelines have been introduced and rewritten with rapid pace in response to a number of social and political factors, including demographic change, government funding, service planning and levels of reliance upon technology (Parkin, 2009). This has resulted in the NHS as a workplace being understood to be in "almost continual reform and restructuring" (Walshe, 2003, p. 106) with the concomitant levels of workplace surveillance, performance management and managerial control which that involves (Liefooghe and Mackenzie Davey, 2001). The NHS working climate has also been described as a "hyperinterventionist style of micromanagement" due to the "floods of directives" and "endless central plans" (Walshe, 2003, p. 108) and it has been suggested that the cumulative effect of so much reform has engendered a cynical and resistant attitude to innovation within the workforce (Parkin, 2009; Walshe, 2003). Some midwives have reported emotional exhaustion or hardening in response to the occupational burnout caused by this (Deery, 2005; Sandall, 1998).

Midwifery is connected to both nursing and obstetric medicine, and must adhere to rules of, and experience surveillance from, uniquely maternity-focused governing

bodies. This fact may not always be easily discernible to the general public, however midwives themselves are made cognisant of the regulations and scrutiny from the start of their training and throughout their careers. Increased governance, with its 'overwhelming' expansion of workload has the consequence of intensifying midwives' fear of making mistakes (RCM, 2016), and increasing general workplace stress (Edwards et al., 2018; Scamell, 2011).

Associated institutions are The Royal College of Midwives (RCM) and The Nursing and Midwifery Council (NMC). The RCM is midwifery's professional association which acts as a trade union and representative body, offering its members free legal advice and general workplace representation. They also conduct and commission research, provide education and training, and organise conferences and campaigns (RCM, 2022). In addition, the college produces a report called 'The RCM standards for midwifery services in the UK', (RCM Standards, 2016) which offers advice for midwives towards offering quality maternity care. The NMC is the governing and regulatory body for midwives (and nurses) and they have input into all aspects of the profession, including for students. All midwives must be registered with the NMC if they wish to be employed in midwifery in the UK. The NMC's regulatory activity includes registration and revalidation, education, fitness to practise, and professional standards. Midwives make up approximately just 5% of registrants, with nurses constituting the majority of the NMC register. The NMC is the author of The Code which is a set of professional standards for the practice and behaviour of nurses and midwives. It is fairly lengthy: 25 directives with 109 individual sub-rules, but a sample is provided at Appendix 1.

2.1.5 Guidelines

Clinical guidelines exist at local, national and international levels. Within maternity care they may be produced at the national level by bodies such as the National Institute for Health and Care Excellence (NICE), or by the Royal College of Obstetricians and Gynaecologists (RCOG). Although maternity units are not mandated to adopt national guidance, they may be challenged by the Care Quality Commission (CQC) in England, (or Regulation and Quality Improvement Authority (RQIA) in Northern Ireland, or the Care Inspectorates of Wales and Scotland) if they fail to adapt to them appropriately (Jokhan et al., 2015). This has sometimes led to perception of there being a hierarchy of guidelines, which may lead to inconsistencies between healthcare providers and may even conflict with each other (Whitehead, 2019). Nevertheless, the guidelines—which are defined as "systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances" (Field and Lohr, 1990, p.10)—are introduced in an effort to improve and standardise clinical care. They may take the form of explicit instructions on which diagnostic tests a doctor should order, or how to ideally offer medical services, or how long patients should remain in hospital, or other details of clinical practice. They are generally seen as a useful tool for making care more consistent, efficient and evidence based (Woolf et al., 1999). Evidence-based medicine is the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996, p. 71) and is a concept well known to all clinicians in the maternity care workplace.

However, the guidelines are not designed to supersede women's human rights of bodily autonomy, and therefore cannot be imposed without consent, nor used as a tool of coercion (RCM, 2022). There has been little evaluation of the quality or efficacy of guidelines (Jokhan et al., 2015) which has made them sometimes contentious.

2.1.6 Working structures

The midwifery workforce is often grouped together with nurses in instances of workforce reporting. The blurring of the two professions in the public consciousness is probably due to the fairly recent divergence of the two. Until the 1990s, the 18-month midwifery training programme was only accessible to those who had already completed training towards nursing registration. The 1990s saw the introduction of a direct-entry 3 or 4 year university degree to achieve midwifery qualification and registration. This has resulted in a contemporary workforce in which the longest serving members of the profession will have trained quite differently to those who qualified since then. A typical NHS Trust will contain several areas in which a midwife can work. There will usually be antenatal clinics, an antenatal ward, a labour ward (mostly for higher risk pregnancies, depending on the area), a postnatal ward, a team who work in the community, and possibly a birth centre (for lower risk pregnancies). All midwives will be very used to working as part of a multi-disciplinary team (MDT) which will include doctors.

Midwives who work full time in a hospital ward, or birth centre, will usually be required to work a round-the-clock schedule which entails three shifts per week, each approximately 12 or 13 hours, and which could be days or nights. Community staff and clinic staff will work a more traditional Monday to Friday 9-5 kind of timetable, although this has some variation between trusts, and does not account for being oncall for home births. Overtime is nearly always available. There is no regimented NHSwide protocol which determines how individual trusts or teams manage workplace allocation, and it can be subject to change by the personalities involved and the needs of the service. It is not unheard of for staff in any area to be contacted by senior management and asked, or told, to move to a different area at short notice. This can be a source of frustration for midwives. For many midwives, the feelings of burnout, pressure, stress, emotional distress and bullying are common, as evidenced in the NHS survey (Hunter et al., 2019). The 2019 WHELM Study also confirmed that NHS clinical midwives (who took part in the study) are experiencing emotional distress, burnout and work-related stress (Deery, 2005; Hunter et al., 2019; Sandall, 1998).

All midwives in the NHS are paid according to the Agenda for Change pay scale, which is a transparent banding system. Each band has several points through which midwives can progress. Newly qualified midwives will typically start to earn the figure at the bottom of Band 5, and will embark on a preceptorship programme in their employed role. This involves completing a series of competencies designed to ensure midwives have experience across different areas of care provision. Successful completion of the preceptorship programme (usually 12 to 18 months) will see a banding and pay increase to Band 6. There is some variation on whether a midwife is

able to freely choose which area she commits to as a Band 6. Many midwives will continue their career without ever moving on to Band 7, as this can require a move into management which is not always appealing. It is a small minority of midwives who visit the banding beyond 7, and it is not unheard of for those who do reach Band 7 to return to a senior Band 6 position in order to practise more in the clinical setting. All midwives are expected to offer choice, one-to-one care, and to respect women's decisions. The analysis chapters develop these concepts.

Section 2.2: Society and maternity care

2.2.1 Medical and Midwifery paradigms

Within western history, the story of midwifery written from the mid twentieth century often referred to a friction between the medical view of pregnancy and childbirth, and the more traditional holistic view held by midwives. The tension between the two models of care has led to a huge amount of scholarship on the topic (see for example Davis-Floyd and Sargeant, 1997; Donnison, 1988; Gaskin, 1996; Kitzinger, 2005; McIntosh, 2013; Payer, 1996) and was traditionally summarised as a divergence between doctors who wish to intervene medically and surgically in pregnancy and birth, and midwives who prefer to practise "watchful waiting" (Carlson and Lowe, 2014).

It could be argued however that, in recent years, this debate has moved on from presenting the two viewpoints as strictly dichotomous. Both the National Institute for Health and Care Excellence (NICE) and the American College of Obstetricians and Gynaecologists (ACOG) have demonstrated moves towards minimising the use of intervention of childbirth (NICE, 2021; ACOG, 2019). Further, midwives (and nurses, pharmacists and some allied health professionals) have been eligible to train as Non-Medical Prescribers since 1992 (Cope et al., 2016) implying an increasing acceptance of the need for medical intervention.

Broadly speaking, the 1970s was the era when Britain saw intervention become a routine feature of childbirth (Johanson et al., 2002). The medical and surgical interventions which require hospital confinement include induction and acceleration of labour, artificial rupture of membranes, increased electronic fetal monitoring, instrumental delivery, analgesia, anaesthesia, Caesarean section and safe blood transfusion. These interventions, combined with increasing use of antiseptic and aseptic techniques, lowered the maternal mortality rate considerably, making hospital based births increasingly common (Loudon, 2000). However, throughout this era, vigorous public debate continued. By the early 1990s there had been a significant change in public attitudes, and in 1992, The Winterton Report (HoC, 1992) was published which argued that the medical model of care was 'inappropriate' for the majority of fit and healthy women and babies. This sentiment was echoed by the Department of Health's 'Changing Childbirth' report in 1993, and the argument that medicalisation of childbirth had gone too far thus gained traction (Johanson et al., 2002). The report's recommendations have been only partially achieved however,

due to political commitments limiting the extent to which they could be implemented (Jowitt, 2018).

2.2.2 The role of technology

It could be the case that in the contemporary United Kingdom, technological intervention has been normalised to the point that it is no longer viewed as unnatural (Luce et al., 2016). The increased reliance on technology within the workplace is thought to improve efficiency, while technological tools can be made to provide greater consistency of service than humans. Electronic blood pressure measurement, neonatal incubation, electronic fetal heart monitoring, ultrasound visualisations of a fetus and digital data collection are routine practices nowadays which might be considered unexceptional. This use of technology ensures uniformity of action, and also enables surveillance and recording of the clinical event (and person) (Hunter et al., 2008). However, within maternity healthcare provision, the relationship between healthcare providers and technology use has been inconsistent.

The medical field has been described as more likely to commend the use of technological advancement with the optimistic spirit "that anything was possible if only the natural environment [...] could be conquered' (Payer, 1996, p. 127). This has occurred within the wider context of increased technology contributing to "the happiness of mankind" in the name of "progress and power" (Postman, 1992, p. 35).

Early exposure to the kinds of medical technology mentioned above has normalized it as a method for achieving optimal reliability when it comes to physical measurement.

The concept of the "technocratic model of childbirth" was developed by Davis-Floyd (2001). This term was used to denote a paradigm that "stresses mind—body separation and sees the body as a machine" (Davis-Floyd, 2001, p. 6) where authority is invested in physicians and institutions, rather than the subject (pregnant woman) under discussion. Women who are pregnant or giving birth are often "willing to do whatever they have been led to believe might help to ensure a well baby and control of birthing processes" (Klein et al., 2006, p. 247). It has been suggested that this has led to women experiencing a new type of relationship with their bodies, which is mediated by the doctor or midwife, and their expert use of technology (Klein, et al., 2006; Lazarus, 1997).

In contrast, there is a 'humanistic' school of thought which questions the primacy of technology in the context of pregnancy and birth. The humanistic view rejects the notion that birthing bodies can be adequately measured using a machine, as technological inquiry excludes the emotional, relational factors which have long been recognised to impact the physical state (Klaus et al., 1993; Davis-Floyd, 2001).

2.2.3 Maternal requirements

The wishes and experiences of pregnant and birthing women have not always been perfectly aligned with what maternity services were offering (see for example Kirkham, 1999; Oakley, 1986). For instance, some women may advocate for easier access to medical interventions, like caesarean section on demand (Duperron, 2011). Conversely, some women would prefer if healthcare providers were more cautious about implementing interventions (RCM, 2022). Since the 1950s, service users have been collectively voicing feedback through the National Childbirth Trust (NCT), and since the 1980s through the Association for the Improvement of Maternity Services (AIMS) and the Maternity Services' Liaison Committees (MSLC). A personalised route to making a complaint or seeking a response from a hospital Trust in England, is to submit a query through a hospital's Patient Advice and Liaison Service (usually known more colloquially as PALS). A similar service called Patient Advice and Support Service (PASS) is available in Scotland. Through this route, women are able to give feedback on their patient experience.

The Audit Commission in 1997 identified that while women mostly reported satisfaction with their clinical care, dissatisfaction with the emotional and interpersonal aspects of their care was apparent. Further, the 2003 NICE Antenatal Guidelines referred to evidence that suggested women sought more respect, competence, support and communication in pursuit of feeling more valued and in control. Women have described feeling vulnerable during birth (Simkin, 2002) and wish to communicate that they are not entirely satisfied with the care they are receiving.

2.2.4 Demographic changes

The requirements of the maternal population in the UK have changed to some extent over the years. As noted earlier in the chapter, maternal mortality rates dropped dramatically after the introduction of antimicrobials and antibiotics during the early 20th Century, and then dropped further with the introduction of blood transfusion, and better antenatal care in the decades that followed (Loudon, 2000). However, health complexities have evolved in the maternal population since that time. The health complexities thought to be on the rise include cardiovascular disease, type 2 diabetes and various cancers (Hancock, 2021). Co-morbidities which result from complexity include gestational diabetes, and pre-eclampsia (RCOG, 2010), while the management of anaesthesia, and increased risk of caesarean section is another factor to consider (Denison et al., 2018; Gupta and Faber, 2011). The increase in the number of pregnant women with conditions like these has resulted in a higher proportion of births involving more complex care, requiring risks to be managed and more interventions to be delivered (National Audit Office, 2013).

The requirement to provide care for a population with increased medical issues impacts the midwives, creating a role which now scarcely resembles that of their 1950s counterpart. This has had the benefit of improving good outcomes for complex cases, but has also resulted in care providers taking a generally more risk-focused perspective with all of those under their care. Some have argued that the impact of placing the concept of risk ahead of individualised care has not been properly

considered (Lupton, 2012; MacKenzie Bryers, and van Teijlingen 2010; Nolan, 2015; Scamell, 2011, 2016).

2.2.5 Public opinion

The fragility of the profession has been understood by academic midwives for decades (e.g. Barker, 2016; Curtis et al., 2006a; Davies and Coldridge, 2015; Deery, 2005; Gillen, 2002) and the issues of burnout, bullying and increasing bureaucracy are well known within the profession (eg. Kirkham, 1999; McIntosh, 2013). British news media portray an embattled and beleaguered midwifery profession which is struggling to hold onto its workforce (e.g. Campbell, 2018; Roberts, 2021; Topping, 2020). Conversely, entertainment media provides a view of midwifery which, while not directly contradictory, may be depicting the profession in quite a different light (Hundley et al., 2019). This discourse usually focuses on the production of unrealistic birth expectations for pregnant women, which could then go on to create unexpected outcomes in the childbirth event. However, similar could be said for the expectations of midwives and those hoping to join the profession, which shows that the image of midwifery is something which could benefit from greater attention. Since 2012, programmes like Call The Midwife and One Born Every Minute have led to an increase in applications to study midwifery, and it remains still a very popular course to take at university (Blamire, 2013).

2.2.6 A values-based approach

The public enquiry into the tragic failings of the Mid Staffordshire NHS trust—as investigated by the 2013 Francis Report—led to an understanding that poor leadership which focused on targets, rather than people, led to health professionals failing to provide those under their care with safe, high quality care. This represented a turning point in the way the NHS approached the question of workplace culture. Since this time, there has been increased focus on promoting the values of compassion, personalised dignity and respect (DoH, 2012). To this end, a new midwifery 'values-based' curriculum was introduced to support the strategy of recruiting those who fit a criteria which defines caring as an 'art' rather than a 'science'. This was designed to counter what has been called a "factory assembly line" mentality (Walsh, 2006), which put the needs of the institution above the needs of the women (Deery and Kirkham, 2006). The importance of meaningful relationships which enable support of individuality and humanity is fundamental here (Kitzinger, 2005).

This represents a key factor for the profession of midwifery: the balance and fine line between being a competent professional who uses evidence-based knowledge alongside a more relational, emotional and sensitive type of work. This requirement to work within different paradigms of knowledge has been addressed as a requirement of healthcare providers in the past. The four "fundamental patterns of

knowing" are described for nurses as being empirical (factual knowledge from science), personal (derived from empathy), ethical (awareness of moral questions), and aesthetic (an awareness of the immediate situation, acknowledging the patient as uniquely individual) (Carper, 1978). Incorporation of 'aesthetic knowing' into nursing education is thought to foster caring, compassion, and self-awareness in practice (Koithan, 1996). Similarly, since working within a medicalised paradigm, midwives have questioned what is eligible to be considered 'authoritative knowledge' in maternity care provision (see for example Davis-Floyd and Sargent, 1997; Gaskin, 1996). What this thesis seeks to foreground is the acknowledgement that this conflict does not exist solely in the philosophical or theoretical plane. In a demonstrable sense, the midwifery 'way of knowing' is encountering resistance from the structures of employment upon which midwives rely. The structural reality of the workplace relies heavily upon acceptance of progressively more technocratisation.

2.3 Chapter summary

This chapter has aimed to broadly illustrate and contextualise the role of a contemporary midwife. In the first section I described some of the bureaucratic factors and governing principles of the profession. This was intended to convey the material reality of being employed as an NHS midwife. The second section portrayed some of the more intangible qualities of working within the maternity care field. This was provided to give insight into the kind of unquantifiable knowledge which is

neither taught nor formally recognised, but which continues to influence midwifery practice and all of those involved in the delivery of maternity care. Taken as a whole, this chapter should reveal that while clinical competency and recognition of employment factors are integral to the work of the NHS midwife, there is further nuance to consider. The parts of the role which rely upon relational, emotional factors represent important central elements for many midwives. The value of this aspect of midwifery has been recognised by service-users and midwives alike, and legitimised within NHS policy and clinical governance frameworks (Cummings and Bennett, 2012; Francis, 2013). By uncovering the effects of workplace bullying, this thesis demonstrates that maternity care provision cannot flourish within organisational structures which discourage a relational perspective.

Chapter Three: Reconceptualising bullying in the literature

Bullying is one of the most troubling and persistent issues faced by workplaces globally (Einarsen et al., 2003; Gillen et al., 2004; Hoel and Salin, 2003). This chapter confirms this with discussion of the considerable attention that has been paid to the phenomenon within academic and social discourse. The traditional construction portrays workplace bullying as primarily an intentional phenomenon—characterised by an individual (or group of people) purposely inflicting ill-treatment upon another with the aim of causing a negative impact (Branch et al., 2007; Einarsen et al., 2003). This approach to understanding bullying could be described as "institutionalized" however, resulting in a "limited understanding" of the ways that bullying is defined, constructed, and experienced in workplaces (Liefooghe and MacKenzie Davey, 2010, p. 71). At the root of my concern about the traditional understanding of workplace bullying, is that the term is usually portrayed objectively as quantifiable, deliberate behaviour, when, as the empirical chapters demonstrate, it is often a subjective experience. Within an objective conceptual framework, organisational efforts to reduce or eliminate bullying focus on tackling measurable and intentional actions. The essentialist view of bullying is therefore problematic as it does not explain staff experiences of being bullied, and interventions to reduce bullying which are grounded in this perspective do not work. When bullying is reconceptualised as a depersonalised phenomenon, efforts to reduce targets' sense of being bullied could be reinforced by an approach which acknowledges the depersonalised nature of the phenomenon.

Reading the literature on bullying in the light of my own experiences as a midwife who has experienced behaviour that was felt subjectively to be bullying—but which did not conform to essentialist definitions—I was drawn to sociologically informed perspectives which have been synthesised into the theoretical concept of Depersonalised Bullying. In this chapter I make a case for why this is a useful lens for understanding bullying in NHS midwifery. I argue that if the bullying is instead considered as a feeling which is experienced by the target, rather than a behaviour which is enacted by a bully, it is possible to imagine and apply new ways of dealing with the problem. While the motivation to reconceptualise the issue arose from frustration with the persistence of workplace bullying, the form of the reconceptualisation emerged from the reflexive approach to the interview data analysis, and is described in subsequent empirical chapters.

New perspectives can be created by reframing a question and re-specifying the boundaries and what falls inside, and what falls outside the definition under investigation (Goffman, 1974). Within this chapter, I critically evaluate the dominant objective theoretical approaches to bullying. I then introduce the subjective conceptualisation as an alternative—using the slim field of extant research which utilises the novel approach to conceiving of workplace bullying, to illustrate its value. The conceptualisation to be used is commonly described as 'depersonalised bullying' (D'Cruz and Noronha, 2015; Liefooghe and Mackenzie Davey, 2001) and refers to workplace subordination which is not related to personality clashes, but rather to the mechanisms of organisational control. The abuse and hostility which is often used in pursuit of organisational effectiveness (D'Cruz and Noronha, 2015) can feel like being

bullied, and leave the target feeling just as demeaned and disempowered as victims of interpersonal encounters (Liefooghe and Mackenzie Davey, 2001). Throughout conception and delivery of this research project, my position as a former NHS midwife has required me to take a reflexive stance. I believe that consideration of a subjective perspective to workplace bullying arose from my own experiences in the maternity workplace. This is explored in greater detail in the empirical chapters, however also accounts for this methodological choice.

The aim of reconceptualising the phenomenon this way is to produce original insight into how the midwifery profession within the NHS can address the enduring problem. In this chapter the reframed approach to workplace bullying is introduced and presented, while being contextualised within the traditional, dominant discourse on workplace bullying. Despite having its origins in organisational studies which are neither midwifery related, nor even health or social care adjacent, the 'depersonalised bullying' perspective represents a useful critical research position which can complement the dominant objective tradition from which most bullying research arises (Liefooghe and Mackenzie Davey, 2001). This study thus provides a convincing foundation from which future researchers can realise the potential for this novel approach to reconceptualising the bullying phenomenon.

Structure of the chapter

This chapter starts with a brief exploration of the arguments for exploring subjective approaches to understanding bullying. This serves to better contextualise the proposed reconceptualization which follows as the chapter continues. Following this, I present analysis of how bullying is typically conceptualised. Within this section, the two primary traditional conceptualisations are discussed: 1) Interpersonal bullying, and 2) Organisational Bullying. These frameworks of understanding are the most commonly utilised with the extant literature on bullying. For this reason, these firmly embedded conceptualisations inhabit a somewhat presupposed position in the discussion of bullying research.

In the section which follows that, the specific literatures on NHS and midwifery workplace bullying are evaluated. Then, the characteristics of a nascent type of critical framework, Depersonalised Bullying, are introduced, and compared to the extant literature on the issues of professionalisation and bureaucratisation of workplace factors in the NHS. It can be understood that midwifery bullying research has conceptualised bullying within either the interpersonal or organisational frameworks, but that a critical view has not yet been taken, and more specifically, the Depersonalised Bullying lens has not yet been applied to this particular area of workplace bullying.

Finally, I give an overview of the prevailing landscape, which serves to contextualise and justify the change of framework which I have proposed for the study of workplace bullying in NHS midwifery. Within this broad view, conceptualisations of bullying have varied, but can be usefully categorised as generally one of three types: interpersonal, organisational, and depersonalised.

3.1 Arguments for a subjective approach

The problematisation of received wisdom is considered useful when wishing to better understand concepts and phenomena (Alvesson and Kärreman, 2011), and in this thesis has been undertaken with respect to the study of bullying in the workplaces of NHS midwives. Established theory regarding what is thought to qualify as workplace bullying has so far been anchored in the positivist paradigm (Samnani, 2013). Target subjectivity is often overlooked in favour of objective and measurable behaviours, which then results in negative target experiences which diverge from those being measured being discounted (D'Cruz, 2015; Hoel et al., 2004). A move towards a post-positivist paradigm then allows consideration of the more puzzling, emotive or complex aspects of organisational life (Prasad, 2005) along with the subjective meanings that participants attach to events or phenomena (Ryan, 2006). In anticipation of developing new perspectives of enquiry, the post-positivist tradition serves as an ideal foundation from which to conduct research (D'Cruz et al., 2018).

3.2 Current conceptualisations of bullying

This section describes the three main lenses through which workplace bullying has been perceived. The first describes the type of bullying which may first spring to mind: one person deliberately victimising another. Reasons for the bullying, and the methods used can vary, and can cause serious and unpleasant effects. The impetus for this type of bullying remains personal. The second lens through which workplace bullying is perceived is 'organisational bullying' which is used to describe bullying which still occurs between individuals, but which can be explained as being caused or influenced by workplace pressures which emanate from the organisation. This approach is still focused on the individual as the primary unit of analysis. However, bullies in this situation may not have a personal reason for targeting someone. Rather, they have succumbed to strain, or have taken advantage of competitive situations or power struggles at work, to assert dominance over a victim. This type of bullying retains an element of intentionality, and any gain they achieve will be personal to them. An emerging alternative framework for conceptualisation of workplace bullying is also described. The third form—Depersonalised Bullying—describes situations in which workplace structures themselves are responsible for causing pressure which makes workers feel bullied. This nascent approach represents a far smaller bank of research literature, and has been applied to a far narrower variety of organisations than either the interpersonal or organisational lenses. Next, I give descriptive evaluations of the three aforementioned methods of conceptualising of workplace bullying.

3.2.1 Interpersonal

The first is an interpersonal approach—where bullying is conceived of as a phenomenon which exists between individuals. In these instances, the employing institution responds to bullying complaints by seeking to repair individual behaviours, or by moving or removing individuals (Marzionna, 2020). The interpersonal approach was originally dominant, and accounts for the large number of studies dedicated to identifying individual actors (bully and victim), the prevalence of acts of bullying, and antecedents and outcomes (Carter et al., 2013; Hoel and Cooper, 2001; Quine, 1999).

Much bullying research continues to favour definitions of bullying which stem from the work of the 1970s "founding father" of bullying research, Dan Olweus (Smith and Norman, 2021). A social scientist from Norway, concerned primarily with bullying in schools, Olweus favoured essentialist, structured and precise definitions of bullying, which contained elements of intention, repetition and power imbalance (Olweus, 1993; Solberg and Olweus, 2003). These portrayals of bullying suggest personal interaction with egregious intent. Consistent with this definition of bullying, workplace research literature often describes bullying as 'social exclusion' (Einarsen et al., 2011), 'withholding information', 'humiliation and distress' (Douglas, 2014), and 'harassment' (Hoel and Cooper, 2001). Olweus' essentialist approach has its limitations, however. By positioning the actions and behaviours of individuals as the most valuable or relevant consideration, structural, institutional and social power differentials are thus neglected. With bullying widely conceived of as solely

behavioural and relational, the corrective interventions which follow would necessarily be directed towards fixing the issue at this level. The wealth of programs and policies designed to combat bullying evidently conceptualise of the phenomenon in a similar fashion. So far it seems that this system has been ineffective.

Interpersonal antecedents to workplace bullying usually aim to identify the characteristics of individual participants (Ariza-Montes et al., 2017; Coyne et al., 2000; Illing et al., 2013; Mikkelsen and Einarsen, 2002; Zapf, 1999; Zapf and Einarsen, 2005). Within this interpersonal framework of bullying, bullies have been described as dominant, aggressive, and self-confident (Olweus, 1993), while "passive-avoidant" and "non-responsive leadership behaviour" (Glambek et al., 2018, p. 297) have been described as enabling and allowing bullying. However, there is something of a 'black hole' in the research field regarding the objective motivations and perspectives of the alleged bullies (Hutchinson et al., 2008; Rayner and Cooper, 2003).

Among victims of workplace bullying, the characteristics of submissiveness, introversion and having a neurotic personality are thought to be common (Brodsky, 1976; Coyne et al., 2000; Mikkelsen and Einarsen, 2002). However, in contrast, provocative personalities have also been correlated with victimhood in bullying (Matthiesen and Einarsen, 2007; Glasø et al., 2009). Both victim and bully characteristics prove difficult to map via the route of objective measurement (Leymann, 1996). I propose that searching to objectively describe the characteristics of individuals distracts from the more useful task of discovering what is leading to

people feeling bullied at work. For this proposed approach it is useful to consider the workplace structures which influence the sense of being a victim of bullying.

3.2.2 Organisational

The second category of conceptualisation is *organisational*—when bullying behaviour is seen to be caused or influenced by workplace pressures which emanate from the organisation (Fox, 1974). This approach is still focused on the individual as the primary unit of analysis, with their employing organisation positioned as little more than a background context, enabling the phenomenon to occur. Studies like this examine organisational antecedents to workplace bullying and have focused on organisational responses to bullying events or climates of negativity or insecurity which allow bullying behaviours to flourish. This then advances the 'work environment hypothesis' (Salin and Hoel, 2011) which usually identifies factors like job design and the organisation of work, leadership style (Hoel et al., 2004) or organisational change (Baillen and De Witte, 2009) as background elements which foster a 'pressure-cooker environment' (Salin, 2003) beset by stress, overwork or competitiveness (Hoel and Salin, 2003; Zapf, 1999) thus providing the conditions for workplace bullying to flourish.

Organisational culture and organisational hierarchy are regularly implicated in discussions of workplace bullying (Beswick et al., 2006; Darbyshire et al., 2019; Enoka, 2018). When organisational characteristics are taken into account, bullying is

then conceived of as a strain outcome of workplace power imbalances (Hansen and Kahnweiler, 1993; Van den Brande et al., 2017), or a reaction to emotionally-critical internal states (e.g. anger, anxiety) generated by poor working conditions (Balducci et al., 2012; Einarsen et al., 2003; Hoel and Cooper, 2001; Langan-Fox et al., 2007; Salin, 2003a, 2003b). Often, bullies are cited as being 'managers' who take advantage of 'power imbalances' at work in order to behave in 'negative' ways towards junior staff who feel unable to defend themselves (Einarsen, 1999, 2005; Leymann, 1996; Zapf, 1999). These negative acts are viewed by victims as behaviours of manipulation and destruction (van de Vliert, 1998). In response to this, researchers have examined the properties of hierarchical organisations, and so introduce the concept of power as a mediator in the bullying relationship.

Power is fundamental to most social relationships, and, central to the definition of bullying in all contexts, is the concept of asymmetrical power (Monks et al., 2009). Issues of power and powerlessness permeate the bullying literature, with particular organisational contexts thought to facilitate or inhibit abuses of relational power (Hodson et al., 2006). However, there are differences between the way imbalance of power, and its relation to bullying is approached, depending on the institution under review. A brief critical review follows, of how power and bullying are investigated within three types of organisations: prisons, schools, and workplaces.

Organisational bullying in prisons is rarely researched without consideration for Goffman's theory of Total Institutions (1961). The definition of a Total Institution—which requires members to sleep, play and work (Giddens et al., 2018) in the same

place—clearly fits prisons more closely than schools or workplaces. Conclusions regarding prison bullying are often associated with the prison population being intrinsically powerless and under the bureaucratic control of the 'totalising' prison system (Ireland, 2000, 2002). Analyses of the power structures in school bullying recognise the compulsory aspect of schooling, which makes it difficult for bullied students to leave (Duncan, 2013). Additionally, schools are often marked by control and competition, as pupils are constantly being measured and judged against each other. It is thought that this serves to facilitate dominance struggles which fosters the establishment of hierarchies and can lead to bullying (Duncan, 2013; Jacobson, 2010; Walton, 2005). Power analysis in workplace bullying has to consider that the members of these organisations attend voluntarily and are compensated for their attendance. They are neither mandated to attend, like prisoners, nor (usually) judged and hierarchised, like school pupils. In the case of workplace bullying, power relations are often related to career progression and professional alliances (Hutchinson et al., 2009). Pursuing career aspirations can also require uncritical organisational loyalty (Soylu, 2010), which would not be the case for prisoners or pupils. These factors are stated in order to underscore that the concept of 'organisational bullying' is not unambiguous and could therefore be an unreliable tool to measure bullying at work. Even with a particular understanding of which type of organisation is being discussed, when bullying is thought to be caused or influenced by workplace pressures which emanate from the organisation, it is still being thought of objectively as an intentional behaviour which happened, even if the trigger was impersonal. The influence of organisational types of bullying is evident.

3.2.3 Depersonalised

This third frame of reference follows the tradition of Fox's (1974) critical perspective when understanding employment relations. It is used when the workplace is perceived as a forum in which conflict and unequal power dynamics are intrinsic features of the system leading to a sense that the worker feels bullied by the systems of the workplace (Fox, 1974). Within the depersonalised framework, researchers ask whether workplace structures themselves are responsible for creating an occupational pressure which makes workers feel bullied. The depersonalised framework rejects the notion that workplace bullying can be explained solely by personality clashes. This perspective considers organisational culture, policies and embedded practices to be tools of subjugation which ensure compliance from the workforce in deference to the expectations of the organisation (Alvesson and Deetz, 2012; D'Cruz and Noronha, 2008; 2013b; Evesson et al., 2015; Liefooghe and MacKenzie Davey, 2001). By situating analysis of workplace bullying within assumptions about the nature of managerial control of labour, it is possible to incorporate broader sociological dimensions (Beale, 2011; Ironside and Seifart, 2003). The depersonalised bullying framework sees bullying as a socio-structural entity (D'Cruz, 2015) stemming "not so much from abusive or illegitimate use of power, as from power which is considered legitimate, and tightly related to the managerial prerogative to manage" (Hoel and Salin, 2003, p. 205). Managers thus rely on abusive behaviours with subordinates in order to realise the organisational agenda (Berlingieri and D'Cruz, 2021), and justify getting the job done (Brodsky, 1976;

Beale and Hoel, 2011; Ironside and Seifert, 2003). This represents a relatively new direction of research within bullying scholarship.

The concept of Depersonalised Bullying originated from Liefooghe and MacKenzie Davey's (2001) examination of the different ways in which the term 'bullying' is used in the context of what they describe as the "pathologized organisation". In this study they noted that employees used the term 'bullying' to describe their discontent at increasingly difficult work situations, due to the word's impact as an "emotive and highly charged term" (Liefooghe and MacKenzie Davey, 2001, p. 375). Use of the term did not go much further until it was adopted by D'Cruz and Noronha (2008) who referred to it (seemingly for the first time) in 2008 to deliver a presentation relating the work experiences of Indian call centre agents, entitled 'Employer as Oppressor: Engaging the Organisational Framework in Understanding Workplace Bullying' at the 6th International Conference on Workplace Bullying in Montréal. A publication clarifying their definition of the term followed (D'Cruz and Noronha, 2009). Thus, the depersonalised conceptualisation of bullying acknowledged that victims can also feel bullied by:

routine subjugation, both covert and overt... by contextual, structural and processual elements of organisational design, which are implemented by supervisors and managers who resort to abusive behaviours in an impersonal way, to achieve organisational effectiveness (D'Cruz and Noronha, 2013a)

In the context of the original study of Depersonalised Bullying, the authors first describe the material benefits enjoyed by the call-centre workers. The call-centres were located in ultra-modern, state-of-the-art buildings. Employees were offered relatively attractive pay packages and incentives such as gift vouchers, clothes and accessories. Employee self-esteem was enhanced by job titles like 'call centre executive' and 'customer care officer', while status improvement could be earned by working with overseas clients (D'Cruz and Noronha, 2015). These benefits coalesced to create a sense of superiority in the call-centre workers. Employers then emphasised the professionalism of the call-centre workers, in comparison to factory workers, enabling the employer to suppress any aspiration of worker collectivisation (D'Cruz and Noronha, 2015).

"For what do we need unions? Professionals do not need unions. Unions are for factories where the workers are weak. Here we are all educated and independent" (D'Cruz and Noronha, 2015, p.30).

The financial benefits and incentives also strengthened the workers' compliance with the very demanding requirements of the role. The job demands which workers were expected to fulfil were designed to enable completion of very high volumes of work. These would include repetitive, standardised tasks which were strictly monitored and measured with technology. Employees were required to work long and variable shifts, often without breaks. During phases of high call volume, shifts may be extended with little warning, with agents often receiving no overtime pay. The call centre employees' narratives highlight employee subjugation through a variety of elements of organisational design. There follow some sample statements from participants in

the study. These excerpts demonstrate the impact of the depersonalised processes of the workplace.

"How did you handle the call, how long you took to pick up, how much time, did you speak properly, could you meet the target. Metrics will be done for you and your team. Per day, per week, per month, performance is tracked"

"You cannot take a breather. Basically, you are tied down. And everything is logged into the system – our time in, our time out, our schedule"

"One is on edge all the time – everything is monitored from the time you step onto the floor til the time your shift is over... it never ends, day after day. I feel tense and anxious all the time. They keep records too. If you make a mistake they will scream at you" (D'Cruz and Noronha, 2015, p. 32).

The outcomes of this kind of employee subjugation were not dissimilar to those experienced by victims of interpersonal bullying. Health problems, nausea, diabetes, hypertension, insomnia, chronic fatigue, repetitive strain injury, anxiety and depression were all commonly reported (D'Cruz and Noronha, 2015, p. 36). However, the outcomes were endured as long as the call-centre worker wished to maintain receipt of the income, benefits and prestige conferred by the job title (D'Cruz and Noronha, 2015).

Suitability of Depersonalised Bullying lens for NHS midwives

Call centres' dual focus on efficiency alongside customer service, which creates an inherent tension between quality and quantity (Houlihan, 2001), is a feature which has already been documented within NHS workplace literature. The nascent approach of viewing bullying through the depersonalised lens represents an original, and appropriate way to examine bullying in NHS midwifery. In doing so it uncovers the blurred boundary between how the midwife interviewees perceive their personal selves in relation to their professional selves, the role that work has in mediating this, and why it matters. Taking a depersonalised view of bullying is not only disruptive to the previously objective, defined theories of bullying (Walton, 2011), it acknowledges complexities which better capture the nuance of how bullying feels and is experienced (Rawlings, 2017). When definitional boundaries are imposed upon a group who state they are feeling harmed, researchers are (inadvertently) conveying that some types of harm may be less meaningful than others. A depersonalised framework corrects this limitation.

Depersonalised bullying is characterised by rigid monitoring and inflexible rules which are insensitive to the personal circumstances of those to whom they are applied. The distinctive features of depersonalised bullying are detailed in figure 2.

	Depersonalised Bullying	Interpersonal Bullying
Source	Downwards	Downwards, upwards, horizontal
Visibility	Public/Obvious or Private/ Subtle	Public/ Obvious or Private/ Subtle
Form	Real or Virtual	Real or Virtual
Aetiology	Achieving Organisational Goals	Personal or Work Characteristics
Target focus	General	Specific
Temporality	Chronic or Episodic	Chronic or Episodic
Power Dynamics	Blurs legitimate and illegitimate organisational power	Illegitimate personal power
Outcomes for targets	Negative	Powerlessness
Outcomes for organisations	Mixed/Negative	Mixed/Negative

<u>Figure 2: The distinctive features of Depersonalised Bullying at work (Source: D'Cruz, 2015, p. 60)</u>

The rows highlighted in bold are of particular interest here. By reframing the source (aetiology) of the bullying, the largest shift in perception occurs. Depersonalised bullying imagines that subordination is not related solely to personality clashes, but

is a course of action aimed towards successfully realising the goals of the organisation. By reframing the concept thus, the normalised tools of managers are recategorized as bullying, precisely because this is often how it feels to the target.

This approach has limited precedent, although has been taken before. Liefooghe and Mackenzie Davey (2001) offer, as an example, the organisational practice in a telecommunications company of publicly displaying statistics relaying employees' performance. This practice is devised as a tool to embarrass workers into working faster, which is designed to benefit the organisation economically. Similarly, intrusive levels of electronic workplace surveillance where employees must account for every minute of their time has previously been described as a tool of "control... and cultural manipulation", at least within the context of an Australian call-centre (Townsend, 2005, p. 47). This type of surveillance can feel demeaning to workers. Next, I describe efforts within the NHS to achieve the aims of the organisation, and it becomes clear that these intersect with the principles of Depersonalised Bullying, even if it has not yet been expressed explicitly as such.

Taking a depersonalised view of what constitutes bullying allows the definition to "rest on the subjective perception made by the victim that these repeated acts are hostile, humiliating and intimidating" (Niedl, 1995, p.49). This approach allows focus to rest upon the perceptions of the targets, turning it into a subjective construct which does not require the element of intentionality.

3.3 Bullying in the NHS

While the depersonalised bullying conceptual framework has not been applied to scholarship set in the NHS, much progress has been made within the interpersonal and organisational paradigms. Alongside this, there is a long history of interrogating the professional structures of the professions within the NHS. However, these studies have been completed without a link being made to how these structures are perceived by the staff, and what their relation is to staff feeling bullied. It is within this gap that this thesis is set.

As noted in Chapter Two, large studies (see for example Carter et al., 2013; Illing et al., 2016) have already successfully established the size of the bullying problem in the NHS using questionnaires or systematic database searches. For instance, UNISON has defined workplace bullying as persistent, offensive, intimidating, humiliating behaviour, which attempts to undermine an individual or group of employees (UNISON, 2010). The NHS Workforce Bullying and Harassment Policy adopts a similarly interpersonal perspective when it characterises bullying as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate, or injure the recipient (NHS, 2021). The rich pool of NHS bullying data (such as Carter et al., 2013; Hadikin and O'Driscoll, 2000; Illing et al., 2016) then serves to illustrate the persistence of the phenomenon, but there is no easily discoverable data relating to the impact that anti-Bullying

literature and programmes has had. The ever-increasing levels of bullying—reported by victims, as shown in figure 3—suggests that these efforts have been ineffective.

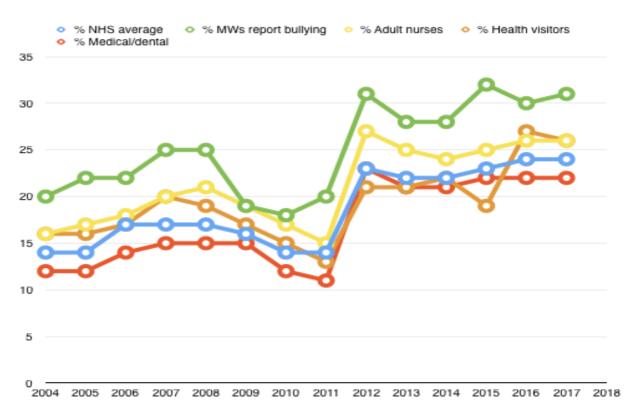


Figure 3. Levels of bullying reported by differing NHS professions. (Source: NHS Survey Co-ordination centre, 2019)

What is acknowledged within the NHS, is that workplace culture and climate act as a predictor or mediator of bullying (Gillen et al., 2004; Hadikin and O'Driscoll, 2000; Hugman, 1991; Pezaro et al., 2016; Wilson, 2016). In particular, the presence of hierarchical power structures is known to be influential. Within nursing research, it is believed that 'organisational obedience' from nurses is achieved via the use of bullying from management (Hutchinson et al., 2006; MacMahon et al., 2018), while workplaces which foster pressure to 'fit in' can create a culture of workplace bullying (Francis, 2013; Hadikin and O'Driscoll, 2000; Paley, 2014). The hierarchical nature of most NHS workplaces has led some researchers to advocate for removal of hierarchy

in healthcare as a means of eradicating bullying (Leap, 1997) and preventing workforce attrition (Curtis et al., 2006b).

3.4 Bullying in NHS midwifery

In Chapter Two I outlined the structural and organisational aspects of the profession of midwifery in the NHS. The tensions between the risk-focused medical model, and normality-led midwifery models of care are well represented in the way the profession is understood—and understands itself. Midwives describe their attraction to the profession as coming from a desire to work autonomously while providing care and support for their patients. These factors form a large part of a midwife's feelings about her professional identity and thus her feelings about being bullied. Much of what midwives base their professional identity upon originates from the NMC Code of Conduct (parts of which are attached at Appendix 1). This too is borne out by much of the extant literature on bullying in NHS midwifery.

Within midwifery bullying research, the overall findings bear a resemblance to those of the wider working world. General issues with the workplace climate are acknowledged to act as a predictor of midwifery bullying (Hastie, 1995, 2006; Pezaro et al., 2016). Students and newly qualified midwives (NQMs) are known to be negatively impacted by the imbalance in the mentor-student relationship and hierarchical power imbalances generally (Begley, 2001, 2002; Finnerty and Collington, 2013; Gillen et al., 2004; Green and Baird, 2007; Hugman, 1991; Pezaro

et al., 2016; Pisklakov et al., 2013; Randle et al., 2007). Gillen et al.'s (2004) huge study into bullying in midwifery highlights 'permissive culture' as the reason for midwives having "no confidence in the support mechanisms currently available within the workplace", where "the most senior person's story would be believed" and "the victim's point of view was easily dismissed... speaking out left them vulnerable" (p. 17). This resembles the findings on whistleblowing and grievance procedures from the more general NHS bullying research.

On a related note, when student experiences have been examined in contexts other than bullying—such as student attrition rates, the role of mentors or traumatic birth events—student midwives have reported feeling stupid or belittled (Hughes and Fraser, 2011), diminished and humiliated (Davies and Coldridge, 2015), and frustrated, isolated and angry (Green and Baird, 2007). It should be noted that it is qualified colleagues causing these feelings (rather than patients). The question of what to do with senior staff members who bully is posed by Curtis et al. (2006a) in their six-part published study of why midwives leave the profession. Organisational fear of losing experienced staff who also bully is described as a prime inhibitor of dealing with bullies, which is explained in the context of a workplace which suffers chronic understaffing. Managing bullying behaviour perpetrated by 'valuable' or 'experienced' staff members then becomes a quandary (Curtis et al., 2006d). These experiences reinforce how common the unsupportive, hierarchical work environment is (Hadikin and O'Driscoll, 2000).

3.5 The NHS and achieving organisational goals

Next, a brief sample of research literature is presented, in order to demonstrate that the drive of the NHS towards achievement of organisational goals has been the focus of much academic enquiry in recent decades. In Chapter Two, the tools of organisational management were described, and are known to include rapid expansion of workplace governance, alongside a restructuring of welfare and increased use of technology. The pursuit of efficiency monitoring and systems of surveillance—a form of 'organisational violation' (Daly et al., 2005)—in the NHS has become increasingly prevalent since the 1960s in the UK (Bolton, 2004), but has been described, by nurses, as obstructing their ability to practise as holistically as they would like (Bolton, 2004; Cooke, 2006). The 1980s Thatcher government implemented recommendations from the Griffiths enquiry—that budgetary control of resources be passed to general managers recruited from the private sector (Ackroyd and Bolton, 1999). This transferred a lot of power and influence to non-clinical managers, possibly initiating the process of shifting organisational goals away from compassionate care and patient-centredness.

This field of enquiry also identified that pressure on resources and increasing demand for healthcare led to increased emphasis on the pursuit of efficiency in 1990s Great Britain (Harrison and Pollitt, 1994). This, in turn, required closer control of health professionals. Multi-layered strategies of control were implemented, and concerned the introduction of measures like performance indicators and league tables, the

weakening of trade unions, introduction of audit schemes, and the creation of the internal market which was introduced in an attempt to "empower" NHS consumers (Bloor, 1994; Greener and Mannion, 2009).

By the 2000s, academic discourse concerning the National Health Service's organisational goals continued to problematise the issue, usually with reference to the impact upon patient outcomes (Cooper et al., 2010; Greener and Mannion, 2009; Hall et al., 2016), economic factors (Pollock, 2004) and bureaucratic complexity (Lewis, 2020). This era of academic enquiry had developed to incorporate acknowledgement that the NHS was being "broken up and dismantled" in changes which were concealed by the rhetoric of "choice", "diversity", and "modernisation" (Pollock, 2004). However, the main goal of increased efficiency, albeit with a more conspicuous emphasis on cost cutting and economic impact, remained at the forefront of analysis (Propper et al., 2008; Timmins, 2005).

This is of significance to this thesis—and to the study of Depersonalised Bullying in the NHS in general—as it demonstrates that the pursuit of organisational goals is an established cause of conflict in the NHS. However, so far, a perspective which centres the impact of the phenomenon upon individuals of specific professions does not appear to have been taken, while the extensive literature concerning the pursuit of organisational goals in the NHS has not been previously widely considered in association with bullying behaviours. This equates to a gap in understanding how the clinical professionals employed in the workplace have

negotiated the wider organisation's pursuit of goals, with reference to their own perception of how they fulfil, and feel about, their work role.

3.6 Professionalisation

Further changes in the NHS workforce introduced around this time include the drive towards professionalisation (Hugman, 1991). The dynamic process involved in identifying as a professional is well represented by a large field of academic study on workplace identity (Ashforth et al., 2008; Larson, 1977). The ability to call oneself a 'professional' is a coveted and prestigious accomplishment (Evetts, 2003; D'Cruz, 2015) which confers respect and social status (Waring and Bishop, 2011). There is an argument that when occupations achieve professionalisation they improve their own independence of control, but simultaneously make themselves more susceptible to the imposition of regulation (Hugman, 1991). Thus, it can be wielded as a device of control (Fournier, 1999) and a tool for achieving compliance (Larson, 1977; Salvage, 1985). The professionalisation of midwifery has been researched at length with reference to its impact upon patients, midwife autonomy and relations with medical colleagues (Donnison, 1988; Larsson et al., 2009; Vermeulen et al., 2019). The main consequence appears to be an element of de-legitimisation—or at least, redefinition— of midwifery knowledge due in no small part to the interprofessional rivalry (with medicine) which surfaced as a result (Hugman, 1991; Harrison and Pollitt, 1994; Meerabeau et al., 1999; Sonmezer, 2020).

The NHS as a workplace is understood to be in a state of "almost continual reform and restructuring" (Walshe, 2003, p. 106) with the concomitant levels of workplace surveillance, performance management and managerial control which that involves (Liefooghe and Mackenzie Davey, 2001). The pressure imposed by working in a climate of perpetual change and increasing reliance upon service planning and technology (Parkin, 2009) may also lead to uncertainty and a sense of role ambiguity (Leymann, 1996; Kalkman, 2017; Salin and Hoel, 2011), which is already known to have a detrimental and destabilising influence on workers (Baillien et al., 2011; Kalkman, 2017; Mahfouz et al., 2013; Tarrant and Sabo, 2010). Employees whose job necessitates ever-increasing change and flexibility, in keeping with the needs of the organisation, have previously reported experiencing stress (Randle, 2011), a sense of being bullied (Illing et al., 2013; Martin and Klein, 2013; Quine, 2001) and reduced self-esteem (Begley and White, 2003). The "floods of directives" and "endless central plans" favoured within the NHS workplace have been described as a "hyperinterventionist style of micromanagement" that "simply cannot work" (Walshe, 2003, p. 108). The challenges relating to professionalisation have clearly been addressed in the existing literature on the evolution of the NHS. These findings also contain elements pertinent to bullying in this same environment. The depersonalised bullying framework allows analysis of, and findings from, the two fields to be merged.

3.7 Conflict with midwifery philosophy

The vast majority of working midwives in the United Kingdom are employed within the NHS, which is where this research is situated. Midwifery has specific and unique properties which differentiate it from the other professions within the NHS. As described in Chapter Two, the guiding principles of midwifery practice are womancentredness, a sense of confidence in normality, and professional autonomy. Unusually for an NHS profession, the patients being cared for by midwives are typically neither sick, nor dispirited to be engaging with their healthcare provider. Midwives are proud to focus on health maintenance and vigilant observation of the subject. This means however that the question of the value of medical intervention is a topic of debate within the profession, with zero intervention often being as credible an option as any other. This makes midwives a fairly unique population within the NHS organisational structure. Presently, midwives employed within the NHS are required to practice according to the organisational rules and guidelines of the NHS while maintaining professional integrity as stated by the NMC Code of Conduct. This dualism has been covered extensively—and is described too in Chapter Two—but can be summarised as a tension experienced by working midwives, as they balance working to two divergent philosophies (Scamell, 2011).

The framework of Depersonalised Bullying allows a new perspective on this tension. It enables a framing of the debate which acknowledges the crucial traditional philosophical conflict, but which moves to place it more firmly within the more pragmatic zone of employment relations. Thus, researchers recognise that midwives view themselves as professionals, but within a paradigm which incorporates a type of 'caring' which remains unaccounted for by the organisational structure. The

depersonalised framework is then used to show why working as a midwife in the contemporary NHS feels like being bullied.

3.8 Application of depersonalised framework to bullying in midwifery

Within the context of NHS midwifery, the 'tools' of Depersonalised Bullying can be read as institutional structures which represent these dimensions. Enforced achievement of organisational goals, among a generalised non-specific target population can be seen in the widespread use of workplace surveillance and performance management aimed towards standardised ways of working. One-way surveillance is achieved in the NHS and in midwifery through the use of regular audit of the clinical records kept by the staff. The primary purpose of keeping records is to have an account of the care and treatment given to a woman and baby, and The Nursing and Midwifery Council's revised Code (NMC, 2018) imposes a duty on midwives to keep clear and accurate records relevant to their practice. But records also have an important legal purpose as they provide evidence of a midwife's involvement with a woman and baby. They must be sufficiently detailed to demonstrate that the midwife has discharged their duty of care (NMC, 2018). The increased technocratisation of maternity care—as outlined in detail in Chapter Two—as well as the digitisation of many of the documentation platforms, makes it much easier for observers to monitor the actions of a midwife in real time, or close to real time. The presence of inscrutably blurred power dynamics can be seen in the presence of hierarchy in the workplace, and is represented in the unclear

demarcation between midwifery and medical opinion. Midwives have been described as historically excluded from power (Elliott-Mainwaring, 2021), and there is already a large body of literature dedicated to examining this phenomenon (see, for example, Beech, 2009; Donnison, 1988; McIntosh, 2013). It has also been suggested that bullying within the midwifery profession is a direct result of midwives' perceived lower position on the hierarchy of maternity care (Leap, 1997; Hunter and Henley, 2019)—an argument which bears a very close resemblance to the aforementioned issues with asymmetrical power imbalance.

3.9 Chapter summary

This chapter has introduced and described the notion of reconceptualising the ostensibly familiar concept of bullying in NHS midwifery. It has been shown that by utilising a strictly objective, essentialist definition of what bullying is, researchers are limiting their understanding of what can be causing employees to feel harmed at work. It has shown that while this approach to tackling workplace bullying can result in a greater understanding of who is doing what to whom, the motives behind the practise are not fully explored. Applying a depersonalised framework to the field allows researchers to approach the question from a different direction. Rather than seeking to apply blame to individuals, this novel framework asks instead which workplace practices cause employees to feel bullied. It further enables investigation of how the application of these workplace practices may be experienced differently depending on the contexts in which they occur. In this thesis, I describe the findings

from utilising the depersonalised bullying framework to understand the experiences of NHS midwives. This has enabled an understanding that the structures and practices of the NHS are in some way responsible for NHS midwives feeling bullied at work.

Chapter Four: Methodology

When a long-standing issue like workplace bullying has been the subject of countless

research studies, yet remains a problem, a new perspective is required. In Chapter

Three I outlined the traditional route to studying workplace bullying, while

presenting an argument in favour of reframing how we understand the

phenomenon. It also described the data which reveals that traditional methodology

has done little to impact the extent of workplace bullying in the NHS. In the face of

such a pervasive problem, a new approach was sought. This new tactic utilises the

novel conceptual framework of Depersonalised Bullying (as outlined in Chapter

Three), which acknowledges that victims can also feel bullied by:

the routine subjugation, both covert and overt, of employees, by contextual,

structural and processual elements of organisational design, which are

implemented by supervisors and managers who resort to abusive behaviours

in an impersonal way, to achieve organisational effectiveness (D'Cruz and

Noronha, 2013a)

This framework has, prior to this point, not been applied to studies of NHS workplace

bullying. In Chapter Three I revealed that more attention has been paid to

interpersonal factors, or studies of organisational influence, when studying

workplace bullying. The studies that have turned attention to the role of the

organisation within bullying scenarios (see for example Liefooghe and MacKenzie

Davey, 2001), have not been directed towards NHS midwifery.

Structure of the chapter

This chapter begins by detailing the aims of the research, followed by outlining the research design which was chosen to best suit the aims. Discussion of philosophical assumptions follows, which is designed to allow the reader insight into the methodological decisions I made throughout the research process. Next, a detailed description of how I negotiated my positionality and insider status is given, which emphasises the significance of the fact I used to be a midwife. A full illustration of the research procedure is then presented. This section details the interviews, and the processes undertaken to achieve them. Discussion of the value of reflexivity is then described, highlighting the impact this had upon the research. Finally, a full breakdown of the data analysis portion of the research is presented, including discussion of Braun and Clarke's Reflexive Thematic Analysis (2019b) method. The research process is related to the novel conceptual framework of Depersonalised Bullying throughout. Finally, a summary of the thematic findings is depicted in Figure 5 in the form of a table.

Research Aims

The main aims of the research are:

- i- to explore the routes by which midwives feel bullied at work
- ii- to determine how this impacts midwives' feelings about their job

iii- to uncover what this means for the profession

This chapter describes the chosen methodological tools and shows that they align with the primary goals of the project: to gain insight into midwives' perceptions of workplace bullying, through a reframed definition of workplace bullying, and all while reflexively acknowledging the impact of my own professional background. The structure of the chapter is as follows: Firstly, I outline a summary of the research design. My philosophical assumptions follow. My particular positionality is then discussed, and research methods are discussed after this. Then, the data analysis is presented, which includes my use of reflexive thematic analysis.

4.1 Research Design summary

This chapter gives details of the methodology and study design employed in exploring the experiences of workplace bullying in NHS midwives. Within this qualitative study, I conducted semi-structured online interviews with forty-seven participants who are, or had been, registered midwives working in the NHS. This chapter will focus on the chosen methodology, drawing particular attention to the importance of maintaining a reflexive approach with the use of Braun and Clarke's Reflexive Thematic Analysis (2019b), and the unique consequences of conducting health-care related research as the impact of a global pandemic becomes understood. The chapter illustrates why the research method was selected to achieve the aims and objectives of the study. The research design is justified, ethical considerations and processes are outlined and the methods used for data collection and analysis are described and reflected upon.

Finally, the characteristics of the researcher are given, in a reflexive effort to convey the position and perspective from which the research originates.

4.2 Philosophical Assumptions

This thesis has been written with the acknowledgement that the researcher is an integral part of that which is researched, and researcher interpretations make key contributions to the research (Clarke and Braun, 2013). This position is reflected in the choice of analysis method and its position within the intrepretivist paradigm.

4.2.1 Ontology and Epistemology

At the heart of making methodological choices are assumptions of ontology and epistemology. The research data which I planned to collect was always going to be a product of my own values. Acknowledging my own theoretical assumptions was the first step, and this will be used to justify the uses of particular approaches. My ontological and epistemological assumptions will be made clear next.

Assumptions about reality and the nature of existence constitute the ontological outlook of a researcher, and affect how a research project is constructed and conducted (Willig, 2019). Ontology and epistemology are interdependent with a close relationship and are sometimes difficult to differentiate conceptually (Crotty, 2003).

Philosophical assumptions and what is thought of as legitimate knowledge can be mapped, however, onto a continuum of research paradigms, which stretches between positivism at one extreme and interpretivism/ constructivism at the other (Cresswell, 2014). An interpretivist view assumes that experiences are interpreted by each human and are used to construct their reality (Cresswell, 2014), while the contrasting positivist view takes the position that there is a real, objective world located outside the experience of the individual and that it can be discovered, studied and measured (Clarke and Braun, 2013).

My philosophical stance is found within the interpretivist/constructivist school of thought, which acknowledges the complexity of reality and recognises my impact upon, and contribution to, the research study. I rejected a positivist stance as the aim of the research was not to identify specific behaviours, or personality types, but to understand how participants felt about workplace processes and why. Additionally, one of the central aspects of the research project involved questioning the ways in which bullying is understood. At its core, the project is receptive to the possibility of reconceptualising bullying. Further, I undertook to do so from the subjective perspective of midwives whose experiences I wished to understand. These factors combined directly align with interpretivist and constructivist stances.

The philosophy which acknowledges the possibility of multiple truths, and asserts that the experiences, beliefs and opinions held by anyone are fundamental to how they construct their own reality (Saunders et al., 2019) is typically associated with the qualitative research paradigm. The contrasting positivist philosophy usually aligns

more closely with the quantitative research paradigm (Saunders et al. 2019). The qualitative approach generally focuses on how people make sense of their experiences and the world context in which they live (Holloway and Wheeler, 2010). This amounts to exploring qualities, processes and meanings, which are not examined via experiments which measure factors such as quantity, frequency, or intensity (Denzin and Lincoln, 2011). Through this effort to gain a deeper, more detailed understanding of participants' perceptions (Silverman, 2010) my aim is to understand the meaning that midwives give to the problem of bullying at work. Within the arena of this research project, an interpretivist perspective allows for the use of a new conceptual framework (Depersonalised Bullying) and Reflexive Thematic Analysis.

4.2.2 Methodological rigour

Despite qualitative research methods enjoying increasing popularity (Barbour, 2001), a continuing accusation against findings is that—unlike those from quantitative studies—validity and reliability of conclusions cannot be ensured (Mays and Pope, 1995). Qualitative inquiry retains its value and trustworthiness by clearly demonstrating best practices as they relate to the steps of designing, conducting and reporting the research (Johnson et al., 2020) and the context within which data was coded and evaluated (Nowell et al., 2017).

The research process undertaken for this study benefitted from methodological rigour which was maintained through a self-conscious approach to research design

and data collection and interpretation. In seeking to produce a plausible and coherent explanation of the phenomenon of workplace bullying in NHS midwifery, steps towards achieving methodological rigour are included at each stage of the process description.

4.3 Positionality

The term positionality describes an individual's world view and reflects the position they inhabit when conducting a piece of research and its social and political context (Griffiths, 1998; Holmes, 2020). Positionality—or situatedness—is never fixed and is always dependent on the context (Rowe, 2014). It influences how the research is designed, executed and interpreted (Holmes, 2020), which, in turn, requires the researcher to make clear their own ontological, epistemological and axiological assumptions (Dolan et al., 2022).

From the outset, my position as a former NHS midwife required me to take a reflexive stance on the conception and delivery of the research project. Familiarity with common vernacular or "insider" knowledge about how life on an NHS maternity ward is generally organised was extremely helpful, and I have no doubt that the participants felt able to speak freely about the operations of daily work life knowing that I had experienced similar scenarios. This section of the chapter outlines my acknowledgment of this and clarifies my thinking on the topic.

My position as a former midwife influenced not only my perception of the interview process and data, but also, as mentioned, the ways in which the interviewees had perceived me. When the interviews commenced, I felt the benefits of having experienced the work environments discussed by my participants. Clearly, they had been able to make assumptions as to my level of knowledge regarding a variety of topics, including the structure of the midwifery profession, typical work tasks for a shift on labour ward, or the requirements for qualifying as, and remaining employed as, a midwife in the NHS. I had what other researchers have called 'insider' status, which can be seen as an epistemological matter, as my position in relation to the participants has a direct impact on the knowledge that is co-created between us (Berger, 2013; Griffiths, 1998).

On the whole, I had much in common with the forty-seven midwife participants. Like all of the interviewees, I am female. I am also white, which is something I had in common with forty-three of the respondents. I am from the UK, as were forty-four of the midwives I spoke to. These factors alone make me, and most of my interviewees, very typical and average among the midwife demographic of the NHS. With respect to how I experienced my own midwifery career, neither my gender, my race, nor my nationality would have caused me to feel any different from the vast majority of my colleagues. My age at the time of interviews (40) was, I would estimate, approximately equidistant between my oldest and my youngest interviewees. In this respect I inhabited a position which potentially seemed average, unsurprising, likely to be a midwife, and convincing as someone who might be

conducting this kind of research. This could only have assisted with my efforts to break down any barriers to communication that might have arisen.

The midwife participants in my study could tacitly imagine that I would understand some of the unspoken realities of midwifery; for example, the (sometimes) unpredictable relationships between physicians and midwives, or between newly qualified midwives and very senior staff, or the feeling of joining a new NHS Trust while being several years qualified, or even the giddy sense of relief with which nightshift midwives welcome the day staff. In more solemn moments, the participants could assume that I would understand the feeling of having to break bad news, or being present as a team recognises a poor outcome has transpired. Further, the sense that, as a midwife, grief is experienced second-hand, yet causes pain nonetheless, and which must be negotiated as part of the job. Thankfully these moments are not usually too common, however when they arose within the interviews, I felt that our shared understanding of these experiences helped to create a researcher-participant bond which allowed the provision of great depth to the answers that I was given. These examples are used to illustrate factors which may not even be consciously recognised by those involved, and there is no way to prove that one midwife experiences them the same way as another. However, through use of a reflexive analysis method like RTA, it is possible to honour the intentions of the participants, while recognising my own role in the production and interpretation of the stories.

4.3.1 Impact of insider status

The need to reflect on insider/outsider researcher positions is an essential part of conducting a reflexive piece of research (LaSala, 2003; Watts, 2006) and is ultimately a critical epistemological matter (Griffith, 1998). In midwifery research, being an 'insider' has the advantage of not needing to learn the routines and jargon of the organisational group under study (Green et al., 1994). Since the 1990s, it has been thought that 'insider' researchers hold an advantageous and privileged position which puts them in a strong position to conduct ethical research and represent the voices of the participants (Griffith, 1998; Gair, 2012). As Clegg and Stevenson (2013) realised,

The problem, as well as the advantage, of insider research is the sheer immersion of the researcher in the field she is researching. She is a fish in the water, part of the habitus, with a feel for the rules of the game (p.7).

My understanding of the world of midwifery has been determined by my own experience of it (Sayer, 2011) and it was important to be constantly reflective of my own position as a researcher in my field. The particular issue of making assumptions about shared understandings (from both researcher and participant) can be problematic (Perry et al., 2004). The questions I asked may have been received and interpreted in a particular way due to the fact the participants knew I had been a practising NHS midwife. Had they been asked by somebody in a more objective, or 'outsider' position, the answers given would possibly have been quite different.

While both the participants and I were able to make assumptions regarding what each of us know about the job, I needed to be wary of considering myself overly similar to, or familiar with, the midwives I was interviewing. With hindsight, I can see that the questions I asked seemed to make perfect sense to the participants. There were virtually no occasions when a participant requested further guidance regarding what was being asked, and the most common response to every question was a detailed, relevant and fairly extensive answer. While the interview answers were often filled with remarkable or unexpected content, this reflected only the diversity of the midwives' experiences. More importantly, the answers that I was given made sense to me, and certainly, within the context of each specific interview question, did not feel misplaced or inappropriate.

How to present myself to my respondents was an early query. This could clearly influence not just the content of the interviews, but also the willingness of participants to come forward at all. As it was, the advertising poster stated my identity as: "Sarah Spence, former midwife, PhD student". The poster contained a header which revealed that I was acting under the guidance of "Leeds University Business School. Work and Employment Relations", and my email address was also included. Interestingly, while some of the participants expressed curiosity about my motivation for researching this topic, none of the participants enquired about why I had left the profession (although I had been prepared to offer a vague reason along the lines of seeking a new challenge). This limited level of curiosity might have reflected merely weak attempts to find out more about me, or were maybe just

questions of conversational politeness. Additionally, I recognised—from experience—that midwives spend their working lives asking questions to others, and doing so in a way that appears caring and concerned (even if this is not always entirely the case) while fulfiling professional mandates. It is possible that the opportunity to be the subject of the interview, rather than having to be the caring, concerned "interviewer", was rare enough not to be diluted by asking unnecessary questions of the interviewer.

So, I declined to disclose where I had been employed, or how many years I had worked as an NHS midwife, as it felt easier to maintain a slightly neutral positioning in this regard. The interviews could be something of a balancing act, however. In order to encourage openness and trustworthiness with the participants I tried to maintain candour at all times, yet I was always keen to keep dialogue focused upon the midwives themselves. There was little threat to achieving this in the moment however, as all of the midwife participants were very happy to talk exclusively about their own experiences and feelings. Positionality is informed by reflexivity, which is discussed next.

4.4 Research methods

In this section I outline the steps taken to prepare for and complete the data collection portion of the research. This includes discussion of the research sample,

followed by description of the interviews themselves. Following this, I explore the value of reflexivity in a research project like this. Finally, ethical considerations are discussed, with consideration given to planning a qualitative research project within the wider setting of the Covid-19 pandemic and the newly introduced rules concerning social distancing

4.4.1 Data collection

After discussion with my supervision team, it was decided that placing an online advertisement on a platform which I knew to be frequented by NHS midwives would be a good first step in the new, revised recruitment process. I was optimistic that the Facebook group would produce at least enough potential respondents to form a solid start to the interviewing process.

Once ethical approval from the Leeds University Ethics Committee had been granted, I was able to post adverts online encouraging midwives to take part in interviews. Responses to the advert came almost immediately. By the end of the day, I had received several emails and Facebook comments, and within a week I had such a volume of responses I had to close the advert temporarily. The next few days were spent fielding emails, elaborating on the topic to interested midwives and arranging the first round of interviews.

As per the ethical approval application, the proposed online platform Zoom was used to conduct the interviews as this enabled a form of interaction which closely resembled an in-person meeting with the participants. Telephone interviews would have been as simple, however I felt that the ability to make (virtual) eye-contact, and the opportunity to observe and assess mood and visual, non-verbal cues would be beneficial (O'Connor et al., 2008). Combining the semi-structured interview schedule with the fairly informal method of online interviewing produced a relaxed, conversational dialogue.

Recruitment of participants

The proposed methods for approaching and selecting participants required adjustment at the start of the COVID-19 pandemic. This impacted not just the medium with which I communicated with participants, but also widened the pool of individuals who might feasibly be approached. Prior to 2020, the plan had been to contact a number of maternity units across Yorkshire, Lancashire, and the North-West of England which were within a reasonable distance of my own location (Greater Manchester) in an effort to achieve a broadly representative sample of participants.

As the recruitment was underway it quickly became clear that the prospect of being interviewed was attractive for an unexpectedly large number of midwives. With awareness of the complexities of what constitutes an adequate sample size for a piece of qualitative research (Vasileiou et al., 2018), the achievement of data which

allowed "richly textured understanding" (Sandelowski, 1995) was prioritised. The number of interviews suggested by my academic supervisors was 'around fifty'; a number also suggested by Ritchie et al. (2003), as beyond this was thought to make unmanageable "the complexity of the analytic task" (Vasileiou et al, 2018). Further supporting this goal, a review of the extant literature had shown that most similarly targeted studies (qualitative interviews regarding workplace bullying) had utilised between twenty-four and fifty-nine interviews (see Branch et al., 2007; Carter et al., 2013; Curtis et al., 2006a; D'Cruz and Noronha, 2015). In this piece of research, and after only two rounds of recruitment, forty-seven interviews were achieved.

Limitations of technology

By advertising through Facebook, the general study population for inclusion was greatly expanded. Nevertheless, there were some limitations that need to be acknowledged. Video interviewing requires reliable technology, where both a stable internet connection, and good quality microphone are crucial. In the research literature it is noted that some groups may be excluded because they do not feel comfortable with or have access to the technology required (O'Connor et al., 2008). This did not pose much a problem for my participants. A couple of midwives found that their wi-fi connection was not as reliable as they thought it might be. However, this was easily overcome by taking a break, or making a plan to resume another day.

Maintaining anonymity

The issues of confidentiality and anonymity were more pressing. I had made it explicitly clear from the advertising stage that their anonymity was guaranteed, and confidentiality was paramount. I was surprised that several midwives declared that this was not necessary, and they very much wished to have their opinions and feelings made public. However, I reiterated that their data would be kept confidential and their identities would never be revealed by me. Only a very small number of midwives appeared to exhibit any concern that their identity would be revealed. Most of the participants, however, seemed happy with the reassurance I gave them, and expressed no concerns in this area. As sensitive topics were to be addressed in the interview, I further emphasised that there was no possibility of third parties overhearing our conversations.

4.4.2 Participant sample

I was keen to keep the pool of participants as broad as possible, and therefore did not specify age or years of service in the advert. I did not ask the participants to disclose their level of midwifery experience either, although I did require them to have qualified and worked as a registered midwife. As a result, I spoke to a huge variety of midwives and was able to infer ages from early 20s to early 60s. The midwives ranged from newly qualified band 5s, up to and including a couple of band

8s. Most of the midwives were employed within midwifery at present, although some had retired, some had resigned, and some were on maternity leave or extended sick leave. All of this information was either volunteered or implied, and I felt that by not asking I was conveying that I did not consider one type or level of midwifery experience to be more important than any other. As it happened, the vast majority of the midwife participants did not require much encouragement to talk, and some had even made notes (unprompted) prior to the interview to ensure that they expressed all that they wanted to talk about.

4.4.3 Sampling strategy

The participants involved had all responded to a Facebook advert placed in a private Facebook group called 'Say No to Bullying in Midwifery' which has almost four thousand members. This allowed recruitment of a more theoretically focused sample of midwives, although the invitation itself did not specifically mention bullying. The recruitment poster (attached at Appendix 2) stated the title of the research project as 'Under Pressure: The experiences of NHS Midwives', and also described my role as 'former midwife, PhD student'. All of these choices were made intentionally to fulfil a particular criteria. The group was chosen as I was already aware that it was well populated and is what might be called a busy group. Posts were at least daily, so I was able to predict a reasonable amount of people would see my advert. The title excluded the word 'bullying', as institutional processes which feel oppressive may not be considered by the individuals to qualify as 'bullying' as they perceived it.

Asking to hear about 'pressure' was designed to be a wide net to allow the midwives opportunity to convey all difficulties they may have felt within their workplace, without making them feel that they had to feel limited by whichever definition of bullying they currently held. My own title of 'former midwife' was used intentionally to convey to potential participants that I had at least some familiarity with their lived experience of midwifery. It was intended to imply that they could speak comfortably in the knowledge that I was aware of the operational side of the job.

4.4.4 Interview procedure

Interviews as the method of data retrieval were chosen early in the planning phase, as it fits the aim of the study (Bryman, 2012). Having known that I would want to pursue in-depth and interpretive analysis of my findings, a qualitative study design utilising interviews allows for opportunities to retrieve many perspectives and develop new theory (Baillien et al., 2018). Keeping interviews semi-structured leaves space for flexibility to adapt and ask follow-up questions as the discussion moves along (Thomas, 2017). A less in-depth process such as a survey or questionnaire would have and illustrated the presence of the phenomenon (such as Carter et al., 2013 and Zapf, 1999), but revealed little about how the characters involved comprehended it. In the case of midwifery bullying research (see for example Curtis et al., 2006e, Elliott-Mainwaring, 2021 and Hunter et al., 2019) the argument has long been made, and proven, that there is extensive bullying in the profession. It is upon this foundational understanding that I wished to contribute insight by utilising a

novel perspective which could only be imposed upon rich, detailed data such as that which an interview produces. I wanted to understand the bullying beyond its objective occurrence, seeking an understanding of why it had the impact it did. I also understood that there was a degree of sensitivity surrounding my research topic. An interview provides the ideal platform to allow respondents the time and space to reflect upon their answers, without feeling that they must commit to a binary (or similarly limited) response.

Participants were emailed with a Participant Information Sheet (PiS) prior to the interview and encouraged to read it thoroughly (see Appendix 3). The rate of interviewing took place at approximately five or six interviews per week. I had realised that a maximum of one interview daily was ideal, due to the surprising mental and emotional effort required to conduct the interviews. While many of the interviews were enjoyable and eye-opening, a large minority contained quite explicit description of difficult, upsetting, or emotional content. After these interviews I preferred to gather my notes, and ensure that I had processed the stories I had been told. In addition, I liked to make a start on transcribing interviews as soon as possible, and interviewing no more than one person each day made this possible. The content and experience of the interviews themselves are discussed in the next section.

The interview schedule and Data collection

This part of the chapter presents the thinking and planning behind the development of an appropriate interview schedule and its delivery in the context of online video interviews.

Interview setting

Moving to online interviews had been a concern primarily at the point earlier in the year when I realised the study design needed to be altered. My previous experience in interview-type scenarios (as a former recruiter, and then as a midwife who often had to deliver and extract sensitive information in a face-to-face setting) had all taken place in person. I had felt that this enabled a degree of intimacy and informality leading to naturalistic dialogue and the building of a strong rapport (O'Connor et al., 2008). However, the benefits of an online interview soon emerged. The immediate advantage—as I perceived it—was logistical, as extensive driving was no longer required, which in turn lifted a large number of possible temporal and economic constraints (Sedgwick and Spiers, 2009).

The worry of whether I would be able to achieve the informality and intimacy required to conduct the interviews was also soon assuaged. As previous researchers have found, using an online video platform to conduct interviews may bring some surprising benefits. Removing the need to travel was the first benefit. I was able to conduct all of the interview from my spare bedroom, and the vast majority of my interviewees remained at home too. Just two of the interviews took place while the

respondent was in their workplace. I now believe that removing the need for one or both parties to embark on stressful travel was the first step in improving the comfort levels of the participants beyond what they would have been for an in-person interview. They did not have to leave their homes, nor prepare it for a visit from a stranger. Usually, the midwives were sitting in their kitchens or living rooms and a couple of interviewees spoke to me while lying down on their beds. It has been suggested that due to (often) taking part in a more familiar and comfortable environment, online interviews allow for more intimacy which can be a useful forum for asking sensitive or personal questions (O'Connor et al., 2008) and can produce more reflective responses (Johnson and Rowlands, 2012). My assessment, after the fact, is that this is correct.

The geographical spread of participants was also widened by conducting the interviews online. I did not ask for the locations of the respondents. I had already stated that I would remove any identifying factors in an effort to maintain confidentiality and anonymity of my respondents. However, and probably due to this, I would say a majority of the midwives seemed to be very comfortable telling me where they lived and worked. From these admissions alone I am aware that my interviewee locations spanned all corners of the United Kingdom. This would not have been possible with face-to-face interviews, and although the geographical data does not constitute any part of the analysis, it is nevertheless interesting to me to know that the research project ended up including such a variety of locations and that the issue of workplace bullying is not unique to one relatively small part of the country.

The interviews

The overall aim of the interview was to gain an understanding of how the midwives experienced the organisational processes of the workplace and midwifery profession, with a view to then understand why they felt this way and what impact it had upon them both personally and professionally. The questions were composed with a view to allowing midwives the opportunity to share as much or as little information as they were comfortable with. Participants were interviewed once each, and interviews took place between the months of June and September in 2020. Interviews typically lasted between forty-five and seventy-five minutes resulting in between 8 and 20 pages of transcribed data. I chose to record the interviews in order to ensure they were documented verbatim, and as I knew that extensive note-taking would interrupt the flow of the conversations. All participants were happy to be recorded as they had been reassured that all audio files would be deleted after transcription, and all transcribed documents would be anonymised from the outset.

The interview questions were constructed so as to enable multiple opportunities, throughout each interview, to gain a deep understanding of what their work-life looked like, and how they felt about it. In some instances, revelations were offered by the participant which seems interesting or unusual enough that I happily changed course and asked additional unplanned questions to supplement the interview schedule. This was later seen to add embellishment to these particular transcripts.

The bare bones of each interview, however, remained the same, and are included below:

- How long have you been a midwife? And why did you become one?
- Is the job what you thought it would be? (How does it compare to any other jobs you've had?)
- Do you think you are well-suited to the role?
- Can you tell me about your experiences of feeling under pressure at work?
- Do/did you make any distinction between being a member of the midwifery profession and a member of the NHS?
- If you had a magic wand, what changes would you make to working life?
- Future of midwifery are you optimistic or pessimistic?
- What would your advice be for those starting midwife training?

In fact, it was often not necessary to ask each individual question as most midwives were happy to embark, unprompted, on long stretches of narrative which not only answered a question, but went on to describe, illustrate, analyse and draw conclusions which served to answer questions which had not even been asked yet. I certainly did not attempt to curtail any answer which veered from the original question while remaining within the larger topic. As noted by Wellington (2000), there is value in probing "an interviewee's thoughts, values, prejudices, perceptions, views, feelings and perspectives" in order to elicit their version of situations (p. 71). As the interviewer I could often identify from the first response which aspect of the participant's story was most meaningful or influential for them. I was then able to

continue with the semi-structured interview schedule in a much more appropriate way, and in many cases focus my questioning in directions which could not have been predicted beforehand. This approach worked well within this distinctly interpretive research study in which there was no aim to establish "some sort of inherent truth" (Wellington, 2000, p. 71), but rather a wish to seek the views and perspectives of affected parties.

4.4.5 Reflexivity

To put it simply, reflexivity is the concept that researchers should acknowledge and disclose their selves in their research, seeking to understand their part in it, or influence on it (Holmes, 2020). A reflexive approach also strengthens the validity of the research leading to more effective analysis (Subramani, 2019) by enabling sensitivity to the cultural, political and social context of the research (Bryman, 2012). Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity, then, urges us to explore how a researcher's involvement with a particular study acts upon the research (Willig, 2019), and acts as an essential tool in the pursuit of trustworthiness and rigour in qualitative research.

While a quantitative study may seek to ensure validity or reliability through factors like use of a representative sample, elimination of researcher 'bias', reduction in external variables or the ability to replicate the study (and therefore the findings), these considerations do not apply to qualitative work. Within a qualitative framework it is understood that themes are not 'hidden gems', waiting to be found, and do not spontaneously emerge from data; rather, they are created by the researcher (Braun and Clarke, 2021). By engaging with reflexivity, I then strengthen the validity of the research, making it more rigorous (Subramani, 2019).

Of clear importance was the fact that I used to be a midwife. As the interviews continued, I was confronted with many midwives who were keen to tell their stories, often accompanied by a strong surge of emotion. As during my professional midwifery life, the emotions I was confronted with required a careful response. I wished to show support and empathy, but falling short of explicit solidarity. I was careful not to disclose my own personal experiences or thoughts as I had no wish to take time away from those I was interviewing. Fortunately, none of the participants ever asked for my own experiences or feelings about factors within the field. I believed the midwives took this position as they considered my stated recent history as an NHS midwife to be sufficient proof of my trustworthiness, and this interview to represent a long-awaited, possibly unique, opportunity for them to share their stories, in all their depth. I found that keeping journal-style entries alongside my interview notes and memos helped me to clarify my own relationship with my research data.

An important consideration within the context of my 'insider status' is the assumptions, implicit in the dialogue. At the most basic level, tacit knowledge was useful, in that I did not need participants to explain details of the job to me.

4.4.6 Ethical considerations

This section of the Methodology Chapter describes the somewhat protracted journey towards achieving ethical approval for the research project. The road to approval was the first aspect of the project to be impacted by the COVID-19 pandemic, with events unfolding in the first half of the year 2020. The facts of the research project being broadly situated within the National Health Service, and initially designed to include face-to-face engagement with participants, led to a requirement to change the methods employed in the early stages of data collection.

What was ethical approval needed for?

In the case of midwives becoming emotionally upset by participation in the interview, they were encouraged to refer to a Professional Midwife Advocate (PMA) within their department. The PMA is able to address the emotional needs of staff and support the development of resilience in the workplace. Interviewees already knew that the Occupational Health Department at their Trust has professional advisors who are able

to assist with feelings of negativity, trauma, depression or similar. Midwives were also reminded that information on making an appointment with the Occupational Health Team is available through every hospital switchboard.

Ethics in the time of COVID-19

The route to ethical approval was affected by the COVID-19 pandemic which had started to gain global momentum around the time of my first application for ethical approval. In April 2020, the Leeds University Research Ethics Committee approved my initial application to them. Of course, by this point, it was clear that many of the methods would need to be revised, and a new application submitted. This issue was discussed with my academic supervisors and it was agreed that the recruitment phase of the project could now take place digitally, using the prepared documentation in PDF form, and through the medium of social media—specifically, Facebook. Later on, in May, a revised application was submitted to the Research Ethics Committee at the University of Leeds. The revised ethics application took account of recruitment, consents, and interviews essentially moving online. On the 16th of June 2020 I was pleased to receive ethical approval for the revised application (documents relating to ethical approval can be found in Appendices 4 and 5).

4.5 Data Analysis

This section will provide a detailed introduction to, and evaluation of, the method of Reflexive Thematic Analysis (RTA) (Braun and Clarke, 2019a). The steps towards generating codes and themes are then outlined. Finally, a table is presented which gives a visual impression of the final themes and their constituent sub-themes.

4.5.1 Reflexive Thematic Analysis (RTA)

This piece of research is situated within an interpretivist paradigm, which emphasises understanding the subjective experiences of individuals (Braun and Clarke, 2019b). This thesis seeks to understand the factors which influence midwives' feelings of being bullied, and this demands a subjective, yet fully contextualised, method of analysis (Kvale, 1996). Because I was interested in the meanings that participants created and attributed to their experiences of being bullied at work, I applied a Reflexive Thematic Analysis (RTA) as per Braun and Clarke (2006, 2019b) to analyse the interview data.

This method is ideal for identifying patterns across an entire data set, while allowing for a theoretically-informed interpretation of meaning. RTA does not pretend to be neutral: all analysis is influenced by the researcher, as it encourages the researcher to embrace subjectivity and reflexivity as advantages in knowledge production, while allowing the freedom to draw on the theoretical framework of their choosing. This approach allows me to collect and analyse participants' accounts while

acknowledging the research values and subjective skills that I—a former midwife—bring to the process.

Meaningful analysis and knowledge production typically reflect the underlying paradigmatic, ontological and epistemological assumptions of the researcher (Carter and Little, 2007). As this project was concerned with exploring midwives' workplace experiences, and I understand the workplace to be a social construct, the analysis was broadly informed by a social constructionist approach which recognises the impact and effect of historical and socio-cultural factors. The interpretation of the data was grounded concretely in D'Cruz and Noronha's (2015) conceptual framework of Depersonalised Bullying (which is discussed in Chapter Three). A Reflexive Thematic Analysis is therefore appropriate for examining participants' lived experiences, while identifying the social processes that shape meanings and assumptions (Braun and Clarke, 2019a). This also allows the qualitative data to be respected, while expressing the subjectivity of participant midwives' accounts of their experiences.

4.5.2 Measuring quality in Reflexive Thematic Analysis

The question of what constitutes good Reflexive Thematic Analysis has been answered in a variety of ways, sometimes confusingly, often due to lack of clarity regarding theoretical and philosophical assumptions. An over-riding concern within the positivist paradigm is with demonstrating the reliability or accuracy of coding,

and this prioritisation shapes how analysis is conducted. Within a qualitative, interpretivist paradigm, demonstrating coding reliability and loudly avoiding 'bias' is illogical and ultimately meaningless, as knowledge is understood as situated, with researcher subjectivity conceptualised as a resource for, not a threat to, knowledge production. Additionally, within a constructivist and interpretivist paradigm, the concept of 'saturation' is often utilised to describe the point at which researchers can feel comfortable with having done 'enough' to ensure quality. However, a note about the use of the 'unfortunate metaphor' (Dey, 1999) of saturation here might be useful. Critical discussion of the concepts of code- data- and thematic-saturation in qualitative research has emerged in recent years which challenges the unquestioned acceptance of the concept, and reconsiders its plausibility in the context of qualitative approaches (see Braun and Clarke, 2019c; Dey, 1999; Nelson, 2016; O'Reilly and Parker, 2012). Despite the concept of data 'saturation' being firmly embedded in (some) qualitative research methodologies as a criteria for quality (Braun and Clarke, 2019c), it might be argued to that it is inconsistent with the values and assumptions of Reflexive Thematic Analysis (RTA). The concept of code, or theme, saturation—implying that 'nothing new' can be found—relies on the perspective that there is an imagined concrete basis of data waiting to be discovered. One of the central principles of RTA (Braun and Clarke, 2019b)—and thematic analysis in general—is a rejection of the idea that "themes reside in" and can "somehow miraculously emerge from the data" like "diamonds scattered in the sand" (Braun and Clarke, 2016, p. 740). Instead, in RTA, the researcher's subjectivity as an analytic resource is emphasised. It is in this way that themes are generated, as

they have been actively created by the researcher through interpretative

engagement with data (Braun and Clarke, 2021).

For this reason, the terms 'theoretical sufficiency' (Dey, 1999) and 'conceptual

density' (Nelson, 2016) have been offered as alternatives to 'saturation'. These terms

are designed to capture the notion that data collection may stop when the

researcher has reached a sufficient or adequate depth of understanding to build a

theory. Due to the richness and volume of the data achieved for this thesis, my own

preference is to state that conceptual density was accomplished within the dataset

produced by the forty-seven interviews. This thinking is reflected too in rejection of

the idea that themes can be 'found', or miraculously 'emerge' from the data (Holmes,

2020) with little intervention from the researcher (Braun and Clarke, 2021). This

approach argues that a rigorous reflexive researcher will be able to present their

findings and interpretations with confidence when they have acknowledged and

been explicit about their stance and positionality, and the influence this has had on

their work, rather than relying on positivist markers of quality (Berger, 2013; Braun

Clarke, 2021). Next, implementation of the six-phase process of analysis proposed by

Braun and Clarke (2012, 2014, 2021) is described.

Phase one: Familiarisation

Common to all forms of thematic analysis, familiarisation with the data is the

recommended first step (Braun and Clarke, 2012). Having conducted the interviews

myself, and transcribed each one myself, I felt already very familiar with the interview answers. Unsurprisingly, transcribing forty-seven lengthy interviews with participants who were very happy to speak in great detail took a long time. However, this allowed for an effective way to start properly familiarising myself with the data (Braun and Clarke, 2006). To reinforce my familiarity with the data, I then listened to each interview again, and checked that my transcription was a justifiable representation of not just what had been said, but also how it had been said. Alongside this, I referred to my handwritten notes—made during the interviews—to ensure that my contemporaneous thoughts on the interview data had survived the transcription process. Here, it was clear that my positionality needed to be clarified yet again. I was finding patterns in the data which reflected my personal knowledge of life as a clinical NHS midwife. As had occurred with transcription, my understanding of the interview data was neither neutral nor objective. One result of conducting the interviews in an intentionally informal, congenial manner, was the production of often disarmingly honest accounts of bullying events and their thoughts about them. The emotion contained within many of the transcripts is impossible to conceal, and reflects the

Phase two: Generating initial codes

The interview data was uploaded into NVivo12 and coded, with a view to enabling inclusion of all and any interesting segments of raw data (Boyatzis, 1998). Wishing to

nature of the interviews, which were often heartfelt, profound, and deeply personal.

ensure breadth of findings I did not limit myself to any number of codes. Inevitably, both variety and commonality could be detected in the midwives' tales, which resulted in a generous number of descriptive initial codes. The codes at this early stage were both latent and semantic, and identified features of the data that were theoretically interesting to me as an analyst who has understanding of antecedents, experiences and outcomes of bullying. At this point, the definition of interesting remained quite broad, and could relate to features such as the individual midwife, the midwifery profession, bullying, workplace processes, the impact of work or emotions in general. At this level, the codes mostly illustrated what the midwives had said, and did not particularly refer to how these occurrences had transpired and why it might be considered depersonalised bullying. The data extract in Figure 4 below is offered as an example to demonstrate how codes were applied.

Data extract	Coded for
"And yeah, it's definitely much more stressful and I think that is because of the responsibility and because you always have to be thinking of what's going to happen next. You know if you work in in retail, yes, you know, you're there and you have some responsibilities, but you're not in control of lives" (Danielle)	 Feeling stressed by the workload (semantic) Fearing the magnitude of responsibility (latent)

Figure 4: Pseudonymised data extract with codes applied

Phase three: Generating themes

This phase of theme generation will be described with reference to one of the three main themes uncovered: The Conveyor Belt. At this stage the coded data was reviewed and analysed, with a view to assembling the codes into initial candidate themes. The theme 'The Conveyor Belt' was the first one that was easily discernible, with the constituent coded data presenting at first three (but later four) concurrent narratives, which then became sub-themes. 'The Conveyor Belt' theme represented coded data items that addressed operational factors which the midwives had described as being oppressive. These included being treated like inhuman robots, being forced to follow a conformist program of care, and feeling like they had no control over any aspect of their working lives. The thread which appeared in all of these factors was a complaint that they felt like some workplace processes left them unable to offer woman-centred care. As the provision of woman-centred care is such a central principle of midwifery, and could be detected so widely throughout the data, it then became the fourth sub-theme, which allowed me to consider its broad applicability with more nuance. Figure 5 below gives a visual illustration of this process, and the way in which the Conveyor Belt theme is comprised of its four subthemes, and codes.

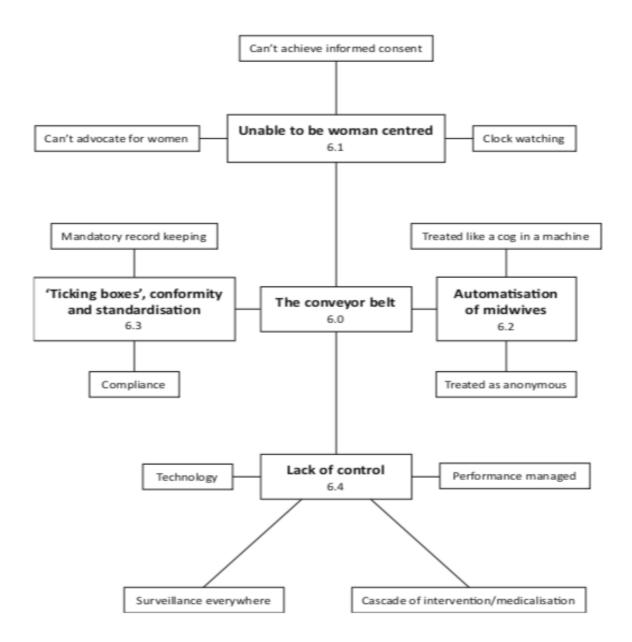


Figure 5: Visual representation of the Conveyor Belt theme, with its four component sub-themes, and codes.

In keeping with Braun and Clarke's (2006) best practice guiding principles, these themes were then reapplied to the interview transcripts, to check the extent to which they provided a clearer view of the data with regards to the research question. As the three themes were noted to contain some degrees of overlap, this led to a rethink of the patterns of shared meaning in the data (Braun and Clarke, 2006, 2019a).

Phase four: Reviewing themes

Braun and Clarke (2006) suggest that interpretive themes should have a clear

theoretical significance to the research aims, as well as broader implications in

connection to previous literature on the topic. Regarding wishing to understand how

midwives experience workplace bullying, it was clear that neglecting an evaluative

position would defeat the purpose of the study (Sayer, 2011). In other words, while

it is interesting to understand the acts that were perceived as bullying, and their

consequences, without asking why the acts were perceived this way, and why it even

matters, not much is learned. Use of the novel Depersonalised Bullying conceptual

framework aids greatly in this. This allows for reinterpretation of previously known

workplace factors, and enables a more critical understanding of how these factors

are perceived. From here I went back and forth between the data and the themes in

order to create a "coherent and internally consistent account" (Braun and Clarke,

2006, p. 22). This involves constructing a deep analysis beyond that of just a

descriptive paraphrase. In doing so it was possible to identify the story of each of the

themes as well as clarify how this story (theme) fits the wider tale of the dataset as

per the research questions (Braun and Clarke, 2019a).

Phase five: Defining and naming the themes

This naming portion of the thematic analysis was in many ways helped by the many creative and articulate turns of phrase employed by the midwife participants. The three final theme titles were lifted almost exactly from phrases uttered by midwives during the interviews. However, I was still required to ensure that the 'essence' of each theme was captured by the name, and that the name reflected the data appropriately and related to the research aims and questions (Byrne, 2022).

4.6 Chapter Summary

In this chapter I have discussed the methodology that has guided my study of workplace bullying in the midwifery profession in the UK, using 47 semi-structured interviews. Utilising an interpretivist approach has allowed me to explore the phenomenon and understand it within its socio-cultural context of the contemporary NHS. Using the novel conceptual framework of Depersonalised Bullying further enabled an opportunity to reimagine the factors which contribute to workplace bullying in the NHS. The three subsequent chapters present the findings as they relate to the three major themes which analysis produced.

Summary of themes

Through thematic analysis of the interview data, three major themes were produced (see Figure 6) which conceptualise how institutional bullying operates within the

context of NHS midwifery and how this impact midwives: 'The Damage Done' (Chapter Five), 'The Conveyor Belt' (Chapter Six) and 'Identity Disruption' (Chapter Seven). The theme of 'The Damage Done' denotes the various ways in which midwives felt they were either being harmed, or causing harm. The relational nature of the work undertaken by midwives is the reason for their frustration and dissonance, and the depersonalised nature of the workplace oppression explains why it feels so insurmountable. The Conveyor Belt' represents the ways in which midwives metaphorically describe what is wrong with the workplace. The mechanisms of the conveyor belt constitute the bullying tools which make the midwives feel frustrated that they cannot accomplish the full role of a midwife. This has been identified as a key reason for midwives leaving the profession (Curtis and Kirkham, 2020). 'Identity Disruption' refers to the way that midwives perceive themselves in this work context. While a sense of vocational self-sacrifice to midwifery was described by a very small minority of midwives, more common was a sense that they wished to occupy a professional position which satisfied emotional needs alongside professional excellence. The realisation that the workplace itself was incongruent with their ideals, was all the more bewildering and distressing for the midwives. The next three chapters present the empirical findings of the research undertaken for this thesis. I show how the lens of Depersonalised Bullying can illuminate the aspects of midwives' experiences of being bullied that essentialist definition framed studies might miss.

<u>Theme</u>	Sub theme
The Damage Done	Harm to the midwives
	Compassion deficit
	Harming women
	Damage to the midwifery profession
The Conveyor Belt	Unable to be woman centred
	Automatisation of midwives
	'Ticking boxes' - conformity & standardisation in midwives labour process
	Lack of control
Identity Disruption	Unstable working structures
	Reputation
	The role of emotion
	Existential crisis

Figure 6: Summary of thematic findings

Chapter Five: The Damage Done: The Wider Consequences of

Depersonalised Bullying

This chapter presents the first major theme, 'The damage done', and relates the extent to which the midwives fear that harm is being inflicted by the processes of Depersonalised Bullying towards various groups and at various levels within the maternity care system. This theme was produced to encompass the different types of damage which the midwives felt had been caused by the depersonalised bullying processes of the organisation. Not only did they feel personally injured by the workplace structures, they felt that women passing through the system were often also being harmed. The midwives were concerned that the organisational processes fostered a lack of compassion in the care environment and that all of these factors combined threaten the continuation of the ethos of midwifery.

As I discussed in Chapter Four, midwife participants seemed to embrace the opportunity to talk about their workplace experiences, and shared lengthy stories disclosing their experiences of feeling bullied in the workplace. The Depersonalised Bullying framework usefully enables an understanding of workplace processes as creating a *feeling* of being bullied. The midwives noted several of the distinctive features of Depersonalised Bullying in their discussions of harm at work, most discernibly those regarding power dynamics and the aetiology of the bullying (see Chapter Three for the characteristics of Depersonalised Bullying table). Regarding the

aetiology of the Depersonalised Bullying in the NHS, the interview data unveils the drive towards organisational goals as the primary explanation. However, this leads to speculation regarding what the organisational goals truly are. Midwives who felt that compassionate and relational patient care should be the main ambition voiced frustration upon recognising that the main goal of the NHS seems to be navigating the potential threat of litigation. There are various points throughout this chapter where the impact of a perceived fear of litigation is considered.

This chapter argues that the structural processes of the NHS workplace resulted in burnout, fear and helplessness for the midwives and have created a work environment without compassion. Compassion constitutes one of the principal values of midwifery care provision, making its absence incongruous with the ideal model of midwifery care. It is also argued that the lack of compassion, alongside the depersonalised bullying, leads to negative consequences for the women who make use of maternity services. This then advances the idea that Depersonalised Bullying can inflict harm, and illustrates that the study of bullying benefits from being viewed through a subjective lens. The fact that this resembles the impact of interpersonal bullying (D'Cruz and Noronha, 2015; Einarsen et al., 2003) despite being of organisational origin and not inflicted in a targeted way, demonstrates the subjective nature of Depersonalised Bullying. These arguments coalesce in the assertion that the midwifery profession itself is at risk due to the contemporary processes of the institution.

The chapter is structured in the following way: it starts with the first sub-theme which conveys the impact that structural processes had upon individual midwives, describing the physical and emotional burnout, fear, and helplessness they experienced. Following this, the subtheme 'Compassion deficit' is presented. Next, the third sub-theme is examined, which considers the detrimental effect of Depersonalised Bullying on the service-users of NHS Maternity. The midwives described feeling like their skills are not valued, and those workplace processes which constitute Depersonalised Bullying are detrimental to the close and trusting relationship that midwives are required to build with women. In the final section, the previous arguments coalesce in the assertion that the midwifery profession itself is at risk due to the contemporary processes of the institution.

5.1 Harm to the midwives

Personal sickness

In some cases, the midwives cited physical discomfort or pain due to the workload. A lack of breaks during the working day and the inability to drink or eat enough during a shift was cited as a cause of headaches and urinary tract infections which could make working life more difficult. Physical impairment with an occupational cause is unremarkable in the context of healthcare workers. Midwives, nurses and doctors often report dehydration at work (El-Sharkawy et al., 2016) while midwives and nurses are known to suffer musculoskeletal disorders at a higher rate than the

general population (Aksoy et al., 2022; Wang et al., 2017). The midwives interviewed did not seem distressed when reporting physical injury through workplace strain. Instead, the stories which conveyed anguish were the stories of emotional stress and psychological burnout. This was exemplified by Jennie, who recalled when her husband revealed the destructive impact that long-term workplace stress had had upon her personality. The fact that she did not realise she had changed to such a degree demonstrates the gradual but egregious impact of sustained stress.

It wasn't until I left that I realised how sick it had made me, in terms of the tiredness, the lack of self-confidence, self-motivation, you know. And two or three months down the line when I was out, my partner said, "Oh, my God, I've got you back", and I said, "What do you mean?" and he said, "You are starting to be the person I met 12 years ago". And that you just haven't been for the last-however long it was. And so, I really, I don't think you realise what it's doing to you as a person (Jennie)

The mental load required to continue working in difficult circumstances was more than many could bear. Midwives spoke of mental health challenges like depression and anxiety, and some midwives had considered suicide and self-harm. The midwives had also discovered, when chatting to colleagues, that feeling demoralised by work was a common feeling within the profession. Here, Danielle demonstrated that while many colleagues in her workplace shared her negative reaction to workplace stress, they did feel close enough to be able to confide this to each other.

We both kind of talked about when you drive into work and you're maybe considering that you, kind of, wish you'd have a little accident, not enough to kill you, but enough to stop you going to work. And then we all kind of looked at each other a bit like, Oh my god, do you think that too? (Danielle)

They commonly discussed feeling burnt out and helpless, and described how they "couldn't think, couldn't function" (Marina), "had a huge breakdown, a complete depression, complete breakdown, no support" (Joanna) and "couldn't switch off... it, sort of, dominated my life" (Gillian) In 2019 the World Health Organisation's International Classification of Diseases (ICD-11) defined burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed" and recognised burnout as an 'occupational phenomenon' which can potentially harm physical and emotional health (WHO, 2019). Along with exhaustion and negativity, burnout can have the effects of reducing professional efficacy (WHO, 2019), and undermining care quality (Collins et al., 2009), although the midwives already knew this. As Lydia asked:

How can you empower a new mother and support her when you, you're feeling crushed, stressed, dehydrated, disempowered. Yeah. It just became impossible (Lydia)

The burn-out described by Lydia is known to be occur particularly frequently in workers whose role involves formation of close, human relationships (Yoshida and Sandall, 2013). This acts to reinforce the notion—considered in the previous

chapter—that midwifery should be considered a strongly relational profession (Kirkham, 2007), and that the employer's approach to this aspect of the role should be managed more effectively.

It is widely acknowledged that midwifery is a demanding role (Hunter, 2001, 2004; Rice and Warland, 2013; Pezaro et al., 2017) due, in part, to the emotionally charged nature of pregnancy and childbirth themselves (Davis-Floyd and Sargent, 1997). Midwives typically are aware of this, and often actively seek out the positive emotional connections that they are able to create with the women they care for. They say, for example, "that's what I love, that family liaison and supporting families" (Jenny), "I love caring for people and I love going the extra mile" (Caroline), "the joy of delivering someone's baby and being there in that moment... that's amazing" (Mary). In these cases, the midwives were keen to stress that their enjoyment of specific aspects of their role remained intact, despite difficulties elsewhere. This shows a desire to focus on the positive aspects of job as a means of justifying continuing in the role.

Resilience

The importance of coping with workplace strain is recognised within the NHS workforce, as health professionals seem to suffer disproportionately high rates of stress-related issues like coronary disease and suicide (McAllister and McKinnon, 2008). Among the recommended actions is to strengthen the resilience of individual

workers (Hunter and Warren, 2014). Within the professions of nursing and midwifery, resilience has become an increasingly popular expression, attracting mounting attention from researchers. Studies generally aimed to identify how best to build resilience with a view to enjoying a long career (Hunter and Warren, 2014). In these studies, a variety of interventions have been recommended for developing resilience through improved separation of home and work life (Jackson et al., 2007), self-awareness, clinical supervision and improving self-confidence (McDonald et al., 2012). However, within the midwives' interview data some resistance to the notion of resilience can be detected.

I don't think midwives' lack of resilience is the problem. I think resilience has become another stick to beat us with, something else to feel bad about yourself for, another, another weakness that you have, and something that you need to work on (Phoebe)

The midwives' opposition to the suggestion that they be resilient came from rejecting the notion of individualism within resilience.

It makes me cross, that we all have to be resilient, and that it's our own time management, it's our own resilience, and we have to build up a thick skin, but we're human beings, we're not robots, and we need support as well (Susan)

Applying the Depersonalised Bullying framework to understanding resilience reveals it to be another issue which cannot be mastered if approached only from an interpersonal perspective.

Moral distress

The British Medical Association defines moral distress as "the psychological unease generated where professionals identify an ethically correct action to take, but are constrained in their ability to take that action" (British Medical Association, 2021). Specific causes of moral distress in clinical situations have been examined by Hamric (2012) who describes 'perceived powerlessness', 'institutional constraints' and 'inadequate informed consent' as three potential causes. Within the Depersonalised Bullying framework, it can be understood as disquiet which comes from situations where the institutionally required behaviour does not align with individual moral principles (BMA, 2021).

And when you're being coerced into being that midwife that practised like that, it makes you poorly. I'm not doing it! (Isobel)

This then classifies this kind of workplace strain as a type of bullying which is experienced not just as a fear of embarrassment or job loss, but as an assault upon their highly valued sense of being ethical and relational caregivers. In some ways, the midwives were aware that they were being pressurised into acting coercively

towards the women they looked after. While this was often acknowledged, midwives were also resentful of, and even morally distressed by, their involvement in using fear as a tool towards achieving compliance in maternity services.

The role of fear

Fear is a far bigger part of the lives of midwives than outsiders might imagine. They talked of having "a fear of going to jail" (Danielle) and worrying that they were the reason "why so many of them [women] have birth trauma" (Sophie). I have already shown in Chapter Five that pressure and coercion play a role in midwives' daily working lives, and that these factors are made possible by, and enacted through, the depersonalised processes of the organisational structures of the NHS. The midwives cited a variety of reasons for feeling fear at work. One was the (presumably quite natural) fear of being present when something upsetting transpired, such as injury to a mother or baby.

I felt completely out of my depth. I've never seen what I would describe as violence like that before, of him trying to absolutely yank this child out. (Danielle)

The midwives also described a persistent fear of being responsible for a clinical error.

I didn't feel safe, and I felt unsafe in that I might, because of the pressure, and the workload and the lack of breaks, and with stress, that I might make a mistake. Honestly, and when I handed in my notice, it was relief (Lydia)

Lydia describes here more than just a fear of making a mistake and being discovered or reprimanded. Her fear relates to the safety she should be entitled to feel at work. Midwives are aware that they undertake some work that requires critical accuracy. Having trained to carry out this kind of work, they are frustrated that the work environment creates barriers to ensuring its successful completion. The implication here is that mistakes cause more than just embarrassment, they can cause injury to others. Injuring a woman who is using the maternity service is a direct contradiction to what a midwife hopes to achieve. Therefore, it becomes intolerable to work in an environment in which there is a very real risk of causing injury.

5.2 Compassion deficit

The midwives commonly considered characteristics like empathy and compassion to be fundamental, if mostly implicit, elements of midwifery care provision. Meanwhile, they also recognised that some of their colleagues appeared to reject this notion. Explanations for this were considered, including the idea that some care-providers become insensitive to the pain of others due to repeated exposure to it. Helen considered this unacceptable, although acknowledged that the insensitivity might have a self-protecting component to it.

I've met so many people who have said, "Oh, I hated my midwife". And, you know, as strong as that, or, you know, who just say "Midwives are horrible".

But those other midwives, I don't think they should be in the profession. I really think they need to consider why they do what they do. You hear these midwives saying like, "Oh, she's moaning so much" or "She won't stop going on about the pain". Well, pain is horrible! Really just, distressing, you know! I can understand, you know, you just sort of think they forget. Maybe forget, well, they just, they've built this wall so it doesn't- They can block it off. I don't know, I just, I absolutely don't know (Helen)

Acknowledging that the development of compassion deficit might act to protect the midwife in certain circumstances alludes to the emotional resilience of the midwife. This well known concept is usually discussed as a symptom of a difficult job (Figley, 1995). But there seems to also be cognisance of how they come across to others. It would fit with the midwifery reputation to hope that outsiders would view midwives as caring and compassionate practitioners. Any members of the profession who projected an image contrary to that might be seen to risk the reputation of the profession as a whole. It is unknown how patients or service users experience the compassion deficit at the receiving end, however it could also be understood as something which might result in degradation of the midwife reputation.

The midwives often described compassion as something which should be an inherent characteristic of both the people they worked with, and the system they worked within. The concept of compassion implies a sense of recognising others as worthy

of depth of care—one that exceeds a common working relationship, and which is characterised by being loving and empathetic (Coetzee and Klopper, 2010). Compassion is also described as being one part of the "A, B, C, and D of dignity conserving care" and is defined as "a deep awareness of the suffering of another, coupled with the wish to relieve it" (Chochinov, 2007, p. 186). Within midwifery literature, the provision of compassionate care is conflated with "caring, and kindness … eschewing power and manipulation" (Walsh, 2010) and is a desirable characteristic for midwives (Waugh et al., 2014).

Traditionally, the issue of compassion shortage in healthcare provision has been attributed to the development of 'compassion fatigue' within the workforce. This has been referred to as "the cost of caring" (Figley, 1995) and is defined as a condition in which a care provider's compassionate energy is exhausted by working in care situations which pull on their energy resources (Coetzee and Klopper, 2010). When care providers are relied upon to practise compassion as part of their professional role, there is a real risk of that the staff member will become burnt out and suffer compassion fatigue (Coetzee and Klopper, 2010; Sabo, 2006; Yoder, 2010).

Research into the phenomenon usually concludes with proposals to increase awareness-raising resources or with recommendations for preventative measures. These processes generally take the shape of engaging in adequate self-care and employee assistance programs (Coetzee and Klopper, 2010), or calls for increased education and peer support networks (Figley, 1995). This approach to understanding compassion at work was made clear in the aftermath of various NHS scandals in

which poor care was given to patients, resulting in tragic outcomes. The Francis Inquiry Report which had investigated the causes of the 2010 tragic failings in care at the Mid Staffordshire NHS Foundation Trust in one example of this. The report attributed the failings to a number of factors including poor communication, a lack of compassion in the workplace, a shortage of patient centred thinking, and a tolerance of low standards (Francis, 2013). Very similar conclusions were reached in two more high profile investigations which took place at different NHS Trusts—the Kirkup (Morecombe Bay) Report of 2015 (Kirkup, 2015) and the Ockenden (Shrewsbury and Telford) Report in 2022 (Ockenden, 2022). Compassion deficit in maternity services has been reported by the World Health Organisation (WHO, 2014), while efforts to address the need for compassion education in midwifery training have also been related (Bray et al., 2014; Byrom and Downe, 2015; Hall, 2013; Pearson, 2018).

As a consequence of the Francis Report, the NHS introduced the 'Compassion in Practice' strategy, leading to production of the 6Cs, which has sought to articulate the values which underpin the professional care provided by nurses and midwives (Beale, 2014). The 6Cs denote Communication, Care, Compassion, Courage, Commitment, and Competence, and the midwives interviewed seemed to consider them to be values which ought to be innate in a midwife. A proportion of the midwives advocated for more effort towards ensuring that only certain types of personalities were able to embark on midwifery training at university, or regular "compassion training or something like that" (Katie), for the workforce. They

generally expressed concern that unsympathetic individuals would even be tolerated in an organisation which had explicitly pledged to deliver 'The 6Cs'.

The question of compassion fatigue, and the approach behind implementation of the 6Cs focuses on compassion as an individual trait, but this addresses only part of the story. The interview data show that in discussions about compassion, the midwives identified two layers of compassion practice. The first of these relates to individualised 'practical compassion' which exists at an interpersonal level and includes the verbal, physical or emotional aspects of the role (Brown et al., 2014). The midwives identified instances when colleagues had purposely disregarded taking a compassionate approach to caregiving: "she told her, her baby would get stuck and probably would die" (Sophie). The midwives also detected that while the inconsiderate words had been delivered personally, it had been done in pursuit of organisational goals: "they just coerced her into doing what they wanted" (Helen).

Organisational compassion

The second layer concerning compassion related to the constraints of mandated organisational processes which limit individual capacity to practice compassion (Brown et al., 2014). The processes described within this layer could be temporal or procedural:

Why can't we make sure she's getting the time with her baby for skin to skin? If we gave women that extra little bit of time, we would dramatically reduce birth trauma. The midwife that's been with her is suddenly caught up and doing all this stuff. She's busy dealing with notes and procedures and equipment and occasionally she might be able to turn to the women and say 'how you doing? I'm still here'. But some midwives are exhausted, and they can't, and so they cope by disengaging a bit from the woman, in order to get all those things done, because they know they'll be hammered if they don't. (Zoe)

Organisational processes such as record-keeping are monitored and measured internally and form part of what would be considered quality control activity (as discussed in Chapter Five). These were then viewed as impositions which reduced the opportunities for compassionate practice (Brown et al., 2014). Revealing another source of tension within the depersonalised bullying framework, this demonstrates one of the challenges in trying to ensure compassion in a workplace. The midwives' data reveals that effort at the practical, personal level will remain unrewarded if the organisational context—and the depersonalised processes within in—do not allow compassionate care to take place.

For example, my daughter was on maternity ward for four days whilst her baby was in special care and not one midwife asked how the baby was. Now, you know, this is basic caring for somebody isn't it? It shouldn't be about dishing out the tablets, and ticking the chart that they've done this or that, it's

actually looking at somebody and seeing if they're okay and asking what's happening with their baby. Because that's their world, isn't it? (Marina)

In this thesis I show that while training and support programs may provide benefit at individual levels, compassion deficit exists mainly as a symptom of bureaucratic organisational structures which are increasingly impersonal and market-led. Following from the arguments in the previous chapter, the "ritual task performance" mandated by working in a conveyor belt-like environment results in depersonalised relations with the woman being cared for. This undermines and neutralizes the care provider's sense of moral responsibility, destroying their ability to act compassionately (Gabriel, 2015, p. 618).

I argue then for the possibility that if compassion is fundamentally antagonistic to certain kinds of bureaucracy, and bureaucratic working in healthcare feels like bullying, a worker who values compassion above all else is fundamentally incompatible with this kind of working environment. Midwives are essential active components to a service which works to best fulfil the requirements of the organisation. They do this even when it means employing behaviours and actions which do not align with their specific professional principles, and which feel complicit in dehumanising the patients. As this section shows, the workplace pressure inflicted on the midwives serves the purpose of maintaining the 'conveyor belt' upon which the pregnant women travel; the existence of which causes distress to both women and midwives. This thesis argues that the midwives perceive the strict

implementation of organisational principles as Depersonalised Bullying, and can themselves feel dehumanised by this.

But then I hated myself. I didn't like being that kind of midwife. So yeah, it's not rewarding to not fully engage with women (Olivia)

5.3 Harming women

There were a number of ways in which the midwives described this situation causing harm to the women they cared for 1) by increasing their levels of fear, 2) by breaking the mother/midwife bond and 3) by manipulating the ways in which choice was offered and framed. First, the midwives described their concern that workplace processes were harming the women under their care by causing fear. The midwives had a clear understanding that they operate in a society which fosters fear within the women being cared for. This is well documented and has been examined within a variety of arenas, including feminist scholarship (Bordo, 2003; Firestone, 2015; Young, 1984), the sociological construction of women's bodies (Blood, 2005; Schiller, 2016), media portrayals of both real and fictitious birthing women (Clement, 1997; Luce et al., 2016; Maclean, 2014), plus the raft of legislation which aims to ensure that women remain fearful of what their bodies may be capable of (see for example Lupton, 2012; Valenti, 2009). The midwives comprehend the role they play in alleviating women's fears, and so the structural, organisational barriers to doing this

successfully are a major cause of stress and frustration for them. They particularly resent the role they are sometimes forced to play in perpetuating fear in women.

Like, we wouldn't go on to cancer patients all day about the death rates. It wouldn't be appropriate, yet we put the absolute fear into the women. When you come to midwifery and it's like, you're supposed to be an individual woman, you're supposed to trust your body. But yet we're going to sit you down and we're going to tell you all these horrible scare stories and make you feel like your body can't do what it's meant to do (Sophie)

Breaks the mother/midwife bond

They described scenarios when they had been ordered to withdraw care from a woman, so that they (the midwife) may plug a gap elsewhere in the service. This demonstrates the sense (which will be uncovered in Chapter Six) that the midwives felt they were treated as interchangeable cogs. This infuriated the midwives, especially when they had already established a tacit commitment to the individual they were caring for. They felt that their ability to craft their midwifery care to each individual was a valued aspect of being a midwife. However, the indifference displayed by the employer to this valued behaviour felt like it could be potentially damaging to the woman.

You literally just want me to leave now? While I've literally, all day, been up to my eyeballs with this case? This woman won't talk to people. She's mad as a box of frogs. We've built up a rapport. And you want me to go because it tidies up your books. And you're telling me that you just want me to walk out the door now and say to that woman, see ya! good luck! Don't kill yourself! (Betty)

The importance of rapport and relationship-building between the midwives and the women they care for is well understood. It is a recurrent theme in maternity services policy which seeks to implement a 'continuity of carer' ideology, such as the Changing Childbirth report (DoH, 1993), and Maternity Matters (DoH, 2007). A Cochrane review in 2016 found that the benefits of a continuity of care model for the women and their families are decreased risk of preterm birth or losing the baby in pregnancy or in the first month following birth (Sandall et al., 2016). It is an appealing model of care for many midwives.

Parts of the job, when I was actually able to be with women, have that continuity of care, really get to know her, build up a relationship, be the key carer for that woman. That was like I expected it to be, that's what I wanted to do (Zoe)

The advantages of the continuity model in maternity are understood globally (Homer, 2016). There was frustration that one of the idealised relational principles of midwifery was so regularly abandoned by senior managers within the

organisation. The interviews here show that many of these NHS midwives contested the obstruction when possible, although felt distressed when they were unable to.

Limits choice

The midwives were concerned that women's choices were being limited by the imposition of depersonalised processes.

I feel the role of the midwife is gently being pushed out. The woman doesn't have any choice, you're not allowed to speak up. You're not allowed to be an advocate for women these days. The sort of relationship you have with a woman, to support a woman's choice is that much more difficult to do (Olivia)

The discourse around a woman's ability to choose the circumstances of her labour and birth often coalesces around talk of risk and the imposition of time limitations. The phrase which midwives, and all healthcare providers, will utilise within this area of discussion is 'informed choice'. As described in the Changing Childbirth report, women must be offered information on the pros and cons of all of the available options suitable for her pregnancy and birth so that she can "make her choice after full discussions of all the issues with the professionals... confident that those professionals will respect her right to choose her care on that basis" (Department of Health, 1993).

Framing of choice

However, choice can be shaped and limited by the way information is framed or delivered (Levy, 1999). This might be because of the practical, tangible, and most likely temporarily unresolvable limitations of the service, such as unavailability of beds, equipment, or staff. However, these kinds of choices may also be framed to accommodate the preferences of the healthcare provider, which is in direct opposition to the recommendations of the 1993 Changing Childbirth report. Issues of patient choice operate at micro (individual), meso (organisational) and macro (structural) levels (George et al., 2019). The macro level framing of a woman's ability to choose the circumstances of her birth would consider concepts which exist at a social or cultural level. This framing of the issue is clearly enmeshed with the concepts of fear discussed earlier in the chapter.

I mean, how good have we been at brain-washing women in maternity, so they actually feel that their body doesn't belong to them! So, they don't feel like they can- or the doctor knows best or midwife knows best. It's obviously a culture (Kirsten)

At the micro level, the requirement to offer choice extends to women having the choice to say no if she wishes. A woman may wish to decline an intimate procedure, or refuse a treatment or intervention that she does not want.

You get to choose it somebody touches you. That particularly includes somebody putting their fingers in your vagina! They have to have your consent! (Kirsten)

At the meso level, women may want to make choices which fall outside the realms of accepted guidelines and policies (Feeley et al., 2019; Morris, 2023; Thompson, 2013). Examples at this level might include requesting a vaginal delivery after a caesarean section, or when the baby is known to have a breech presentation. These choices do not represent illegal or immoral choices on behalf of the woman, however guidelines will be geared towards her accepting a highly monitored, and interventionist style of labour and birth within the clinical hospital setting, directly discouraging her from 'birthing outside the guidelines' (Morris, 2023). Meanwhile their midwife will often be, or feel, pressured into talking the woman out of pursuing her preference. This is even when the midwives themselves do not agree with the woman's choice:

It might not be my personal choice, but I would give my life to defend her right to make that choice, for her and her baby. If she feels that's her safest option for her and her baby, then I will support that. That's my duty (Isobel)

From here, the dichotomy between organisational loyalty and patient choice is revealed (Elliot-Mainwaring, 2021).

Midwife responses to limited choice

While the women were described as being deprived of choice, the midwives also saw themselves as restricted from offering choice. The mechanisms which restrained them from offering the full range of choices available to women, were enforced by the depersonalised processes of the organisation, such as surveillance and social ostracism.

if you are one of those midwives who is prepared to support women to make choices outside of the guidelines, then every single word that you document will be scrutinised and questioned. And that's another thing that you'll be gossiped about (Phoebe)

The matter of power—and who has it—is central. The extent to which the depersonalised bullying processes of the organisation configure the power to choose in a clinical context was not only acknowledged by the midwives, but often actively navigated. The midwives understood the rights of women to choose their treatment, however also understood the difficulties the women might have in navigating this unfamiliar terrain. An experienced midwife would consider that the labour event is not an ideal time for women to make big decisions as they will likely feel overwhelmed and vulnerable, which may impact their ability make clear, balanced decisions.

One of the consultants put up a memo stating: All MY women, when they reach three centimetres must have an ARM [artificial rupture of membranes].

Well funnily enough, if I happened to be looking after the lady, one, she wasn't HIS anyway. And none of the ladies I looked after ever reached three centimetres, funnily enough. They were either two or four. (Rosie)

In some cases, a midwife may be trying to avoid embarking on what is often called a 'cascade of intervention'—such as the positive association between receiving an ARM, the use of epidural analgesia and electronic fetal monitoring, and oxytocic augmentation leading to increased potential for fetal distress and thus surgical delivery by caesarean section (Fox et al., 2021; lobst et al., 2019; Newnham et al., 2017). In these instances, if the midwives were challenged, or reprimanded for disobedience, they cited adherence to the NMC midwifery code which requires midwives to "be aware of, and reduce as far as possible, any potential for harm associated with your practice" (NMC, 2018). This course of action could also be interpreted as simply another method of limiting women's choice. Dogged pursuit of achieving "normal birth" at "any cost" and "beyond the point of safety" (Sandeman, 2017) was found to result in the tragic failings at the Morecambe Bay NHS foundation Trust (Kirkup, 2015). In this instance the midwives' relationship with doctors had become "seriously dysfunctional" with reports of midwives neglecting to alert doctors in time about patient complications. Meanwhile with the Montgomery vs. Lanarkshire case, in 2015, an obstetric doctor was found to have chosen to omit giving information on "material risks" of planned medicalised procedures to a patient which would have enabled the patient to make an informed decision (Lokugamage

and Pathberiya, 2017). By intervening before a woman can objectively consider advantages and disadvantages of an intervention, midwives and doctors assume the role of decision maker, creating conflict between the professionals' and the woman's ability to make choices, and objectively problematising the entire effort to provide women with autonomy (Thompson, 2013).

Using loopholes and ambiguities to circumvent instructions is therefore a route of resistance for midwives who wish to manage the tension between their loyalty to the NMC Code, and the depersonalised structures of the organisation of employment (Mander and Melender, 2007). This kind of behaviour has been described as a 'surreptitious' and 'stealthy' path to achieving objectives which cannot be voiced clearly and directly (Kirkham, 1999). The activity may then achieve the immediate aims of the midwife (in this case, the avoidance of a potential cascade of intervention), however it does not resist the depersonalised processes of the organisation on a larger scale, as both the activity, and the motivations for it, are concealed (Kirkham, 1999). Thus, the perception of harm against women will continue to require intercession by midwives at an individual level.

5.4 Damage to the midwifery profession

I used to be proud to say I was a midwife. But I've met so many women and families who have had an awful experience that I now just say, 'I'm a midwife', and wait for their response. And that's really sad. That's, that's a real shame (Helen)

As outlined in previous sections, the midwife participants had felt that the depersonalised structures of the workplace interfered with their duty to be 'with woman'. Contemporary media outlets have disseminated images of midwifery as troubled and weak (Maclean, 2014). It appears that the employing institution is allowing this to continue, and possibly enabling it. This could act to justify the workplace surveillance, performance management and managerial control which has been increasing in recent years (Liefooghe and Mackenzie Davey, 2001), further cementing the primacy of the 'conveyor belt'. The midwifery profession already identifies as embattled due to its workplace structures, but it also contends with service-users who are increasingly likely to consume media representations of midwifery and childbirth. While this is not a direct consequence of the depersonalised processes of the NHS maternity care system, it serves to potentially destabilise the trusting relationship that should exist between midwives and women.

The reputation of midwifery

The midwifery reputation used to be respected and trusted, as demonstrated by the common belief that the period 1948 and mid 1970s was a golden era for the social model of midwifery care (McIntosh, 2013). This is reflected also in the popularity of the highly idealised TV series 'Call the Midwife' that focuses on the midwife as part of their community. While this television representation of midwives as wholly altruistic, self-sacrificing heroines of society is not automatically credible, histories of

maternity care do teach us that the midwife used to be considered "powerful, respectable, bossy and a bit scary", but also "kind and caring" (McIntosh, 2022).

In recent years, the reputation of midwifery in social discourse has changed, which has been reflected in media commentary—for example, the headlines 'I loved being a midwife, but bullying, stress and fear made me resign' from the Guardian (Anon., 2015), and 'New mothers left alone and in pain as maternity crisis worsens' from The Times (Lintern, 2022)¹. There is also a media tradition of representing fictional midwife-led births as a frightening and irrational choice (Kline, 2017; Luce et al., 2016) further undermining the profession's reputation.

The burden of high volumes of administrative tasks was recognised to be one obstacle to providing ideal care.

People say midwives are shit, and they don't know what they're doing, you know, and you just sort of think well, I can see why you might think that sometimes. A man on the Postnatal Ward once shouted to us all. Do you mind if I swear? He said, he said, 'You're all a bunch of fucking idiots! you're all useless!' So, I kind of, it was really shocking. But he was trying to get discharged home. And he'd been trying for hours and hours. And it was purely paperwork, it was holding them back and it was just so frustrating for him. (Helen)

¹ The two examples given here are offered solely to illustrate the existence of media stories which demonstrate a negative commentary on midwifery.

Excessive paperwork was one of the most common complaints from the midwives.

The women (and their families) being cared for are evidently also inconvenienced by this, and this acts to hurt the reputation of midwives as competent practitioners.

Media alarm surrounding midwifery practice

Meanwhile, a rise in alarming media stories has been detected which has served to escalate the public fear of childbirth (Hundley et al., 2019; Maclean, 2014). Recent NHS scandals (e.g. Francis, Kirkup and Ockenden) have not escaped public attention, and the failings of many aspects of NHS Maternity provision have been made clear. The media both creates and reflects public opinion, and so discrepancy between media messages and the reality of most births leads to a distorted perception of the midwives who are present within the stories (Maclean, 2014). This then increases fear in birthing women which studies have shown may increase the risk of undergoing an emergency caesarean section (Dick-Read, 2004; Ryding et al., 1998).

On the telly, you've got programs like 'One Born Every Minute' that usually show quite dramatic, TV-worthy births. Most births I've attended are really not that dramatic though! But this is the normalisation in the consciousness of the new generation of women coming up, they're fairly addicted to their screens aren't they (Isobel)

In recent years, organisations like human rights champions Birthrights (founded 2013) and the Positive Birth Movement (founded 2012 with the aim of combatting fear in childbirth) have emerged. The existence of these organisations implies tacit acknowledgement that midwives cannot be relied upon to provide care and advocacy like might be assumed, and that compliance in medicalised care is simply an easier route for pregnant women to take on their pregnancy journey (Newnham and Kirkham, 2019).

Erosion of remit

The midwives also identified the erosion of their sphere of professional responsibility. The first of these concerns a fear that the midwifery profession would mutate into an 'obstetric nurse' role. This phrase was employed regularly despite no clear definition being offered for what their understanding of 'obstetric nurse' actually meant. While this job title does exist in the NHS, it is a fairly uncommon position—only about a quarter of Trusts employ nurses within maternity services, and even then, usually only one or two of these nurses per Trust (RCN, 2019). Since registered nurses cannot legally deliver babies, they are typically employed to assist within obstetric theatres or high dependency areas or in the provision of nursing care to women postnatally (RCN, 2019). These are areas which would otherwise, and usually, be occupied by registered midwives.

A year ago, I'd have said I'm an optimist. I would have. I'm more of a pessimist now, as in, all I see is the spiral of us becoming more of an obstetric nurse than a midwife, depending on the area you're in, and women becoming less and less confident about their ability to birth babies, midwives becoming less confident and less, less kind of caring and less compassionate (Danielle)

It seems likely that the term 'obstetric nurse' has been informally adopted within the midwifery profession as an emblematic device. When the midwives' described their fear that midwifery would transform into obstetric nursing, they voiced concern that they would be required to work within a medicalised paradigm, and not be able to employ their relational skills: "I don't want to do a sliding scale, or a CTG and synto, I didn't join midwifery to do those things, I came in to provide care for women" (Ellie); "In my Trust I feel like my skills are not valued. I can accept a fearful woman, and support her without an epidural, but that's not what they want me to do" (Tanya); "I have so many midwife skills and attributes that I can't use in midwifery anymore. Because it's become obstetric nursing I suppose" (Isobel). Here, the term 'obstetric nurse' symbolises something which is less desirable than a midwife, and is characterised by rejecting various principles of midwifery.

Fearing the loss of midwifery was described beyond the personal level, but also on the societal one. The data shows that the midwives understand that the profession's position within the wider context of UK politics is a precarious one, and for a number of reasons. From the standpoint of professionalism, they expressed some concern that the right to practice independently was becoming endangered despite being

received gratefully by the women, as "independent midwives practice midwifery how the midwife wants to do and how women want it, yeah, they can't practice anymore". An independent midwife is a fully-qualified midwife who works outside of the NHS and is a self-employed professional who is employed privately by individual families to provide continuity of care with some or all of their maternity care (NMC, 2018). It is then understood that by diminishing the rights of midwives to work independently they will be forced to be employed within the NHS as their only other avenue for midwifery employment in the UK.

Fear of litigation

Fear of legal reprisal is a key driver of behaviours and guidelines within the maternity system workforce. Maternity claims represent the highest value and second highest number of clinical negligence claims reported to the NHS Litigation Authority (Mead, 2013). Claims arise in response to different categories of perceived clinical negligence, and usually refer to incidents concerning management of labour, caesarean section, cerebral palsy, ultrasound investigations, CTG interpretation, perineal trauma, and uterine rupture (Mead, 2013). Between 2000 and 2010, over five thousand claims, with a total value of over £3 billion were reported (Mead, 2013). Overall, obstetrics and gynaecology claims account for a fifth of all clinical negligence claims and almost half of the total value notified to the NHSLA (Mead,

2013). In an increasingly 'cash-strapped' National Health Service this is clearly a priority to be managed (Mosley and Lockwood, 2008).

The magnitude of litigation fear is understood by midwives, as they acknowledge they operate within a model of healthcare which is guided by risk, cost and fear, often at the expense of personalised care (Lokugamage and Pathberiya, 2017). There is a sense, that focus and motivation would be better served, instead, towards ensuring a woman-centred type of care.

There's the fear of litigation as a big thing. But to me, ultimately, if you're going to be scared, you should be scared of doing something wrong. So, you should be scared of making women feel frightened when they shouldn't feel frightened. That should be more scary to you. And because of the way we've spoken to them in labour, and their pregnancy, they're all going to have PTSD, just by the way we have spoken to them. And are you not scared of that coming back? Because that's what you've done (Sophie)

5.5 Chapter summary

This chapter demonstrates that Depersonalised Bullying can cause harm to be inflicted at various levels and towards various players. The pregnant women, and the midwives, are bound within a multi-level system in which individual care providers, organisational strategy and society itself appear to be conspiring to create a paradigm

of care which promotes fear and constraint, which can lead to harm. The damage which can be generated is reflected in the well publicised and intensifying concerns regarding the National Health Service's ability to retain the midwifery workforce. The midwives themselves described how the organisational processes of the NHS maternity system could lead to them suffer personal sickness. The interviewees felt frustrated by this, and they expressed resentment that despite their sicknesses often being caused by organisational pressures, they were advised to grow a "thick skin" and learn to be more resilient. Interpretation of the interview data also shows that the midwives were troubled by the decline in workplace compassion which occurred due to the Depersonalised Bullying processes of the maternity workplace. The women who used the service were further injured by the weakening of the midwife/mother bond which occurred due to Depersonalised Bullying. The value of a trusting relationship between a midwife and the women she looks after is credited even within maternity policy at Government level, and its deterioration due to organisational processes was felt keenly by the midwife interviewees. Finally, the interview data showed that Depersonalised Bullying may have the cumulative effect of destabilising the profession of midwifery itself. It would be difficult to measure the impact of total depletion of the midwifery profession, although scrutinising outcomes in countries which operate maternity services without midwives is likely to be a sensible place to start.

Chapter Six: The Conveyor Belt

It's not midwifery, you know, it is like a conveyor belt (Isla)

The theme of "the conveyor belt" describes and explains how important elements of

the structures and processes of NHS midwifery result in depersonalised bullying that

causes harm to midwives and others. The lens of Depersonalised Bullying was applied

to the interview transcripts to reveal that organisational implementation of

standardized practice feels like bullying and is the cause of much professional unease

among midwives. Recall that the Depersonalised Bullying lens reconceptualises

bullying from an interpersonal behaviour with bullies and targets, to something that

can be more widely experienced in everyday interactions as a result of structural and

processual elements of organisational design intended to achieve organisational

effectiveness (D'Cruz and Noronha, 2015). The theme of 'the conveyor belt'

describes and explains how these elements of the structures and processes of NHS

midwifery result in depersonalised bullying that causes harm to midwives.

Data from the research interviews is used to illustrate the various features of

midwifery that inspire midwives, along with the aspects of the 'conveyor belt' that

thwart fulfilment of these professional aspirations. Four factors of working life which

jointly constitute the conveyor belt metaphor were uncovered. These are 1)

midwives' inability to work in a woman-centred way, 2) a sense of being treated like

a cog in a machine, 3) pressure to conform to provide a standardised type of care, and 4) a feeling that midwives lack control at work.

All of these factors are discussed within the context of an environment which suffers from Depersonalised Bullying. This shows that harm and dysfunction can arise from the processes of Depersonalised Bullying, despite it not conforming to the typical, traditional characteristics of how bullying is imagined. By acknowledging that the consequences of this type of bullying can be just as detrimental as they are from traditional bullying actions, it becomes clearer that this is a perspective which requires attention.

Within midwifery and maternity literature, the treated-as-a-machine analogy has more commonly been used to describe how pregnant women feel they are treated. Davis-Floyd (2001) felt that the practice of treating the pregnant body as a machine turns the birthing woman into a metaphorical factory. This then turns the process of pregnancy and birth into mechanical manufacture of a baby. Supporting this viewpoint, Martin (2001) discussed the use of technical metaphors in obstetric textbooks where the uterus is compared to a 'mechanical pump', or when the doctor is described as a 'mechanic, or technician who "fixes" it' (p. 54) concluding that "the woman herself hardly has a role at this point [...] sometimes it is hard to even detect a person present in the complex medical terminology" (p. 62). To develop upon this argument, I contend that the technocratised paradigm of a dehumanised and mechanised approach to controlling childbirth can be applied yet further to the midwives who work in the environment. That is to say, rather than being controllers

of the machine, they too are controlled by it. The midwives felt that their employer was attempting to automate them and treat them as interchangeable with each other.

The midwives' responses to the organisational structures of Depersonalised Bullying illustrates the fundamental antagonism of the organisation to their distinctly socio-emotional core midwifery principles. This first findings chapter supports findings from earlier research studies (see for example Hunter, 2004 and Scamell, 2016) and corroborates the idea that midwives find working outside of a woman-centred paradigm to be stressful and unrewarding. This is not least because it is already shown that the two models of care have a "disproportionate coexistence... one model overwhelms the other" (Scamell, 2016, p. 19). Existing theory argues that midwives find it stressful working outside a woman-centre paradigm. This study takes these ideas forward by arguing that this is compounded by organisational structures which they experience as depersonalised bullying.

The structure of the chapter is as follows. Using the four sub-themes which represent the 'conveyor belt' workplace practices, I examine these factors in relation to midwifery principles. First, the chapter examines the concept of woman-centred care, and the ways in which 'depersonalised bullying' subverts midwives' ability to practise it.

Second, midwives' feelings towards the imposition of automation in working life is uncovered. This includes the midwives feeling like they themselves are being treated

as anonymous cogs in a machine. The workplace processes in contemporary midwifery have resulted in midwives feeling like their humanity is not recognized, and they are interchangeable with each other. This is made worse by feeling that they are being pushed to act like robots or machines, and discouraged from employing their own values-based initiative to practice midwifery at work.

Third, the workplace practices which encourage, or require, a highly standardized way of working are discussed. The workplace processes which seem to demand the delivery of highly uniform care strike directly at the midwifery principle of offering individualized care to the women they look after. I assert that this standardized uniformity is encouraged by the workplace is experienced by many midwives as a form of bullying.

Fourth and finally, I consider the sense—described by many midwives—of being controlled by workplace processes that seek to curtail their professional autonomy. The midwives valued their sense of being in control of their own work. Various workplace practices, and their enforcement work together to make midwives feel that control at work was beyond their reach. The chapter concludes by arguing that contemporary midwifery within the NHS workplace is experienced, by many midwives, as alienated labour.

The midwives felt that their ability to practice midwifery is being curtailed within the workplace. However, although there were instances which seemed to represent interpersonal bullying, interpretation of the findings shows that the barriers to

providing midwifery-principled care are better described as being within the fabric of the NHS 'system' itself. The lens of Depersonalised Bullying was applied to the interview data to reveal that organisational implementation of standardised practice feels like bullying and causes professional unease among midwives. Next, the four sub-themes which constitute the chapter theme of 'A Conveyor Belt' are presented.

6.1 Unable to be Woman-Centred

It's taken a step back from being an advocate as a midwife. And you know, you have to go and sort of like say, 'Hold on! There's a woman under all this here!', because they're going, 'I'm doing this, I'm doing that, I'm doing the other, get me this, get me that, get the lights on', you know and you're just like, 'Hold on a minute!' (Charlotte)

This section represents the sub-theme of 'woman-centred care' and the ways in which the contemporary midwifery workplace disables midwives' ability to offer it. The requirement for woman-centred care can be detected in position statements of midwives' professional organisations (Leap, 1997), policy documents (Nursing and Midwifery Council, 2018; International Confederation of Midwives, 2010) and research literature (Freeman et al., 2004; Fontein, 2009; Leap, 2004). It is a central – and possibly the defining – feature of midwifery (Brady et al., 2019; Davis et al., 2021). Studies have been conducted into the concept to uncover what care providers believe it to mean (see for example Brady et al., 2019; Maputle and Donavon, 2013,

Fontein-Kuipers Y. et al., 2018), but it is generally understood to be a focus on the pregnant or birthing woman's unique and distinctive needs, expectations and aspirations (Deery and Kirkham, 2006; Leap, 2004).

As previously discussed (Chapter 2) the adoption of a more industrial, commercial model by the NHS was very much in keeping with the general pattern of the twentieth century (McIntosh, 2013), as healthcare moved into the modern age. Pregnant women who move through the maternity care system have described their journey through the system as "a bit like a conveyor belt - you get on and have the treatment laid out for you" (Haslam, 2014). Less commonly spoken of is the extent to which the workers within the technocratised system feel impacted by it.

The professional requirement to offer woman-centred care is described by the midwives as an essential ingredient to their enjoyment of their role. It often provided their motivation to enter the profession: "I was interested in being an advocate for women" (Anna); "[I wanted to] help that woman, and have a profound effect on that baby for the rest of its life" (Jennie); "I wanted to support women through the most vulnerable and important transitions in their life" (Lydia). These individuals had become midwives with a view to purposely providing this particular type of care. In their view, midwives should possess not only clinical competency, but also an empathetic perspective which acknowledges the human being at the centre of all decision making, and which informs their modes of practice. The pride that midwives experienced being able to call themselves midwives is partially reliant upon delivering this particular type of care. For this reason, the gains achieved from

practising woman-centred midwifery were often largely affective, and organisational factors which prevented this were viewed negatively. The barriers to working in a woman-centred way are understood to come from a variety of different places. For the midwives, working in a woman-centred way includes an acknowledgment that that each woman should be treated as an individual, and that it can be the midwife's responsibility to shield the women from the overpowering, efficiency pursuing influence of some other organisational factors.

The midwives expressed concern that placing women onto a pre-decided pathway of care required the healthcare professionals to ignore, or avoid, prioritising patient consent. Point 4.2 of the NMC Code of Conduct (2018) requires midwives to 'make sure that you get properly informed consent and document it before carrying out any action' (p. 8). Midwives are aware that in order to do so, a patient must be provided with all of the relevant information about the intervention, and in such a way that is individualised to them. In reality, working with organisational processes which do not centre the woman, makes it much more difficult to achieve full informed consent from every single person they cared for. What often remains unspoken and unnamed in this field is that failure to gain consent for an intrusive procedure, and then proceeding anyway, is clearly a violation of the patient. Further, is the question of whether consent is considered an issue of ethics, or of the law. Acts done to a body without permission would be described as 'battery' (DoH, 2007). In 2010, Harvard School of Public Health classified interventions without consent as 'disrespect and abuse' (Bowser and Hill, 2010). The report describes it as negatively impacting women's willingness to use 'facility based' childbirth services, and in fact research on

this area most commonly describes how these factors influence the pregnant and birthing women. This thesis, instead, takes into consideration the processual structures which may lead a care professional to omit obtaining consent. The processual elements of the maternity workplace have the effect on NHS midwives of feeling that they are violating their professional principles. This leaves them feeling browbeaten by the employment environment.

The midwives often referred to the ability to act in a woman-centred way as practising advocacy on behalf of each woman.

Can you engage with somebody? Can you engage with women well? Can you communicate not just in terms of information, but in terms of compassion and kindness and advocacy? Either with women or with your colleagues? So all that interpersonal stuff, that needs to be embedded right through and seen as important as all the physical stuff (Zoe)

The midwives valued the humanistic and relational aspects of providing woman-centred care. This part of the job is known to be highly valued by the pregnant/birthing women also. Even a cursory check of the literature reveals that in relation to their pregnancies and birth event, women's "memories were vivid and deeply felt" and "the birth experience contributed to their self-confidence and self-esteem" (Simkin, 1992, p. 203). Indeed, when women perceive themselves as having an element of control throughout an extremely vulnerable and sometimes

frightening experience, their subsequent long-term emotional well-being is improved (Green, Kitzinger and Coupland, 1994).

Relatedly, the economic cost of a mother suffering Postpartum Depression (PPD) arising from the greater reliance on state social services and the increased consumption of NHS services for treating worse maternal and child health—is estimated at £8bn each year in the UK (Bauer et al., 2014). However, taking a longterm economic perspective to the way women are cared for is perhaps an underutilised approach. Fear of litigation claims is thought to be the rationale behind the intense focus on having a risk-averse system of maternity care which demands compliance to a non-individualistic approach (Mead, 2013). Payments to settle claims in 2021/2022 reached almost £2.5billion, with maternity related claims making up 62% of this value (NHS Resolution, 2022). In fact, since 2021, NHS Resolution has stated maternity care to be a stand-alone priority, which serves to underscore the magnitude of the financial impact of poor maternity care. Nobody is claiming that women having a trusting relationship with a friendly midwife will eliminate PPD and the resultant economic burden. However, from a purely fiscal perspective, the benefit of allowing midwives to work in ways that are proven to result in improved maternal well-being, is evident.

Within the research data, woman-centredness was seen to mean not only that women should be treated as individuals, rather than as a homogeneous group, but also that care providers considered the impact of their decisions on the woman, before considering the impact upon themselves (and the institution).

This echoes statements made in studies of the American maternity system which questioned whether the common practice of augmenting labour through administration of synthetic hormones to the labouring woman was in fact aimed at augmenting the productivity of the medical care providers (Perkins, 2004). The question of having to choose between quantity and quality of care is not new to NHS employees either (Som, 2009; McCann et al., 2015). It has been asked in the context of reviewing the impact of clinical governance, and in particular, the imposition of targets applied to the management of patient caseloads (reducing waiting lists, and waiting times etc). There is no doubt that the midwives perceived (and resented) this type of pressure at work, as they commonly lamented that the women were treated as "an absolute encumbrance" (Marina) and that "they're the last ones being considered" (Ellie). The sense amongst participants was of trying to make women fit into the organisation's schedule by placing them on a metaphorical conveyor belt.

The midwives were clear that childbirth should be recognised as "unpredictable" and not be manipulated into something it is not, in order to suit the organisation, and that working 'against nature' felt inauthentic and even detrimental.

I stopped trying to put a time on it, you know, even if you go back to the basics.

'Oh, this next thing has to happen in one hour'. Shut up. Nature doesn't work
that way. How dare we try to put a clock on it, but that's what we do (Annabel)

The increased use of clock-watching and technology, within maternity services is central to the discussion of woman-centeredness. The notion of temporal flexibility

to provide appropriate care is commonly understood within midwifery scholarship (see for example Bayes et al., 2019; De Leo et al., 2019; Toolhill et al., 2017). However, it can be argued that time-keeping is applied both to the midwives and to the women they look after. While it is the actions of the woman's body which are routinely being timed (weeks taken to gestate the fetus, hours taken to dilate the cervix or to push out the baby) it is the midwife's performance which is measured and judged in terms of complying with the pre-approved ideal timeframes. Of course, the pregnant woman will be the one to undergo medical or surgical intervention if her body has not kept up with the timescale forecasts. However, in terms of professional repercussions, the midwife will feel pressurised in a way that may impact her employment and performance measurement. This works to reinforce the sense that midwives feel bullied by workplace processes, when they (the midwives) attempt to allow a woman's body to proceed on its own timetable. In fact, this is the first of several instances uncovered within this piece of research, when the fate of the midwifery profession is seemingly critically interwoven with the rights of women to practise self-determination. This also highlights that the pregnant woman's options are tethered to the midwife's own professional agency: so that when a woman's choice poses a challenge to hospital policy, the midwife is caught between allegiances. She must balance the knowledge that women trust her to practice appropriately (Bluff and Holloway, 1994; Cook and Loomis, 2012), against the expectations of her environment. The next section unpicks the midwives' feelings about being reduced to little more than machines.

6.2 Automatisation of Midwives

It felt like I was a cog you know, like, in a huge machine. And I was just part of the machine (Lydia)

This section explores midwives' responses to feeling like "cogs" in the conveyor belt, implying that their human value and contribution was not recognized. Other terms used to convey the same feeling were "I'm just a number, I'm not a person, I'm just a servant to the system" (Ellie), "we're just seen as little pegs to be moved around the board" (Tanya), "it's an organisation that seeks to manipulate people as widgets, in order to tick the boxes" (Emily), each of which express a sense of being dehumanized, and mechanized by the imposition of the efficiency making measures of the workplace. They felt that the structures of the workplace, and therefore their managers too, did not view them as individuals, and placed no value on their distinct human contributions or needs.

It's very much a business and midwives are treated as commodities. It's not about people, it's about moving units to where they will be most efficiently used (Helen)

A large number of midwives described themselves as anonymous and interchangeable 'cogs', suggesting that the sense of having their humanity erased was commonplace.

The midwife interviewees worked across a variety of clinical areas, however they all felt that low staff numbers obstructed their ability to provide adequate care. The measures which result in understaffing are presumably financially motivated cost-cutting strategies to save the organisation money, although the midwives generally felt that this was a false economy. They described their frustration that decision-makers did not seem to agree that midwifery was important work which required an appropriately supported workforce.

We're a birth centre! We're not Topshop! I get passionate about it, because we're a birth centre! It's like everyone is in this big haze about what we actually do. We're not a shop, we're a birth centre! There's babies being born.

This is big stuff! We need staff there. And staff just in case. It's staffing, better staffed. I think that would solve most issues to be honest. (Susan)

When midwives made their feelings known, their complaints had no effect, and they were even encouraged to work far beyond their contracted hours to 'plug gaps' in the rota in order that all servicer-users received care.

I did work a 22 hour day once. I did 10 hours community, got called out to a birth at the unit, got in bed after showering, got called out again in the same day. So how safe is that? But they, you know, it's blackmail. 'We haven't got anybody else who will go, anybody else to do it. You'll have to come in'. Like, crazy (Gillian)

The midwives understood, however, that accountability for their own performance still lay with themselves.

So, I phoned and said, 'Look I've been up all night at a homebirth and blah blah', right? 'We need you to go into your clinic'. I'm like, 'I'm dead. I can't do clinic!' And they said, 'You have to go, you have to go'. Okay, so I went to do this clinic. How I got through that clinic, I don't know..... It was awful.... And if anything had happened, God forbid, I wouldn't have had a leg to stand on (Katie)

This demonstrates a classic dilemma experienced by NHS midwives. They can find that the pressure applied by the structures of employment will encourage (or even compel) working beyond the limit of their ability, but will meanwhile not provide the support required in order to do so safely. The predicament lies in the fact that the midwives understand and care about the value of their profession and the implications of not turning up. As previously discussed, midwifery is a work role that many people actively pursue, and enthusiastically accomplish. The reasons for this are often emotional, and participants particularly enjoy the social, relationship-building and caring aspects of the job. It can seem like the employer is equally aware that many midwives approach their professional duties from a position of concern regarding the care service recipients, and uses guilt as a tool to enforce compliance from the midwives.

The midwives understood that the needs of the organisation were considered the priority, as they had no choice but to do as told, regardless of whether or not they felt comfortable doing so. The upshot—for so many of the midwives—was that they felt like they themselves were dehumanised and viewed as part of a machinery. The midwives were clear that in order to provide appropriate care and support to their women, they themselves required care and support appropriate to their needs. The midwives acknowledged that their pregnant and birthing women are individual humans with particular needs, but in order to provide those, midwives too must be treated as individual humans with particular requirements. It seems that the midwives understood the humanity of their jobs, but as their employers do not, working had become too difficult. This section shows that the midwives were able to identify the elements of organisational design that were implemented by supervisors and managers to achieve organisational effectiveness. They perceive the surveillance, audits, guideline compliance and low staffing levels which were often implemented by overbearing and even abusive managers, as forms of depersonalised bullying. This makes them feel like mechanised cogs and removes their ability to practise compassion (which was one of the reasons they entered the profession in the first place). In the sections that follow I show that the antagonism felt by midwives towards their workplace is based upon a series of misalignments between professional motive and organisational goals.

6.3 'Ticking boxes': conformity and standardisation in midwives' labour processes

You have to tick a lot more boxes. And the focus is on ticking the boxes rather than really giving holistic care (Anna)

Organisational drive to standardise practice (using the techniques and processes that constitute Depersonalised Bullying—such as stringent lists, record keeping, and guideline adherence) implies a lack of trust in midwives, and is a big factor causing them to leave the profession.

Midwives complain that high levels of mandatory record-keeping reduce the amount of time that they can spend with a woman. They also feel that the need for standardised record-keeping has less to do with improving patient care, and more to do with the organisation being able to carry out the surveillance—and possibly the punishment—of midwives. In some cases, the need for strict compliance was viewed in similar terms to law enforcement: or "grind work" (Harriet) which felt "very much like policing" (Phoebe)

We started working to checklists. And you were judged by ticks on a checklist rather than having a relationship with a woman. And then I thought we were just sending out the wrong message of what a good midwife is (Olivia)

The practices of the NHS, in the increasingly industrialised modern age, have already been accused of taking on an assembly line form (Walsh, 2006). One aspect of midwifery care compromised by the conveyor belt is having temporal flexibility to "build up a rapport and get to know them" (Linda). The move towards a task-oriented way of working, as opposed to a person-centred one, was felt as a negative across the board. There was even a sense that the institution considered the documentation of the task to be more important than the doing of it.

If I could just take care of the women and have no documentation, then that would be fine. But it's the fact that if you've not documented it, you've not done it, have you? (Betty)

This has previously been described as 'goal displacement' representing a 'political act' whereby targets being met is valued more highly than the completion of the actual practical work itself (McCann et al., 2015). In this case, the excessively large documentation burden was felt throughout the data to be a considerable barrier to being a 'good midwife'. The record-keeping associated with policies and guidelines didn't only prevent midwives from practising autonomously, they also provided the tools to surveil which midwives were compliant and which were not. The midwife participants were clear about where their key responsibilities lie, however: with the pregnant woman and within the professional standards set out in the NMC Code (2018). The midwives talked about how practising autonomously would enable them to work towards these goals in more appropriate, individualised ways, which would benefit both themselves and the women under their care. They recognised also,

however, that their quest for self-determination in this area may not succeed within the inflexible framework of the NHS. Enforced standardisation of care was viewed as anathema to the core principles of midwifery, and is one factor creating tension between midwives and the NHS.

6.4 Lack of Control

I feel we're very controlled, controlled by the governance, risk assessment and paperwork. And just being told how we have to think and operate, how to work, how to speak, how to do things, and we're punished for any challenges where we don't comply (Charlotte)

Primary among the mechanisms of control was the sense of being surveilled and performance managed. The technology of the workplace (such as the framework of surveillance and rules discussed in Chapter Two) has not only replaced the autonomy of the midwife, it is also the tool by which the organisation can engage in Depersonalised Bullying of the midwife to ensure she complies. The implication with respect to excessive monitoring is to reinforce the idea that the individual employee – and their workplace output - is considered deficient or even unfit for purpose.

Discourse regarding control within maternity care has traditionally stated that professional groups have gained control over birthing women by claiming authority over which events can be deemed as 'risky' (MacKenzie Bryers and van Teijlingen,

2010). Thus, when maternity care professionals allocate women into 'risk' categories, the institution gains control of the choices available to women, which leads to "overmonitoring", which may be facilitated by technology (MacKenzie Bryers and van Teijlingen, 2010). At this juncture it is useful to return to the birth literature, and in particular Davis-Floyd (2001), who argues that the structures which enable analysis of the body, redefine the female birthing body as "inherently defective" and "due to its unpredictability" requires "constant manipulation by man" (Davis-Floyd, 2001, p. 51). While Davis-Floyd implies there is ingrained lack of trust in women's bodies, this thesis moves a step further to say that this lack of trust extends to the midwives who work with them. The organisational tools of Depersonalised Bullying work to capture both women and midwives in the control of the system. Thematic analysis of the research findings reveals that factors which are implemented to optimise efficiency and conformity have done so at the cost of professional autonomy and patientcentredness. This has turned the maternity workplace into what many midwives described as a 'conveyor belt', as they experience limitations on their ability to work as desired

The midwives described the surveillance taking place on both daily procedural (micro) and general professional (macro) levels. A micro instance of surveillance might include managerial efforts towards midwives completing necessary and specific paperwork.

If you expect me to do a set of observations and chart it and put it on the partogram and put it on a computer system. And you know, do everything three times. Write that I've given Vitamin K in three different places. And then have somebody auditing all that. That's not, that's not efficient (Phoebe).

On a macro scale, surveillance would take the form of ensuring the midwives followed certain care 'pathways'. These pathways are almost always concerned with risk management and clinical governance—another contentious topic in the world of maternity care (MacKenzie Bryers and van Teijlingen, 2010). The midwives often spoke of the many checklists and 'tickbox' exercises which they felt pressurised them into providing care as directed.

You follow the, the guidelines, you don't put a toe out of line necessarily, you know, still telling women that, you know, we have to do this- and you're not allowed to do that. And yeah, it's sad. (Danielle)

With the increased use of technology and so much administration moved into the electronic and digital domains in recent years, it is now even easier for managers to monitor midwives' compliance with the rules. Midwives say they always want to deliver what is best and safest for the woman, but also believed that the guidelines did not allow for enough nuance of individual situations. Therefore, they resented that their level of competency at the job was measured by their adherence to a set of predefined guidelines, rather than by the satisfaction of the women they were looking after. The guidelines in question are often bound by the National Institute for Health and Care Excellence (NICE). Because of these frameworks, midwives will

practise fairly uniformly across a variety of maternity areas as a form of "collectivized responsibility", which serves to both relieve individuals of the need to make decisions while denying them the ability to do so (Hillier, 2003, p. 133).

The midwives know that their compliance with the rules of record-keeping (whether written checklists or digital software systems) will be monitored, further contributing to 'audit culture' which disempowers professionals to fulfil the ideals of autonomy (Power, 2008), thus increasing the 'coercive accountability' of each individual in the organisation (Sonmezer, 2020). For the midwives, failure to satisfy these rules could lead to very serious consequences such as having a Fitness to Practice (FtP) concern being brought against them (NMC Code, 2018). This can potentially lead to the penalty of job loss, which is why rule-following is often prioritised over compassionate relationship building.

There's a tension isn't there, between your ideals of what the job is, and what you want to offer to the women but then there's the pressures from the organisation itself, like what they expect from you (Caroline)

It is a very normal occurrence for midwives to work in what is called a "rotational" role which requires them to move periodically between the different departments of maternity care (antenatal clinic, labour suite, postnatal ward etc.). These areas tend to require quite different skillsets (for instance an antenatal clinic midwife may start to lack confidence in assisting with infant feeding, or a postnatal ward midwife might become unfamiliar with routines involved with the induction of labour). Rotation is

therefore favoured by management and is required in order that midwives maintain their full spectrum of skills. Inevitably midwives learn to prefer different areas, but the organisation often dictates that they may not stay too long in one department. The inflexibility of employers was also seen as a factor in employee attrition, which then led to understaffing. The midwives felt saddened that so many of them were leaving due to blanket application of a rule which refuses to accommodate individual midwives' needs. The need to control where each midwife worked was not only damaging to the midwife but to the service as a whole. The midwives were disappointed and confused at managers' willingness to lose midwives—a practice so detrimental at times of staff shortages that it is difficult to reconcile. However, I believe it points towards a wider reverence for organisational rules, and does have a relation to the arguments made elsewhere (Kirkham, 1999) that resistance to change within the service may be a pivotal problem to overcome.

6.5 Chapter summary

Within the context of NHS maternity departments, midwives describe several organisational factors which turn work into a 'conveyor belt' and are experienced as depersonalilised bullying. The sub-themes which constitute the conveyor belt theme are 'Unable to be woman-centred', 'Automatisation of Midwives', 'Ticking boxes: conformity and standardisation', and 'Lack of control'. Each of these represent distinguishing characteristics of Depersonalised Bullying—an institutionalised phenomenon which bears down on employees with the aim of achieving

improvement in workplace efficiency (D'Cruz and Noronha, 2013a). The impacts of this type of bullying are shown to be remarkably similar to those of interpersonal bullying. As described in Chapter Three (Reframing Bullying) the targets of interpersonal bullying describe consequences like feeling powerless (Ashforth, 1999), absenteeism (Spratlen, 1995), psychological distress (Pezaro et al., 2017), negative physiological health (Einarsen et al., 2003; Hoel, 2013), and reduced productivity (Hogh et al., 2021).

When the employing organisation fosters a conveyor belt environment at work, midwives are provoked into working in ways which are not woman-centred, leading to a feeling of powerlessness and adverse mental health. When the midwives described themselves as pegs and widgets and cogs, they convey distress that their employer has conjured a mechanised version of them in the pursuit of organisational effectiveness. The focus on box ticking as a route to standardisation of practice ends up feeling like unnecessary surveillance which makes them *less* productive, and the feeling that they lack control at work causes a sense of powerlessness. By reframing the way bullying is understood, the experiences which qualify as being bullied take on a new meaning.

This chapter has shown that viewing the midwives' stories through the lens of Depersonalised Bullying allows for a new understanding of the conveyor belt-like processes at work, and how the midwives feel bullied by having to work with them. While interpersonal conflicts undoubtedly also took place, there was an unmistakeable sense that the organisation was equally responsible for them feeling

damaged by oppression, overwork and alienation. The theme of the 'conveyor belt' was comprised of four sub-themes, all of which represent an element of a conveyor belt. These are the factors which can make working life feel like being carried forcefully forward in a manner which is impersonal, mechanistic, regimented and scrutinised. The inability to be woman-centred describes organisational processes which impede a midwife's capacity to practise the central tenet of her profession. This was demonstrated by scenarios in which they were prevented from advocating for their women, discouraged from achieving informed consent, and felt required to rely on watching the clock, rather than the women they were caring for.

The sub-theme of automatisation of midwives comprised of being treated like an anonymous character, or worse, a robotic piece of machinery. It was frustrating for the midwives to feel like the workplace systems did not value them as individual people, but instead seemed to view them solely by their function. There are unmistakeable parallels here to how some women have described feeling while they engage with maternity services. The midwives also understood that even while being asked to act like anonymous robots, any errors on their part would doubtless result in them being admonished in a very identifiable and human way.

Enforced conformity to standardised procedures is the third sub-theme in the chapter. Just as a conveyor belt leaves little room for variation of action, the midwives described how they were so regularly pushed—sometimes in a way that felt quite threatening—to work more 'efficiently', and much faster, than they wanted

to. They described working towards an ever-increasing number of targets, many of which the midwives did not view as beneficial at all.

The final sub-theme is a feeling that they lacked control, and was demonstrated by the various levels of surveillance and monitoring the midwives felt they were subjected to. The requirement to move and work between departments at the convenience of the organisation is one indication of midwives' lack of professional control. The feeling of injustice is compounded by the organisation's apparent willingness to lose them altogether. The sub-theme of having no control also draws comparisons with the ways pregnant and birthing women have reported feeling treated by the maternity system. This serves as another reminder that working on-and being cared for on a conveyor belt are surprisingly similar.

In the following chapter, the midwives describe the pervasive sense of harm detected in the workplace. The midwives described the organisation as harming their ability to practise safely, their confidence, and their mental health. The major theme of harm at work was a cause of distress to midwives and felt incompatible with their reasoning for being in the profession in the first place. An inescapable sense of harm all around was facilitated, again, by organisational structures which took the form of depersonalised bullying.

Chapter Seven: Identity Disruption

How did midwives cope with the experience of depersonalised bullying and the harms they experienced as a result? This chapter investigates this question, arguing that the harms caused by depersonalised bullying and the structures and processes that underpinned it undermined the midwives, giving rise to insecurities and disconnection with their midwives' identities. The disruption to their identity was experienced due to the impact of organisational structures and Depersonalised Bullying, but in a number of ways. The midwives described a perceived instability in working structures, as well as an assault on the midwifery reputation. They also conveyed a sense that Depersonalised Bullying processes worked to interrupt what they viewed as the normal and expected emotional aspect of their job. These factors combined led to something of an existential crisis for the midwives, as they struggled to reconcile the organisational processes of their workplace with their cherished midwife identity.

This identity disruption necessitated identity work to rehabilitate the midwives' sense of self. There appeared to be a paradox in that to remain happily employed in the role of midwife, the participants felt they had to practise in a manner which felt quite removed from the principles and practices of midwifery. Further, they recognised that it was the organisation itself (via Depersonalised Bullying) that was discouraging them from enacting their 'true midwife' identity. The paradox lies in the fact that maintaining an identity as a happy NHS midwife requires abandoning many

features of the traditional midwife identity. In this chapter, I show that the midwives felt strongly about maintaining the traditional core values of the midwifery identity. Maintaining this form of identity was clearly cherished. However, they also realised that to be able to carry on calling themselves a midwife, they would have to perform the midwife identity which the organisation required of them. For many of the midwives the paradox was ultimately irreconcilable, and they had to leave the profession, either by choice or by force.

In Chapter Five, I revealed the damage that this type of bullying inflicts upon various maternity service stakeholders. In Chapter Six, the maternity workplace was revealed to feel like a conveyor belt, illustrating the real-life ways that the processes are experienced by midwives. This chapter continues the analysis by arguing that the constructs explored in the preceding chapters requires the midwives to inhabit two often conflicting identities, creating a tension between professional fidelity and organisational deference. This chapter starts with discussion of the concept of identity, and relates it to how it is perceived within NHS midwifery. Following this, I discuss the destabilising impact of Depersonalised Bullying on the midwives' daily working structures, which then required them to work on the outward facing midwifery identity. Next, the important role of emotion in midwifery, and its relation to the midwife identity is considered. The depersonalised structures and processes of the organisation often interrupted either their emotional response to their work, or their ability to positively influence the emotions of the women under their care. The value of the emotional and relational aspects of midwifery are re-emphasised here. The final section of this chapter describes cases when the midwives talked of existential crisis. These midwives had invested a large degree of their personal identity into being a midwife. They felt that the depersonalised bullying processes of the workplace disrupted this to such a degree that they questioned themselves on an existential level.

The value of the midwife identity

The question of what constitutes identity is itself a contested issue within organisation and management studies (OMS) (Alvesson, 2010; Ashforth and Schinoff, 2016; Brown, 2017, 2020). Efforts to address questions of identity work within the healthcare professions are similarly focused upon the lived experience of professional identity (see for example Cornett et al., 2023), the influence of workplace professional hierarchies, and the sense of belonging within an organisation (Walsh and Gordon, 2008). Research within the healthcare workplace paradigm also addresses the notion of the 'self' as a component of professional identity, with nurses (Cowin et al., 2008; Peter et al., 2018), physicians (Cruess et al., 2015; Kyratsis et al., 2017), pharmacists (Salim, 2016) and social workers (Beddoe et al., 2019) all reporting tension between the self and professional identity when triggered by "work-identity integrity violations" (Cornett et al., 2023, p. 607). Research on identity work within midwifery has been conducted globally, with

findings fairly consistent across cultures. Midwives from Sweden and Brazil have felt their identities were challenged by increased use of technology (Larsson et al., 2009; Nicácio et al., 2016). Meanwhile midwives from both China and Italy describe a contradiction between their core midwifery identity and what can actually be achieved in a hospital environment (Vincifori and Min, 2014; Zhang et al., 2015). While these factors speak to a sense of shared experience across the global profession, they do more to underline what the midwifery identity is not, rather than what it is. This itself hints at one of the structural problems of midwifery as a profession. The midwives who were interviewed generally favoured—and felt greater loyalty to—their professional identity over the organisational one, and were frustrated that the organisational processes interrupted their ability to practice their professional identity

At the point of submission, no research could be found which examined the relationship between NHS midwives' sense of professional identity and the impact of Depersonalised Bullying, or indeed any kind of bullying. For this reason, I rely upon Brown's subjectively construed definition of identity as 'the meanings that individuals attach reflexively to themselves' (Brown, 2015, p.23). This approach allows for the subject to state their own identity as they perceive it.

Next, I describe the four subthemes which constitute the Identity Disruption theme:
7.1) Unstable working structures, 7.2) Reputation, 7.3) the role of emotion in midwifery and 7.4) Existential crisis. These combine under the main theme to depict

the factors that contribute to midwives feeling depersonalised bullying was testing and obstructing their much loved midwife identity.

Midwives had a clear sense of what they thought midwifery should be. At the same time, it's clear that contemporary midwifery was not currently fulfilling this expectation, causing an antagonistic approach to their work tasks (Chapter Five). This definition of what the midwives felt midwifery is supposed to be has already been described (Chapter Four), however a brief return to the topic is warranted here. On a global scale, midwifery professional bodies define midwives as being 'with woman' (Australian College of Midwives (ACM), 2004; Larsson, et al., 2009; RCM, 2015; CAM, 2017; Bradfield et al., 2019). The Royal College of Midwives provide a more detailed version of this definition: "The role of the midwife is diverse. Midwives carry out clinical examinations, provide health and parent education and support women and their families throughout the childbearing process to help them adjust to their parental role" (RCM, 2021). Similarly, the NHS careers website advises that, "Midwives provide care and support to women and their families while pregnant, throughout labour and during the period after a baby's birth" (NHS, 2021). These definitions certainly reflect how midwife interviewees described their view of what midwifery should involve. They described their motivations to enter the profession: I was interested in being an advocate for women (Caroline); [I wanted to] help that woman and have a profound effect on that baby for the rest of its life (Jennie); I've always wanted to work with families, and improve outcomes for mums and babies (Sheila); I wanted to support women through the most vulnerable and important transitions in their life (Lydia). Elsewhere, the motivation was more personal:

An attempt to settle inequalities I'd experienced as a patient from the inside...

I thought that the system was corrupt and the care was substandard... I vowed to make a difference (Iona).

These were women who had purposely become midwives with a view to providing a particular type of care. It would also appear that they - to a certain extent - hung their identities upon this fact. The conflict between their expectations and realities was experienced as a confrontation between their personal motivations and a desire to belong.

7.1 Unstable working structures

The participants noted that an unpredictable working environment led to a feeling of instability in their sense of being a midwife. The unpredictability arose from the Depersonalised Processes of the institution which sought to prioritise organisational efficiency over the wishes of the staff. Often, midwives were redeployed to alternative areas in the Trust which were suffering a staff shortage. In some cases, the shortage was temporary, and short-lived, and staff need only work elsewhere for one shift. Sometimes staff were transferred on a permanent basis, although it was not always made clear to them what the reason for this was. The enforced change was distressing at the time of the event, but developed into a chronic sense of

unsteadiness, as they realised that what they thought was a static element of their midwifery career, was not.

So basically, I got back from holiday, and they'd transferred me! I didn't even get to go and say goodbye. I'd worked at this hospital for two and a half years and trained there as well. They're like, you're not on the rota anymore. So, I didn't even get a goodbye. Nothing. You don't work here anymore. Sorry. And I had to go to the other hospital, which I did, but it just felt like a real kick in the teeth (Mary)

Unexpected unmooring also occurred on a day-to day-basis when midwives would be transferred between work areas at short notice and against their will. Many complained that their working days were marked by an anxiety that a manager would move them to an area of greater need, even if the midwife did not feel confident working in that area. This led to a feeling that they were not in control of their own careers.

You don't know where you're going to get pulled to, so you can't really sort of mentally prepare (Grace)

The midwives acknowledged that a spectrum of midwifery practice exists, however felt most confident in one particular area and used this confidence to feel justified in using the title of midwife. Being moved to another department could disrupt their

ability to call themselves a midwife which demonstrates the precarity/fragility of the midwife identity.

I had to ask myself, what am I going to do if I walk in and, and they pull you.

You think you're going to have a nice lovely shift on postnatal or something and they ended up pulling you into a room with a high-risk labour and you haven't done any of that in a year, you know, is that, could that happen? And I thought, yeah, it could, they could say, 'Sorry, no choice, you're the only person available to do it'. And I just thought, I don't want to put myself in that position. So, it wasn't worth it (Mary)

The midwives recognised that in many cases they had made huge behavioural adaptations in order to complete the tasks required of them in the workplace. It was important to them that they fulfilled the midwifery tasks required in order to maintain their midwife identity and so they adapted, or expanded, their practice in order to be able to do so. This identity work comprised of anticipating the unpredictable and acquiescing to working far beyond a reasonable amount.

Last Monday I didn't eat anything all day, to get through the clinic, and to make sure all the women are seen. If only I could clone myself! So, I could see multiple patients at once! (Carole)

Strategies to maintain justification in their sense of being a midwife were detected in the interviews, however, were scarce. Some midwives, like Carole, resorted to denying themselves basic human needs as they felt that this was the only way to fulfil their midwifery obligations. Occasionally, strategies to forcibly enact what they saw as rightful midwifery behaviours were described. This kind of behaviour, which would have involved insubordination, appeared very scarcely throughout the interviews. Rosie described her rebellious activity with pride though.

I was well suited to the role, because I am a rebel. I question. I am totally devoted to a cause and in this case, the women, and giving them the best experience possible... So, I said, I would like to be on call tonight. In case she goes into labour. The response was, 'You can't do that, I need you here on the early shift'. And my response was, 'I'm not asking permission I am informing you that this is what I plan to do' (Rosie)

Rosie was in the unique position of being multi-lingual and able to provide exceptional service for some typically under-served populations who had not lived in the United KIngdom for very long. The ability to be vocal and rebellious in the delivery of midwifery care was understood to represent something of a risk though.

A lot of people said to me, why don't you just keep your mouth shut? But our Code says that we have to give the best evidence and the best care. And if I had kept my mouth shut, which a lot of people do, I wouldn't have been adhering to the NMC code of practice. And I would do the same again. I think

there's a few things I would change. I would certainly be a bit more careful about who I trusted. And I would still be, still be as vocal. Because we have to be rebellious because at the end of the day: women's choice (Anna)

More often though, when behaviours of colleagues become unsettling or unpredictable, threatening the midwife's sense of identity, it could only be managed through avoidance.

I only did it once, but I remember parking outside like 6.30am and it was foggy. And she was walking in, and she just always went on and on and on at me, she'd say 'stop, stop, stop, who are you?'. And at the time I would think, 'well, you're on shift with me, you know who I am'. Anyway, I actually phoned in sick, I said, I'm really sorry, I'm having an asthma attack. I wasn't. I drove home again. Because it was, I cannot spend 12 hours with her (Katie)

This reaction from Katie was fairly typical of the midwives who expressed frustration at feeling powerless in the face of workplace victimisation.

7.2 Reputation

Being a midwife is described as "a privileged role" (Page and McCandlish, 2006, xiii; RCM, 2021), and while midwives truly enjoyed certain aspects of the job, they also enjoyed being seen as inhabiting the role.

All my friends were like, 'Oh my god I don't know how you do it', and all my parent's friends were really in awe of it, so yeah it was a real struggle to give up that title. It was held in quite high esteem (Lorna)

The participants believed that the positive reputation isn't always warranted however, meaning that for some midwives, the public face associated with the midwife identity was sufficient, and fulfilment of certain midwifery values was a lesser priority.

They see us as the, sort of, superhero who comes to the door with all the answers. You know that kind of- Saviour complex? Yeah, and I think there's definitely some of that. But people do the job because they think it makes them superior (Helen)

An identity is a continuous self-defining process, and is created by socially comparing oneself to others (Wharton, 1992). The workplace identity can be both an inward facing self-concept and an outward facing—and often status-enhancing—performance, which represents "who the individual thinks he or she is and who is announced to the world in word and action" (Charon, 1992, cited in Walsh and Gordon, 2008, p. 2). Within the context of a workplace aggravated by Depersonalised Bullying processes, the maintenance of the outward facing midwifery identity is assisted by the publicly acknowledged job title and place of employment. However, internally, the aggressively delivered and unpredictable behaviours endured from superiors "in the course of ensuring organisational effectiveness" (D'Cruz and

Noronha, 2015), and which were identified in Chapters Five and Six, can have the outcome of making a midwife feel unmoored in her identity.

Some women tell me that they maybe had a midwife who was absolutely lovely, and they couldn't bear it when a senior midwife came in and gave her an absolute dressing down, and they could obviously see what was happening, and I really just think that is so inappropriate. You want the woman to feel confident in who is looking after her (Carole)

Here, Carole affirms that upholding the reputation of midwives as competent and capable is vitally important. In cases where the depersonalised working structures of the organisation prevent this, it is not just the individual midwife, or pregnant service-user, who is impacted, but the credibility and status of the midwife identity overall.

7.3 Emotion in midwifery

The third subtheme considers the significance of emotion in the construction of the midwife identity. Emotion plays a fairly notable part in the role of a midwife, and the midwives expected to experience emotional reciprocity in the job, meaning they expected to emotionally influence, and be influenced by, the pregnant and birthing women they encountered in the workplace. It is likely that on a daily basis a midwife might be offering congratulations for happy news, or condolences for a sad,

unwanted result. She may also offer reassurance to anxious women, or provide support to families impacted by mental health problems. Interpretation of the research themes suggests that for the midwives interviewed, their sense of midwife identity was partially constructed by both positive and negative emotions in the course of their work. This refers to both the emotions felt by the midwife in response to their workplace scenarios, as well as the caring emotions that they expected to convey in the provision of midwifery support. The impact of Depersonalised Bullying on this facet of identity is argued to be that it restricts or prevents the full emotional experience in a way that feels like being denied part of their midwife identity. The distinctly relational aspect of the midwife identity was considered important in the achievement of professional fulfilment.

The concept of emotional labour has previously been described as the "invisible aspect of work" (Hunter, 2001, p. 436). It was initially described in the context of public-contact workers (flight attendants and bill collectors) and referred to the work of managing one's own emotions that was required by certain professions (Hochschild, 1983). The meaning has since expanded somewhat to include households and communities (Hackman, 2023; James, 1989). However, Hochschild's initial definition involves evoking and suppressing organisationally desired emotions in the service of the *paid work* being undertaken (Hochschild, 1983; Morris and Feldman, 1996), and remains appropriate in the study of midwives' emotional labour.

This iteration of emotion work conceives of it as a reactive performance, involving the suppression of 'real' feelings, and with the potential to lead to damaging

outcomes such as emotive dissonance or alienation (Ashforth and Humphrey, 1993; Hunter, 2001; Jeung et al., 2018). Emotional labour in midwifery is discussed primarily as a response to working in an emotionally charged environment (Davis-Floyd and Sargent, 1997), and is described as a cause of job stress and burnout (see for example Creedy et al., 2017; Doherty and O'Brien, 2022; Hildingsson et al., 2013; Hunter et al, 2019). Midwives in this study confirmed that this remains the case for many today.

If you're not working the shifts, and you've got more space in your head, you don't realise how much it takes from you, emotionally, you've got space in your head to be, to consider doing other things, rather than either being so tired or constantly worrying or thinking about what's gonna creep up on you next, and come back and bite me! (Kirsten)

Regarding midwife emotional responses to work, negative sentiments are often expressed. Midwives have described working in a task oriented, conformist system as causing "reductive and fragmented" care (Hunter, 2010), causing them to engage in emotion work to mitigate against these challenges (Hunter, 2004). Findings from the seminal study 'Why Midwives Leave' reported that midwives felt stressed, undervalued, unsupported and demotivated (Curtis, Ball and Kirkham, 2002). The very recent 'Work, Health and Emotional Lives of Midwives' (WHELM) study in the UK (2019) further underscored the levels of burnout, stress, and depression experienced by midwives employed in the NHS. The emotion work employed by the

midwives could take the form of hyper-vigilance, or might cause a feeling of exhaustion.

When you're doing that day in, day out, it really does take it out of you, and I just sleep all the time. But I just cannot do anything else, because I'm so exhausted, both emotionally and physically, from the work (Carole)

Expectation of positive emotion

Conversely, it seems that there is an expectation for midwives that they themselves will experience happy emotions as part of the role. This was confirmed by the midwife participants who had expressed what they enjoyed about midwifery, citing "meaningful satisfaction ... so much more than I ever thought it could have been" (Marina), and "spending time with women,... that's what gives me joy at work" (Olivia).

The emotion being described was always tied to the relationship that they had with the women being cared for, and it is this relational source of emotion that is a valued part of the midwife identity.

I've done sales jobs, you know, where my reward has been financial and, and that's never made me happy. So, you know, I take the good and the bad with my job and I focus on the good. I have amazing days where I know I've done

amazing work and I can see that I've done the best for the patients, and I feel amazing and I didn't feel that when I got a good bonus for my sales jobs (Monica)

Emotional reward was therefore sometimes considered as valuable as economic reward. Positive emotions in midwifery are more commonly understood for the role that they play in creating a trusting bond between midwife and mother (Hunter, 2001; Kitzinger, 2005; Walsh, 1999). It has been understood for some time that child-bearing women are significantly impacted by the quality of emotional support they receive from their midwife (Berg et al., 1996; Halldórsdóttir and Karlsdóttir, 1996; McCourt and Stevens, 2009; Walsh, 1999). This could take the form of the midwife providing a calm and relaxed birthing atmosphere, or offering authoritative reassurance to troubled service users (McCrea and Crute, 1991). The element of emotion work involved in these scenarios is very closely aligned with the idealised version of the midwife identity, and is willingly and purposely performed.

You have everything in midwifery, for you have the lowest of lows, but the highest of the highs... You cry with a woman. You can experience her loss as much as he does. But you can also walk on cloud nine the moment you've had a nice delivery (Rosie)

The midwife participants identified that in their role as midwife, they saw the expression of positive emotion as an intrinsic part of their midwife identity.

Pregnant ladies are the least of my problems. They are absolutely not what is stressful about my job and caring for women, no matter what complexities they have. They are not the source of my stress. Because there is- I know how to be a midwife. I know, I just don't feel like I'm allowed to get on with it. And that's what's stressful (Phoebe)

Here, Phoebe identifies the difficulties she faces attempting to realise the relational and emotional aspects of her midwifery identity. Depersonalised bullying at work is known to cause stress through often subtle or ambiguous means which prevent the target from accomplishing what they want to, at work.

Conveying emotion

The midwives expect to experience emotional reciprocity in the job. An aspect of midwifery which demonstrates this phenomenon is the encouragement of positive emotions during labour and birth which can facilitate release of certain hormones which can assist the birth process. One such hormone is oxytocin—which is sometimes known as the 'love hormone'—which is naturally secreted from the pituitary gland, and can produce a sense of trust and affection. During labour it causes contraction of the uterine muscles, which is obviously useful for the purposes of expelling a baby from the body. Therefore, an environment in which oxytocin can flourish is, in fact, physiologically beneficial for the labouring woman. This is deeply understood by midwives, who also acknowledge the impact that they have on the

emotional state, and therefore production of oxytocin, of the women under their care (Uvnäs-Moberg et al., 2015).

The Depersonalised Bullying processes which interrupt the midwife's ability to feel emotionally rewarded, lead to a disruption of the midwife identity, and potential abandonment of the job. When depersonalised bullying processes at work prevent this, midwifery work becomes less rewarding. Thus, the relational and emotional aspects of midwifery have an uncomfortable co-existence with the contemporary healthcare systems which favour 'efficient' processing of the woman service-users and standardisation of care (Hunter, 2004)

7.4 Existential crisis

Some midwives described the experience of being a midwife as integral to their own personal identity, and feeling of being bullied was felt as a challenge to their personally held values and beliefs. The midwives often spoke of expecting the maternity care workplace to embody caring, supportive attitudes, and feeling shocked when this was not the case. The participants found themselves questioning their fellow colleagues' intentions, and felt quite demoralised that those with the same professional identity and job title could behave so contrastingly from themselves.

I naively thought I was joining some sort of Sisterhood of women. That sounds a bit airy-fairy, but, you know, that I was going to join this community of midwives, women working with women. Working together, teaming up, supporting each other and trying to make these really good experiences for women. And then I just found that there are an awful lot of people who just wanted to trip you up and pin you down and make you stand out from the crowd and I found that really, really difficult. I became really scared. I didn't expect that at all. (Zoe)

It is understood that workplace identity can hinge off feeling comfortable with the tasks which are required, but can become problematic when a person's self-worth is too closely connected to their career (Sulphey, 2020). This can be the case for individuals who think of their work as their 'calling', inseparable from their life in general (Walsh and Gordon, 2008; Wrzesniewski, et al., 1997). Work that people feel called to do is usually seen as socially valuable, leading to creation of a positive associated workplace identity, as much as for themselves as for outside parties (Ashforth and Kreiner, 1999). Within the academic literature, midwifery is described as being "an inextricable part of who the person is" (Bryar and Sinclair, 2011, p. 4); a sentiment which was echoed in the interviews.

I absolutely love being a midwife. It's, it's part of who I am. It's not just a job, it's actually part of who I am as a person (Monica)

The role of a midwife and myself are so intertwined that I'm not really sure what my own personality is anymore (Carole)

I still really miss midwifery, I feel a bit like a stick of rock, if you broke me in the middle it would say 'midwife' across the centre (Isobel)

It just runs through me. I love it. I love it (Olivia)

Individuals can often have a strong desire to select identities that positively reinforce themselves, and their self-image (Ashforth and Kreiner, 1999). In order to maintain the positive aspect of their identity many midwives undertook attempted restoration of their belief systems. Workplace bullying can be a traumatic life-change experience (D'Cruz and Noronha, 2012) which threatens targets' sense of self and prompts a struggle for existential stability.

The midwives often demonstrated a greater concern with maintaining an identity which had less to do with the employing organisation and more to do with themselves, having attached themselves to the notion of being a midwife. With regards to a hypothetical theorising of what constitutes midwifery, the concept of it being something you are, as opposed to something you do, was fairly commonly (although not universally) expressed.

With this understanding of how midwives view their professional role, the challenge that bullying presented to their self-identity is more clearly contextualised.

Depersonalised Bullying acts to unmoor the anchor of midwives' identities. The researchers who initially conceived of Depersonalised Bullying - D'Cruz and Noronha (2008) - described how call-centre workers in India had anchored their identity and self-worth to the coveted concept of professionalism, as provided by their contract of employment with the call-centre, and then endured this form of bullying as the price they paid to maintain a professional profile. In this thesis it is clear that the midwives who have suffered Depersonalised Bullying have anchored their identity to more than just a sense of professionalism, but to a more personal discourse which sees them as emotionally, morally and mentally intertwined with all of the 'goodness' that the title of midwife insinuates.

Therefore, coercive behaviour which forced them to perform in ways antagonistic to their moral midwife identity was a major cause of mental and emotional distress. Interpreting the interview data through the Depersonalised Bullying lens allows a novel understanding of how midwives experience workplace bullying. Feeling bullied by institutional coercion to practise midwifery in ways at variance with their wishes was enough to cause midwives to feel decoupled from their personal-professional ambitions. In response to this, many of the midwives felt unable to re-establish a stable identity in midwifery, and decided to leave the profession.

Being a midwife was very much who I am. And so, when I gave that up, I gave up a massive part of who I am... that's who I am, and who am I now, if I'm not

doing this? what am I and who am I? You know, it felt like a real existential crisis (Caroline)

Here, Caroline exemplifies the intensity with which some of the midwife interviewees felt about their midwife identity.

7.5 Chapter summary

These findings engage in the analysis of professional identity within the context of NHS midwifery. As has been widely researched within Organisational Identity studies (see for example Ashforth et al., 2008; Brown, 2020; Weick, 1995), the reputation and identity that is attributed to an organisation (in this case, the profession of midwifery) can be an important conveyor of self-worth for its members. This acts as an anchor for social status (Whetten and Godfrey, 1998), but in the case of these midwives, for a moral status too. A chief concern for the midwives was the tension they felt when attempting to justify their actual (and enforced, due to depersonalied bullying) work behaviour in the context of what they viewed as credible midwifery practice.

This section analyses the journey travelled by midwives as they came to understand their disidentification with their organisation of employment, and the realisation that their identity was not the static thing that they may have once thought. This realisation was troubling for the midwives and triggered some emotional responses

from them. Strategies to manage the identity disruption typically involved feeling frustration or practising avoidance of the difficult situation. However, there was some evidence of midwives acting defiant in the face of barriers posed by Depersonalised Bullying.

Chapter Eight: Discussion

With this thesis, I aimed to examine the utility of the sociologically informed theoretical concept of Depersonalised Bullying in understanding bullying in NHS midwifery. The traditional, essentialist explanations of workplace bullying are found to be limited in explaining staff experiences and interventions to reduce bullying which are grounded in this perspective have so far failed to achieve desired outcomes. I argue that failure to capture the impact of the bullying structures and cultures of the bullying workplace is responsible for this. Thus, this thesis uses a conceptual framework of Depersonalised Bullying to explore factors which have so far been obscured. The organisational processes which can lead to NHS midwives feeling bullied, but which thus far have escaped scrutiny in this context, are identified. Application of the novel conceptual lens therefore moves beyond the identification of practices which felt oppressive to this particular group of individuals. Rather, this thesis frames bullying in midwifery upon the processes of organisational effectiveness and efficiency which have become standard practice within the NHS workplace. The main research questions were:

- i- By which routes do midwives feel bullied at work?
- ii- How does this impact midwives' feelings about their job?
- iii- What does this mean for the profession?

By drawing on in-depth, semi-structured interview data, I argue that structures and processes of the NHS organisation can cause midwives to feel oppressed, and bullied,

at work. The severity of the effects of the organisational processes is due, in large part, to the philosophical underpinnings of the midwifery profession. The midwives felt the impact of the organisational processes more acutely than might be expected due to their incompatibility with some of the central principles of midwifery practice.

Attempting to be a good midwife in this setting involves balancing the demands of the organisational processes and structures with the central principles of midwifery practice. The guiding principles of midwifery practice are woman-centredness, a sense of confidence in normality, and professional autonomy (see Chapter Two). They may be considered unique to the midwifery profession (Scamell, 2011) thus accounting for why midwives consistently report the highest levels of bullying in the NHS—as, in comparison with other professions, midwifery core professional principles are the most divergent from NHS central processes.

The responses to organisational processes are informed by the relationship midwives have with their own professional title. This is due to holders of the title of midwife being emotionally attached to the concept of what their job represents. This is further complicated by the gap which exists between the career expectations of midwives and the reality of work in the NHS.

8.1 Thesis contributions

The perspectives addressed in this thesis were varied, and therefore several theoretical contributions are made. These include contributions to the workplace

bullying literature, and research on the midwifery profession. Additionally, a proposal for interdisciplinarity is also made, encouraging greater connection between the fields of research concerning bullying in midwifery, and the expansive field of literature regarding organisational management and workplace governance within the NHS.

First, the thesis provides a methodological contribution to research in workplace bullying. Responding to the calls of D'Cruz and Noronha (2015), this thesis complements understanding of intra-organisational bullying at work—particularly within those workplaces with triadic employment relationships, which feature not just employers and employees, but also service-users (whether customers, or patients) (Korczynski, 2002). Second, this thesis explores the organisational processes and structures of the midwifery profession within the context of the National Health Service. While the thesis does not advocate for midwifery separating from the NHS, it does provide insight into some concerning tensions that should be addressed. Thirdly, a proposal is made towards greater communication between related fields adjacent to this topic.

8.1.1 Workplace bullying literature

First, the thesis offers a methodological shift away from traditional conceptualisations of what it means to be bullied at work. The substantive area of workplace bullying research focuses mainly on the interpersonal level of analysis,

resulting in analysis which rarely considers the bully to be anything other than an individual character enacting an intentional misbehaviour (see for example, Einarsen, 1999; Hoel and Cooper, 2001; Leymann, 1996). However, on some occasions, during which research related to workplace bullying in an Indian call-centre (D'Cruz and Noronha, 2015), and a large telecommunications company in the United Kingdom (Liefooghe and MacKenzie Davey, 2001) a more critical evaluation was undertaken. From this perspective came acknowledgement that to focus on an individualised approach was "reductionist... and precludes appropriate attention to the more systemic root cause" (Liefooghe and MacKenzie Davey, 2010, p. 88). The conceptual model of Depersonalised Bullying was developed by D'Cruz and Noronha (2015) to counter the individualised, interpersonal approach and led an understanding that workers could feel bullied by the

routine subjugation, both covert and overt... by contextual, structural and processual elements of organisational design, which are implemented by supervisors and managers who resort to abusive behaviours in an impersonal way, to achieve organisational effectiveness (D'Cruz and Noronha, 2013a)

It is within this paradigm that the research for this thesis was completed. Thus, the contribution made by this thesis represents the first time the conceptualisation of Depersonalised Bullying has been applied to the workplaces of a specific group of clinical healthcare professionals in the National Health Service. This has added to the diversity of research settings, allowing a greater understanding of workplace bullying conceptualisations across a broader variety of industries.

It should be understood that acknowledging the presence of Depersonalised Bullying does not negate or minimise the impact of interpersonal and organisational bullying. Indeed, Depersonalised Bullying should be understood to occupy the 'macro' layer of the conceptualisation of workplace bullying. The macro level exists together with both meso (organisational) and micro (interpersonal) levels of bullying, and is often interwoven with both (Berlingieri, 2015; Lutgen-Sandvik and Tracy, 2012). Interrelation between these levels was detected within this thesis when midwives described a lack of clarity about the ways in which they felt oppressed. It could be unclear whether they were being targeted personally, or due to their professional role. The legitimacy of the power dynamics in the workplace were also often queried, and could benefit from further unpicking.

This thesis contends that the generally under-examined interrelationship between the macro and micro levels is a critical perspective in the consideration of workplace bullying. Integrating the study of macro level depersonalised workplace bullying with both meso and micro level, follows the fields of sociological research which have similarly examined intersecting layers of a phenomenon. Examples would be the multi-level analysis of racial and sexual oppression (see for example Foldy, 2012; Lopez et al., 2009; Wharton, 1992) or investigation into mechanisms of power and control in society (Hearn and Parkin, 2005). In each of these cases, taking account of the complexity of the interlinked influences of both micro and macro facets of phenomena has led to greatly enhanced understanding of the issues. This thesis similarly demonstrates the benefits of adopting of a multi-level perspective to the study of workplace bullying.

This thesis has also identified the utility of making an association between the extensive extant literature concerning the NHS's pursuit of organisational goals (see for example, Cooper et al., 2010; Greener and Mannion, 2009; Harrison and Pollitt, 1994; Pollock, 2004; Propper et al., 2008; Timmins, 2005) and bullying behaviours. Through this thesis, the value of this association has been demonstrated.

8.1.2 The midwifery profession

Secondly, this thesis has explored the tensions between organisational structures of employment in maternity services and delivery of the core tenets of midwifery practice. Any tensions experienced in relation to the principles of midwifery practice are traditionally contextualised within arguments concerning the increasing medicalisation, or risk-averse nature of pregnancy and childbirth (see for example, Davis-Floyd, 2001; Scamell, 2016; Walsh, 2006), or questions concerning maternal choice in pregnancy and childbirth (e.g. Green et al., 1994; Lazarus, 1997; Levy, 1999; Nolan, 2015). Thus far, research which analyses the compatibility—or incompatibility—of midwifery principles and specific employment structures and processes has not yet been detected. This thesis offers a tentative first step towards this area of research.

Critically, I argue that the existing approaches to measuring and understanding midwifery philosophy remain crucial, but must be situated within a framework which

acknowledges contemporary structures of employment. Further incorporation of the dominant social, political and economic discourses which impact midwives—both as individuals and as a group—would provide further depth to understanding.

8.1.3 Proposal for interdisciplinarity

This thesis also makes a methodological contribution to the wider pool of workplace research. Accomplishment of the project illuminated the need for greater communication between two discrete, but related, fields: the research concerning bullying in midwifery, and that regarding organisational management and workplace governance within the NHS. This proposal is suggested due to two features of the thesis production. The first feature is found within the thesis data and research findings. Application of the Depersonalised Bullying lens to the interview transcripts illuminated the extent to which organisational processes, rather than solely interpersonal factors, can cause NHS midwives to feel bullied and oppressed and lead to negative outcomes such as sickness, fear, and role abandonment (see Chapter Five). This shows that the two areas of research can be of mutual benefit to each other.

The second feature of the research process which has led to this proposal relates to thematic commonalities between the fields which were encountered during the literature review portion of the research. Reconceptualising bullying to include a depersonalised definition led to diversifying the foundational pool of literature to be

evaluated early in the research process. It became quickly evident that without examining the research concerning NHS organisational structures and processes, a thorough review would not be possible. However, literature from this field barely overlapped with research which sought to understand bullying in midwifery. By combining these two areas, this thesis demonstrates the value of utilising findings from an area which has so far remained discrete from the substantive area of interest: bullying in midwifery.

8.2 Limitations of the study

Specific issues could potentially be identified related to the recruitment of midwife participants who had chosen to join an online community (the Facebook group 'Say No to Bullying in Midwifery') which, by virtue of its existence, recognised the existence of workplace bullying in midwifery. Therefore, the findings of this study relate only to midwives who have prior experience with this phenomenon. Had the initial plan for recruitment—which had been to advertise within the physical work areas of hospital maternity units within a certain radius of my location—been possible, it would possibly have resulted in a very different demographic of midwives taking part in the interviews.

Another limitation could possibly have resulted from undertaking emotive research of this sort among healthcare providers within the first few months of a global pandemic (the novel Coronavirus, COVID-19). With time it might be possible to ascertain if the circumstances of the pandemic caused either an increase or a

decrease (or neither) in emotional sensitivity in either the participants, or myself. However, the findings achieved for this thesis do represent those who were interviewed in the year 2020, and may be contextualised within the disruption or unanimity they were experiencing that year.

A final limitation identified towards the final stages of the project was the absence of intersectionality in construction of the study design. Due to the gendered and raced history of healthcare in general, intersectionality has been usefully applied to identify myriad intersecting social power structures (Crenshaw, 1990) which can create inequality for child-bearing women (see for example, Levesque et al., 2013; Holman et al., 2021). It is known that black women in the UK are four times more likely to die in pregnancy and childbirth than white women, and Asian and mixedrace women twice as likely (Freedman and Lucas, 2016). Further, research on racism as a systemic issue in the NHS workforce has been underway for many years (Kline, 2017). Findings built on a framework of intersectionality would presumably also highlight presently obscured characteristics of midwives' experiences of Depersonalised Bullying within the context of the NHS. Including intersectionality as a central feature would highlight specifically the instances of marginalisation, professional bias, and disproportionality of staffing statistics that negatively affect and oppress women of colour and would have provided some useful insight in addition to the findings discussed in the empirical chapters. Next, I present the ways in which the findings from this piece of research have implications for future research.

8.3 Recommendations for future research

Opportunities for further research emerge from this thesis. These relate both to the limitations recognised in the study but also to some emerging concepts. First, research undertaken so far regarding bullying in midwifery has taken the essentialist view that bullying is a behaviour (e.g. Begley, 2002; Douglas, 2011) and has identified workplace culture as a strong predictor of bullying (e.g. Carter et al., 2013; Farrell and Shafiei, 2012; Hastie, 1995, 2006; Pezaro et al., 2016). This has served to illuminate the scale of work-related bullying and distress within midwifery populations (Curtis et al, 2006d) and rightly associates the phenomenon with concerns about high staff turnover (Douglas, 2011; Hall et al., 2016). The findings from this thesis present an opportunity for researchers to diversify the methodological approach taken. In Chapter Three, I made the argument that new insight could be realised by reconceptualising bullying as

"routine subjugation, both covert and overt... by contextual, structural and processual elements of organisational design, which are implemented by supervisors and managers who resort to abusive behaviours in an impersonal way, to achieve organisational effectiveness" (D'Cruz and Noronha, 2013a).

This thesis demonstrated some of the nuance that exists regarding the application of the Depersonalised Bullying lens upon the experiences of NHS midwives. For example, it was determined that newly qualified midwives employed within the hospital wards maintain a fear of unstable working structures, and being asked to move to a different area. I also determined that midwives valued offering personalised, woman-centred care, and felt that the enforced conformity and surveillance of the organisation made this impossible. Future research in the midwifery field can corroborate or expand upon the findings presented in this thesis. It may also seek to identify specific professional factors (such a work location, or years of experience) that influence an individual feeling that they have been oppressed by the workplace structures. Taking a more intersectional approach to examining this area would further strengthen the findings. The circumstances of the research for this thesis did not allow for measurement of participants diversity as pertains to race, ethnicity or gender. An intersectional approach which uses these factors as analytical categories to examine and compare outcomes, would be useful and extremely valuable.

Secondly, there is scope for further research into the emerging theory of professional expectations for those entering the midwifery workforce. At present, the concept of disappointed expectations remains an emerging concept based upon the experiences of a minority of participants. However, evidence of it within the data can be detected, and perhaps most powerfully throughout the final empirical chapter 'Identity Disruption', in particular, the concept of conflict between the ideological expectations of a profession and the requirements of the workforce. Future research could explicitly explore this concept to understand the rationales behind midwives holding the professional expectations that they do. Additionally, this could be situated within the wider study of employment relations, and in particular those

studies which seek to understand the 'psychological contract' that exists between workers and employers (Rodwell et al., 2015; Rousseau, 1989, 1995). The psychological contract describes an employee's perceptions with regards to "the reciprocal obligations between themselves and their employing organisation" based on promises that the employee believes were made to them (Rodwell et al, 2015, p. 690). While this area has been investigated widely from a number of perspectives which have overlapping features with this study (see for example, Bunderson, 2001; Sheehan et al., 2019; Sturges et al., 2005), research towards the psychological contract and associated work expectations of NHS midwives has yet to be undertaken. Understanding the relationship between NHS midwives' psychological contract and the influence of Depersonalised Bullying structures would provide further insight into the workplace challenges experienced by this group.

8.4 Policy recommendations

The research presented in this thesis has implications for policy makers to support improvement in the working lives of midwives. In particular, for policy which acknowledges the composition of the employment structures of this working group, and its bearing upon the provision of support specific to the midwifery profession.

Policy specific to midwifery has so far tended to focus on how midwives and their midwifery practice can optimally impact those around them. This area of policy includes enforcing adherence to professional standards and guidelines (Nursing and

Midwifery Council, 2018), enabling the provision of woman-centred care (see for example Department of Health, 1993; Nursing and Midwifery Council, 2008), and recognising the importance of the practice of compassion (Kirkup, 2015; Ockenden, 2022).

More rarely considered at the policy level is the impact of the workplace environment upon the midwives themselves. While burnout and disillusionment have been noted, suggested mitigation strategies tend to be for individual midwives to improve their resilience at work (Sandall, 1998) or for managers to receive training which develops their communication and advocacy skills (West et al., 2015). However, these approaches do not account for the influence of organisational structures, which have been shown so clearly to impact midwives on an individual level.

This thesis, then, advances the calls of the Royal College of Midwives' (RCM) 'Work, Health and Emotional Lives of Midwives' (WHELM) study (Hunter and Henley, 2019) which exposed the relationship between an oppressive work environment and reduced well-being in midwives. While such research significantly legitimises arguments for change, the instigation of concrete improvement in the well-being of midwives in the maternity workplace—through policy or legislation—remains lacking.

Accordingly, the thesis advocates for the introduction of a multi-stakeholder action plan designed to address the findings of this, and other, research projects. Proposed

Stakeholders would be the professional organisation and trade union The Royal College of Midwives (RCM), and the Department of Health and Social Care (DHSC). Additionally, an independent regulator should be established to consider the extent to which NHS midwives are being required to work in ways outwith their remit. It is imperative that the regulator understands both the structures of employment which guide midwifery practice, and the value of the philosophy of midwifery and womancentred care. It is possible that this function could potentially be exercised by the existing regulator, the Nursing and Midwifery Council (NMC). However, this thesis has shown that midwife respondents have expressed a lack of confidence in the NMC's capacity to focus upon the specifics of midwifery. This is an argument towards the benefits of a unique regulatory body which specialises in the distinctive features of midwifery.

8.5 Closing remarks

The findings of this thesis have exposed, above all else, the value of taking a critical approach to understanding the phenomenon of workplace bullying. By resisting a "limited understanding" of the way bullying is defined, constructed, and experienced (Liefooghe and MacKenzie Davey, 2010, p. 71) I have provided insight into a phenomenon that puzzled me for years. It remains important to consider the role of both interpersonal and organisational bullying in them midwifery workforce. The approach taken in this thesis is designed to complement, not replace, the existing

knowledge in the field. The findings from this thesis have also enabled me to better contextualise some of my own personal experiences within the profession, which has been profoundly enlightening. But, there remains work to be done if the profession of midwifery is to regain a strong position within contemporary healthcare. It seems fitting to conclude by co-opting the words of one of the midwives who kindly agreed to be interviewed for this thesis:

I've had an interesting journey. I absolutely love the job. It's not the job that it was ... We have to be rebellious, because at the end of the day: women's choice. Midwifery is a great art form. And it's been, it's been demolished systematically. I do care passionately about midwifery (Anna)

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Appendices

Appendix 1: Sample of The Code (NMC, 2018)

rofessional standards of practice and behaviour for nurses, midwives and nursing

Prioritise people

You put the interests of people using or needing nursing or midwlifey services first. You make their care and selfely number of the interest are the third dignit; to preserved and their needs are recognised, assessed and responded to. You make sure that those reciving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

Treat people as individuals and uphold their dignit

To achieve this, you must:

- 11 treat people with kindness, respect and compassion
- 12 make sure you deliver the fundamentals of care effectively
- 13 avoid making assumptions and recognise diversity and individual choice
- 14 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
- 15 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing

The fundamentals of care include, but are not limited to nutrition, hydration, blooder and bowle one; physical handing and naking sure that these receiving care are kell, in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration; and making sure that purp provide help to those who are not able to feed themselves or drink fluid unsided.

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- 2.3 encourage and empower people to share in decisions about their treatment and care
- 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care
- 2.5 respect, support and document a person's right to accept or
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

- 3.1 pay special attention to promoting wellbeing, preventing ilhealth and meeting the changing health and care needs of people during all Ife stages
- 3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life
- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
- 3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

- 4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment.
- 4.2 make sure that you get properly informed consent and document it before carrying out any action

The Code (

frofessional standards of practice and behaviour for nurses, midwives and nursing: All standards apply within your professional scope of practice

- 43 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who back capacity are still at the centre of the decision-making process
- 4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that persons care

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you mus

- 5.1 respect a person's right to privacy in all aspects of their care
- 5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care
- 5.3 respect that a person's right to privacy and confidentiality continues after they have died
- 5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality
- 5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

You can only make a 'conscientious objection' in Amited circumstances. For more information, please visit our website at www.rmc.org.uk/standards.

Nursing and Midwifery Council

Professional standards of practice and behaviour for nurses, midwives and nursing associate

All standards socky within your professional scope of practice

Practise effectively

You assess need and deliver or advise on treatment, or give help (Including preventative or rehebilitative care) without too much delay, to the best of your sobilities, nith be ask of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on an Wedasck you reset to introve you reactice.

6 Always practise in line with the best available evidence

To achieve this, you must:

- make sure that any information or advice given is evidencebased including information relating to using any health and care products or services
- 6.2 maintain the knowledge and skills you need for safe and

7 Communicate clearly

To achieve this, you must

- 71 use terms that people in your care, colleagues and the public can understand
- 7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
- 7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs
- 7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

7.5 be able to communicate clearly and effectively in English

rofessional standards of practice and behaviour for nurses, midvives and nursing associate

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8 Work co-operatively

To achieve this, you must:

- 8.1 respect the skils, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
- 8.4 work with colleagues to evaluate the quality of your work and that of the team
- 8.5 work with colleagues to preserve the safety of those receiving care
- 8.6 share information to identify and reduce risk
- 8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

- 9.1 provide honest, accurate and constructive feedback to colleagues
- 9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
- 9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times
- 9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

Professional standards of practice and behaviour for nurses, midwies and nursing associal All standards apply within your professional acops of practice

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- 10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- 10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- 10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
- 10.5 take all steps to make sure that records are kept securely
- 10.6 collect, treat and store all data and research findings

Nursing and Midwifery Council The Code: 1

Appendix 2: Recruitment poster

Leeds University Business School



WORK AND EMPLOYMENT RELATIONS

Short Information Leaflet – Midwives

Research by: Sarah Spence, former midwife, PhD Student

I hope to gain insight into how midwives experience work in the NHS. Would you be willing to discuss this in a confidential interview?

If so, please contact Sarah by email: <u>bnsms@leeds.ac.uk</u>
for further information about how to take part

Thankyou

Appendix 3: Participant Information Sheet (PiS) 1/3

Participant Information Sheet V3 14Dec2019



How do NHS midwives experience pressure at work?

You are being invited to take part in this study because you are – or have been - a registered midwife who works within the NHS. Before you decide to take part, it is important that you understand why the research is being done, what it will involve and what will happen to the data you provide.

Please take the time to read the following information and discuss it with the researcher if you wish. Please do not hesitate to ask if there is anything that is not clear, or if you would like more information.

WHAT IS THE STUDY ABOUT?

The purpose of the study is to gain an understanding of the experiences of midwives and the pressures of work in midwifery. The study seeks to understand how the many aspects of work life shape the way that midwives think about their role in the workplace.

Who is the target audience?

Midwives working within the NHS Maternity System.

What will I need to do?

If you agree to take part in the study you will be interviewed to discuss your experiences and the factors which cause you to feel under pressure in the workplace. The interview will take place at a time and location which is convenient for you, and should last about an hour. Interviews will be audio recorded to ensure data is collected accurately and the data will be kept on a secure University Drive. Recordings will be destroyed once they have been transcribed.

Do I have to take part?

You are free to decide whether or not to take part, and the decision will remain confidential and will not affect you in any way. If you decide to participate you will be asked to sign a consent form. Should you decide to withdraw from the study, you can do this at any time before or during the interview, and up to 2 weeks after the interview has taken place,

How do NHS midwives experience pressure at work?

Appendix 3 cont: Participant Information Sheet (PiS) 2/3

Participant Information Sheet V3 14Dec2019

without giving a reason. You can decide whether any information you have provided up to this time is used in the study.

Who is doing the research?

I am a midwife and PhD student funded by the Leeds University Business School.

Who will have access to my data?

No-one will have access to your personal data, except for me. I will use this information to make sure that the research is being done properly. All names spoken and recorded will be removed during transcription. Your data will be coded with a number instead.

You can find out more about how your information is used by asking one of the research team, or by sending an email to the University's Data Protection Officer at dpo@leeds.ac.uk. The University of Leeds is the Data Controller.

Will my taking part be kept confidential?

Yes. No-one, apart from me will be able to identify the source of any information included in this study. All names spoken and recorded will be removed as the interview is transcribed and where any direct quotations are used, any potentially identifying information will be removed. All rules and guidelines regarding privacy will be adhered to.

What will happen to the results of the research study?

The results from this study will be used in the development of my PhD thesis, and articles will be written for professional journals and papers and presented at conferences to share the findings with others. Upon request, I can let you know when the work will be published. No-one who has taken part in the research will be identified in any report or publication and all names will be changed to protect confidentiality

Ethical approval

The project has obtained ethical approval from the University of Leeds Research Ethics Committee.

CONTACT DETAILS

To take part, or simply learn more, please contact Sarah Spence at (bnsms@leeds.ac.uk) in the first instance.

How do NHS midwives experience pressure at work?

Appendix 3 cont: Participant Information Sheet (PiS) 3/3

Participant Information Sheet V3 14Dec2019

If you have any problems or are unhappy with the study

you can contact the University's Data Protection Officer at dpo@leeds.ac.uk and/or my doctoral supervisors:

Prof. Andy Charlwood. Professor of Human Resource Management a.charlwood@leeds.ac.uk

Dr. Kate Hardy. Associate Professor in Work and Employment Relations $\underline{\text{k.r.hardy@leeds.ac.uk}}$

Dr. Tomasina Stacey. Reader in Midwifery Practice University of Huddersfield t.stacey@hud.ac.uk

Right to complain

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns

Appendix 4: Documents relating to ethical approval.

Initial application

From: ResearchEthics <researche cs@leeds.ac.uk> Sent: Monday, April 20, 2020 1:13:10 PM

AREA 19-108 Pressure at work: The experiences of NHS midwives

tee note: All approval types are with the caveat that the applicant's study design fully complies with current UK Government and University of Leeds Health & Safety advice during the Covid-19 outbreak

I am pleased to inform you that the above research ethics application has been reviewed by the AREA/FREC Committee and on behalf of the Chair, I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology, all changes must receive ethical approval prior to implementation. Please see https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx or contact the Research Ethics Administrator for further information researchethics@leeds.ac.uk if

Elthics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

Best wishes Kaye On behalf of Dr. Matthew Davis, CHAIR,AREA Faculty Research Ethics Committee

Research Integrity & Governance Team | The Secretariat | University of Leeds | Leds | LS2 9JT | 0113 34 34873 | ResearchEthics@leeds.ac.uk | www.leeds.ac.uk/ethics

Revised application

From: John Hardy
From: John Hardy
From: John Hardy
John Spence
hardy@leeds.ac.ul

Co: ResearchEthics
Co: ResearchEthics <a href="LE-Hardy@leeds.ac.u

AREA 19-108 Amd June 2020 - Pressure at work: The experiences of NHS midwives.

I am pleased to inform you that the above research ethics application amendment has been reviewed by the Business, Environment and Social Sciences (AREA) Faculty Research Ethics Committee and on behalf of the Chair, I can confirm a favourable ethical based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any further amendments to the original research as submitted and approved to date. This includes recruitment methodology, all changes must receive ethical approval prior to implementation. Please see https://leeds355.sharspoint.com/sites/Researchandinnovation/Service/Sites/Pages/Amendments.aspx or contact the Research Ethics Administrator for further information (researchethics/Releads.ac.uk) if required.

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On behalf of Matthew Davies, Chair, AREA FREC

Research Ethics & Governance Administrator

University of Leeds, LS2 9LT

Appendix 5: Consent form

[Consent Form v2 LUBS WERD]



Consent to take part in 'Pressu	re at work. The experiences of NHS Midwives'	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated 14 December 2019 explaining the above research project and I have had the opportunity to ask questions about the project.		
I understand that my participation is voluntary and that I am free to withdraw at any time within two weeks of being interviewed, without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. [Beyond the two week boundary, data already provided will remain as part of the findings of the study and may be used for completion of the PhD thesis as well as for future publications or conference presentations. Interviewee identity will remain strictly confidential and will be anonymised.]		
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.		
I agree for the data collected from me anonymised form.	to be stored and used in relevant future research in	
I understand that other genuine reseat to preserve the confidentiality of the in	archers will have access to this data only if they agree information as requested in this form.	
	hay use my words in publications, reports, web pages, by agree to preserve the confidentiality of the	
by auditors from the University of Lee	the data collected during the study, may be looked at ds where it is relevant to my taking part in this individuals to have access to my records.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.		
Name of participant		
Participant's signature		
Date		
Name of lead researcher	Sarah Spence	
Signature		
Date*		

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

Project title	Document type	Version #	Date
Pressure at work. The experiences of NHS midwives.	Consent form for	V2	11 Nov
	interviewees		2019

 $^{{}^{\}star}\mathsf{To}$ be signed and dated in the presence of the participant.