

**The Second Victims: A Grounded Theory  
explanation of the experience and impact of  
traumatic births amongst midwives and obstetricians**

Harriet Kemp

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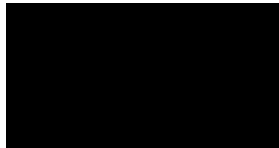
University College London

## **UCL Doctorate in Clinical Psychology**

### **Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:



Name: Harriet Kemp

Date: 28.6.2020

## Overview

This thesis explores the perception and impact of traumatic perinatal events amongst midwives and obstetricians - an area which has received little attention.

Part One is a Conceptual Introduction. This aims to outline key concepts and review and synthesise current literature outlining the “Second Victim” (SV) phenomenon. Gaps in the literature will be identified, and a rationale provided for the current study. Part One highlights that there is a vast body of research exploring the SV phenomenon. However, midwives and, even more so, obstetricians, are largely ignored within the evidence base, despite being at high risk of becoming “Second Victims” (SVs). Continuing to overlook their experiences holds concerning implications for psychological wellbeing, professional practice and mothers’ birth experiences.

Part Two provides a qualitative analysis using a Grounded Theory approach, to explore midwives’ and obstetricians’ experiences of traumatic perinatal events. Eight midwives and six obstetricians working within the NHS took part in the study. Analysis of semi-structured interviews generated two theoretical frameworks, both of which included six main themes. The themes identified factors which define a traumatic perinatal event, psychological and professional consequences, factors which exacerbate or lessen these impacts, and suggestions for organisational change to better support staff. Differences between midwives’ and obstetricians’ experiences of traumatic events were also revealed. An initial discussion of strengths and weaknesses of the study, clinical implications and suggestions for future research are included.

Part Three provides a critical reflection on the process of the research, focusing on recruitment and sample characteristics, the interview process, analysis, results and

clinical implications. This section also includes an expanded discussion of insights, limitations and suggestions for future research.

## **Impact statement**

The process and outcomes of this thesis have generated significant implications for research, academia and healthcare organisations in the UK and globally. The findings have generated new insights into midwives' and obstetricians' experiences of traumatic births. The research gave an insight in to key differences between the experiences of midwives and obstetricians, which indicated that the perception and impact of traumatic perinatal events are largely influenced by modifiable aspects of healthcare organisations. Thus, the research has highlighted that the NHS has the power to lessen the impact of traumatic perinatal experiences, by addressing contextual exacerbating factors.

Utilising Grounded Theory (Charmaz, 2008; Glaser & Strauss, 1967) has maximised the impact of the current findings, as the models are easily disseminated and are accessible to a range of recipients. Using the "Make Birth Better" network and existing links via social media will enable the findings to be disseminated to a large audience working within the field. The frameworks can be utilised on differing levels: by health care organisations as evidence for generating funding to develop support systems; by maternity teams to educate staff and begin to embed change; and within professional training programmes as a tool to facilitate discussions about exposure to adverse events and managing the impacts. In the longer-term, effective dissemination has the potential to improve psychological wellbeing amongst maternity staff, reduce organisational stressors, and improve mothers' birthing experiences.

The research has also contributed to the wider "Second Victim" (SV) literature, in which a Grounded Theory approach, and maternity staff have been ignored. In particular, the role of position in hierarchy, and specific differences between

professions were not revealed in the conceptual introduction. Future research should recognise these benefits of using Grounded Theory when exploring the SV phenomenon, as it facilitates the rich exploration of individual experiences, whilst generating theoretical frameworks from which comparisons can be drawn. Moreover, researchers exploring support systems following traumatic perinatal events can be informed by current findings; particularly aspects of support viewed as beneficial, and recommendations for organisational change.

Beyond the maternity sector the research is significant in the context of Covid-19. HCPs globally will have been exposed to an increased number of traumatic events, and extreme organisational stress as direct and indirect consequences of this pandemic. Work-related psychological distress and burnout are also likely to have increased as a consequence; factors which will influence the perception and impact of traumatic events. The current study has drawn attention to the needs of HCPs, and how the consequences of Covid-19 can have damaging consequences for the HCPs, those accessing care and the organisation as a whole. Whilst providing healthcare organisations with recommendations for how to address these issues.

## Table of Contents

Section	Page
Table of contents	7
List of Appendices	13
List of Figures	14
Acknowledgements	15
Part 1: Conceptual Introduction: The Second Victim Phenomenon	16
Abstract	17
1.0 Introduction	18
1.1 The Second Victims (SVs)	19
1.1.1 Definition and prevalence	19
1.1.2 The course of recovery	20
1.1.3 Psychological experiences amongst SVs	20
1.1.4 SVs: Related concepts	22
1.1.5 Implications for professional practice	24
1.1.6 Benefits to professional practice	26
1.1.7 Vulnerability factors	26
1.1.8 Workplace environment	27
1.1.9 Beneficial support structures	27
1.1.10 A cultural shift	28
1.1.11 Interventions	29
1.2 The SVs: Obstetricians and midwives	30
1.2.1 Traumatic perinatal events	30

1.2.2 Consequences of traumatic perinatal events	32
1.2.3 Vulnerability factors	33
1.2.3.1 Empathy	34
1.2.3.2 Organisational stress	35
1.2.4 Professional practice and compassionate care	36
1.2.5 Support in the maternity profession	38
1.3 Rationale and study aims	39
2.0 References	41
Part 2: Empirical paper: The Second Victims: A Grounded Theory explanation of the experience and impact of traumatic births amongst midwives and obstetricians	56
Abstract	57
1.0 Introduction	58
1.1 The Second Victims	58
1.2 Traumatic perinatal events	59
1.3 Support and cultural change	62
1.4 Aims and rationale	63
2.0 The researcher's position	65
3.0 Method	66
3.1 Grounded theory	66
3.2 Participants	68
3.2.1 Inclusion criteria	68
3.2.2 Recruitment and sampling	69
3.2.3 Participant characteristics	69
3.3 Ethical approval	75



3.4 Procedure	75
3.4.1 Interviews	76
3.5 Analysis	77
3.5.1 Credibility checks	79
3.6 Bracketing: Excerpts from the researcher’s reflective journal	80
during throughout the interview process	
4.0 Results	82
4.1 The midwives’ model	83
4.1.1 Traumatic births	84
4.1.1.1 Severe events	84
4.1.1.2 Chaos	84
4.1.1.3 Moral injury	85
4.1.2 The aftermath	85
4.1.2.1 A fresh attitude	85
4.1.2.1.1 Hypervigilance	86
4.1.2.2 Emotional wellbeing	86
4.1.2.2.1 Replaying the event	87
4.1.2.2.2 It lives with you	87
4.1.2.3 Struggling to cope	87
4.1.3 Position in hierarchical system	88
4.1.4 Exacerbating factors	88
4.1.4.1 Lack of preparedness	88
4.1.4.2 Culture	88
4.1.4.2.1 Lack of support	89
4.1.4.2.2 Stiff upper lip	90

4.1.4.2.3 Blame	90
4.1.4.3 A world war one analogy	91
4.1.4.4 A closer bond	92
4.1.5 Buffering factors	92
4.1.5.1 Receiving support	92
4.1.5.1.1 Talking	93
4.1.6 Cultural change	94
4.1.6.1 To be treated like humans	94
4.1.6.2 Structured support	94
4.1.6.2.1 Time to debrief	94
4.1.6.2.2 Emotional support and preparedness	95
4.2 The obstetricians' model	96
4.2.1 Traumatic births	97
4.2.1.1 Severe events	97
4.2.1.3 The clock stops	97
4.2.1.2 Responsibility	98
4.2.2 The aftermath	99
4.2.2.1 Emotional wellbeing	99
4.2.2.2 Professional practice	99
4.2.2.3 Coping	100
4.2.2.3.1 Soft enough to care, hard enough to cope	101
4.2.3 Position in hierarchical system	101
4.2.4 Exacerbating factors	102
4.2.4.1 Lack of preparedness	102
4.2.4.2 Culture	102

4.2.4.2.1 Stiff upper lip	102
4.2.4.2.2 Lack of support	103
4.2.4.2.3 Unsupportive colleagues	103
4.2.4.3 On-going investigations	104
4.2.5 Buffering factors	105
4.2.5.1 Receiving support	105
4.2.6 Cultural change	106
4.2.6.1 It's alright to cry	106
4.2.6.2 To protect us as well	107
4.3 4.3 Reflexive statement: The process of analysis and the end models	107
5.0 Discussion	110
5.1 Introduction	110
5.2 Traumatic births	110
5.3 Position in hierarchical system	111
5.4 The aftermath	112
5.5 Exacerbating factors	115
5.6 Buffering factors	118
5.7 Cultural change	119
5.8 Clinical implications	120
5.9 Strengths and limitations	125
6.0 References	128
1.0 Part 3: Critical Appraisal	147
1.1 Recruitment and sample characteristics	148
1.2 The interview process	150

1.3 The analysis	151
1.4 The results	153
1.5 Covid-19	155
1.6 Implications for clinical practice and future research	155
1.7 Conclusions	156
2.0 References	157
Appendices	161

## **List of Appendices**

Appendix 1	Recruitment flyer
Appendix 2	Ethical approval
Appendix 3	Sources of support
Appendix 4	Participant information sheet
Appendix 5	Participant consent form
Appendix 6	Interview schedule
Appendix 7	Midwives' process of analysis
Appendix 8	Obstetricians' process of analysis
Appendix 9	Reflective journal excerpts
Appendix 10	Participants responses

## **List of Figures**

Figure 1	Table 1. Participant characteristics
Figure 2	Model A. The experience and impact of traumatic births: Midwives
Figure 3	Model B. The experience and impact of traumatic births: Obstetricians

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## **Part 1: Conceptual Introduction**

### The Second Victim Phenomenon



## **Abstract**

Healthcare professionals (HCPs) are at significant risk of becoming “Second Victims” (SVs); whereby exposure to unexpected adverse medical events can leave HCPs traumatised, eliciting the same psychological reactions as the patient’s. This conceptual introduction provides an overview of the “Second Victim” (SV) phenomenon and, review of previous literature relevant to midwives’ and obstetricians’ experiences of traumatic perinatal events.

The impacts of the SV phenomenon are vast, manifesting psychologically, cognitively and physically, and negatively impacting on professional practice and patient care. A number of factors may influence risk of becoming a SV, however organisational culture is fundamental to recovery. Concerningly, SVs globally are unsupported, and may suffer in silence due to absent support systems, and cultures of judgement and blame.

Factors which increase vulnerability to becoming SVs (including the type of event, a lack of support, organisational stress and empathetic engagement with the patient) may be particularly prevalent amongst midwives and obstetricians, and potential professional consequences may compromise the ongoing provision of compassionate care and negatively impact mothers’ birthing experiences. However, existing research exploring midwives’ and, even more so, obstetricians’ experiences of traumatic events is sparse. Further research is fundamental to understanding the perception and impact of traumatic events within these groups and to enabling organisations to support their staff in a way which minimises the potential impacts of the SV phenomenon on individuals, mothers and maternity organisations.

## **1.0 Introduction**

The current study aims to increase knowledge about how midwives and obstetricians experience adverse perinatal events. Healthcare professionals (HCPs) globally are at significant risk of becoming “Second Victims” (SVs), (Scott et al., 2009; Wu, 2000), whereby exposure to unexpected adverse events in the workplace has significant psychological and physical consequences. Research indicates that midwives and obstetricians may be at increased risk of becoming SVs due to multiple factors that will be explored on pg. 25 (Nydo, Pillay, Naicker, & Moodley, 2019). The psychological consequences of adverse events on maternity staff may compromise the ongoing delivery of compassionate care; negatively impacting mothers’ birth experiences and post-natal mental health (Iles & Pote, 2015). However, evidence exploring the “Second Victim” (SV) phenomenon amongst this group is limited. The current study aims to address this gap, via qualitative analysis of interviews with obstetricians and midwives, with a view to gathering a thorough understanding of how midwives and obstetricians experience traumatic events, and the factors that moderate perception and impact of the event. It is anticipated that the use of Grounded Theory methodology (Glaser & Strauss, 1967) will facilitate the generation of clinically relevant models, which can inform organisations about how to support their staff, to prevent or reduce the risk of becoming SVs and mitigate the potential consequences on mothers’ birth experiences. This conceptual introduction aims to introduce and consider the key conceptual and methodological underpinnings of the current study, alongside reviewing and synthesising relevant previous literature. Attention will be drawn to gaps within the literature, and justification provided for the current study.

## 1.1 The “Second Victims”

### 1.1.1 Definition and prevalence

The term “Second Victim” was first defined by Albert Wu in his description of the impact of medical error on HCPs (Wu, 2000). Scott et al. (2009) further defined SVs as

‘health care providers who are involved in an unanticipated adverse event, in a medical error and/or a patient-related injury and become victimised in the sense that the provider is traumatised by the event. Frequently these individuals feel personally responsible for the patient outcome...that they have failed the patient, second guessing their clinical skills and knowledge base’.

The SVs are part of a domino effect whereby the impact of an event continues through four groups. The patient and their families (first victims), the HCP, (second victims), the reputation of the hospital (third victims), and future patients who are harmed as a consequence (fourth victims) (Ozeke, Ozeke, Coskun, & Budakoglu, 2019).

Between 10% and 72.6% of HCPs will experience the SV phenomenon at least once in their career (Coughlan, Powell, & Higgins, 2017). Some may not be affected, due to factors which may predispose or protect the HCP from enduring the consequences (e.g., event characteristics). However, prevalence rates are likely to be under-representative, as many “suffer in silence”, due to unsupportive working environments, poor reporting procedures, and fear of litigation (Nydoe et al., 2019; Ozeke et al., 2019). The term SV is well established internationally (Wu et al., 2020), although it has received some criticism as a consequence of appearing insensitive to the experience of the patient and their families, and removing responsibility from the HCP and the organisation (Clarkson, Haskell, Hemmelgarn, & Skolnik, 2019).

### **1.1.2 The course of recovery**

In a qualitative study, exploring the experiences of 31 self-identified SVs, Scott et al. (2009) identified a predictable trajectory of recovery following exposure to an adverse event. The six-stage process includes i) Chaos and accident response: the clinician recognises that the event has occurred and is filled with inner turmoil, easily distracted and unable to think logically; ii) Intrusive reflections: the clinician is 'haunted' by the event and replaying 'what if' questions in their mind; iii) Restoring personal integrity: the clinician seeks support from a trusted individual, and may hold significant doubt over their future career and moving forward. This is exacerbated by unsupportive working environments, which can magnify self-doubt and low self-confidence; iv) Enduring the inquisition: concerns regarding litigation and job security; v) Obtaining emotional first aid: SVs seek emotional support in various ways, from others with whom they feel safe to share their experiences; and vi) Moving on: SVs are categorised as either 'surviving' - whereby the victim is working but is still plagued by the event - or 'thriving' - those clinicians who have taken something positive from the adverse event into their practice, or changed career or left the profession.

### **1.1.3 Psychological experiences amongst SVs**

The symptoms of the SV phenomenon are vast, manifesting psychologically, cognitively, physically and behaviourally (Seys et al., 2013; Sirriyeh, Lawton, Gardner, & Armitage, 2010). HCPs are traumatised and can experience the same psychological reactions as the first victims (Wu & Steckelberg, 2012). The psychological symptoms have been compared to acute distress disorder, including 'initial numbness, detachment, and even depersonalisation, confusion, anxiety, grief

and depression, withdrawal or agitation, and re-experiencing of the event' (Wu & Steckelberg, 2012). Additional symptoms include, shame, anger, frustration, guilt, self-criticism (Nydoe et al., 2019; Ozeke et al., 2019; Waterman et al., 2007), suicidal ideation, post-traumatic stress disorder (PTSD) (Coughlan et al., 2017; Seys et al., 2013; Waterman et al., 2007), sleep difficulties, fatigue, confusion, and poor concentration (Mira et al., 2015). For some, the impact can last for several years or even indefinitely (Nydoe et al., 2019; Ullstrom, Andreen Sachs, Hansson, Ovretveit, & Brommels, 2014).

In a systematic review and meta-analysis, Busch et al. (2019) reviewed the prevalence of psychological and psychosomatic symptoms amongst SVs. Eighty-one percent reported troubling memories and over two-thirds reported anxiety, anger, remorse, and distress. Greater than half reported embarrassment, guilt and fear of future errors. Difficulty sleeping was reported by one-third. Actual prevalence of PTSD was not reported, although previous studies have found symptoms of PTSD, including intrusive thoughts, flashbacks, hypervigilance and a loss of confidence, to be highly prevalent (Edrees, Paine, Feroli, & Wu, 2011; Mira et al., 2015). Further longitudinal research is needed to determine the degree, type and duration of psychological symptoms (Chan, Khong, & Wang, 2017).

An increased risk of burnout (Maslach, Jackson, & Leiter, 1997), the psychological strain caused by prolonged exposure to chronic emotional and interpersonal stressors in the workplace, has also been associated with exposure to adverse events (Schwappach & Boluarte, 2009; Tawfik et al., 2017). Further research is needed to determine if burnout is a consequence of exposure to traumatic events, or increases vulnerability (Sheen, Slade, & Spiby, 2014; Slade, Sheen, & Spiby, 2017).

#### **1.1.4 SVs: Related concepts**

Alongside the SV phenomenon, there are several frameworks which conceptualise an individual's response following exposure to indirect trauma, whether through witnessing or listening to another's account of an event. These include PTSD (DSM V: American Psychiatric Association [APA], 2013), secondary traumatic stress (STS) (Figley, 1995), vicarious traumatisation (VT) (McCann & Pearlman, 1990) and compassion fatigue (CF) (Figley, 1995; Joinson, 1992). Due to the associated 'costs of caring', HCPs are at increased risk of developing PTSD, STS, VT and CF (Leinweber & Rowe, 2010). Such frameworks provide consideration for how the consequences endured by the SVs may occur.

The most commonly associated response to trauma exposure is PTSD (APA, 2013). It is characterised by direct or indirect exposure to a traumatic event involving threat to self, or another's personal integrity or life. Consequences manifest cognitively, emotionally, and behaviorally. Symptoms are described across four dimensions: Intrusions; avoidance of reminders; heightened arousal; and negative changes in beliefs and mood.

STS is conceptualised as 'stress resulting from helping or wanting to help a traumatised or suffering person' such that, 'the event experienced by one person becomes traumatising for another person' (Figley, 1995). STS is similar to PTSD; however, exposure is indirect, and intrusions can relate to oneself or the person who directly experienced the event. Symptoms occur shortly after exposure and are associated with a specific event (Guitar & Molinaro, 2017).

VT (McCann & Pearlman, 1990; Pearlman & Mac, 1995) theoretically develops over time from repeated exposure to accounts of traumatic events. It is

postulated to manifest as enduring alterations to cognitive schema about the self, others and the world. Beliefs about safety, trust, intimacy, esteem and control can be disrupted. Schemas become more negative and general in their application to the world. The severity of symptoms and consequences are not well defined for either STS or VT (Elwood, Mott, Lohr, & Galovski, 2011).

CF was developed by Joinson (1992) to describe the negative impact of providing care over an extended period of time. CF is associated with physical and mental exhaustion, and emotional withdrawal; a caregiver who is tired of caring and being compassionate. CF is a descriptive term which is hypothesised to comprise the symptoms of two components; burnout (BO) and STS (Stamm, 2010). More recently, CF has been merged into a wider concept and measure; Professional Quality of life (ProQOL; Stamm, 2010). ProQOL combines helpers' positive and negative perceptions of their role – compassion satisfaction (CS) - and compassion fatigue (CF). CS measures the positive aspects of individuals' experiences, such as helping others and making a difference. CS and CF function at opposing ends of a spectrum; higher CS is associated with lower CF and vice versa. ProQOL is a complex concept, which is associated with aspects of the workplace environment, the individual and trauma exposure. However, it can be used as a guide to work towards healthy levels of CS/CF, BO and STS.

The development of ProQOL emerged from the recognition that STS, VT, and CF overlap in criteria for onset and symptomatology (Sheen et al., 2014; Slade et al., 2017; Stamm, 2010) and true differences remain unclear. However, the terms are still used independently and are considered to be distinct but inter-related forms of work-related stress responses and traumatised states which emerge as a consequence of exposure to another's suffering and adverse events (Leinweber & Rowe, 2010).

However, all the frameworks discussed are limited to set criteria and focus on the experience of the individual alone.

The current study has purposefully focussed on the SV phenomenon and the term ‘Second Victim’ as this concept holds important connotations which are lacking from the related frameworks discussed. The SV phenomenon takes a broader systemic perspective of the experiences of HCPs in the context of adverse and traumatic events and is not limited to diagnostic criteria. The phenomenon recognises that these experiences are vast and idiosyncratic, whilst giving equal consideration to systemic factors which contribute to the occurrence and impact of adverse events, and how, in turn, these experiences impact further patients and the organisation. It draws attention to the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> victims in the occurrence of adverse events, seeking to understand the processes surrounding the individual which maintain this domino effect and moving away from seeing the HCP in isolation. This aligns to the systemic lens through which the current study is conducted, and the use of Grounded Theory which seeks to explore processes and the relationships between these (Charmaz, 2008). Furthermore, it is the researcher’s perspective that to fully understand, prevent and/or minimise the impact of traumatic events amongst obstetricians and midwives, the systemic factors and processes surrounding the individual require exploration.

### **1.1.5 Implications for professional practice**

The consequences experienced by SVs can significantly compromise professional practice (Vanhaecht et al., 2019). An adverse event is often experienced as a personal failure with threats to personal and professional identity, and reputation (Busch et al., 2019; Chan et al., 2017; Scott et al., 2010). SVs are left feeling uncomfortable within the team, doubting their expertise and ability to provide quality



care (Vanhaecht et al., 2019). In some cases they will take time off, change role or leave the profession entirely (Mira et al., 2015; Scott et al., 2009).

It is now recognised that subsequent patients treated by the SVs are the ‘fourth victims’ as consequences suffered by the SV can compromise quality of care (Ozeke et al., 2019) and patient safety (Quillivan, Burlison, Browne, Scott, & Hoffman, 2016; Scott et al., 2009). The initial four to twenty-four hour time period is crucial, as HCPs are more likely to be involved in another adverse event during this time (Martens et al., 2016). Schwappach and Boluarte (2009) outline a vicious cycle which describes how the psychological impact of the event, including distress, guilt, shame and responsibility, can provoke symptoms of burnout, depression and reduced empathy, which contribute to the delivery of suboptimal care and increase the likelihood of future error.

SVs may fear the occurrence of future errors, avoid risk situations, become hypervigilant in their practice (Chan et al., 2017; Vanhaecht et al., 2019), and detach from or reduce kindness towards patients (Sirriyeh et al., 2010). High levels of anxiety can impact cognitive functioning, leading to challenges in carrying out work-related tasks (Busch et al., 2019). SVs with a diagnosis of depression may be more likely to make an error compared to their colleagues (West et al., 2006). Furthermore, HCPs may be more likely to engage in “defensive medicine” (Ozeke et al., 2019), defined as ‘the practice of ordering medical tests, procedures, or consultations of doubtful clinical value in order to protect the prescribing physician from malpractice suits’ (Merriam-Webster, n.d.).

### **1.1.6 Benefits to professional practice**

A proportion of SVs will respond by ‘thriving’ in the profession and ‘making good’ of an adverse clinical event (Scott et al., 2009). In a review of the literature, Sirriyeh et al. (2010) reported that professional practice can benefit when the event leads to increased communication about the event within teams. Learning from the event facilitates the ability to move on and maintain professional integrity (Treiber & Jones, 2010). Chan et al. (2017) reported that SVs may engage with problem-focused coping strategies, such as talking about the event, learning from it, and acting to prevent recurrence. These strategies were linked to increased knowledge, and self-monitoring to reduce the occurrence of future errors. This process seemingly aligns to Gibb’s reflective practice cycle (Gibb, 1988), suggesting this as a useful framework for organisations to utilise following adverse events.

#### **1.1.7 Vulnerability factors**

A number of factors have been associated with severity of response (Coughlan et al., 2017; Nydoo et al., 2019). The risk is higher amongst those working in paediatrics, surgery, anaesthesiology or obstetrics and gynaecology (Ozeke et al., 2019). Reported distress is higher in practitioners spending more time in clinical practice, amongst females, (Chan et al., 2017; Mira et al., 2015; Waterman et al., 2007), and when perceived responsibility and self-blame is increased (Engel, Rosenthal, & Sutcliffe, 2006; Sirriyeh et al., 2010). Severe psychological reactions have been associated with incidents involving multiple lives and young, healthy people (Coughlan et al., 2017; Nydoo et al., 2019), and when events led to death or temporary/permanent harm (Vanhaecht et al., 2019).

#### **1.1.8 Workplace environment**

It is argued that SVs are impacted by the event itself, and how the organisation responds (Ullstrom et al., 2014). SVs are often unsupported due to the absence of effective support systems, poor reporting procedures and debriefing (Edrees et al., 2011; Ross, 2018; Ullstrom et al., 2014), causing more severe and enduring consequences (Quillivan et al., 2016). In a survey of over 3,000 clinicians, only 10% reported to receive, what was perceived as, 'adequate support' following an adverse event (Waterman, 2007).

In a sample of Swedish HCPs, Ullstrom et al. (2014) found that inadequate support and the absence of clear investigation processes intensified and prolonged the emotional impact following an adverse event. The authors suggested that disorganised follow-ups prevented HCPs from processing and putting 'closure' on the event. Gossip, unsupportive, blaming, and judgmental colleagues can exacerbate emotional distress and hinder the ability to move on (Edrees et al., 2011; Ullstrom et al., 2014). Those who do seek support can feel stigmatised (Edrees et al., 2011; Scott et al., 2009), whilst others suffer in silence due to cultures of blame, fear of litigation, unsupportive or judgmental colleagues (Ozeke et al., 2019), guilt, shame and isolation (Pratt & Jachna, 2015).

### **1.1.9 Beneficial support structures**

Effective support can significantly reduce the SVs distress (Nyadoo et al., 2019; Sirriyeh et al., 2010), and benefit patient safety (Ross, 2018). Non-punitive workplace support has been associated with a significant reduction in psychological and physiological distress (Quillivan et al., 2016), whilst peer support and sharing experiences with trusted, empathetic and non-judgmental colleagues, are viewed as critical (Chan et al., 2017; Manser, 2011). In a survey exploring support structures for

SVs (Edrees et al., 2011), HCPs were most likely to seek informal emotional support from colleagues, managers, a spouse/ significant other and friends. They were least likely to seek support from those in leadership roles and, least of all, from trained professionals. Prompt debrief, opportunities to discuss ethical concerns, and how similar events could be prevented, were viewed as beneficial.

#### **1.1.10 A cultural shift**

It is argued that organisations should take responsibility and become vigilant to emotional wellbeing following an adverse event. However, in practice, little attention has been paid to the needs of the SVs (Manser, 2011; Pratt & Jachna, 2015; Ross, 2018). Denham (2007) outlined the five rights of SVs, which he argued should be integral following an adverse event. Using the acronym TRUST, the five rights include:

**T**reatment that is just

**R**espect

**U**nderstanding and compassion

**S**upportive care

**T**ransparency and opportunity to contribute.

As outlined by Denham (2007), TRUST emphasises the importance of non-punitive approaches that remove guilt and break the name-blame-shame cycle. This approach should be modeled by leaders, in order to become embedded into the organisational culture. HCPs should be entitled to psychological and support services, which are delivered systematically. Systems should support disclosure and recognise that error is unavoidable and a consequence of several factors. A culture of identifying,

disclosing and reporting medical errors encourages learning and directly improves patient safety.

Many agree that a cultural shift is required; moving away from perfectionism and blame and towards a 'just culture', to break down barriers to seeking and accessing support (Busch et al., 2019; Chan et al., 2017; Denham, 2007; Ozeke et al., 2019). In a review of the literature, Busch et al. (2019) concluded that the experiences and needs of the SVs should be recognised in practice, education, and policy.

### **1.1.11 Interventions**

Several SV support programmes have been developed. However, these are predominantly in the USA and are based on western concepts of health and healthcare (Nydoe et al., 2019). Most commonly cited are the RISE (Resilience in Stressful Events) intervention developed by the John Hopkins Hospital (Edrees et al., 2016), and the 'forYOU' programme at the University of Missouri Health Care (MUHC). These initiatives are based on guidelines for the treatment of PTSD (NICE, 2018), which recommend Psychological First Aid as an early intervention for all survivors of potentially traumatic events (Forbes et al., 2010).

The MUHC programme is based on the Scott et al. (2010) model, which outlines a three-tiered response system following an adverse event. Tier One includes support within the workplace from supervisors, managers and colleagues. Tier Two provides one-to-one crisis intervention from trained peer-support workers who also provide mentoring, team debriefings, and support during investigation and litigation. Tier Three offers support from professionals such as psychologists, social workers, or religious leaders. Training is provided to all staff allocated to provide support.

The ‘Second Victim Support Unit Scoping Project’ (Jones, Robertson, Chamdal, Maltby, & Weger, 2019) was piloted at the Children’s Hospital, University Hospital Leicester to assess applicability of the Scott et al. (2010) to the UK health care system. Outcomes were positive; HCPs valued the service, as it normalised their experience and provided supported to remain in work. Speaking with someone who had knowledge of their role and who shared similar experiences, was particularly beneficial reducing feelings of loneliness. The outcomes led to the following recommendations for UK healthcare:

- 1) Staff need support following a patient safety incident.
- 2) Wide dissemination and communication of SV support programmes is required.
- 3) Peer support workers need structured and on-going training.

## **1.2 The SVs: Obstetricians and midwives**

HCPs working in maternity care may be more vulnerable to becoming SVs due to greater exposure to dramatic adverse events, given the wide range of risks associated with childbirth, the potential loss of multiple, young, healthy lives and severe life-limiting consequences (Nydoe et al., 2019). However, most studies exploring the SV phenomenon have neglected those working in maternity care, limiting current knowledge of the impact of adverse events on midwives, and, to an even greater extent, on obstetricians.

### **1.2.1 Traumatic perinatal events**

A “traumatic perinatal event” can be defined as a situation where an individual has ‘experienced fear, hopelessness, or horror, in response to the perceived threat of

death or damage to someone in their care' (Slade et al., 2020). A "traumatic birth" has been defined as:

'...A complex concept which is used to describe a series of related experiences and negative psychological responses to childbirth. Physical trauma in the form of injury to the mother or baby may be involved but is not a necessary condition' (Greenfield, Jomeen, & Glover, 2016, p.2).

The definition of a "traumatic birth" has been developed largely from the perspective of the mother's experience. This differs marginally from a "traumatic perinatal event" which is derived from the perspective of the HCP. In reality both result from subjective experiences.

More than two-thirds of midwives and obstetricians report having witnessed a traumatic perinatal event (Leinweber, Creedy, Rowe, & Gamble, 2017; Slade et al., 2020; Slade, Sheen, Collinge, Butters, & Spiby, 2018). Events which are perceived as traumatic by midwives include those which are unexpected, highly severe, involve multiple complications and are difficult to control. Such as infant resuscitation, maternal death and shoulder dystocia; which describes the incident of a baby's shoulder becoming caught above the mother's pubic bone following delivery of the head. Witnessing suboptimal care, overly forceful interventions, not being able to access resources, delivering devastating news, personal salience, having an established or difficult relationship with the mother or family, feeling unsupported or blamed by colleagues, and self-blame, have also been reported to contribute to the perception of trauma amongst midwives (Sheen, Spiby, & Slade, 2016b). Studies exploring obstetricians' experiences predefine a traumatic event.

The midwifery model of care is based upon the philosophy that pregnancy and birth is normal and an important life stage, the profession is autonomous, and midwives provide women centered and continuity of care (Royal College of Midwives [RCM], 2016). The medical model advocates the medical management of pregnancy, labour and birth is necessary for a positive outcome, and is only normal in hindsight. Working between these two philosophies can leave midwives traumatised, as a consequence of feeling powerless to provide midwifery-led care due to the power of the medical model and hierarchical working (Rice & Warland, 2013).

### **1.2.2 Consequences of traumatic perinatal events**

Few studies have explored the impact of traumatic events on midwives, and even fewer on obstetricians. Qualitative explorations are sparse, as most studies use self-report measurement tools, focusing on symptoms of PTSD, and predefining a traumatic perinatal event. In large-scale UK studies exploring experiences of traumatic events, 33% of midwives (Sheen, Spiby, & Slade, 2015), and 18% of a sample of obstetricians and gynecologists, reported symptoms meeting criteria for clinical PTSD (Slade et al., 2020). In a Swedish sample 15% of obstetricians and midwives reported partial symptoms of PTSD, whereas 7% of obstetricians and 5% of midwives met full criteria for PTSD following an adverse event. Although prevalence rates differ, sub-clinical PTSD symptoms are reported frequently (Sheen et al., 2015; Slade et al., 2020; Wahlberg et al., 2017).

In both groups, traumatic events may lead to a decline on measures of psychosocial health and wellbeing, sleep disorders and depressive symptoms. In addition to guilt, fear of blame from patients or colleagues and greater contemplation about the meaning of life (Schroder, Jorgensen, Lamont, & Hvidt, 2016).



In a qualitative analysis (Sheen, Spiby, & Slade, 2016a) midwives reported to feel emotionally distraught, shocked, in despair and struck with feelings of self-blame, guilt and vulnerability, following adverse events. Midwives have also reported immediate feelings of helplessness, horror and fear. Then, later, deep concern, anger, powerlessness, guilt, responsibility (Leinweber et al., 2017) and an increase in scores on measures of burnout (Schroder, Larsen, et al., 2016). Responsibility and guilt leave midwives ruminating about what they could have done differently (Rice & Warland, 2013).

Slade et al. (2020) explored obstetricians' and gynecologists' experiences of work-related traumatic events. Traumatic events were reported to impact all aspects of personal and professional lives. Clinical levels of PTSD were associated with increased emotional exhaustion and depersonalisation. Fear, helplessness, panic, guilt, reexperiencing the event, and avoidance, have also been reported amongst obstetricians (Wahlberg et al., 2017).

### **1.2.3 Vulnerability factors**

Prior trauma exposure, less professional experience, organisational stress and higher empathy are reported to increase vulnerability to traumatic stress following an adverse event (Slade et al., 2017). In a study carried out with midwives, greater exposure to traumatic perinatal events, personal experience of trauma and high empathy scores were associated with more severe symptoms of post-traumatic stress following an adverse event (Sheen et al., 2015). Witnessing disrespectful and abusive care, and not knowing the final outcome, can worsen and prolong psychological impact, particularly feelings of guilt, self-blame and ruminations (Leinweber et al., 2017; Rice & Warland, 2013).

Midwives may be more vulnerable to experiencing poorer psychosocial health and wellbeing compared to obstetricians (Schroder, Larsen, et al., 2016), whilst being female, feelings of guilt and blame from parents may increase the risk of developing PTSD (Schroder, Larsen, et al., 2016; Wahlberg et al., 2017). In Slade et al. (2020) obstetricians of Black Asian and Minority Ethnic (BAME) background had increased risk of developing PTSD, although reasons for this were not explored. The following section will explore aspects of vulnerability in more detail.

### **1.2.3.1 Empathy**

Empathy is fundamental for the delivery of sensitive care. However, it is postulated that higher empathetic engagement increases the risk of traumatic stress, due to an increased likelihood of internalising the event (Figley, 1995; Leinweber & Rowe, 2010). Exposure to adverse events may also contribute to diminished empathy, compromising compassionate care (West et al., 2006). Findings indicate that an “optimal level” of empathy is required, to protect the psychological wellbeing of the HCP, whilst facilitating compassionate care.

Midwives may be at greater risk of experiencing STS following a traumatic birth due to the high degree of empathetic engagement that characterises the midwife-women relationship (Leinweber & Rowe, 2010). In qualitative interviews with ten Australian midwives (Rice & Warland, 2013), having an established bond and “feeling” for the mother increased distress during and following an adverse event. Furthermore, Sheen et al. (2015) found high levels of post-traumatic stress to be associated with higher scores on a measure of empathetic concern, however causality cannot be implied. Additional research is needed to understand the extent to which

empathy is a vulnerability factor, particularly for obstetricians (Sheen et al., 2014; Slade et al., 2017).

### **1.2.3.2 Organisational stress**

Organisational climate influences the perception of trauma and psychological response (Sheen et al., 2014). Professionals experiencing traumatic stress frequently report simultaneous work-related stress, although the direction of this effect remains unclear (Cohen, Leykin, Golan-Hadari, & Lahad, 2017; Sheen et al., 2014; Slade et al., 2017). This is highly pertinent, as maternity staff face increasing pressures due to workforce shortages, increased birthrate and case complexity (RCM, 2017).

Work-related psychological distress is prevalent amongst midwives worldwide, (Geraghty, Speelman, & Bayes, 2019; Pezaro, Clyne, Turner, Fulton, & Gerada, 2016; Stoll & Gallagher, 2019). The seriousness of this within the UK was highlighted in a survey of 1997 midwives (B. Hunter, Fenwick, Sidebotham, & Henley, 2019). More than one-third of midwives reported moderate to extreme stress, anxiety, depression and burnout. 83% percent demonstrated moderate levels and above for personal burnout, and 67% reported moderate levels and above for work-related burnout. Younger, more recently qualified midwives, those reporting a disability, and those working in a clinical setting as opposed to management or education, reported significantly higher levels of distress. Organisational pressures, interprofessional conflicts, bullying, unsupportive cultures and trauma exposure are commonly reported, and have been found to contribute to midwives' experiences of psychological distress (Pezaro et al., 2016).

Work-related distress is argued to contribute to the chronic shortages of UK midwives and likelihood of leaving the profession (Hunter et al., 2019). PTSD,

burnout, anxiety and depression may result in unhealthy coping strategies, impaired cognition, poor decision-making and an increase in adverse outcomes (Pezaro et al., 2016). Such findings hold serious implications for the delivery of care, and retention of a healthy and motivated workforce.

Similar research focusing on obstetricians is sparse, however, there is global concern for the impact of doctors' work on their mental wellbeing and professional practice (Slade et al., 2020). The current attrition rate of doctors training in obstetrics and gynaecology is 30% (Royal College of Obstetricians and Gynaecologists [RCOG], 2018). In a UK study exploring burnout amongst obstetricians and gynecologists, nearly half of trainees and one-third of consultants reported burnout. Presence of burnout was associated with higher rates of suicidal ideation, depression, anxiety, sleep problems, anger, irritability, substance misuse, poorer physical wellbeing, and an increased likelihood of engaging with defensive medicine (Bourne et al., 2019). Further research is needed to explore obstetricians' experiences of organisational stress and how this may impact perceptions of, and response to, adverse events.

#### **1.2.4 Professional practice and compassionate care**

Following an adverse event midwives and obstetricians may take sick leave, make short-term changes to their daily allocation, or change profession (Sheen et al., 2015; Slade et al., 2020; Wahlberg et al., 2017). These consequences are prevalent in those with clinical levels of PTSD, and may differ between obstetricians and midwives (Sheen et al., 2015; Wahlberg et al., 2017). In Schroder et al. (2019), significantly more midwives than obstetricians found it difficult to continue clinical practice and work safely after an event, potentially due to poor psychological and physical wellbeing.

Exposure to traumatic events may lead to desensitisation, depersonalisation, distancing from patients, withdrawal from emotional intensity and reduced empathy (Schroder, Larsen, et al., 2016; Sheen et al., 2015; Slade et al., 2020). Obstetricians have reported heightened anxiety within the workplace, increases in insensitive and defensive practice, and high rates of clinical intervention, such as use of, forceps, to reduce the occurrence of further adverse events (Slade et al., 2020). Midwives may go into ‘autopilot’, ignoring their emotions to maintain professional integrity (Sheen et al., 2016a). The tendency to emotionally distance from patients and colleagues is recognised as a maladaptive coping strategy which is used by midwives to manage the emotional toll of the role (Hunter, 2016)

Empathetic engagement is essential, given that mothers’ perceptions of the birth experience is significantly impacted by the care they receive (Ayres, Bond, Bertullies, & Wijma, 2016; Iles & Pote, 2015). Iles and Pote (2015) grounded theory model of post-partum PTSD highlights the importance of continued support from HCPs throughout the birth process, and how this can increase resilience to birth trauma. Empathy was a key aspect of a positive birth experience and post-partum mental health. The support received is critical in the context of historical trauma and challenging birth procedures (Ayres, 2014; Ford & Ayers, 2011). Greater satisfaction with HCPs is associated with resilience to developing PTSD following a traumatic birth (Dikmen Yildex, Ayres, & Philips, 2017).

Seemingly, empathetic engagement is crucial for the mother, whilst potentially harmful to the wellbeing of the HCP, and in some cases may contribute to emotional distancing. Leinweber and Rowe (2010) discussed the conflict between mothers’ need for empathetic and compassionate care, and midwives’ need to withdraw to protect their own mental wellbeing. It is suggested that empathy may be a greater risk factor

for midwives, as compared to obstetricians. Midwives are more likely to develop a deeper empathetic relationship with mothers, whereas obstetricians' interactions are short-lived (Schroder et al., 2019). Further research is needed to better understand this hypothesis.

### **1.2.5 Support in the maternity profession**

Organisational support can lessen the impact of a traumatic perinatal event (Sheen et al., 2015, 2016a; Slade et al., 2020). Unfortunately, midwives and obstetricians often face absent or inadequate workplace support, and a lack of clarity about where and how to access support (Schroder, Larsen, et al., 2016; Sheen et al., 2016a; Slade et al., 2020). In both groups, insufficient support and poor debriefing may increase vulnerability to PTSD (Wahlberg et al., 2017). Managing in the aftermath of a traumatic perinatal event may be hindered by having no opportunity to process the event, no access to support, and a lack of acknowledgement that the event was traumatic, in addition to receiving criticism, "gossip" and feeling judged. Obstetricians value the opportunity to have open and honest discussions with supportive colleagues (Slade et al., 2020), whilst midwives value emotional support, speaking with colleagues who have had similar experiences and discussing how similar events may be prevented (Sheen et al., 2016a; Slade et al., 2020).

Maternity care is criticised for cultures of blame, criticism and the expectation that staff should "carry on regardless"- help-seeking is stigmatised (Slade et al., 2020). Midwives and obstetricians stress a need for cultural change and access to systemically-embedded support following an adverse event (Sheen et al., 2015, 2016a; Slade et al., 2020). No specific interventions exist to support staff following traumatic perinatal events, however initial steps have been made to address this issue.

Slade et al. (2018) developed a stepped care support programme: The Programme for the prevention of PTSD in midwifery (POPPY). Step One involves a training workshop, which supports midwives to understand how they experience trauma, and introduces self-help methods. Step Two includes confidential peer support via telephone from a trained midwife. If difficulties exceed 3 months after the traumatic event, midwives may contact a clinical psychologist for an assessment and trauma-focused intervention (Step Three). The workshop was tested for utility in 153 UK midwives. At six-month follow-up, midwives showed a significant increased confidence in their knowledge of trauma, managing emotional responses and supporting colleagues, and an increase in professional accomplishment and satisfaction. There was a significant reduction in the number of midwives reporting moderate to high depersonalisation. There was a non-significant trend towards a reduction in PTSD symptomology. Initial outcomes were promising however findings are limited due to small sample size, short-term follow-up, and no control group to detect statistical differences.

Slade et al. (2020) made similar recommendations for how services should support obstetricians and included suggestions to regularly review trust guidelines to ensure staff are considered in the management of serious incidents. Nevertheless, when developing support systems, health-care services should consider potential differences between obstetricians and midwives experiences and tailor support to their needs.

### **1.3 Rationale and study aims**

Midwives and obstetricians may be more vulnerable to becoming SVs, due to high levels of risk, organisational stress, absent support systems, cultures of blame and

high rates of emotional exhaustion, burnout, depression and anxiety; factors which may impact the perception and impact of traumatic events. Despite this, research exploring midwives' and obstetricians' experiences of adverse events is limited, particularly for obstetricians.

Evidence suggests that midwives and obstetricians display responses similar to those outlined within the wider SV literature. However, their experiences, and factors which contribute to this may differ. This warrants further investigation to inform the development of effective support systems. Qualitative investigations are limited; the majority of studies predefine a traumatic perinatal event and utilise quantitative outcome measures which align with symptoms of PTSD. Thus, further investigation is needed to determine pertinent vulnerability factors, and which coping strategies and support methods are viewed as being helpful or unhelpful.

Empathetic and compassionate care is fundamental to a mother's birth experience. However, the psychological distress resulting from trauma exposure and insufficient organisational support, in addition to "maladaptive" coping strategies may hinder the delivery of optimal care. There exists a concerning unmet need amongst maternity staff, which has significant consequences for the mother and the wider organisation. For those in the UK, it is argued that it is the responsibility of NHS employer to address this need (Slade et al., 2020).

The current study aims to address gaps within the literature through gathering a greater understanding of the experiences of obstetricians and midwives in the context of traumatic events. The study will explore how midwives and obstetricians define traumatic births, how they are impacted by these experiences, and the factors which may influence their experiences. It also seeks to explore coping strategies and



experiences of workplace support. The role of empathy and compassion will be considered.

Given the subjective and exploratory nature of the topic, a qualitative approach will be used to address these aims. Grounded Theory Methodology will facilitate the generation of clinically useful models, which will be developed separately for midwives and obstetricians. This will inform conclusions about similarities and differences.

This research is fundamental to the psychological wellbeing of midwives, obstetricians, and the women and families they care for. The study is in keeping with the focus on staff wellbeing in the NHS five-year forward implementation plan (NHS England, 2016b), commissioning for workplace compassion (NHS England, 2018), and drive towards ensuring maternity services deliver empathetic and women-centered care (NHS England, 2016a).

The research will potentially hold significant clinical implications, through informing organisations about the experiences of both midwives and obstetricians in the context of traumatic events. It is hoped that the findings provide greater insight into how to support maternity staff and reduce the impact of adverse events; potentially through addressing pertinent risk factors and meeting individual needs in support methods. These outcomes have the potential to minimise the impact on mothers' experiences, through facilitating compassionate care, improved wellbeing of the workforce and reducing organisational consequences.

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## **Part 2: Empirical Paper**

The Second Victims: A Grounded Theory explanation of  
the experience and impact of traumatic births amongst  
midwives and obstetricians



## Abstract

**Aim:** Midwives, and obstetricians may be at increased risk of becoming “Second Victims” (SVs) due to increased exposure to severe medical events. However, current evidence exploring their experiences of adverse events is sparse. The current study aims to better understand the perception and impact of traumatic perinatal events amongst midwives and obstetricians, and to generate clear theoretical frameworks that can be translated into clinical settings.

**Method:** Eight midwives and six obstetricians working within the NHS were interviewed about their experiences of traumatic perinatal events. Semi-structured interviews were conducted and analysed using constructivist Grounded Theory (Charmaz, 2008).

**Results:** Two theoretical frameworks emerged from the data. Six main themes reflected participants’ experiences: traumatic births; exacerbating factors; buffering factors; the aftermath; position in hierarchical system; and cultural change.

**Conclusion:** The study provided novel insights, revealing similarities and differences between midwives’ and obstetrician’s experiences of traumatic events. Position in hierarchical system was influential in the differences observed. In both groups, organisational factors contributed significantly to the perception and impact of traumatic events. Maternity organisations have the power to reduce the risk the “Second Victim” (SV) phenomenon amongst staff and mitigate potential consequences to the mothers' birthing experience.

## 1.0 Introduction

### 1.1 The “Second Victims”

Healthcare professionals globally are at risk of becoming “Second Victims” (SVs) (Wu & Steckelberg, 2012) , with prevalence rates estimated at between 10% and 72 % (Coughlan, Powell, & Higgins, 2017). Scott et al. (2009) defined the SVs as:

‘...health care providers who are involved in an unanticipated adverse event, in a medical error and/or a patient-related injury and become victimised in the sense that the provider is traumatised by the event. Frequently these individuals feel personally responsible for the patient outcome...that they have failed the patient, second guessing their clinical skills and knowledge base’.

The consequences are vast and, for some, enduring, manifesting psychologically, cognitively, and physically (Nyadoo, Pillay, Naicker, & Moodley, 2019; Ozeke, Ozeke, Coskun, & Budakoglu, 2019). Most commonly, SVs experience guilt, anxiety, fatigue, sleep difficulties, frustration, anger, difficulty concentrating and self-doubt. Depression, suicidal ideation and symptoms of post-traumatic stress disorder (PTSD; APA, 2013) are also reported (Busch et al., 2019; Coughlan et al., 2017; Seys et al., 2013) Professional practice, patient safety, and quality of care may be compromised as a consequence of increased hypervigilance, risk avoidance, engaging in defensive medicine (Chan, Khong, & Wang, 2017; Vanhaecht et al., 2019), and detaching from patients (Sirriyeh, Lawton, Gardner, & Armitage, 2010). Taking sick leave, changing role, or leaving the profession are also consequences (Mira et al., 2015; Scott et al., 2009). More recently, the “fourth victims” have been recognised as the patients who may suffer as a consequence of the “Second Victim”

(SV) phenomenon (Ozeke et al., 2019). The recovery process amongst SVs is largely predictable and has been outlined by Scott et al., (2009) as a six-stage process: i) Chaos and accident response, ii) Intrusive reflections, iii) Restoring personal integrity, iv) Enduring the inquisition, v) Obtaining emotional first aid, and vi) Moving on (see Chapter One for a detailed overview).

Various factors have been associated with severe and prolonged reactions (Coughlan et al., 2017) however the organisation's culture and response is fundamental (Ullstrom, Andreen Sachs, Hansson, Ovretveit, & Brommels, 2014). Inadequate support systems, disorganised follow-ups, unsupportive colleagues, and cultures of judgement and blame are reported to exacerbate emotional distress and prevent help-seeking following adverse events (Edrees, Paine, Feroli, & Wu, 2011; Quillivan, Burlison, Browne, Scott, & Hoffman, 2016; Ross, 2018). Talking with trusted, empathetic, non-judgmental colleagues and receiving non-punitive support can lessen psychological distress (Edrees et al., 2011).

## **1.2 Traumatic perinatal events**

A "traumatic perinatal event", can be defined as a situation where an individual has 'experienced fear, hopelessness, or horror, in response to the perceived threat of death or damage to someone in their care' (Slade et al., 2020, p.4). Two-thirds of midwives and obstetricians will witness a traumatic event at least once in their career (Leinweber, Creedy, Rowe, & Gamble, 2017; Slade et al., 2020). Moreover, large-scale UK studies reported that 33 % of midwives (Sheen, Spiby, & Slade, 2015), and 18% of obstetricians and gynecologists (Slade et al., 2020), were experiencing symptoms commensurate with clinical PTSD. Despite this, little is understood about midwives' and, even less so, obstetricians' experiences of adverse events.

In a study including UK midwives (Sheen, Spiby, & Slade, 2016b), events which were unexpected and severe, involved multiple complications, were difficult to control, involved difficulties accessing resources, and held personal salience, were perceived as traumatic. Having an established or challenging relationship with the family, and delivering devastating news also contributed to their perceptions of traumatic events. Event characteristics have not been explored amongst obstetricians.

Midwives and obstetricians have reported fear, helplessness, panic, guilt, symptoms of PTSD (Sheen, Spiby, & Slade, 2016a; Slade et al., 2020; Wahlberg et al., 2017), an increase in scores on measures of depression, and an increased occurrence of sleep difficulties following a traumatic event (Schroder et al., 2016). Midwives also report feeling emotionally distraught, angry, responsible and powerless (Leinweber et al., 2017; Rice & Warland, 2013). Preliminary evidence suggests that professional consequences may differ. Midwives may be more likely than obstetricians to take sick leave (Wahlberg et al., 2017) and find it more challenging to continue working following a traumatic event, potentially due to poorer psychological wellbeing (Schroder et al., 2019). In comparison, obstetricians report increases in defensive practice and rates of clinical intervention following traumatic events (Slade et al., 2020).

Exposure to traumatic events may also result in desensitisation, depersonalisation, and distancing from patients (Schroder et al., 2016; Sheen et al., 2015; Slade et al., 2020). Detaching emotionally is recognised as a long-term maladaptive coping strategy amongst midwives (Hunter, 2016) although it has not been explored amongst obstetricians. Furthermore, greater empathetic engagement may increase vulnerability to traumatic stress following an adverse event (Figley, 1995). These findings are concerning given that compassionate and empathetic care

are critical to the mother's birthing experience and are associated with increased resilience to post-partum mental health difficulties (Ayres, 2014; S. Ayres, Bond, Bertullies, & Wijma, 2016).

Insufficient or absent workplace support, less professional experience, prior trauma exposure (Slade, Sheen, & Spiby, 2017) and being female (Schroder et al., 2016) are reported to increase vulnerability to traumatic stress in midwives and obstetricians. However, vulnerability factors may differ. Witnessing disrespectful and abusive care has been found to intensify psychological consequences in a sample of midwives (Leinweber et al., 2017; Rice & Warland, 2013). Whilst obstetricians of Black, Asian or Minority ethnic background (BAME) have been reported to be at greater risk of developing PTSD following a traumatic event, although reasons for this were not reported (Slade et al., 2020).

Organisational stress may influence the perception and impact of traumatic events (Slade et al., 2017). This is significant given increasing pressure on maternity services as a consequence of increased birth rates, case complexity, and staff shortages and funding (RCM, 2017). It is argued that work-related distress contributes to chronic shortages of UK midwives and an intention to leave the profession (Hunter, Fenwick, Sidebotham, & Henley, 2019). The attrition rate of trainees in obstetrics and gynaecology is 30% (RCOG, 2018). Emotional exhaustion, burnout, depression and anxiety are prevalent in both groups (Bourne et al., 2019; Pezaro, Clyne, Turner, Fulton, & Gerada, 2016).

Effective workplace support is reported to significantly lessen the impact of traumatic perinatal events (Sheen et al., 2015; Slade et al., 2020). However, at present, no specific interventions exist to support maternity staff following a traumatic event.

Instead, maternity HCPs commonly face absent or inadequate support, and cultures of blame and criticism, in which help-seeking is stigmatised (Sheen et al., 2016a; Slade et al., 2020).

### **1.3 Support and cultural change**

There exists a global drive for healthcare organisations to take responsibility for and pay attention to the needs of the SVs. Denham (2007) outlines the five rights of the SVs, using the acronym TRUST, arguing that SVs deserve: **T**reatment that is just; **R**espect; **U**nderstanding and compassion; **S**upportive care; and **T**ransparency and opportunity to contribute. Scott et al. (2010) outlines a three-tiered rapid response system to support HCPs following adverse events:

**Tier One:** workplace support from colleagues.

**Tier Two:** one-to-one crisis intervention, mentoring, team debriefings and support through litigation processes; delivered by trained peer support workers.

**Tier Three:** support from professionals such as psychologists, social workers, or religious leaders.

However, in practice, the needs of HCPs are overlooked. A few organisations in the USA have adopted Scott's model, however in the UK this has only been piloted by one team (Jones, Robertson, Chamdal, Maltby, & Weger, 2019). Reasons for this are unknown, however it is plausible that this reflects a combination of organisational pressures to prioritise other issues within healthcare, limited funding to embed these programmes, and less recognition of the SVs within the UK healthcare system. Obstetricians and midwives have stressed the need for maternity organisations to address problematic cultures, and embed routine support following traumatic events (Sheen et al., 2016a; Slade et al., 2020). Slade, Sheen, Collinge, Butters, and Spiby

(2018) recently piloted a programme for the prevention of PTSD in midwifery (POPPY) in a sample of 153 UK midwives. The programme provides a stepped care model of support: 1) a training workshop focused on managing responses to traumatic events; 2) access to confidential peer support from a trained midwife; 3) onward referral to a clinical psychologist for trauma-focused intervention, if needed. Initial findings at six-month follow-up were promising; the training workshop led to increased confidence in knowledge of trauma, managing emotional responses, supporting colleagues, and a reduction in depersonalisation. Authors suggest the model has potential to be adapted across maternity staff, however preliminary findings suggest that midwives and obstetricians' value different aspects of support. Thus, these differences warrant further exploration to ensure support is correctly tailored to their needs (Slade et al., 2020).

#### **1.4 Aims and rationale**

Obstetricians and midwives may be at greater risk of becoming SVs due to increased exposure to unexpected and severe events, involving the potential loss of multiple young and healthy lives (Nydoon et al., 2019), in addition to organisational stress, cultures of judgement and blame, and absent support systems. Nevertheless, research exploring midwives', and even less so, obstetricians' experiences of traumatic perinatal events is limited.

Preliminary findings suggest that midwives and obstetricians display similar responses, outlined in the SV phenomenon (Scott et al., 2010). However, qualitative investigations are sparse; existing evidence has focused on symptoms of PTSD, utilising self-report measurement tools, and pre-defining traumatic perinatal events. Few non-UK studies have included both groups in the same study, which is

fundamental given that initial evidence suggests that obstetricians' and midwives' experiences may differ. Furthermore, exposure to traumatic events may compromise patient care as a consequence of psychological distress, desensitisation and distancing from patients, in addition to potential impacts on professional practice. This is fundamental given that a mother's birth experience, perception of traumatic birth, and post-natal mental health is impacted by the care received, with empathy being a crucial aspect.

The current study aims to address pertinent gaps in the existing literature, through a qualitative exploration of midwives' and obstetricians' experiences of traumatic perinatal events; pertinent factors which moderate the perception and impact of traumatic events, coping strategies, and experiences of workplace support. Compassion and empathy will also be explored.

Grounded Theory methodology (Charmaz, 2008; Glaser & Strauss, 1967) is appropriate for the subjective and exploratory nature of the topic and will facilitate the generation of clinically useful models. It is anticipated that the models can be utilised by healthcare organisations to support their staff in a way which prevents or minimises the risk of becoming SVs. Producing separate models will draw attention to differences in their experiences, which may be critical when tailoring support.

The findings have the potential to improve the psychological wellbeing of obstetricians and midwives, maintaining a healthy workforce and, consequently, minimising impacts on the mother's birth experience, by supporting staff to deliver empathetic and compassionate care. Moreover, the study aims to align with NHS goals to focus on staff wellbeing (NHS England, 2016b), and mothers' birth experiences (NHS England, 2016a).



## **2.0 The researcher's position**

A key aspect of qualitative research is reflexivity; the researcher's awareness of their role in the research process, and how their preconceptions, positions and interests influence the research process. Researcher reflexivity allows the researcher to scrutinise their research approach, decisions and interpretations in a way that recognises how these aspects of themselves influence the research process and outcomes; and how they are also shaped by the research process (Symon & Cassell, 2012).

My epistemological position aligns to the social constructionist perspective, which is adopted in Charmaz's approach to Grounded Theory; that reality and knowledge are actively constructed through social situations, relationships and language (Charmaz, 2008). As explored on p. 24, I also approach this research with a systemic lens. As is fitting with the SV phenomenon, and Grounded Theory, this reflects my preconception that to fully understand these experiences, and in-turn act to prevent and/or minimise the SV phenomenon amongst midwives and obstetricians, a broad exploration of the systemic process surrounding the SV phenomenon is fundamental.

I am a white British middle-class female. I have no children however I hope to become a mother in the future. My prior conceptions of childbirth come from the experiences of my siblings which were described as positive with minimal trauma. Prior to clinical training I had experiences of working with women experiencing mild to moderate mental health difficulties during the perinatal period. A professional interest in this area drew me to the topic of research. During the stages of data gathering I completed a 6-month placement in a Perinatal Mental Health Team, broadening my

understanding of mothers' experiences of traumatic births. As a trainee clinical psychologist, I have personal experience of the emotional impact of working in a non-medical caregiving role; however, I had no previous knowledge of the Second Victim Phenomenon.

Although I have attempted to bracket my experiences, the process of data gathering, analysis and interpretation, will have been influenced by my previous experiences, preconceptions, and new experiences encountered during this time. Completing a reflective log allowed me to take a reflective stance as I was able to document how these factors influenced my approach throughout the research process, and how the research process also shaped and developed my approach and assumptions. This was an invaluable process which gives greater credibility to the research outcomes. For example, being able to look back through the log entries which documented how I experienced the interviews allowed me to consider how this process may have influenced how I approached the analysis, and for example, how I named the themes and developed the shape of the models. This is discussed further in section 4.3.

### **3.0 Method**

#### **3.1 Grounded Theory**

A constructivist version (Charmaz, 2008) of the original Grounded Theory method (Glaser & Strauss, 1967) was used. Grounded Theory is a qualitative research method which focuses on creating theories or conceptual frameworks which are 'grounded' in the data. The method goes beyond the direct experience of the individual and provides abstract and conceptual understandings of the studied phenomenon. The theories generated are constructed from inductively drawing codes and categories from the data which are uninfluenced by pre-existing theories and constructs. This differs

from quantitative methods which test hypotheses that are predetermined by existing theory and knowledge.

The constructivist approach follows the principles of data collection and analysis as outlined by Glaser and Strauss (1967), whilst encouraging continued flexibility within this process. Charmaz (2008) moves away from the position that theories emerge from data in isolation, and towards a symbolic interactionist perspective; recognising the subjective nature of research and how the process of data collection, analysis and the theory generated, is shaped by the researcher's experiences, interactions, perspectives and research practices. From a personal perspective, the researcher aligned with this position, and principles of the approach which was influential when selecting the method.

Adopting a qualitative approach was fundamental, given the paucity of existing literature and limited knowledge of how midwives and obstetricians experience traumatic perinatal events and the factors surrounding this. Furthermore, the current literature overlooks the individuals experience and does not provide a conceptual understanding of how and why perinatal events are experienced as traumatic. For example, although preliminary research has explored characteristics of traumatic events and what might help or hinder the impact, these outcomes are purely descriptive, providing no understanding of how these factors 'fit together'.

Grounded Theory was chosen as an appropriate method to address these deficits. Within Grounded Theory the individuals experience is the source of data, and the method aims to explore processes and how experiences are embedded within wider circumstances and relationships. As a consequence, the outcomes of a Grounded Theory analysis provide an understanding of the conditions under which processes and

their consequences emerge and change (Charmaz, 2008), fitting with the aims of the current study. This method also aligns to the systemic lens through which the current research is conducted and facilitates a broader conceptual understanding of the studied data.

The method was also chosen as it facilitates the generation of clinically useful models outlining midwives and obstetricians' experiences of traumatic births. This goes beyond other alternative qualitative approaches such as IPA, as the theory generated can be presented in a conceptual framework which is accessible and easily distributed across healthcare services. It was anticipated that this approach can provide a model which could better inform services about the experiences of midwives and obstetricians, the structures and processes which may contribute to their experiences and how they should be supported. This is particularly pertinent given the SV phenomenon and current status of support within maternity services.

## **3.2 Participants**

### **3.2.1 *Inclusion criteria***

Qualified and trainee midwives and obstetricians were eligible for inclusion in this study. Midwives and obstetricians who were no longer practicing but showed interest in the study were considered on an individual basis, depending on time since leaving the profession. It was initially proposed that only midwives and obstetricians working in hospitals and birth centres would be included. However, during recruitment it was realised that midwives may practice within community and inpatient settings throughout their career. Thus, a proportion of midwives who had combined experiences took part in the study. This was based on the pre-requisite that they were able to draw on experiences from both settings.

### ***3.2.2 Recruitment and sampling***

Self-selected sampling was used. Initially participants were recruited via social media. A recruitment post, including the study flyer (Appendix One) was shared via the Twitter and Instagram pages of the Make Birth Better (MBB) network. The network is a collective of professionals and parents campaigning to increase awareness, prevention, diagnosis and treatment of birth trauma. This was seen as an effective recruitment platform due to extended links to obstetricians and midwives. The researcher's Twitter page was set up specifically for the purpose of recruitment and the researcher followed pages which were relevant to the topic. Followers of all accounts shared the recruitment post further. Members of the MBB network were also informed of the study via email, and the advert was shared on the 'Perinatal Research' Facebook page. Recruitment posts were shared multiple times over ten months, and more regularly as participant interest slowed. Potential participants contacted the researcher via email for more information and, if willing to participate, an individual interview was arranged.

### ***3.2.3 Participant characteristics***

Grounded theory asserts that data collection should stop once categories have reached theoretical saturation or sufficiency, such that no new properties or patterns emerge within new data (Glaser & Strauss, 1967). Six to twenty interview transcripts are generally found to be sufficient for saturation to occur (Francis et al., 2010; Guest, Bunce, & Johnson, 2006). Thus, to achieve the aim of including obstetricians and midwives in the study, whilst working within the time constraints of doctoral research, the number of participants was roughly predetermined at sixteen. Fourteen participants (six obstetricians and eight midwives) participated. The researcher was unable to

recruit further obstetricians. This was a consequence of less interest from this population. Additionally, recruitment was terminated earlier than anticipated, in March 2020, due to the impact of Covid-19. All participants were located within the United Kingdom, working within the NHS.

The following information was also collected from the participants:

- Length of time in profession since training
- Ethnicity
- Sexuality
- Gender
- Number of children

Time in profession, ethnicity, sexuality and gender were collected to inform the conclusions drawn from the results and generalisability. Whether participants had children was directly relevant to questions in the interview schedule. Participant details are provided in Table 1.

**Table 1.***Participant characteristics*

<b>Participant number</b>	<b>Profession</b>		<b>Interview format</b>	<b>Length of time in profession</b>	<b>No. of children (ages)</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Sexuality</b>
<b>P1</b>	<b>Obstetrician</b>	Registrar	UCL	3 years	0	Female	White British	Heterosexual
<b>P2</b>	<b>Midwife</b>	Qualified	UCL	5 years	0	Female	White British	Heterosexual
<b>P3</b>	<b>Midwife</b>	Left profession 6 months prior to interview	Skype	9 years	1 (3 years)	Female	White British	Heterosexual

<b>P4</b>	<b>Midwife</b>	Professor of midwifery	Skype	40 years	0	Male	White British	Homosexual
<b>P5</b>	<b>Midwife</b>	Currently working in community	Participant's home	8 years 6 months	0	Female	White British	Heterosexual
<b>P6</b>	<b>Obstetrician</b>	Consultant	Face time	13 years	1 (2 years)	Female	White British	Heterosexual
<b>P7</b>	<b>Midwife</b>	Community experience- left profession 6 months prior to interview	Participant's home	10 years	1 (2.5 years)	Female	White British	Heterosexual
<b>P8</b>	<b>Obstetrician</b>	Registrar long term sick leave	Skype	6 years	3 (10,6,3 years)	Female	British Pakistani	Heterosexual



<b>P9</b>	<b>Obstetrician</b>	Consultant and clinical director	Skype	30 years	1 (9 years)	Male	British Indian	Heterosexual
<b>P10</b>	<b>Obstetrician</b>	Consultant	UCL	14 years	3 (8,6,4 years)	Female	White British	Heterosexual
<b>P11</b>	<b>Midwife</b>	Bereavement specialist midwife	Participant's home	22 years	2 (8, 5 years)	Female	White British	Heterosexual
<b>P12</b>	<b>Midwife</b>	Changed to non-clinical maternity role 1 year prior	UCL	15 years	0	Female	White Scottish	Heterosexual
<b>P13</b>	<b>Midwife</b>	Community experience	Face time	7 years	0	Female	White British	Heterosexual

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<b>P14</b>	<b>Obstetrician</b>	Registrar	Face time	5 years	2 (3, 1 years)	Female	White British	Heterosexual
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### **3.3 Ethical approval**

Ethical approval for the study was granted by The University College London (UCL) Research and Ethics committee in February 2019 (Appendix Two). It was acknowledged that recalling previous traumatic experiences could be distressing for participants, however it was not anticipated that interviews would cause extreme emotional distress. These issues were addressed in the ethics application and the below procedure was followed.

The potential emotive nature of the interview was discussed with participants beforehand. All participants were informed that they could pause or stop the interview at any time and that they did not have to talk about anything they did not wish to. All participants were offered time to debrief after the interview and were provided with sources of support (Appendix Three).

At points during the interviews some participants became tearful when discussing past experiences. When this occurred, the researcher drew on her skills as a trainee clinical psychologist, responding in an empathetic manner. Participants were also asked if they wished to continue before proceeding with the interview. No participants displayed a concerning level of distress or requested to stop the interview. Participants frequently reported that they had found the process helpful as they had not previously spoken about their experiences in depth.

### **3.4 Procedure**

All participants who were interested in taking part in the study contacted the researcher via email; participants were given more information about the study, and an interview was arranged. The information sheet and consent forms were sent via

email prior to the agreed interview date (Appendices Four and Five). Confidentiality, right to withdraw and data protection were discussed at the beginning of each interview. Participants were informed of the limits of confidentiality and that the relevant agencies would be contacted if they disclosed anything that caused the interviewer to be concerned that they or another person was at risk. Participants were also asked to be mindful of disclosing names of colleagues and locations due to confidentiality. Informed consent was obtained prior to each interview.

### **3.4.1 Interviews**

Data was collected via semi-structured interviews. Using qualitative interviews aligns with the aims of Grounded Theory, as this facilitates in-depth exploration of participants experiences, yielding detailed accounts and revealing complex aspects of experiences. Furthermore, the semi-structured interview schedule is designed to be used flexibly, allowing the researcher to pursue topics which emerge during the interview (Charmaz, 2008).

The interview schedule (Appendix Six) was designed in accordance with Grounded Theory guidance, following an intensive interview format, comprising open-ended and non-judgemental questions (Charmaz, 2008). This was developed by the research team and reviewed by members of the MBB network. Using planned open-ended questions and prompts to encourage exploration allows the researcher to concentrate on the participants' conversations and reduces the likelihood that topics which require exploration will be missed (Charmaz, 2008).

The interview schedule was used in all interviews, however adapted accordingly for each participant. The development of the interview schedule is seen as an iterative process within Grounded Theory; however, no significant amendments

were made to the initial schedule as interviews progressed. Approximately halfway through the interviews, it was recognised that the researcher was avoidant of asking participants whether they engaged with ‘unhelpful’ coping strategies, which was a prompt in the schedule. This was discussed in supervision and the researcher recognised that, whilst this question felt somewhat blaming and exposing of the participant, it was an important aspect of the interview. It was agreed that the researcher would approach the question in a different way, such as “is there anything you do to cope which you would view as unhelpful”.

The interviews were completed individually between researcher and participant and were face to face, via Skype or Face time. One-to-one interviews were completed at University College London (UCL), or at the participant’s home address.

### **3.5 Analysis**

All stages of analysis are documented in Appendices seven and eight. The process of data collection and analysis was informed by Charmaz (2008) approach to Grounded Theory. The computer programme NVivo was used to support the process of analysis. As reviewed in Chapter One, previous literature suggests that obstetricians’ and midwives’ experiences of traumatic births may differ. In the wider SV literature further evidence suggests the experience of adverse events may differ between professional groups, which is as expected given the systems around the various fields within healthcare are likely to differ. As a consequence of these findings and the researchers aim to give each professional group sufficient space to voice their experiences, the data for the two professional groups was analysed separately, leading to two end theories. This approach facilitated the process of identifying similarities

and differences between the two groups. Minor amendments to the interview schedule were made during this time period, as discussed in section 3.4.1.

After each interview the researcher listened to the audio recording, and subsequently transcribed each recording verbatim; allowing the researcher to become immersed in the data. After each interview the researcher took notes to inform the process of analysis (Charmaz, 2008). This included observations that could not be captured by the audio recording, such as reasons for the researchers' approach, or pertinent feelings elicited (Appendix nine and section 3.6).

After a period of reviewing the transcripts several times, the researcher completed the initial stage of line-by-line coding, which involves designating each line of the transcript a name which categorises each segment of the data (Glaser & Strauss, 1978). Half-way through line by line coding the researcher found it useful to pause, review, and compare initial codes. This facilitated aggregation of similar codes and refined the developing coding framework. Following this the, line-by-line coding continued, the researcher remained open to other possibilities, and progressively followed up codes. Subsequently focussed coding (Glaser, 1978) was conducted. The researcher sorted through larger segments of data using the most significant or frequent earlier codes. This stage allowed the researcher to determine the adequacy of initial codes and which made the most analytical sense to effectively categorise the data. Following this, theoretical coding (Glaser & Strauss, 1978) allowed the researcher to conceptualise how the codes were related. This facilitated the generation of hypotheses about the relationships between codes, making them more theoretical and building a coherent analytical story. During the later stages the researcher found it helpful to export codes into a word document, to further review and compare codes, and the related quotes and memos.

The analysis process was facilitated by the use of ‘constant comparative method’, memo-writing, and diagramming (Charmaz, 2008; Glaser & Strauss, 1998). Memo-writing combined with diagramming allowed the researcher to document the analytic story, including pertinent ideas, insights, possibilities, and how these developed over time. This process facilitated an in-depth analysis of the data and codes, leading to the generation of more abstract ideas and theoretical categories, and providing rationale for the decisions made. The researcher also kept a reflective journal which further supported the analysis process.

Due to constraints to sample size, as discussed in section 3.2.3, the process of analysis continued until eight midwives, and six obstetricians had completed interviews. Due to relatively small sample size, it was unrealistic that theoretical saturation would be achieved, and plausible that new details would have emerged, had further interviews been carried out. However, I would argue that theoretical sufficiency (Dey, 1999) is likely to have been reached as the end models hang together in an apparently logical manner and were validated by those participants who took part in credibility checks.

### **3.5.1 *Credibility checks***

The analysis was subject to stringent checks. All participants were sent a copy of the relevant model and brief description of the themes identified. Participant validation is an important process within Grounded Theory research to ensure the final theory resonates with the participants and portrays their experiences (Charmaz, 2008). Due to the on-going presence of Covid-19, an informal email was sent to participants giving them choice to respond. Five participants responded (three midwives and two obstetricians); all of whom provided positive feedback on the models (Appendix Ten)

for anonymous feedback. In addition, the coding process received consensus checks with a co-researcher. Emerging theory and hypotheses about the data were discussed with the research team. The team worked collaboratively to refine the final structure of the theoretical frameworks to ensure accessibility upon dissemination.

### **3.6 Bracketing: Excerpts from the researcher's reflective journal during the interview process**

February 2019: Following ethical approval

*'I feel excited as I am due to embark on the interview process and am hopeful for the potential impacts of the research study, although I do have anxieties about the stories I will hear...I am aware that the literature I have read for thus far highlights a certain perception of obstetricians, as though they are 'the bad guys'. I need to be aware of this although I feel I hold no position...I hope to position myself between researcher and psychologist and manage my style as the participant needs whilst staying on task.'*

Following the initial three interviews

*'Listening back to the first three interviews, I notice my struggle in finding a balance between being curious and focussing more directly on the interview questions'*

*'I am getting a sense that what makes a birth more traumatic is the lack of support, within the event and after; relationships with colleagues; no time for debrief. These aspects feel more prominent beyond the labour event in itself...the environment appears to lack any compassion for staff, a sense of blame...'*



October 2019

*'My felt emotion seems to decline with distance from the participant, and also seems to impact how I utilise the interview schedule...Interviews completed via video call seem to be more manageable emotionally...face to face interviews are more emotive...being with the person allows me to focus more on the conversation and be more curious although can feel as though I've missed aspects of the interview schedule'.*

February 2020

*'Recruitment has hit a plateau. I need to recruit more obstetricians- although the rest of the interviews have been transcribed. I have spent a number of study days attempting the conceptual introduction...In a recent tutor meeting, I reflected that I started making links between my initial ideas about the data and what I was reading for the conceptual introduction. We decided to put the review to one side, limit this influence and potential bias on the analysis- as is true to GT'.*

March 2020

*'Nearing the end of a placement in a Perinatal mental health team and I feel like I am beginning this phase of analysis with a wider knowledge of the area of mothers' and partners' mental health during the perinatal period, and the wider impact on the baby and additional children. I have also been working with birth trauma- listening to the service user's perspective of their labour and delivery experiences. Although I am consciously aware of how this might impact the analysis, it is important to recognise (as I have also wondered how my research may have impacted my therapeutic work in this area)...having more of a 'seeing it from both sides' perspective....but having not gone through this experience myself'.*

## 4.0 Results

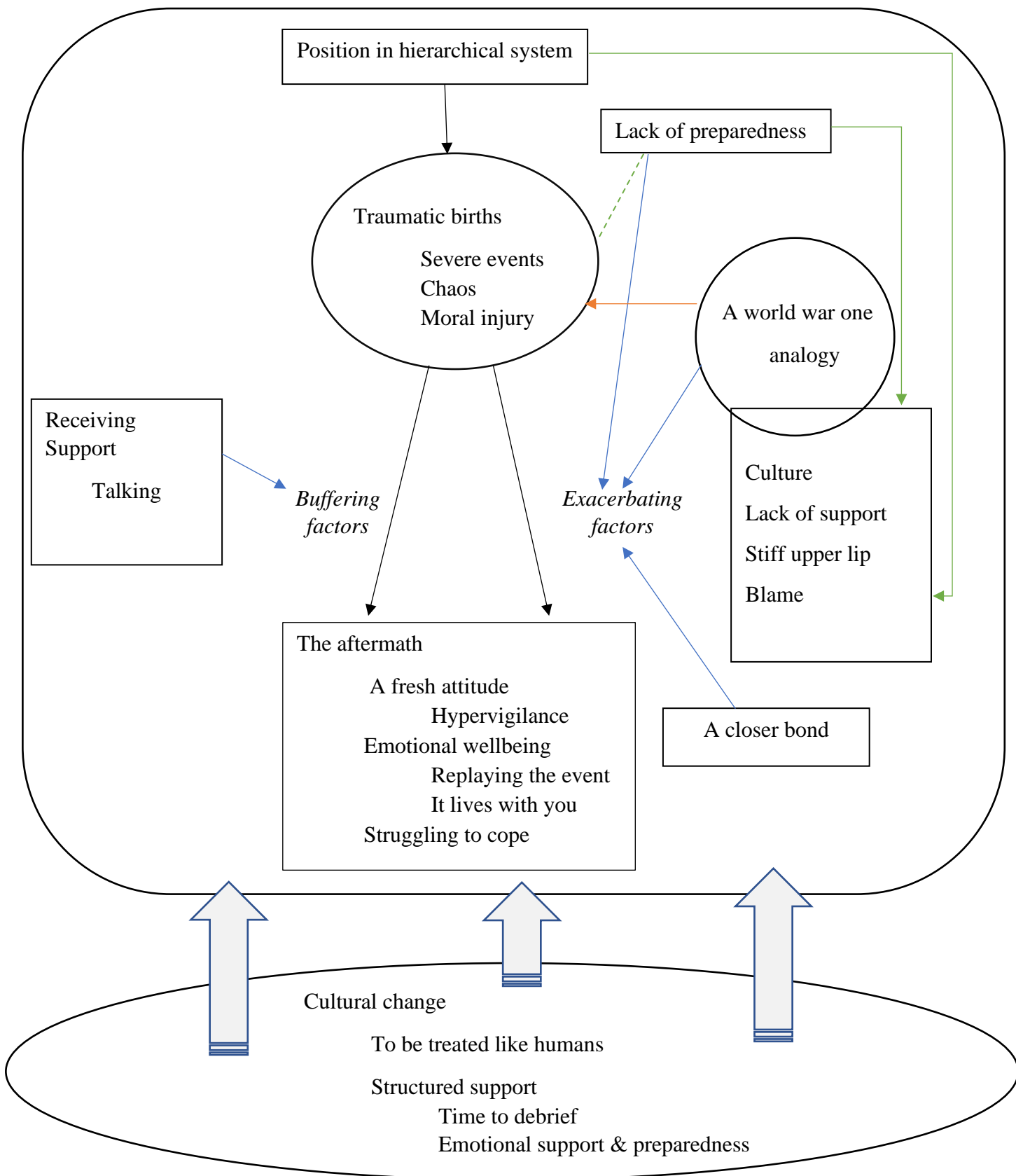
Grounded theory analysis generated six main themes with additional subthemes. Two theoretical models emerged (Models A and B), outlining:

- Factors which define a traumatic birth.
- Psychological and professional impacts.
- Exacerbating factors (worsening ‘the aftermath’).
- Buffering factors (lessening the ‘the aftermath’).
- Suggestions for cultural change within maternity organisations, allowing staff to access support following traumatic events.

Similarities and differences are explored in the discussion.

## Model A

### *The experience and impact of traumatic births: Midwives*



## 4.1 The midwives' model

**4.1.1 Traumatic births:** Three event-related aspects, which elicited feelings of fear, loss of control or helplessness, defined a traumatic birth.

**4.1.1.1 1) Severe events:** Unexpected events leading to death or long-term consequences for mother and/or baby.

P2 *'A life or death situation...serious harm of death. For the baby or the mum... the main one that I perceived to be the most traumatic that I have experienced was a maternal cardiac arrest in labour'.*

P13 *'The ones that I feel are traumatic, are the ones that have really unexpectedly poor outcomes for mother or baby'.*

Some felt traumatised regardless of the outcome, potentially due to feelings of fear, uncertainty, and lack of control during the event.

P7 *'The fact that I thought the baby was going to die and also...maybe the mum...the baby eventually came out, needed a little bit of resuscitation and was actually completely fine but I wasn't'.*

P12 *'...an out of control feeling, not being able to control things, not knowing what's going to happen'.*

**4.1.1.2 2) Chaos:** A chaotic environment resulting from poor team management.

P5 *'the times where the baby's fine at the end...those ones where its crappily managed or stressful and everyone is shouting at one another...I totally get it can be really*

*stressful but them setting up that environment as stressful makes the whole thing awful and traumatic’.*

*P4 ‘sometimes when it’s not normal, it’s not traumatic because it’s been well managed... it’s the chaos that is traumatic’.*

**4.1.1.3 3) Moral Injury:** Witnessing senior colleagues deliver unacceptable care and consequently being unable to advocate for the mother due to being overruled by senior colleagues.

*P3 ‘sometimes you feel like your hands are tied, and you find yourself becoming complicit in what’s happening, and I find that traumatic...If I feel the mum is not getting what she needs, or I’m not being able to give it to her, it’s the not being able to meet expectations that makes it traumatic’.*

*P4 ‘I think a lot of it is guilt. I feel like I’ve not done my job properly because I’ve not properly advocated for the women’.*

#### **4.1.2 The Aftermath:**

**4.1.2.1 A fresh attitude:** In the immediate aftermath, midwives described putting their emotions aside to minimise the impact on subsequent patients:

*P2 ‘you have to block it out temporarily and it is only later on that you think about it... I’m like a robot, I go in, introduce myself and tell them what the plan is. But I like to think I do that in a friendly open way regardless of how I’m feeling’.*

P3 *'I would just walk in with a new fresh attitude. Because when you walk into that room and you are with that family, you are like right this is new, and you forget everything that's just happened and carry on'.*

**4.1.2.1.1 Hypervigilance:** Some became hypervigilant in their practice over subsequent weeks to prevent further severe events.

P7 *'I felt like I would have done things sooner, like maybe if I was at a home birth transferring in sooner than I had to'.*

P2 *'definitely more hypervigilant. Obviously, I have to grant wishes...but sometimes part of me doesn't want to mention those things are an option because... in my mind I'm protecting them and me...'*

**4.1.2.2 Emotional wellbeing:** Sadness, anxiety, guilt, withdrawing from others, and feeling fearful about going to work were most commonly reported.

P3 *'It would be when I got home that it would hit me'.*

P7 *'I was terrified of being in that environment...I did go back after two weeks, but the idea of going back and doing births was awful'.*

P3 left the profession due to *'very low mood, (being) irritable, pessimistic, not looking forward to anything, stressed and anxious'* and P2 reported *'it's very easy to fall into a state of post-traumatic stress or even depression after it'.*

**4.1.2.2.1 Replaying the event:** trying to make sense of what happened and ruminating about what they could have done differently was experienced by all; interfering with sleep and eliciting self-doubt and self-blame.

P12 *'thinking about it, replaying it, thinking was there something different I could have done'.*

P4 *'I have laid awake, hot and cold oh my god, did I do that, contribute to that, continuously analysing what has gone wrong, which can be really unsettling'.*

**4.1.2.2.2 It lives with you:** Memories of traumatic events were long-lasting, particularly when the outcome remained unknown.

P11 *'I wonder about where they are and how the babies are, you worry but there's nothing I can do...there are certain people...they haunt you. The family were in my head for years'.*

P2 *'From years ago I still often think about families that I've been involved with, and you don't know what's happened to them'.*

**4.1.2.2.3 Struggling to cope:**

P2 *'It's more of you're not actually coping, you are struggling to cope'.*

Most midwives had not developed effective coping strategies. For some, leaving the profession, taking time off or breaking from clinical duties were the only ways to manage their wellbeing.

**4.1.3 Position in hierarchical system:** A hierarchical working structure was apparent. Midwives often felt undervalued and not listened to, due to being overruled by senior colleagues; eliciting a sense of hopelessness and lack of control. As a consequence, midwives spoke of being complicit in decisions which they deemed inappropriate, resulting in the aforementioned '*moral injury*'. Consequently, their position influenced their perception of traumatic births.

P5 *'This particular birth we had I did step in on several occasions, and unfortunately the doctor carried on even though I asked her to stop a number of times'*.

P3 *'The response I'd get from the doctors wouldn't be a positive one, my experience was that they felt their plan was the only option and were quite inflexible to any suggestions...It would mean that I would end up doing things I didn't feel comfortable in doing but knowing there was no point doing anything else because it was only going one way'*.

#### **4.1.4 Exacerbating factors:**

**4.1.4.1 Lack of preparedness:** No midwives had received any training relating to 'traumatic births' from the perspective of themselves or the mother. As a consequence, they were 'ill prepared' for the experience and impact of adverse events. It was hypothesised that '*lack of preparedness*' feeds '*traumatic births*'; this will be explored in the Discussion.

**4.1.4.2 Culture:** Problematic organisational cultures exacerbated the '*Aftermath*', due to barriers to accessing support following a traumatic event:



**4.1.4.2.1 Lack of support:** Midwives reported that the emotional impact following traumatic events is unacknowledged, and support systems are absent.

P4 *'When it comes to your feelings, your mind and your psychological wellbeing there is no real structure. They don't have an overarching reliable system in which you can say I know where to go to and who to talk to'.*

P12 *'There's nothing in place, not an appreciation that there should be an ongoing service that anybody can go to any time'.*

It was recognised that absent support systems *'can emotionally do people a lot of harm if there are no steps in the process that says if this happens someone needs to pull them aside, sit them down and say let's talk about this'* (P4). This left some avoidant of seeking help or choosing to leave the profession.

P12 *'I think because there is nothing in place, it's like you are asking for something out of the ordinary whereas if there was something dedicated in place and well signposted, you know'.*

P7 *'I had said I don't feel comfortable in going back in to the birth environment for a while at least and she just rang me up and said I'm moving you to this team, there was no we are going to support you...if I had been supported, I would have felt like I could have gone back again'.*

This theme reflected a systemic **'lack of preparedness'** for supporting midwives following traumatic events.

**4.1.4.2.2 Stiff upper lip:** Experiences reflected a ‘stiff upper lip’ culture, with no time or place for emotions and an expectation of resilience.

P3 *‘get your head down, get on with it, there is no time for emotions because it’s seen as a burden... another thing they’ve got to deal with’.*

P2 *‘It comes from a higher... from management that we signed up to do the job so we must expect these things and get on with it’.*

A ‘stiff upper lip’ permeated the profession. Seemingly midwives *‘don’t talk about their feelings (P7)’*, it’s *‘unheard of to be crying in front of each other, it’s seen as not an acceptable thing (P2)’*, and colleagues are largely unsupportive.

P4 *‘In 40 years of working in the NHS, I have never had a professional sit down and talk to me’.*

**‘Position in hierarchical system’** maintains this culture; midwives seemingly adopt this ethos and feel powerless to challenge these norms.

**4.1.4.2.3 Blame:** All midwives reported cultures of blame and gossip which prevent help-seeking, due to fears of judgement.

P13 *‘When you are on the labour ward it’s such a gossip culture, when something happens it’s so quick to get around the staff ... who was the doctor involved? Who was the midwife? That’s really difficult, that encourages a blame culture’*

P2 *‘The blame culture is so embedded... In my eyes people would start judging me and question why she is upset, did you do something wrong, why is she’*

*feeling guilty, that's why it led to a traumatic situation....not everyone knows what went on in the room, people talk, and think did she do something wrong?'*

Seemingly '**position in hierarchical system**' influences experiences of blame.

P4 *'we have to tell them where the midwife went wrong. The doctors already say it was the midwives' fault... the midwives weren't properly monitoring them, or the midwives didn't do this or do that...it's our fault when anything happens, when in fact it's the organisation or the NHS's fault'*.

**4.1.4.3 A world war one analogy:** A significant lack of time and pressures to continue working immediately after traumatic events prevented midwives from managing difficult feelings and seeking support. Seemingly this maintained '**lack of support**' and '**stiff upper lip**'.

P2 *'there is no time for any of that, because the situation is done, the patient is stable and you have to move on to the next patient because we are so busy... sometimes there's questions you wanted to ask, things you want to go back on but at the time it is too late...you still might have unanswered questions, or feelings you haven't dealt with'*.

P3 *'everyone was so busy that they are like well that happened go and look after that woman, because you know there was no time to reflect and get that support from the team'*.

P4 highlighted the damaging consequences of this work ethic, indicating that '**a world war one analogy**' influences the occurrence of '**traumatic births**'.

P4 *'It's like PTSD after the first world war, they recognised something was going on but getting these men back to the front was the priority and that's what we do in the NHS, it's a world war one analogy, we throw you straight back on to the front line'.*

*'In my view, 90% of all damage to women in hospitals is caused by the organisation rather than the individual, it is the way they are made to work'.*

**4.1.4.4 A closer bond** with the mother worsened the emotional impact following severe events. This was prevalent amongst community midwives.

P2 *'The closer bond you have, the more it does impact you, because you feel like you're a friend, so you see their relatives grieving or upset and you take that on yourself...it makes it harder to break bad news or be in that environment with them because you feel everything they feel'.*

P5 *'On labour wards you don't have the post-natal care, I don't know if it's now doing the job I'm doing, its more emotional...you see the aftermath...because I know them, I can't pretend healthy baby, healthy mum'.*

#### **4.1.5 Buffering factors:**

**4.1.5.1 Receiving Support:** A few midwives had received workplace support which helped manage the emotional impact. The past 'Supervisors of Midwives' initiative, which allocated midwives a supervisor to support them in practice and, for some, offered emotional support, was viewed as beneficial.

P2 *'There was something about supervisors of midwives, they were very special people, you felt like you could trust them, they understood it, they were good midwives'.*

*themselves, they were that maternal figure you share your emotions with and they would understand and they would listen. You got to know them over the years, you got to see them over the year, at least once. You built a relationship and that was really important’.*

Feeling supported by colleagues, receiving recognition, and opportunities to talk, also lessened the emotional impact:

P13 *‘I felt well supported. My team leader was very supportive...all the obstetricians, all the midwives, because we spoke a lot about it afterwards... I felt pretty well supported. We had the space to talk about it...there was recognition from our trust that it was a difficult experience’.*

**4.1.5.1.1 Talking** to friends, family, and trusted colleagues was viewed as most helpful. Discussing the event, receiving emotional support, feeling listened to and validated were key. Some midwives sought personal therapy or had considered accessing this.

P12 *‘It’s the talking it through..., we both find it helpful, we might need to do this a couple of times, and go back and think yes, I remember this and this...that’s when I can go into detail about the actual... and I have another good friend who is a social worker in mental health and so I often chat about, more about how I’m feeling about it’.*

P4 *‘I’ve got my partner so I can talk to him. I’ve got very good midwife colleagues so I can offload with them... you do need that safety valve, rather than bottling it up’.*

#### **4.1.6 Cultural change:**

**4.1.6.1 To be treated like humans** was key; to have basic needs met, be treated with compassion, and have recognition for the emotionally challenging aspects of their role:

P2 *'We need to be seen as humans, ok we have a job to do, but we have feelings and emotions as well... I don't think we are perceived as human and that's why there is no support'*

P3 *'It's treating people like human beings because at the moment it feels like you're a factory worker their ticking boxes, making the cogs turn, but there is no compassion for anyone'*

P12 *'An acknowledgement afterwards that this was traumatic, for everyone...more recognition, like on our annual training, that the mental wellbeing element is looked at and not excluded'*

**4.1.6.2 Structured support:** All midwives emphasised a need for structured support systems:

**4.1.6.2.1 Time to debrief:** Embedding routine debriefs to facilitate learning from the event and learn they are not to blame, was viewed as a valuable way to lessen emotional impacts:

P5 *'A structured debrief system is what people need. A lot of the time you need to go through the notes and say this is what happened at this point, this is what I did this is what they did, a lot of the time that's enough for you to go away and say no I did do what I should have done...then having a channel to seek support'*

P13 *'I think really good debriefing...if there was time that was protected and said this is an incident that has happened recently you may have all heard about it... this is having a review of the facts and thinking about what happened, in a non-blaming way, saying this could have been done differently, in a methodical way'*.

**4.1.6.2 Emotional support and preparedness:** Access to support services delivered by trained professionals was viewed as critical following a traumatic event.

P12 *'A dedicated service with trained staff. Speaking to someone who was trained, not just having to rely on whoever you think will have a conversation.'*

P11 *'Quick access to counselling...and perhaps that the counsellor's ability and skill mix is to deal with specific trauma'*.

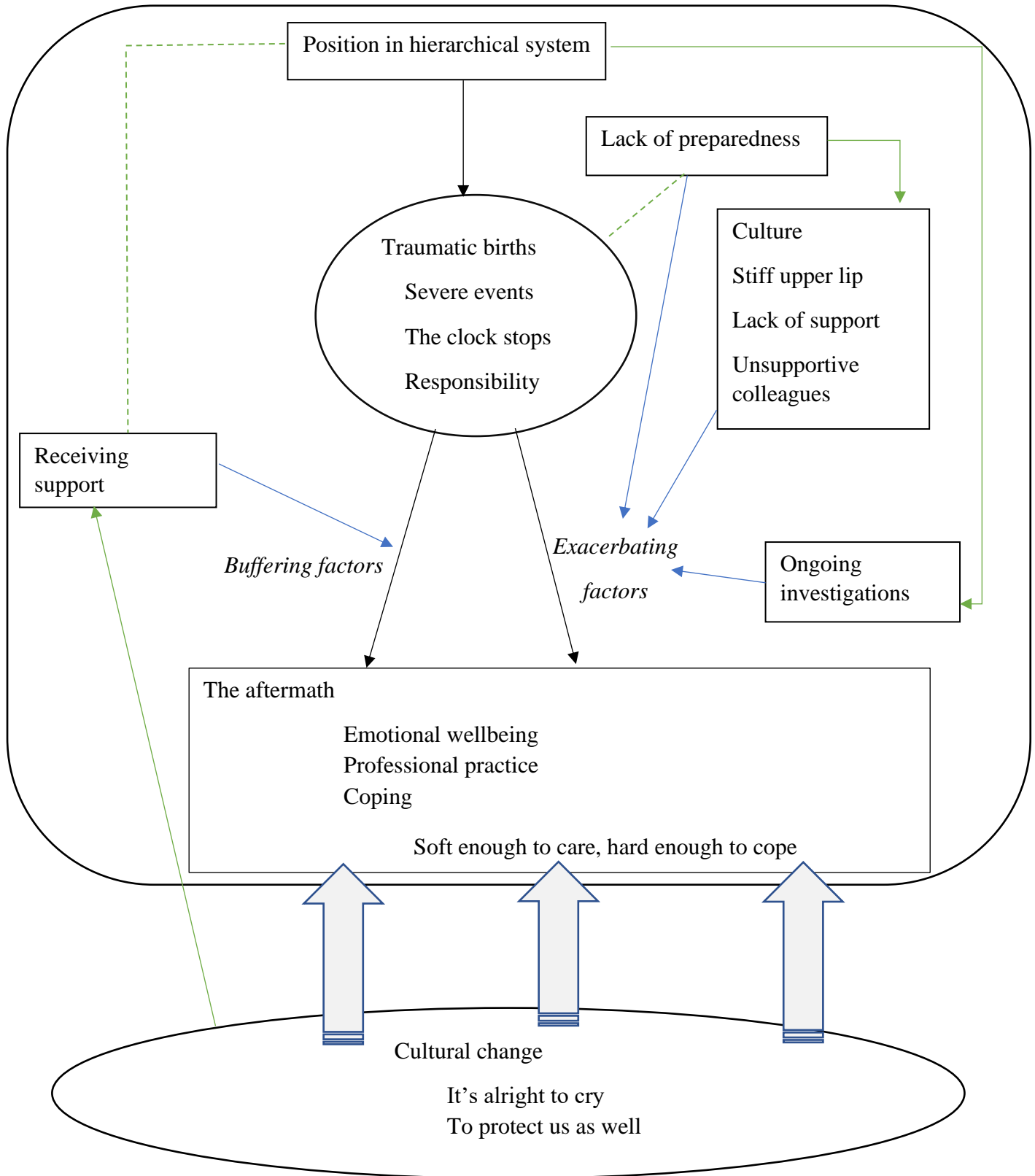
Midwives recommended that awareness of traumatic events should be embedded in training, to better individualise support and teach midwives skills to manage the emotional aspects of their role:

P2 *'Everyone will have different coping mechanism, there won't be one that fits all but working with people from day one to find out what best suits them and practicing it from the start'*.

P5 *'I feel like the students need to be given tools to be able to talk about it... you need to be taught it; we need those tools.'*

## Model B

### *The experience and impact of traumatic births: Obstetricians*





## 4.2 The obstetricians' model

**4.2.1 Traumatic births:** Three event-related aspects defined a traumatic birth.

**4.2.1.1 1) Severe events:** Events resulting in poor long-term consequences for mother or baby were perceived as most traumatic, in addition to problematic procedures, delivering traumatic interventions and witnessing distress.

P8 *'A still birth delivery, that's the one that really sticks out as a traumatic delivery'*

P14 *'You can see how frightened they are...for me you have to spend time looking them in the face and see how frightened they are, that's the bit that gets me'*.

**4.2.1.2 2) The clock stops:**

P6 *'The trauma is not necessarily related to severe outcomes, the trauma is related to the process of everyone struggling and sweating, the clock stops, and two minutes seem like a lifetime'*.

A stressful environment was key to the perception of traumatic events. Calm, well-managed events were perceived as less traumatic; facilitated by good team dynamics and perceived control.

P14 *'there are so many people in the room, there is so much going on, it is so noisy, that in itself makes it more traumatic because no one can hear what anyone is saying... I've done emergency deliveries but what makes it less traumatic is the calm and the atmosphere in the room and being able to talk to people because if you know they can hear you, you know your patient can hear you. You automatically feel like there is a better sense of control in the room'*.

P1 *'I didn't think that was traumatic...because we were on it that day, we had a drill'.*

P10 *'I didn't have the back-up of the second consultant...I felt like it was just me running around and I was trying to press on the anaesthetist we needed to go now, everything felt like I was pulling teeth and this doubt in my mind as I got the impression everyone thought I was overreacting'.*

**4.2.1.3 3) Responsibility:** Greater responsibility during the event was perceived as traumatic, particularly when obstetricians felt they could have done something differently to prevent the outcome:

P9 *'Once you become a consultant there is an expectation that you are the cavalry that's coming to save the day... as a junior you can look back and say call this person call this person, as a consultant there's no-one to call for help'.*

P10 *'The hardest cases, it's where I feel like I could have done something different...for example a few days ago, I was on nights and a woman walked in with a dead baby and massive placenta abruption which was horrible, but I couldn't change that. There was nothing in that moment that I could have done...It didn't cut into me, I went home and walked away'.*

*'Being confident that nobody else could've got a different outcome that day' (P1) and handing over to a senior clinician, lessened the emotional impact amongst registrars:*

P1 *'I think less so because the consultant was there when the baby died...often I think if I've called for the boss and they are there it's their ownership, in their situation'.*

This was influenced by '*position in hierarchical system*' through influencing obstetricians' perceived and actual responsibility during and following traumatic events.

#### **4.2.2 The aftermath:**

**4.2.2.1 Emotional wellbeing:** Obstetricians spoke of feeling extremely emotional, low in mood, tearful, and having difficulties sleeping. For some these consequences lasted months and, although they fade, the memories are long-lasting.

P6 *'I cried for about a month about anything, I found it very difficult...I don't sleep properly and I'm probably quite distracted'*.

P10 *'that's where the case sits with me and makes me cry. I remember...I cried my eyes out the whole way home... the first 6 months after that day I felt low'*.

P9 *'There are certain births where I still worry about the baby and how it turned out. Those memories are vivid it's like it happened yesterday, you have those memories, you know what happened, exactly what the junior did exactly what you did, and you are still worried as I hope the baby is fine, 5 years, 8 years down the road...Over time you get over it, but the memory comes back when you encounter a similar situation and those become war stories'*.

**4.2.2.2 Professional practice:** Some obstetricians felt unable to work efficiently immediately after and, over subsequent weeks, doubted their professional ability and became anxious in their practice. The potential impact on patient care was recognised:

P14 *'It makes it really hard to do your job for the rest of the day, because you don't really get time to process it before you have to move on and deal with someone else. It is difficult to concentrate...you find yourself distracted, you don't feel like you can give your full attention because you are still preoccupied, so I find that I work slower, it takes me much longer to get stuff done after that'.*

P1 *'It makes you more anxious in your decision making and you definitely overreact to things in the short-term'.*

P6 *'I think professionally it can make you very cautious, which makes you not look after patients properly because you assume every situation like that will have the same outcome, which is not good because it's likely to have been a rare occurrence'.*

**4.2.2.3 Coping:** Most obstetricians had not developed effective coping strategies.

Instead they would try to forget it had happened or cry, and give themselves time, knowing the emotion would pass. Two obstetricians had sought personal therapy.

P6 *'I still don't deal with it as well as I should, I still very definitely put it to the back of my mind and try to forget about it'.*

P10 *'I can manage initial upset because I know that will pass...I just went home and didn't sleep and cried...but I sort of knew it would pass and my feeling about it would pass, with time'.*

P4 *'I thought that I would get better at mentally dealing with them and I realise it's more of a cumulative event and the more things happen the more you realise you didn't deal with the one before, and it brings back more stuff you had forgotten.'*

**4.2.2.3.1 Soft enough to care, hard enough to cope:** Some obstetricians spoke of becoming emotionally detached from aspects of their work, and their patients. This was recognised as a coping strategy to help manage emotional aspects of their role:

*P10 'I think I am quite shut off in some ways...maybe that has got stronger over the years. I say that cos a couple of my friends I can tell them the technicalities of something, and it will make them cry, whereas I feel quite matter of fact about it. That makes me question myself because I think, have I got numb to this, should I be crying about this, or is it helpful to feel numb'.*

*P1 'Somebody said to me we need to be soft enough to still care, but hard enough to be able to cope. You think you are going to treat everyone like your sister or your mum but if you genuinely operated like that you would be a complete wreck'.*

*P8 'It's that self-talk, this is obstetrics, I need to carry on, we are here to serve them - this is what I say to myself. It's that psychological talk, don't get too attached, move to the next room'.*

**4.2.3** As is discussed in section 4.1.3, **Position in hierarchical system** influenced obstetricians' experiences of traumatic births. This was inferred from their experiences and not drawn from direct quotes.

#### **4.2.4 Exacerbating factors:**

**4.2.4.1 Lack of preparedness:** As described within midwives' experiences. See section 4.1.4.1

#### **4.2.4.2 Culture:**

**4.2.4.2.1 Stiff upper lip:** Obstetricians reported that maternity cultures are '*not known for having a really supportive culture*' (P1); consideration for emotional wellbeing is poor, and people rarely open up about their emotions.

P10 '*Even from day one as someone junior, fresh out of medical school, there was never any discussion about this will upset you and that's ok. We get training on so many other things and yet we get no discussion on how to cope, who to talk to, whether it's normal or not*'.

P9 '*We do not have a culture in the NHS or maternity of people opening up and having a group conversation for things that go wrong. They don't have anything which says you guys are working in a traumatic area, so we meet every two to three months to go through these cases or hear how people are coping*'.

Traumatic events are viewed as inevitable, and consequently obstetricians are expected to be resilient, and 'get on with it', with no time allocated to process the event.

P8 '*I broke down in the doctor's office and she said, oh what are we going to do with you, because this is how the culture is, suck it up and get on with it, we had to do it*'.

P14 *'you don't really get time to process it before you have to move on and do something else...deal with someone else'*.

**4.2.4.2.2 Lack of support:** Most obstetricians spoke of absent support structures following traumatic events. A few had been referred to Occupational Health, although experiences were poor:

P9 *'There isn't any true set-up that is designed predominantly for maternity where these things happen almost every two or three days, it doesn't exist because if you address the problem the solutions are time-consuming and expensive, so failure to do this makes the NHS run'*.

P6 *'I called occupational health... three or four times, finally got through and had to spell my profession to them, which made me think you are not going to have a clue what I am talking about...it put me right off and I never called them back'*.

**4.2.4.2.3 Unsupportive colleagues:** Lack of support from colleagues, gossip and blame were common experiences; recognised to worsen the emotional impact and discourage help seeking due to fears of judgement.

P10 *'I don't think anyone has ever come to me and said how are you feeling about that, do you want to talk about it'*.

P1 *'what was hard was that it was the topic of conversation on the labour ward, so it was like gossip about it and that really got to us... It would have been*

*really hard to say I'm not coping...I think on some level people would say if you can't take the heat you will have to get out of the kitchen'.*

P14 *'It feels like a witch-hunt and people constantly looking for who they can pin blame on. I think sadly it's still a blame culture'.*

**4.2.4.3 Ongoing investigations** and litigation prolonged emotional impact and prevented obstetricians from moving on, particularly when they were uninformed during these processes:

P10 *'It dragged on because I kept thinking I was going to be called up to do an interview...I didn't hear anything, no one told me anything. It was a good two months before someone said you are not going to be asked for an interview'.*

P14 *'Talking frankly, the paperwork, you have to write statements, there are clinicians waiting around corners finding out what you did and what went wrong. We live that event fifteen times in various forms with various people, all with a slightly different agenda. So, you can never really let it go...by the time all of that litigation goes through it could be a year or more for any closure'.*

**'Position in hierarchical system'** influenced this theme. Obstetricians are involved as a consequence of their role, yet powerless as investigations are led by senior colleagues.



#### **4.2.5 Buffering factors:**

**4.2.5.1 Receiving support:** Having a supportive team and receiving support from colleagues who had similar experiences and could offer reassurance lessened the impact of traumatic events.

P8 *'The difference was the consultant said it happens, it's happened to me and the chat I had with the consultant. She kept reassuring me and I wasn't that traumatised by that'.*

P1 *'Because I had a supportive team. The consultants were really supportive...I just cried on her shoulder, she just cuddled us like a child...what was helpful was when the consultant said to me, this has happened to me.'*

One obstetrician valued having an informal space for registrars to discuss difficult cases. Speaking with trusted colleagues, in a non-judgemental, non-blaming environment facilitated open discussion:

P14 *'You can be very honest in that group, and because you're all...on an even level you don't feel like anyone is ever looking at you to blame. I think the reason it works well is because it is informal and when you find people you trust you can talk...that's something we've all found quite helpful, and it's not in a judgemental fashion.'*

Another spoke about the value of using 'Hot' (emotion focused) and 'Cold' (learning focussed) debriefs following an adverse event:

P6 *'We try and do that within 72 hours of the event with as many people as possible. I was trained with a hot debrief to process emotions, tell each other who you are, what role you played in that scenario and you tell the story briefly about what you saw happening...It's largely about their experience and sharing different perspectives'.*

As indicated in the model, it was hypothesised that obstetricians' '*position in hierarchical system*' contributed to increased positive experiences of workplace support; indicating that small cultural changes had begun to occur amongst obstetricians.

#### **4.2.6 Cultural change:**

**4.2.6.1 It's alright to cry:** Obstetricians stressed that organisations need to normalise the emotional impacts following traumatic events, by facilitating open discussion about these experiences and where to access support.

P8 '*We need to be told it's alright to cry. It needs to be said, the culture needs to change. Make people aware of what support is out there because when the maternal death happened, I didn't even know what was available*'.

P10 '*I think culturally it must be different, that discussion about it. I've never been into an induction where someone has said you can talk about this, or these are the people to talk to*'.

It was recommended that trainees should be targeted, to embed this culture and prepare them for how to manage the emotional aspects of the role.

P1 '*I think stuff early on in training, I don't think anyone really said to us before that bad stuff is going to happen. Like I knew it was but, someone highlighting that. So that being the culture early on*'.

#### **4.2.6.2 To protect us as well**

P10 *'It has an impact on everyone, and whilst rightly there's a focus on mothers and their families, in the long term we need to protect us as well.'*

All obstetricians discussed the need for support following a traumatic event, to lessen the emotional impact, and maintain a healthy workforce, *'If people continue obstetrics will be a dying breed'* (P9). They spoke of needing *'support on the ground'* (P6); allowing staff to process the event, and support colleagues.

P14 *'Asking the managers for protected time is frequently met with 'no'...but that is something that needs to change to stop trauma impact building up. I don't see why we don't have it built into the day where there is a half hour handover period where if people need time to chat about what's happened that they can.'*

Offering support to everyone involved was viewed as a helpful way to overcome barriers to help-seeking and manage wellbeing before it deteriorates further.

P1 *'As a routine that they would sit down with you. That you didn't have to ask for it...then it's not you having to say you need support and admitting you are not coping, but for anybody that is involved in this situation you will need support so here it is. Getting people really early on to access stuff before it gets worse'.*

#### **4.3 Reflexive statement: The process of analysis and the end models**

I was extremely struck by the emotional impact of interviews and how my emotional response continued through the stages of transcription and coding. I felt a strong sense of need to maintain each participants voice, which seemed to link to my own feelings and how honoured I felt to be able to hear the participants stories.

Breaking down the transcriptions during the coding process was personally challenging as I didn't want to lose the reality of these experiences.

Throughout the process I continued to view the two groups as very separate- and as the models emerged I felt a sense of protection over the obstetricians' accounts, particularly in the context of seeming 'less impacted', being 'further up' the hierarchy, and sharing more positive experiences of support. During the interviews I didn't sense these differences, and I didn't want the research to portray a narrative that 'obstetricians fair better' in the context of traumatic events, when actually the differences observed were subtle.

On reflection I was struck by how similar the models were and recognise now that my preconceptions were that the models would look much more different than was found. However, despite this, keeping the models separate for the purpose of the research paper felt appropriate and was always an intention, as one of the research aims was to identify if obstetricians' and midwives' experiences differed. The subtle differences which did emerge are likely to have been masked if all the data was analysed together. However, I also think my desire to provide each participant and each group the space to voice their experiences has driven my choice to develop two separate models.

Two themes which require further reflection are 'position in hierarchical system' and 'a world war one analogy', mainly due to the potentially powerful, yet damaging implications in using these terms in the end models.

The theme 'position in hierarchical system' was drawn from the data amongst midwives, and within the obstetrician's model this emerged from processes which were drawn from the data. The theme portrays the impact of organisational structure

and captures how the presence of ‘power’ within the NHS is significant in the processes which contribute to the experiences of traumatic births and factors which worsen or lessen the impact. It is recognised that the phrase is likely to have been driven by the researchers’ experiences of working in the NHS, and preconceptions about the dominance of hierarchical working within this organisation. However, although ‘professional role’ or ‘organisational structure’ could be suggested as alternatives, the chosen phrase seemed to better capture and reflect the reality of the system and how damaging this is in the context of adverse events. Moreover, it is recognised in the wider literature that position in hierarchy is impacted by other factors, such as gender. Thus, this term gives more space for idiosyncratic experiences within the models, whereas other terms suggested would be more separate from the individual.

The theme ‘a world war one analogy’ seemed to be a true reflection of how midwives (and potentially obstetricians as discussed on pg. 116) experience their day to day working. Interestingly this also holds theoretical and historical links to PTSD, and ‘shell shock’ during world wars, and thus provides a true context and strong visual image of the ways in which midwives feel they are made to work- this theme felt true to the data. It quotes one of the participants responses, and I remember how powerful this felt during the interview. It strikes similarities to, ‘to be treated like humans’- the two almost go ‘hand in hand’ and highlight the impact of working environment on the experience of traumatic births.

## **5.0 Discussion**

### **5.1 Introduction**

This was the first UK study to explore both midwives' and obstetricians' experiences of traumatic perinatal events. A Grounded Theory analysis generated two parallel theoretical models. Overarching themes were similar across both models, highlighting key aspects relating to the event, psychological and professional consequences, factors which exacerbated or lessened these consequences, and the change needed for organisations to better support their workforce. Many aspects of their experiences aligned to the course of recovery amongst Second Victims (SVs) (Scott et al., 2009; Wu & Steckelberg, 2012), however fundamental differences emerged, which have not previously been reported.

### **5.2 Traumatic births**

Three aspects relating to the event, either occurring separately or collectively, defined a traumatic birth. Events perceived as traumatic were severe in nature, resulted in poor long-term consequence for mother, and/or baby, and occurred in a stressful and chaotic environment, indicative of poor team dynamics. Loss of control was associated with these characteristics across both midwives and obstetricians.

Witnessing inappropriate care and feeling powerless to intervene due hierarchical working were experienced as traumatic amongst midwives, leaving them feeling guilty and wishing they had acted differently. In a qualitative study, Rice and Warland (2013) described this as being 'stuck between two philosophies' (p.1058) of care', whereby midwives are traumatised as a consequence of being unable to practice within their philosophies due to the power of the medical model and hierarchical working. Severe events and witnessing abusive care have previously been reported to

contribute to midwives' perception of trauma (Leinweber et al., 2017; Sheen et al., 2016b). Amongst obstetricians, greater perceived responsibility (e.g., no-one more senior to hand over to) during the event was experienced as being traumatic, particularly when they felt they could have prevented the outcome.

This was the first study to explore how obstetricians define traumatic births. Events which were perceived as traumatic were similar to midwives' perceptions, eliciting a perceived lack of control, and helplessness; all of which are central to the perception of trauma (Ehlers & Clark, 2000) and have previously been reported in the context of traumatic perinatal events (Wahlberg et al., 2017). Key differences emerged as a consequence of position in a hierarchical system. This influence of hierarchical working within the event is concerning given it may compromise patient care, due to poor teamwork, and failure or reluctance to challenge senior colleagues (Green, Oeppen, Smith, & Brennan, 2017). This suggested that factors which influence the perception of traumatic events, may also increase the likelihood of occurrence.

### **5.3 Position in hierarchical system**

A novel finding was the theme, 'position in hierarchical system'. This influenced both the perception and impact of traumatic events. Rigid hierarchical structures are commonplace within the NHS, despite requests for these structures to be eradicated. These are embedded across the system in many ways, such as the business management of the organisation and the model of banding pay scales. Hierarchical structures are viewed as detrimental to the safety culture, as a consequence of preventing staff from speaking up in the context of adverse events and service protocol (Care Quality Commission, 2018). These structures rely on 'top down' processes of reform which prevent services and staff from leading on change

and improvement (Ham, 2014). Moreover, hierarchical structures are criticised for maintaining a blame culture, and due to uneven distributions of power and leadership, moving towards a 'just' culture is extremely challenging (NHS Resolution, 2019). Fitting with this model of working, NHS maternity teams will function within a hierarchical system, with those 'higher up' the system holding more power in decision making. In the context of the current study this would place participants in the ascending order of trainee midwife, qualified midwife, obstetric registrar and consultant obstetrician. It is also important to note that different professions will also 'rank' below trainee midwives, and above consultant obstetricians. Other factors beyond professional role (some unobservable) will also impact an individual's position in hierarchy (green).

As is documented globally (Pezaro et al., 2016) midwives spoke of dominant hierarchical structures, in which they are often overruled by senior colleagues, leaving them feeling powerless and helpless. This is concerning given that hierarchical structures may lead to subordination of midwives, bullying, ineffective team working, and may prevent midwives from developing confidence and leadership skills; factors which increase vulnerability to psychological distress (Begley, 2002). Although obstetricians may take a senior position in this hierarchy, the findings revealed that greater perceived responsibility and ownership, influences their perception of traumatic events and worsens the impact; this is consistent with previous research amongst SVs (Engel, Rosenthal, & Sutcliffe, 2006).

#### **5.4 The aftermath**



The impacts of traumatic events manifested both professionally and psychologically. Symptoms associated with PTSD (APA, 2013) were reported across both groups, including hypervigilance, guilt, self-blame, avoidance, and sleep disturbances. These responses are consistent with previous literature (Sheen et al., 2015; Slade et al., 2020; Wahlberg et al., 2017). Both reported increased hypervigilance in their practice over subsequent weeks, indicative of offering less choice or making decisions sooner. Increased anxiety around procedures and high rates of clinical intervention have previously been reported as consequences of traumatic events amongst obstetricians (Slade et al., 2020). These findings have not previously been reported amongst midwives.

The emotional consequences were amongst those previously reported within both groups (Sheen et al., 2016a; Wahlberg et al., 2017). These included feeling emotional, low in mood, tearful and withdrawn, in addition to doubting professional ability and blaming themselves. Replaying and ruminating about the event was common amongst midwives, whilst obstetricians would 'try to forget' the event had occurred. Both have been viewed as "maladaptive" responses to trauma exposure. In a study exploring ambulance workers' responses to traumatic events, both ruminating and suppressing memories were associated with greater symptoms of PTSD (Clohessy & Ehlers, 2010).

The findings revealed that midwives were impacted to a greater extent than obstetricians, indicated by feelings of helplessness, guilt, self-blame, work-related anxiety and longer-term deterioration in mood. Leaving the profession, taking time off sick, or a break from clinical duties were also more frequent responses. Although these consequences have previously been reported amongst obstetricians (Slade et al., 2020; Wahlberg et al., 2017) and SVs (Scott et al., 2009), differences have been reported.

When compared with obstetricians, midwives have reported poorer psychological wellbeing before and after traumatic events (Schroder et al., 2016), are more likely to take sick leave (Wahlberg et al., 2017) and find it more challenging to continue clinical practice afterwards (Schroder et al., 2019).

The current study provides insight into these differences. Firstly, the findings revealed that the position in a hierarchical system, resulting from professional role and dominance of the medical model, influences the experience of traumatic births. Midwives' position in the hierarchy results in an actual lack of control during traumatic events, whilst obstetricians have greater control over decision-making during the intervention. Thus, fear, perceived lack of control and helplessness may be greater amongst midwives, leaving them symptomatically more traumatised (Ehlers & Clark, 2000).

Secondly, the midwives' sub-theme, 'a closer bond', revealed that a greater emotional connection with the mother exacerbated the aftermath; consistent with previous findings (Rice & Warland, 2013). Greater empathetic engagement may increase vulnerability to traumatic stress (Figley, 1995) and has been associated with high levels of PTSD amongst midwives following traumatic event (Sheen et al., 2015). It is suggested that the midwife-mother relationship contributed to greater emotional impacts, whilst, the short-lived nature of the obstetrician-mother relationship may make empathetic engagement a lesser risk factor amongst obstetricians (Leinweber & Rowe, 2010).

Comparably, the sub-theme 'soft enough to care...' revealed that obstetricians may emotionally detach from aspects of their work. Previous literature has found that traumatic events can lead to desensitisation, distancing from patients, and withdrawal

from emotional intensity amongst obstetricians and midwives (Sheen et al., 2015; Slade et al., 2020) The current study did not find this amongst midwives, as has previously been reported. However, the current findings did map onto existing literature, indicating that emotional detachment may be a coping strategy amongst obstetricians. This is clinically important, given that distancing emotionally may inhibit the delivery of effective care, which is a key to mothers' experiences of traumatic birth (Ayres et al., 2016).

### **5.5 Exacerbating factors**

Maternity cultures played a significant role in exacerbating the impact of traumatic events; the presence of unsupportive and emotionally stifled and/or stifling cultures, prevent access to support and discourage help-seeking. This is consistent with existing literature which highlights the pivotal role of organisational culture, and management of adverse events, in terms of psychological outcomes for SVs (Quillivan et al., 2016; Ullstrom et al., 2014).

Having no access to formal support, a lack of support from colleagues, and the presence of gossip and blame, were reported to worsen the emotional impact in both groups. These factors have previously been associated with midwives' and obstetricians' perceptions of traumatic events (Sheen et al., 2016a, 2016b; Slade et al., 2020). As indicated in the current models, blame appeared more prevalent amongst midwives. It is argued that hierarchical structures in healthcare maintain a blame culture due to preventing learning opportunities following adverse events. As a consequence the occurrence of further error is increased, which leads to greater control and regulation from superior figures; strengthening the blame culture (Khatri, Brown,

& Hicks, 2009). Thus, it is hypothesised that midwives' experiences of blame were a consequence of their role within the hierarchy.

The findings provided new insights into organisational factors. A 'stiff upper lip' was identified as permeating the system and professionals' attitudes and behaviours. Both groups spoke about an expectation of being able to cope with traumatic events, as they are part of the job, and found themselves 'buying in' to this expectation. This stigmatised being open emotionally, leaving both groups avoidant of help-seeking due to fears about judgement of blame.

'A world war one analogy', a sub-theme amongst midwives, highlighted that a lack of time prevented opportunities for processing the event afterwards, leaving midwives with difficult feelings and, later, worsened mood and increased ruminations. To a lesser extent, this was also apparent amongst obstetricians. Seemingly this expectation was driven by senior managers and maintained by "unspoken" cultures. Slade et al. (2020) reported that obstetricians' coping following a traumatic event was hindered by not being able to process the event at work. Mental disengagement following traumatic events has previously been associated with greater symptoms of PTSD (Clohessy & Ehlers, 2010) providing insight into this finding and highlighting the consequences of this professional expectation. One midwife in the current study argued that working in this way compromises patient safety, bringing attention to the 'fourth victims' in the aftermath of an adverse event (Ozeke et al., 2019) and the finding that healthcare professionals are more likely to be involved in another adverse event in the initial four to twenty-four hours (Martens et al., 2016). This is captured within the model as 'a world-war one analogy' – feeding 'traumatic births' through potentially increasing both the likelihood of traumatic events and a chaotic environment. Moreover 'a world war one analogy' maintains the culture ('lack of

support' and 'stiff upper lip'); lack of time prevents the development and implementation of support systems, and there is no time in the working shift to seek or offer informal emotional support.

Amongst obstetricians, 'ongoing investigations' following severe events were found to prolong the emotional impact, preventing them from moving on, particularly when they are uninformed throughout. When providing feedback on the model, one obstetrician in the current study stated that time to completion of investigations is the highest stress factor for the teams (Appendix Ten). Ullstrom et al. (2014) argue that disorganised follow-ups prevent healthcare professionals from processing the event, thus prolonging the emotional impact. This theme seemed to be influenced by their seniority within the hierarchy, with more senior obstetricians speaking of this as a significant factor in the impact of traumatic events. Ongoing investigations were not discussed by midwives, although have been reported to impact their perception of traumatic events in previous research (Sheen et al., 2016b).

A 'lack of preparedness' featured in both models, indicating the absence of training about traumatic births. Both groups were ill-prepared for the aftermath of adverse events, which is reflected in absent or unhelpful coping strategies. It is hypothesised that a lack of preparedness influences the actual event - being poorly prepared for how to respond during an emergency may facilitate fear, panic, chaos, and poor team working. These models indicate that the unsupportive cultures described reflect a systemic lack of preparedness to manage adverse events in a way which prioritises both staff and patient wellbeing. Seemingly a systemic lack of preparedness begins at the top levels of NHS structure, within government and policy. Patient safety, quality of care, and treatment are viewed as paramount, and as a consequence staff experience and learning is given less priority; particularly given the challenging climate of the

NHS. When policy relating to staff experience does exist, commissioners can also be placed in situations where alternative policy takes priority (NHS, 2018). Naturally this permeates the whole organisation, leaving services and their leaders ‘unprepared’ and unable to manage adverse events in a way which considers staff experience. Moreover, the lack of power which is experienced by individual teams and staff prevent these issues from being addressed at a service level. **5.6 Buffering factors**

Few studies have explored what moderates the impact of traumatic events. Preliminary outcomes suggest that obstetricians’ value open and honest discussion (Slade et al., 2020) whilst midwives’ value emotional support, speaking to colleagues with similar experiences, and learning how to prevent similar events (Sheen et al., 2016a).

In the current study, receiving support was the only factor identified as lessening the emotional impact, across both groups. Midwives found talking to friends, spouses and trusted colleagues most helpful. Receiving emotional support, discussing the event, feeling listened to, and receiving recognition that the event was traumatic, were the most helpful aspects of talking. Seeking emotional support from non-judgemental/non-blaming colleagues who had similar experiences and could offer reassurance were viewed as being most helpful amongst obstetricians. A small proportion of both groups had found personal therapy equally helpful. Findings are consistent with research amongst other HCPs, following exposure to adverse events. HCPs are most likely to seek informal emotional support from colleagues, family and friends and are less likely to seek support from trained professionals (Edrees et al., 2011). Moreover, non-punitive workplace support (Quillivan et al., 2016) and sharing experiences with trusted, empathetic and non-judgemental colleagues (Chan et al., 2017) can significantly reduce psychological consequences. The differences which

emerged are critical for organisations to consider when developing support systems, to ensure they are tailored to individual needs; as discussed below.

### **5.7 Cultural change**

As has previously been reported (Sheen et al., 2015, 2016a; Slade et al., 2020), midwives and obstetricians voiced a need for cultural change to minimise psychological and professional impacts following adverse events. Recommendations aligned with Denham (2007) five rights of the SVs: **Treatment** that is just; **Respect**; **Understanding** and compassion; **Supportive care**; **Transparency** and opportunity to contribute.

Both groups requested routine emotional support. Obstetricians spoke of this being ‘on the ground’, with time allocated to process the event, whilst midwives suggested having a specific service delivered by trained professionals, in addition to routine debriefs to learn from the event and be reassured that they are not to blame. Seemingly it is important for midwives to hear that they are not to blame, and to receive support from someone outside of the team, whilst obstetricians require timely opportunities to process the event with colleagues.

The sub-theme ‘to be treated like humans’ highlighted that midwives felt they would better cope if they were treated with compassion and received recognition for the emotionally challenging aspects of their role. This also highlighted the need to change the ‘world war one analogy’. Obstetricians felt that it was critical to dissipate the view that emotion is a sign of weakness, through encouraging open discussion and help-seeking.

Interestingly, midwives seek change on a micro-level, specific to their role, and indicate a preference for confidential emotional support, whilst obstetricians suggest a

global shift within maternity services and seem less averse to support being received from colleagues. Furthermore, obstetricians recalled more positive experiences of workplace support, suggesting that small changes have already occurred. It is hypothesised that these differences are a consequence of obstetricians having greater control over the systems as a consequence of their seniority.

Factors which ‘buffer’ the aftermath, combined with suggestions for cultural change across both groups align with aspects of stepped care models of intervention for SVs (Jones et al., 2019; Scott et al., 2010), which have been piloted amongst midwives (Slade et al., 2018), and suggested for obstetricians (Slade et al., 2020). Findings suggest that this model of support would effectively address varying needs, such as education and self-help, peer support, and access to specialised support if needed.

## **5.8 Clinical implications**

Unexpected and severe perinatal events are not always avoidable. However, the current study revealed that the organisation plays a critical role in the perception and impact, of traumatic events. Disregard for psychological wellbeing, absent support systems, cultures of blame and judgement, unsupportive colleagues, an expectation to be emotionally resilient, and sources of organisational stress, prevent midwives and obstetricians from accessing support. As a consequence, both are left with the emotional burden of unprocessed events and professional practice is impacted, which may compromise subsequent mothers’ birth experiences. Furthermore, hierarchical structures, poor team dynamics, and a lack of preparedness may contribute to the perception that events are traumatic. Employers have the power to minimise these



consequences by addressing key issues. Thus, drawing on the current findings, the following recommendations are made:

- To address a ‘lack of preparedness’, trainees should be taught about the occurrence of traumatic births, from the perspective of the professional, the mother, and their families. This should include workshops focussed on monitoring and managing wellbeing, encouraging help-seeking, and providing information about where to access support. For qualified midwives and obstetricians similar training and workshops need to be accessible. Utilising education is an avenue to increase awareness amongst leaders and support them to embed change.
- To address a systemic ‘lack of preparedness’, organisations need to embed routine support systems following traumatic events. Including routine debriefs, informal peer support, and access to specialist support would meet the varying needs raised in the current study. Seemingly a stepped care approach (Scott et al., 2010) would be an appropriate, however it is critical that support systems are developed collaboratively with staff, and frequently reviewed, given their experiences and needs are likely to differ.
- Policy makers need to be active in responding to the needs of the maternity workforce. Funding needs to be generated to address staffing issues and workload, in addition to the structure of a maternity shift, to allow time to process traumatic events, and access support.

Recommendations are in-line with NHS initiatives, to improve staff wellbeing, maintain a healthy workforce (NHS England, 2016b); and for maternity services to facilitate the delivery of empathetic and women-centred, quality care (NHS England, 2016a). However, given the overarching impact of the organisation on the perception

and impact of traumatic births, fundamental aspects of NHS culture need to shift to allow for such recommendations to be possible. Healthcare organisations need to take accountability for the damaging consequences of hierarchical working structures, blaming and insensitive cultures, and recognise the detrimental consequences these have for staff wellbeing and patient safety. The dominant culture within the NHS fosters powerlessness and a lack of control amongst midwives and obstetricians; key tenets in the development of trauma symptoms. Organisations need to encourage help-seeking by shifting towards a ‘just culture’, and away from judgement and blame; flattening the gradients of hierarchical working and acknowledging the emotional aspects of the profession.

Barriers to embedding these recommendations are prevalent and provide explanation for why existing recommendations have not been acted upon. These may include, limited knowledge about the SV phenomenon, alternative priorities for NHS funding, and not having the staff or resources within individual teams to embed change. Furthermore, the dissemination of the current findings is likely to be met with defensiveness and viewed as potentially destructive for the NHS as the model’s name cultures which are harmful to staff, patients and the organisation.

Seemingly, it is not that policies focussed on these recommendations are totally absent, the challenge is creating change which enables these to become embedded in the workplace. Thus, without a system wide cultural change within the NHS, obstetricians, midwives and the mothers they care for will continue to be victims of the SV phenomenon.

One approach which has proven effective in addressing the dominant cultures which maintain the SV phenomenon is for services to adopt a business model of

workplace compassion (NHS England, 2018). Commissioning for workplace compassion is found to challenge hierarchical working, blame cultures, and improve staff wellbeing and patient experience. Enabling a compassionate workplace is found to flatten the gradient of hierarchy through equally distributing leadership and giving all staff a sense of power and permission to change aspects of the workplace. It is argued that commissioners need to enable this change; only seeking to procure services from organisations that can demonstrate compassionate environments, incorporating this as a contractual agreement which is monitored and evaluated, and including workplace compassion into service objectives and targets. Compassion needs to be modelled by everyone in the team, and embedded within core values, leadership style, and activities and actions. NHS England (2018) provides a support guide for embedding compassion across the organisation.

A proportion of NHS trusts (NHS Resolution, 2019) have also trialed different approaches to support a 'just' and learning culture following adverse events, which models openness and fairness, and removes blame from the individual. Learning is only possible in environments which are compassionate and enable people to speak openly without fear of judgement and blame. Utilising a checklist or framework to manage adverse events in the aftermath has been used as a simple, yet effective way to support organisations to begin to develop 'just' cultures. One example is the Restorative Method (Dekker, 2018) which asks three key questions (Who is hurt? What do they need? Whose obligation is it to meet this need?) referring to staff and the patients and families involved. This approach has been found to reduce the occurrence of serious events and disciplinary procedures.

Such processes provide promising approaches to addressing organisational factors which are detrimental to staff and patients in the context of adverse events. It

is evident that the initial stages of change require a top down approach, and for leaders to be motivational role models of behaviour change. However, once power and leadership are distributed across the system all staff have permission to contribute to change initiatives. Creating kind and compassionate environments seems critical to embedding existing frameworks and policies.

The role of clinical psychology could be instrumental in facilitating organisational change due to the diverse skill set that the profession offers. Clinical psychologists are able to formulate complex team dynamics which maintain problematic cultures and offer interventions to facilitate positive team working. They are able to facilitate conversations across the whole system and lead reflective practice spaces which can offer a psychological perspective and encourage open discussion and compassion for others. Moreover, they can offer psychological support following adverse events, and team debriefs such as Swartz Rounds (Goodrich, 2011). Clinical psychologist can also adopt a research role, contributing to business plans for additional funding and generating an evidence base to allow for support systems to be piloted. The additional benefits of utilising Clinical Psychologists are that they are able to be flexible in their role and prioritise their skills in a way which meets individual team needs. They are also working from an ‘outsiders’ position as their role is not placed within the existing team dynamics and hierarchical structures of individual maternity services, thus their ‘voice’ can be a powerful avenue to impact the system.

For the purpose of the study the generation of two separate models seemed key in the context of previous literature. This approach allowed equal space for both groups to have their experiences heard, without masking subtle differences. Although the models are largely similar, differences were found which highlighted the impact of position in hierarchy, and how different professional groups in the same system can

have different experiences and needs, in the context of adverse events. However, in practice, these models are encouraged to be used flexibly depending on the group of professionals to which the models are being shared. If a group is either midwives or obstetricians, then the relevant model can be used. However, if the audience includes a mix of obstetricians and midwives, the models could be amalgamated given they are largely similar, and both groups work within the same system. Within this approach wider discussions could be driven from the differences which emerge. In practice this approach is likely to avoid the amplification of splits across the two groups.

### **5.9 Strengths and limitations**

The study provides two qualitative models which can facilitate a better understanding and aid organisations in supporting maternity staff following traumatic events. New findings have been revealed, highlighting fundamental differences which can inform support systems. Attention has been drawn to the potentially damaging consequences that can occur, and which will continue if the issues raised are not addressed.

The research has also added to the wider literature, providing a greater conceptual understanding of the processes surrounding the SV phenomenon. The study has highlighted the benefits of utilising Grounded Theory when exploring the experiences of SVs. It provides a method which is explorative in its approach, yet also generates logical theoretical frameworks which can explain and compare the experiences of different groups of HCPs in the context of adverse events.

Constructivist Grounded Theory does not aim to explain the experiences of those not studied (Charmaz, 2008). However, it is important to be aware of sample context and methodological limitations when assessing the wider applicability of the

theories. The sample was predominantly white British heterosexual females. This is concerning given maternity staff from Black Asian and Minority Ethnic (BAME) backgrounds may be more vulnerable to becoming SVs, as a consequence of high levels of discrimination (NHS, 2020), and a disproportionate likelihood of facing disciplinary proceedings with severe outcomes amongst BAME midwives (RCM, 2018). Moreover, Slade et al. (2020) found that BAME obstetricians were at increased risk of developing PTSD following traumatic events. An underrepresentation of BAME participants is common in research, potentially due to barriers of language, differing beliefs between the participant and the researcher, stigma and lack of trust (Farooqi et al., 2018). It is plausible that experiences of victimisation, bullying, harassment, and increased likelihood of undergoing disciplinary proceedings whilst working within the NHS (NHS, 2020) prevented BAME midwives and obstetricians from participating due to issues of trust and safety in the context of disclosing work-related experiences. Recognising heterogeneity in BAME groups, conducting effective recruitment, ensuring cultural competency in the conduct of the research, and preparing grant funding which prioritises recruitment, are recommended to increase participation of BAME groups in health and social care research (Farooqi et al., 2018).

As discussed in section 3.5 it was unlikely that the themes which emerged reached theoretical saturation due to the small number of participants. It is argued that that theoretical sufficiency (Dey, 1999) was achieved, which was more realistic in the context of the current study. Theoretical sufficiency is argued to provide rich conceptual understandings of the data, and to better reflect how researchers conduct Grounded Theory (Dey, 1999). Moreover, although including both professions in one study restricted sample size the research has revealed pertinent differences which would have not been captured otherwise.

Using self-selected sampling via social media platforms was likely to bias the sample. Those who were drawn to participate were likely to connect with the term “Second Victim”, whilst those who do not access to these platforms will have been excluded. To overcome these limitations future studies could additionally recruit within the hospital setting to target a wider audience. Highlighting the rationale of research and ensuring potential participants know about confidentiality within the research process could lessen concerns about participation.

Various factors which were not captured in the study will have influenced how an individual perceives and responds to traumatic situations, such as prior beliefs, and experiences or personal traumatic experiences (Ehlers & Clark, 2000). Furthermore, many factors other than profession, influence someone’s position within the team hierarchy (e.g., gender/sex, personality, and education) (Green et al., 2017). These limitations should be considered when utilising the model; it can guide organisations as to how to target modifiable factors, but it cannot be assumed that ‘one size fits all’. Findings were not always consistent with previous studies. This may be a consequence of individual differences, differences in trauma symptomology, which were not captured in the current study; or when comparing with studies from health care systems outside of the UK.

Given the preliminary nature of this research, and limitations raised, it is critical for future research to expand the current findings by including a wider and more varied sample, across cultural and ethnic backgrounds, gender and sexuality. Research should also consider others working in maternity services, such as health care assistants, and admin staff, who are exposed indirectly to traumatic events. Maternity services need to support all staff to ensure a healthy workforce, and effective teamworking. Gathering feedback on the current models and identifying barriers to organisational

change would be an informative way to assess feasibility and encourage conversations about the findings within organisational contexts. Research can also happen within maternity teams, by reviewing existing policy, and gathering feedback from teams which have been effective in developing compassionate and 'just' workplace cultures in the context of adverse events. This method could inform how maternity teams begin to reform their services.

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## **Part 3: Critical Appraisal**

## **1.0 Critical Appraisal**

### **1.1 Recruitment and sample characteristics**

The initial stages of recruitment were successful, however the general level of interest from obstetricians was less than that from midwives and, due to Covid-19, recruitment was terminated early. The final number of participants was eight midwives and six obstetricians.

Recruiting via social media platforms was useful for targeting a large number of individuals in a short space of time. However, we cannot assume the majority of these groups access social media regularly, or indeed at all, so there will be a proportion of individuals who the recruitment post did not reach. Furthermore, those that shared the post showed interest in areas related to the field of 'Birth Trauma', and maternity care, which were closely aligned with the focus of this research project. Thus, those who participated in the current study might have exhibited greater insight into their experiences as a consequence of personal interest, and this may have influenced the findings. Targeting maternity services more directly could address these issues.

Participants' level of professional experience varied enormously, with trainee, qualified, community, and specialist midwives, plus registrar and consultant obstetricians taking part in the study. This was beneficial, particularly given the preliminary and explorative nature of the research; however, it is plausible that this masked differences between the groups. For example, whilst no pertinent differences emerged between community and inpatient midwives, community working is inherently different to inpatient working, particularly in terms of continuity of care and the number of births attended during one working shift. It is plausible that the pressure

to ensure I had explored community midwives' experiences in both settings prevented a rich exploration of how experiences of traumatic events might differ within in community working. Furthermore, given the influence of position in hierarchical system, and perceived responsibility, it could be assumed that differences would emerge between registrar and consultant obstetricians' experiences if larger sample sizes were used.

Participant characteristics were limited to predominantly White British female. In light of the current findings, midwives and obstetricians from BAME backgrounds may be more vulnerable to becoming Second Victims (SVs). This is due to high levels of discrimination experienced by NHS workers from BAME backgrounds (NHS, 2020) and a disproportionate likelihood of facing disciplinary proceedings with severe outcomes amongst BAME midwives (RCM, 2018). Furthermore, BAME obstetricians are reported to have an increased risk of developing PTSD following a traumatic event (Slade et al., 2020). Potential barriers to participation, and how research can address these issues (Farooqi et al., 2018) are discussed in section 5.9 of Chapter Two.

Given the beneficial clinical implications of this area of research, it is imperative that future studies address these limitations and explore the perception and impact of traumatic perinatal events across a broader sample in terms of culture, ethnicity, and professional role. This is critical to ensure that the necessary support is provided. Moreover, generating a broader understanding of how the whole maternity workforce experiences traumatic events has the potential to facilitate compassion for others and promote effective teamwork; factors which may contribute to flattening the gradient of hierarchy (Green, Oeppen, Smith, & Brennan, 2017).

## **1.2 The interview process**

I valued the steady pace of recruitment, as interviews were well spaced out, allowing me time to reflect upon each interview before proceeding to the next. This facilitated the process of refining my approach and identifying gaps and ambiguities within in the data to follow up subsequent interviews (Charmaz, 2008).

As a novice researcher I initially found it challenging to gauge my approach. As outlined in my research journal (Appendix Nine) during the initial interviews I noticed that I struggled to find a balance between adhering strictly to the interview schedule, and using it more flexibly, facilitating greater curiosity. After approximately five interviews I noticed that I had become confident and naturally curious in my approach and was able to use the interview questions more flexibly. The process of listening back to recordings, critiquing and adapting my response benefited this learning. As discussed in section 3.4.1 of Chapter Two, I recognised that I was avoidant of asking about ‘unhelpful’ coping strategies, as this question felt blaming and exposing of the participant. I was able to adapt my approach following supervision, and by including this question it was identified that, for both groups, coping strategies are largely absent.

I was struck by how the interview context impacted my approach and emotional response following the interview. Face-to-face interviews are considered gold standard in Grounded Theory methodology; providing more accurate responses and allowing the researcher to observe visual cues (Oltmann, 2016; Ward, Gott, & Hoare, 2015). Telephone interviews have been criticised for masking these aspects. However, in a qualitative exploration of participants’ experiences of completing telephone interviews within a Grounded Theory study (Oltmann, 2016) reported that

these were viewed as beneficial; participants felt more confident and less inhibited and found that the method facilitated rapport with the researcher. Lo Iacono, Symonds, and Brown (2016) explored the use of Skype to complete interviews within qualitative research. It was concluded that although video interaction cannot replace face to face interviews, this is an advantages alternative; a time efficient and affordable modality to reach participants internationally, increasing variability within samples.

In the current study, there was an apparent hierarchy of context: the participant's home; face-to-face at UCL; via skype or facetime, with the latter being the least anxiety provoking, In online interviews, I seemed to focus more on the interview schedule, but this did not seem to limit my curiosity. Face-to-face interviews, particularly those completed in the participant's home, felt more natural, as though I was talking with someone I knew. I felt more 'absorbed' in their experiences and noticed a significant emotional impact. Although Skype and Facetime have a visual image, it is plausible that my response in face-to-face interviews was a consequence of greater to exposure to richer non-verbal cues which were minimised in the other modalities. Seemingly there are advantages and disadvantages to each. However, using a variety of formats in the current study allowed flexibility; meeting individual needs and including participants from across the UK.

### **1.3 The analysis**

Initially, the prospect of conducting a qualitative study was daunting, as most of my prior experience was in using quantitative approaches. However, I soon realised the benefits of this approach, and found the process more enjoyable as a consequence.

Although it is traditional to conduct a literature review after Grounded Theory analysis, the timeframe of doctoral research does not facilitate this order. I started the

literature review when writing the research proposal and began working on the conceptual introduction during the early stages of analysis. However, after completing a large segment of this section, I recognised I was making links between emerging data and previous literature. It was important to bracket these insights to ensure that my analysis was not unduly influenced by pre-existing knowledge. Thus, I paused the conceptual introduction and returned to it following analysis. I feel that this benefited both the analysis and the conceptual introduction.

Although time consuming, transcribing the interviews verbatim allowed me to become immersed in the data, allowing me to record initial ideas, comparisons, and questions I wanted to explore. This was the first time I had coded interview transcripts using Grounded Theory methodology, and I was determined to ‘do it correctly’ and remain inductive throughout. First, I completed the analysis for midwives. Moving to the obstetricians’ data was a challenging step (Appendix Nine). Naturally, I had the midwives’ model in my mind, but it was fundamental that I bracketed this knowledge when analysing the obstetricians’ data. I managed this process well, and consequently the initial models looked very different (Appendices Seven & Eight). However, when reviewing the themes and models with the research team it became apparent that the models could be structured in a similar format whilst remaining true to the data; making them more accessible for clinical use, particularly when comparing experiences between the two groups.

During the process of analysis, I did notice the smaller sample of obstetricians as the themes which emerged appeared less robust than those within the midwives’ analysis. This is consistent with sample size and the acknowledgement that theoretical sufficiency opposed to theoretical saturation was achieved. However, this is important to consider when interpreting the results, as it is plausible that additional themes could



have emerged if sample sizes were increased, particularly for obstetricians. For example, I would predict that a similar theme to ‘a world war one analogy’ would have emerged had more obstetricians had participated.

#### **1.4 The results**

The study generated more new insights than I had expected. Subtle differences emerged between the current findings and previous literature, although this is expected given the preliminary nature of these studies. Furthermore, differences in countries, health care system, and individual factors are likely to have influenced the differences observed. Previous research has found responses to differ dependant on the presence of PTSD symptoms. However, in the current study there was no measure to assess the current wellbeing of the sample.

The most striking findings related to empathetic engagement and emotional distancing. Previous research indicates that empathy may be a greater risk factor to traumatic stress in midwives due to characteristics of the midwife-mother relationship (Leinweber & Rowe, 2010; Slade, Sheen, & Spiby, 2017). Current findings are indicative of this, as ‘a closer bond’ was identified as an exacerbating factor amongst midwives but not amongst obstetricians. Seemingly previous research suggests midwives may detach emotionally; a maladaptive coping strategy to manage emotional toil of the role (Hunter, 2016). Whilst this was found as an adaptive coping strategy amongst obstetricians in the current study, it was not found amongst midwives.

Previous research suggests that these two factors are connected, such that detaching emotionally is a consequence of the negative impacts of empathetic engagement (Joinson, 1992; Leinweber & Rowe, 2010). Although this is likely, it was

not indicated by the current findings. Instead, the findings indicated that those who detach emotionally to cope are ‘protected’ from the impact of empathetic engagement; whilst those who are impacted by empathetic engagement are unlikely to have developed the maladaptive coping strategy.

Position in hierarchical system is a dominant feature in both models. This theme provided significant insights into the differences observed between the two groups, and how damaging the hierarchical organisational structure can be to HCPs, patients, and organisations. It was also highlighted that holding more power within a hierarchy is not necessarily a positive experience. Although this may have fostered increased support amongst obstetricians, the associated responsibility within their role contributed to the perception of traumatic events. Given that this theme is preliminary, it is important to recognise that an individual’s position in a hierarchy is not impacted by profession alone; gender/sex, personality, education, ethnicity and a number of other factors will also contribute (Green et al., 2017).

It is important to recognise that the models do not incorporate individual and historical factors which are found to influence the perception and impact of traumatic events (Ehlers & Clark, 2000). These were not a specific focus in the current study, and more time would have been needed to fully consider personal aspects of the individual’s life within the interviews. Adding these aspects to the models may not be necessary, however it is important for organisations and individuals to have awareness of individual factors which may influence the perception and impact of traumatic events. Including this awareness within training would allow HCPs to consider whether they may be more vulnerable to traumatic stress, allowing them to better monitor their own wellbeing.

## **1.5 Covid-19**

The contents of the conceptual introduction, and findings of the study are extremely relevant in the context of Covid-19. HCPs globally will have been exposed to an increased number of traumatic events as direct and indirect consequences of this pandemic. Undoubtedly, organisational stress, work-related psychological distress and burnout will have increased as a consequence; factors which will influence the perception and impact of traumatic events. Maternity staff are likely to have been exposed to increased organisational stress and risk of own illness/that of colleagues/witnessed distress amongst mothers and their families, as a consequence of giving birth under the restrictions of Covid-19. Now is the time for organisations to address the needs of HCPs; this is critical to maintain a healthy workforce and ensure that patients globally are protected from the potential domino effect.

## **1.6 Implications for clinical practice and future research**

Despite the recognised limitations it is fundamental that organisations address the needs of midwives, obstetricians, and other professionals working in the maternity sector. There is a chronic shortage of midwives (RCM,2017), and the attrition rate of trainee obstetricians and gynaecologists is 30 % (RCOG, 2018). Furthermore, 4% of women experience PTSD after birth (Dikmen Yildex, Ayres, & Philips, 2017), and 20 to 48% of women will report their experience as traumatic (Ford & Ayers, 2011); the quality of care received contributes significantly to these experience (Ayes, Bond, Bertullies, & Wijma, 2016). If the NHS does not take responsibility, shift problematic cultures, and support maternity staff, there will be a continued vicious cycle between traumatised care providers, and traumatised mothers following birth.

Undoubtedly further research is needed, some of which has been discussed. However, organisations can begin to make changes based on the current evidence available. It is important that future research continues to explore aims of the current study, in addition to developing and piloting support programmes. Researchers should work with organisations and HCPs to identify barriers to embedding support systems and consider ways in which these can be addressed. Dominant cultures may pose a greater challenge; however, leaders need to be educated about the negative impacts and supported to facilitate change.

### **1.7 Conclusions**

The exploratory focus of this study has gathered new insights into midwives' and obstetricians' experiences of traumatic events. Although limitations are recognised and further research is needed, a key finding is that the psychological and professional impacts of traumatic events can be minimised via access to appropriate and timely support, which would potentially both be facilitated by and contribute to changes in professional cultures and hierarchies. Thus, at this stage organisations can draw on current, and previous literature to initiate change.

Undoubtedly, I have experienced a personal shift in my preconceptions of childbirth, and the experiences of those working in the NHS daily. Although the focus of these experiences was traumatic in nature, having this knowledge has only strengthened my passion to work within Perinatal services, in addition to using my role as a clinical psychologist to ensure the wellbeing of staff teams. It has been a privilege to share the experiences of those who participated, and I am hopeful that these insights will contribute to positive change.

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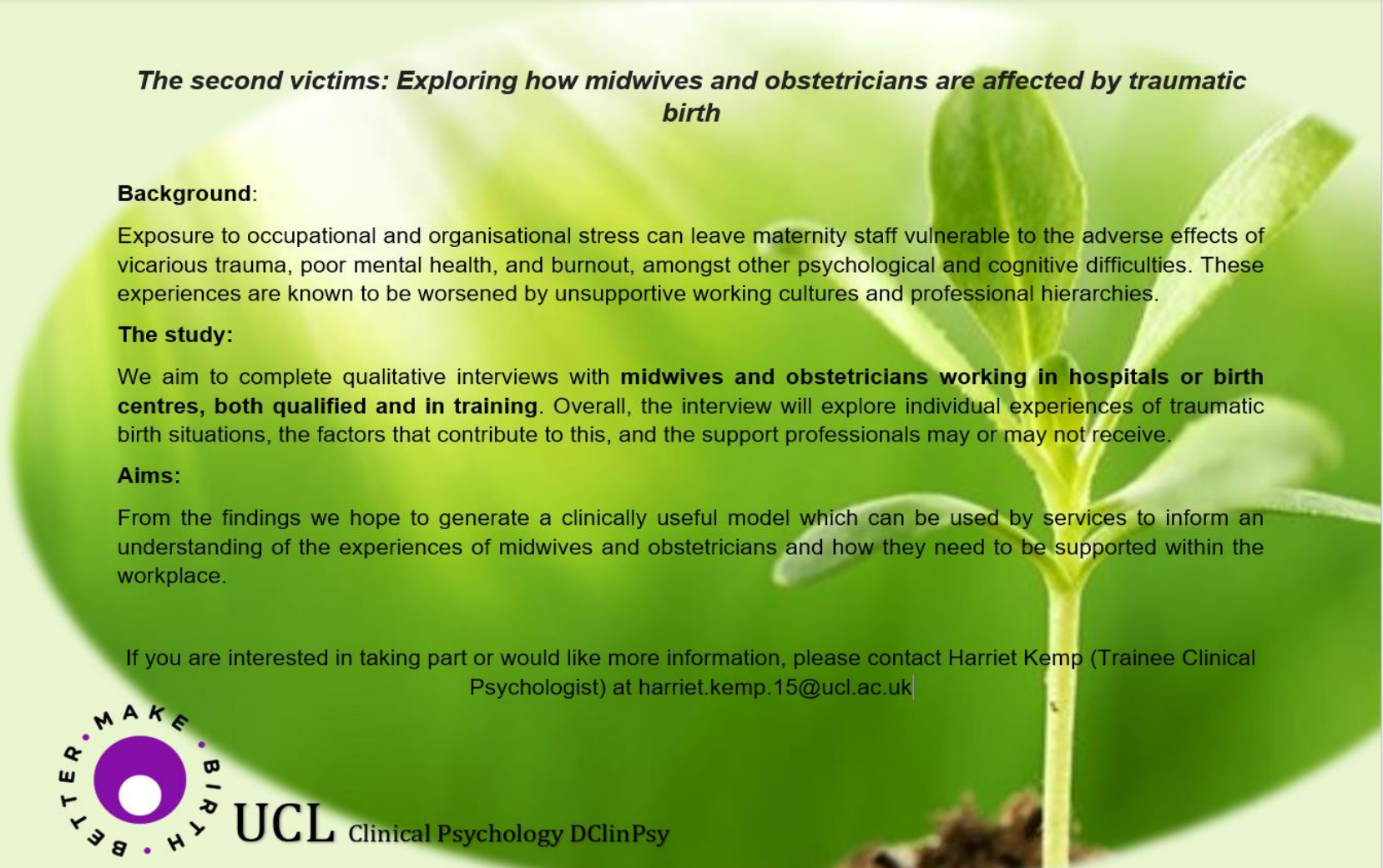
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## **Appendices**

## **Appendix One**

### Recruitment Flyer



***The second victims: Exploring how midwives and obstetricians are affected by traumatic birth***

**Background:**

Exposure to occupational and organisational stress can leave maternity staff vulnerable to the adverse effects of vicarious trauma, poor mental health, and burnout, amongst other psychological and cognitive difficulties. These experiences are known to be worsened by unsupportive working cultures and professional hierarchies.

**The study:**

We aim to complete qualitative interviews with **midwives and obstetricians working in hospitals or birth centres, both qualified and in training**. Overall, the interview will explore individual experiences of traumatic birth situations, the factors that contribute to this, and the support professionals may or may not receive.

**Aims:**

From the findings we hope to generate a clinically useful model which can be used by services to inform an understanding of the experiences of midwives and obstetricians and how they need to be supported within the workplace.

If you are interested in taking part or would like more information, please contact Harriet Kemp (Trainee Clinical Psychologist) at [harriet.kemp.15@ucl.ac.uk](mailto:harriet.kemp.15@ucl.ac.uk)



## **Appendix Two**

### Ethical Approval



27<sup>th</sup> February 2019

Dr Katharine Alcock  
Research Department of Clinical, Educational and Health Psychology  
UCL

Dear Dr Alcock,

**Notification of Ethics Approval with Provisos**

**Project ID/Title: 14965/001: The second victims: Exploring how midwives and obstetricians are affected by traumatic birth**

I am pleased to confirm in my capacity as Joint Chair of the UCL Research Ethics Committee (REC) that I have ethically approved your research study until **30<sup>th</sup> June 2020**.

Ethical approval is subject to the following conditions:

**Notification of Amendments to the Research**

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'  
<http://ethics.grad.ucl.ac.uk/responsibilities.php>

**Adverse Event Reporting – Serious and Non-Serious**

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator ([ethics@ucl.ac.uk](mailto:ethics@ucl.ac.uk)) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

**Final Report**

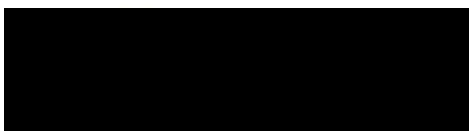
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.  
In addition, please:

Office of the Vice Provost Research, 2 Taviton Street  
University College London  
Tel: +44 (0)20 7679 8717  
Email: [ethics@ucl.ac.uk](mailto:ethics@ucl.ac.uk)  
<http://ethics.grad.ucl.ac.uk/>

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: <http://www.ucl.ac.uk/srs/governance-and-committees/resgov/code-of-conduct-research>
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely



**Professor Michael Heinrich**  
**Joint Chair, UCL Research Ethics Committee**

CC: Harriet Kemp

## **Appendix Three**

Sources of support provided at the end of each interview

## Sources of support

**The Doctors Support Network:** <https://www.dsn.org.uk/>

**The Midwives Haven:** <https://www.midwifery.org.uk/the-midwives-haven/>

**All4Maternity:** <https://www.all4maternity.com/>

**NHS Practitioner Health Programme:** <https://php.nhs.uk/>

You may wish to contact your Royal College or organisational body

### General mental health

**MIND:** [www.mind.org.uk](http://www.mind.org.uk)

**The Samaritans:** Freephone 116 123

**SANE:** [www.sane.org.uk](http://www.sane.org.uk)

**Rethink:** [www.rethink.org](http://www.rethink.org)



## **Appendix Four**

### **Participant Information Sheet**

UCL Research Ethics Committee Approval ID number:  
**14965/001**

YOU WILL BE ABLE TO KEEP A COPY OF THIS INFORMATION SHEET

**Title:** The second victims: Exploring how midwives and obstetricians are affected by traumatic birth

**Name and Contact Details of the Researcher(s):**

Dr Kat Alcock, [k.alcock@ucl.ac.uk](mailto:k.alcock@ucl.ac.uk), Harriet Kemp [harriet.kemp.15@ucl.ac.uk](mailto:harriet.kemp.15@ucl.ac.uk), Dr Emma Svanberg, [mumologist@gmail.com](mailto:mumologist@gmail.com)

**Name and Contact Details of the Principal Researcher:**

**Dr Kat Alcock**, Dr Kat Alcock, [k.alcock@ucl.ac.uk](mailto:k.alcock@ucl.ac.uk), 020 7679 5949

You have been invited to participate in this research study being conducted at University College London. Before you agree to take part, it is important that you understand the rationale of the research and your role as a participant. Please read through this information in detail and ask any questions you may have prior to making your decision.

**What is the study about?**

The study aims to explore how obstetricians and midwives experience, and are impacted by traumatic birth situations, the factors which contribute to this, and the role of coping and support. We are recruiting obstetricians and midwives which work within hospitals or birth centres, both who are qualified and completing training. It is anticipated that this research will help us to generate a clinically useful model which can be used by services to inform an understanding of the experiences of midwives and obstetricians and how they need to be supported within the workplace.

**What will happen if I take part?**

If you consent to take part, you will be contacted by phone or email to arrange an interview. The interview will take place at a date and location which is convenient to both the participant and the researcher. The interview is expected to last up to 60 minutes. The interview will be audio recorded and subsequently transcribed.

**What will I be asked to talk about in the interview?**

The interview will involve talking about your experiences of traumatic birth situations. You will be asked questions around factors which make a birth traumatic and how this impacts you personally and professionally. You will also be asked about coping strategies and sources of support, which may be helpful or absent.

### **What if I want to withdraw from the study?**

If you decide to take part you will be asked to sign a consent form, however you are free to withdraw from the study or withdraw your data at any time, without being asked to give a reason. Your participation is completely voluntary, and you may refuse to answer any questions or stop the interview at any time.

### **What are the possible disadvantages of taking part?**

It is possible that discussing difficult past experiences may cause you to feel distressed or emotionally upset. If you feel distressed at any time you are able to pause the interview, or fully withdraw as outlined above. As the researcher is a trainee clinical psychologist, they will be able to offer support if you do become distressed during the interview. There is also time allocated to complete a full debrief at the end of the interview and if needed you will be signposted to the appropriate sources of support.

### **What are the possible benefits of taking part?**

You may find it helpful to talk through difficult past experiences as this is known to have a therapeutic benefit. In addition, it is anticipated that the outcomes of the project will lead to a positive clinical impact through providing services with a better understanding of the experiences of midwives and obstetricians and how they are best supported. It is hoped that this will offer wider benefits to the professions.

### **What happens if there is a problem?**

If you wish to complain or discuss any aspect of the way you were approached or treated during participation, please contact Dr Kat Alcock, Principal Investigator of this project, who is based at UCL, Department of Clinical, Health and Educational Psychology, 1-19 Torrington Place, WC1E 7HB ([k.alcock@ucl.ac.uk](mailto:k.alcock@ucl.ac.uk)). If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee – [ethics@ucl.ac.uk](mailto:ethics@ucl.ac.uk)

### **Will taking part in this project be kept confidential?**

All personal details and information you provide will be stored securely and remain confidential throughout the course of the project. Your participation will not be identifiable within reports or publications of the outcomes.

### **Limits of confidentiality**

It is important to note that confidentiality will be adhered to at all times. However, if I hear anything during the interviews that makes me concerned that yourself or another person may be at risk of harm, I have duty to inform the relevant agencies of this.

### **What will happen to my data?**

The data collected will remain confidential and only be accessed by the researchers. The information gathered will be analysed to find common themes and generate a theoretical model of the themes. The content of the interviews will be anonymised prior to the reporting of the

results. If the results are published within an academic journal, your identity and contributions will remain anonymous throughout.

### **Data Protection Privacy Notice**

The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk). UCL's Data Protection Officer can also be contacted at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk).

Further information on how UCL uses participant information can be found here:

[www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice](http://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice)

Your personal data will be used for the purposes outlined in this notice. The categories of personal data used will be as follows: N/A

**Thank you for reading this information sheet and considering taking part in this research study**

## **Appendix Five**

### **Participant Consent Form**

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**CONSENT FORM**

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**Title of Project:** The second victims: Exploring how midwives and obstetricians are affected by traumatic birth

**Please complete the following questions about your participation and consent.**

Please initial all boxes

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
  
2. I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
  
3. I understand that relevant sections of the data collected during the study may be looked at by individuals from the research team at University College London. I give permission for these individuals to have access to my data.
  
4. I understand that the discussion will be audio-recorded for transcription and analysis and that the original recording will be destroyed once this is done.
  
5. I understand that transcripts will be anonymous, with ID numbers
  
6. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 2018.

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

## **Appendix Six**

### **Interview Schedule**

## Interview schedule

**Nb. Questions in italic are prompts**

### Introduction

- Check understanding of information sheet; informed consent; confidentiality any questions?
- Tell me briefly about your role and why you were drawn to the study?
- Is your role as you expected it to be when you decided to become a midwife/obstetrician?

### Traumatic births

- How would you define a traumatic birth in the context of your work?
- Have you been present during a difficult or traumatic birth at work? Tell me about it
- What is it about the birth that makes it traumatic?
  - *Factors during or following the event*
  - *Labour procedure*
  - *Factors relating to the mother, baby, family*
  - *Work environment/ colleagues*
- Have you been present at a birth out of your working context? How did you experience this?
- Have you received training in prevention or treatment of traumatic births?

### Impact

- How do traumatic births impact you?
  - *Personal impact*
    - *Mental health, physical health, personal life*
  - *Professional impact*
    - *Approach to care during the event, long-term impact, relationship with patient & family*
- What do you think makes the impact of a traumatic birth worse?
- What do you think reduces the impact of a traumatic birth?
  - *Personal factors, patient, event, workplace environment, relationships with colleagues, previous traumatic births, professional experience.*
- How has the way you react changed over time?
  - *What has influenced this?*
- What contributes to the decisions you make?
  - *Values, relationships with colleagues, previous experience*
- (If experienced birth in personal context) has this influenced how traumatic births impact you?

### Compassion and empathy

- What does empathy and compassion mean to you?
  - *How would you know you are being empathetic/compassionate?*



- Do traumatic births influence your ability to act in this way?
  - *How? (work related factors? Relationships with colleagues?)*
  - *What do you notice about how your practice is impacted?*
- Do you have training in compassionate care?

### **Coping/ support**

- How do you cope with your own wellbeing following in a traumatic birth?
  - *Helpful coping (therapy, social support, relaxation?)*
  - *Have you ever engaged in unhelpful coping (e.g. drinking alcohol)?*
- Do you have support at work/ Have you received support from work in the past?
  - *Tell me about this*
  - *What has been helpful/or unhelpful? Why?*
- Do you receive support from colleagues?
  - *How do they support you?*
  - *How do you support your colleagues in situations of a traumatic birth?*
- Do you feel confident to ask for support at work following a traumatic birth?
- Given your experiences what support do you think is needed?
  - *What needs to be considered when developing interventions*
  - *What could be different from current support?*
  - *Support during training*
- **FULL DEBRIEF, SIGNPOSTING IF NEEDED**

## **Appendix Seven**

### Process of Analysis: Midwives

## Example of line-by-line coding

Look for  Search In  Find Now Clear Advanced Find

**Nodes**

Name	Sources	Referen
A closer	5	16
avoi	1	1
a	3	5
bein	1	1
Kno	2	3
post	1	1
seei	2	2
AEQUIP	1	1
An inqu	1	1
automat	3	6
Benefits	1	1
Birth en	0	0
Cha	7	22
F	3	5
births o	1	1

P12

**which could make it less traumatic for you?**

I think and acknowledgement afterwards that this was traumatic, for everyone, and that doesn't always happen, and I know that, with junior colleagues, new colleagues I'll say to them are you alright do you want a chat, because I just don't think that's ever offered. We had something a couple of weeks ago where it was a preterm delivery, breach and the baby got stuck and died. So that's obviously traumatic. it happened on a night shift so you've got the women, you've got the midwife, doctors, neonatal doctors, and I can imagine what that would have been like. I know that something was offered for the doctors, but I don't know if anything was offered for the midwives. And I know it was difficult for the doctor because it was her responsibility for getting the baby born but it was again another reminder that, why isn't there anything there, an acknowledgement or. huh.

**Before I move on is there anything you would like to add about how you are impacted?**

Obviously other people might go off sick, cause it really really impacts them particularly if there is an element of malpractice

**Have you ever had to take time off?**

Comfortable no, I ended up leaving in 2012 for a year id had enough felt like I was burnt out, was really questioning if I still wanted to be a midwife. Left for a year came back to Scotland,

recognition the situation was traumatic  
A closer relationship with the mother  
maternity is an after thoughts  
Severe outcomes  
The mothers experience  
Talking  
Support  
Coding Density

In  Code At

HK 233 Items Nodes: 69 References: 151 Editable Line: 296 Column: 36 100%

## Example of line-by-line coding

**Sources**

- Internals
- Externals
- Memos
- Framework Matrices

**Sources**

- Nodes
- Classifications
- Collections
- Queries
- Reports
- Maps
- Folders

Look for:  Search In: Internals Find Now Clear Advanced Find X

Name	Nodes	References
P11	50	80
P12	69	148
P13 C	56	113
P2	76	173
P3	61	154
P4	41	71
P5 C	72	133
P7 C	57	100

P3 X

**How would you define a traumatic birth in the context of your work?**

Erm, either where there's physical harm to the mum or baby, where they are physically traumatised in some way, or where I've felt mum was not listen too, pressured, abused or not treated in a way that I feel she deserved to be treated.

**By other professionals?**

Yeah, or by myself, sometimes, sometimes you feel like your hands are tied, and you find yourself becoming complicit in what's happening, and I find that traumatic and sometimes I look at mums and they seem fine. Like you know that's birth isn't it, and I like Nooo, and I find it traumatic and it's almost like they don't find it traumatic. sometimes I think I find it more traumatic than families, sometimes.

**So when you say you have to react in a different way, have you got an example of that?**

**When I said acting in a way that I don't want to act?**

**Yes.**

For example, if for a vaginal examination if I'm looking after a mum and I can see she doesn't want one, she's given consent but I can see from her body language and demeanor that that isn't what she wants, I know that if I start saying you don't have to have it, and then if I

Coding Density

Support

own birth experiences

Mood

unable to make a difference

Advocating for the women

The mothers experience

In: Nodes Code At: Enter node name (CTRL+Q)

HK 8 Items Nodes: 61 References: 154 Editable Line: 24 Column: 57 100%

### Example of focussed coding

Look for  Search In  Find Now Clear Advanced Find X

Name	Sources	References
A closer rela	5	16
avoiding	1	1
avoi	3	5
being e	1	1
Knowing	2	3
post nat	1	1
seeing t	2	2
AEQUIP new	1	1
An inquest	1	1
automatic m	3	6
Benefits of t	1	1
Birth enviro	0	0
Chaos	7	22
Feeli	3	5
births out of	1	1

Chaos X

P11 (2) P12 (4) P13 C (4) P2 (3) P4 (1) P5 C (7) P7 C (1)

<Internals\IP11> - § 2 references coded [1.50% Coverage]

Reference 1 - 0.09% Coverage

everything is changing quickly

Reference 2 - 1.41% Coverage

So I suppose just being in that situation where you get the baby he was born and then you have to resuscitate you have your colleague with you, you have the ambulance there you have to get into hospital, you are still doing CPR, you've left mum at home and she's been separated from her baby because she still needs to deliver her baby. I had dad in the rig with me and then getting into an A and E department, you have a whole team waiting for you and you have to hand over what's

In  Code At

HK 7 Items Linked Sources: 7 References: 22 Unfiltered 100%

## Example of focussed coding continued

The screenshot displays a software interface for qualitative data analysis. At the top, there is a search bar with the text "Look for" and a dropdown menu. Below this, a search filter is set to "Nodes". The main area is titled "Nodes" and shows a list of nodes on the left and search results on the right. The node "Chaos" is selected, and its search results are displayed. The results are organized into sections based on internal codes: <Internals\IP2>, <Internals\IP4>, and <Internals\IP5>. Each section lists references and their coverage percentages. The interface also includes a status bar at the bottom showing "7 Items", "7 Sources", "22 References", and "Unfiltered".

Look for [ ] Search In [ Nodes ] Find Now Clear Advanced Find X

**Nodes**

Name /

- A close
- avo
  - bei
  - Kn
  - pos
  - see
- AEQUI
- An inq
- autom
- Benefit
- Birth e
- Cha
- births

Chaos x

<Internals\IP2> - § 3 references coded [1.09% Coverage]

Reference 1 - 0.11% Coverage

chaos in the resuscitation process

Reference 2 - 0.45% Coverage

Noise, everybody shouting, everybody knows their role and what actions to take but it suddenly still becomes a very stressful environment.

Reference 3 - 0.52% Coverage

how it is dealt with at the time, like I said some of them can be very chaotic, some not so chaotic, and that's all the environment factors that come into that.

<Internals\IP4> - § 1 reference coded [0.25% Coverage]

Reference 1 - 0.25% Coverage

sometimes when it's not normal, it's not traumatic because it's been well managed.

<Internals\IP5> - § 7 references coded [7.40% Coverage]

Reference 1 - 0.95% Coverage

In [ Nodes ] Code At [ Enter node name (CTRL+Q) ] X

HK 7 Items Linked Sources: 7 References: 22 Unfiltered 90%

## Example of focussed coding- exporting themes from NVivo into a word document

AutoSave  Off

Hierarchical working - Compatibility Mode Harriet Kemp HK

File Home Insert Design Layout References Mailings Review View Help EndNote X9 Search Share Comments

**Name:** Hierarchical working

**Description:** colleagues not supporting decision making

<Internals\IP11> - § 1 reference coded [0.53% Coverage]

Reference 1 - 0.53% Coverage

. I knew that something was going to happen on those wards because they just weren't safe, and I tried writing letters to senior people, meetings with obstetricians and senior midwives,

<Internals\IP12> - § 2 references coded [1.46% Coverage]

Reference 1 - 0.61% Coverage

I can be quite mouthy (laughs) as a newly qualified midwife and some qualified, I think some midwives don't feel they can stand up and challenge the doctors.

Reference 2 - 0.86% Coverage

Erm, not being listened too, there was an awful lot of stuff going on a staff bases, anonymous letters to MRC about managers, it was a toxic environment, so it was mainly, to do with colleagues and the working environment.

<Internals\IP13 C> - § 2 references coded [1.56% Coverage]

Reference 1 - 1.09% Coverage

I'm sure its getting better now, but I think, especially because often when you are quite junior, when an emergency happens you end up taking more of a back step and maybe just holding a women's hand. You might not be necessarily directly involved, but that doesn't mean that you haven't watched it and that you are not affected by it, but that maybe forgotten.

Reference 2 - 0.48% Coverage

But when you are looking at it you are thinking I'm involved, I am the midwife what could have been done. Having the outside perspective is also important.

<Internals\IP2> - § 3 references coded [2.04% Coverage]

Reference 1 - 0.82% Coverage

Yes I think depending on the skill set and some people within the environment can be more overpowering and oyu might want to make a decision or suggest something but immediately you get shut down because they are more senior and you must listen to them

Reference 2 - 0.71% Coverage

sometimes you feel like you are being told off in front of the patient, and you know then that makes you doubt yourself and you feel embarrassed in front of them, and then you think the patient will doubt my ability.

Reference 3 - 0.51% Coverage

Sometimes I take it as a personal dig, and I think f you have got any criticism or feedback that needs to be done away from patients after the situation.

<Internals\IP3> - § 13 references coded [10.24% Coverage]

Reference 1 - 0.73% Coverage

I know that if I start saying you don't have to have it, and then if I go outside and say she doesn't want the examination the midwife staff are likely to come into the room and persuade her to have that examination.

References 2-3 - 1.11% Coverage

Yeah yeah and that's worse because then they undermined me and then the mum looses her faith in me because the mum says well you said I didn't need an examination but that senior midwife said I do, and that's with no actual evidence or why but that's it its undermined what I said and effects the relationship I have with the mum.

Reference 4 - 1.03% Coverage

You are constantly trying to juggle everything and build a relationship with a mum you have never met before but at the same time understanding who is in charge on the ward that day, what are they going to say are they open to choice or are they like what's the point and everything has to be very medical

Reference 5 - 0.57% Coverage

It would mean that I would end up doing things are didn't feel comfortable in doing but knowing there was no point doing anything else because it was only going one way.

Reference 6 - 0.67% Coverage

basically I had no support from my colleagues, no one would listen to me, no one would let me allow her stay in the hospital they said she would have to leave and I felt so bad about sending her home

Page 2 of 4 At: 6.9cm 1474 words English (United Kingdom) 70%

## Example memos exported from NVivo

### **Name:** *Colleagues abilities and actions*

*This node overlaps with 'advocating for the women'*

*observing these situations is hard, but also the element of not being able to step in  
does this link to being undermined or the apparent hierarchy?*

### **Name:** *unable to advocate for the women*

*Significant theme about midwives finding it traumatic when they are unable to advocate for  
the women, give the women what she needs/wants, intervene or challenge inappropriate  
procedures*

*seems to be influenced by superiority*

*not being able to give a mother what she wants or what she needs, knowing she doesn't want  
something, but she is saying otherwise*

*There seems to be a link/cycle between 'not being able to speak up' --> being  
silenced/undermined by colleagues exacerbates not speaking up or learned helplessness, then  
have to witness women receiving procedures they don't want, which is traumatic for the  
midwife?*

### **Name:** *Lack of acknowledgment*

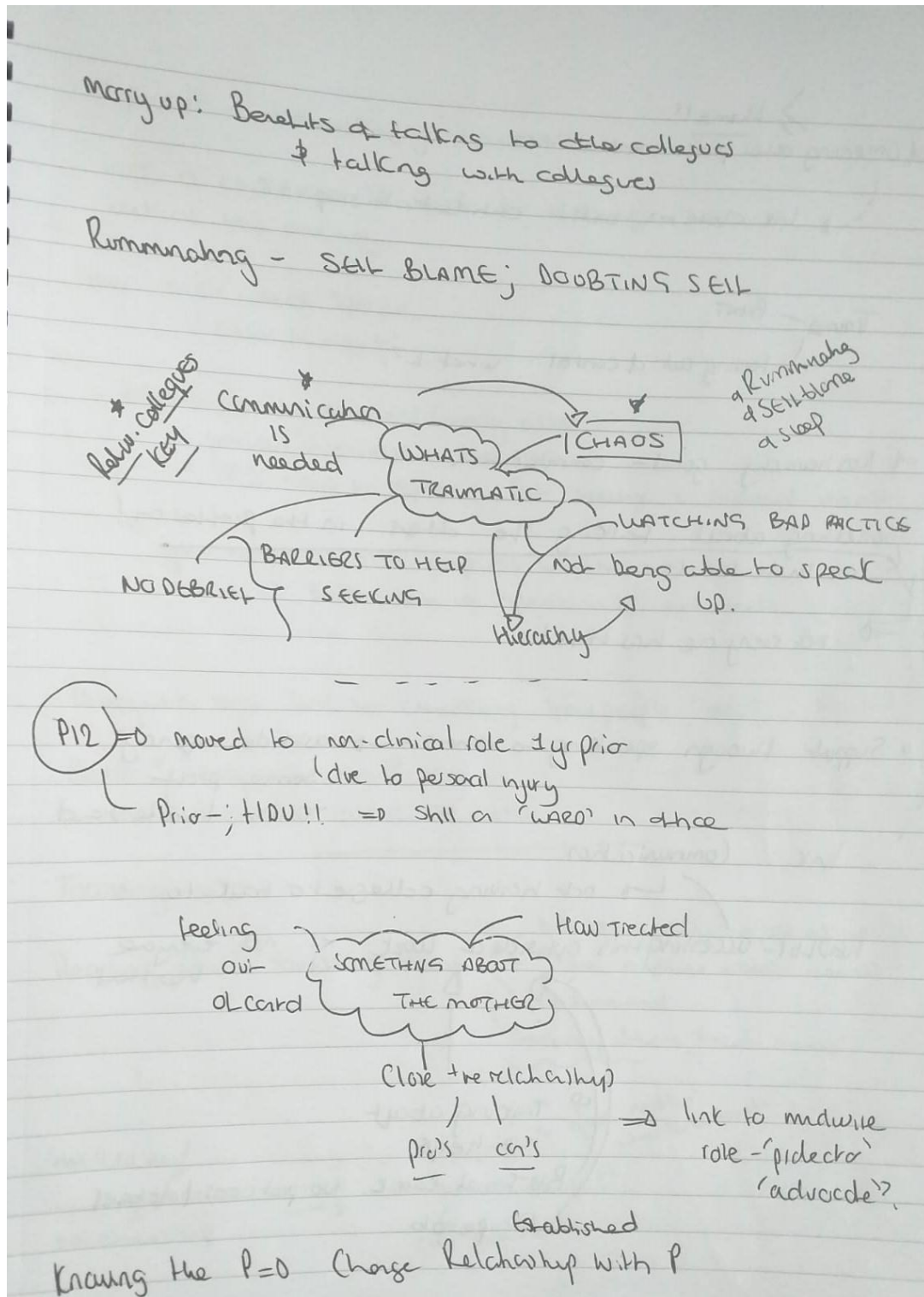
*Renamed node to lack of acknowledgement- drawing 2 notes together, as it seems that the  
impact isn't recognised as need for support is not acknowledged/offered. The traumatic  
nature of the event isn't recognised by the organisation.*

*Additional lack of acknowledgement in the environment, and from colleagues*

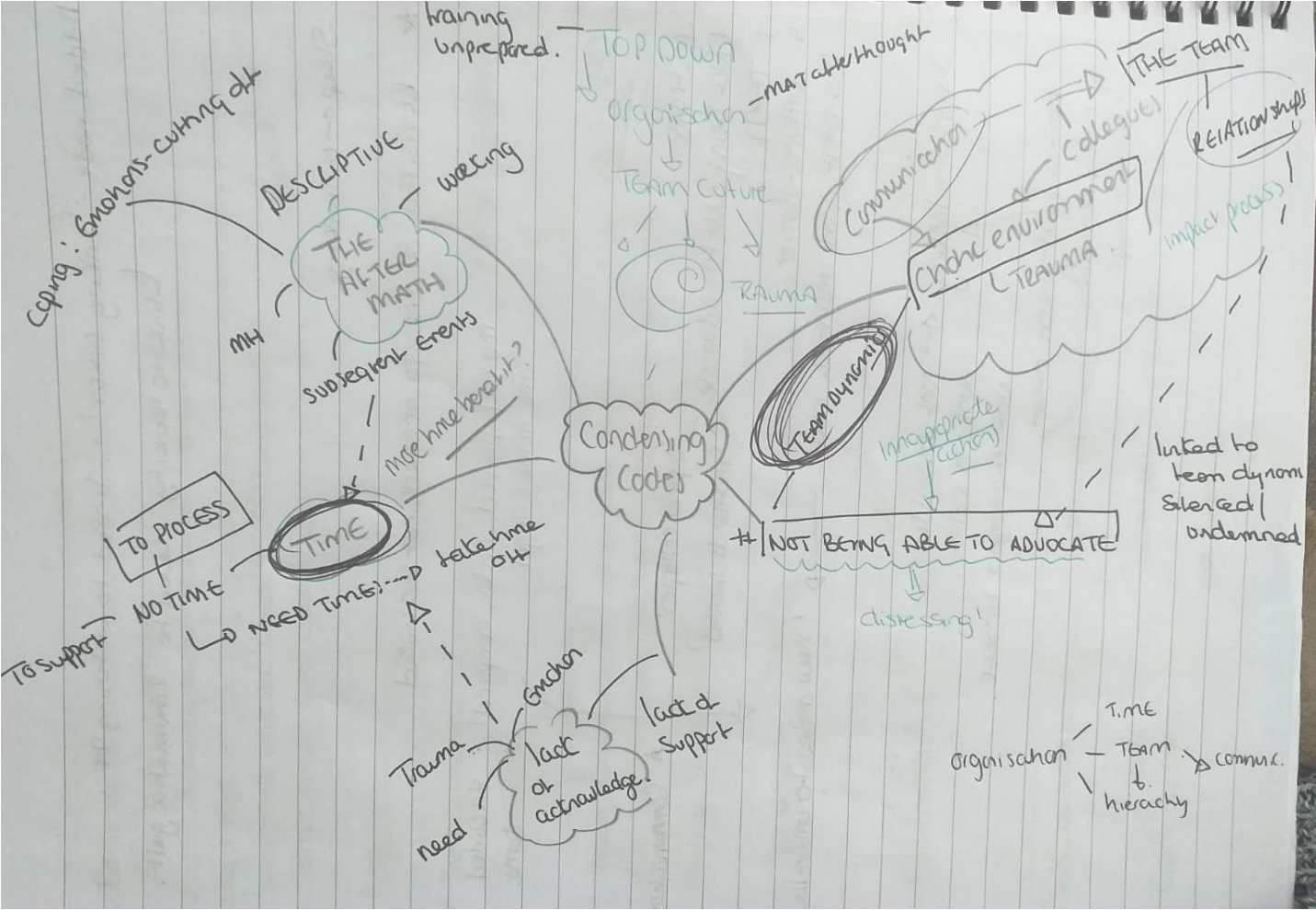
*Overall lack of acknowledgement is a potential barrier to asking for support and causes  
midwives to be silent*



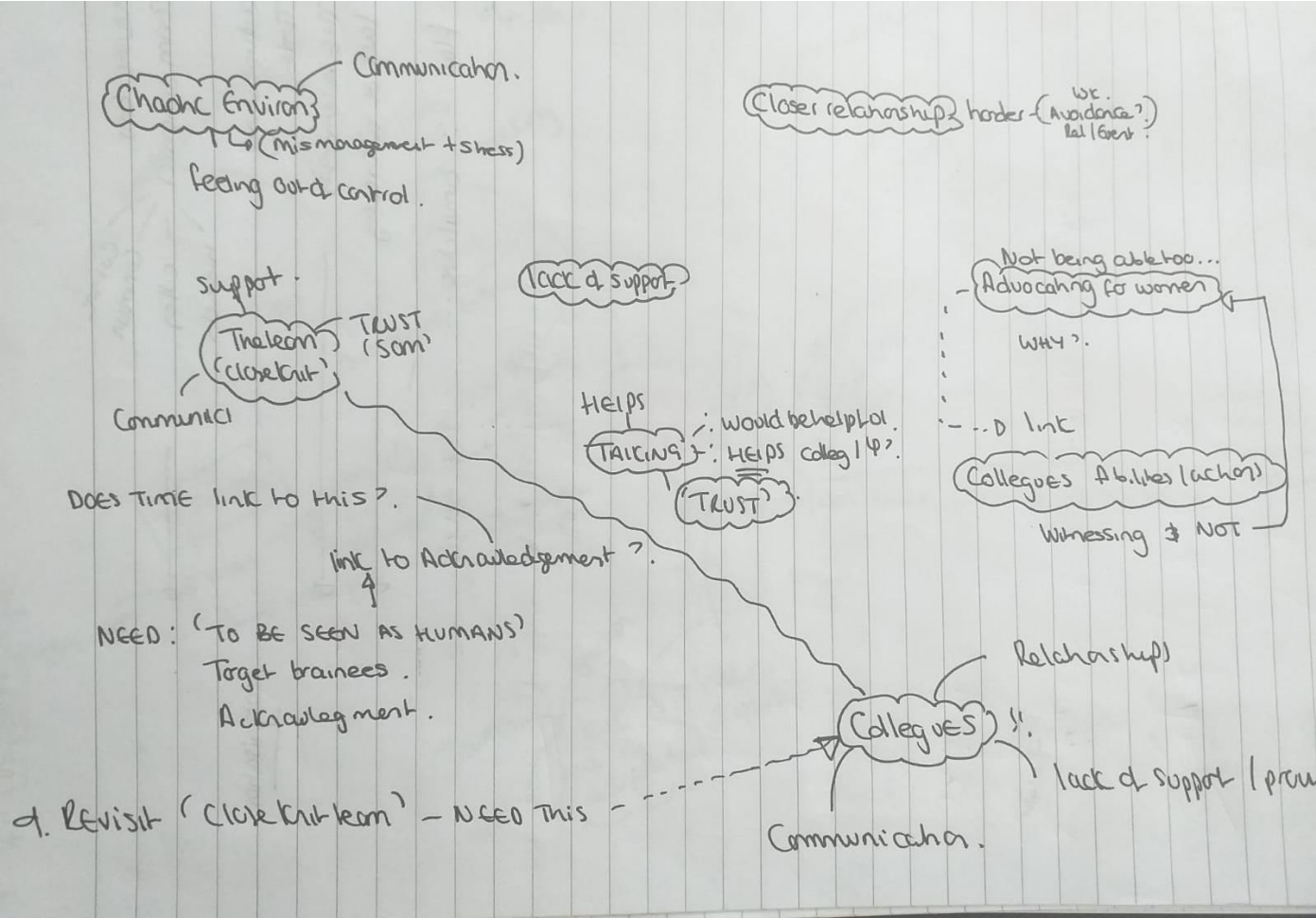
**Example of diagramming**



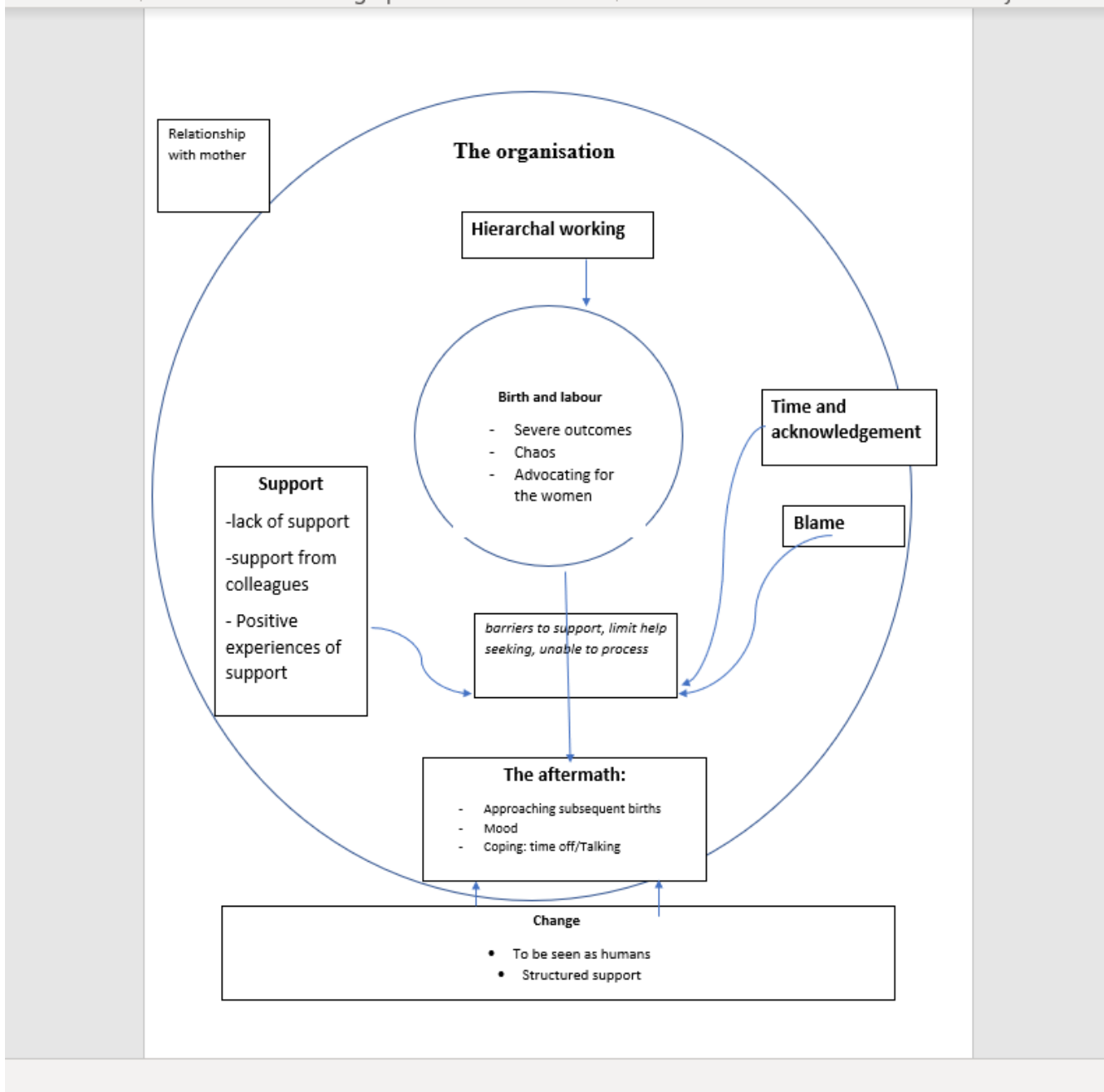
Example of diagramming



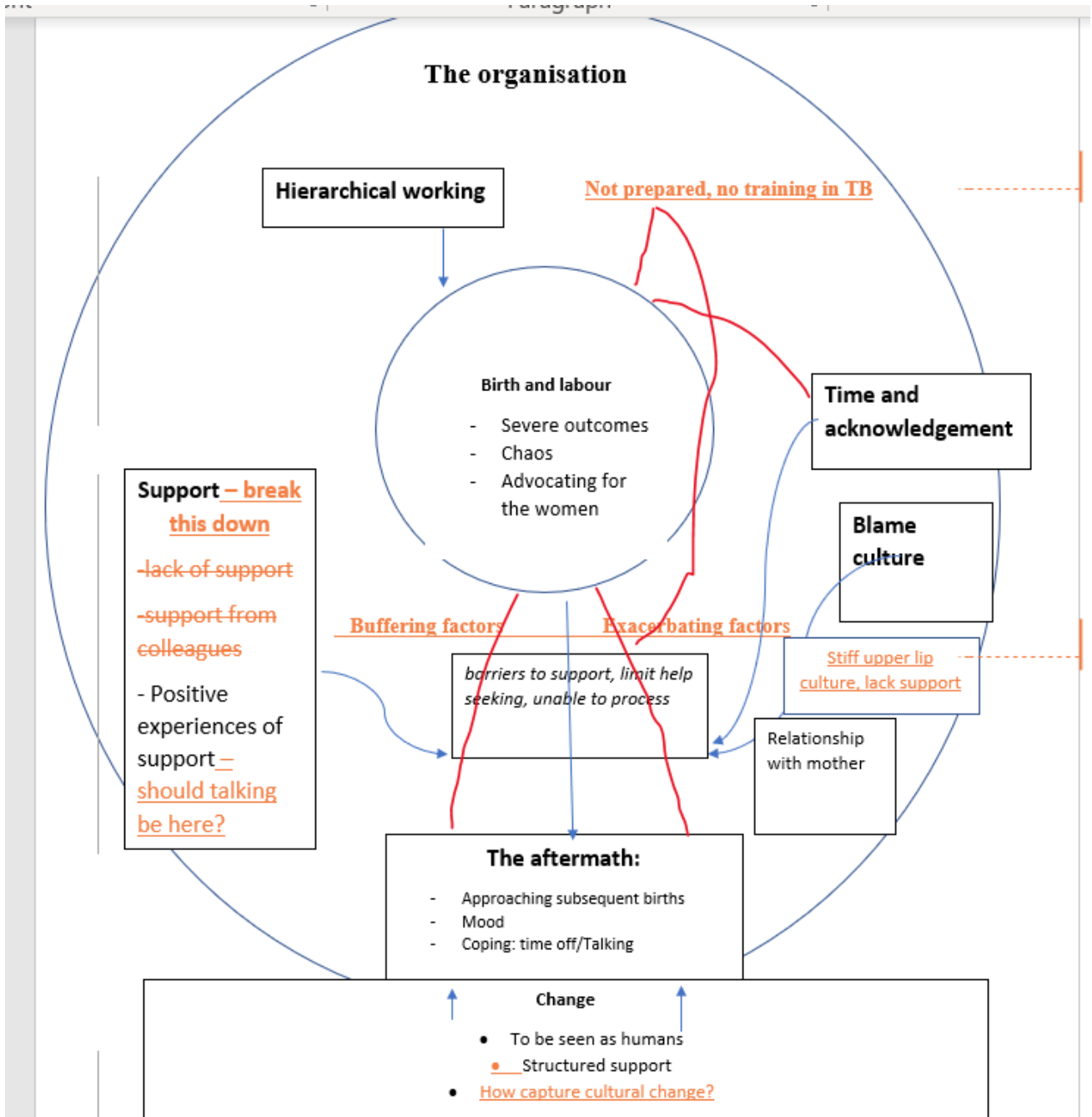
Example of diagramming



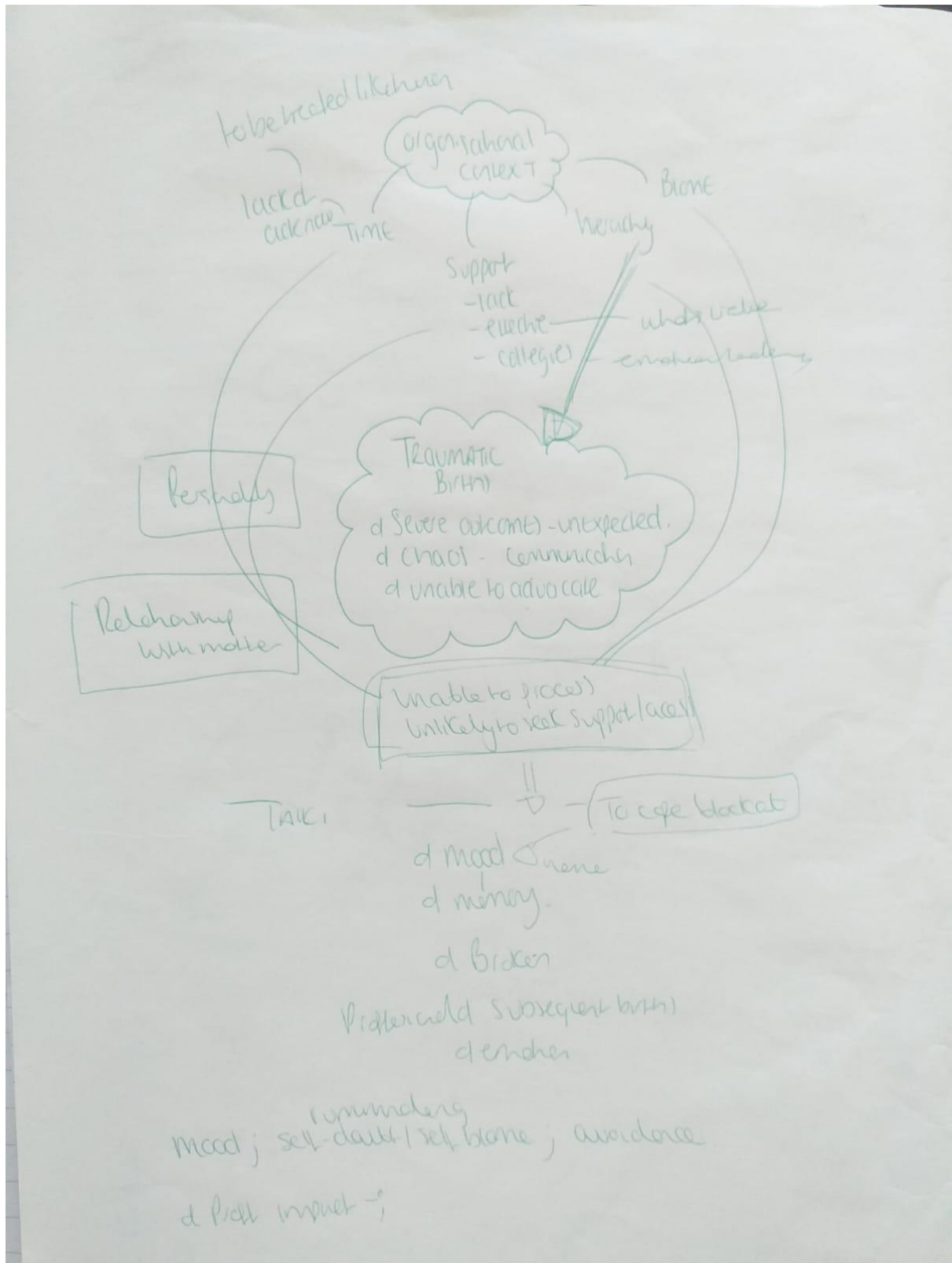
## Development of midwives' model: First draft



## Development of midwives' model

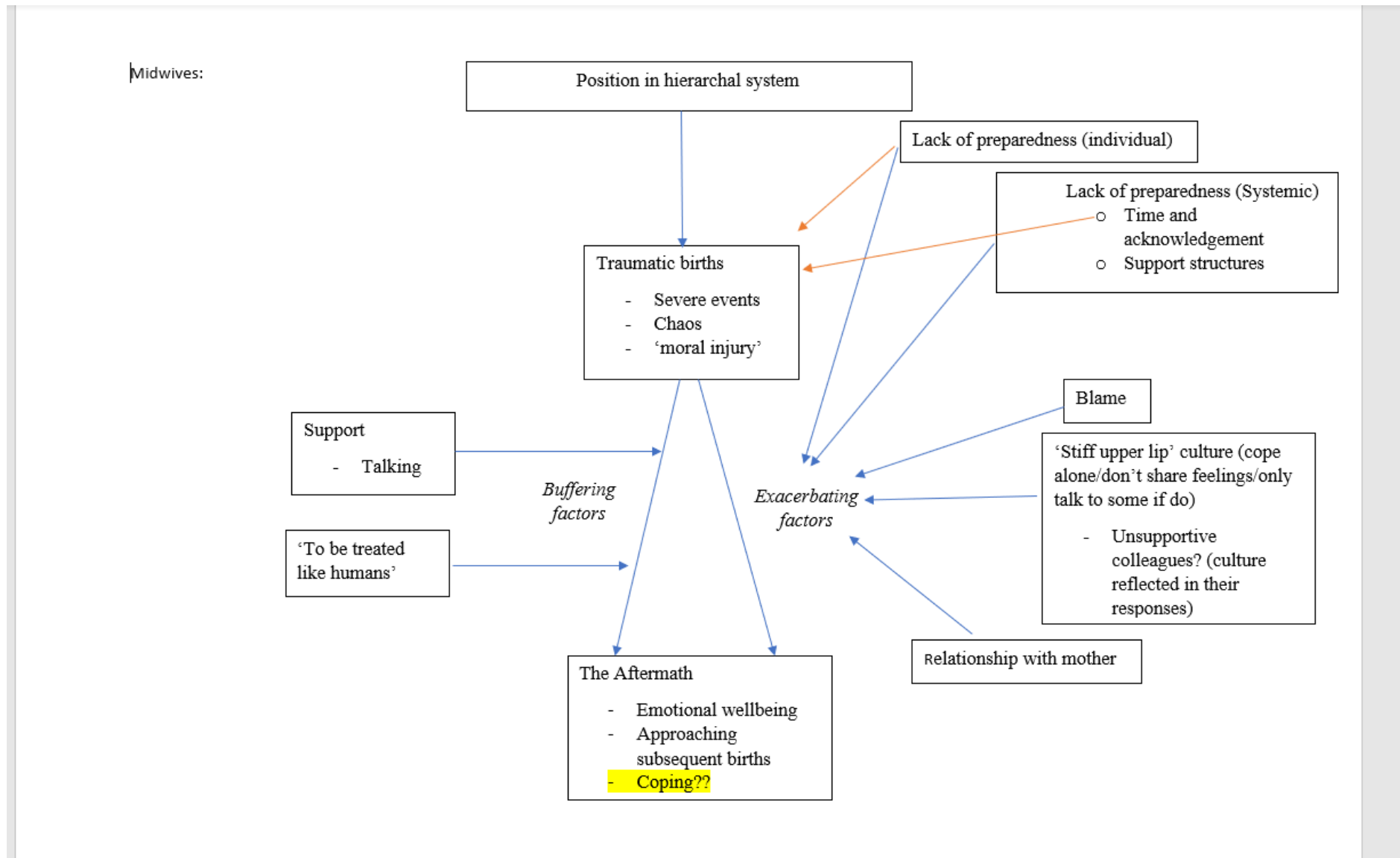


# Development of midwives' model

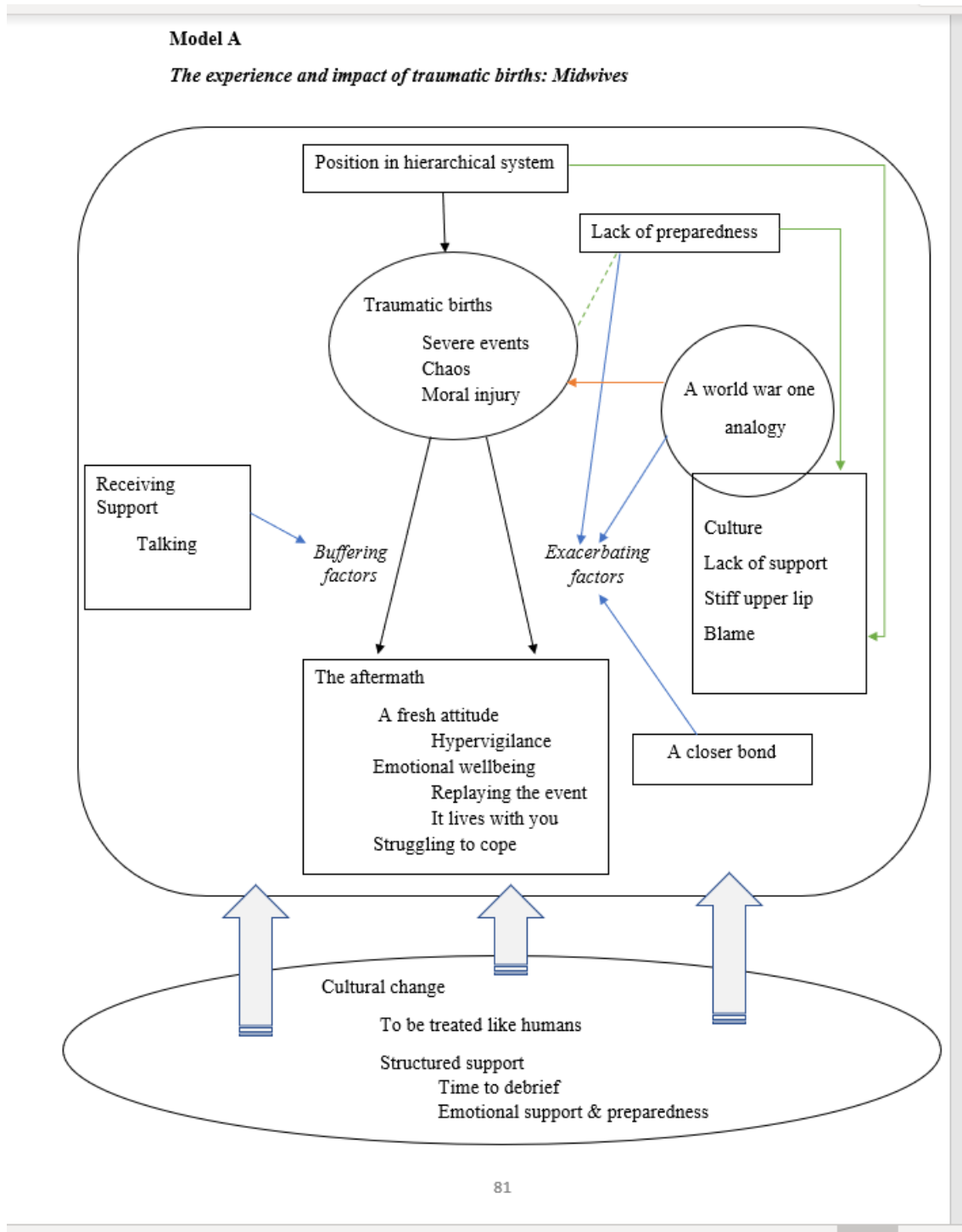




## Development of midwives' model



## Development of midwives' model: Final draft





## **Appendix Eight**

### Process of Analysis: Obstetricians

## Example of line-by-line coding

**Nodes**

Look for  Search In  Find Now Clear Advanced Find

Nodes

Name	Sources	Referen
A cum	5	8
Alone	5	12
Assum	1	1
Bad pr	1	1
Becomi	5	14
Benefic	1	1
Blame f	2	3
Cant ex	1	1
Colleg	5	12
Comm	3	3
Compa	1	1
compe	1	1
Coping	1	1
coping	4	7
Culture	5	10
Debrief	3	3
Differ	2	3

Sources

**Nodes**

Classifications

Collections

Queries

Reports

Maps

Folders

In  Code At

HK 282 Items Nodes: 76 References: 135 Editable Line: 160 Column: 69 100%

**Do you want to tell me more about the culture and what is the support like?**

It depends who you work with, like generally, its not know for having a really supportive culture, bad stuff happens and you have to get on with it. Erm but yeah some of the consultants, she gave us her phone number that weekend and said if there's anything running over your head come and speak to us. Erm one of the other consultants text us, so people that weren't even there, younger consultants, are probably more aware of this stuff and the way it impacts upon you. But I still think it would have been really hard to say I'm not coping.

**OK, so what do you think it is the contributes to that?**

I think its an acceptance that it is an inevitable part of the job, and I think on some level people would say if you cant take the heat you will have to get out of the kitchen, if you cant cope, you are either cut out for it if your not.

**So do you feel that if you asked for support in the workplace that would be seen as sign that you weren't coping?**

Yeah, so there's that self-sigma, they probably send you off to occupational health. I know people who have been there and it's not particularly helpful, one of the midwives who went said they said nothings going to change so you will just have to get on with it.

Coding Density

- Different perception from mothers
- Supporting junior colleagues
- Colleagues reactions
- Get on with it
- Supportive team
- Carrying out traumatic procedures
- Traumatic births

## Example of line-by-line coding

The screenshot shows a software interface for qualitative data analysis. The main window displays a text document with several lines highlighted in yellow. To the right of the text, a list of codes is visible, including 'Coding Density', 'Traumatic births', 'Supportive team', 'A good team during the event', 'Becoming emotionally detached', 'Unfamiliar team', 'Impact-professional', and 'Not being able to reassure the parents'. The bottom status bar shows 'HK 6 Items Nodes: 67 References: 119 Editable Line: 62 Column: 0'.

**Sources**

- Internals
- Externals
- Memos
- Framework Matrices

**Internals**

Name	Nodes	References
P1	76	135
P10	74	129
P14	67	119
P6	63	87
P8	67	106
P9	78	110

**How would you define a traumatic birth in the context of your work?**

I think erm, emergency scenarios, where the buzzer is called, and a lot of staff run into the room and we are having to deliver the baby very quickly without the time to explain to the women and partner what's happening. I think that's what I would describe as typically traumatic because there is such a hurry of activity, and not enough time to explain things as you would want to. Especially births where we are running to theatre, when we must whip people out of rooms and take them down the corridor, take them under bright lights with lots of strangers, again when they probably aren't that aware of what's happening.

**So, for you it sounds like a chaotic and unexpected environment which make the situation feel traumatic?**

Yes

**Could you tell me about a birth that you found particularly traumatic for yourself?**

It was actually very recently, I had just returned to work after having my daughter and it was my very first shift in a new hospital on the weekend, I was alone, the consultant was at home and a lady came in for induction and when she arrived, she was very unwell the baby was very distressed.

**Code At** Enter node name (CTRL+Q)

HK 6 Items Nodes: 67 References: 119 Editable Line: 62 Column: 0 100%

Example of focussed coding

The screenshot shows a software interface for focused coding. On the left is a sidebar with a 'Nodes' panel containing a list of nodes and their source/reference counts. The main area is divided into a search bar at the top, a list of nodes, and a detailed view of a selected node. The selected node is 'Becoming emotionally detache'. Below the node name are five reference thumbnails labeled P1, P10, P14, P6, and P8. The detailed view shows the text of the selected reference (P1) and its coverage percentage (2.75%).

Name	Sources	Referen
A cum	5	8
Alone	5	12
Assum	1	1
Bad pr	1	1
Becomi	5	14
Det	1	1
Em	1	1
Fea	1	2
Lim	1	1
Mo	3	4
Benefic	1	1
Blame f	2	3
Cant ex	1	1
Colleg	5	12
Comm	3	3
Compa	1	1

Search: Look for [ ] Search In [ Nodes ] Find Now Clear Advanced Find

Selected Node: **Becoming emotionally detache**

Reference	Coverage
P1	(2)
P10	(6)
P14	(4)
P6	(1)
P8	(1)

<Internals\VP1> - § 2 references coded [2.75% Coverage]

Reference 1 - 1.34% Coverage

Somebody said to me we need to be, softer enough to still care, but hard enough to be able to cope with it. Probably most people go into health care are really compassionate have loads of empathy, really care, really want the best for people, you think you are going to treat everyone like your sister or your mum but if you think if you genuinely operated like that very day you would be a complete wreck, you give so much of yourself

Reference 2 - 1.41% Coverage

I think it possibly drops off a little bit when you have to make a decision and you just need to get

Status: HK 5 Items Sources: 5 References: 14 Unfiltered

## Example of focussed coding continued

The screenshot displays a software interface for focused coding. On the left, a sidebar lists various analysis tools: Nodes, Cases, Relationships, Node Matrices, Sources, Nodes (selected), Classifications, Collections, Queries, Reports, Maps, and Folders. The main window is titled 'Nodes' and features a search bar at the top with 'Look for' and 'Search In' dropdowns, and buttons for 'Find Now', 'Clear', and 'Advanced Find'. Below the search bar is a table of nodes:

Name /	Sources	Referen
A cum	5	8
Alone	5	13
Assum	1	1
Bad pr	1	1
Becomi	5	14
Det	1	1
Em	1	1
Fea	1	2
Lim	1	1
Mo	3	4
Benefic	1	1
Blame f	2	3
Cant ex	1	1
Colleg	5	12
Comm	3	3
Compa	1	1

The right pane shows a detailed view of the selected node 'Becoming emotionally detache'. It contains several text excerpts with associated reference and coverage information:

- Reference 6 - 0.26% Coverage:** I do a very high risk clinic with women with mental health problems and people will tell you the most awful lives, and you listen to that quite matter of fatly
- Reference 1 - 0.47% Coverage:** It makes you feel a bit like, have I lost my emotions for certain things.
- Reference 1 - 0.47% Coverage:** <Internals\WP14> - § 4 references coded [3.18% Coverage]
- Reference 1 - 0.47% Coverage:** Reference 1 - 0.47% Coverage
- Reference 2 - 0.34% Coverage:** I think I'm aware this time around, coming back from maternity leave that you come a bit hardened, the more you are at work.
- Reference 2 - 0.34% Coverage:** Reference 2 - 0.34% Coverage
- Reference 3 - 1.60% Coverage:** You almost get to a point where the level of emotional trauma at work becomes normal again
- Reference 3 - 1.60% Coverage:** Reference 3 - 1.60% Coverage
- Reference 3 - 1.60% Coverage:** Yes, I think so because of the pressure of time, I think when it comes down to it, you have a team

At the bottom, a status bar shows 'HK Sources: 5 References: 14 Unfiltered' and a zoom level of '100%'.

## Example of focussed coding- exporting themes from NVivo into a word document

AutoSave Off Alone - Compatibility Mode Harriet Kemp HK

File Home Insert Design Layout References Mailings Review View Help EndNote X9 Search Share Comments

**Name:** Alone

<Internals\VP1> - § 3 references coded [1.28% Coverage]

Reference 1 - 0.64% Coverage

I almost didn't apply at training because of a bad experience where a **cesarian** section and where I struggled to get the head out and its one of the worst obstetric **emergency's** because nobody else can help you

Reference 2 - 0.50% Coverage

So that's probably why the last few months and acting up as registrar has been **moretricky** because **its** been on me, you were the senior **decion** maker at that point.

Reference 3 - 0.14% Coverage

we are a team but sometimes I'm like I'm it.

<Internals\VP10> - § 1 reference coded [0.93% Coverage]

Reference 1 - 0.93% Coverage

That's probably the one that's had the biggest impact. \I think that's just quite recent and at a time when I got to the point and I think I'm the most senior person on the floor, and I was most personally involved in, in terms of the decision making and what's done

<Internals\VP14> - § 2 references coded [1.06% Coverage]

Reference 1 - 0.54% Coverage

I was alone, the consultant was at home and a lady came in for induction and when she arrived, she was very unwell the baby was very distressed

Reference 2 - 0.52% Coverage

Yeah, the adrenaline rush is insane, and you are exhausted afterwards. Just the physical effects are you feel like you want to go to sleep

<Internals\VP8> - § 1 reference coded [1.02% Coverage]

Reference 1 - 1.02% Coverage

I delivered her on Thursday, it was one of the worst night shifts of my life, as it was her and another lady who had dangerous levels of blood pressure and I remember pushing the trolley

between the 2 women, not support from my senior because she was on gynaecology, I was on labour ward

<Internals\VP9> - § 6 references coded [4.51% Coverage]

Reference 1 - 0.66% Coverage

Absolutely and at a junior level, at a consultant level you put on a fake persona that you have everything under control, because **its** not only about the parents **its** also about the team around you

Reference 2 - 1.02% Coverage

Once you become a consultant there is an expectation that you are the cavalry that is coming to save the day and you **cant** look back, as a junior you can look back and say call this person call this person, as a consultant there is none to call for help on.

**Does that increases the trauma?**

Yes

Reference 3 - 0.42% Coverage

So, you must ensure you stay calm, it comes with great difficulty, you must ensure you don't snap, and being human we all do

Reference 4 - 1.28% Coverage

You have to make a conscious choice not to do it, but sometimes you have to raise your voice to tell people to calm down, to say you need to stand there and do what you are told, and sometimes people don't realise that that is not because one person is saying are superior, but one person has to take charge otherwise everyone is going to be running around like headless chickens

Reference 5 - 0.74% Coverage

I find it a difficult balance trying to find out who can do what and how often can I step back, trying to take over is a natural instinct, because you think the outcome is going to be poor I might as well do it myself

Reference 6 - 0.39% Coverage

You know **its** not a horizontal system, as it goes up there is no-one to your left or right and that's how it works

Page 2 of 2 At: 11.6cm 605 words English (United Kingdom) 60%

## **Example memos exported from NVivo**

**Name:** *Knowing couldn't have done anything differently*

*Significant theme: - important for obstetricians to know they couldn't have done anything differently. knowing this helps, but more traumatic when think they could have done something differently. Results In self-blame*

*heightened by feeling 'alone'-main decision maker- part of their role*

*Important to be able to recognise it wasn't their fault?*

*Links to knowing they could have done something differently (Traumatic when feel they could have done something differently resulting in self-blame/ feeling responsible*

**Name:** *Reflection*

*Seems to be less richness within the codes, and significantly less felt trauma amongst the doctors...seems to be more about feeling responsible*

*but when they know they have done all they can its better*

*potentially due to their role- saving lives, less interaction with the family?*

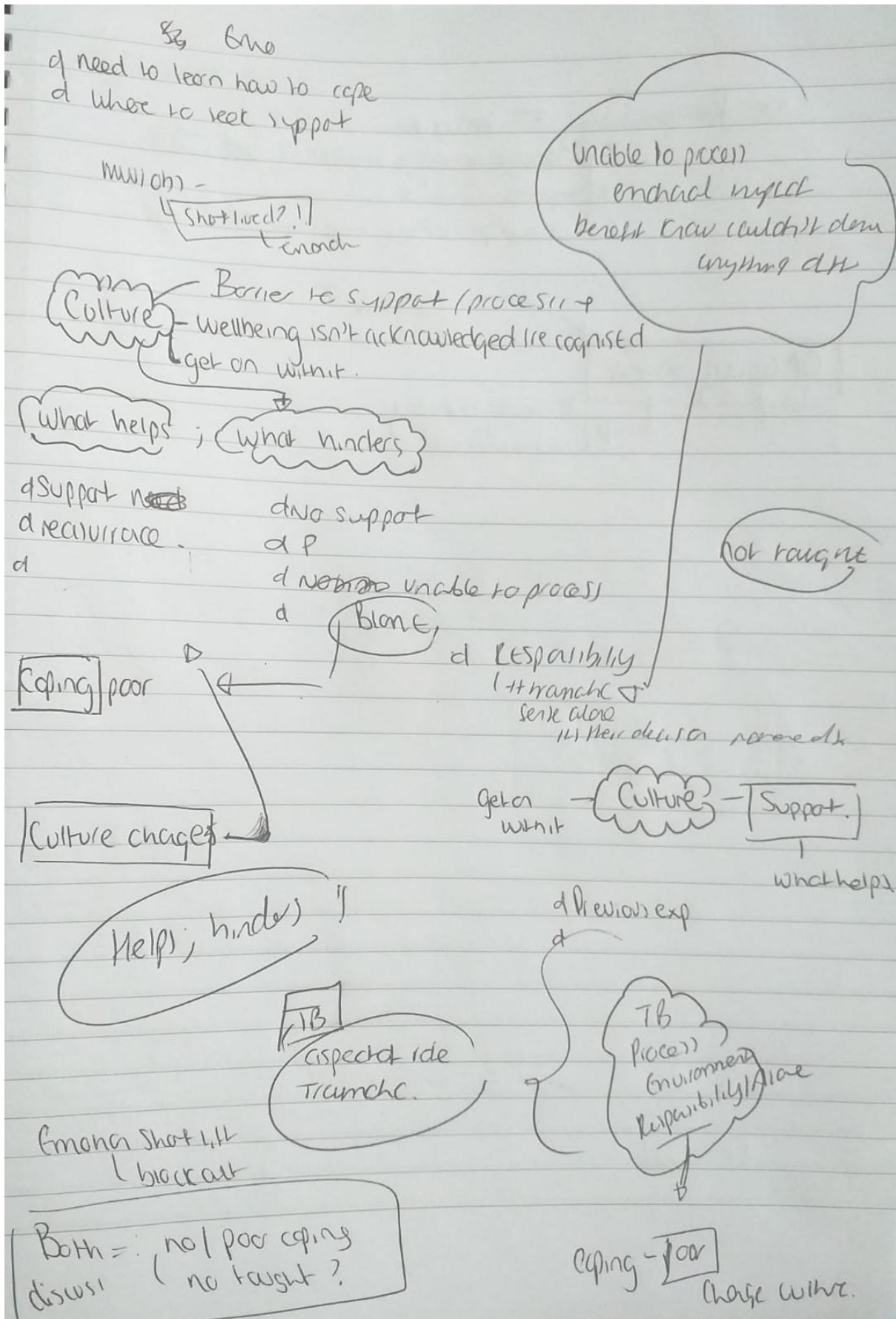
*whereas midwives, more interaction and unable to do their role 'advocate'??*

**Name:** *get on with it*

*No expectation from the start that things should affect you: not prewarned, impact isn't discussed, not taught how to cope --> sets a culture of coping alone/ shouldn't be impacted/ should be resilient.*

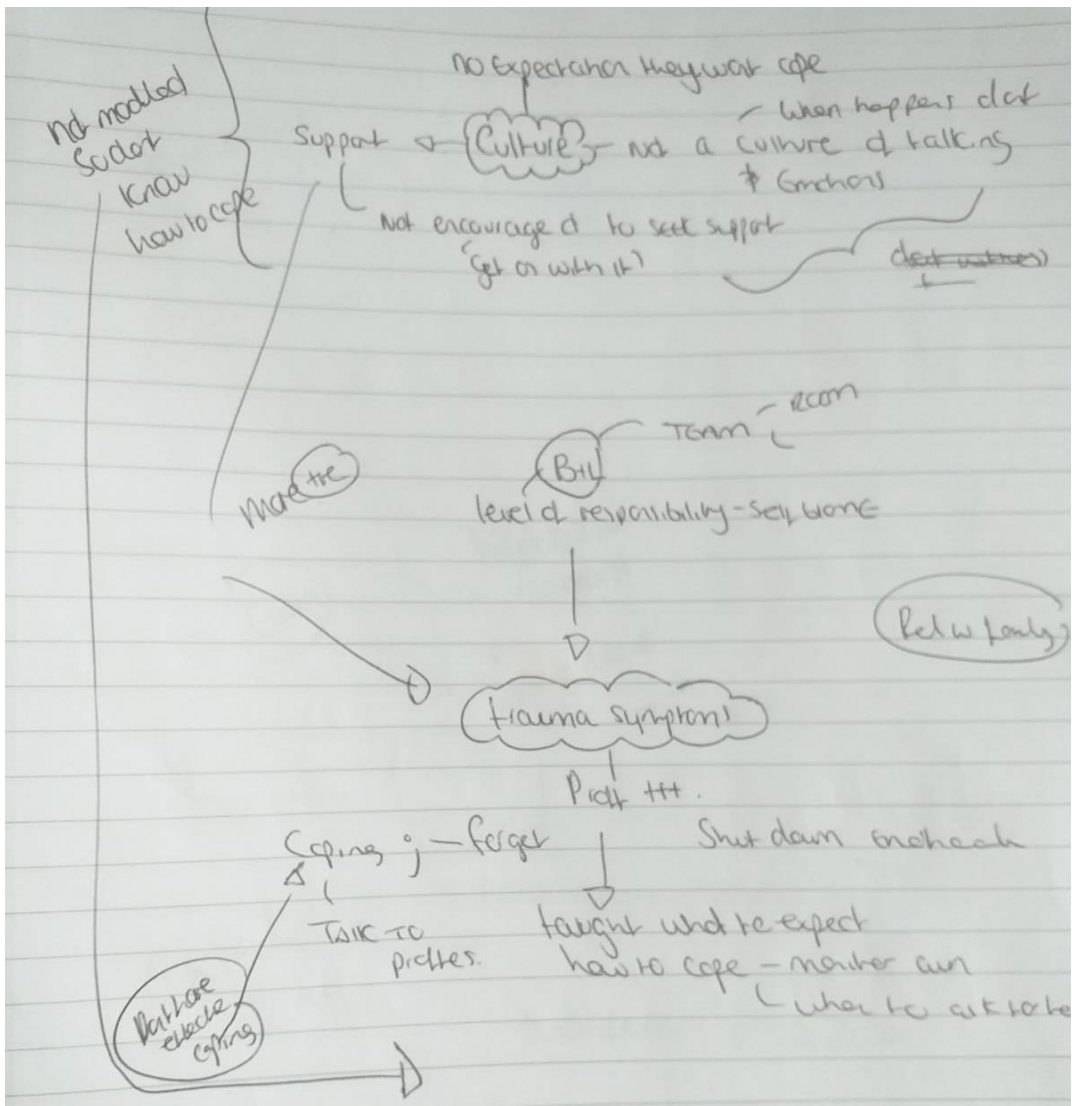
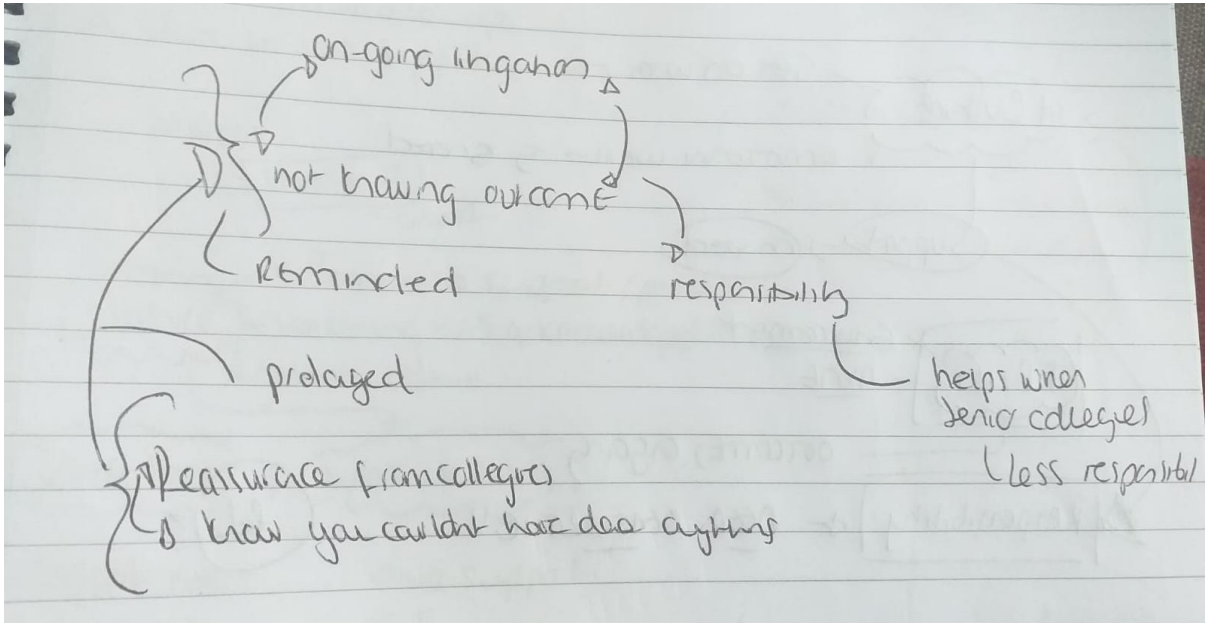


**Example of diagramming**

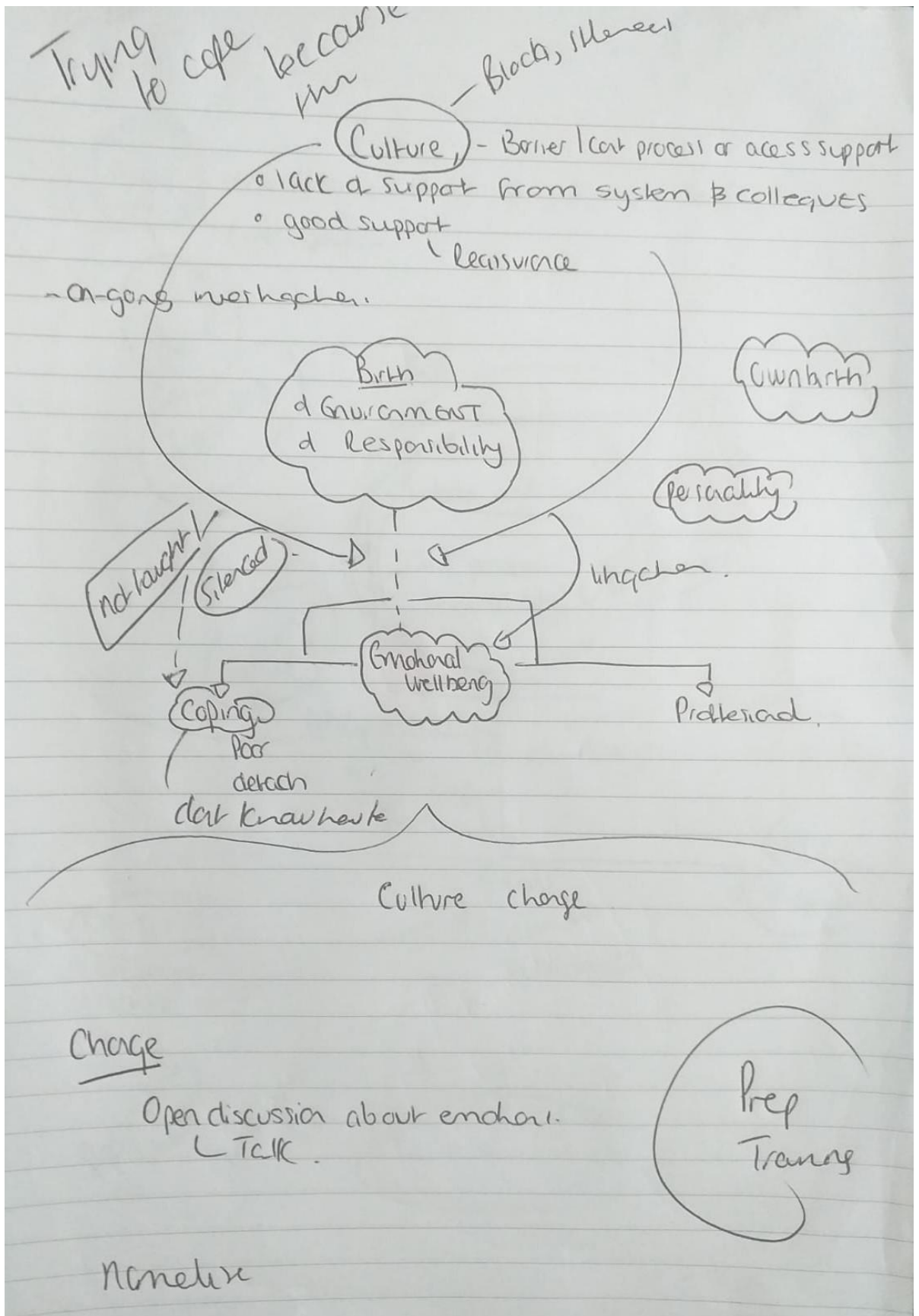




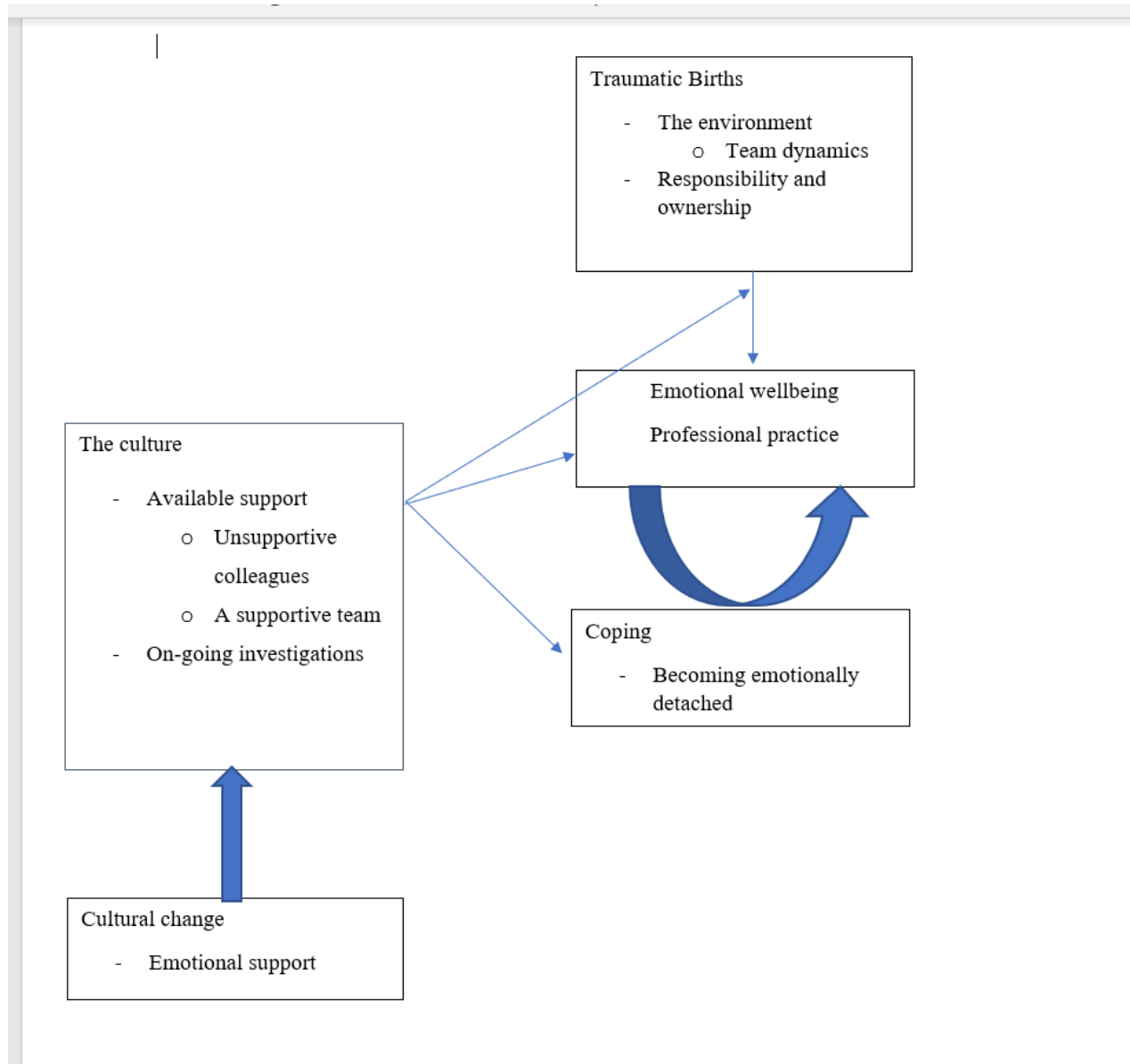
**Example of diagramming**



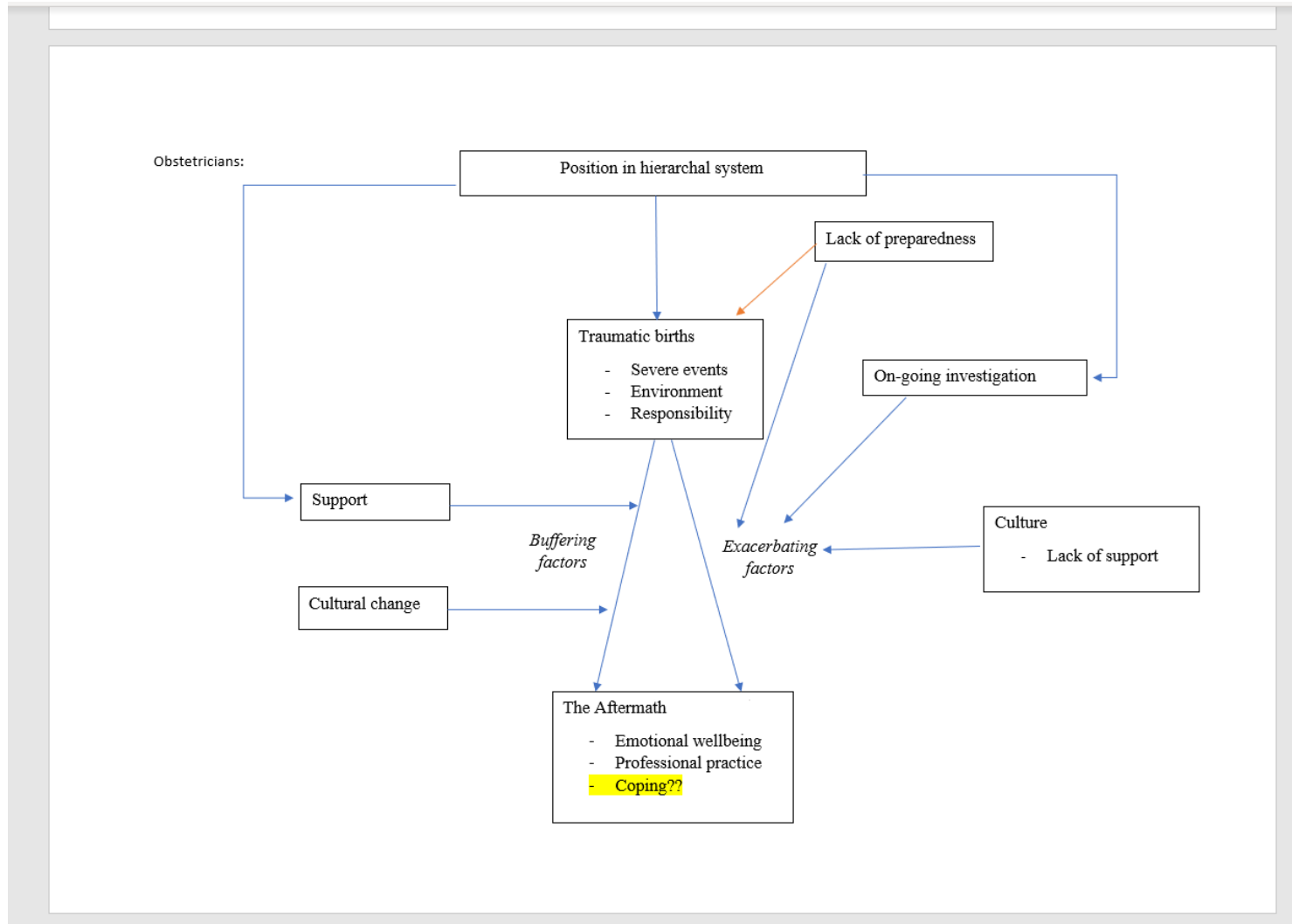
**Example of diagramming**



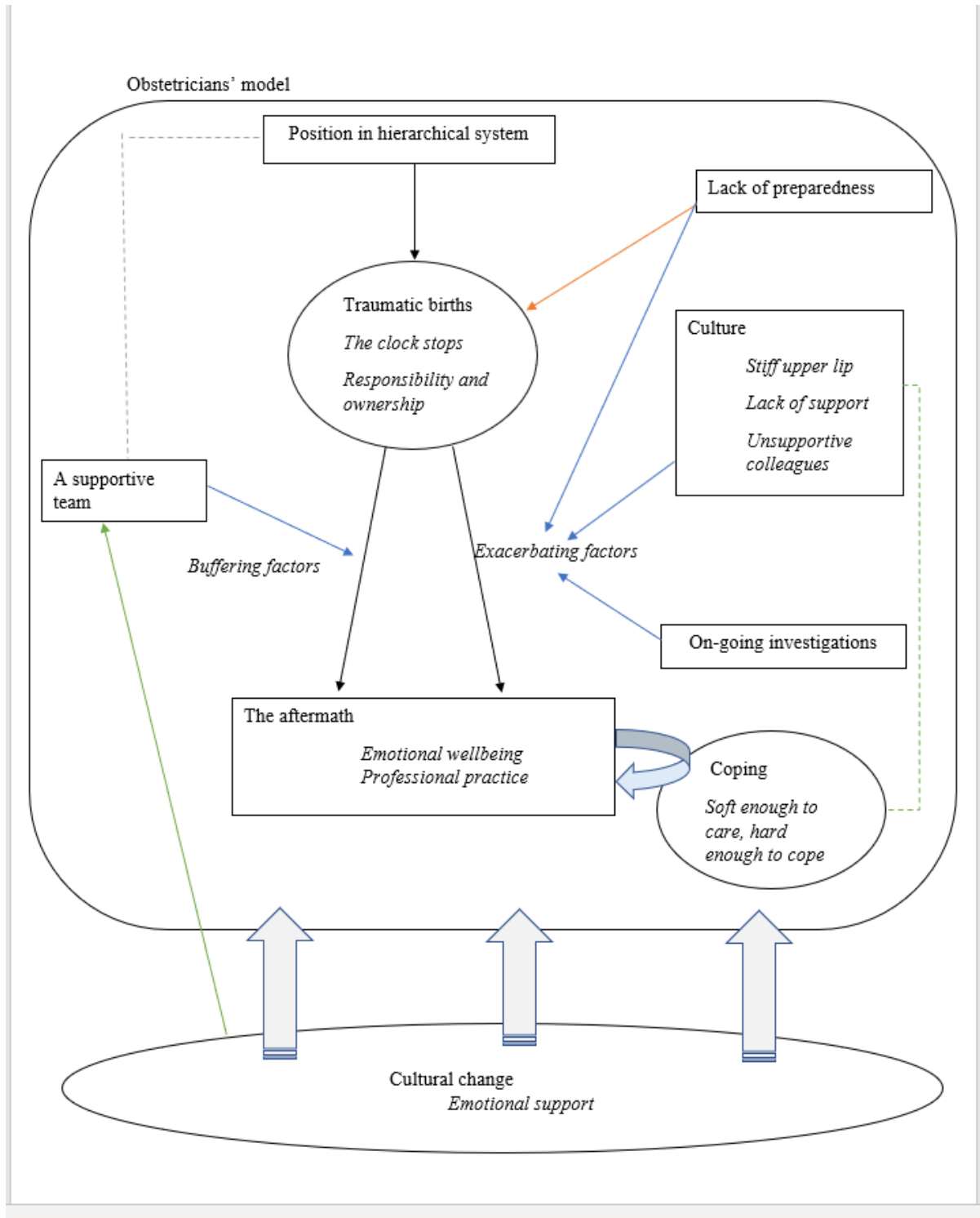
## Development of obstetricians' model: First draft



## Development of obstetricians' model



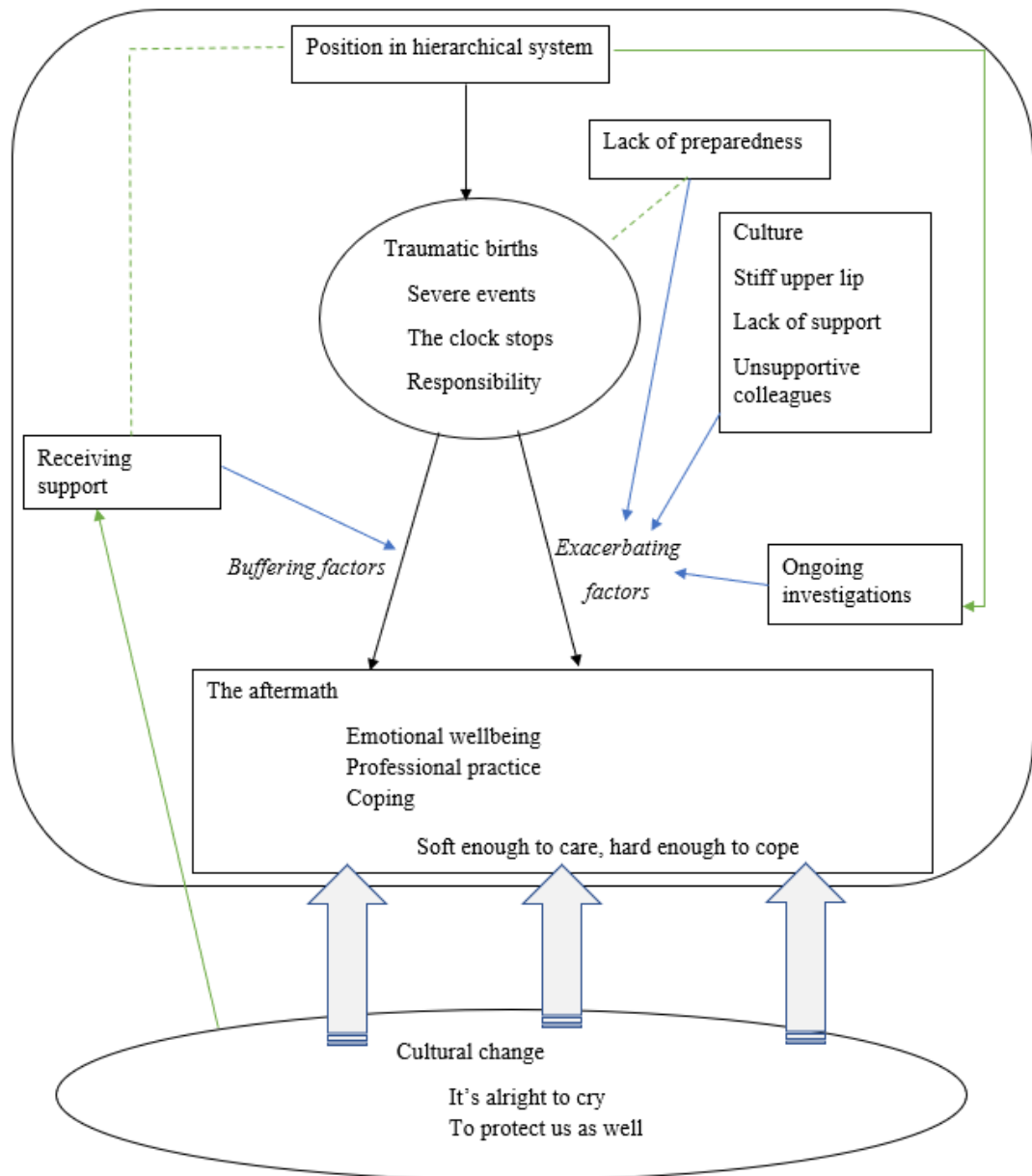
## Development of obstetricians' model



## Development of obstetricians' model: Final draft

### Model B

#### *The experience and impact of traumatic births: Obstetricians*



## **Appendix Nine**

### **Reflective Journal Excerpts**

### **Following interview no. 3**

*Listening back to interviews, I notice my struggle in finding a balance between wanting to converse and be genuine versus focussing on the questions...I felt like I didn't explore impact enough, note to self- pay more attention to prompts in impact.*

*Emerging ideas:*

*What makes a birth more traumatic is the lack of support, within the room and after; relationships with colleges; no time for debrief...this feels more prominent beyond the labour event in itself*

*The environment appears to lack any compassion for staff, a sense of blame...*

### **Following interview no. 5**

*I'm noticing my interviews flip, structured...to more curious and structured again. The balance is hard. When I feel I need to be more structured, I then listen back and when I'm trying to be more structured I feel like I haven't listened well enough, and should have opened up the conversation on more points...I am coming to recognise that the context of the interview is going to impact my approach which is natural. Interview five I was in the participants home and that made me feel more nervous...*

*I seem to focus more on different areas on different interviews, and assuming this is being led by the participant and their experiences...I am weary not to 'over probe' remembering this is not a psychology assessment*

*Another theme? Communication in the room and chaos; guilt for not intervening in practices which feel unethical... making it traumatic for the midwife even if the mum doesn't experience it as traumatic. Again, it is not the procedure, it is the environment, communication...and time to debrief is key!*

*Rumination and loss of sleep.... memories triggered*

### **Reflection of the settings the interviews were held in...**

*Sept/October 2019-In a recent tutor meeting I reflected on how my experiences differed depending on the setting of the interview. This was following an interview completed in a participant's home- I left this interview feeling extremely overwhelmed*



*When in someone's own home I become more immersed in the conversation and the person's experiences.*

*This intense sense of felt emotion seems to decline with distance from the participant, and also seems to impact how I utilise the interview schedule*

### **Moving on to obstetrician's analysis**

*Although I feel more confident about the process of analysis, I need to bracket the MW's model in my mind and approach obstetricians' interviews from a fresh perspective, not being influenced by MW's coding...*

## **Appendix Ten**

### **Participant Responses**

*Dear Harriet,*

*Many thanks for sending me the finalised analysis and Grounded Theory Model, both of which I was grateful to receive.*

*Well done and now the hard part starts, trying to get into the organisations and ways of doing the will bring about the necessary change.*

*Best Wishes*

*Harriet,*

*well- done on completion of project.*

*I would suggest that time to completion of investigations is the highest stress factor for the teams. Especially now since all major investigations in maternity are done by a national body called HSIB which is taking 9-12 months for investigations which in the past would take 8-10 weeks.*

*wishing you all the best for the future.*

*Kind regards*

*This looks fab Harriet! I hope you get top marks, all the best in your future career as a clinical psychologist!*

*This looks great, I'd be interested to read your thesis at some point!*

*Best of luck with it all*

*BW,*

*Many thanks for sending this through, very interesting. Good luck in your final writing stage!*

*BW*