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Save lives, protect the NHS: An autoethnography of a community Midwife during the COVID 19 pandemic

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Abstract

COVID 19 is an unprecedented pandemic unparalleled to any global health issue experienced in the modern world. Consequently there is no data, research or guidance to follow to provide effective, quality healthcare that protects and promotes well being in patients and staff. Research is currently being collaborated rapidly into patient and public experience during the pandemic, however, research into the experiences of front line staff during the pandemic is currently minimal. This article aims to initiate this discussion by use of an autoethnography to provide rich qualitative data into the experience of working as a community midwife during the COVID 19 pandemic.

Keywords: autoethnography, COVID-19, midwifery, stress.

Introduction

I have been a qualified midwife for 3 years working in the UK's National Health Service (NHS). The NHS is a government funded institution which allows citizens of all income groups to access free healthcare. For the last year, I have been working as a community midwife. I was working within this role when COVID-19 spread and eventually became a pandemic. This is an unprecedented time and there is currently little research on the experiences of midwives working during the pandemic. I shall be writing an autoethnography as the benefits of this mode of research are that with little existing evidence available autoethnography offers an opportunity to produce rich qualitative data which can be then used in turn to inspire further research (Pavlenko 2002, 2007).

As I was undergoing research into how to properly write an autoethnography, I stumbled upon an article in which the writer created a piece of art to begin their reflection (Averett and Soper

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2011). I began my training in the NHS when I was 18 years old and have been thoroughly entrenched in a culture of stiff upper lips and of keeping calm and carrying on, so when I approach writing this article, I am faced with a lot of guilt and fear in saying anything negative about the NHS, so creating a visual reflection on my feelings has been a useful way of beginning this discourse (appendix 1). What I can analyse from this illustration and from my initial analysis of my feelings working as a community midwife during the pandemic can be separated into three predominant categories; stress, fear and disappointment. For the purposes of this article, I shall explore each separately.

Stress

When lock-down was initially announced, I was on annual leave visiting my family, I was asked to return to work earlier than expected and did so happily. I am proud to work in the NHS and proud to play a role during the pandemic. I returned to many members of my team now shielding which meant staffing levels were very poor and consequently, work-load increased. This took a toll on my colleagues and myself; very often we would finish work an hour or so later than anticipated. In community midwifery, there are a clinics and visits that are time sensitive and so if you don't get the work you've been allocated finished within your working hours you must keep going until all the tasks are completed as they cannot be done on a different day. If all of your colleagues have the same workload as yourself, you all keep going. This then affects your personal and family life with childcare and household dynamics.

In addition to this, clinics that were under the care of midwives that were now shielding had to be covered. This would often be by whichever midwife was available on the day, which would again be affected by staff isolating if they were symptomatic. The result of this would be that clients would be seen by different midwives at each appointment and you did not know the clients you attended very well. This would cause further stress to the client as they were having to repeat themselves and could not develop a trusting relationship with their care providers as they did not know them. As a midwife, this would cause me stress also as I did not know the client well, so was permanently worried that I had missed a vital element of care that was particular to them (a certain test for example) or that there were underlying social issues that they would not disclose to me as they had only seen me for 20 minutes. Each antenatal appointment is allocated 20 minutes. 20 minutes is not enough time to learn each person's complete medical and social history, provide all clinical care needed, provide relevant information and education in relation to their particular situation, develop a rapport and document all conversations and clinical findings.

Taking on additional clinics also meant that workload significantly increased, seeing more people and those that weren't familiar to you means that there is a lot more to remember. I was

permanently worried that I was forgetting something; a follow up appointment, a certain referral, a document to be filled out and returned to the client. This stress was so profound, the fear of forgetting, that I would have vivid nightmares in which I would see a client I did not recognise and there would be something that I forgot to do that impacted their care and I would try to identify them so intensely that I would wake myself as I was thinking so hard about who they were. In reality, they did not exist but the fear was so prominent it would wake me. I still have those nightmares to this day.

Throughout the pandemic, there was a feeling of solidarity amongst our team. We were all struggling but we were struggling together. We helped each other and to an extent relied on each other for help and support. However, we are not immune to COVID. In early June, I started developing mild symptoms of coronavirus. I became feverish, developed a cough and had reduced sense of smell. I was not uncomfortable but I was plagued with uncertainty and guilt. Even though I felt well enough to work, I could not. I contacted my manager and was advised not to attend work and a test was organised for me. This was prompt and efficient, however, the lead up to calling my manager was wrought with anxiety. She was empathetic and understanding, however I knew that my absence would be a huge burden on her and the team as we were already incredibly short staffed. My test was negative and I returned to work feeling incredibly guilty that I had burdened others for nothing.

Fear

As lock-down continued we received further guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) on how to schedule and conduct antenatal care in order to ensure less contact and consequently less risk of transmission of the virus (RCOG 2020). This was accompanied by hospital guidance on patterns of postnatal care. This involved telephone contact for the first two antenatal appointments at 16 and 25 weeks with the first face to face visit at 28 weeks, almost ¾ of the way through the pregnancy. Postnatally, you would ordinarily see a family the day after intrapartum discharge, at day 5, day 10 and if consequent visits were needed or wanted then by discretion between the family and the midwife. During the pandemic, these were limited to telephone consultation on the day after discharge, a day 5 visit in person and a telephone consultation on day 10. This scared me immensely as reduced contact, both in the antenatal period and postnatally, leaves a lot of room for certain sensitive topics to be more easily hidden or swept under the rug, for example depression, anxiety and domestic violence. Research shows that families had an increase in these feelings but I did not have them reported to me as frequently as before (Dib et al 2020). I was permanently worried that families would not disclose these issues and something catastrophic would happen. I perceived these new working conditions as dangerous. Coupling this fear and the stress from a suddenly increased workload of people I struggled to remember, for the simple fact that there were so many of them. I no longer

felt as if I was doing my job well and my confidence in my knowledge and abilities diminished rapidly. This led to a permanent state of anxiety and a feeling that I was a bad midwife.

Another fear that was present and often discussed within our team was the fear of passing the virus on. As the rest of the nation went into lock-down, healthcare workers were one of the only remaining demographics that were still in contact with others outside our households. We feared passing the virus onto our families and households and onto other service users. As more information was made available that many people were testing positive for COVID without presenting with any symptoms, this fear was made worse. I saw myself as a threat of transmission to others, more so than them to me, and as lock-down lifted slightly I would be ever more cautious and try not to meet others socially, which was quite isolating.

Disappointment

The largest feeling I experienced throughout the pandemic however was disappointment. In recent years, it feels as if the NHS has been used as a tool to gain political popularity by different parties. Big promises are made to entice the public, promises of funding and more staff but what we actually get are cuts, pay freezes and less investing in the future workforce. At the start of the pandemic, a lot of fuss was made about how the NHS staff were 'heroes', the public and government would clap for us every week, set off fireworks, bang pots and pans. At the time, because there was so much stress and fear this felt like finally the acknowledgement we deserve. I was optimistic that cultural changes may be made; if people thought we were heroes, then maybe we would start being listened to, given appropriate funding and staffing. However, as things started to settle down, at almost every turn it seemed like we were being dismissed, when public sector pay rises were announced, nurses and midwives were not included (HM Treasury 2020). It was a quick and firm reality check. Alongside this, regular COVID testing for NHS workers was voted against (UK Parliament 2020). This would have relieved a lot of anxiety I personally felt about spreading the virus to my loved ones, to my colleagues and to other service users. Recent research shows the infection rate in maternity staff was twice as high than the general public (Bampoe et al 2020). This seems as though it should be common sense, but in consideration of this it is shocking to think in a service that is so radically understaffed that you're having to come into contact with more service users than you would ordinarily, that regular testing would be declined. In the space of a few months, we were neither rewarded for our hard work and personal risk nor merely protected and kept safe. If this is how heroes are treated, it does not surprise me that they do not exist.

I love the NHS. It represents the most beautiful aspects of British culture. Of coming together, of caring, of looking after one another. It is the most beautiful reminder of an ideal that all people, regardless of their background, should have equal access to health services. However, the

COVID-19 pandemic has been eye-opening. The most beautiful part of our culture is being strangled and suffocated by underfunding, understaffing and greed. COVID-19 has led me to believe that working conditions are not likely to improve and for the sake of my own mental health and happiness I cannot continue to work in the NHS. I left the NHS during the COVID pandemic. I should have had a long and beautiful career for at least another 40 years. Midwifery is my passion and love and so this decision has been heart breaking. I am not alone in my feelings, many NHS workers feel similar panic, fear and anxiety (Horton 2020). Since March 2020 we have been bombarded with the phrase "Save Lives, Protect the NHS" by the Government to the public, however they have shown in their actions they are not protecting the NHS and consequently they are not saving lives. And with this statement I conclude my article.

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Appendix 1