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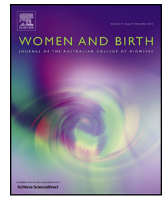

What do midwives fear?

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ABSTRACT

Background: There is evidence that a significant number of women are fearful about birth but less is known about the fears of maternity health providers and how their fear may impact on the women they care for.
Aim: The aim of this study was to determine the top fears midwives in Australia and New Zealand hold when it comes to caring for childbearing women.
Method: From 2009 to 2011, 17 workshops were held in Australia and New Zealand supporting over 700 midwives develop skills to keep birth normal. During the workshop midwives were asked to write their top fear on a piece of paper and return it to the presenters. Similar concepts were grouped together to form 8 major categories.
Findings: In total 739 fears were reported and these were death of a baby (n = 177), missing something that causes harm (n = 176), obstetric emergencies (n = 114), maternal death (n = 83), being watched (n = 68), being the cause of a negative birth experience (n = 52), dealing with the unknown (n = 36) and losing passion and confidence around normal birth (n = 32). Student midwives were more concerned about knowing what to do, while homebirth midwives were mostly concerned with being blamed if something went wrong.
Conclusion: There was consistency between the 17 groups of midwives regarding top fears held. Supporting midwives with workshops such as dealing with grief and loss and managing fear could help reduce their anxiety. Obstetric emergency skills workshops may help midwives feel more confident, especially those dealing with shoulder dystocia and PPH as they were most commonly recorded.
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1. Introduction

Significant attention is focused on women's fear of birth in both the contemporary scientific literature[1,2] and the media.[3] There appears to be less focus on the fears of maternity care health providers and how their fears, and the way maternity services are constructed and delivered may be impacting on women's fear.

The limited literature available about how health care provider's fears can impact women and childbirth suggests there could be a link.[4,5] In Powell Kennedy's qualitative study examining midwives beliefs about normal birth some of the midwives reported that when they became fearful when caring for women giving birth they were less able to care effectively for the woman and they felt their anxiety may have impacted negatively on the birth outcome.[6] A study undertaken by Regan and Liaschenko in the US showed that nurse–midwives viewed birth through a lens of risk with three categories found: birth as a natural process; birth as lurking risk and birth as a risky process. The authors found the nurse–midwives beliefs about birth could influence their care and resulting interventions such as caesarean section.[4]

Styles et al. found that midwives in Scotland working under different health boards referred at different times during labour and the authors suggest highly publicised adverse events in that health service might be making midwives more conservative in their practice, suggesting negative recent events could impact on midwives perception of fear and risk and thus impact on practice.[7] Morris describes an atmosphere of anxiety and lost confidence in midwives as impacting on their ability to facilitate normal births. Morris argues that while midwives are less likely to be the direct cause of birth trauma that results in litigation, they are encouraged to practice within a *just in case* framework and spend much of their

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time in documenting and justifying their decisions.[8] Other writers report anecdotally on the fear that governs midwives' practice and how this shapes practice and feeds the current risk agenda in maternity care.[9–13]

Likewise there is evidence that obstetric practice may be influenced by particular beliefs. A commonly cited study, where 31% of female London obstetricians indicated that they would opt for a Caesarean for their own births,[14] is used to argue that this indicates choices made by 'an informed cohort of women'.[15] However, it is equally interesting to look at other less commonly cited studies from developed countries where the caesarean section rate is low, such as Norway, Denmark and the Netherlands. Here similar surveys indicate that small numbers (1.1–2%) of obstetricians would choose caesarean section for themselves or partners.[16,17]

The aim of this study was to determine the top fears midwives in Australia and New Zealand hold when it comes to providing care to childbearing women.

2. Method

From 2009 until 2011 the two authors were involved in undertaking 17 two day workshops on keeping birth normal and grief and loss in Australia (15) and New Zealand (2) with a company called *Capers*. *Capers* is an Australian company that specialises in books and resources on women's health, pregnancy, birth and breastfeeding. It also runs education seminars and conferences for health professionals, primarily midwives and lactation consultants.

We did not have formal ethics approval for this study but detail the ethical approach taken. As part of the workshop on normal birth, a session on fear was run. This involved getting midwives to write down on a piece of paper their greatest fear. These fears were then collected in a box, mixed up and collated and reported back anonymously to the group. The group was asked permission for the pieces of paper to be kept and combined with other fears collected. They were advised we would analyse these fears and write a paper on the major categories that emerged with the aim to present the findings at conferences and in a publication. Participants were reassured about confidentiality and that there would be no way to identify their individual comments as there were no names on any of the papers. If they were worried about this they could abstain from writing anything down. There were very few midwives who did not participate and only one midwife wrote that she had no fear.

3. Participants

In total 667 midwives and 72 student midwives recorded fears. We also had 10 obstetric registrars document their top fear to compare and contrast with the midwives fears, but they were not included in the analysis in Table 1. We analysed the student midwives fears together with all the midwives fears and separately to see if there were any differences. Likewise, we examined the fears from homebirth midwives separately and together. In total 739 fears were recorded and only one midwife reported that she had no fear. We did not gather demographic data in this study.

4. Analysis

This is a qualitative descriptive study that examined 739 fears reported by midwives in Australia and New Zealand as their top fear. All fears were transcribed from the bits of paper collected and recorded on an excel spreadsheet with 67 different categories initially listed. Where the same fear was expressed a number was assigned to the category. For example death of a baby was listed 177 times. Similar categories were then grouped together and collapsed down to 32 subcategories which were grouped under eight major categories. For example, where midwives had recorded 'being watched', 'persecuted', 'judged', 'surveillance', 'doctors always behind me', these were grouped under the heading being watched. Some of the categories such as maternal death or death of a baby were pretty straight forward while other categories such as 'being watched' had several subcategories incorporated into them. For the category obstetric emergency any obstetric emergency was grouped under this heading and subcategories counted to get the top emergency feared, such as shoulder dystocia and post partum haemorrhage. We did not include quotes as the fear was often written as one or two words. Some midwives did write long descriptions of their feat but we asked midwives not to do this and urged them to write the first thing that came into their heads. We did not specify which area of practice to focus on but note with interest much of the fear reported related to intrapartum care.

Table 1
Midwives top fears.

Categories/sub categories	Number
(1) Death of a baby	177
(2) Missing something that causes harm	176
Not knowing enough and making a mistake	80
Doing something wrong/damage/harm	43
Not recognising something is wrong	31
Causing poor outcome for mother and baby	13
Causing serious perineal damage/episiotomy	9
(3) Obstetric emergencies	114
Shoulder dystocia	23
Postpartum haemorrhage	21
Obstetric emergency (not defined)	14
Foetal distress	14
Neonatal resuscitation	11
Cord prolapse	6
Other (APH, ruptured uterus, eclampsia, etc.)	25
(4) Maternal death	83
(5) Being watched and criticised	68
No support from doctors/organisation	19
Litigation	16
Being criticised/persecuted/judged	9
Workplace stress (bullying/surveillance)	9
Doctors criticising/pressuring/questioning	7
Support people/relatives	4
Professional standards/tribunals	4
(6) Being the cause of a negative birth experience	52
Saying the wrong thing	21
That I will disturb the process	8
Woman's satisfaction	7
Negative experience for the woman	6
Women being exposed/disturbed/no privacy	5
Intervention/trauma during birth	5
(7) Dealing with the unknown and not being prepared	36
Not knowing what to do/say	18
The unknown	10
No time to think/feeling out of control	8
(8) Losing my passion and confidence in normal birth	32
Not having a relationship with women	9
Losing passion/confidence in normal birth	8
'Going to the dark side'	6
Loss of trust in women/birth/midwifery	9
No fear	1
Total fears	739

5. Findings

In total 667 midwives, 72 student midwives recorded their top fear. A total of 739 fears were recorded. One midwife recorded that she had no fear. Most of the fears were from Australian midwives with 32 being from New Zealand midwives.

The top fear of Australian and New Zealand midwives and obstetric registrars in particular was death of a baby ($n = 177$). We

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