REVIEW ARTICLE

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Workplace violence in the Australian and New Zealand midwifery workforce: A scoping review

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Abstract

Aim: The aim of the study is to identify and map what is known about workplace violence involving midwives in Australia and New Zealand.

Background: Research from the United Kingdom demonstrates that workplace violence within maternity services is a pervasive issue with significant and wide-ranging clinical, individual and organisational consequences. To date, little is known about this issue within Australian and New Zealand maternity services.

Evaluation: A scoping review, guided by Arksey and O'Malley's framework, was conducted. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews checklist. Just one identified study aimed to explore midwives' experiences of workplace violence. A further nine arrived at related results or themes.

Key issues: Workplace violence is present in a variety of forms across maternity services in Australia and New Zealand. Its prevalence is, however, yet to be understood. Workplace violence causes physical and mental health issues for midwives, premature workforce attrition, and jeopardizes the quality and safety of maternity care.

Conclusions: Workplace violence has been acknowledged as one of the key contributing factors towards premature attrition from the midwifery profession, with new graduate midwives most likely to leave. With the midwifery workforce ageing and evidence of serious clinical implications emerging, workplace violence needs urgent research and organisational attention.

Implications for nursing management: Workplace violence is a key contributing factor towards recruitment and retention challenges for managers. To help tackle this, managers have a key role to play in identifying and effectively addressing workplace violence by acting as positive role models, taking a zero-tolerance approach and fostering collegial relationships. Managers, holding key clinical leadership positions, are pivotal to ensuring all complaints raised are handled with transparency and

consistency regardless of one's position within the clinical hierarchy and organisational structure.

1 | INTRODUCTION

Workplace violence (WPV), also referred to in the literature as *workplace bullying*, *incivility* or *mobbing*, has become a heavily researched field, in part because it is a pervasive public health issue affecting almost half of the working population (Fink-Samnick, 2017). WPV is often classified into behaviours targeting those of equal (*horizontal*) or lesser (*vertical*) power (Zhang & Wright, 2018). Health care organisations, with strong hierarchical structures and staff power imbalances, are places where both forms of WPV can thrive (LaGuardia & Oelke, 2021). Whilst there is no universally accepted definition of WPV, it broadly refers to *intentional* inappropriate behaviour or unfair treatment of an individual in the workplace (Van Fleet & Van Fleet, 2022). Within the Australian and New Zealand context, WPV involving nurses has attracted considerable research interest (Hawkins et al., 2021); however, little research has explored this issue related to *midwives*.

2 | BACKGROUND

The Ockendon Report (Ockenden, 2022), described in the *British Medical Journal* (BMJ) as 'another shocking review of maternity services' (Knight & Stanford, 2022 p. 1), revealed many serious incidents causing injury or death to women and infants at a maternity unit in the United Kingdom (UK). The report has drawn international focus to a body of work that has its origins in the mid-1990s (Hastie, 1995). Despite the ensuing three decades of research, evidence suggests that WPV continues to be an inherent part of midwifery culture today (Catling et al., 2017), a culture within which the future midwifery workforce is being socialized, learning and reciprocating poor behaviours (Capper et al., 2021). A growing body of literature, primarily from the United Kingdom, suggests that WPV in midwifery has adverse far-reaching impacts for individuals, employing organisations and the profession as a whole.

2.1 | Midwives and midwifery students

WPV is a key source of distress for midwives, contributing to a decline in physical and mental health, workplace absenteeism, burnout and job loss (Gillen, 2007; Yoshida & Sandall, 2013). Collectively, these consequences are costly to employers, exacerbating staffing costs and shortages (Kline & Lewis, 2019). In addition to registered midwives, it has been noted that midwifery *students* also experience WPV whilst on clinical placement (Capper et al., 2020a), again leading to attrition, in this case prior to registration (Capper et al., 2020b).

2.2 | Midwifery workforce provision and sustainability

There is a global shortage of midwives (United Nations Population Fund, 2021). With the Nursing and Midwifery Board of Australia (NMBA) December 2021 registration data revealing that over 40% of midwives are aged 55 or over (Nursing and Midwifery Board of Australia (NMBA), 2021), it can be assumed that as this group retires, clinical staffing levels and skill mix will be affected. Concerningly, Harvie et al. (2019) identified that early career midwives are the group most likely to leave the profession prematurely, suggesting that significant attrition can be anticipated from both ends of the workforce. The international literature demonstrates a correlation between premature workforce attrition and poor workplace culture, including WPV. The 2016 Royal College of Midwives (RCM) 'Why Midwives Leave' report presents the survey results of 2719 UK midwives, revealing that 19% cited bullying from colleagues and 11% from managers (Royal College of Midwives, 2016) as the impetus for departure.

2.3 | Care quality and safety

The broader literature has demonstrated a link between workplace factors including staff shortages, stressful work environments, poor working relationships and adverse patient outcomes (Sizmur & Raleigh, 2018). When translated into the midwifery context, where these workplace factors are common, the potential for harm to mothers and babies is evident. The recent release of the Ockenden Report (Ockenden, 2022) brought this into focus. The independent review of an English maternity service examined and reported upon high numbers of adverse clinical incidents spanning two decades. Staffing shortages and the presence of workplace incivility, underpinned by a strong culture of bullying and fear, were identified as causal towards these incidents. Staff had become desensitized to bad behaviours, with violence accepted as a cultural norm, lifting individual incivility to the level of organisational abuse. In this culture, whistleblowing even through formal pathways was avoided; midwives feared being perceived as troublemakers. The report suggested that failure to act at every level of the organisation resulted in the avoidable deaths of nine mothers and over 200 babies (Ockenden, 2022).

This is a UK example, but Australia and New Zealand have comparable maternity services structures and workforce challenges and thus may be vulnerable to the occurrence of similar incidents.

2.4 | Objective

In order to better understand and begin to address one of the key 'human factors' contributing to both premature workforce attrition and the risk of harm to mothers and babies, it is important to identify what is currently known about WPV involving midwives in Australia and New Zealand.

3 | METHODS

This scoping review was conducted following the Arksey and O'Malley five-step process (Arksey & O'Malley, 2005). This enabled the available evidence on the topic to be identified and mapped to determine the extent, nature and breadth of the literature (Munn et al., 2018). The Arksey and O'Malley (2005) framework consists of five stages: Stage 1: identifying the research question; Stage 2: identifying relevant studies; Stage 3: study selection; Stage 4: charting the data; and Stage 5: collating, summarising and reporting the results. Each step ensured transparency and rigour. Reporting was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist (Tricco et al., 2018).

3.1 | Identify the research questions

The research question is: 'What is known about workplace violence involving midwives in Australian and New Zealand?'

3.2 | Identify the relevant studies

A prior preliminary search of the literature was undertaken to identify any international studies exploring the phenomenon of interest. Frequently used words were identified in the article titles, abstracts and keywords and used to develop the search strategy for this scoping review. Once the search terms were agreed, the following combinations were applied to CINAHL, Web of Science, PubMed, Medline and EMBASE.

'midwife*' OR 'midwives' AND 'bullying' OR 'vexatious complaint*' OR 'workplace violence' OR 'vertical violence' OR 'horizontal violence' OR 'mobbing' OR 'workplace incivility' AND 'Australia' OR 'New Zealand'

The titles and abstracts of the articles were searched within the preselected databases, chosen due to the exhaustive coverage of the literature they provide (Bramer et al., 2017). A follow-up search in

TABLE 1 Inclusion and exclusion criteria

Included	Excluded
Primary research	Articles including only nurses
Full-text availability	Unable to differentiate the midwifery findings from nurses
Published in English	Reported upon the same dataset as another included paper
Published 1990–2021	Reported the development of an unrelated theoretical framework article
Participants are midwives in Australia/New Zealand	Reported the development of a survey tool
Practising or non-practising	Articles including only midwifery students

Google Scholar was undertaken using the same search terms to capture additional grey literature. The reference lists of the included articles were reviewed, followed by a hand search of any key identified journals.

An example of the database search in CINAHL is presented in Appendix S1.
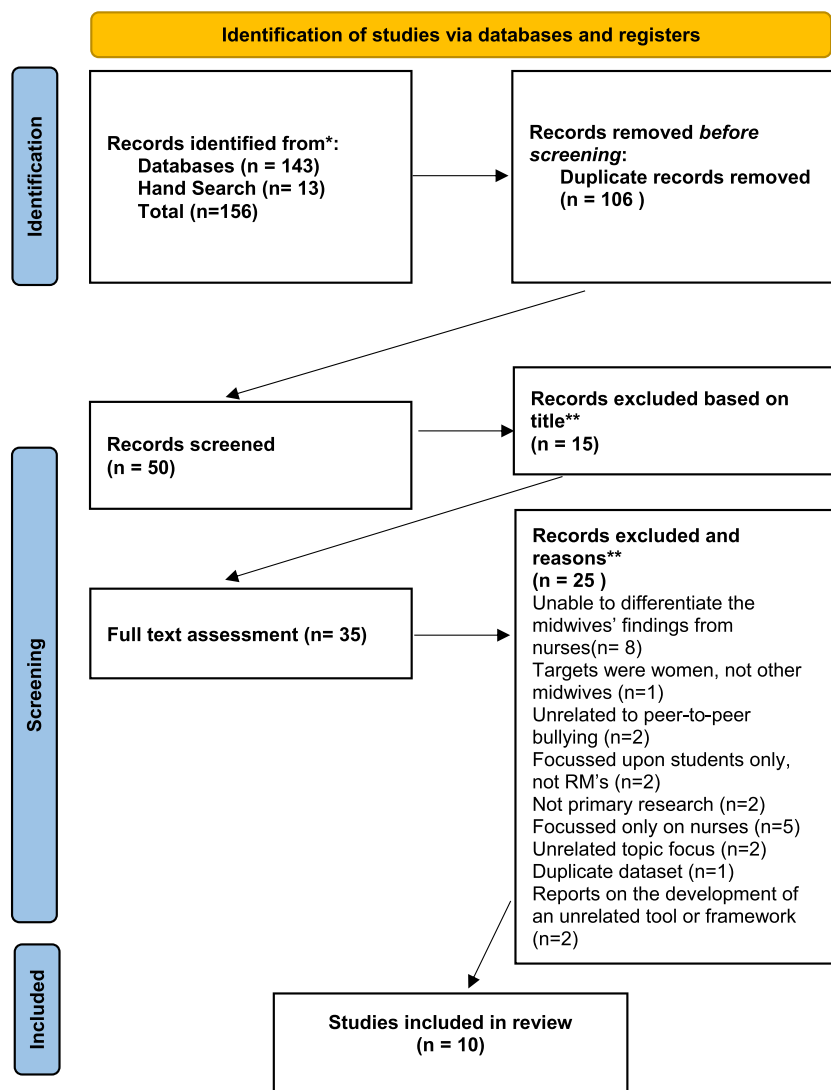
3.3 | Study selection

The exclusion and inclusion criteria are listed in Table 1.

The year 1990 was chosen as a start date as this was when midwifery workplace culture issues began to gain prominence. Initially the aim was to include only articles with the specific focus of exploring WPV in midwifery, however, as just one study, located in the grey literature was identified meeting this criterion, the decision was made to include articles that arrived at results or themes related to WPV.

In total, 156 articles were identified through the database and additional searches; 106 duplicate articles were removed leaving 50 articles for title screening. Fifteen papers were removed based on title leaving 35 for full-text assessment. Two reviewers screened the full-text documents and applied the inclusion and exclusion criteria to determine their eligibility. Differences were reconciled with the third author and resolved. This process resulted in the removal of a further 25 articles, leaving 10 studies for final review. The reasons for exclusion are included in PRISMA flow diagram (Page et al., 2021) (Figure 1).

3.4 | Charting the data

Three main types of data were retrieved from each article and charted using a standardized data abstraction tool. Author details, year of publication, country of origin, methods/methodology, aim/purpose, population and sample size were captured at the first stage. Quantitative data were retrieved if variables were present that were relevant to

Identification of studies via databases and registers

Identification

Records identified from*:
Databases (n = 143)
Hand Search (n= 13)
Total (n=156)

Records removed *before screening*:
Duplicate records removed
(n = 106)

Records screened
(n = 50)

Records excluded based on title**
(n = 15)

Screening

Full text assessment (n= 35)

Records excluded and reasons**
(n = 25)
Unable to differentiate the midwives' findings from nurses(n= 8)
Targets were women, not other midwives (n=1)
Unrelated to peer-to-peer bullying (n=2)
Focussed upon students only, not RM's (n=2)
Not primary research (n=2)
Focussed only on nurses (n=5)
Unrelated topic focus (n=2)
Duplicate dataset (n=1)
Reports on the development of an unrelated tool or framework (n=2)

Included

Studies included in review
(n = 10)

FIGURE 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart

the review question. Qualitative data, consisting of key findings related to the review questions, were finally charted. The charted data formed the basis for the collation, summarization and reporting of the results.

3.5 | Collating, summarising and reporting the results

Once the key data items were charted, the collation process was undertaken by two reviewers independently. The descriptive and quantitative data and the key relevant findings were placed into a Microsoft Excel document. Paragraphs from the corresponding articles that related to the review question were retrieved and added to the spreadsheet for analysis and to provide context.

The Krippendorff (2018) method of content analysis was selected to analyse and report the review findings. This approach enabled the data from the included articles to be systematically read and

categorized according to the overarching and sub review questions. This review team was able to make inferences from the data, which were guided by the aim of the review and the review questions (Krippendorff, 2018). All members of the review team reached consensus.

4 | RESULTS

The charted data from the 10 articles is presented in Table 2. Of the 10 included studies, eight were from Australia, and two were from New Zealand (both from the grey literature). All studies included midwives from rural, regional and metropolitan areas, with data from a total of 1514 midwives captured across the studies. Eight studies employed a qualitative methodology, whereas two took a mixed-methods approach. The participants were at various stages of their midwifery careers ranging from new graduates to midwives with over 50 years of experience.

TABLE 2 Data extraction table

Author/s Year of publication Country of origin	Aim	Population sample size	Methodology methods	Key relevant findings
Alexander et al. (2021) Australia	To explore the lived experiences of clinical investigation and identify the personal and professional impact on midwives.	Twelve (12) midwives, seven (7) under investigation.	Qualitative	Confidential information was used against the midwife Felt bullied by supervised practice midwives and unable to speak up. Felt ostracized. Stigmatized at work—expertise not sought. Vexatious complaints had no repercussions. Singled out unfairly targeted. Used as a scape goat.
Catling et al. (2017) Australia	To explore the midwifery workplace culture from the perspective of midwives themselves.	Twenty-three (23) midwives	Qualitative	One theme: 'Bullying and resilience' Conflict and bullying common the workplace, many targeted by bullies. An 'us' and 'them' culture exists. New staff and students targeted as 'outsiders'. Victims were 'too tired' to fight. MGP/CoC midwives felt marginalized by the hospital midwives. Students and MGP midwives at the bottom of the pecking order. Physical symptoms of stress experienced and considered leaving.
Catling and Rossiter (2020) Australia	To examine Australian midwives' perceptions of workplace culture using a specifically developed instrument.	1st stage: (Qual): Twenty-Three (23) midwives 2nd stage: (mixed methods): 322 midwives completed a survey and 150 completed qualitative responses.	Mixed methods	One strong theme: 'Bullying' Bullying occurred horizontally between peers and vertically from managers to staff and staff towards students. Wanted to leave their job. The workplace was 'bitchy', 'backstabbing' and 'toxic'.
Fenwick et al. (2012) Australia	To explore the experiences of newly qualified midwives and described the factors that facilitated or constrained their development during the transition from student to registered midwife.	Sixteen (16) new graduate midwives.	Qualitative	'The pond'—clear and peaceful or murky and infested. There is a pecking order: not all equals: 'low life', 'bottom of the barrel' and 'a nobody' Given challenging and complex cases unsupported. Poor communication engendered feelings of blame and exclusion. Spoken to badly in front of women. Received mixed messages and were chastised. Had fingers pointed in their face and told off. Scared to ask questions. Ignored and left out. Senior midwives use their power

(Continues)

TABLE 2 (Continued)

Author/s Year of publication Country of origin	Aim	Population sample size	Methodology methods	Key relevant findings
				inappropriately. Feel excluded, belittled. Changeable behaviour. Passive aggressive behaviour included eye rolling, sighing—like high school…
				Felt small belittled, foolish and intimidated—humiliated
				Scared to speak out in case labelled as a troublemaker. The environment was hostile. Cycle of fear exists damaging confidence
				Palpitations and nervous stomach. Adrenal glands working overtime.
Fox et al. (2018) Australia	To explore the views and experiences of women, midwives and obstetricians on the intrapartum transfer of women from planned homebirth to hospital in Australia.	Twenty-one (21) were midwives	Qualitative	'Them and us' culture. Unpleasant animosity was present. Stereotyping, blaming and taking over were common. Home birth midwives seen as hostile and uncooperative by the hospital team whilst the home birth midwives felt intimidated and bullied by hospital midwives. Doctors demonstrated bullying behaviours.
Harvie et al. (2019) Australia	To determine the incidence of midwives indicating their intention to leave the profession and explore the reasons for this decision including what might cause the midwives to be dissatisfied.	1037 midwives	Mixed methods	Theme: 'My work environment is a nightmare'. 42.8% considered leaving midwifery. A culture of mistrust and rudeness exists. Fear of being reported and blamed. Game playing and power struggles exist. Horizontal meanness occurs. Relationships with doctors and managers were unsupportive and obstructive.
Javanmard et al. (2020) Australia	To explore the transitional experiences of internationally qualified midwives practising in Australia.	Eleven (11) internationally qualified midwives	Qualitative	Felt racially discriminated against. Bullying by peers occurred. Felt invisible, lost, isolated, outsider, intimidated, anxious, stressed, panicked, lost confidence. Pick holes in each other's work and blame each other. Backstabbing was common. Midwives gossip about others. Lacked respect due to their accent. Racial discrimination was evident—passed over for promotion. Entrenched cultures of bullying and discrimination Australian midwifery. The hierarchy of bullying within the Australian

(Continues)

TABLE 2 (Continued)

Author/s Year of publication Country of origin	Aim	Population sample size	Methodology methods	Key relevant findings
				workplace was very high. No support—if you spoke out of line, you would be the next victim. Ignored when asked a question. I wanted to give up my midwifery—completely destroyed my passion of wanting to be a midwife. I wanted to leave that workplace. Managers did not act on bullying complaints because the bully was quite high up. The ringleader. Not overly accepting of midwives come from overseas. More racism towards African midwives in the workplace. Skills and competencies acquired overseas were not respected or valued. Needed treatment for anxiety and panic disorder. Persistently had clinical practice and experience questioned. Bullying worse if first language was not English.
McIver (2002) New Zealand	To explore the experience of horizontal violence and the effects of that experience on the provision of midwifery care.	Twelve (12) midwives	Qualitative	Bullying fractured relationships and the stress created risk. Relationships with mothers suffered as did the quality of care provided. Felt isolated and feared communicating with peers. Midwives felt the risk to women was heightened as a result. Policies need to address workplace bullying. Midwives working in MGP need zero tolerance for bullying.
Sheehy et al. (2021) Australia	To explore the experiences of early career midwives in Australia and identify the organisational, work environment, personal factors and stressors that influence workforce participation.	Twenty-eight (28) new graduate midwives.	Qualitative.	Experiences of bullying were ubiquitous and described by most of the participants. New graduates experienced passive aggressive behaviour and 'eye rolling' from senior midwives. 'Rite of passage' mentality in order to be initiated into the profession. The graduates received sarcastic comments and were mocked. Midwifery was seen as a 'dog eat dog' 'every man for himself' and 'no one is going to look after you' profession. New midwives are vulnerable to bullying in the workplace due to being junior. The bullying culture is pervasive. Felt

(Continues)

TABLE 2 (Continued)

Author/s Year of publication Country of origin	Aim	Population sample size	Methodology methods	Key relevant findings
Welfare (2018) New Zealand	To explore the experiences of midwives who transition work settings.	Nine (9) midwives	Qualitative	Sub-theme horizontal violence/bullying Every midwife interviewed had experienced bullying Unsupportive environment—culture of horizontal violence and bullying. Bullying has a negative effect on midwives and is present in every aspect of the midwifery workforce. Considered going to work overseas. Bullying was overt: snide comments, gestures, covert: ostracization, isolation and unsupported. belittled and questioned career choice. Considered leaving midwifery due to bullying.

4.1 | Prevalence

Just one study specifically aimed to explore midwives' experiences of WPV and due to the purposive sampling method used to recruit participants was unable to provide insight into the prevalence of WPV (McIver, 2002). Despite the remaining nine papers arriving at findings related to WPV, demonstrating that this problem does exist in Australia and New Zealand, none provided insight into prevalence. One Australian study (Harvie et al., 2019) did however suggest that almost 43% of 1037 midwife participants surveyed had considered leaving midwifery in the preceding 6 months, of whom 48.6% cited dissatisfaction with their workplace relationships.

4.2 | Perpetrators

All 10 studies provided evidence related to perpetrators. Midwifery colleagues were consistently identified across all studies as being the principal perpetrator, acting either alone or in groups. Four of the 10 studies (Catling & Rossiter, 2020; Harvie et al., 2019; McIver, 2002; Welfare, 2018) described managers (in one case 'senior managers') (Catling & Rossiter, 2020) as complicit or enacting acts of vertical violence towards junior midwives or students. Two studies identified doctors as perpetrators (Catling et al., 2017; Javanmard et al., 2020). A consistent characteristic of the perpetrators of WPV was seniority within the workplace. In three studies, the participants spoke of the 'pecking order' or 'the hierarchy' and how being closer to the top increased the tendency for a midwife to target more junior staff (Catling & Rossiter, 2020; Fenwick et al., 2012; Javanmard et al., 2020).

4.3 | Targets

The studies provided no indication that a particular stage of career or clinical practice setting was differentially associated with WPV. Some midwives however felt that particular *characteristics* made them a target. For example, the two studies that captured new graduate midwives' experiences of WPV suggested bullying was ubiquitous, however, being at the bottom of the hierarchy or lacking in skills and knowledge, increased vulnerability (Fenwick et al., 2012; Sheehy et al., 2021). New midwives (regardless of their seniority) (Catling et al., 2017) and students (Catling et al., 2017; Catling & Rossiter, 2020) were likelier targets. Internationally qualified midwives (IQMs) felt that their accents and overseas qualifications were used as justifications/avenues for abuse (Javanmard et al., 2020), and midwives that were under investigation were also targeted (Alexander et al., 2021).

4.4 | Location and types of WPV

There is little reference in the literature as to the *where* of WPV. One paper did however refer to 'the ward' being a place where those at

the bottom of the pecking order are frequently targeted (Catling et al., 2017) and a second paper by Fenwick et al. (2012) referred to midwives being spoken to badly *in front of women*. It can therefore be assumed that such behaviours are being enacted in the clinical areas, in close proximity to mothers and babies.

WPV took several forms in the 10 included studies. Covert and passive aggressive behaviours were described in six studies (Alexander et al., 2021; Fenwick et al., 2012; Javanmard et al., 2020; McIver, 2002; Sheehy et al., 2021; Welfare, 2018) including being ignored, ostracized and excluded. Five papers outlined overt bullying behaviours including rudeness, sarcasm, mocking, finger pointing, snide comments and rude gestures (Fenwick et al., 2012; Harvie et al., 2019; McIver, 2002; Sheehy et al., 2021; Welfare, 2018). One paper described the abuse of the levers of power to bully junior staff (Fenwick et al., 2012); in a similar vein, vexatious complaints were made to harass and victimize targets (Alexander et al., 2021). One study outlined racist and discriminatory behaviour towards IQMs from Africa, Iran, Japan and the United Kingdom (Javanmard et al., 2020). The IQMs described being ignored, treated as outsiders, intimidated and repeatedly challenged on their knowledge and skills. Being unfairly blamed (Alexander et al., 2021; Fenwick et al., 2012) and used as a scapegoat (Alexander et al., 2021) was reported along with the deliberate use of poor communication, giving mixed messages (Fenwick et al., 2012) and 'game playing' (Harvie et al., 2019).

4.5 | The impacts of WPV

All 10 papers referred directly or indirectly to the impacts upon midwives both personally and professionally, employing organisations and the quality and safety of maternity care provided to mothers and babies.

4.5.1 | Personal impacts upon midwives

Both the personal and professional impacts of being the target of WPV were touched upon in the 10 papers. Midwives spoke of feeling powerless (McIver, 2002), ostracized (Alexander et al., 2021), isolated (Fenwick et al., 2012; Welfare, 2018), belittled (Sheehy et al., 2021), intimidated (Fox et al., 2018; Javanmard et al., 2020), humiliated and fearful (Harvie et al., 2019). Some midwives also experienced physical and mental health issues (Catling et al., 2017; Fenwick et al., 2012), whereas others felt fatigued, burned out and worried about their future (Catling & Rossiter, 2020).

4.5.2 | Professional impacts upon midwives

All but one study by Alexander et al. (2021) referred to the *professional* impacts that WPV had upon the midwives. Some felt disrespected by their wider colleagues (Fox et al., 2018), whereas others

lost confidence in their skills and knowledge (Javanmard et al., 2020; McIver, 2002; Welfare, 2018), and some feared asking others for support (Fenwick et al., 2012). An IQM spoke of their impaired passion for midwifery as a result of being bullied, and another felt passed over for promotion due to not being Australian (Javanmard et al., 2020). Some participants questioned their career choice (Sheehy et al., 2021) or wanted to leave their job (Catling et al., 2017; Catling & Rossiter, 2020).

4.5.3 | Employing organisations

Every paper included in this scoping review apart from Alexander et al. (2021) and Fox et al. (2018) highlighted the impact on workforce attrition. Several studies specifically documented cases where midwives had left or were considering leaving their job due to WPV (Catling et al., 2017; Catling & Rossiter, 2020; Harvie et al., 2019; Javanmard et al., 2020; Sheehy et al., 2021; Welfare, 2018).

4.5.4 | Quality and safety of maternity care

A minority of the papers included in this review referred to the potential impact WPV poses to the safety and quality of care provided to mothers and babies, which was the key finding of the Ockendon report. Direct as well as indirect risks associated with staffing shortages, poor skill mix and unrealistic workloads were associated with WPV (Catling et al., 2017; Catling & Rossiter, 2020; Harvie et al., 2019). An example of direct risks was outlined in the paper by Fenwick et al. (2012) where participants spoke of being abandoned in complex clinical situations, and McIver (2002) described midwives lacking confidence in escalating care of mothers and babies due to poor collegial relationships (McIver, 2002). Fenwick et al. (2012) also reported new graduate midwives being denigrated in front of the women they were caring for impacting the women's childbearing experiences and damaging confidence in the profession.

5 | DISCUSSION

The results of this scoping review have identified and mapped what is currently known about WPV involving midwives in Australia and New Zealand. The evidence is scant. Although the literature provided no clear insight into prevalence, the significant numbers of midwives considering leaving the profession prematurely, many of which are early career midwives (Harvie et al., 2019), is a worrying indicator. The research suggests the presence of WPV within the Australian and New Zealand midwifery workforces, affecting midwives from a range of ethnic backgrounds, at various stages of their careers, working in all models of care. This aligns with the broader health care literature that demonstrates that WPV is a global issue impacting our nursing counterparts across their career trajectory, infiltrating all areas of clinical practice (Hawkins et al., 2021).

This raises significant concerns for the adequacy of the future workforce, emphasizing the vital need to urgently address the factors that lead to attrition. Nursing research suggests that early career nurses who fail to transition smoothly into a new work environment are more likely to leave, resulting in costly staff turnover and an over reliance on temporary staff (Hampton et al., 2021). Whilst research exploring the correlation between WPV and premature midwifery workforce attrition is in its infancy in Australia, literature from the United Kingdom has demonstrated that poor collegial relationships that are fraught with stress, poor teamwork and bullying, particularly when compounded by high workloads and staffing challenges, can lead to the decision to leave midwifery prematurely (Royal College of Midwives, 2016).

It is important to recognize that the types of workplace issues highlighted in this review, whilst leading to workforce burn out and attrition, also place the safety of mothers and babies at serious risk of harm, as demonstrated by the 2022 Ockenden report. Although the impacts of WPV identified in this review fell into three broad categories, some did in fact overlap, demonstrating that WPV often does not occur in isolation, and its drivers, impacts and the barriers to change can be somewhat cyclical in nature. This is supported by the nursing literature that suggests that WPV is self-perpetuating, fuelled by a toxic workplace culture (Krut et al., 2021).

This review identified that WPV takes a number of forms and is generally enacted by other midwives or midwifery managers towards more junior targets. This aligns with international research that demonstrates that employees within organisations with strong hierarchical structures experience power struggles that promote bullying behaviour (Witzel, 2019).

WPV was described as being 'led' by senior management, filtering down through the staffing structure (Catling & Rossiter, 2020). Targets were subsequently fearful of speaking up, assuming their concerns will not be heard, or acted upon, or will lead to further abuse (Fenwick et al., 2012). This again is in alignment with the findings from the Ockenden review (2022). Most WPV behaviours fall into two main categories of being overt or covert in nature; however, some can be more difficult to categorize. For example, making vexatious complaints or using a position of power inappropriately was also identified. Nursing research has suggested that managers, must, as positive role models, identify and address negative workplace behaviour (Krut et al., 2021). This must include supported escalation pathways that reduce the power imbalance, enabling victims to report WPV, regardless of its nature or their level of seniority in the hierarchy (Hawkins et al., 2021). This is the first literature review to identify and map what is known about WPV involving midwives in Australia and New Zealand. Identifying the key characteristics, contexts and consequences of WPV that this review has identified provides a starting point for the development of targeted interventions.

5.1 | Limitations

A very small pool of literature currently exists in this area, and the included 10 studies were primarily qualitative and did not provide clear insight into prevalence. Similarly, insight into geographical distribution or the distribution of organisational contexts of the problem is limited. Just two studies, both from the grey literature, examined the New Zealand context, together contributing just 19 participants. It could therefore be suggested that the existing research does not provide a true representation of the midwifery workforces across Australia and New Zealand.

6 | CONCLUSIONS

The focus the UK Ockendon report has drawn attention to the impacts that WPV can have upon the safety of mothers and babies. This highlights the need for reform: robust and transparent clinical governance, improved management structures and a change to procedures and culture within maternity services. This review has highlighted a gap in understanding about the status of WPV in the midwifery context in Australia and New Zealand, both of which share many characteristics of the UK model, suggesting that the problems identified in the United Kingdom could occur in Australia and New Zealand. Work needs to be done to explore the prevalence and organisational covariables of WPV in the midwifery context as a critical first step towards creating interventions to ensure such behaviours are eliminated from the workplace. In describing the characteristics of the problem, the existing literature hints at solutions. The insight into the role played by racial discrimination, for example, points to a need for increased workplace diversity training. The role played in power imbalances within the workplace, in turn, points to a need for a restructure of hierarchies within the clinical setting. Finally, evidence of the consequences for midwives, mothers and babies; the reputation of the profession; and the organisations in which midwives practice should act as a powerful driver of reform.

7 | IMPLICATIONS FOR NURSING MANAGEMENT

As recruiting and retaining midwives become increasingly challenging for maternity services across Australia and New Zealand, it is important to acknowledge WPV as a likely contributing factor towards premature attrition from both the workforce and midwifery education programmes. Nursing and midwifery managers play a key role in identifying and effectively addressing WPV to help stem premature attrition from the profession. Clinical managers must lead by example, taking a zero-tolerance approach to WPV and by encouraging strong collegial relationships between clinical staff. Whilst managers are central to ensuring that complaints of WPV are documented and relevant policies are followed in a consistent and transparent way, the evidence suggests managers are also potentially perpetrators in a systemic culture of WPV. It is vital that managers remain professional and impartial and ensure the complainant feels supported and empowered to *stand by* their complaint. If victims of WPV feel able to

come forward in a safe and supported context, managers will play a pivotal role in tackling WPV in midwifery.

CONFLICT OF INTEREST

None.

ETHICAL STATEMENT

Ethical approval was not required for this scoping review of the literature.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.