RESPONDING TO CATASTROPHE: LEARNING FROM PERINATAL DEATH IN MIDWIFERY PRACTICE

By

Robert Laing

RN, BA (Psychology) Hons, MCur

This thesis is presented for the degree of Doctor of Philosophy at Murdoch University

June, 2018
Declaration

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

Robert Laing

Signature:

Date: 9/06/2018
Acknowledgements

An epic journey weaved around life, family and travel.

I am sincerely grateful for the support and encouragement that I have received along this journey. Thank you to my supervisors, Professor Paul Morrison and Associate Professor Cathy Fetherston for your support, guidance and supervision throughout this study. Thank you to family, friends and colleagues whose encouragement and interest has helped to sustain me over the years of this study.

Kristina Medigowich, thank you for your belief in my ability. Your wisdom, guidance and counsel through the tough times has been instrumental in my successful completion. My only regret is that I did not complete in time for you to bear witness to this moment.

My precious family, this is all for you. Thank you, Shelley, for your constant love and support. You picked up all of the slack. Your turn next! Boys, I am finished playing games on the computer!

For your many hours of proof reading, Shelley and Linda, I am truly grateful.

To all the little ones who will always be loved and never forgotten; you will live on through the hearts and minds of midwives who have dedicated their all to be with you and your family.
Abstract

Perinatal death has far reaching emotional effects for all involved in this devastating event. The opportunity for learning as a result of this catastrophe, however, remains unexplored. This study aimed to examine midwives’ experiences of caring for women through perinatal death, exploring personal and professional impacts to uncover what midwives learn from this experience.

A naturalistic interpretive approach, with a multiple case study design, explored this frequently occurring, yet neglected area of midwifery practice. Seventeen midwives, located in Australia, participated in an online group activity hosted as a blog, followed by telephonic focus groups and in-depth email interviews. Data collection activities took place from August 2012 to February 2014. This approach allowed for personal story telling across the participant group in ways that resonated with the experiences of others and enhanced their understanding of the experience of perinatal death.

Thematic data analysis revealed seven major themes. These new understandings emerged as: Grappling with the reality of perinatal death; Struggling with personal and professional heartache; Seeking the space to grieve as a professional; Being with the woman and her family; Finding a new purpose; Strengthened through support; and Developing the courage to care.

The initial turmoil and impact of loss reflected the catastrophic nature of perinatal death. Midwives uncovered a journey to acceptance and learning, realising a determination to enhance expertise and discovering value in experiential knowledge. The challenges experienced by a perceived lack of content in formal midwifery education and its influence on midwives’ confidence to manage perinatal death and bereavement care is highlighted. However, sharing their stories revealed professional fulfilment, personal strength, and solidarity amongst midwives who have endured similar experiences.

A coordinated approach to support and the dissemination of experiential knowledge and learning could be developed within an online model of narrative sharing and discussion. Debriefing, support and sharing of expertise in this way may foster engagement within and beyond the workplace.
Table of Contents

DECLARATION ........................................................................................................................ I
ACKNOWLEDGEMENTS ......................................................................................................... II
ABSTRACT ............................................................................................................................ III
LIST OF TABLES ................................................................................................................... VII
LIST OF FIGURES ................................................................................................................. VII

CHAPTER 1: INTRODUCTION ................................................................................................. 1
  1.1 Background .................................................................................................................. 1
  1.2 Aims of the Study ......................................................................................................... 3
  1.3 Research Questions ..................................................................................................... 4
  1.4 Significance .................................................................................................................. 5
  1.5 Clarification of Terms ................................................................................................... 7
  1.6 Structure of the Thesis ................................................................................................. 8

CHAPTER 2: LITERATURE REVIEW ......................................................................................... 9
  2.1 Introduction ................................................................................................................. 9
  2.2 Search Strategy ............................................................................................................ 9
  2.3 The Nature of Catastrophe .......................................................................................... 11
  2.4 Responses of Helping Professionals to Death-Related Traumatic Events ............... 13
    2.4.1 Responses to death for first responders ............................................................. 15
    2.4.1.1 Responses by police ..................................................................................... 15
    2.4.1.2 Responses by paramedics ............................................................................ 18
    2.4.1.3 Responses by firefighters ............................................................................. 20
    2.4.3 Responses by medical officers ......................................................................... 23
    2.4.4 Responses by nurses ....................................................................................... 28
    2.4.5 Responses by midwives .................................................................................... 31
  2.5 Midwives’ Experiences of Caring for Women Through the Catastrophe of Perinatal
    Death .............................................................................................................................. 37
    2.5.1 Midwives’ emotional responses to perinatal death ............................................. 39
    2.5.2 Emotional labour ............................................................................................... 41
    2.5.3 Professional image and the effects of blame, shame and guilt as a response to
        perinatal death ........................................................................................................... 43
    2.5.4 Midwives’ education and training needs ............................................................. 46
    2.5.5 Midwives need personal and professional support ............................................. 54
  2.6 Learning ..................................................................................................................... 57
4.3.3.1 Challenging their view of them self as a professional. ................................. 131
4.3.3.2 Feeling the trauma personally .................................................................... 136
4.3.3.3 Living with the enduring impact. ................................................................. 142
4.3.4 Theme three: Seeking the space to grieve as a professional. ....................... 144
4.3.4.1 Confronting personal grief. ......................................................................... 145
4.3.4.2 Managing grief across professional and personal lives .............................. 149
4.3.5 Theme four: Being with the woman and her family. ..................................... 152
4.3.5.1 Understanding that it is their loss, not ours. ............................................... 152
4.3.5.2 Listening to, caring for and supporting mother and family. ......................... 154
4.3.6 Theme five: Finding a new purpose. .............................................................. 158
4.3.6.1 Being inspired to evolve their practice and strive to be a better midwife. .... 158
4.3.6.2 Finding personal and professional fulfilment .............................................. 162
4.3.7 Theme six: Strengthened through support. ..................................................... 165
4.3.7.1 Listening to, caring for and supporting each other. ..................................... 165
4.3.7.2 Encouraging the organisation to evolve their support role. ......................... 169
4.3.8 Theme seven: Developing the courage to care. ............................................. 173
4.3.8.1 Engaging coping strategies. ......................................................................... 173
4.3.8.2 Drawing on the expertise of midwives and mothers who have travelled this road ....................................................................................................................... 177
4.3.8.3 Empowered through professional development. ........................................ 180
4.3.8.4 Realigning the pieces through reflection and meaning making ................. 181
4.3.8.5 Healing through the telling and the listening ............................................... 184

CHAPTER 5: DISCUSSION ......................................................................................... 187
5.1 Introduction ........................................................................................................ 187
5.2 Characteristics of the Sample ............................................................................. 188
5.3 Experiencing the Catastrophe of Caring for Women Through Perinatal Death .... 188
5.3.1 The unexpected nature of perinatal death. ..................................................... 189
5.3.2 Feeling unprepared for the depth of emotion. ............................................... 190
5.3.3 Breaking the natural order of birth, life and parenthood. .............................. 192
5.4 Travelling the Road to Acceptance and Learning ............................................ 194
5.4.1 Acknowledging the depth of their attachment and loss. ............................... 195
5.4.2 Learning to acknowledge compassionate care within a professional role. ...... 196
5.4.3 Learning about support. .................................................................................. 200
5.4.4 How midwives envisage learning taking place. ............................................. 202
5.4.5 Harnessing the experience of others. ................................................................. 205
5.4.6 The outcomes of learning. .................................................................................. 206
5.5 Learning Through the Research Process. ............................................................. 208
  5.5.1 A model for data collection based on outsider witness practices. ................. 208
5.6 Recommendations ............................................................................................... 211
  5.6.1 Recommendations for policy makers. ............................................................. 211
  5.6.2 Recommendations for education and research. .............................................. 212
  5.6.3 Recommendations for clinical practice. ......................................................... 213
5.7 Limitations ........................................................................................................... 214
5.8 Conclusion .......................................................................................................... 215

REFERENCES ........................................................................................................ 217

LIST OF APPENDICES .......................................................................................... 234
APPENDIX A: ACM E-BULLETIN AND FACEBOOK EXPRESSION OF INTEREST TO PARTICIPATE ................................................................. 235
APPENDIX B: PERSONAL INVENTORY QUESTIONNAIRE (PIQ) ................................................. 236
APPENDIX C: AUSTRALIAN COLLEGE OF MIDWIVES (ACM) MIDPLUS CPD POINTS APPROVAL ................................................................. 238
APPENDIX D: PARTICIPANT INFORMATION LETTER ..................................................... 240
APPENDIX E: PARTICIPANT CONSENT ..................................................................... 242
APPENDIX F: MURDOCH UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE STUDY APPROVAL ................................................................. 243

List of Tables
Table 1. Recruitment ................................................................................................. 91
Table 2. Participant demographic information. ......................................................... 119
Table 3. Participation profile according to data collection method. ......................... 120
Table 4. Themes and sub-themes. ............................................................................ 121

List of Figures
Figure 1. Literature retrieval process. ................................................................. 11
Figure 2. Three ontological strata in critical realism. .......................................... 76
Figure 3. Data collection timeline. ........................................................................ 92
Figure 4. Page from the blog. ............................................................................... 97
Figure 5. Model of data collection related to outsider witness practice. .............. 210
Chapter 1: Introduction

1.1 Background

Loss and associated grief has been, and continues to be, an inevitable aspect of human existence. The human relationship with the experience of death has attracted research and discussion from areas such as religion and politics through to philosophy and psychology. The variation in human response to death, as well as comparisons and contrasts of the differing experiences resulting from the wide range of preventable, non-preventable, expected and unexpected causation, namely accidents, murder, illness, wars, conflict, natural disasters, drugs and alcohol, now form a well-developed body of knowledge. We do not encounter death and dying people in the same way as our predecessors did, explains Leishman (2009). Firstly, the medicalisation of death has largely taken the dying process out of the home and community as it was for our ancestors, and secondly, improved lifestyle and modern medicine have increased life expectancy. This being said, death remains inevitable, and under some circumstances is a catastrophic event.

Catastrophe has been described as a personal experience precipitated by an intense, adverse event such as sudden or traumatic death, devastating illness or injury, and life-threatening circumstances (Raphael, Taylor, & McAndrew, 2008). Professionals in the helping and service industries, for instance, police, fire fighters, paramedics, doctors, nurses and midwives, are exposed to loss, death and human suffering as a part of their professional lives. Exposure to sudden and traumatic death has been described as a catastrophic event for all those who are directly involved (DeRanieri, Clements, & Henry, 2002), and has been reported to result in severe stress reactions in helping professionals (Cacciatoore, Schnebly, & Froen, 2009; Leinweber, Creedy, Rowe, & Gamble, 2017; Showalter, 2010; Skogstad et al., 2013). Some losses may be perceived as catastrophic due to the implications of the loss and the intensity of the grief experienced, with the loss of a child associated with the most intense grief (Clohessy & Ehlers, 1999; Haugen, Evces, & Weiss, 2012; Raphael et al., 2008). Consequently, the loss experienced through perinatal death may be viewed as a catastrophe not only for the parents, but also those with the responsibility for providing care to the family at this time.
Perinatal death has been defined to include both fetal and neonatal death, hence encompassing the period from 20 weeks gestation to within 28 days of birth (Australian Bureau of Statistics, 2011; Australian Institute of Health and Welfare, 2017; Barfield, 2016; Nguyen, Gee, & Le, 2008). During 2008 to 2010 in Western Australia, 882 perinatal deaths were recorded, which represents a perinatal mortality rate of 9.5 per 1000 births (Ballestas, 2014, p. 13). These statistics are similar to perinatal death rates for Australia, which ranged between 8.9 and 10.2 per 1000 births from 2008 to 2012 (Australian Bureau of Statistics, 2011; Monk et al., 2016), and 9 per 1000 births in 2015 (Australian Institute of Health and Welfare, 2017). On consideration that midwives are the primary care providers for childbearing women (Sandall, Soltani, Gates, Shennan, & Devane, 2016), there is a high likelihood that a midwife will, at some time during their working life, care for a mother whose baby has died during this perinatal period.

The experience of loss as a result of a life crisis, such as perinatal death, is intensely individual and highly personal for parents and health professionals (Gardner, 1999). Existing research suggests that health care professionals, including midwives, see perinatal death as a catastrophic event, which generates intense emotional responses, as well as feelings of failure and guilt that challenge professional purpose (Alghamdi & Jarrett, 2016; Beck, LoGiudice, & Gable, 2015; Black, Hardoff, & Nelki, 1989; Mander, 2004; McCreight, 2005). Midwives are intimately involved with the process of birth. Accordingly, the nature of their caring role, combined with the expectation of new life, often results in the development of a personal relationship between the midwife and mother that is likely to be further intensified by the unexpected nature of perinatal loss (Fenwick, Jennings, Downie, Butt, & Okanaga, 2007; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Homer, Davis, Cooke, & Barclay, 2002; McCreight, 2005). This relationship and associated circumstances may exacerbate the effects of the death of a perinate, contributing to the catastrophic nature of the event for both the midwife and other staff in the maternity unit.

The bulk of research discussing learning from all types of catastrophe within the medical profession usually concentrates on errors and failure of the individual and organisation. Perinatal death, on the other hand, occurs predominantly as a result of unavoidable factors, such as congenital abnormalities, unexplained antepartum death or maternal conditions
(Monk et al., 2016). This suggests that both avoidable and unavoidable incidents may need to be examined in order to determine learning experiences from catastrophic events such as perinatal death. The research into learning that occurs as a result of catastrophes in healthcare is scant, with the empirical evidence available predominately focusing on the investigation, reporting, prevention and risk management of incidents. When faced with a difficult event that one may feel unprepared for, it is imperative to recognise learning experiences that will help to develop one’s practice for future events. To further explicate, Dewey (1934, p. 50) explains that “If the artist does not perfect a new vision in his process of doing, he acts mechanically and repeats some old model fixed like a blueprint in his mind”. Carl Rogers declared that "Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience" (Rogers, 1961, p. 23). This may be true, but how does one extract and harness this learning from an experience that is laden with shock, stress and raw emotion? Learning through one's experiences has been described by Kohner (2001) to be the most appropriate form of training to effectively prepare and support midwives. A vehicle for achieving this, on the one hand, includes simulated learning experiences. On the other hand, existing scholarly views examining the effectiveness of knowledge and skill acquisition through simulation suggests that learning how to cope and be effective through catastrophic and stressful situations is complex with considerable ethical and administrative considerations when attempted in a simulated environment (Borodzicz & Van Haperen, 2002). Even so, a more recent study by Goldberg et al. (2015) demonstrated success in simulating patient death for anaesthetist residents.

Learning opportunities that result from midwives' experiences are rich and untapped. Investigating what they learn through catastrophic incidents will benefit midwives, women in their care and all maternity health care professionals, including doctors and allied health professionals. Equally important, it may also assist in the planning and delivering of further education to midwives, women and their families to improve care and self-care.

1.2 Aims of the Study

There are different types of deaths (preventable, non-preventable, expected and unexpected), as well as a variety of potential responses to these deaths. The personal
learning that occurs through all of these, especially in relation to a catastrophic event such as perinatal death, warrant investigation. The aim of this study will be to examine midwives' perceptions of the learning that occurs during and as a result of caring for women through perinatal death. With the help of reflection and “meaning making”, these learning opportunities will be detected and further investigated to foster constructive examination and evaluation of developmental needs for the management of support for midwives and families into the future. To this end, the study will:

- explore and describe midwives’ experiences of the catastrophic nature of perinatal death.
- investigate perceptions of the learning that occurs in response to perinatal death from the perspectives of the midwives caring for affected parents.
- explore and describe the attitudes of midwives towards perinatal death.
- determine whether new realities and learning possibilities can be realised through reflection and reconstruction of meaning.
- Consider how these new understandings might help midwives to examine and evaluate developmental needs for future events.

1.3 Research Questions
Four research questions aimed to explore what and how midwives learn as a result of their experiences of caring for women through the catastrophic event of perinatal death.

1. What are midwives' perceptions of the catastrophic elements of perinatal death?
2. What do midwives perceive they learned following their involvement in perinatal death and how did this knowledge influence their practice?
3. What does a midwife need personally and professionally to improve their capacity to care for a mother and her family through perinatal death?
4. How does reflection, sharing and the reconstruction of meaning of the experience of perinatal death influence midwives' learning and their ability to examine and evaluate developmental needs for future events?
1.4 Significance

When death is anticipated or prepared for, as in terminal illness, grief still accompanies death. In the same way, midwives may be theoretically prepared for the possibility of death, but is that where their education ends? (Laing, 2004). One may contemplate what could be missing from a midwife’s education to enable them to care for those experiencing traumatic events such as perinatal death. However, when considering the personal and professional factors surrounding such a catastrophic event, the significance in this study may be found in a re-focussing away from what is missing, to an exploration of recognising and harnessing what is already there.

A growing body of literature describes the responses of midwives to the experience of caring for a woman through perinatal death (Alghamdi & Jarrett, 2016; Fenwick et al., 2007; Jonas-Simpson, Pilkington, MacDonald, & McMahon, 2013; Jones & Smythe, 2015; McCool, Guidera, Stenson, & Dauphinee, 2009; McCreight, 2005); some, more specifically, have investigated the resultant traumatic stress symptoms (Beck et al., 2015; Leinweber et al., 2017; Leinweber & Rowe, 2010; Sheen, Spihy, & Slade, 2014). Preparatory education for midwives has been considered, and an investigation into midwives’ and nurses’ attitudes toward bereavement care has been described (Chan & Arthur, 2009; Chan et al., 2008), with attention given to how to teach bereavement care to student midwives (Hollins Martin, Forrest, Wylie, & Martin, 2013; Hollins Martin, Forrest, Wylie, & Martin, 2014; Hollins Martin, Robb, & Forrest, 2016). This current study will attempt to move beyond what has already been examined and undertake to explore what midwives perceive to have learned themselves through this experience. The aim of this is to be able to harness this experiential learning in order that, firstly, these new knowledge and skills can be shared; and secondly, midwives may be able to recognise their own individual strengths and developmental needs. An assumption being made is that midwives have learned and developed, but may not have recognised this learning.

The shock, stress and raw emotion that is an intricate part of this catastrophic event may mask the experiential gain. A midwife’s priority is to the woman and her family; hence their own learning may not be recognised. The feelings of guilt, helplessness and lack of confidence in ability may have midwives doubting their knowledge, skills and competence,
rather than identifying knowledge and skill development that has taken place as a result of this event. In order to develop both personally and professionally, it may not be enough to learn from or react to only that which is required to cope with one's day-to-day tasks, but to be able to go beyond just competence and skill development. Midwives need to adapt personally and professionally to the experiences within their working environment, generating knowledge and skills in order that they can be active participants in determining their own reality (Senge, 1990). To that end, this study will be significant in its attempt to analyse the type of learning that the midwife perceives to have taken place. On reflection, “meaning making” and seeing their story through the eyes of others, midwives may discover new realities and possibilities; determining generative learning possibilities within the same experience.

There is significance in elements of the design of this study. The traditional approach to conducting research of this nature has been to collect data by means of interviews, focus groups and questionnaires. Interviews and focus groups have the ability to gather rich data, however, in most cases, they do restrict participants to a particular geographical location. Questionnaires are capable of broadening the sample base, and with the use of open-ended questions, can collect rich qualitative data. They are, however, restricted to the written answers without the option of delving deeper into a participant’s response. This study is significant in its methods of data collection. The use of online and telephonic data collection allows for further discussion and exploration of responses; hence, providing thick descriptions of midwives’ experiences without the restriction of time and place, or indeed, the need to negotiate appointments, availability and venues for interviews.

There may also be the opportunity to adapt the data collection model for use in other studies seeking to discover alternate perspectives that may result in new answers and realities from a participant’s story. In addition, learning discovered by midwives may be able to be compared to what may be experienced by other health professionals for the purpose of helping to increase our understanding and knowledge in this area.
1.5 Clarification of Terms

**Fetal death**: The complete expulsion or extraction from its mother of a product of conception of at least 20 weeks gestation or 400grams birth weight, which after separation did not show any sign of life (Barfield, 2016, p. e2; Nguyen et al., 2008, p. 32). Signs of life include breathing, heartbeat, pulsating of the umbilical cord or definite movement of involuntary muscles (Barfield, 2016, p. e2).

**Miscarriage**: International Classification of Diseases 10th Revision (ICD 10): pregnancy loss before 22 completed weeks of gestational age (Lawn et al., 2016, p. 589).


**Perinatal death**: the death of a fetus or neonate during the perinatal period (Nguyen et al., 2008, p. 33), therefore inclusive of twenty weeks gestation to within 28 days of birth (Australian Institute of Health and Welfare, 2017, p. 35; Nguyen et al., 2008, p. 33).

**Stillbirth**: WHO definition: fetal death at birthweight of 1000g or more with an assumed equivalent of 28 weeks gestation (Lawn et al., 2016, p. 589).

**Stillbirth**: ICD 10 definition: late fetal death at 1000g or more or 28 weeks or more or 35cm or more; Early fetal death at 500g or more or 22 weeks or more or 25cm or more (Lawn et al., 2016, p. 589).

**Learning**: the process by which knowledge is created, retained, or transferred (Argote, 1999) and is evidenced by changes in performance (Chuang, Ginsburg, & Berta, 2007).

**Catastrophe**: an experience at a personal level of an incident that is intense, powerful and damaging, adverse and extreme. A high level of exposure to multiple stressors with profound and usually ongoing implications (Raphael et al., 2008).

**Crisis**: a negative event that commands a person's attention (Sweeny, 2008).
**Midwife:** a responsible and accountable professional providing support, care and advice in partnership with women during pregnancy, labour and in the postpartum period. A midwife conducts births and provides care to newborns and infants. A midwife will have completed an education programme based on the International Confederation of Midwives essential competencies for practice and global education standards. A midwife has the requisite qualification to be registered or licenced to practice as a midwife in their country of practice (International Confederation of Midwives, 2017).

**1.6 Structure of the Thesis**

In this first chapter, the background, aims and significance have been introduced. Research questions that guide the study are identified and relevant terminology defined. The following chapter details an in-depth literature review as a way to understand how this particular issue relates to the experiences of death for midwives, as well as for other professionals. Chapter two also provides an overview of relevant adult learning concepts. Chapter three outlines the theoretical underpinnings of the research, provides a reflection on personal assumptions related to the study, and identifies research methodologies. Chapter four contains the findings of the study. Chapter five discusses the implication of the findings related to the broader framework of knowledge from previous research findings. In the fifth and final chapter, conclusions are also drawn and recommendations and limitations of the study are detailed.
Chapter 2: Literature Review

2.1 Introduction
This chapter’s focus is the review of current research and theoretical discourse relating to the experience of perinatal death from the midwife’s perspective, and the effect this experience has on the midwife’s learning; in particular, any professional and personal transformation that may occur. To provide context for this focus, literature that more broadly describes the meaning of catastrophe is explored. The manner in which people in the helping professions experience death-related incidents, crisis or events as a part of their work is analysed. This provides a basis for an examination related to the complexity of learning that can occur through practice, experience and stressful work-related events, such as exposure to death-related incidents.

Following the broader discussion on catastrophe, the literature around how people in the helping professions respond to and manage catastrophes related to death and trauma is explored. Particular emphasis is placed on how midwives are prepared for and experience caring for women through the catastrophe of perinatal death. This is followed by an examination of literature that may help to explain how learning could occur during and from such experiences and the role this has in the midwives personal and professional development.

2.2 Search Strategy
A search of the literature was performed in March 2014, and then updated in April 2017 and February 2018, using CINAHL, PubMed, PsychInfo, Proquest and Cochrane Library to identify relevant studies to contribute, in the first instance, to a narrative review of the experiences of emergency and helping professionals when exposed to work-related catastrophe, crises or critical incidents. Articles that informed the topic on how comparable professionals may experience and react to a catastrophic event, such as the death of someone in their care, were chosen. The literature on learning theory relevant to this topic provides an overview of how learning may take place under these circumstances. This was followed by a systematic literature search for studies that more specifically described midwives’ experiences of caring
for women through perinatal death and the factors that characterise these experiences. The following search terms were applied to identify literature that described the experiences of midwives, midwifery students and nurses working in maternity settings, as well as learning that may result, in caring for women through a catastrophe such as perinatal death: ‘midwi*’ and ‘perinatal death’ or ‘stillbirth’ or ‘intrauterine death’ or ‘neonatal death’ or ‘dead baby in utero’, as well as ‘midwi*’ and ‘death’ and ‘learn*’ or ‘educat*’ or ‘train*’. Original articles and reviews from inception to February 2018 were included. The searches were not limited by study design, but were limited to peer reviewed journal articles written in English. As narrative or commentary-based articles, unpublished theses and other ‘grey’ literature may still shed light on the experience, these were considered to help inform the narrative review of the experiences of helping professionals. The searches yielded a total of 347 possible articles for the experiences of midwives, and 29 related to midwives’ learning and death (Figure 1 below provides further details of the literature retrieval process). Upon removal of duplicates, screening of title and abstract, a total for 28 articles describing experiences and four articles detailing learning met the inclusion criteria. A backward and forward reference chaining search of the reference lists of included articles and of Google Scholar was also conducted, further identifying three studies that met the search criteria.
2.3 The Nature of Catastrophe

A catastrophe has been described as a sudden and unexpected event that can occur anytime, anywhere and under any circumstances, leaving those directly and indirectly involved experiencing a range of emotions, including helplessness (Figley, 1983; Raphael, 2007). A catastrophe or traumatic event is not limited to only the result of a major disaster, but describes any event that carries the risk of inducing a major stress reaction for those who experience the event (Gamble & Creedy, 2009). Described as unpleasant and resulting in injury, violence or emotional shock, as well as usually occurring suddenly and without warning, catastrophes can be dangerous and emotionally overpowering (Boss, 2006; Figley, 2002). The unexpected nature of a catastrophe leaves no, or very little time to prepare (Figley, 2002), and may result in a sense of loss of personal control, which can lead to fear (Weisæth, 2007).
Catastrophic events occur across all sectors of the health industry and the resulting effects of incidents on patients, families and staff can be long lasting. In the health care industries, these types of events attract a number of descriptors including crises, sentinel events, critical incidents and catastrophe, the majority of which tend to be an event stemming from error, whether preventable or not, and will usually be followed by investigation. In their examination of learning in crisis simulations, Borodzicz and Van Haperen (2002) note that the terms emergency, disaster, catastrophe and civil emergency may be used when describing the same thing, therefore any of these events could be described as a catastrophe if it is sudden, unexpected and has a negative result. The way in which each individual responds to a catastrophe is unique according to their own psychological, physical, emotional, and spiritual characteristics, as well as their previous experiences and personal traits (Borodzicz & Van Haperen, 2002; Linnell, 2014; Williams, 2005).

Perinatal death has often been described as being catastrophic. This is in keeping with the term catastrophe being viewed as a descriptor for extreme events that are “intense, powerful and damaging, adverse and extreme” and experienced at a personal level (Raphael et al., 2008, p. 13). Such events generally include death, injury, illness and life-threatening circumstances that are also often sudden and unexpected (Borodzicz & Van Haperen, 2002; DeRanieri et al., 2002; Raphael et al., 2008; Williams, 2005). A negative event is a catastrophe if it is perceived by the individual to be so (Sweeney, 2008), and it is not only the individual who has had a personal relationship with the dead or dying who may experience this as a catastrophe. People working within human service professions have been reported to experience stress from secondary or indirect exposure as a result of working with people who have experienced a trauma (Cieslak et al., 2014). Furthermore, media coverage has been reported to have resulted in psychological distress in individuals outside of the directly affected community (Holman, Garfin, & Silver, 2014). These types of secondary traumatic stress responses experienced by health professionals, including midwives, will be discussed further in this review.

Catastrophe has been explained in terms of chaos theory, which proposes that systems that appear to be disorganised and random are in actual fact a part of a larger organised pattern (Lanza, 2000). This helps to explain incidents when either a well maintained aeroplane
crashes because of a minor fault, a patient dies as a result of a few unrelated events or what seems to be a normal pregnancy results in the death of the fetus (Lanza, 2000). Chaos is associated with change, surprise and unpredictability, but chaos theory sets out to demonstrate that the system can be understood if broken down and each piece examined, revealing that the complicated behaviour of systems is a result of simple nonlinear interactions of some of its components (Lanza, 2000). By breaking down and exploring the pieces that make up the responses of people in the helping professions to the experience of helping through death, resultant behaviour, interactions and possibly learning may be revealed. Accordingly, it could then be extrapolated that if the event of perinatal death is allowed to be compared, explored and reflected on, midwives may be able to examine each component of the event with a view to understanding how it has affected their work, relationships, practice and sense of themselves as midwives, and subsequently, what has been learned; what needs to be learned; and what could be learned from this catastrophe.

2.4 Responses of Helping Professionals to Death-Related Traumatic Events
An examination of the literature describing catastrophic events for professionals in the helping and service professions confirms that they are exposed to trauma on a regular basis (Showalter, 2010) and the impact can be far reaching (Cacciatore, 2012). Sudden and traumatic death has been described by DeRanieri et al. (2002) to be a catastrophic event resulting in significant disruption to those who have a relationship or connection to the deceased. The unexpected loss of a life affects many through their professional lives, whether as a result of the sudden, violent, or traumatic experiences of some catastrophes, or possibly the fact that other’s deaths may remind us of our own mortality, as Freud (1915, p. 289) explains:

"It is indeed impossible to imagine our own death ... at bottom no-one believes in his own death, or, to put the same thing in another way, that in the unconscious every one of us is convinced of his own immortality. When it comes to someone else's death, the civilised man will carefully avoid speaking of such a possibility in the hearing of the person under sentence."
Exposure to severe or traumatic events, such as death or the resulting human suffering, can lead to stress reactions which, if delayed or protracted, could be diagnosed as post-traumatic stress disorder (PTSD) (Skogstad et al., 2013). A necessary diagnostic criterion for PTSD requires exposure to a traumatic event (American Psychiatric Association, 2013). Exposure to such a trauma, according to American Psychiatric Association (2013) diagnostic criteria, does not only include direct exposure, but also includes witnessing someone else’s exposure; knowledge of violent or accidental trauma to a close friend or relative; repeated or extreme exposure to traumatic details and consequences of events, often in the course of professional duties. That is to say, those who are vicariously exposed to trauma related to death as a part of their professional duties, may develop secondary traumatic stress (STS) symptoms (Beck et al., 2015; Hargrave, 2010; Kunst, Saan, Bollen, & Kuijpers, 2017), experiencing emotions and behaviours that result from helping or wanting to help someone involved in a trauma (Beck et al., 2015; Kunst et al., 2017) and resemble traumatic stress symptoms that have been caused by direct exposure to a trauma (Chrestman, 1995; Figley, 1995); symptoms typical of PSTD (Beck et al., 2015; Kunst et al., 2017).

Researchers have been attempting to define treatment models that support the bereavement resulting from trauma for both clients and those who work with them (Cacciatore, 2012). Correspondingly, Showalter (2010) asserts that those who are both witnesses and healers may vicariously experience the emotional pain of those in their care. Whether it is a case of "blurred boundaries", or being strongly empathetic, involvement in other people's trauma affects helping and service professionals psychologically (Showalter, 2010, p. 239). STS (also known as compassion fatigue or vicarious traumatisation) has been shown to be experienced by the service professionals first on the scene where death has occurred, as well as through helping bereaved survivors (Hargrave, 2010). Accordingly, journalists, prison workers, clergy, attorneys, researchers, first responders (police, paramedics, fire fighters and other emergency service workers), doctors, mental health professionals, nurses, and midwives may thus experience loss and symptoms of STS. These professionals have the duty to care for people and may also have made a connection in some way. As a result, they may experience trauma themselves due to the tragedy of the death of someone who was in their care or with whom they engaged empathetically (Hargrave, 2010; Pearlman & Saakvitne, 1995; Sweeny, 2008).
2.4.1 Responses to death for first responders. A broad group of different professions has been identified as having the potential for experiencing symptoms of STS as a result of helping bereaved survivors in the course of their professional role. The first part of this review will concentrate on those in the helping professions who may have made a connection in some way, through short interactions. These professionals are generally first responders who have been described by Haugen et al. (2012) as those paid professionals and volunteers who respond to emergencies. In general, and for the purposes of this review, these occupations include police officers, fire fighters and emergency medical response professionals who, as first responders, may only make a brief connection with the patient/victim on the scene. This discussion will be followed by a review of the literature related to medical officers, nurses and midwives, all considered to be a part of helping professions that potentially would result in the establishment of a relationship over time with those who are in their care.

2.4.1.1 Responses by police. As frontline workers, and due to the nature of their work, police officers have an anticipated risk of significant exposure to potentially traumatic events, including witnessing other peoples’ suffering and death (Korre, Farioli, Varvarigou, Sato, & Kales, 2014; Skogstad et al., 2013). Police officers have reported working with the deceased and with bereaved survivors to be amongst their most frequent job stressors (Hargrave, 2010; Karlsson & Christianson, 2003; Sugimoto & Oltjenbruns, 2001). A sudden death is not only distressing for family and friends, but also for those who are first on the scene to help (Hargrave, 2010). According to Hargrave (2010), the impact of such situations in contributing to STS for those who are first at the scene is largely unknown.

In a study investigating factors that contribute to and result from peri-event distress in sudden death for family and friends (n=125), police officers (n=165) and victim support volunteers (n=148), Hargrave (2010) found that violent death, distress at survivor reaction and identification with the survivor were predictors of peritraumatic distress for first responders as well as affecting their ability to support survivors. The findings from this study by Hargrave (2010) were determined through a questionnaire completed by 165 police officers in New Zealand sampled from a list of officers generated by a computerised randomly generated list. A similar strategy was also used to recruit 148 victim support
workers, resulting in a mix of participants who were professionals and volunteers. The most distressing component for first responders working with sudden death was the interactions with the bereaved survivors, with the witnessing of grief and trauma reactions the leading predictor of peritraumatic distress (Hargrave, 2010). The findings from this study are comparable to similar studies that confirm that exposure to death and those affected by death may leave police officers vulnerable to adverse mental health effects, including traumatic stress disorders, as well as confirming the effect of social support in counteracting stress disorder symptoms (Haugen et al., 2012; Marmar et al., 2006; Stephens, Long, & Miller, 1997; Yuan et al., 2011).

The increased engagement by police officers in support strategies increases as the experience of distress becomes greater, according to Hargrave (2010), and the most helpful and most frequently used method of support for police officers was found to be talking to colleagues. This confirms the findings of Stephens et al. (1997) who reported that support from peers restricts the correlation between the event and PTSD. In contrast, Hargrave (2010) determined that talking to family and friends also corresponded to greater STS symptomology. This, however may be the result of reaching out to those closest at hand once STS symptoms were already being experienced (Hargrave, 2010). Various forms of support following an incident involving death were explored by Hargrave (2010). Participants were asked to rate on a five point scale how helpful they found “debriefing, supervision, talking to colleagues, talking to family and/or friends, and professional counselling” (Hargrave, 2010, p. 110). Although talking to colleagues and talking to family and/or friends rated highest as being helpful, unfortunately Hargrave (2010) does not provide an operational definition for 'talking', leaving the findings related to this relatively unclear. Nonetheless, Stephens et al. (1997) also describe the emotional support from peers, supervisors and people outside of work to be of benefit, and they explain that this may be due to the ability to communicate the negative aspects of their work experiences.

In an effort to determine the work activities that result in stress, the various duties of a police officer were ranked by Korre et al. (2014) according to the level of stress incurred. A list of duties was prepared and corroborated through a survey in order to compile the questionnaire that was then sent to senior police officers and frontline police officers. A
total of 27% (n=93) of eligible police departments returned the senior police officer survey, with 951 frontline police officers completing the frontline officers’ survey. Although analysed separately, Korre et al. (2014) found that senior or managerial police, and frontline police officer results were highly correlated, agreeing that the second highest stress causing duties for police officers is the witnessing of a traumatic event; findings that are consistent with those of Anderson, Litzenberger, and Plecas (2002), who used heart rate monitoring equipment to determine stress levels in working police officers.

Exposure to trauma as a result of responding to critical incidents is an expected part of a police officer’s work (Manzella & Papazoglou, 2014; Violanti et al., 2007). With this in mind, Manzella and Papazoglou (2014) sought to establish a standardised component of the police officer training curricula to help trainees to handle and process trauma by expanding the focus of training to include maintaining mental as well as physical fitness. At a three-day training seminar for senior police educators across Europe, Manzella and Papazoglou (2014) recruited 18 educators to take part in a study to learn ways to train trainees in handling exposure to trauma and loss. Participants engaged in three different learning intervention exercises, including: psycho-education about trauma, mindfulness and journal writing, followed by the completion of a questionnaire. One of the components of the mindfulness training included the sharing of a traumatic experience by participants, as well as receiving and giving feedback, in pairs. Only three out of the 18 senior police educators who participated in the study reported having in-depth knowledge about trauma, however, they stated that they appreciated having the issues highlighted and discussed (Manzella & Papazoglou, 2014). The mindfulness training was considered useful by 17 participants, and journal writing by 11 participants. These practical tools, according to Manzella and Papazoglou (2014), were designed with the knowledge that police officers belong to and value a police culture, and also consider police officers’ preferences to speak to a fellow officer rather than a health professional. Senior police educators are in a unique position to influence training as well as police culture, and Manzella and Papazoglou (2014) hope that this study will be a catalyst for further development of training and even collaboration with mental health practitioners for better teaching of how to manage trauma-related situations.
In an overview of previous research on the risk and resilience factors for PTSD in police and other first responders, Marmar et al. (2006) and Skogstad et al. (2013) confirm that police officers are continuously exposed to stressful and traumatic incidents. Police officers are at risk of developing PTSD with an incidence rate of up to 20%, not to mention those who fail to meet the full diagnostic criteria, but still suffer disturbing and debilitating symptoms (Marmar et al., 2006; Skogstad et al., 2013). Interestingly, results from a three group quasi-experimental study, which included rescue workers responding to a freeway collapse as a result of an earthquake, showed higher peritraumatic dissociation for rescue workers compared to police officers. These results are corroborated in studies reviewed by Haugen et al. (2012), highlighting the need to examine responses to trauma in emergency service workers as well as to consider preparation for managing these situations.

2.4.1.2 Responses by paramedics. Similar to police officers, the nature of the profession means that paramedics are likely to be exposed to death and related trauma. However, compared to police officers, paramedics are recorded as having a higher prevalence of PTSD, which is thought to be due to rescue workers’ difficulties in remaining detached (Haugen et al., 2012; Marmar et al., 2006). Additionally, paramedics, compared to other first responders, respond to more emergencies than those of police and fire services combined (James & Wright, 1991), resulting in greater psychological distress (Marmar et al., 2006). Subsequently, frequent exposure to critical incidents has been associated with higher reports of health problems in paramedics compared to analogous professions and the general population (Skogstad et al., 2013).

The experiences of paramedics working with victims of violence were explored in one study of 86 paramedics in a large urban emergency service (Regehr, Goldberg, & Hughes, 2002). The aim of the study was to understand which types of exposures are the most difficult for paramedics, and to explore the consequences, coping strategies and support. All participants completed questionnaires developed by Regehr et al. (2002) and 18 were interviewed to further explore their experiences. Paramedics did experience distress when they had been exposed to critical events, according to Regehr et al. (2002), with the most significant being when the incident involved the death of a child. A total of 84.9% of respondents were involved in an incident where a child died and 78% of them reported that
they experienced distress as a result. Incidents involving children were also rated as the most stressful in a study of paramedics by Clohessy and Ehlers (1999). These results are supported by a number of studies that indicate a higher rate of PTSD in paramedics compared to police and fire fighters, which appear, in part, to be because paramedics report incidents involving children to be particularly difficult (Haugen et al., 2012; Regehr, 2005; Skogstad et al., 2013). Respondents also reported that they found dealing with the grief of others to be distressing, with one paramedic saying, "it was just heart wrenching, I didn't want to talk to her, I didn't want anything to do with her at all, I couldn't even look at her." (Regehr et al., 2002, p. 507). These findings support Clohessy and Ehlers (1999) who also ascertained that paramedics' most intrusive memories involved the death of another person in 86% of the participants. The most common incident that lead to symptoms of PTSD were fatal vehicle accidents where children were involved (Clohessy & Ehlers, 1999; Skogstad et al., 2013).

Symptoms reported by paramedics in relation to PTSD associated with events involving death included, but were not limited to, anger and irritability, intrusive memories, flashbacks, diminished concentration, as well as significantly increased alcohol use, psychiatric medication and mental health stress leave (Clohessy & Ehlers, 1999; Hegg-Deloye et al., 2014; Regehr et al., 2002). Cognitive techniques were used to cope (Clohessy & Ehlers, 1999; Regehr et al., 2002), with paramedics reporting that they needed to maintain focus and have an enhanced ability to function during a crisis (Regehr et al., 2002). A conscious process of emotionally distancing themselves was used while making sure that they did not become emotionally attached (Regehr et al., 2002). To help with what Regehr et al. (2002) termed as closure, paramedics reported that it was helpful to seek information about events afterwards. This allowed paramedics to review their performance, ensuring that everything had been done correctly and learning opportunities from the incident had been explored.

Coping strategies that have been described by paramedics as useful and important following catastrophic events included having a friend, family member or spouse to share experiences with (Donnelly, Bradford, Davis, Hedges, & Klingel, 2016; Regehr et al., 2002), or having a safe place away from the stressors of work; with those who did not have these outlets
describing frustration about not getting support at home (Regehr et al., 2002). Peers form an important part of paramedics’ support structure, where the sharing of tales and telling jokes was reported to be helpful, although the 'macho atmosphere' did prevent real concerns and fears being discussed (Halpern, Maunder, Schwartz, & Gurevich, 2014; Regehr et al., 2002, p. 510). Similarly, Clohessey and Ehlers (1999) described a culture of distancing oneself from emotional reactions, making it difficult to find support at work. The majority of respondents indicated that there was little or no support from employers or unions (Regehr et al., 2002), or that these were their least preferred sources of support (Donnelly et al., 2016). Interestingly, participants reported that incidents where support is automatically offered generally are not incidents that have had the greatest impact on them. In contrast, it is often the smaller and 'less sensational' events that trigger an emotional response (Regehr et al., 2002, p. 505). Although these studies were each conducted in only one emergency service, the number of respondents for both, together with the inclusion of in-depth interviews by Regehr et al. (2002), provides a rich description of the paramedics’ experiences within those organisations. The rates of exposure to incidents and the vast differences in age and experience of the paramedics involved in the studies also help to provide results that are comparable to other studies across professions, organisations and geographical locations (Haugen et al., 2012; Marmar et al., 2006).

2.4.1.3 Responses by firefighters. Considered to be a highly dangerous and stressful occupation because of risk to self, as well as being witness to the suffering of others, firefighters have been described to have a prevalence of PTSD reaching 20% (Skogstad et al., 2013). Firefighters, in some countries, are also required to perform paramedic work. Under these circumstances, firefighters are not only exposed to similar experiences as paramedics, but may also be required to risk their own lives in entering a burning building (Skogstad et al., 2013). Considered a dangerous, stressful and physically taxing occupation, professional firefighting exposes firefighters to significant risk of injury, both fatal and non-fatal, intense and physically demanding working conditions, long hours (Lavee & Ben-Ari, 2007; Paulus, Vujanovic, Schuhmann, Smith, & Tran, 2017; Skogstad et al., 2013) and exposure to traumatic incidents (Corneil, Beaton, Murphy, Johnson, & Pike, 1999; Skogstad et al., 2013).
The most traumatic event determined by Katsavouni, Bebetsos, Malliou, and Beneka (2016, p. 33) in a cross-sectional study of 3289 professional firefighters in Greece was, as also described by paramedics, “dealing with death or rescue of a child”. In this study, which aimed to determine physiological, psychological and respiratory problems experienced by firefighters, respondents were asked to give a brief account of a traumatic event as a part of a self-reporting questionnaire. The top stress factors experienced by respondents was reported to be depression as a result of feeling responsible for the quality of victims’ lives, as well as pressure from observers (Katsavouni et al., 2016). This study found that, in general, firefighters reported a significant risk of occupational related problems as a result of physical and psychological stress. The great responsibility borne by firefighters is suggested by Katsavouni et al. (2016) to be related to firefighters often being the first responders, together with the belief that the first few minutes after injury are crucial to survival of the victim. The rate of PTSD was found to be 13% which is lower than those in similar studies in other countries that range from 22% amongst American firefighters (Corneil et al., 1999) to 18% in Germany (Heinrichs et al., 2005). With this in mind, Katsavouni et al. (2016) suggests that psychopathology of individual participants has an influence on the incidence of PTSD, which supports findings that determined that victims who suffered emotional disturbances prior to an incident, or those with a psychiatric history, were more likely to develop PTSD than other victims (Atkeson, Calhoun, Resick, & Ellis, 1982; Brewin, Andrews, & Valentine, 2000; Skogstad et al., 2013).

In order to identify predictive risk factors for PTSD in firefighters, Heinrichs et al. (2005) assessed 43 professional firefighters immediately after their academy basic training, then at 6, 9, 12 and 24 months after entering into a fire department. All participants underwent a medical and mental health screening before taking part in the study and were excluded if they presented with any mental health, drug or alcohol problems (Heinrichs et al., 2005). At each scheduled interval, data were collected using a questionnaire to assess personality characteristics and psychopathological symptoms using the PTSD Symptom Scale, the General Health Questionnaire, Zung Self-Rating Depression Scale, the State-Trait Anxiety Inventory, the SCL-90-R, the Toronto Alexithymia Scale, and the Inventory on Competence and Control Beliefs. Endocrine assessment was also completed by Heinrichs et al. (2005) using saliva and urine samples. The assessments undertaken by Heinrichs et al. (2005) on
completion of the participants’ basic training as firefighters were used as baseline data. Significant changes by the 24-month follow-up were that 16.3% of participants met PTSD criteria, within the ranges of similar studies, and 18.6% met criteria for subsyndrome PTSD; as well as an increase in body weight (Heinrichs et al., 2005). Interestingly, Heinrichs et al. (2005) found no correlation between the number and severity of traumatic events experienced and PTSD symptoms. The stepwise multiple linear regression analysis revealed two significant predictors of PTSD after participants had completed two years as firefighters. A high level of hostility and low level of self-efficacy at baseline, recorded before job entry, significantly predicted high PTSD symptom levels (Heinrichs et al., 2005). Those participants who had both the high hostility and low self-efficacy risk factors were found by Heinrichs et al. (2005) to show a general increase in all psychopathological symptoms across the duration of the study. The important question of the extent to which this data can be generalised to other populations is raised by Heinrichs et al. (2005) who suggest that the majority of studies have focused on male dominated populations, such as combat veterans, firefighters and police officers, and the risk factors may not be applied to more gender equal or female dominated populations.

Volunteer firefighters have shown incidences of PTSD greater than that of professional firefighters (Skogstad et al., 2013), suggesting that training and experience may be protective factors (Hytten & Hasle, 1989; Psarros, Theleritis, Martinaki, & Bergiannaki, 2008). Social support was also found to be a factor that reduced PTSD symptoms (Skogstad et al., 2013). Notably, when feeling supported and valued, people experience lower levels of distress (Regehr, Hill, Knott, & Sault, 2003). Although no connection could be confirmed in contemporary literature, it may be worth considering the potential similarity to the police culture influences described by Manzella and Papazoglou (2014).

To explore what caused high stress levels in new firefighters, as well as whether experienced firefighters have higher self-efficacy and social support to protect them from stress, Regehr et al. (2003) compared new recruits to a group of experienced firefighters. From a fire and emergency service in Toronto, Canada, 65 new recruits either just starting or just completing their training, and 58 experienced firefighters were recruited to take part in this mixed methods study. A questionnaire collecting demographic information also
gathered data on perceived social support and exposure to critical incidents by participants. Data was also gathered using The Beck Depression Inventory (BDI), the Impact of Event Scale (IES), the Social Provisions Scale (SPS) and the Self Efficacy Scale. No significant difference in trauma stress was found between participants at the start of their ten week firefighter training, or from those completing the training, therefore suggesting that exposure to training does not initiate a trauma response (Regehr et al., 2003). Significantly lower levels of social support from family and employer was reported by experienced firefighters, and support decreased as number of years of experience increased. Support from friends was significantly associated with traumatic stress scores, while depression was significantly associated with support from both friends and family. To that end, as the levels of perceived support for experienced firefighters decreased, depression and traumatic stress increased (Regehr et al., 2003). The self-efficacy scores of experienced firefighters was significantly lower than new recruits, and the greater the number of years employed was associated with lowering of self-efficacy (Regehr et al., 2003). These low self-efficacy scores of experienced firefighters are supported by the findings of Heinrichs et al. (2005). Based on the results of this study, Regehr et al. (2003) recommend that critical incident stress and self-care education be introduced into training and continue throughout a firefighter’s career. In this way, an individual will develop skills from the outset and continue to build on these as they are exposed to traumatic experiences.

Although there is no comparison in the literature, firefighting, as a male dominated profession, may be considered opposite to midwifery in terms of gendered professions. Reflecting on the core stressors for a male dominated profession such as firefighters, similarly with paramedics and police officers, the establishment of a relationship may just be one of several factors when considering similarities and differences in experiences of trauma between first responders and health care professionals. With the link being their exposure to death and human suffering, including the care of bereaved loved ones or survivors, other influences such as gender and type of exposure may also prove to be significant in acknowledging and managing learning from these experiences.

2.4.3 Responses by medical officers. Medical officers are likely to be treating patients in hospital or practice clinic situations as opposed to first responders who would
attend to people at the scene of events. It could, therefore, be proposed that medical officers and other health professionals may have a more personal experience with death. In particular, health professionals have direct interaction with a patient and are involved in care as well as learning about the patient as a person (Smith-Han, Martyn, Barrett, & Nicholson, 2016). Dealing with emotion and grief as a result of the death of a patient is an inevitable, but under researched part of medicine (Smith Bachman, 2016). Patient death is seen by some physicians as failure, while others experience it with heart-wrenching grief, but all need to navigate the uncertainty of practice and discover ways of coping (Smith Bachman, 2016). There is an expectation that doctors have the capacity to react to death in a professional manner:

"The civilised adult can hardly entertain the thought of another person's death without seeming to himself hard-hearted or wicked; unless, of course, as a doctor or lawyer or something of the kind, he has to deal with death professionally." (Freud, 1915, pp. 289-290)

In the face of these expectations, doctors find themselves having to transition to situations involving death with limited experience, and into a role of responsibility where they must manage working with uncertainty as well as negotiate multidisciplinary teams (Brennan et al., 2010). The experience of the unexpected death of a patient, together with managing day to day responsibilities, were reported by Brennan et al. (2010) to be significantly stressful for doctors. Despite revision to the curriculum and emphasis placed on learning about the clinical realities that will be faced, junior doctors experience the transition from student to newly qualified doctor to be extremely stressful (Brennan et al., 2010). Most notable was the expression of stress, lack of support, the feeling of being ill-prepared and the difficult emotions that arise when faced with death and dying. In this case, Brennan et al. (2010) revealed that, although changes to the medical programme curriculum had been implemented for greater support of doctors in their transition to practice, when death occurs or a patient is dying, there remains a lack of support for junior doctors.

In a study that specifically examined junior doctors’ first clinical experience of death, Kelly and Nisker (2010) elucidate a tension between professional detachment which medical
students perceive is expected of a good doctor, and emotional concern, which is influenced by support and debriefing opportunities. Three categories of death are experienced by doctors in different ways, according to Kelly and Nisker (2010), namely death of the elderly, death of a young person and the unexpected death. The death of a young person was seen as an unfair tragedy, and an unexpected death elicited questioning by the doctor as to their role, ability and control. Both of these latter types of death brought about contemplation of personal views on the meaning of life and death (Kelly & Nisker, 2010). The most common emotions expressed by participants following their encounter with death for the first time was sadness and shock, while the most common coping strategy used was to transform the death into a learning experience (Kelly & Nisker, 2010). Learning takes the form of contemplation of personal views of the meaning of life and death, and according to Kelly and Nisker (2010), the success of this learning is influenced by the support and debriefing received, particularly from supervisors and peers. Whether informal or formal, from supervisors or from family and friends, support and the opportunity to debrief leads to skill acquisition, affirming of professional relationships and reflection, which helped the medical student to integrate being professionally detached and emotionally involved. On the other hand, a lack of debriefing sees learning remaining an academic exercise, the patient tends to go unnoticed, and emotional concern was seen to be inappropriate and detachment appropriate and professional (Kelly & Nisker, 2010).

The health professional’s capacity to do their job can be affected by stress as a result of "give[ing] of themselves to support vulnerable and dying people" (Sorensen, 2009, p. 6). This is evidenced in the findings from studies on medical doctors’ experiences of death and dying by Jackson et al. (2005); Sorensen (2009) and Zambrano, Chur-Hansen, and Crawford (2014). In a mixed methods study, Jackson et al. (2005) explored the experiences of 196 physicians related to patient death using semi-structured, in-depth interviews as well as a purpose developed survey. Principal components analysis was used to produce key thematic clusters from the quantitative data, and these were used as the basis for initial coding of the qualitative data. All participants rated their memorable patient deaths to be "emotionally powerful" (Jackson et al., 2005, p. 650). The range and degree of emotion experienced was determined by a number of factors, including the relationship with the patient,
identification with the patient, coping strategies already learned, available support, as well as whether the death was expected or not (Jackson et al., 2005).

Similarly, in a qualitative study with seven palliative medicine specialists, Zambrano et al. (2014) also described the intense emotional reactions experienced by participants. Interestingly, these authors found that participants developed intense relationships with the dying patient that resulted in a blurring of boundaries, which doctors believed was acceptable as long as they were aware of their level of involvement and could assess and renegotiate boundaries. However, participants were all palliative care specialists with the expectation of the death of their patient, and as Zambrano et al. (2014, p. 311) reports, “Being a palliative care specialist was considered as an opportunity to know patients and to be present in a way that no other medical specialty or health profession could.”.

Physicians' experiences of death were not all negative, with 28% of experiences described as "good" deaths (Jackson et al., 2005). However, 44% of respondents reported deaths that were shocking or unexpected to be more emotionally powerful and disturbing, making them question their personal competence. Physicians also often experienced a lack of emotional and intellectual closure, according to Jackson et al. (2005), and felt, in part, responsible for the death. Junior clinicians reported experiencing patient death in isolation of senior colleagues, thus losing the opportunity to learn from senior clinicians (Jackson et al., 2005). To that end, this may help to explain junior doctors’ experiences of a lack of support, which has also been identified by Brennan et al. (2010). Similarly, Ratanawongsa, Tehrani, and Hauer (2005) give details around the strong influence that resident and attending physicians' attitudes had on students' perception of end of life care.

An examination into the effect of 89 clinician's attitudes and practices to end-of-life care by Sorensen (2009), found that doctors and nurses described their dealing with death to be anxiety invoking on a number of levels. Nevertheless, despite describing the experience to be emotional and stress inducing, participants also maintained that not all deaths were traumatic, and that the experience could be a positive one on the occasions where death was anticipated and prepared for (Sorensen, 2009). Participants in the study by Zambrano et al. (2014) downplayed the negative impacts of patient deaths by reframing their
experiences to highlight the positive meanings for both themselves and the patient. The findings of Sorensen (2009) and Zambrano et al. (2014) are comparative to similar studies even though they were elicited from the experiences in the intensive care unit (ICU) and palliative care environments, which would hold more of an expectation of death occurring. Moreover, the social context may shape the experience, suggesting that the catastrophic nature of the events experienced that are explored in this current study may elicit new and unexpected insights and understandings under different circumstances.

The notion of a ‘good death’ referred to by Jackson et al. (2005), was further explored by Trankle (2014) in a study examining the factors that influence a physician’s ability to manage death in an ICU environment. The study aimed to elicit meanings and experiences of end-of-life care in palliative and critical/acute settings in Australia. Thirteen specialist physicians with experience across palliative care and ICU took part in semi-structured in-depth interviews. Although the focus of this study was to explore end-of-life care for the 15% of deaths that occur in ICU, a setting not known for its ability to provide a ‘good death’, Trankle (2014) described what physicians consider to be a good death. Participants reported a multifaceted view of a good death that was centred around death being peaceful and in comfort. Participants also highlighted symptom control as well as good planning opportunity, in other words, not unexpected but rather having time for appropriate transition of the goals of care that also includes family input (Trankle, 2014). Communication was regarded by participants as crucial in fostering a good death, together with patients having control and input into treatment goals and decisions (Trankle, 2014). Participants considered addressing existential aspects of a patient’s life and death to be important to a good death, where meaning and purpose can be found, as well as looking beyond the disease and regarding the real person as valuable and important. In his recommendations, Trankle (2014) highlights the need for education and expresses the importance of consideration at a cultural level to dispel the unrealistic expectation of cure, a view that has been supported by Smith-Han et al. (2016).

To explore what medical students learn from their experience of the death of a patient, Smith-Han et al. (2016) followed 10 undergraduate medical students through their 3 years of clinical medical education. Using grounded theory analysis, 53 individual semi-structured
interviews were analysed to extrapolate how medical students experience the death of a patient (Smith-Han et al., 2016). In the first of three themes, participants described feeling emotionally diminished, decreasing empathy in order to cope with the emotional pain. A second theme described how medical students experienced a transformative change in perception in what it meant to be a doctor; from a heroic curative role, to a more caring role where death becomes a part of life rather than something traumatic. This role perception change also resulted in medical students perceiving a change in their identity which included a dulling of their emotions. The final theme, described by Smith-Han et al. (2016), explained the medical students’ experience of their professional environment, witnessing the ordinariness of death, understanding their role in finalising death, and feeling responsible to patients. An integrated approach to death and bereavement studies is required through the curriculum with the emphasis targeting the clinical years of study (Smith-Han et al., 2016). A key recommendation proposed by Smith-Han et al. (2016) included the need to translate the distressing experiences of students into worthwhile learning experiences; a recommendation that can also be found in literature exploring the experiences of nurses.

2.4.4 Responses by nurses. Registered nurses, like medical officers, provide end of life support and care to patients and their families as a regular part of their duties. As it was noted by researchers exploring the experiences of medical officers, the experiences of nurses around the death of their patients is still a growing body of knowledge (Brunelli, 2005; Gerow et al., 2010; Shariff, Olson, Salas, & Cranley, 2017). To this end, with the aim to describe the lived experience of nurses related to the death of their patients, Gerow et al. (2010) conducted semi-structured interviews with 11 registered nurses in Kansas, United States of America (USA) who represented a range of nursing specialties. Four themes were identified by Gerow et al. (2010). Firstly, as noted with doctors, the nurse may form a reciprocal relationship with the patient and family, which frequently can go beyond the typical professional relationship that would be expected. Subsequently, with the death of the patient, that relationship is lost. Secondly, all of the nurses participating in the study had clear and vivid memories of their first patient deaths and these experiences impacted on their future grief responses. That is to say, if it was a difficult and traumatic experience, this was carried through to subsequent experiences. Thirdly, also seen in doctors, nurse
participants’ view of death changed over time through their experiences and they reported finding ways to protect themselves emotionally and cope with the grief. Finally, nurses felt conflicted in that they were responsible for providing the best care for patients and believed that they were not meant to grieve when their patient died (Gerow et al., 2010). Nurses participating in this study by Gerow et al. (2010) believed that their role as a nurse did not allow them to become so invested in a patient as to feel grief, they should not feel the loss and should rather say goodbye and move on to the next patient. Nurses learned that the best way to protect themselves was to put up boundaries, compartmentalise their feelings and move on (Gerow et al., 2010). The data is limited in its sample from just one institution, although there was a diverse cross section of age, experience and area of specialisation. The researcher mentions that data was collected by five different interviewers and analysed by two. This may result in differing degrees of intimacy with the data on analysis. However, reassuringly, these results support those described by van Rooyen, Laing, and Kotze (2005).

A qualitative study of second year degree programme nursing students was undertaken by van Rooyen et al. (2005) to explore and describe the way in which nursing students experience the death of a patient. Unstructured interviews with six participants from a single university in South Africa found that student nurses experienced turmoil in their intrapersonal, interpersonal and transcendental relationships as a result of their first experience of caring for a dying patient (van Rooyen et al., 2005). Nursing students felt that they were not fully prepared for the challenges that the clinical setting delivered, where they experienced emotions of personal loss, grief, helplessness, self-doubt, fear and frustration as a result of caring for a dying patient. These second-year student nurses stated that they did not want to become “immune” to death in the way they had witnessed from more experienced nurses. Student nurses had an expectation, according to van Rooyen et al. (2005), that more experienced nurses would serve as role models. This however eventuated into an unmet expectation that resulted in conflict for nursing student participants. Instead, participants noted a lack of respect paid to the dying; insensitivity and indifference; isolation of the dying person; and a lack of teamwork (van Rooyen et al., 2005). Participants also described the need to find or create meaning through spirituality, religious practices and belief in what happens after death (van Rooyen et al., 2005). This study examined first experiences of patient death and concluded that student nurses needed
access to appropriate support to enable the first experience of caring for the dying to positively influence a nurse’s attitude toward subsequent occurrences (van Rooyen et al., 2005), a similar recommendation was concurred by Smith-Han et al. (2016) in their study of medical students’ experience of death. Although van Rooyen et al. (2005) collected data from only six participants in a single institution who had only been exposed to clinical practice as nursing students in a metropolitan hospital, the results from this study do compliment other research (Anderson, Kent, & Owens, 2015; Gerow et al., 2010; Smith-Han et al., 2016) and adds to the body of knowledge across different areas of nursing.

The influencing factors in nurses’ experiences of death and dying in wards caring for elderly patients in two hospitals in the United Kingdom was the notion of good or bad deaths (Costello, 2006). Data was collected by Costello (2006) using in-depth interviews with 29 registered nurses. The main factors that led to a good death, according to Costello (2006), included whether there were positive benefits, such as relief from pain and symptoms; the expectation of death; a high level of awareness for the patient and family; an absence of distressing symptoms; and limited impact on ward activities. Having control over the death and dying process was a most important determinant (Costello, 2006), similar to the finding of Trankle (2014) regarding doctors’ perceptions of a good death. Bad death was reported to have a traumatising effect on nurses, resulting in a negative impact on morale, and the potential for creating conflict. Bad death experiences for nurses was strongly influenced by situations of limited control, according to Costello (2006), as well as a lack of preparation, lack of dignity and respect, the patient suffering pain and unrelieved symptoms, and unexpected death situations. Improved communication to family members was suggested by Costello (2006) to be key to improving some of these issues, together with ensuring that the focus of attention remains on the death process and the patient, rather than organisational needs. Although this study focussed solely on elderly patients, it was able to highlight the conflict that can occur for nurses even when death is seen to be expected or likely and supports similar findings for experiences by doctors in studies undertaken by Jackson et al. (2005); Trankle (2014); and Zambrano et al. (2014).

An interpretive phenomenological study of a diverse group of 20 registered nurses in New Zealand was conducted by Anderson et al. (2015) to seek to understand participants’
experience of patient death. Registered nurses from a variety of training and practice backgrounds with a wide range of experience were asked by Anderson et al. (2015) to provide detailed descriptions of their earliest memorable experience with patient death. Occurrences ranged from a few months prior to participation in the study to over 30 years in the past. Significant findings described by Anderson et al. (2015) included the vivid recalling of events that potentially exerted lasting impact; distressing or negative experiences were frequently associated with being unexpected, unacknowledged and the nurse feeling inadequately prepared or helpless. When nurses felt that they had learned something, had the supportive influence of a role model and felt included and acknowledged, then the experience was regarded as a positive memory (Anderson et al., 2015). As noted with medical students, student nurses also reported enhanced learning when having the opportunity to share experiences with colleagues and to have practical and emotional support from a mentor nurse. Aside from reduced death anxiety and increased self-efficacy, unfortunately Anderson et al. (2015) did not report the specific learning that took place. Participants regarded these experiences as a “rite of passage for a nurse”, however, they did express frustration at their perceived lack of preparation, skills and knowledge related to death and dying, as well as identifying learning opportunities provided by these experiences (Anderson et al., 2015, p. 699).

The majority of nurses understand that it is inevitable that they will have contact with death and dying as a part of their professional role (Anderson et al., 2015). Given this point, one of the prominent themes through these experiences of nurses, and indeed most of the other professionals reviewed, appears to include education, skill development and a call to ensure that the experiences translate into positive learning experiences.

2.4.5 Responses by midwives. Midwives, like doctors and nurses, are likely to have formed a personal connection to those in their care. This close relationship that can develop between midwife and women in their care, for the majority, includes the establishment of a high level of empathetic identification with childbearing women (Beck et al., 2015; Ben-Ezra, Palgi, Walker, Many, & Hamam-Raz, 2014), placing them at risk for developing STS (Leinweber & Rowe, 2010). The experiences of professionals in other areas and disciplines must be synthesised to help inform future research into midwives’ experiences (Sheen et
Comparison to other professionals’ experiences alone however, may have implications for midwives who would have the expectation of involvement with new life and may experience elevated stress due to the expectation of life rather than illness, trauma and death (Alghamdi & Jarrett, 2016; Mander, 2004). Although bringing new life into the world is typically seen as a time of joy and awe, the maternity setting does have its risks and challenges in addition to being a happy environment in which to work (Goldbort, Knepp, Mueller, & Pyron, 2011; Sheen, Spiby, & Slade, 2016a).

Described as the guardians of normal birth by Fahy and Hastie (2008), midwives do witness traumatic and catastrophic events related to childbirth, as well as positive and uplifting births (Rice & Warland, 2013; Sheen et al., 2014). A traumatic perinatal event has been described by Beck (2004) to include incidents that occur during labour and birth, and a few hours into the postpartum period. These incidents are considered to be when a mother or baby is potentially at risk of death or injury (Beck, 2004). Under these circumstances, through providing care, the midwife is exposed to the trauma either as a direct witness, or by being told about the event by the woman during postpartum care (Sheen et al., 2014). The risk of STS in midwives, as a result of caring for women and witnessing traumatic perinatal events, has been reported by a number of researchers, including Beck et al. (2015); Ben-Ezra et al. (2014); Leinweber et al. (2017); Sheen et al. (2014), with an incident rate for labour and delivery midwives and nurses being reported as 35% (Beck & Gable, 2012). Despite this potential for STS related responses as a result of exposure to traumatic births by midwives (Leinweber & Rowe, 2010), there remains little empirical investigation into midwives’ responses and experiences (Sheen et al., 2014).

In keeping with what has been noted from the literature around traumatic stress responses in various professions thus far, Leinweber and Rowe (2010) describe compassion fatigue, PTSD, STS and vicarious traumatisation, in a review of literature of secondary stress responses in health care professionals, to all be stress related conditions caused by emotional labour. These stress responses, or ‘costs of caring’ (Foureur, 2013, p. 115), have been described in literature for midwives and nurses (Domínguez-Gomez & Rutledge, 2009; Foureur, 2013; McCool et al., 2009; Mollart, Skinner, Newing, & Foureur, 2013; Thomas &
Wilson, 2004), as well as other professions, with one explanation, according to McCreight (2005), being that this is as a result of under preparation in education and training.

The possibility that midwives experience Critical Incident Stress (CIS) following adverse pregnancy outcomes has also been highlighted by McCool et al. (2009) in their study of experiences and coping methods of midwives involved in adverse perinatal outcomes. This term for recurrent intrusive recollections of an event was first described by Laws and Hawkins (1995), and manifests in similar cognitive, physical, behavioural and emotional reactions as other stress related conditions. Twenty-two midwives from America, Asia, Africa, Australia and Europe were interviewed, and although accessing only a small sample, the study reached out for experiences across 6 continents. The semi-structured interviews conducted by McCool et al. (2009) focussed the data collected to an exploration of coping, as well as personal and professional consequences, to determine whether midwives' experiences were similar across different countries, and whether the outcomes of these experiences resembled CIS. All of the participants displayed symptoms of CIS, but differences in the causes of fear and anxiety were noted by McCool et al. (2009), especially between midwives in developed and developing nations. Interestingly, following an adverse event, the two main concerns for midwives in developed countries were the fear of litigation and the desire to be able to move beyond the strong emotions they felt, and to heal personally (McCool et al., 2009).

In contrast, midwives from developing nations feared the loss of their livelihood due to public humiliation. There is the risk of public exposure through the woman’s family or the media, which can lead to defaming of the midwife’s skills in order to gain retribution or cause humiliation (McCool et al., 2009). This finding is however based on a small number of participants, which limits the findings, considering the study included midwives from multiple countries. Critical incidents have been defined by Laws and Hawkins (1995) as events causing an individual to experience strong emotions contributing to impairment of daily functioning. Maternal and fetal deaths were deemed by McCool et al. (2009) to be critical incidents that contribute to CIS symptoms in midwives, and are considered by midwives themselves to require development of skills to assist them in personal and professional coping. This study by McCool et al. (2009) however does not explain how
midwives manage and counteract these CIS symptoms in order to maintain professional functioning, growth or development.

An online survey of 687 members of the Australian College of Midwives by Leinweber et al. (2017) sought to assess the exposure and reactions of midwives to perinatal trauma to determine prevalence of PTSD. Participants identified types of traumatic birth events that they had witnessed and Leinweber et al. (2017) produced a pilot-tested measure, The Traumatic Events in Perinatal Care List (TEPCL), to assess the different types of traumatic events that may take place during labour and birth. Categories finalised for the TEPCL measure included maternal or fetal death (actual or threatened); maternal or fetal injury (actual or threatened); abusive care; poor care; and interpersonal disrespect. Participants were asked to indicate the type of perinatal trauma witnessed and specify whether or not they experienced fear, horror and helplessness during or shortly after the event. Participants were also asked to express whether or not they had feelings of anger, guilt, powerlessness or accountability during or shortly after the event. To assess for evidence of PTSD, the PTSD Symptom Scale Self-Report (PSS-SR) was administered by Leinweber et al. (2017) to participants.

Reactions to perinatal trauma by midwives indicated that 92% experienced helplessness and 75% were horrified (Leinweber et al., 2017, p. 42). Results revealed that 51% of the participants recalled an immediate fear reaction, 97.2% felt deep concern, 84.2% felt anger, 82% felt powerlessness and 65.3% recalled having guilt feelings, while 46.7% of participants felt responsible for the event that they had witnessed (Leinweber et al., 2017, pp. 42-43). Scores for the PSS-SR ranged from 0 to 46 out of a possible total of 51 and the prevalence of probable PTSD was 17% (Leinweber et al., 2017, p. 43). This finding for the prevalence of PTSD symptoms in midwives is lower than other studies such as Sheen et al. (2014) with 33% and Beck et al. (2015) at 36%. Such differences between studies was also noted in prevalence of PTSD related research in first responders. The difference, according to Leinweber et al. (2017), may be as a result of differences in conceptualisation and measurement of PTSD, together with the use of different PTSD scale instruments. With each of these studies taking place in a different country, namely the USA, United Kingdom (UK) and Australia, it may be interesting for future studies to examine how different training and
professional practice arrangements may be an influencing factor for the prevalence of PTSD in midwives as a result of exposure to traumatic birth related events.

An interesting finding by Leinweber et al. (2017), the only study to differentiate types of perinatal trauma, was that perinatal trauma events that included death, poor care or interpersonal disrespect were not significantly associated with PSS-SR scores. However, this study suggests that traumatic events where injury has been caused, or when abusive care has been witnessed by midwives, are the most likely to result in PTSD symptoms (Leinweber et al., 2017). Unfortunately, Leinweber et al. (2017) does not categorise birth trauma into maternal or fetal, or indeed delineate or make comparisons in their findings regarding maternal birth trauma or fetal birth trauma. Nonetheless, the significance of the findings of Leinweber et al. (2017) for this current study may be in the type of reaction by midwives and their subsequent needs following an event resulting in perinatal death as opposed to when injury or potential injury has occurred.

As a part of their study to determine psychological impacts on midwives due to experiencing traumatic births, Sheen et al. (2014) and Sheen, Spiby, and Slade (2016b) analysed event descriptions to elucidate types of events that midwives consider to be traumatic. A survey of work related trauma was completed by 421 midwives in the UK who had experienced a traumatic perinatal event (Sheen et al., 2014). As a part of the survey, midwives were asked to describe the traumatic perinatal event that they had experienced. These three to four line descriptions of events, either witnessed by themselves or recounted by women in their care, were analysed to portray the types of perinatal events that midwives consider to be traumatic (Sheen et al., 2016b).

Midwives participating in this study by Sheen et al. (2016b) were all currently working in clinical practice and had been midwives for between six months and 44 years. Descriptions of 399 witnessed events and 283 events told to midwife participants by women in the midwives’ care were provided and analysed using thematic technique with six main themes emerging, each with a number of sub-themes (Sheen et al., 2016b). In one of the main themes, ‘Event Characteristics’, perinatal death was described to be a traumatic event under the sub-themes ‘Unexpected and Sudden’ and ‘Difficult to control’ (Sheen et al.,
Another main theme described the relationships between midwife, mother and partner. Two sub-themes, ‘Supporting or delivering devastating and difficult news’ and 'Difficult relationships with parents', recognised the trauma for a midwife who has built a relationship with a woman and her family before their baby dies (Sheen et al., 2016b, p. 58). Midwives described events, including perinatal death, as traumatic when they had not felt supported by their colleagues and when blame was attributed either personally or when perceived as coming from others for what had happened. These findings support those by other authors who have investigated the effects of traumatic events on midwives (Beck & Gable, 2012; Beck et al., 2015; Rice & Warland, 2013) and highlight the importance for organisations to recognise that traumatic events, such as perinatal death, may be perceived as difficult by staff as well as for women and their families (Sheen et al., 2016b).

Managing critical situations is an inevitable part of midwifery practice, however, suitable support is imperative to prevent devastating consequences to the midwife as a result of the impact of a traumatic practice event, and to maintain a confident and competent midwifery workforce (Calvert & Benn, 2015). Using biographical narrative interviews, 16 midwives shared the stories of their traumatic practice experience with Calvert and Benn (2015). A range of traumatic events were described by participants, including neonatal death. This study by Calvert and Benn (2015) found that midwives experience similar physiological and psychological effects that have been noted in other health professionals exposed to traumatic events, however for midwives, the trauma event is exacerbated by a breach of relational trust. Midwives participating in this study demonstrated there having been an impact on their personal and professional identities as a result of the traumatic event as well as loss of identity, grief and a need for support (Calvert & Benn, 2015). A common thread through the stories was reported by Calvert and Benn (2015) to include a failure to acknowledge loss, experiencing grief, lack of support, disruptive debriefing sessions and workplace violence in the form of shaming and blaming. Although these were the general findings, conversely in the case of neonatal or maternal death cases, midwives found the midwifery community to be caring and supportive. These findings possibly suggest that grief associated with death is more socially acceptable (Calvert & Benn, 2015).
Although the relatively low number of participants may influence the ability to gain a complete understanding of the range of different types of traumatic events experienced by participants, the findings by Calvert and Benn (2015) do support findings from other studies. Midwives experience feelings of guilt and responsibility for the inability to change an outcome outside of their control (Pezaro, Clyne, Turner, Fulton, & Gerada, 2016; Rice & Warland, 2013); asking “what could I have done differently?” (Rice & Warland, 2013, p. 1061). This in turn diminishes professional confidence and makes them more likely to leave the profession (Pezaro et al., 2016). Authors have commented that midwives are not adequately prepared to cope with the emotional side of midwifery (Coldridge & Davies, 2017; Hunter, 2005) and need to have a safe place to be able to talk and reflect on experiences (Coldridge & Davies, 2017; Halperin et al., 2011) rather than maintaining the culture of soldiering on in silence (Kirkham, 1999; Pezaro et al., 2016).

2.5 Midwives’ Experiences of Caring for Women Through the Catastrophe of Perinatal Death

In previous sections, an exploration of the literature has aimed to gain an understanding of how first responders and health professionals respond to traumatic events, including the death of someone in their care. Thereupon, the possible similarities and differences in response to traumatic events for midwives has been extrapolated. Under the circumstances that limited research was found that directly examines the way in which midwives experience caring for a woman through perinatal death, all literature that describes midwives’ and obstetric nurses’ responses to witnessing traumatic births has been analysed. The following section will henceforth elucidate the literature that specifically investigates the experiences and responses of midwives to the death of a fetus occurring in the perinatal period.

Midwives are intimately involved with the process of birth. Accordingly, the nature of their caring role, combined with the expectation of new life, often results in the development of a personal relationship between the midwife and mother that is likely to be further intensified by the often-unexpected nature of perinatal loss (Hodnett et al., 2011; Homer et al., 2002; McCreight, 2005). This relationship, and associated circumstances, may exacerbate the effects of the death of a perinate, an event that has been described as a life crisis for both
parents and health professionals (Gardner, 1999). The experience of loss is intensely individual and highly personal, and existing research suggests that health care professionals, including midwives, see perinatal death as a catastrophic event, which generates feelings of failure and guilt and challenges professional purpose (Black et al., 1989; Mander, 2004; McCreight, 2005).

In midwifery, the act of caring for women is often referred to as ‘being with’ the woman (Hunter, 2009; Page, 2003; Thelin, Lundgren, & Hermansson, 2014); that is to say, it is the provision of emotional, physical, spiritual and psychological support to the labouring woman (Hunter, 2009) through a relationship built on mutual confidence and trust (Berg, 2005; Hunter, 2009; Kennedy, Shannon, Chuahorm, & Kravetz, 2004). This ‘being with’ is not just a physical locality, but a journey travelled together (Jones & Smythe, 2015); a caring relationship that is based on confidence and trust, requiring the provision of sensitive, high quality care according to individual needs (Bakhbakhi, Burden, Storey, & Siassakos, 2017; Downe, Schmidt, Kingdon, & Heazell, 2013; Mander, 2009). For these reasons, it is apparent that there are expectations on midwives with seemingly little consideration for the emotional impact on the midwife (Wallbank & Robertson, 2013).

There has been limited research into how healthcare professionals experience caring for women at a time of perinatal death (Andre, Dahlø, Eilertsen, & Ringdal, 2016; Mander, 2009; Wallbank & Robertson, 2008, 2013). This claim is also supported by a systematic review of studies between 1990 and 2016 that explore and describe midwives’, obstetricians’ and nurses’ experiences of caring for women at a time of perinatal death. In this review, Andre et al. (2016) found only ten articles meeting the criteria to be included in the review. All ten studies reported on emotional reactions, with the most intense and frequent being stress and shock with other responses including, sadness, guilt, self-blame, withdrawal, depression, denial, anxiety, fear and lack of meaning. All of the studies reviewed by Andre et al. (2016) expressed a need for a change in culture, with health care professionals needing to break the silence that surrounds emotional responses related to perinatal death; thereby acknowledging and normalising these reactions. Education and training were highlighted as important issues, particularly in bereavement care. Formal and
informal support from colleagues, friends, family and support groups was reported to be valued on both a personal and professional level (Andre et al., 2016).

The maternity setting context, as a female gendered healthcare setting revolved around birth rather than illness, may need to be considered in a different light to other professions who must also face death and trauma as a part of their work. Current research reports intense emotional responses; however there tends to be a culture that allows for relatively little acknowledgement of these type of feelings. Additionally, the assumption that a maternity unit is always a positive environment filled with only happy events, potentially leaves midwives encountering difficulty in voicing their feelings (Wallbank & Robertson, 2013). Even so, research conducted thus far suggests that the need to develop and deliver empathetic interactions may stand in conflict with healthcare professionals’ need to protect themselves emotionally (Wallbank & Robertson, 2008). Equally important, the emotional responses of healthcare professionals to perinatal death often remain unacknowledged by the profession and unspoken about by those involved (Cowan & Wainwright, 2001; Mander, 2009; McNamara et al., 2017). Significant and personal adverse effects have been reported to be experienced (Andre et al., 2016), and understanding the potential impact of these experiences may help midwives to better prepare themselves and be able to express their emotions in an adequate way (Andre et al., 2016), which may, as a result, lead to assisting in the provision of higher quality care (Wallbank & Robertson, 2008). To better understand the experiences of midwives, and nurses working within maternity settings, while caring for women through perinatal death, the literature will be further discussed within the categories: emotional responses to perinatal death; emotional labour; professional image and the effects of blame, shame and guilt; education and training; personal and professional support.

2.5.1 Midwives’ emotional responses to perinatal death. Research into midwives’ experiences of perinatal death most frequently report the expression of stress and shock (Andre et al., 2016; Gardner, 1999; Jones & Smythe, 2015; McCool et al., 2009; McNamara et al., 2017), as well as feeling personal loss and sadness (Alghamdi & Jarrett, 2016; Jones & Smythe, 2015; McCool et al., 2009), guilt, self-blame, anxiety and fear (Jones & Smythe, 2015; McCool et al., 2009; Montero et al., 2011; Nallen, 2006, 2007). Midwives describe a
tendency to want to withdraw from the situation (McCool et al., 2009; Montero et al., 2011) and find it difficult to handle the parents’ emotions, while at the same time trying to cope with their own feelings and reactions (Gardner, 1999; Nallen, 2006, 2007).

To gain an understanding of the stress responses of those professionals providing maternity and obstetric care in situations such as miscarriage, neonatal death and stillbirth, Wallbank and Robertson (2013) implemented the transactional model, a validated framework for assessing stress in the workplace. A response rate of 54% of doctors, nurses and midwives, employed in obstetric and gynaecological settings in 5 hospitals in the United Kingdom, and eligible to take part in the study, resulted in 184 participants. Only 17% of eligible midwives did not return questionnaires, making the midwife response rate significantly higher than from doctors and nurses (Wallbank & Robertson, 2013). The questionnaire included 4 measures; the Impact of Event Scale (IES), the Positive and Negative Affect Scale (PANAS), the Work Environment Scale (WES) and Brief COPE. Subjective distress levels indicating a high level of clinical concern by the IES was recorded by Wallbank and Robertson (2013) in 55% of respondents, with a further 24% recording a moderate level of clinical concern. Interestingly, in Wallbank and Robertson’s (2013) findings, there was no significant correlation between amount of formal training and total IES score; suggesting that training is necessary, but not sufficient on its own, to support midwives. Perceived inadequacy of social support was however revealed to significantly predict increased distress (Wallbank & Robertson, 2013). Maladaptive coping styles, such as self-blame, disengagement and denial, were the strongest predictors of distress, exacerbating the negative effect of the stressor (Wallbank & Robertson, 2013). The total PANAS score was also a compelling predictor of distress, with those reporting more negative emotions also reporting greater stress (Wallbank & Robertson, 2013).

As has been noted, managing emotional reactions to loss by disengaging and withdrawing; focusing rather on physical care and administrative tasks, are ways in which midwives attempt to cope with this difficult aspect of their work (Mander, 2009; Wallbank & Robertson, 2013). Equally important is the concept of emotional labour, which has emerged in opposition to the view that expressing one’s emotions is not appropriate, or even dysfunctional, within professional practice (McCreight, 2005).
2.5.2 Emotional labour. Childbirth is an emotionally laden event across cultures, a time that can bring about joy and delight, to extremes of fear and anxiety (Hunter, 2010). Furthermore, midwifery is an example of a gendered profession, a predominantly female workforce providing intimate and sensitive care predominantly to women (Hunter, 2010). The concept of emotional labour was developed by Arlie Hochschild in her study of airline attendants (Hochschild, 1983), and has been defined as “The induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place” (Hochschild, 1983, p. 7). As a conceptual device, emotional labour can help to explore the culturally imposed rules about feelings, where it is required to sustain relationships under challenging, demanding or difficult circumstances, and help us to understand emotions management within different occupational groups (Hochschild, 1979; Hunter & Smith, 2007).

In some occupations, such as flight attendants, the concept is in the expressive emotion work, such as a smile for all circumstances (Hochschild, 1979, 1983). Real feelings are suppressed to maintain a pleasant and reassuring environment, and this suppression of genuine feelings comes with degrees of personal cost that can include burnout, cynicism and distancing (Hochschild, 1983). Within the healthcare context, emotional labour is particularly needed in distressing situations, such as caring for terminally ill patients, as well as pain, emergency and loss events (Hunter & Smith, 2007). In midwifery, empathetic engagement with women has been determined by Moloney and Gair (2015) to be an important factor in women’s positive birth experience. Then again, empathetic engagement is a potentially vulnerable factor for midwives (Sheen et al., 2016b).

Emotional labour and its connection to midwifery work has been explained by Hunter (2001) in a literature review of relevant midwifery, nursing and sociological literature. Based on the work by Hochschild (1979, 1983, 1989), Hunter (2001) ascribes emotional labour to the midwifery context as management of feelings and the expression of emotion that is a significant and demanding aspect of working with and caring for people. The context of midwifery work, particularly when it involves childbirth, could be described as an emotional minefield (Hunter, 2001). There are often high levels of expressed emotion, from both woman and partner, which in turn require emotion work on the part of the midwife.
(Hunter, 2001). Equally important, the notion that a midwife’s role in birth and new life is a joyful experience that is a privilege to be a part of, may in fact prevent midwives from acknowledging the emotionally demanding reality of their work (Halperin et al., 2011; Knapp, 2015). Interestingly, in a study of nurses experiences of perinatal death in obstetric, emergency department and surgical wards by Hutti et al. (2016), participants described switching their emotions between happy and sad to be congruent with the emotional state of the woman in their care. For the participants in labour and delivery units, however, this was particularly difficult as they were caring for an intensely grieving family in one room and a joyous family next door. These labour and delivery unit nurses described this to be emotionally draining (Hutti et al., 2016)

Emotional labour is guided by ‘feeling rules’, according to Hochschild (1979, p. 563), governing both displayed and felt emotions. In the same manner as most organisations, maternity units have feeling rules that influence the way in which emotion is expressed by midwives (Hunter & Deery, 2005); and the stressful, exhausting and onerous effort to disguise real emotions also requires emotion work (Hunter & Deery, 2005). In a review of two different studies of midwives’ experiences to determine emotional labour, Hunter and Deery (2005) suggest that amongst other experiences, caring for a woman whose baby has died is a source of emotion work. Midwives participating in these studies reported using ‘impression management’ behaviour (Hunter & Deery, 2005, p. 12) to mask personal feelings as a way of coping and remaining professional. As an illustration, one midwife admitted to waiting until she is driving home before she cries following an event such as a stillbirth (Hunter & Deery, 2005). In contrast, not all midwives expressed the need to mask their emotions, feeling that it was appropriate to share emotional experiences with colleagues and express emotions in front of the woman in their care (Hunter & Deery, 2005).

Understanding emotional labour and the role that it plays for midwives who are caring for an expectant or new mother is essential when considering the impact that catastrophic events, such as perinatal death, may have on the midwife. The high degree of empathy required of midwives has been associated with high levels of workplace stress (Abendroth & Flannery, 2006; Maytum, Heiman, & Garwick, 2004). Additionally, the concept of emotional
labour is a potential area of role conflict for the midwife (McCreight, 2005) as health care professionals, from areas such as medicine, nursing and psychology, describe a high degree of empathy to have the potential for distortion of appropriate boundaries between patients and professionals (Leinweber & Rowe, 2010). This may have an effect on midwives’ concept of professional image as well as their grief response.

2.5.3 Professional image and the effects of blame, shame and guilt as a response to perinatal death. Acknowledgement by midwives of their deepest responses to the grief encountered has the potential to leave them at odds with the institutional demands for professional behaviour. Such demands may require a minimisation of the emotional aspects of the midwife’s role, and their view of emotions as being significantly embedded in the work of midwifery (McCreight, 2005). By the same token, Showalter (2010, p. 240) expresses concern that some professionals define themselves as “being what they do”, and in doing so, are blurring the professional boundaries between themselves and those in their care. This is further explained by Showalter (2010) as a blurring of boundaries that may lead to professional disappointment, which would also link to self-worth. Following the death of a person in their care, the grief process for midwives and nurses is different to that of the family and friends as nurses and midwives find themselves in this conflicting role of grieving a loss, yet needing to remain supportive and professional at the same time (Brunelli, 2005; Gerow et al., 2010).

In exploring the emotional reactions of midwives to perinatal death, studies have reported a need to break the culture of silence or the maintaining of a stoical image in relation to emotional reactions, and to communicate these emotions to normalise and promote acknowledgement (Jones & Smythe, 2015; McCool et al., 2009; McCreight, 2005; McNamara et al., 2017). Midwives reported feeling unprepared as they knew little about others’ reactions and feelings (Gardner, 1999; Montero et al., 2011) with the focus having been on the physical care during these events (Montero et al., 2011).

Following a crisis, Smith and Elliott (2007) suggest that there is often a search for a culprit or possibly a search for scapegoats. Strategies used by those involved in the crisis to preserve self-esteem and to attempt to reduce psychological pain was found by Smith and Elliott
(2007) to potentially severely inhibit learning. Declaring a change to the blame culture in healthcare, The Institute of Medicine’s report (Donaldson, Corrigan, & Kohn, 2000) asserts that a new culture of promoting disclosure and learning in the aftermath of an adverse event now exists (Denham, 2007; Scott et al., 2009; Woodward, Lemer, & Wu, 2009).

Feelings of shame, blame, guilt and existential concerns were explored in a mixed methods design study by Schrøder, Jørgensen, Lamont, and Hvidt (2016). In this national study conducted in Denmark, 293 obstetricians and 944 midwives (52% and 61% respectively of registered professionals in Denmark) responded to the survey (Schrøder et al., 2016, p. 736). Traumatic childbirth was determined by Schrøder et al. (2016) to include events in which baby or mother suffered permanent, severe and possibly fatal injuries related to birth. Participants completed a questionnaire pertaining to the traumatic birth that had had the greatest impact on them, and 14 participants were recruited from these to participate in individual semi-structured interviews. Midwives and obstetricians participating in this study who had experienced caring for women through traumatic childbirth expressed a fear of being blamed by the woman, colleagues or through official complaints. In reality though, few had experiences of actual blame being levelled against them (Schrøder et al., 2016). Half of the respondents expressed having feelings of guilt even when there had been no blame levelled against them. Participants described agonising over whether they could have done something to prevent the outcome, and some stated that the guilt would never leave them (Schrøder et al., 2016).

Existential considerations for respondents were reported by Schrøder et al. (2016) to include pondering the meaning of life, contemplating emotional and/or spiritual personal development opportunities, and considering that the experience has made them a better midwife or obstetrician. Leaving the profession was not a consideration for 75% of participants, however two did leave following a traumatic childbirth experience (Schrøder et al., 2016). There was no discussion related to learning or support for participants in this study, but the results do support the notion that a culture of blame toward clinicians does appear to be low, with guilt and self-blame being mainly administered by the clinician toward themselves.
In a similar study conducted in Sweden, Wahlberg et al. (2017) directed their questionnaire to explore whether midwives and obstetricians had experienced negative reactions from babies’ parents or family members following a traumatic event, whether the event was subject to event analysis, reported to the relevant board or a case of medical negligence laid. A breakdown of the number of incidents by type of traumatic event was included by Wahlberg et al. (2017). This indicated that perinatal death during delivery was experienced by 22.2% of midwife respondents and 28.3% of obstetricians. Death after delivery, but due to delivery-related causes, was experienced by 18.4% of midwife respondents and 34.7% of obstetricians (Wahlberg et al., 2017, p. 12). Midwives and obstetricians self-reported that 20.8% and 35.4% of events respectively were subject to event analysis; 10.2% of incidents for midwives, and 23.7% for obstetricians were reported to the relevant board by the hospital; while 14% (midwives) and 22.4% (obstetricians) of incidents attracted complaints by women and their family (Wahlberg et al., 2017, p. 12). Unfortunately, these results are not broken down according to type of event, as it would be valuable to be able to determine which events attract referral or complaint. However, this does support the notion by Schrøder et al. (2016) that blame is more often self-apportioned rather than actually levelled by other practitioners. These two studies by Schrøder et al. (2016) and Wahlberg et al. (2017) include obstetricians as well as midwife participants, and although they examine traumatic births rather than exclusively exploring the experiences from perinatal death, they do facilitate in understanding the professional turmoil that can be experienced by midwives.

Fostering a no blame culture is an important step towards allowing midwives to express their feelings and reactions (Nallen, 2007). In a study to determine midwives’ needs for providing bereavement care, Nallen (2007) reported that midwives frequently felt guilty about the death of a baby, even if it was beyond their control. Participants in this study expressed feeling guilty even when knowing it was not their fault, as well as needing to have someone tell them that it wasn’t their fault (Nallen, 2007); findings confirmed by Wahlberg et al. (2017) and Schrøder et al. (2016). Midwives felt strongly about a no blame culture, stating that there was need for an “absence of blame, that you wouldn’t be blamed, that you don’t feel accountable for what has just happened”, and “you don’t need this dissected into something looking for someone to blame, absolutely not!” (Nallen, 2007, p. 106).
Displays of emotion by midwives is surrounded by dissonance in what is construed as professionally acceptable and unacceptable. In a critical review of key research into the experiences of midwives caring for women through perinatal death, Wallbank and Robertson (2008) agreed that there was a consistent indication by midwives that they needed to manage their responses actively and the difficulty experienced in maintaining a professional persona whilst not appearing ambivalent. Nurses in the study by McCreight (2005) asserted that the experience of showing the strength of their feelings was not a collapse of rationality unrelated to rational thought and knowledge, but rather asserting a holistic view of knowledge inclusive of the need for acknowledgement of the deepest responses to the grief they encountered. The necessity for nurses and midwives to engage in real time critical reflection as a means of professional development that incorporates emotion work was expressed in this qualitative study of 14 nurses working in a gynaecological unit in Northern Ireland by McCreight (2005). Responses by nurses highlighted the need for nurses to value their emotion as a part of rational thought and knowledge, rather than as either a marginal or dysfunctional aspect of their work (McCreight, 2005). To facilitate the culture change, healthcare professions needed to allow, acknowledge and understand the expression of emotion within one’s work. Adequate education and training for midwives has been proposed by a number of authors to be a key factor, including Rich (2002) who suggests the introduction of relevant professional educational programmes.

2.5.4 Midwives’ education and training needs. The 'costs of caring' (Foureur, 2013, p. 115) have been well described in literature for midwives and nurses (Domínguez-Gomez & Rutledge, 2009; Foureur, 2013; McCool et al., 2009; Mollart et al., 2013; Thomas & Wilson, 2004) with one explanation, according to McCreight (2005), being that this is as a result of under preparation through education and training. This may be a somewhat generalised view if one considers how different each midwife is as an individual, in their training and experience, as well as the setting and circumstances surrounding a perinatal death. However, those who are charged with the care of women and families through this devastating time have been reported to be inadequately trained and prepared for either perinatal death (Alghamdi & Jarrett, 2016; McCreight, 2005; McNamara et al., 2017), or for providing support to parents, or for their own self-care (McNamara et al., 2017). This lack of
preparation leaves midwives to learn these skills through experience. Learning through one's experiences has been described by Kohner (2001) to be the most appropriate form of training to effectively prepare and support midwives. In reality however, this experiential learning will be influenced by a number of factors, including the work setting and role models available. Vehicles for achieving learning through experience, on the one hand, include simulated learning experiences. On the other hand, existing knowledge examining the effectiveness of learning through simulation suggests that learning how to cope and be effective through catastrophic and stressful situations is complex and fraught with ethical and administrative difficulties when attempted in a simulated environment (Borodzicz & Van Haperen, 2002).

Confirming the emotional work required, in addition to the difficulties experienced due to differing professional attitudes toward reason and emotion, a narrative approach was used by McCreight (2005) to enable nurses to construct their own form of explaining and of understanding. Although the participants were nurses rather than midwives, they all worked within a gynaecological unit where women were nursed following perinatal death. Participants were however taken from only one unit, which is limiting and may lead to a focus on just a set of phenomena specific to that one unit. Challenges faced by nurses were highlighted, but McCreight (2005) did not address the learning opportunities that may have been derived from these situations, although they did mention the need to examine nurses' education and training in perinatal loss. Notwithstanding, the findings by McCreight (2005) have been supported by a growing body of literature that describes midwives’ experiences of caring for women through perinatal death, and assert that midwives would benefit from additional bereavement support, educational support and mentoring (Chan et al., 2007; Fenwick et al., 2007; Foster, 1996; Gardner, 1999; Kohner, 2001; McCreight, 2005; McNamara et al., 2017; Zeidenstein, 1995).

Educational support and mentoring should include being equipped with relevant knowledge and skills (Begley, 2003; Chan et al., 2007; Kohner, 2001; Modiba, 2008; Nallen, 2007) particularly around, communication, coping, reflection and the reduction of stigma associated with stress (Gardner, 1999; Jones & Smythe, 2015; Montero et al., 2011; Nallen, 2006, 2007). Preparation for bereavement care requires a provision of opportunities to
express one’s own feelings and needs, together with the prospect of sharing experiences with colleagues (Begley, 2003; Chan et al., 2007; Modiba, 2008; Nallen, 2007) as well as grief training, communication skills and paperwork guidelines to assist midwives to develop the clinical expertise that will help them to feel comfortable and competent to care for families during this devastating time (Chan et al., 2008; Jonas-Simpson et al., 2013; Roehrs, Masterson, Alles, Witt, & Rutt, 2008) and to be able to heal personally (McCool et al., 2009).

Midwives in a hospital in Hong Kong were given the opportunity by Chan, Day, and Chan (2005) to complete a questionnaire to determine their attitude toward bereavement care and to identify their required support and training needs. Ninety-three midwives from an obstetrics and gynaecology unit in one hospital completed a self-administered questionnaire distributed to them in their place of work by the ward manager. According to Chan et al. (2005), a greater awareness and knowledge of grief counselling by midwives would lead to more sympathy, understanding and practical help from midwives. To achieve the goal of holistic quality care, education and training needs must be addressed (Chan et al., 2005). Otherwise, without sufficient knowledge and skills, caring for a family that has experienced perinatal death creates a crisis situation for midwives. These findings by Chan et al. (2005) also emphasised the need for increased knowledge and experience, improved communication skills, as well as greater support from team members. This study was based on the responses of 93 midwives, which is a good sample, but only from a single unit in one hospital. The questionnaire was distributed during work by the ward manager, which could influence participation in the study as well as the motive for participation. There may be scope to question these results considering the possibility that a self-reporting questionnaire such as this within the workplace may have participants responding in the way that they think the organisation wants them to respond, a concept referred to as the Hawthorne effect (Paradis & Sutkin, 2017).

A similar study was undertaken by Chan et al. (2007) using a larger sample across two hospitals. A self-reporting questionnaire was also administered in the workplace by the unit manager. A total of 154 questionnaires were returned, a response rate of 76.2%. Cluster analysis following descriptive statistical analysis of the qualitative data yielded two clusters based on the similarity of responses to the questionnaire (Chan et al., 2007). The main
difference between clusters was in the experience and seniority. Participants who were the more junior midwives reported being less prepared and in need of more education and support than their more experienced colleagues (Chan et al., 2007). However, Chan et al. (2007) reported that almost all respondents stated that their grief counselling knowledge and understanding was deficient. One third of midwives in this study had undertaken courses in bereavement care, however respondents still felt that they lacked education in grief counselling and would benefit from further education in bereavement care. For this reason, Chan et al. (2007) suggested that junior midwives were in urgent need of education and institutional support to be able to recognise the needs of and provide support to bereaved parents. Perhaps these results may also support the value in learning through experience and future research may consider how to harness that experience and filter it through the organisation across all levels of experience.

As it appeared that there was considerable research investigating the needs and feelings of bereaved parents and comparatively little investigation into the needs and feelings of those who care for them, Modiba (2008) undertook a study to investigate the needs of health professionals in situations related to caring for the bereaved parents at the time of pregnancy loss. Focussed semi-structured interviews with nine midwives and seven doctors were conducted by Modiba (2008) in the labour ward duty room of a public hospital in South Africa. Both doctors and nurses were overwhelmed by staff shortages and overcrowding, according to Modiba’s (2008) findings. A lack of time due to workload and staff shortages can lead to feelings of demotivation and social disconnection due to the effects of work environment. Consequently, the influences of this stressful environment may lead to physical effects (Modiba, 2008). Similar conclusions were drawn by Modiba (2008) to those of Chan et al. (2005) and Chan et al. (2007) in that there is a lack of knowledge and skills in giving emotional support, together with a willingness expressed by respondents to undergo training in counselling and bereavement support. One of the recommendations by Chan et al. (2007) was for further research to be conducted using face-to-face interviews as they speculated whether this would influence the accuracy of results.

Although Modiba (2008) collected data by face-to-face interview, she did however encounter issues related to interviewing participants that are not as prevalent when using a
questionnaire. The researcher struggled with participants being busy and not keeping appointments and Modiba (2008) reported that participants did not always appear frank, often providing short and to-the-point responses. This could however be associated with interviewer technique and experience rather than solely participant resistance. Given that Modiba (2008) had a relatively small sample of three participants drawn from a single public hospital that included both doctors and nurses together, transferability would be tenuous. Despite the limitations, these three studies using differing methods do draw similar results. These studies suggest that further research is required and indicate that the authors consider that bereavement care and counselling skills for midwives could be enhanced. They also recommend the design of specialised courses as well as development of guidelines, policies and procedures with hospital policy to include provision of support for staff.

The editions of two midwifery textbooks were critically analysed to determine the ideological and professional standpoints presented to readers regarding perinatal death. Textbooks published in the United Kingdom from 1937 to 2004, written or edited predominantly by midwives were sought by Cameron, Taylor, and Greene (2008). Although this is an examination of all editions of only two textbooks, as well as considering that current clinical practice may not always be represented accurately in textbooks, their findings do indicate a gradual shift toward greater understanding of perinatal loss as birth has moved from the home to the hospital. Midwifery textbooks, according to Cameron et al. (2008) may be perceived to be sources of authoritative knowledge, making the inclusion or omission of materials instrumental in reinforcing professional norms and in turn reflecting professional priorities. As a result of examining the content of midwifery texts, Cameron et al. (2008) concluded that sufficient and broad presentation of facts, concepts, ideologies and theories need to be presented to provide midwives with the tools to manage perinatal loss in clinical practice.

Preparation for practice through textbooks is important, so too is building on that knowledge in practice as an ongoing process. The development and evaluation of workshops around perinatal loss for practising midwives was implemented by Cartwright and Read (2005) using pre-and post-workshop questionnaires and focus groups to determine existing knowledge and new knowledge, as well as the potential effect on
practice following the delivery of five workshops on perinatal death. A total of 21 participants took part in these workshops conducted by Cartwright and Read (2005), each of which was spread over two half-day sessions. An understanding of participants’ views of content, delivery and relevance as well as knowledge of the topic before and after the workshops was gained through a 10-item questionnaire designed to measure baseline knowledge and subsequent development (Cartwright & Read, 2005). Additionally, one-hour focus groups asking six open-ended questions were conducted. This study, although examining an intervention designed to improve knowledge and skills in bereavement care, was undertaken with health visitors (registered midwives or nurses with public health qualifications who assess the health needs of individuals and families in the community). While there is potential for findings to be transferred to maternity unit midwives, specific exploration of education for midwives would help to make comparisons and strengthen the knowledge base for all healthcare professionals.

Despite contemporary research recommending education and training for midwives to help prepare for perinatal death care and bereavement care, a search of literature found only two studies that explore the possibilities of education specific for midwives in perinatal death or bereavement care. The first explores a stress reduction technique for midwives and nurses (Foureur, 2013) and the second evaluated a method for teaching bereavement care to student midwives (Hollins Martin et al., 2013; Hollins Martin et al., 2014; Hollins Martin et al., 2016)

Borne from the interest in increasing resilience in midwives and nurses, and to counteract the high levels of stress and tendency for socialisation into ways of working that minimises self-care, Foureur (2013) piloted the effectiveness of an adapted mindfulness-based stress reduction intervention on the psychological wellbeing of nurses and midwives. Based on the theories and practice of Kabat-Zinn’s mindfulness-based stress reduction (MBSR), Foureur (2013) conducted a one day workshop intervention with 20 midwives and 20 nurses in New South Wales, Australia, who then undertook to meditate daily for 8 weeks. Pre-and post-intervention measures included the general health questionnaire (GHQ-12), sense of coherence (SOC) – orientation to life, and the depression, anxiety and stress scale (DASS).
Participants were also invited to take part in individual interviews or focus groups (Foureur, 2013).

Unfortunately, the study did not clarify the types of stressors that the participants considered they had been exposed to and the study also included nurses and no delineation of results between midwives and nurses was made. However, results from the pre- and post-intervention measures reported better general health, a more positive orientation to life and lower stress levels (Foureur, 2013). Interview and focus group data indicated that incorporating mindfulness practice into everyday life was challenging for participants. Be that as it may, participants did report mixed noticeable differences in stress levels from no difference, to gaining awareness at the time of stress and implementation of the techniques (Foureur, 2013). On the whole, participants confirmed that they benefited from mindfulness practice and believed their colleagues would benefit from it too (Foureur, 2013).

Participation in the research, particularly the intervention workshop, was reported to Foureur (2013) by respondents to have stimulated reflection and learning. This pilot study does suggest that mindfulness stress reduction practices can provide insight into the effects of stress, according to Foureur (2013), as well as providing techniques to counteract stress and stress reactions. It would be interesting to be able to compare further research into mindfulness practice, possibly with comparisons to other stress reduction and relaxation techniques, or perhaps what individuals use themselves if not packaged into a formal organisation-based approach.

In response to reports by a charity organisation in the UK, the National Maternity Support Foundation (NMSF), Hollins Martin et al. (2014) devised and evaluated an interactive workbook to develop student midwives’ understanding of bereavement care for clinical practice. The effectiveness of the workbook in equipping students with essential knowledge to be able to deliver quality bereavement care was evaluated using the purpose developed Understanding Bereavement Evaluation Tool (UBET) (Hollins Martin et al., 2013). Perhaps the emotionally evocative nature of topics such as death and bereavement in midwifery has contributed to the seeming lack of educational preparation. Teaching large classes of midwifery students has been noted by Hollins Martin et al. (2014) to be a challenge when approaching such topics, particularly considering the majority of midwifery students are
female and fertile. An interactive workbook that can deliver specific, relevant and applied evidence-based information to students was considered as one possible method to improve bereavement care education for midwives. Validity and reliability of the UBET was measured and demonstrated robustness for measuring student nurses’ knowledge gain (Hollins Martin et al., 2013). Participants for this study comprised of 179 student midwives in their second or third year of a midwifery degree at one of three universities in the UK. The students’ ages ranged from 18 to 49 and all were enrolled in advanced midwifery modules. The usual classes were altered to include the self-directed learning workbook for these students, with a pre-and post-intervention UBET measuring tool being administered to all participants (Hollins Martin et al., 2014).

Markedly higher post-workbook UBET scores demonstrated the effectiveness of the workbook in equipping student midwives with perinatal bereavement care knowledge to underpin clinical skills (Hollins Martin et al., 2014). It is interesting to note that 3rd year midwifery students’ mean UBET scores were higher than those of 2nd year students. This may be the result of greater experience within the clinical practice environment, according to Hollins Martin et al. (2014), with greater potential for exposure to real bereavement events whilst on clinical placements directly complimenting their learning. No frequency of exposure to perinatal death for students was reported in this study, although analysis of qualitative comments in the UBET highlighted a lack of real bereavement care experience by students (Hollins Martin et al., 2016). Nevertheless, considering this potential influencing factor of real experience, it would be prudent for future research to examine whether further perinatal death or bereavement care education would be beneficial at a postgraduate level or within professional development programmes.

The effects of the availability of social support compared to no social support on anxiety and depression for the mother was explored by Cacciatore et al. (2009) who, as a result, suggest that the individual themselves does not know what support they need, they just know when they are getting it or not. In light of this, if midwives do not have the education, training, skills or are not confident in their ability, they may find it difficult to determine the support required by a mother who does not know herself. In like manner, it is also worth considering
that midwives may also not know what support they need, just whether they are getting it or not.

2.5.5 Midwives need personal and professional support. Several studies in the body of literature that explores the risks and prevalence of PTSD in first responders have found that social, family and peer support are protective factors that reduce the risk of PTSD (Haugen et al., 2012; Marmar et al., 2006; Stephens et al., 1997; Yuan et al., 2011). This is echoed by perinatal death research that suggests that midwives, nurses and obstetricians need both formal and informal support, personally and professionally, from colleagues, the organisation, family and friends, and from support groups (Farrow, Goldenberg, Fretts, & Schulkin, 2013; Gardner, 1999; Gold, Kuznia, & Hayward, 2008; Jones & Smythe, 2015; McCool et al., 2009; McNamara et al., 2017; Montero et al., 2011; Nallen, 2006, 2007).

In a study into the effects of social support on maternal anxiety and depression, Cacciatore et al. (2009) mentioned that the need for social support, or even the perception of it, is clearly evident. Participants in this survey were mothers in the United States of America (USA) and a total of 769 respondents completed the survey in full. Average anxiety and depression levels were notably lower with all forms of support. Family support was valued highest by 91.7% of respondents, and noteworthy was support by nurses, a close second with 90% (Cacciatore et al., 2009). This is a clear indication that the support from a midwife through perinatal death is vital. Accordingly, in order to be in a position to support the mother and family, the midwife must surely be adequately skilled as well as supported themselves.

Opinions amongst healthcare professionals differed in a study by McNamara et al. (2017) as to whether formal debriefing sessions or a more casual discussion with colleagues was more beneficial following perinatal death. Participants in this study included 11 consultant obstetrician/gynaecologists; 58 non-consultant hospital doctors (NCHDs); and 20 labour ward midwives from a tertiary referral university teaching hospital in the Republic of Ireland. Data to explore healthcare professionals’ response to perinatal death was collected by McNamara et al. (2017) by means of a questionnaire containing both open and closed type questions. One of the themes described by McNamara et al. (2017) reported that
NCHDs would prefer a more formal approach to support and debriefing that included the involvement of a senior mentor. In contrast, midwives preferred not to include senior management, but rather to debrief immediately with someone who was clinically active; “someone genuinely interested in how you are feeling” rather than just getting boxes ticked and forms filled (McNamara et al., 2017, p. 849). A less formal approach to debriefing, involving peers, was also valued by obstetric nurses in an American study by Puia, Lewis, and Beck (2013). In this case, not only would bonds between obstetric nurses be strengthened, but it also helps to know that the birthing community understands, in spite of the apparent lack of understanding from family and friends not in the profession.

A critical examination of published works by Wallbank and Robertson (2008) used a systematic narrative synthesis to analyse what is known about the psychological responses of midwifery and nursing staff to miscarriage, stillbirth and neonatal loss in their workplace. Despite the difficulties following perinatal death expressed by respondents in the eight studies in this critical review, all reported that midwives do have to make use of some coping activities to mitigate the stressors of caring for women through perinatal death (Wallbank & Robertson, 2008). At the same time, all of the studies also highlighted a perception of limited or absent organisational support and resources (Wallbank & Robertson, 2008). Midwives expressed a need for explicit support as they often felt isolated, particularly whilst dealing with the unique requirements of bereaved families. Although Wallbank and Robertson (2008) found the concept of support to be vague and lacking specificity, they contend that the fact of its consistent referral and request suggests that it needs to be addressed.

Following on from the finding that midwives need support to understand the psychological impact of their work (Wallbank & Robertson, 2008), Wallbank (2010) offered individual clinical supervision conducted by a clinical psychologist to doctors and midwives to determine whether this sort of clinical supervision could be effective in reducing the impact of perinatal death on healthcare professionals. A total of 30 midwives and doctors from an obstetrics and gynaecology unit in a UK hospital agreed to participate, but unfortunately Wallbank (2010) does not specify the breakdown of midwives and doctors who took part. Participants were randomly assigned to the control and treatment groups; both groups
completed two sets of the same questionnaire, and the treatment group received 6, one-hour individual sessions with a clinical psychologist (Wallbank, 2010). The questionnaires included the Impact of Event Scale (IES), the Professional Quality of Life Scale (ProQol), and the Positive and Negative Affect Schedule (PANAS). Post intervention questionnaires revealed significant reduction in subjective stress scores to within non-clinical levels for all participants in the treatment group (Wallbank, 2010). Similarly, burnout scores, compassion fatigue and secondary trauma scores decreased for the treatment group, while there was an increase in compassion satisfaction scores. The results do indicate that debriefing interventions led by a clinical psychologist can reduce some of the reactions by midwives to perinatal death, however these results oppose the findings by McNamara et al. (2017) who suggested that midwives preferred to debrief with a colleague. Knowing the level of reduction in scores for midwives and doctors separately may have helped to understand whether these results supported the different preferences between doctors and midwives that was noted by McNamara et al. (2017).

Key points that have been raised by this review of how professionals experience the death of those within their professional care suggest that an understanding of how learning may take place needs to be considered. Dealing with death, for all professionals, evokes a number of emotions and considerations, particularly when death involves a child and/or is unexpected. There is a significant influence from organisational culture, and profession specific culture, on the way in which these experiences are felt, expressed and dealt with by individuals. Quantitative methods have been successfully used to measure resultant stress levels and the influences of learning, support and coping strategies, but in order to tap into the actual lived experience, qualitative methods have been influential. Uncertainty appears to surround what is meant by support; however it is clear that some form of support is indeed beneficial. Education and training have been highlighted through many of the studies reviewed; however there does appear to be a somewhat over reliance on its ability to be the key factor for improvement. There is no doubt that education and training are important, but this is only one option that still needs further investigation to help elucidate how, what and when education can be most beneficial. Harnessing the benefits associated with professional experience may be one means by which education can occur in such a context.
2.6 Learning

To begin to consider how professional experience is acquired, and equally important, how it can be harnessed and shared, an examination of how one learns is appropriate. There has been some contention around a definition for learning that continues to defy consensus (De Houwer, Barnes-Holmes, & Moors, 2013; Knowles, Holton III, & Swanson, 2014). The inability to pinpoint a definition may be due to the term ‘learning’ being used to describe a multitude of uses, notably, from mastery of current knowledge, through attempting to make sense of one’s experiences, to the testing of possible solutions to problems (Knowles et al., 2014). Rather than defining learning “functionally as the changes in behaviour that result from experience or mechanically as changes in the organism that result from experience” De Houwer et al. (2013, p. 631) suggests defining learning as “ontogenic adaptation – that is, as changes in the behaviour of an organism that results from regularities in the environment of the organism.” (De Houwer et al., 2013, p. 631). Adult learning has received considerable attention as a separate form of learning, however a unified theory of how adults learn remains elusive despite many attempts (Illeris, 2006; McLean, 2006; Sandlin, Wright, & Clark, 2013). Ultimately, how one defines learning is dependent on one’s philosophy of how adults learn (Wlodkowski & Ginsberg, 2017).

2.6.1 Approaches to understanding adult learning. The way in which adults learn is a complex matter that has fascinated us since the times of Plato and Aristotle (Merriam, Caffarella, & Baumgartner, 2007). Learning is a process, and the focus on what happens when learning takes place can be explained through learning theories (Merriam et al., 2007). Learning theories that contribute to various approaches to learning have arisen from several different disciplines including psychology, sociology, education, philosophy and other social sciences (Jarvis, 2004). The primary focus of this current study is on clinical midwifery experiences, with learning as a potential outcome of the experience. With this intention, I have limited the following discussion to the models and theories of learning necessary to provide a language and conceptual framework with which to communicate and understand the complex concepts related to the learning that a midwife may achieve as a result of caring for women through perinatal death. The theories that best support this form of learning include humanism, social learning, social constructionist learning, double loop learning, self-directed learning and transformational learning.
Humanism, influenced by Maslow, Knowles and Rogers, focuses learning on the potential for growth by the learner that is achieved through affective and cognitive processes. Humanism theory suggests a self-directedness of learning and acknowledges the choice and responsibilities of learners, rather than a simple response to a stimulus (Merriam & Bierema, 2013). Abraham Maslow, considered the founder of humanism, posited that the motivation to learn is intrinsic and the overarching goal of learning is self-actualisation (Maslow, 1987).

The theory of humanism resonates closely with this study in its acknowledgement of the active part that the learner plays in their own learning. Both the affective and cognitive dimensions of learning are involved, which may result in a change or the potential for change, and ultimately, a person is free to make choices and determine their behaviour (Merriam & Bierema, 2013). The holistic view of the learner is taken into account with Maslow’s interpretation of a positive connection between learning and the learner’s psychological health (Maslow, 1987).

Social learning, a learning theory with a combination of characteristics from behaviourism and cognitive theory, posits that people learn from one another. Learning, according to social learning theory, is influenced by the learner’s self-efficacy and is based on the observation of others within a social context, acknowledging the reciprocity between learner and environment (Bandura, 1977). People learn from each other and alongside each other in all social relationships. Moreover, these social relationships and interactions may influence learning by promoting or inhibiting learning (Jarvis & Holford, 2003). In this way, midwives may learn through observing, debriefing and discussing with their peers within the birthing context. The social purpose for which people learn also resonates with this current research in the way that learning may be used to advance the interests of a particular group or community; to raise consciousness of a particular section of society (Jarvis & Holford, 2003). Current literature examined strongly emphasises midwives’ desire to advance the education and training of the midwifery profession to continue to improve care to women as well as self-care.
The focus for social constructionist learning theory is on what people do with information to construct knowledge. Having links to various disciplines, such as social science, philosophy, politics and history (Jordan, Carlile, & Stack, 2008), it is not just one theory, but rather a broad group of theories with the common assumption that learning is the means for people to make sense of their experience (Merriam & Bierema, 2013). Social constructionist learning is about making meaning from concepts based on the learner’s experiences and to what degree meaning is altered with new knowledge (Merriam & Bierema, 2013). For the individual learner, this can be considered to influence the way in which the social context allows for construction of meaning and how shared meaning evolves. With this in mind, construction of meaning is subjected to critical appraisal by the learner (Merriam & Bierema, 2013), who actively seeks meaning, rather than waiting to be filled like an empty vessel (Driscoll, 2005). Active engagement with the world allows for the construction of meaning rather than discovery (Bohan, 1990), while communication with others allows for shared social and cultural meaning (Candy, 1991). Perhaps this may help to explain the strong organisational culture element that was noted within the different professions as they faced working with death and dying.

Critical construction of meaning comes from being reflective and challenging dominant views to articulate counter views, making it the basis for experiential learning, perspective transformation and reflective practice, as well as forming the basis for self-directed learning, which involves active inquiry, independence and individuality (Candy, 1991). Interaction with others is important in the constructivist learning process, but it is the learner who is at the centre of the learning experience and the interpretation of the experience allows for the construction of knowledge (Merriam & Bierema, 2013). This current research will explore the learning that may take place within a specific social context, the maternity setting, and through the interview questions will explore potential reflection and meaning making as a result of the experience. The challenge may be in finding the opportunities to realise and articulate counter views and possibly breaking from the established culture.

Learning has been defined by Argyris (2002, p. 206) “as the detection and correction of error” and without either or both of these, learning is inhibited (Argyris, 1976). Double loop learning, a theory proposed by Chris Argyris and Donald Shôn, is about learning to change
one’s underlying values and assumptions. The focus of the theory is on solving problems that are complex and ill-structured and which change as problem-solving advances (Argyris, 1976). An individual, organisation or entity is able, having attempted to achieve a goal on different occasions, to modify the goal or action in the light of experience, or possibly even reject the goal (Argyris, 2002; Greenwood, 1998). This double loop learning model provides feedback and more effective decision making than single-loop learning where there is the repeated attempt at the same problem, with no variation of method and without ever questioning the goal (Argyris, 1976; Blackman, Connelly, & Henderson, 2004; Francis, 2004). Double loop learning is used in one of the data collection activities in this current research to help the midwife to re-look at experiences that may have been privileged by subjective values and prejudices, raising awareness of how an incident can be perceived selectively within the individual’s own personal world view, and enabling consideration of multiple interpretations and contemplation of potential learning opportunities (Francis, 2004).

A comprehensive description of self-directed learning has been provided by Tough (1971), who, drawing on the results of a study of the learning projects of 66 people, found that deliberate efforts to learn are taking place all around us whether we are aware of it or not. The focus of self-directed learning is on adults taking the initiative for the planning, implementation and evaluation of their own learning. It is considered that learning is a natural part of being human, the learner is the initiator of learning, taking responsibility and being proactive in its pursuit (Merriam, Caffarella, & Baumgartner, 2012).

The three main goals of self-directed learning, described by Merriam et al. (2007, p. 107) are firstly, “to enhance the ability of adult learners to be self-directed in their learning”. This first goal is grounded in humanistic philosophy where personal growth is the incentive of learning. Secondly, “to foster transformational learning as central to self-directed learning”. The learner needs to be critically aware of what has been taken for granted about their own learning, being able to reflect and understand the reasons behind their wants, needs and interests. Thirdly, “to promote emancipatory learning and social action as an integral part of self-directed learning.” As adult learners in a profession that encourages self-directed learning, to maintain their knowledge and skills, participants in this study may already be making use of self-directed learning as a framework for their own learning.
The focus of transformational learning on the individual’s learning is represented by the works of Jack Mezirow, Laurent Daloz and Robert Boyd (Merriam et al., 2012). Learning is dramatic, and results in fundamental changes in how the learner views themselves and the environment. Transformational learning is concerned with how adults make sense of their life experiences, it is a meaning making activity through questioning suppositions and perspectives on life (Merriam et al., 2012). As defined by Mezirow, learning is “the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one’s experience in order to guide future action” (Mezirow, 2000, p. 5).

This current research will explore learning that may take place as a result of what is considered a catastrophic or dramatic experience. Based on his study of students across twelve different tertiary education providers, Mezirow (2009) identified ten phases of learning that may be able to guide our understanding of the learning that takes place within this current research. These are:

1. A disorienting dilemma
2. Self-examination
3. A critical assessment of assumptions
4. Recognition of a connection between one’s discontent and the process of transformation
5. Exploration of options for new roles, relationships and action
6. Planning a course of action
7. Acquiring knowledge and skills for implementing one’s plan
8. Provisional trying of new roles
9. Building competence and self-confidence in new roles and relationships
10. A reintegration into one’s life on the basis of conditions dictated by one’s new perspective

(Mezirow, 2009, p. 20).

In their studies of transformational learning within online environments, Dirkx and Smith (2009) explain that human lives reflect both a conscious and unconscious dimension, and it is the unconscious that is the most influential of our actions and decision making. A goal of transformational learning is “to develop a dialogical relationship with one’s unconscious, so
that its dynamic contents may have creative expression within our conscious lives” (Dirkx & Smith, 2009, p. 59), which is mediated mainly through emotion-laden images, relationships and behaviours. Collaborative work stimulated through interpersonal and social contexts can be a catalyst for such emotionality amongst groups and individuals, and the online group work facilitated by Dirkx and Smith (2009) was found to contribute to the frequency and intensity of these emotional experiences.

There can be uncertainty and ambiguity associated with the interpersonal social relations and interactions of an online learning group, according to Dirkx and Smith (2009), which can result in learners projecting deeply held issues in unexpected or seemingly unrelated ways. If these interactions are examined, they may reveal an unconscious issue that was stimulated by the social context of online learning (Dirkx & Smith, 2009). Similarly, the lack of non-verbal cues, together with the potential ambiguity of written words, can lead to a projection of meaning and intent from another’s words to an underlying experience and interpretation of the person reading the words (Dirkx & Smith, 2009). The group blog task that participants in this current research will participate in may give rise to this drawing out of the unconscious issues by engaging in an examination and discussion of others’ experiences. According to transformational learning theory, this may be the stimulation required to make meaning, and to learn from the midwife’s own experiences.

Opportunities to provide learning around end of life care are not easy at any stage of a health care professional’s education (MacLeod & Egan, 2009). In the context of learning to care for the dying patient and their family, MacLeod and Egan (2009, p. 112) explain that transformation is

“the creation of opportunities to stimulate diverse, alternative and multiple perspectives on events through reflection, that is, through changing specific beliefs, attitudes and emotional reactions through such reflection either individually or in groups, and in the classroom or in practice.”

Communicative learning and rational discourse, described by Mezirow (1991), can be achieved through storytelling (Tyler, 2009). The ideal conditions for rational discourse necessary for communicative learning can be challenging, but facilitated storytelling, as
described by Tyler (2009), is an effective approach to foster the discourse that will facilitate the ability to understand what others mean and make one’s own meaning clear.

Storytelling, in this context, refers to the narration of personal experience in a facilitated forum where the teller’s interpretation of their experience, with its potential to foster learning, shift meaning perspectives and establish shared understandings (Tyler, 2009).

The conditions for participation in critical discourse and learning have been described by Mezirow (1991) as seven conditions that can be met through storytelling (Tyler, 2009). Firstly, participants must “have accurate and complete information” (Mezirow, 1991, p. 77). This means that the storyteller must be able to relate their own story, having complete recall and the ability to clarify and answer questions (Tyler, 2009). Secondly, participants will “be free from coercion and distorting self-deception” (Mezirow, 1991, p. 77). Composing groups that lower the risks for participants, so that individuals feel that they can share their story unrestricted from reprisals or other negative outcomes, will foster a willingness and desire to share their story with the promise of possible insights and outcomes (Tyler, 2009).

The third condition for participation in critical discourse and learning is the ability “to weigh evidence and assess arguments objectively” (Mezirow, 1991, p. 77). When participants pose questions to the storyteller, seeking clarification or deeper understanding (which can also prompt the teller to examine the interpretation of their own experience), Mezirow’s third condition of rational discourse is achieved (Tyler, 2009). A fourth condition proposed by Mezirow (1991, p. 77) requires the capacity to “be open to alternative perspectives”. Those who are listening to the storyteller will naturally be filtering it through their own experiences and will therefore potentially have an alternative point of view, possibly considering their own thoughts and actions were it their story (Tyler, 2009).

The fifth condition, the ability “to become critically reflective upon presuppositions and their consequences” (Mezirow, 1991, p. 77), is demonstrated through storytelling and in the listener’s interpretation and questions prompting the teller to explore their own assumptions (Tyler, 2009). It is unlikely, according to Tyler (2009), that two people will experience an event in the same way, even if it is the same event. A sixth condition, the “equal opportunity to participate, including the chance to challenge, question, refute, and
reflect and to hear others do the same” (Mezirow, 1991, p. 78), can be dependent on the forum, facilitator and participants. Equal opportunity needs to be afforded to all participants in storytelling, at the same time, no individual should be coerced into telling or responding (Tyler, 2009).

The final condition is the ability “to accept an informed, objective, and rational consensus as a legitimate test of validity” Mezirow (1991, p. 78). Listeners are able to situate themselves within the experience of the teller and begin to understand it through collaborative exploration. Given sufficient time to explore the stories within each participant's own experiences, “dialogue that includes critical reflection and ideology critique can build to an informed, objective consensus.” (Tyler, 2009, p. 141).

Transformative learning happens when there is a transformation in beliefs or attitudes, or a transformation on one’s entire perspective (Mezirow, 2000). The concept of transformative learning fits well with the current research and the ideas described by Dirkx and Smith (2009); Mezirow (1991, 2009); Tyler (2009) will help to frame the learning that may take place by midwives as a result of their experiences of caring for women through a catastrophic event such as perinatal death.

2.6.2 Learning from catastrophe. Social and experiential models and theories of learning have been examined to gain an understanding of how learning may take place following a catastrophic event such as perinatal death. Literature describes various strategies for learning from catastrophe, with the focus predominantly on learning in relation to prevention of further incidents rather than the broader aim of investigating the learning that enables people to manage or avoid such situations in the future. One method, trialled by the medical physics department of a UK health service, involved a method of learning from adverse incidents concerning medical devices, through the use of feedback notes distributed to staff (Amoore & Ingram, 2002). The feedback note describes the preceding events, highlights good practice and points out where lessons can be learned. This allows recognition of the inevitability of human error and the need to anticipate it while encouraging investigation, looking beyond the immediate causes and including background factors and the positive actions taken (Amoore & Ingram, 2002). The feedback note was
designed to be an educational tool, supporting staff and highlighting what is being done well while encouraging participants to think of wider issues that promote safe practice. Good practices that either minimised or prevented further consequences are included in the investigation process. Not only does this highlight what is being done well, but it also helps to encourage a reporting culture. Through the use of feedback notes, Amoore and Ingram (2002) report that no further adverse incidents have occurred in the test case.

Indeed, only one example of successful use of the feedback note system is described by Amoore and Ingram (2002), yet they do assert that using the feedback note system more widely throughout the organisation and including its use in educational and annual update sessions will improve learning as its success is measured on the dissemination of information. Further evidence of the success of this method could demonstrate the effectiveness of what appears to be a potentially useful tool. This trial does suggest that enhanced learning may be achieved using a purpose developed tool for a specific setting.

Another strategy, this time based on an existing model adapted specifically for a healthcare setting, was developed by Vincent, et al. (2000) based on Reason’s model of organisational accidents. By examining record reviews, gathering data by interviews, and using a checklist of psychological and organisational factors, Vincent et al. (2000) reviewed the data through Reason’s model of organisational accidents to determine errors made and subsequent background organisational factors. This protocol for investigating and analysing adverse events ensures systematic, comprehensive and efficient investigation and was tested by Vincent, et al. (2000) on 40 incidents across health care, including obstetrics, anaesthesia, accident and emergency, orthopaedics, general medicine and psychiatry. Limited detail of the results from these test cases has been provided by Vincent, et al. (2000), and although they do express the need for further research to evaluate and test the model, they do not provide the details to make an adequate comparison.

Insufficient research related to learning from failure in healthcare and a gap between awareness of preventable events and the knowledge required to respond effectively led to the development of a model for learning from preventable adverse events in healthcare by Chuang, Ginsburg and Berta (2007). This model includes individual, group and organisational
learning and details the factors that influence learning at each of these levels. With little empirical evidence related to learning through preventable error, other than at an organisational level, and an equally important need to know how we learn through near-misses, this model may provide direction for this current study in learning through all levels, despite the fact that the model does not appear to have been tested and the emphasis is on preventable adverse events only.

Another model, the generic disaster pathway, which demonstrates the common elements involved in the progression toward disaster in a number of different industries, including healthcare, was developed by Hughes, Travaglia, & Braithwaite (2010). The pathway shows four possibilities of progression through an incident and indicates where the disaster may have been averted, and where areas of learning for prevention in the future can be identified. Six exemplar disasters were drawn from six industries using critical case sampling to include prominent cases from space travel, shipping, aviation, mining, rail, and nuclear power industries. Human, technological, procedural and communicative elements were examined to create a generic model of disaster trajectory based on the pathways of the exemplar events (Hughes et al., 2010). The value of cross industry experience and commonalities have until now been infrequently considered, but learning through the disasters of others can be achieved with the use of a generic model. Equally important is that, although technical issues may differ, procedural, human and communicative characteristics are similar (Hughes et al., 2010).

Generic pathways to disaster can assist in the identification of events and choices that may either lead to or avert disaster; moreover, predictive information can be used to halt or reduce the consequences of disaster if they are recognised and communicated effectively (Hughes et al., 2010). Exemplars for this study were drawn from a very large sample of incidents, but only six prominent cases were chosen, one from each industry. There is no explanation of selection criteria, other than being well-known incidents. Only examples of preventable disasters ending in the loss of life have been used, with no consideration for either near-misses or potential loss of life where intervention has altered the course of the disaster. The generic pathway does allow for this to happen, but appears untested. The significance of this for the current study is in the demonstration of a generic pathway
identifying the potential for learning points along the course. Unpreventable death can also be retrospectively interpreted using the pathway to learn from actions that may affect the outcomes for the midwife, the mother and the family. Further testing of these proposed strategies may facilitate understanding of how individuals and groups learn through experience and exposure to phenomena, as well as analysing their effectiveness in eliciting surface and deep learning.

In order to examine the effectiveness of learning through simulated crisis, Borodzicz and Van Haperen (2002) conducted a review of existing knowledge related to learning through simulation. Using learning theories, including Piaget’s cognitive growth theory; Lewin’s group dynamics theory; and Kolb’s model of experiential learning, Borodzicz and Van Haperen (2002) explain that due to the nature of crises, many variables influence the outcome of the training. Learning in a crisis context occurs along personal, interpersonal and institutional dimensions and simulation needs to be as close to reality as possible. A number of variables, including ethical and organisational constraints, may obstruct the degree of realism that can be implemented in the simulation (Borodzicz & Van Haperen, 2002). Furthermore, the nature of crises may impede learning as psychological factors, such as stress, reduce the ability to learn, thus making it uncertain how realistic the simulated crisis should be. Learning through simulation may also stifle the real response to an actual crisis by restricting the decision making process by making it too rigid and not allowing creativity, as well learned responses are implemented (Borodzicz & Van Haperen, 2002).

Of particular relevance to the current study is the emphasis that Borodzicz and Van Haperen (2002) place on the importance of post simulation debriefing in simulated learning exercises. Good debriefing allows one to reflect on purpose and actions, but when appropriate care is not taken during debriefing, inappropriate learning may be reinforced.

Simulation has emerged as an important aide to modern clinical training in the healthcare professions (Goldberg et al., 2015). Although devastating, crisis, error or near miss events in medicine can be important learning opportunities, encouraging self-reflection and further study (Sirriyeh, Lawton, Gardner, & Armitage, 2010). It is not ideal for errors to be allowed to occur or develop further in real training, leaving a simulated environment the best
opportunity to learn from errors or incidents (Goldberg et al., 2015). Some believe that simulated mortality should not be taught, other than management of death and related scenarios, but on the contrary, Goldberg et al. (2015) suggest that there is little convincing evidence to show that simulated mortality should not be included in teaching and will not have a negative effect on practitioners. With this in mind, Goldberg et al. (2015) aimed to test whether exposure of residents of anaesthetics to a simulated event that results in mortality will improve subsequent practice.

All 24 first year anaesthesia residents at Mount Sinai Medical Centre in the USA agreed to take part in the study by Goldberg et al. (2015). Prior to the simulation intervention, all participants completed the trait portion of the State-Trait Anxiety Inventory (STAI) to measure baseline anxiety levels. Randomly assigned to two groups, participants were either provided no assistance (independent group, n=12) when a contaminated oxygen pipeline scenario occurred, resulting in patient death from hypoxia, or the second group (supervised group, n=12) who received help from an attending anaesthesiologist resulting in survival of the patient (Goldberg et al., 2015). All participants received the same debriefing and the state part of the (STAI) on completion of the simulation intervention. Six months later, having had no further simulation exposure, all participants completed a second simulation scenario with the same potential result as the first; hypoxaemia, cardiac arrest and then death of the simulated patient if correct treatment/action was not followed (Goldberg et al., 2015). Proper treatment, time to diagnosis and non-technical skills were measured. In the initial simulation, Goldberg et al. (2015) found that no participants from either group provided correct treatment.

In the second simulation 6 months later, Goldberg et al. (2015) recorded that 67% of participants in the independent group and 17% in the supervised group resumed adequate oxygen delivery to their patient. For those participants who treated the patient correctly, there was no significant time difference to proper treatment. Participants in the first independent simulation group had higher non-technical skills scores in the second simulation, significantly in situational awareness and decision making (Goldberg et al., 2015). Self-study following the first simulation was found by Goldberg et al. (2015) to have
been undertaken by 58% of participants in the independent group and 8% of the supervised group.

Allowing clinicians to practice independently and fail in a simulated environment has been demonstrated by Goldberg et al. (2015) to potentially be an important part of simulation-based learning. A scenario that would ordinarily be actively avoided, and would not be feasible to replicate in real clinical practice, has resulted in significantly improved response, situational awareness, decision making and desire to improve practice (Goldberg et al., 2015). These abilities would be equally sought by midwives during a perinatal death event. It is unclear as to whether critical assessment of their performance occurred during debriefing, and no comment on the usefulness of debriefing was made. This detail would be good to have compared to Borodzić and Van Haperen’s (2002) finding for the importance of debriefing for learning in simulation scenarios.

The Critical Incident Task (CIT) aimed to encourage nursing students to reflect on everyday events and to provide a framework for double loop learning to take place (Francis, 2004). The CIT is a problem based learning style activity that Francis (2004) implemented with students in order to foster deeper reflection on critical incidents and to provoke the student into challenging the notion that there is no need to question or change regular practice processes and procedures. Through her teaching practice, Francis (2004) found that students have no problem generating potential solutions to problems, but struggle to consider any alternate actions for situations that are regarded as regular practice, even if this is shown to have faults.

Using video scenarios of normal nursing practice, students were encouraged to reflect on and challenge established beliefs using key questions provided by Francis (2004). Through a process involving both group and individual description and analysis, meaning is reconstructed and challenges made to normal practice. Students were encouraged by these key questions to explore the multiple possibilities of their individual thoughts and ideas. Grounded in the notion that knowledge is always incomplete and that there can be multiple knowing of the same phenomena, Francis (2004) has suggested that this method of learning will facilitate new ways of conceptualising knowledge.
Significant limitations to Francis’ (2004) proposed method have been noted in that the findings are based on experience within her own teaching, participants were restricted to students within education and nursing settings and the number of students successfully establishing alternate possibilities within normal situations is not addressed. Neither an evaluation of outcomes has been described, nor has there been confirmation as to whether the development of habitual questioning in the classroom has been transferred into practice. On the other hand, the significance for the current study lies in perinatal death being described to be an unfortunate course of life rather than preventable error. With this belief may come the consideration that, although perinatal death is a catastrophe, it is normal for it to happen to some extent. The CIT will be used in this current research in a group blog discussion to elicit an exploration of what has been normalised and based on individual social and cultural thoughts and beliefs that fit into group norms. Conducting this CIT with midwife participants may encourage them to explore alternative thinking, reaction and practice.

The current study aims to explore the potential learning of midwives by encouraging them to reflect on incidences of caring for women through perinatal death, looking for new realities and learning possibilities as a part of this reflection. A growing body of knowledge emphasises the need to effectively investigate and learn from a variety of events and incidents, and studies exploring the appropriateness of experiential learning and simulation suggest that, although highly successful, true to life simulation or re-enactment can, in some instances, be difficult and indeed detrimental to learning. Through reflection and reconstruction of meaning, this study will attempt to examine learning that takes place through the catastrophe of perinatal death in order that a better understanding of learning through preventable and non-preventable incidents can be gained and developmental needs can be assessed.

The following chapter, chapter 3, will detail the research methodology and methods used to answer the research questions and meet the aims of the study. The research paradigm, theoretical framework and the researcher’s assumptions will be described. The rationale for selection of methods will be explained. The techniques used to collect and analyse the data
will be outlined, as well as steps taken to ensure that a trustworthy and ethical approach has been taken.
Chapter 3: Methodology

The purpose of this study is to explore midwives' experiences of caring for women during perinatal death and what participants may have learned from this experience. Learning from midwives’ experiences could help us to understand responses to these complex events and the impact of perinatal death on the lives of midwives, both personally and professionally. Moreover, such an understanding will help to foster constructive examination and evaluation of midwives’ professional developmental needs.

This chapter discusses the research methodology applied through this study. The research design and framework will be explained, including the approach underlying the procedures and principles that guide data collection and analysis strategies, as well as the practical steps that have been taken to link the research questions to data collection, analysis and interpretation (Hartley, 2004; Yin, 2009). Finally, ethical aspects of this study will be discussed along with the strategies implemented to ensure trustworthiness.

3.1 Research Design

This qualitative study uses a naturalistic interpretive approach with a multiple-case study design underpinned by critical realism to explore the phenomenon of midwives' learning that takes place as a result of their experience of caring for women during perinatal death. This method allowed for in-depth qualitative exploration of the phenomena and the interpretation of data collected through a group activity. This activity, an adaptation of the critical incident task for use in a web-based blog, was followed by focus groups and in-depth participant interviews.

The purpose of conducting research is to discover new knowledge and to be able to adapt existing knowledge (Richardson-Tench, Nicholson, Taylor, & Kermode, 2018). Further to this, qualitative research is about meaning, it is about capturing an aspect of life and recording the messiness of real life by arranging it and interpreting it in a framework of understanding (Braun & Clarke, 2013). This current research aims to understand a midwife’s experience of caring for women through perinatal death to capture the learning that takes place as a
result of this experience and to consider whether the catastrophic nature of this event is influential in what type and how learning takes place.

3.2 Research Paradigm

The set of beliefs and practices, or research paradigms, shared by researchers in nursing and midwifery (Weaver & Olson, 2006) form the basis of the researcher’s position or view of understanding the world and philosophical assumptions (Schneider, Whitehead, LoBiondo-Wood, & Haber, 2013). With the intention to create a holistic view of how knowledge is viewed and how we can see ourselves in relation to this knowledge, and gain an understanding of the phenomenon, Guba’s (1990) explanations of ontology, epistemology and methodology have been examined to guide the research and raise particular questions that are useful in understanding and exploring the varied ways of thinking (McIntyre & McDonald, 2013). Ontology asks questions about the form and nature of reality (Denzin & Lincoln, 2005; Schneider, Whitehead, Elliott, LoBiondo-Wood, & Haber, 2007) and by exploring the nature of the existence of learning under such circumstances, the research asked ontological questions of the existence of learning (Taylor, Kermode, & Roberts, 2006).

The research aims to explore and describe the phenomenon under investigation within a practice context. Clinical practice environments are often described as having different connotations and possibilities with realities that are not fixed (Schneider et al., 2013). Realities are fluid as the phenomenon, which in this case occurs as a result of the experience of caring for women through perinatal death, often transpires in different contexts with different possibilities and naturally occurring situations. For example, birthing of babies occurs across different models of care and in different settings. Cultural, social and religious differences may also influence the setting as well as the woman and midwife and the way in which they approach the experience. The multiple realities of this phenomenon would therefore support a constructionist reality in light of these different realities within different contexts.

Disciplined inquiry is guided by the epistemological question of ‘What is the nature of the relationship between the knower and the known?’ (Braun & Clarke, 2013; Denzin & Lincoln, 2005; Patton, 2002; Schneider et al., 2007). The fundamental concern of epistemology is
explained by Braun and Clarke (2013) as the ability to determine which knowledge is valid, trustworthy and meaningful. This theory of how to obtain the knowledge is influenced by the fact that there is not a single reality, therefore we need to interpret the reality. An interpretivist reality will require the researcher to position himself within the study and have an understanding of the phenomenon to be able to interpret the how, what and why questions. In this study, I have used data collection methods that encouraged close contact between participants and researcher; an essential part of the study as it is the lived experiences of midwives that the research is attempting to discover, therefore requiring close contact between researcher and participants. The question or knowledge that is sought requires the examination and interpretation of multiple realities using a methodological approach that supports this constructionist paradigm.

The methodological question asks: ‘How should the inquirer go about finding out knowledge?’; how are we going to get this data? (Braun & Clarke, 2013; Denzin & Lincoln, 2005; Schneider et al., 2007). In this study, I have gathered knowledge to answer the research questions using a qualitative framework. This qualitative methodology has provided the framework by which I was able to make decisions about how participants were selected, methods of data collection and analysis, as well as my role in the research (Braun & Clarke, 2013).

Another consideration, the axiological assumption, is described by Creswell (2013) as being characteristic of qualitative research. Axiology denotes the theory of values, extrinsic and intrinsic, informing the way in which we see the world and the value judgements we make in our research (Walter, 2010). This is explained by Creswell (2013) to mean that all researchers bring values to a study, but these need to be made known by admitting the value-laden nature of the study and reporting their values, biases and the value-laden nature of data that was gathered in the field. To this end, a reflection on personal assumptions related to the study will be detailed in this chapter.

A naturalistic interpretive paradigm has been used in this study for its fit with the complex experiential questions that are being asked by this study (Thorne, Kirkham, & O'Flynn-Magee, 2004). The basis for enquiry of a naturalistic investigation focuses on the human
experience, which in this instance involves learning through the course of a catastrophic experience (Lincoln & Guba, 1985). Naturalistic inquiry seeks to construct meaning and experience as it is lived by those involved within their own world; acknowledging the multiple constructions that can be formed within the context of the experience (Lincoln & Guba, 1985). Interpretive research seeks to understand the complexity of varied and multiple subjective meanings of the experiences in the world in which we live (Creswell, 2013; Lincoln & Guba, 1985; Polit & Beck, 2010a; Thorne et al., 2004), answering complex, experiential and context based questions relevant to nursing, midwifery and other health care disciplines (Thorne, 2008).

It is the participant’s view that is being relied upon (Creswell, 2013); and the meanings that are socially, culturally and historically influenced and formed are as a result of interaction with others and continually shape and re-shape their realities (Lincoln & Guba, 1985; Thorne et al., 2004). Questions are broad, allowing participants to construct meaning typically through discussion and interaction with others within the same specific context (Creswell, 2013; Schneider et al., 2013) and interaction between researcher and participant generates understanding that is co-constructed according to naturally occurring events and situations (Lincoln & Guba, 1985; Schneider et al., 2013; Thorne et al., 2004).

The researcher’s background shapes his interpretation and he positions himself in the research, acknowledging how his interpretation has been shaped by his own experiences and background (Creswell, 2013; Lincoln & Guba, 1985; Thorne et al., 2004). This is clarified further by Wolcott (1994) as he explains that interpretation is derived from our efforts of sense making, a human activity that involves emotion, intuition, past experience and the researcher’s own personal attributes. The researcher’s intent in this naturalistic interpretive research is to interpret and make sense of the meanings others, interacting closely with the participants in the context of their lives to form a whole picture (Creswell, 2013; Polit & Beck, 2010a) of the learning that has occurred within their experience of caring for women through perinatal death.
3.3 Theoretical Framework
The nature of reality and how we gain knowledge of it in this study will be explored within a Critical Realism framework. Critical Realism is described as a relatively new philosophical perspective combining a realist ontology with a relativist or constructivist epistemology (Easton, 2010; McEvoy & Richards, 2003; Walsh & Evans, 2014) and a generally emancipatory axiology (Easton, 2010). Critical realism theory was employed to gain an understanding of the complex influences on a midwife’s learning through a catastrophic incident. Critical realism helps a researcher to gain an understanding of outcomes as they occur (Bhaskar, 1975) as the stratified ontology, central to this philosophy, makes sense of a phenomenon that exists within multiple contexts. These ontological strata, the ‘empirical’, the ‘actual’ and the ‘real’ domains, have been illustrated by the tree in figure 2, an adaptation from Dyson and Brown (2006, p. 38); and Walsh and Evans (2014, p. 2).

![Figure 2. Three ontological strata in critical realism. This figure illustrates the empirical, actual and real strata represented as parts of a tree.](image)

The empirical domain, the first and most superficial, is where observations are made and experienced (the branches of the tree) (Bhaskar, 1975), and would be the midwives’ actions...
and experiences in caring for women through perinatal death. The actual domain (the trunk of the tree) lies beneath the empirical domain and is where events happen, but may not be observed or may be understood differently by observers, however, it is regulating the empirical domain. This would be the midwives’ conscious consideration of how to react, behave and perform according to their known skills and within their current emotional context. The trunk of the tree, in figure 2, is obscured by the wall, illustrating that the observer knows it is there, but cannot always see what is behind it. The third level is the real domain, the roots of the tree in figure 2, the deepest level, which underpins the actual domain. This domain refers to the underlying structures and powers that can cause changes in events or outcomes (Bhaskar, 1975). These hidden strata are the generative mechanisms, in other words, the predispositions or causative agents whose effects can be observed or experienced, contributing to our understanding of the actual, but are not fully explanatory (Bhaskar, 1975; Dyson & Brown, 2006; Easton, 2010; Walsh & Evans, 2014). The underlying factors and powers at the real domain will exert an influence on the midwife’s experience of caring for women through perinatal death, as well as midwives’ perceptions and learning associated with the experience, irrespective of whether or not they recognise it.

The construction of knowledge, according to Walsh and Evans (2014), occurs as we discover the complexity of phenomena. As we uncover and construct knowledge, we do this through an interpretive lens at an individual and social level, explaining why different people having the same experience can relate it in contrasting ways (Walsh & Evans, 2014). To explore the ontological question from a critical realism perspective, this study has sought to piece together the realities of midwives’ learning experiences through an interpretive, subjective and socially influenced lens (Braun & Clarke, 2013; Walsh & Evans, 2014). In their discussion on critical realism, Walsh and Evans (2014) encourage the use of this theoretical perspective in midwifery research despite its relative complexity. A theoretical underpinning with the ability for deeper exploration of surface phenomena, stimulated through the combination of different ontological and epistemological positions across other disciplines (Braun & Clarke, 2013; Walsh & Evans, 2014), is necessary to examine the phenomena more holistically (Walsh & Evans, 2014).
Critical realism supports a constructionist epistemology, accepting that the world is socially constructed, but acknowledging that reality is there at some point (Easton, 2010). Although the stratified layers of reality are partial and revisable through new research, this is determined as a result of hidden generative mechanisms being never fully explanatory, as well as the interpretive lens that has filtered how we receive and respond to these causative agents (Easton, 2010; Walsh & Evans, 2014). This is elucidated by Sayer (2000, p. 17), stating that

“critical realism acknowledges that social phenomena are intrinsically meaningful, and hence that meaning is not only externally descriptive of them but constitutive of them (though of course there are usually material constituents too). Meaning has to be understood, it cannot be measured or counted, and hence there is always an interpretive or hermeneutic element in social science”.

Through a critical realism framework, this study will explore and elucidate the foundational propensities that are underpinning the phenomena (Walsh & Evans, 2014). Knowledge is constructed as we discover and explicate the intricacy of phenomena, according to Walsh and Evans (2014), and the interpretive lens that is influenced at an individual and social level explains why the same experience can result in differing interpretations (Braun & Clarke, 2013; Walsh & Evans, 2014). At the actual and real levels is where we want to discover the meaning that the midwife makes from their experience of perinatal death and discover the learning that has taken place that the midwife may or may not be aware of until we explore their narratives in more depth.

3.4 Reflection on Personal Assumptions Related to the Study

Prior to outlining the detailed aspects of the study design, it is important to first establish my underlying assumptions and the experiences that have been influential in the formation of these assumptions. Whether consciously or not, the researcher will always bring beliefs and philosophical assumptions into their research (Creswell, 2013). The position of the researcher influences the way in which they approach and understand the research and is relevant in being able to understand the social, cultural and personal identity lens through which the phenomenon will be explored and interpreted (Walter, 2010).
Subjectivity permeates any qualitative study from the outset and the researcher’s subjectivity must be recognised and stated outright rather than viewed as “the prototypical orphan in the cinders ... something to live with, avoid, and never, never be caught consorting with” (Glesne & Peshkin, 1992, p. 104). This notion that the qualitative paradigm values subjectivity in research is confirmed by Braun and Clarke (2013, p. 36) who explain that it is a subjective process where “we, as researchers, bring our own histories, values, assumptions, perspectives, politics and mannerisms into the research”. By being reflexive, Braun and Clarke (2013) clarify that the quality of qualitative research is assured through both functional and personal reflexivity, a valuable tool for examining the researcher’s influence on the research process (Corbin & Strauss, 2008), and for ensuring that subjectivity has been thought about, considered and documented (Braun & Clarke, 2013; Finlay, 2002).

We can evaluate the functional influence on our research by giving critical attention to the tools and processes that we have used (Braun & Clarke, 2013; Green & Thorogood, 2014). For example, this might include consideration of the way in which midwives may have told their stories in face-to-face interaction as opposed to online discussion. Bringing the researcher into the research to be a visible part of the process requires personal reflexivity (Braun & Clarke, 2013). To achieve this, the researcher can acknowledge who he is as a researcher and how his world view may help to shape the knowledge produced (Braun & Clarke, 2013; Green & Thorogood, 2014) as it is a real person making and interpreting the observations and who is the instrument of the qualitative study (Patton, 2002). To assist in recognising this influence, I have reflected in this chapter on my chosen data collection tools, as well as on my visible presence within this research. I have also, as suggested by Braun and Clarke (2013), kept a journal throughout the process to help me to reflect on each aspect of the research. However, as a prelude to this ongoing reflexivity it is also important to consider how my own sequence of experiences has influenced my view towards the research being undertaken.

My interest in the experiences of midwives and nurses who attend traumatic events developed as a result of my own experiences as a student nurse and midwife, and continued into my practice as a mental health nurse working in correctional services. Within the first
hour of my first placement as a first-year student nurse, I experienced the death of a patient. It was not my first encounter with death, as I was a medic in the military for a year after secondary school, but this particular experience, from a nursing perspective, has made a lasting impression as I was alone with the patient, preparing to help him with a wash, when he died. My second day on the ward, the following week, began in the same way, except this time the patient died shortly after his wash. This experience resulted in tremendous anxiety in performing bed-baths on patients, as well as initiating the unanswered question of “what did I do wrong?”. Although I had a number of encounters with the death of patients throughout my training as a nurse, these first two were significant for me and led me to contemplate what a nurse may need to help them during, and as a result, of similar experiences. On reflection, I was not expecting these patients to die at this point. As it was my first exposure to a hospital ward environment as a student nurse, I did not have the experience to assess the patient, but rather performed the task that I had been instructed to do without considering that the patient’s death could be a possibility. By virtue of this particular experience, I learned to assess a patient and situation for myself, rather than blindly follow instructions and be caught unaware again. I had not discussed with my peers, clinical educators or ward staff any previous exposure to death that I had experienced. In spite of this, no debriefing or formal support was offered for either of these occasions. With this in mind, I contemplated to what degree a young school leaver with no previous exposure to death would experience their first time caring for a patient who dies, and the type of support and education they may require to prepare personally and professionally for these types of challenging occurrences.

My initial introduction to fetal and perinatal death occurred as a student midwife, with my first experience being a 19-week-old fetus in a kidney dish in the sluice room. The fetus had been left there specifically for us as students to view before being disposed of in the medical waste. Having never seen a dead fetus at any gestation, this experience struck a personal chord. Particularly so, as my sister had lost a baby at 19 weeks a year earlier, and I was taken aback by the size and advanced development at this gestational age. Having previously seen only pictures in text books, the reality of an actual fetus at the same gestational stage as my sister’s baby made it real and personal; not to mention the way in which this fetus was to be disposed of. A few months after this initial exposure to perinatal
death, while still a student midwife at a different maternity unit, I was engaged in a second significant stillbirth experience.

Following an unusual chain of events in a large public hospital in a developing country, I found myself in the maternity unit with two other student midwives and no other health professionals present. A teenage mother, with limited ability to communicate in English, was brought into the delivery suite by family members. With all midwives and staff from the maternity unit currently in another part of the hospital as they attended a memorial service for a colleague, one of the other students and I delivered this young mother’s baby of approximately 28 weeks gestation, who had died in utero, while the third student went to seek assistance. The language barrier made it difficult to accurately determine all of the circumstances, but it was evident that the mother was in active labour. Within half an hour of the young mother’s arrival in the unit, my peer and I birthed a baby whose skin condition suggested that he had been dead for a few days or more. Sometime after the baby had been born, the maternity staff returned and my peers and I were ushered out of the delivery suite while they took over care of the mother, baby and their family members. A bizarre memory for me at this time was a registered midwife’s concern that I had put up an intravenous line unassisted!

Reflecting back on this event, there are some parts for which I have absolutely no recollection, such as where the family members were throughout the birth. On the other hand, some moments are etched in my memory, such as the fear on the mother’s face, seeing the baby’s head crowning on our first examination and the colour, appearance and feel of the dead baby. I was nearing the end of my midwifery placement and had already achieved all of my required births to be eligible to register as a midwife, but we were still students and expected to be supervised by a registered midwife. Due to the circumstances surrounding the way in which I had to deliver the baby, a difficult relationship between the hospital midwives and I developed, and in hindsight, I never fully came to terms with this experience.

There was a particular song that my sister had said that she wanted played while she birthed her baby. While driving home this same song started playing in the car and I had to
stop. I cried for my sister’s loss, for the 19-week gestation fetus in the kidney dish and for
the young mother and her baby who I had just birthed. My family all lived in other cities and
countries and I was living with a family whose son had died by taking his own life less than
two years previously, so I never spoke to them about the sad or difficult experiences that
happened to me on placements. I was confident that we had done the right thing under the
circumstances, but was concerned about the potential ramifications for the hospital, the
registered midwives, my peers and myself. I think that for these reasons I listened to that
song, cried, was angry and then pushed it to the back of my mind only to be remembered
whenever I heard that song. While the registered midwives attended to the young mother
and her baby, my peers and I wrote a report and handed it to the midwife in charge before
leaving for the day. I never went back to that maternity unit. Writing about this experience,
which happened over 17 years ago, is the first time that I have spoken about what
happened. In retrospect, these events made quite an impression on my practice and career
direction, reinforcing my desire to investigate the type of support that best suits the unique
situations faced by nurses and midwives.

I cannot honestly say whether my experiences with death, and the consequent desire to
consider what support would best suit midwives and nurses, contributed to me
commencing and pursuing studies in psychology. Beginning in the second year of my four-
year nursing degree, I completed extra units in the evenings to be able to graduate with the
required Bachelor of Arts in Psychology units to be eligible to enrol in a BA Psychology
Honours year. As a part of this honours year, I explored the experiences of nurses caring for
a woman after having an intra-uterine death. This qualitative study collected data from
three participants in one postnatal ward by in-depth face-to-face interviews and found that
nursing a woman post intra-uterine death called for the carer to be better equipped for the
emotional care of the woman, as well as needing to develop effective coping mechanisms
for them self. These results were the catalyst for me to want to further explore this
experience, which is unique to this area of healthcare. My Master of Nursing research,
influenced by my own experiences of patient deaths in my first year of study, investigated
nurses’ experiences of the death of patients. In this qualitative study, I explored the needs
of student nurses following their first patient death experience by means of a
phenomenological approach, with data collected through in-depth interviews (Laing, 1999; van Rooyen et al., 2005).

With the assistance of these studies, I discovered that some nurses resist taking part in this type of research, particularly as it involves the disclosure and discussion of emotionally laden topics. In fact, they were also resistant to expressing and exploring their feelings even when consenting to take part in the study. This observation was also made by Elmir (2014), and led to her offering different styles of interview for participants, namely face-to-face; telephone; or email, in the hope that this may encourage participation by those who would not normally feel confident to take part in an enquiry into a sensitive topic.

Owing to my previous studies, I formed the belief that midwives and nurses need to be able to openly acknowledge the emotions, problems and questions that they face when they are in contact with death and bereavement. There can be great psychological stress on midwives and nurses at such times and, by gaining a deeper understanding of this, relevant support programmes for midwives and nurses could be developed (Laing, 1999). The quality of learning that occurs as a result of early death related experiences can be crucial to the foundation that is laid for the rest of a midwife and nurse’s practice. This strong learning base will direct the midwife and nurse through their professional practice and will influence their sharing of experiences with others in similar situations (Laing, 2004). I ascertained that particular attention should be given to content and strategies to secure learning opportunities to empower midwives and nurses to be able to care for dying patients in a way that is optimal for the midwife, nurse, patient, baby, woman and family (Laing, 2004). These assumptions, based on my experiences and studies, were instrumental in the direction that this PhD study would take in order that these assumptions could be further explored.

I have now returned to re-examine this area of research for two main reasons. Firstly, as I reflected on the meaning of these experiences for nurses and midwives and how it affected them personally and professionally, I contemplated how these events can help us to understand what a midwife needs. A growing body of literature is helping to describe how a midwife and other health professionals experience death, but I wondered how they could
use this experience for personal and professional development. Secondly, I began to reflect on how to overcome the limited sample available to a qualitative study of this nature. The geographical restrictions that bound my data collection to one hospital in one city made me begin to consider methods of conducting qualitative research that would be open to participants no matter where they lived. I began teaching online units a few years prior to commencing this study and seeing how these allowed students to complete their degree no matter where they lived and at what time they chose to access the materials, helped me to ponder ways to collect data using online methods.

Having analysed the growing body of literature around nurses’ and midwives’ experiences of death, together with the influential experiences early in my career, my interest became one of how to identify the way in which people learn and make sense of such a difficult and traumatic experience. By what means can we take a real catastrophe, such as the death of a new life, and learn something from it, not letting that life and the trauma that surrounded this tragedy come to nothing? How can we help midwives to grow, using their experiences to help them to develop personally and professionally and remain in the profession? And to be able to understand in what way these events change people.

Given that this type of research involves the study of often unexpected trauma that most often will impact upon people, their family, community and those caring for them in significant ways, there are challenges to conducting research of this nature. In particular, these include dealing with the sensitive and painful nature of the context being studied, the impact that this can have upon both the researcher and participants, and issues related to the experiences of the researcher that may have led to this study. I found it easy to listen to the midwife participants’ stories as they took part in this study and, although I did shed some tears and felt sad, angry, grateful, relieved and honoured to be a part of their stories, it was for them and the families for whom they cared. I did not contemplate my own experiences until the final focus group when, at the end of the discussion, the participants suggested that I should share my experiences as a midwife. I did not share my story with the participants as I felt that this study was about them and their experience and not me. Subsequently, I do not know whether it was their invitation to listen to my story, or if it was the in-depth examination of the transcripts that allowed my own memories to re-surface;
however, I am grateful that the eruption of my own memories occurred once data collection had concluded.

I reached a point where I could not face my data, and found every excuse not to have to read any part it. For a long time, I was not able to return to my data and busied myself instead with other 'safer' parts of this thesis. Thereupon, I reflected on the extent to which my experiences had influenced the path that my research interests have followed, and contemplated the effect it may have had on data collection and analysis. I considered the statements made by Braun and Clarke (2013) regarding subjectivity and reflexivity in qualitative research, and on reading my own journal notes, I realised that my experiences had allowed me to understand and immerse myself in data collection; feeling comfortable and confident in my interactions with participants. I believe that the rapport that developed over the period of data collection was enhanced by an unspoken (on my part) understanding and solidarity.

My background in psychology and mental health nursing has helped me to gain an understanding of people and how they respond to life's challenges. I worked as a mental health nurse in prisons for seven years in the UK and Australia where I developed an understanding of human actions, reactions and their consequences. I learned to put my personal feelings and judgements aside to be able to understand people’s lived experiences and their resulting thoughts, fears, actions and emotions. I believe that my time as a mental health nurse in correctional facilities has facilitated the development of my ability to explore a person’s story without judgement and preconceived notions, and to be able to analyse and interpret their narrative.

My experiences with death, together with my professional and research experiences, have shaped my assumptions and my approach to this study. Firstly, I made the assumption that profession-specific educational and emotional support needs to be developed for midwives. Secondly, midwives ought to be encouraged to discuss their experiences and accept that it is sometimes difficult for them both personally and professionally. Thirdly, I have made the assumption that the context in which these events occur, as well as the support received and resultant learning that takes place owing to these experiences, will influence a
midwife’s subsequent experiences and how they attend to them personally and professionally. Fourthly, I have made the assumption that an event that results in a baby dying before or soon after birth is a personal catastrophe for families and the midwives caring for them. And finally, I have made the assumption that the learning that takes place for the midwife as a result of a catastrophic experience, such as perinatal death, may not necessarily be conscious and may be a different type of learning to what takes place under different professional conditions.

The inadvertent influence on results, or bias, on the part of the researcher is described by Braun and Clarke (2013) to be possible through poor design and processes. Making my assumptions clear and by being reflexive, along with my experiences as a mental health nurse, have helped to guard against bias. Equally important, by sharing and discussing the findings with academics who have sound experience in research, midwifery and in the fields of mental health and counselling; exploring the findings in the light of contemporary literature; and through member checking (Schneider et al., 2007), the risk of bias can be rigorously reduced. One of the elements of a qualitative paradigm, explained by Silverman (2000, p. 8), is "the recognition that researchers bring their subjectivity (their views, perspectives, frameworks for making sense of the world; their politics, their passions) into the research process - this is seen as a strength rather than a weakness." This is supported and further explained by Corbin and Strauss (2008), who consider that researchers can use what we bring to the research process, increasing our understanding into what participants are saying to us. In this way, the researcher immerses them self into the research and is able to have insight and an ability to "pick up on relevant issues, events and happenings in the data." (Corbin & Strauss, 2008, p. 32).

### 3.5 Methodology

#### 3.5.1 Case study.

A case study method was chosen for its ability to facilitate the in-depth examination of complex individual, group or organisational occurrences and issues that occur in healthcare disciplines (Atchan, Davis, & Foureur, 2016; Schneider, Elliott, LoBiondo-Wood, & Haber, 2003); and to establish a focused and detailed inquiry into a particular and complex phenomenon within its real-world context (Saks & Allsop, 2013; Yin, 2009). Case studies are widely used across the social sciences, with Stake (2000, p. 435)
suggesting that case studies have become "one of the most common ways to do qualitative inquiry". Case study is a research strategy and not a method (Titscher, Meyer, Wodak, & Vetter, 2000; Yin, 2009), "it is a choice of what is to be studied. By whatever methods, we choose to study the case" (Stake, 2000, p. 435). Hartley (2004) sums it up as follows: "case study research is a heterogeneous activity covering a range of research methods and techniques, a range of coverage (from single case study through carefully matched pairs up to multiple cases, varied levels of analysis (individuals, groups, organisations, organisational fields or social policies), and differing lengths and levels of involvement in organisational functioning". (Hartley, 2004, p. 332)

A naturalistic approach to case study research concentrates on the particularities of the case as it occurs, following the issues and circumstances from multiple perspectives as they emerge, within the usual setting of the case rather than a scenario produced by the researcher (Abma & Stake, 2014). In a naturalistic case study, the researcher recognises that we may not know enough about the complexities and particularities of the case in advance, and therefore will be in search of issues that emerge from the case (Abma & Stake, 2014).

Case study research, as a method for the investigation of a single or small number of social situations using multiple sources of data and an iterative process to develop a holistic description, and critical realism are particularly well suited to each other (Easton, 2010). A critical realist case study approach is especially complementary to clearly bound, but complex phenomena (Easton, 2010). A case is described by Tellis (1997, p. 2), to be “typically a system of action rather than an individual or group of individuals.” The case and unit of analysis for this study is the experiences of midwives caring for women through perinatal death and the learning that occurs through these experiences. The case was examined within the context of perinatal death being a catastrophic personal life event. It was within the maternity setting and following care of a mother through perinatal death that this learning took place, therefore the context in which the learning occurs is vital in order to gain a true understanding of the learning that may have occurred (Baxter & Jack, 2008).
The multi-perspectival nature of case studies allows the researcher to consider both the voice and perspective of the participants as well as relevant groups and interactions between them (Tellis, 1997). To help maintain the focus of the study, the phenomenon being examined is bound within its natural context as well as by space, time and activity (Hancock & Algozzine, 2011; Moore, Lapan, & Quartaroli, 2012; Yin, 2009). These boundaries contained the scope of this current study to include only midwives and their learning through the catastrophe of perinatal death within a maternity care environment. Their experience of caring for women through perinatal death occurred whilst they were practising as registered midwives and the connections to these learning experiences were examined. By exploring the collective perspective through a group activity designed to encourage reflection and the development of personal meanings, the study aimed to elucidate learning that otherwise may have gone unnoticed and which may be vital in developing appropriate ways and means of supporting midwives through these events and experiences and toward personal and professional development.

3.5.1.1 Precedents for case study. Case study research has a growing popularity in the social and health sciences with a vast number of studies being undertaken using this method (Abma & Stake, 2014; Kohlbacher, 2006; Stake, 2000) due to its ability to yield a detailed, descriptive and comprehensive chain of evidence (Chaboyer, McMurray, & Wallis, 2010) using mixed methods to conduct real life investigations bound by place and time (Hancock & Algozzine, 2011; Moore et al., 2012; Yin, 2009). In midwifery, however, case study research has the potential to be more readily engaged to enhance the understanding of complex, contextual factors and situations (Atchan et al., 2016).

Case study has been successfully used as a method to explore the use of online platforms, more specifically social media, in education, information sharing and for communication strategies (Dabner, 2012; Jones et al., 2016). The medical professions are increasingly using case study research (Abma & Stake, 2014) to evaluate research support programmes (Hauck, Lewis, Bayes, & Keyes, 2015) and to investigate the benefits of interprofessional education, communication and collaboration amongst health professionals (Bail & Morrison, 2011; Meffe, Moravac, & Espin, 2012). There has been limited use of case study method in midwifery research (Atchan et al., 2016). However, researchers have begun to realise the
benefits of exploring issues using a case study approach indicated by a review of midwifery research literature by Atchan et al. (2016). This review found that even though case study method is highly applicable to the issues examined within the profession, the uptake of this approach has been low (Atchan et al., 2016).

For the purpose of exploring the learning that takes place for a midwife as a result of caring for a woman through perinatal death, a method was sought that could ask the ‘what’, ‘why’ and ‘how’ questions, and to analyse real life situations with all of their complexities in an environment that is not controlled or artificial (Kyburz-Graber, 2004). One way to understand the complexities of how midwives learn through such an experience is to investigate the phenomena from the point of view of the midwife who directly experiences it (Emmett, 2011). With the need to take a prismatic look at this complex and sensitive matter in a real-world setting, case study approach was most suitable. On reflection on other research within similar contexts that have successfully explored phenomena using a case study approach, I decided that case study would help to reveal the complexities and uniqueness of the research context while preserving the multiple perspectives and different, even possibly contradictory views of participants (Yin, 2009).

3.5.2 Recruitment of participants. Participants were recruited through an e-bulletin (Appendix A) which was sent to all members of the Australian College of Midwives’ (ACM), as well as through social media pages. Once interested midwives made contact, a personal inventory questionnaire (PIQ) (Appendix B) was sent out to collect initial demographic data and to ensure that the participant met the study criteria. A more detailed presentation of these criteria for inclusion will be included in the sample description.

3.5.2.1 Sample. In qualitative inquiry, the intent is to explore and gain an understanding of central phenomenon rather than to generalise across a population. To achieve this, the researcher must purposefully select individuals who can best help to understand the phenomenon (Creswell, 2012) and should not be regarding sample size as too important, but rather consider that case replication is present (Yin, 2009). Purposive sampling was used with the sample "consist[ing] of participants who are intentionally selected, because they have certain characteristics that are related to the purpose of the
research." (Macnee, 2004, p. 107). The selection of specific sites and individuals is described by Creswell (2007, p. 125) to "inform an understanding of the research problem and central phenomenon in the study" and to this end, participants and sites were chosen for their ability to provide in-depth and rich information (Patton, 2002).

A recruitment medium was sought that could offer a large number of people over a wide geographical area, and for this reason the ACM was the site chosen for recruiting participants before data collection. As ACM is the only professional body for midwives nationally, and has a database of over 5300 members, this was deemed as providing the best opportunity to access participants with an understanding of the phenomenon. First contact was formally made by email to the Executive Officer of the Australian College of Midwives to ask for their assistance in contacting members in order to invite them to participate in the study. Permission was granted on the 12th of March 2012 to provide an invitation to participate that would be distributed as an e-bulletin to all members. The e-bulletin was distributed by the Australian College of Midwives on the 14th of August 2012. Appendix A shows the expression of interest to participate included in the e-bulletin, and Appendix C, the Midplus continuing professional development (CPD) points approval from ACM.

After data collection was underway, further recruitment of participants was conducted through social media groups related to perinatal death. These sites were chosen to recruit individuals as the nature of the group would include members who have experience in caring for families during perinatal death. The second call for expressions of interest was prepared and requests were sent on the 3rd of March 2013 to the administrators of 15 Facebook pages related to midwifery and perinatal death, asking whether the call for participants could be put on their Facebook page. Eight administrators responded with three advising that they were not able to assist. Two sent the information directly to their members by email and two put the information up on their Facebook page. The fifth site was mainly directed at midwives in the United Kingdom, so no information was posted.

For the purpose of this study it was essential that all participants had experienced caring for a woman through perinatal death. The objective of criterion sampling is to ensure
homogeneity; that is, all participants will have had experience of the phenomenon being investigated (Creswell, 2007). For the purpose of this study, the sample population met the following criteria:

1. Participants were currently registered with the Australian Health Practitioner Regulation Agency (AHPRA) as a Registered Midwife or Student Midwife.
2. Whilst practising as a Registered Midwife or Student Midwife, participants had experienced caring for a minimum of one mother whose baby died during the perinatal period.
3. Participants were required to have access to a computer with internet and a telephone to be able to take part in data collection activities.

A total of 63 midwives responded to the first call to participate and 12 to the second. Each was provided with an information letter (Appendix D), consent (Appendix E) and a PIQ (Appendix B), sent to them directly by email. A total of 24 midwives indicated an intention to participate, and completed and returned a PIQ; however, three withdrew before accessing the blog. A further four accessed, but did not actively participate on the blog before withdrawing from the study. Any data contribution from these seven participants was not included in the final analysis. Table 1 below provides details of each cohort.

<table>
<thead>
<tr>
<th>Response</th>
<th>1st Cohort</th>
<th>2nd Cohort</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressed interest in participating</td>
<td>63</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Returned completed PIQ and signed consent</td>
<td>17</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Withdrawals</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Total participants remaining</td>
<td>12</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>
3.5.3 Data collection. Multiple sources of evidence were used to develop converging lines of inquiry (Yin, 2009). These included a PIQ, group blog activity, focus groups and in-depth email interviews. The PIQ, blog and interview made use of the internet and email as a medium for data collection; hence data were in text format. The focus groups were conducted by teleconference and were recorded and transcribed verbatim. The researcher kept field notes throughout all phases of data collection. Figure 3 below captures the data gathering activities and shows the timeline through each of these stages.

Figure 3. Data collection timeline. This figure illustrates the sequence, timing and length of data collection activities.

3.5.3.1 Using the internet to collect data. A setting was sought that would allow the participation of midwives over a wide geographical area, and for this reason internet and telephone-mediated settings were used. The emergence of the internet as a tool for research has been described by Hookway (2008) as a medium that has been more widely
used to collect quantitative data, however, more recently, an increasing body of knowledge is being developed through qualitative data collection methods using the internet (Barratt et al., 2015; Hookway, 2008; Lo Iacono, Symonds, & Brown, 2016). The internet is progressively being used to generate research data across disciplines, including health; however, there is a need for guidelines to help researchers in design decisions for online studies (Kim, Huang, & Emery, 2016; Wilkerson, Iantaffi, Grey, Bockting, & Rosser, 2014). Being able to reach a larger and more diverse population of participants with flexibility, convenience and at limited cost is advantageous when studying a relatively small population (Lo Iacono et al., 2016; Miner, Bockting, Romine, & Raman, 2012; Weigold, Weigold, & Russell, 2013).

Technological advances and internet based communication has progressed at a rapid rate and is becoming increasingly important in our everyday lives (Lo Iacono et al., 2016), while advances in technology, such as the Smartphone, has transformed the telephone into a hand-held computer making the internet more accessible (Muessig, Nekkanti, Bauermeister, Bull, & Hightow-Weidman, 2015; Wilkerson et al., 2014). There will, however, remain barriers to the use of new technology in research for a variety of reasons, including the challenge for the researcher to move away from their comfortable method (Hesse-Biber & Griffin, 2013). On the other hand, there is increasing availability of good practice examples and guidelines for researchers to draw upon (Hewson, 2014; Wilkerson et al., 2014).

3.5.3.2 Personal inventory questionnaire (PIQ). A PIQ (Appendix B) was sent to each midwife who responded to the expression of interest. The PIQ served two purposes; firstly to collect demographic data and to ensure the eligibility of the midwife to participate in the study; and secondly, a set of six qualitative questions was designed to assist them in crafting their story in preparation for the group blog discussion. The six questions were as follows:

1. Please reflect on one particular experience of caring for a woman through perinatal death and describe how this experience changed you (if it has).
2. Please describe the support you received through this experience.
3. How would you like to have been supported?
4. Please describe what you have taken from this experience and put into your working and/or life relationships.
5. What would you like others to know about your experience?

6. Please tell me whether there are any areas that you feel you would like to develop further before encountering a similar experience in the future.

### 3.5.3.3 Group weblog (blog).

Blogs represent just one of many potential internet platforms for collecting data. The rapid development of Web 2.0 technology has also seen blogs being recognised as an effective tool in teaching and learning (Duarte, 2015; Ryan, Heidke, Blunt, Williamson, & Brien, 2017; Wang, Li, Lin, & Shih, 2014). Blogs offer substantial benefits to research by providing a publicly available, low cost and instantaneous technique for collecting extensive data (Singh, 2016). They have become a rich source of data for researchers who have gleaned data from a wide variety of blogs, such as those who share their experiences while travelling (Banyai & Havitz, 2013; Chandralal, Rindfleish, & Valenzuela, 2015; Exley & Willis, 2016; Snee, 2013) to ‘hard to reach populations’ (Wilkerson et al., 2014, p. 561) who may use online environments to express their thoughts and experiences in a public, but relatively safe and anonymous forum (Anderson, Hundt, Dean, Keim-Malpass, & Lopez, 2016; Barratt et al., 2015; Wilkerson et al., 2014), or as a means to enhance engagement in research (Hoang, McCall, Dixon, Fitzgerald, & Gaillard, 2015; Jackson, Waine, & Hutchinson, 2015).

Opportunities to further develop this platform as a rich source of data need not be limited to surveys, teaching and learning or to retrospective data gathering. For example, this current study has made use of a blog as a platform for discussion of a specific experience by a population bound by the experience of caring for women through perinatal death.

Communication is a vital part of healthcare, and Maag (2005) explains that health professionals need to be able to keep up with trends in communication on the internet. Blogs offer online platforms where students can reflect on and express their thoughts and feelings, identifying personal strengths and weaknesses, and creating positive learning experiences from challenging events (Ryan et al., 2017). Blog based reflection activities also allows for the potential scaffolding of novel thoughts through the ability to provide feedback by means of constructive peer feedback as comments on the blog (Maag, 2005). Having the ability to reflect on what has been written on a blog before responding helps the
reader to make deep personal connections before responding and hence has been
described to be a safe place to communicate (Anderson et al., 2016; Maag, 2005). This type
of learning, using critical thinking and reflection on feedback on a blog-mediated internet
platform, fosters a feeling of connection and belongingness when learning experiences
reach beyond the physical space of a classroom (Baker & Ryalls, 2015).

The knowledge base of blog-mediated studies has been growing over the last decade with a
number of studies exploring the area of teaching and learning. For example, in a quasi-
experimental study to compare the quality of writing and peer feedback between a
traditional offline writing workshop and online methods, Novakovich (2016) determined a
significant difference. In this study, the quality of peer feedback on the blog was higher than
for those using a traditional offline workshop method, as well as demonstrating higher
levels of engagement. Overall grades for the piece of writing was also higher in the blog-
mediated writing group workshop (Novakovich, 2016).

Similarly, a mixed method study of English writing performance in Iranian engineering
students by Asoodar, Atai, and Vaezi (2016) showed significant improvement in students’
writing performance as a result of a blog-integrated writing instruction programme.
Incorporated into this programme was a ‘blog-buddies’ system for peer feedback. Written
work was posted onto a group blog where feedback was received from peers and instructor.
The response to this peer feedback system by students indicated that they regarded
feedback on the blog more highly than that received in a Word document style of essay
(Asoodar et al., 2016). These studies using blogs, although mainly for teaching and learning,
indicate the potential for effective sharing, discussion, critical thinking and peer feedback on
a blog platform where, for example, midwives can safely share their experiences of caring
for women through perinatal death.

A number of advantages for the use of blogs in research include anonymity, allowing
bloggers to feel relatively free to express their experiences (Hollenbaugh & Everett, 2013;
Hookway, 2008; Seale, Charteris-Black, MacFarlane, & McPherson, 2009), and an
inexpensive means that removes geographical barriers which may impede other data
collection techniques (Anderson et al., 2016; Asoodar et al., 2016; Hookway, 2008; Seale et
al., 2009; Singh, 2016) that also allows author – reader interactivity (Anderson et al., 2016). The use of a purpose created blog to provide a platform on which to gain a collective of purposely selected participants has mostly been documented in literature exploring internet-mediated teaching and learning or information sharing. Healthcare and illness related blogs that have been the feature of research tend to serve as a means to share an individual’s own health related narrative; to keep family and friends updated on care and health status; or for the sharing of personal experiences in the form of an online diary (Anderson et al., 2016).

A limitation, or rather point to consider when examining data from blogs was raised by Clarke and van Amerom (2008), as the blogs examined will have been written by the blogger for a specific audience, it is not possible to determine how honest the blogger has been in their posting. Similarly, Hewitt-Taylor and Bond (2012) found that some users have posts on more than one and sometimes all of the related blogs which in turn may skew the results. One of the key limitations described by Snee (2013) is the inability to verify the identity of blog authors or to be able to connect their narratives to their background, gender and age, as well as whether they were being completely truthful in their posts, similar to the limitations expressed by Hewitt-Taylor and Bond (2012) and Clarke and van Amerom (2008).

The collection of data through a blog in this current study will avoid some of these limitations as the blog is private, not written for a global audience and the participants were selected to join the blog rather than existing blogs being examined. By setting up a blog specific to the purpose of this study and being immersed in the live collection of data using the blog, the limitations related to honesty will be minimised, and the problem with members posting the same information on other blogs will not be applicable in this case.

The blog was hosted on the blog application, Wordpress, and privacy controls were set to allow only invited participants to read and contribute to the blog. Participants were invited to join the blog by email and each was supplied with a username not related to their real name, ('midwifelearning01' through to 'midwifelearning24') to maintain anonymity amongst participants. Each participant set up their own password for secure access to the blog. As a part of their consent (Appendix E), participants signed a confidentiality agreement
committing to keep all disclosures within the blog confidential and to not use any identifying names, places or occasions in their posts.

Ten participants actively took part in the blog discussion where they examined and commented on initial interpretations, beliefs, values and personal theory for nine narrative event descriptions. The blog was set up with the stories and comments running consecutively on the main page with instructions and information on separate pages, illustrated by Figure 4 below.

![Figure 4. Page from the blog. This figure illustrates the way in which stories were posted onto the blog.](image-url)
I explained to each participant by email that we would all be participating in a group blog where they would complete a task aimed to assist each of them to reflect on and think about what the experience of caring for women through perinatal loss meant for them at the time and for their future practice. I mentioned that we would talk about their thoughts around their learning as a result of the experience as well as by looking at the experience in hindsight through the eyes of other participants. Before the blog commenced I had an informal email exchange with participants and telephone conversations with those who requested an exchange prior to commencing data collection. The purpose of this was to serve as an ‘icebreaker’ and to begin to build rapport as one would do before a face-to-face interview or focus group.

The group blog was based on the critical incident task described by Francis (2004) with the following instructions given to participants in the information pages of the blog:

1. Please begin by writing a full description of what happened. Just describe in as much detail as possible without interpretation or analysis, framed within the “who, where, when, what happened” framework of writing. Please make your description as rich and detailed as possible, devoid of judgement and questions of “why”. Please remember to avoid any identifying names and places in your description.

Your description will not go live immediately. Stories will start going live at Stage 3 and will be staggered so that we are not all overwhelmed. You can post it at any time though as I can keep it offline until it is ready.

2. Please only begin this stage after you have finished writing your story from Stage 1.

Please write a reflection on the incident from Stage 1, but this time I would like you to reflect on the personal meaning given to the incident. Please feel free to include interpretation of intent and outcome, feelings, beliefs, questions and comparisons to other events and experiences. You don’t need to re-tell the whole story, just concentrate on reflecting on the parts mentioned above.
Please email this reflection to me as it will be just between you and I and won’t be uploaded onto the blog.

3. The researcher read through the description produced in the first step to ensure adequacy of detail or any need for clarification as well as taking the opportunity to detect any unintended or sensitive disclosures before they were posted to the blog. Only one story had some detail that the researcher asked the participant to delete as it had the potential to identify the unit where the incident took place as well as the incident itself.

4. The descriptions from the first step were posted on the blog and the following instructions were given to all participants:

Please read through the stories as they are posted onto the main page of the blog and apply the Key Questions that I have adapted from Frances (2004) below. The intention of this stage is to have another set of eyes who wasn’t involved helping to see alternate understandings and interpretations in our story.

Key Questions

• When reading this story, what stands out to you as the main points being made by the author in relation to the experience of the:
  author
  author’s co-workers
  mother
  baby
  family
  hospital

• Do you believe other people reading this story might interpret events in a different way? Can you describe what they might be?
• What outcomes in this story have special meaning for you and why?
• There may be a range of personal experiences and cultural influences that have influenced the way you view this story. Can you describe these?
• Place yourself in the shoes of the midwife who experienced this situation and describe how you believe you would have felt and responded at the time.
• If you had been the midwife involved, what would you have learned from experiencing this incident and how would it be likely to influence your behaviours in the future? Please describe both negative and positive affects you feel it may have.
• Describe the support that you would have given to the author during and after this experience.

Not all participants followed these Key Questions; however the majority provided an in-depth examination of the stories.

5. In-depth individual email interviews were then to be conducted to help each participant to return to their own incident and reconstruct the meaning given to it with the new values, understandings and beliefs attached to the event following peer feedback. I felt that before I could move on to the individual interviews I would need further explanation and the opportunity to explore their experiences as well as their thoughts on others’ stories in more depth. For this reason I decided to first conduct focus groups to help the participants to return to their stories and to be able to gain a "thick, rich description" (Moore et al., 2012, p. 243) of their experiences.

Our own experience represents a familiar and functional source of knowledge. Although it is often said that there is no teacher like experience, each individual’s experience may be too restricted to develop generalisations about new situations, and the same event is generally experienced or perceived differently by two individuals (Laing, 2004). The aim of the critical incident task was to allow the participant to engage in double loop learning (Francis, 2004) to help the midwife to re-look at experiences that may have been coloured by subjective
values and prejudices and hence, potentially learning from the experience. Double loop learning, a theory proposed by Argyris (1976) and detailed in chapter two of this study, is about learning to change underlying values and assumptions. The focus of the theory is on solving problems that are complex and ill-structured and which change as problem-solving advances. In the context of this study, the goal would be the way in which midwives process and manage their experiences, emotions, attitudes and professional development as a result of caring through perinatal death.

This double loop learning model provides feedback and more effective decision making than single-loop learning where there is the repeated attempt at the same problem, with no variation of method and without ever questioning the goal. The critical incident task designed by Francis (2004) is based on a double loop learning model to provide feedback and effective decision making in nursing education. By applying the key questions of the critical incident task, and with the support of peers who were not a part of the event, Francis (2004) suggests that the surface realities may lead to alternatives being posed and multiple ways of analysing the same phenomena. The intent was for this process to raise awareness of how an incident can be perceived selectively within the individual's own personal world view and allow for the consideration of multiple interpretations and contemplation of potential learning opportunities (Francis, 2004).

In recognition of the learning that will be achieved through this group blog activity, an application was made to the ACM for CPD points for each midwife who completes the critical incident task group blog activity. The application was considered by the Professional Development Committee and endorsement as a CPD activity was approved with an allocation of 5 MidPLUS points for each participant (Appendix C). The ACM advises that the purpose of the endorsement process is to promote the provision of high quality, relevant and appropriate CPD activities that meet the ongoing educational needs of Australian midwives.

3.5.3.3.1 Challenges of group blog data collection. The two main challenges that I experienced with the blog activity was with passive participation of a few respondents and some participants not responding according to the key questions. The latter, I concluded,
led to a more honest and heartfelt response to the story, and therefore, may have been a positive outcome. The reasons for passive participation, where some participants only read the contents of the blog and neither contributed their story nor responded to others’, were revealed naturally during the focus groups and interviews. One participant said that she struggled with the technological aspect, having never used a blog before, while others mentioned that they preferred to read about others’ experiences on the blog and were happier to talk about their own in the focus group or interview.

3.5.3.4 Focus groups. In case study research, as in other qualitative methodologies, the analysis of data is a dynamic and interactive process that is taking place at the same time as data collection (Moore et al., 2012). Initial analysis of the blog data highlighted the need for greater engagement of the participants to explore their thoughts and experiences in more depth. Details emerged from participants’ stories for which I wished to explore further but was restricted from asking questions within the forum of the blog. I considered that a group discussion in the form of a focus group would allow participants to engage in further discussion that had been started in the blog.

I had spoken with some participants by telephone during the blog discussion and let all participants know that I was available to talk by phone should they wish to. I had opened up this opportunity to try to counteract possible resistance to providing richer information that may be caused in discussing their experiences in writing on a time delayed online environment rather than by speaking and listening. I considered that possibly a bit of human touch, the understanding that they were talking to a real person with similar experiences, could help some participants to engage. Further, the collecting of data through focus groups with a small group of similar participants can be advantageous as the interaction among participants can enhance the richness of information gathered (Howitt, 2013).

I arranged the blog transcripts into sets of the participant’s story followed by comments, feedback and discussion on that story in chronological order and began to analyse these transcripts to provide the background and insight for my focus group preparation and to help me to formulate questions for the focus groups. The questions also took into consideration the research questions and the need to return the participant to their own
story told in the blog, and for them to begin reconstructing the meaning given as a result of others’ observations and questions to the blog narratives. Within these determinants, the questions were broad and general in order that participants would share their views and experiences relatively unconstrained by my perspective (Creswell, 2012).

Four focus groups were conducted by teleconference with a total of 12 participants, each lasting for an hour-and-a-half. Participants were located across metropolitan and regional areas of New South Wales (NSW), South Australia (SA), Victoria (VIC), Western Australia (WA), Queensland (QLD) and the Australian Capital Territory (ACT), making it unfeasible to conduct face-to-face focus groups. Initially, I arranged three focus groups with four participants each, but two of the participants for the second focus group did not arrive at the arranged day and time. When contacted to check that all was alright, they both advised that they had last minute commitments that needed to be attended to, but were keen to reschedule and still be involved in a focus group if possible. As a result, four focus groups were conducted, two with four participants and two with two participants each.

A group of typically six to ten participants has been recommended for a focus group by Howitt (2013), however I found that as it was a focus group conducted by telephone, the smaller numbers of participants were easier to manage and there was no lack of interaction amongst participants. On the contrary, the two focus groups consisting of just two participants had greater interaction without anyone being left out. The focus groups were recorded through the Murdoch University teleconference system as well as by Windows Sound Recorder through an Acer Notebook and a Dell desktop PC as back up.

An interview protocol was used to help guide the focus groups as suggested by Creswell (2012), who asserts that using an interview protocol creates a means of having the interview questions available to you as well as serving as a place to record notes through the focus groups. Open-ended questions were asked to allow participants to tell their story without being constrained by the perspectives of the researcher or others (Creswell, 2012). The questions formed a guide for the focus groups with not all being asked when topics had already been covered through the discussion or according to time demands. Using a guide is
encouraged by Patton (2002) as it maintains the focus while allowing individual perspectives and experiences to emerge. The guide questions were as follows:

1. In general, what do you believe to be the elements of perinatal death that can make it such a catastrophic event for the people involved?
2. How has your own individual experience shaped the way you now feel about caring for a family experiencing perinatal death?
3. What did you find helped you the most to be able to care for the family?
4. How has this experience influenced your approach to similar situations in your practice now?
5. What about the others’ stories? What for each of you were the things that stood out the most when listening to the other stories?
6. How has sharing these stories added to your thinking about your own practice?
7. Has sharing your and others’ stories influenced or changed how you look back on your own story? In what ways have your perceptions changed?
8. Looking back, after your own experiences and that of others, do you think there were things that would have helped you to be better prepared for this? What are they?
9. What would you do personally to help other midwives who are caring for families during perinatal death?
10. What do you think hospitals and education providers should be doing?
11. Looking back on our discussion, are there now other things that you think help to define the catastrophic nature of perinatal death to those involved?

3.5.3.4.1 Challenges of telephone focus groups. I found that as we had built a rapport through the blog discussions, the discussion and interaction in the focus group was easy and comfortable from the beginning. The anticipated challenges associated with not having visual contact with each other were removed by having had the opportunity to get to know each other through their stories. I found it a challenge, however, to ensure that all participants had the opportunity to contribute, especially in the four participant groups. Halfway through the four participant group, when calling on a participant from whom I had not heard in a while, I discovered that she was no longer on the line. This would have been
evident in a face-to-face scenario, but difficult to manage by telephone. I was able to contact the participant once the focus group had concluded.

There were also occasions where background noise and signal dropout led to not hearing what was being said, but participants were accommodating and happy to repeat themselves. Each focus group was scheduled to take an hour-and-a-half, and I found that, although we had not followed all of my planned questions in sequence, data saturation was being reached by this stage. An informal discussion continued for a few minutes afterward for all four focus groups and one group seemed to be reluctant to end the informal chat and had to be wrapped up by me rather than coming to a natural end.

3.5.3.5 In-depth email interviews. Interviews were conducted by email, a reliable method of interviewing (Fritz & Vandermause, 2017), described by Creswell (2012) to be useful when collecting data from geographically dispersed participants, and as a way of promoting conversation between researcher and participants that extends the understanding of the phenomenon being studied. No detailed comparative analysis could be found prior to the study by Seale, et al. (2009) that reports differences between face-to-face and internet-based interview methods. A comparative analysis was conducted by Seale et al. (2009) of 140 qualitative interviews weighed against archived collections of postings and emails to online forums of the same topics as the interviews. Based on this comparison, Seale, et al. (2009) suggested that web forums are potentially a valuable source of data for sensitive topics in which participants raise and are responding to issues in the here and now. This comparative analysis study found that internet based materials were readily available in larger amounts than could be drawn from face-to-face type of qualitative data collection, and that internet data collection provides an excellent guide to the day-to-day concerns of people experiencing the phenomenon (Seale et al., 2009).

In a study that describes the experiences of women who had an emergency hysterectomy following severe postpartum haemorrhage, Elmir, Schmied, Jackson, and Wilkes (2012) collected data by face-to-face, telephone and email interview. This choice in interview method facilitated participation by women in different geographical locations as well as enhancing autonomy and comfort during the interview process of a sensitive experience.
(Elmir, 2014). Unfortunately, there is no comparative analysis mentioned to determine strengths or weaknesses between the three interview methods used in that research.

A number of advantages to using email interviews over traditional interviewing, as well as some disadvantages have been described (Fritz & Vandermause, 2017; Hunt & McHale, 2007). Advantages include cost, as the requirement for travel, equipment and transcribing are either removed or reduced (Fritz & Vandermause, 2017; Hamilton & Bowers, 2006; Hunt & McHale, 2007); a better range of participants is possible without the travel restriction (Ayling & Mewse, 2009; Elmir, 2014; Hamilton & Bowers, 2006; Hunt & McHale, 2007; Seale et al., 2009); there is an easily maintained audit trail and no loss of data as the email takes place within a single email script with all previous responses and questions available to scroll through (Fritz & Vandermause, 2017; Hamilton & Bowers, 2006). Having the entire interview always available also enables both the interviewer and participant to revisit and reflect on what has been said by just scrolling back to previous emails. This provides the opportunity for deeper processing and a more complete review of the issues under discussion (Ayling & Mewse, 2009; Fritz & Vandermause, 2017; Hamilton & Bowers, 2006; Hunt & McHale, 2007). More than one interview can be worked on at a time (Fritz & Vandermause, 2017; Hunt & McHale, 2007); and as interviews take place over an extended time, a good rapport is likely to be developed (Hunt & McHale, 2007; Lo Iacono et al., 2016) and reflection prior to response improves the quality of data (Fritz & Vandermause, 2017; McDermott & Roen, 2012).

These clear benefits make a compelling case for the use of email interviewing; nonetheless some disadvantages exist and must be taken into consideration. Internet access at home in Australia is high, at 73% (Miniwatt Marketing Group, 2016; Pink, 2009), yet there may be a proportion of midwives who do not have internet access, restricting their ability to participate. Other disadvantages include the length of time an interview can take and the potential for loss of focus (Hunt & McHale, 2007); this could also be as a result of typing for some participants requiring more effort than speaking (Fritz & Vandermause, 2017); more complex consent requirements (Hamilton & Bowers, 2006; Hunt & McHale, 2007); the loss of nonverbal cues and valuable interviewing techniques such as the use of silence (Fritz & Vandermause, 2017; Hamilton & Bowers, 2006; Hunt & McHale, 2007; Seale et al., 2009).
Weighing up the pros and cons, email interviews will be a valuable contribution to this study as one piece of the data collection puzzle.

Out of the 17 participants available to be interviewed, twelve agreed to participate in the email interviews. These informants were interviewed following the blog and focus group to elucidate knowledge, attitudes, beliefs and learning that they may have considered occurred through the group blog task, as well as to gain further clarification on details shared on the blog and during the focus groups. Interviews were conducted as guided conversations following a consistent line of enquiry (Yin, 2009).

The case study interview needs to follow the line of enquiry reflected by the case study protocol and to ask the questions in an unbiased manner that will gather the data required for this line of inquiry (Yin, 2009). The data gathered from the blog and focus groups lead the interview questions, thus maintaining the line of enquiry whilst ensuring the flexibility for the participant to tell their story or to further clarify the story told during the group blog activity, and to be able to reflect on learning and reconstructed meaning. Following Patton's (2002) suggestions, some questions were prepared to provide guidance and maintain focus on the research questions, however wording of questions was flexible and emerging ideas and themes that arose during the interview became triggers for further questions. Yin (2009) describes this as a 'focused interview'. The interview remains open-ended and in a conversational manner, but may be guided by questions derived from the case study protocol, or in this case, from the data obtained from the group blog and focus groups.

The email interviews were conducted using an asynchronous method of interviewing in which participants and researcher are not present at the same time, but are rather having a conversation over a longer period of time (Ayling & Mewse, 2009). Participants were informed that their interview would continue for up to a maximum duration of three months. Once all answers had been exhausted, to conclude the interview, I sent a final email thanking the participants for the time and energy that they so willingly dedicated to helping me with this research. I asked that if anything came to mind over the next few weeks that they would like to add or share to please feel free to email. I also reminded them that help was available if recalling any of these memories was causing them difficulties.
The responses to individual questions ranged in richness from substantial depth to single line responses. I started to conclude the interviews for three reasons. Firstly, because the date that I told the participants we would conclude the interviews was approaching; secondly, I considered that saturation had been reached with no new themes emerging. On examination of the ideas and themes emerging at this time, they were appearing to be no different, offering no additional depth to what had been discussed in the blog and focus group. Thirdly, I got the sense that the participants had been happy to spend the time and energy providing rich stories and discussion, but it was time for them to break from it and get back to their own lives. Times between responses were becoming more protracted and, for the majority of participants’ responses were becoming shorter. I found that I was needing to send a reminder to participants as time between responses began to stretch beyond a couple of weeks.

3.5.3.5.1 Email interview challenges. The email interviews flowed well with each participant and I having developed a good rapport through the study. The main challenge was in trying to reduce the lag time between responses from some participants. I allowed for three months, but hoped that the interviews would not stretch out for this long. Maybe the participants did not feel compelled to respond quickly as they knew that there was adequate time allocated to complete the interview.

3.5.4 Data analysis. Having never met face-to-face with the participants, analysis, right from the beginning, was not only an important progression of the continuing process, but also served to get a feel for who the participant was as a person and a midwife. Initial analysis during the group blog resembled brainstorming, described by Corbin and Strauss (2008), where I was identifying concepts, but was not sure of their level or interpretive meaning. As I got to know the participants through their stories and experiences, I was able to gain more insight and sensitivity, allowing more openness to the possible meanings and relationships between concepts in the data being collected. The blog transcripts were arranged in sets of the participant’s story followed by comments, feedback and discussion on that story in chronological order. The transcripts were read and re-read while searching for meanings, patterns and areas that I thought required deeper inquiry. Notes were made in the margins to mark ideas for what I wanted to know more about and what could be
questioned further in the focus groups and/or in-depth interviews. This early analysis provided the background and insight for my focus group preparation and helped to formulate questions for the focus groups.

This first phase of data analysis was a dynamic and interactive process occurring at the same time as data collection (Moore et al., 2012) and commenced while the blog was still in progress; continuing throughout the blog, focus groups and individual interviews. The data collected was in the form of text generated by the blog activity, transcriptions of individual interviews and focus groups, and to a lesser extent, field notes. During the blog activity, I began to analyse the participants’ stories and responses to others’ stories to help develop guiding questions for the focus groups. Brief notes made on key points during the focus groups helped me to return to these points for clarification and further explanation by the participants as each focus group progressed. This same method was continued through the individual email interviews. In this way, data analysis occurred between the participants and researcher during data collection, and between the researcher and the data following data collection.

Concepts derived from the first sets of data were compared against subsequent sets of data for similarities and differences, adding to and expanding concepts with new properties and dimensions as well as revising previous concepts (Corbin & Strauss, 2008). Additionally, as the study progressed, data analysis was an iterative process, moving back and forwards between prior transcripts and different participants and the present interview, focus group or blog entry. Discussions with research supervisors during and after data collection served to consider emerging themes and deal with inconsistencies. As a result, initial transcripts and decisions made were re-evaluated (DeSantis & Ugarriza, 2000), and this iterative process of data analysis continued after data collection was completed.

According to Creswell (1994), data analysis requires that the researcher be comfortable with developing categories and with making comparisons and contrasts. It requires openness to possibilities and insight into contrary or alternative explanations of the findings. The process of data analysis involves making sense out of text data; it means preparing the data for analysis, conducting different analyses, moving deeper into understanding, representing,
and making an interpretation of the larger meaning of the data (Creswell, 2003). The ability to recognise and give meaning to the data also relies on the researcher having some background or connection, whether through immersion in the data or experiential knowledge. A general sense of the information was obtained by reading through all the data and by the researcher reflecting on its overall meaning. Thematic analysis was used as a coding procedure to reduce the information into themes or categories which then formed the basis for the emerging story to be told (Braun & Clarke, 2013; Howitt, 2013; Moore et al., 2012).

Interpretive analysis of data, as Ayres, Kavanaugh, & Knafl (2003); and Starks & Brown Trinidad (2007) explain, is an iterative, inductive process of decontextualisation and recontextualisation. Data are decontextualised by the analyst separating data from the original context of individual cases and assigning codes. This is recontextualised in the examination of codes for patterns, reintegrated, organised and reduced around central themes and relationships across all cases (Ayres, et al., 2003; Starks & Brown Trinidad, 2007). I favoured Braun and Clarke’s thematic analysis strategy for its flexibility across methods and relative theoretical freedom, yet still being methodologically sound. I could see how this method would identify patterns for description in rich detail. The researcher plays an active role in thematic analysis in identifying patterns or themes and reporting those of interest, and I saw it as a discovery of themes and concepts that are embedded in the data. Writing is emphasised by Braun and Clarke (2006) to be an essential part of analysis in their description of conducting thematic analysis, and I implemented this from the early analysis of the blog, with ideas being jotted down as I read and re-read the data, and continued through the analysis of all data. The six phases of analysis, that are not linear, but a recursive process with movement back and forth throughout the phases, are described by Braun and Clarke (2006) as follows:

1. The transcripts (once transcribed and checked for accuracy against the recordings in the case of the focus groups) were read a number of times to familiarise myself with the data, reading and re-reading the data while noting down initial ideas.
2. Initial codes were generated: interesting features of the data were coded in a systematic fashion across the entire data set, collating data relevant to each code.
Where initial codes appeared incomplete, this was followed up with further data collection and analysis.

3. Theme search: codes were collated into potential themes, gathering all data relevant to each potential theme.

4. Reviewing themes: the themes were checked to ensure that they worked in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.

5. Defining and naming themes: ongoing analysis refined the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.

6. Inclusion of the production of a report as this final phase.

The resulting themes and sub-themes from the thematic analysis of all data collected will be presented in chapter 4.

3.6 Rigour

To ensure the quality and rigour of the study, as the researcher, I have been deeply involved in all aspects of the data and maintained transparency in the detailed description of the research process. Rigour in qualitative research has been referred to as trustworthiness of the research and the importance of establishing trustworthiness in qualitative research has been emphasised by several authors (Guba & Lincoln, 1994; Koch, 2006; Liamputtong, 2010; Lincoln & Guba, 1985; Patton, 2002; Sandelowski, 1986; Schneider et al., 2007) with a number of techniques being recommended (Creswell & Miller, 2000). Various authors have attempted to develop criteria to measure and assess rigour in qualitative research (Leininger, 1994; Lincoln, 1995; Lincoln & Guba, 1985; Sandelowski, 1986; Thorne, 2008), but this study has been guided by the more common of these criteria proposed by Egon Guba, detailing truth value, applicability, consistency and neutrality (Guba, 1981).

Assessing the worth of the findings of how midwives learn through the experience of caring for women through perinatal death has been aided by specific strategies that can be used throughout the research process (Krefting, 1991, pp. 214-222). Additionally, Houghton, Casey, Shaw, and Murphy (2013) describe the way in which some of these same strategies
to ensure credibility, dependability, conformability and transferability have been applied to case study research. Although a number of techniques are available, not all are appropriate to every qualitative study, but the strategies described below, according to their implementation in this study, will ensure that trustworthiness has been established.

Truth-value implies the degree of confidence that the researcher has in the truth of their findings based on the design, informants and context of the study (Krefting, 1991). The strategy for establishing truth-value is credibility (Krefting, 1991), and to establish credibility in a study, the researcher must ensure believability of the findings (Houghton et al., 2013; Leininger, 1994; Lincoln & Guba, 1985). To achieve this, the researcher ensures that descriptions or interpretations of human experience are accurate enough that people who share that experience would immediately recognise the descriptions (Krefting, 1991). Prolonged engagement was highlighted by Lincoln and Guba (1985) as a means to enhance credibility of research. In this case, data collection took place over 18 months (see Figure 3) using three different methods that encouraged engagement and allowed sufficient time to gain a full understanding of the phenomenon under investigation. Using three different sources of evidence also enhanced credibility through triangulation (Krefting, 1991; Yin, 2009) where convergence of information was sought among multiple data collection methods (Creswell & Miller, 2000).

A strong case has been put forward by Sandelowski (1993) with regard to effectiveness of member checking in enhancing credibility. Several authors discuss the use of member checking to enhance the credibility of research findings (Braun & Clarke, 2013; Creswell & Miller, 2000; Lincoln & Guba, 1985), but as Thomas (2016) points out, Lincoln and Guba, who are often cited on this concept, do not describe how member checks should be carried out. There could be issues that affect member checking, such as, participants looking for their own voice within the findings rather than seeing it as a representation or multiple realities (Angen, 2000; Sandelowski, 1993). This notion is supported by Braun and Clarke (2013) who agree that there are critiques and questions that need to be considered before engaging in member checking, such as reluctance of participants to engage in this extra process; reluctance of participants to express doubts or criticisms of the researcher’s analysis; and how to resolve disparities.
A number of researchers, including Cho and Trent (2006); Sandelowski (1993); Thomas (2016), suggest that member checking is an ongoing process throughout the study that includes the engagement of member checking every time the researcher seeks clarification or elaboration of meaning and intention. To this end, member checking was performed in this study through re-visiting, clarifying and asking participants to explain further and reveal their thoughts on others’ stories through varying data collection strategies and, as a result, confirming the evolving interpretations of the data (Cho & Trent, 2006; Sandelowski, 1993).

Applicability refers to the degree to which research findings fit into contexts outside the study situation (Krefting, 1991); that is, how applicable the findings are to another situation or population (Krefting, 1991; Patton, 2002). The criterion against which applicability is assessed is transferability which is met when the reader can see a degree of similarity between contexts (Houghton et al., 2013; Krefting, 1991; Lincoln & Guba, 1985), not to mention that research would have little point if results from one study has no relevance to another situation (Yardley, 2008). Transferability can be enhanced by using thick descriptions; describing the participants, the setting and themes in rich detail (Creswell & Miller, 2000). Thick descriptions, as explained by Denzin (1989), detail accounts rather than simply report facts; the significance of which is that it allows the reader to feel that they have, or could have, experienced what has been described in the research (Creswell & Miller, 2000). By describing, in detail, the setting, participants and methodology, together with the logical flow and step-by-step account of the research process, this study has provided rich detail in its elucidation of learning as a result of caring through the experience of perinatal death. Equally important, I have included verbatim accounts to support the analysis which allows the reader means to examine the experiences of the participants.

The consistency of data refers to the stability of data over time (Guba & Lincoln, 1989), that is, whether the findings would be consistent if the study were replicated with the same participants or in a similar context (Krefting, 1991). Variability is expected in qualitative research as the emphasis is placed on the uniqueness of the human experience. With this intention, consistency is defined in terms of dependability (Krefting, 1991). Ensuring dependability can be enhanced through an audit trail, according to Houghton et al. (2013),
where the decisions made through the study as well as rationale for methodological and interpretive decisions and judgements are documented.

Readers should be able to discern what led to the researcher’s interpretations, even if their own interpretations differ (Koch, 2006), in view of the reader being able to follow the systematic process of the researcher conducting the study (Patton, 2002). Within this study, this chapter has provided an audit trail detailing the methodology, contexts and reasons on which decisions have been made. My decision trail during this study also included the use of a reflective journal, suggested by Houghton et al. (2013), to ensure that decision trails include the personal contributions of the researcher as I recorded my thoughts during data collection, analysis and other matters related to the progression of the study.

Neutrality implies freedom from bias in the research procedures and results (Sandelowski, 1986), the degree to which the findings are the participants’ voices within the context of the study and not of other biases, motivations and perspectives (Krefting, 1991). The emphasis of neutrality in a qualitative study, according to Lincoln and Guba (1985), is on the data and interpretation rather than the researcher; consequently, confirmability is the criterion against which neutrality can be measured. Confirmability is established when credibility, transferability and dependability have been achieved (Guba & Lincoln, 1989), and, as Koch (2006) explains, the inquiry audit trail of decisions and influences throughout the study will achieve this. The nature of a qualitative study is subjective (Braun & Clarke, 2013; Glesne & Peshkin, 1992) and the researcher does become immersed in the study over a protracted period of time, bringing their own beliefs and philosophical assumptions into the research (Creswell, 2013). In view of the transparency in which the research reports the subjective construction of knowledge and the researchers position in the study (Thorne, 2008), the findings will show the participants’ voices within the context of the phenomenon being investigated (Krefting, 1991).

This study does not aim to seek generalisability of the findings, but rather aims to elucidate a commonality of patterns to help to generalise the findings of a particular human experience within the context of the experience (Polit & Beck, 2010b; Thorne, 2008). This study will however foster a deeper understanding of the complexities around the
experience of caring for women through perinatal death. The knowledge gained from this study will provide a more complete picture of the phenomenon being investigated.

3.7 Ethical Considerations

Ethics approval was granted by the Murdoch University Research Ethics Office, approval number 2012/083 (Appendix F). Participants were initially contacted by calling for an expression of interest to participate in the study through the ACM website (Appendix A). Participants who responded were provided with an information letter (Appendix D) and consent (Appendix E) that included a confidentiality agreement. Participants were not sourced through participant employers and data collection was conducted online with no risk to organisations and with no access to places of employment required.

Electronic data collected from the personal inventory questionnaire, the group blog, focus groups and email interviews were de-identified, coded and stored electronically with password protection. Focus group recordings were transcribed verbatim. The password protected and de-identified transcribed data will be stored for five years, and the focus group recordings will be deleted.

One of the risks in research of this nature is that participants may recount experiences that could lead to the recall of painful memories. The researcher scrutinised all blog posts and email interviews to determine any potential adverse events occurring from this process such as unintended disclosures, PTSD triggers or the recall of painful memories becoming too upsetting for the participant. During the focus groups, there were occasions where participants became emotional as a result of the nature of the topic under discussion. There were three occasions during data collection where the researcher felt the need to determine whether a participant should be referred for professional help, but after telephone and email discussions the researcher and participant agreed that there was no need for support beyond their normal networks at that time.

The governance of internet research has been influenced by established guidelines and regulations for research in traditional settings (Buchanan & Zimmer, 2016; Eynon, Fry, & Schroeder, 2008) and the internet has had an impact on most research in some way.
The initial data driven use of the internet in research has evolved to a more human-centred social and communicative tool and venue; consequently, the discussion around ethical dilemmas and controversies with the use of online materials for research has had to evolve and adapt (Buchanan & Zimmer, 2016). The main focus has been on whether conventional ethical guidelines for conducting research are adequate in online contexts (Buchanan & Zimmer, 2016; Hookway, 2008). In the online environment, the concept of public versus private is more complex (Buchanan & Zimmer, 2016), leading to the main ethical consideration to be around privacy and anonymity (Barratt et al., 2015), and to consider whether materials publicly available on the internet require participant consent before use, and the application of copyright law to blog content (Hookway, 2008). Blogging is described by Hookway (2008, p. 105) to be a "public act of writing for an implicit audience." This implies that blog authors have consciously decided to allow their writing to be available to the reader. This study ensured that only the target audience (participants and researcher) had access to the content of the blog by restricting access to those invited (participants and researcher), implying consent for all invited members to access the content, and ensuring that only participants and the researcher can read and contribute to content.

Ethical decision making was applied to ethical issues based on the recommendations presented by the Association of Internet Researchers (AoIR) ethics committee (Markham & Buchanan, 2012) and Internet Research Ethics (Buchanan & Zimmer, 2016). These considerations include divulging technical limits to privacy, etiquette guidelines, how postings are archived and for how long, methods of ensuring exchanges remain private, how identity will be protected, and informed consent (Markham & Buchanan, 2012). These considerations are congruent with the three ethical concepts that Eynon et al. (2008, p. 280) list as confidentiality, anonymity and informed consent; the basic human right to privacy.

The blog was hosted on the blog application, Wordpress (www.wordpress.com). The security of information is maintained according to the Wordpress privacy policy, which details the measures used to protect data. Wordpress facilitates privacy settings that allow a blog to remain password protected and accessible to invitees only, and states that once a blog has been deleted; all posts will be removed from view. On conclusion of the blog
discussion, the data from the blog was saved to a password protected file on the researcher's personal computer and all data was deleted from Wordpress once the findings had been written up.

In Australia, recorded materials, including internet content, is automatically copyrighted (Australian Copyright Council, 2017a), and ‘user-generated content’ on a website is protected unless the user/author provides permission for broader use (Australian Copyright Council, 2017b). Participants in this study have consented to participate in the study prior to inclusion into the blog.

This chapter has outlined the paradigm and philosophical underpinnings of this study, its ontology, epistemology, methodology and axiological assumptions. I have described the method and decisions that underpinned the study, providing an outline of sampling, data collection and analysis processes and the ethical considerations of the study. The next chapter will present the research findings.
Chapter 4: Findings

4.1 Introduction

This chapter presents the findings from data collected to answer what and how midwives learn as a result of their experiences of caring for women through perinatal death. The data was obtained by engaging in four methods of data collection to elicit personal stories and experiences. Initially, a Personal Inventory Questionnaire (PIQ) collected basic demographic data and midwives then participated in an interactive blog, where each participant had the opportunity to share an experience of caring for a woman through perinatal death. The other participants also questioned, commented and provided feedback in this forum. Following the blog, participants were invited to take part in one of four focus groups and individual email interviews to further explore the data already collected. Initial analysis of the data from the blog stories and interactions led to the development of guiding questions for the focus groups and interviews. Interpretations of the participants’ narratives have uncovered a wide range of experiences, opportunities and relationships that they draw on to learn and develop both personally and professionally. Seven major themes, each with sub-themes, emerged from the qualitative data and will be presented in this chapter.

4.2 Characteristics of the Participants

All of the participants (N=17) could converse freely and easily in English, were registered by AHPRA, female, and ranging in age from 20 to over 55, with the majority (N=15) aged from 26 to 55. There was a broad range in the level of experience in midwifery practice with one participant being a student midwife in her final year of study and another having over 30 years of experience. The majority of participants (n=16) had cared for more than one case of perinatal death, with 70.5% having experience in over five cases. The time lapse since their most recent experience ranged to beyond two years, with nine participants having their most recent incidence within six months of enrolment in the study and one reporting that she had cared for a family just two weeks prior to study participation. The demographic data of participants is shown below in Table 2.
Table 2

**Participant demographic information**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registration:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife only</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Dual registration as Midwife and Nurse</td>
<td>15</td>
<td>88</td>
</tr>
<tr>
<td>Student Midwife</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>100</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 to 25</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>26 to 35</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>36 to 45</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>45 to 55</td>
<td>8</td>
<td>47</td>
</tr>
<tr>
<td>over 55</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Length of time registered as a Midwife/Nurse:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>student</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>2 to 5 years</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>11 to 15 years</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>over 15 years</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td><strong>Currently practicing as a midwife:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>88</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Student midwife</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Number of women cared for through perinatal death:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>2 to 5</td>
<td>4</td>
<td>23.5</td>
</tr>
<tr>
<td>more than 5</td>
<td>12</td>
<td>70.5</td>
</tr>
<tr>
<td><strong>Length of time since caring for a woman through perinatal death:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the last 6 months</td>
<td>9</td>
<td>53</td>
</tr>
<tr>
<td>in the last 12 months</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>in the last 2 years</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>over 2 years ago</td>
<td>5</td>
<td>29</td>
</tr>
</tbody>
</table>

A total of 17 midwives completed a PIQ and took part in the study, however these participants did not all contribute to every data collection activity. In particular, although all participants had access to the blog, ten were actively involved and nine stories were posted...
onto the blog. Active involvement was judged to have been where a participant shared their experience and/or made comments on any number of the other nine narratives that were posted. All participants (n=17) were invited to take part in one of four focus groups and an individual email interview. Focus group participation was agreed to by 12 participants, and there were 12 participants, not all of whom had been a part of a focus group, who agreed to an email interview. Table 3 below outlines the participation through all data collection methods.

Table 3

*Participation profile according to data collection method*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Inventory Questionnaire completed</td>
<td>17</td>
<td>100</td>
</tr>
<tr>
<td>Total Blog participants</td>
<td>10</td>
<td>59</td>
</tr>
<tr>
<td>Total Focus Group participants</td>
<td>12</td>
<td>70.5</td>
</tr>
<tr>
<td>Total Email Interview participants</td>
<td>12</td>
<td>70.5</td>
</tr>
<tr>
<td>Participated in one collection method</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Participated in two collection methods</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Participated in three collection methods</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>Participate in all four collection methods</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>Participated in PIQ only</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Participated in Blog and PIQ only</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Participated in Focus Group and PIQ only</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Participated in Email Interview and PIQ only</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Participated in Blog, Focus Group and PIQ</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Participated in Blog, Email Interview and PIQ</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Participated in Focus Group, Email Interview and PIQ</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Participated in Blog, Focus Group, Email Interview and PIQ</td>
<td>7</td>
<td>41</td>
</tr>
</tbody>
</table>
4.3 Findings

4.3.1 Emerging themes. Seven major themes, each with a number of sub-themes, emerged from the qualitative data. Table 4 represents these themes which will each be explored through this chapter.

Table 4
Themes and sub-themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| Grappling with the reality of perinatal death | • Shattering of expectations
• Needing answers |
| Struggling with personal and professional heartache | • Challenging their view of them self as a professional
• Feeling the trauma personally
• Living with the enduring impact |
| Seeking the space to grieve as a professional | • Confronting personal grief
• Managing grief across professional and personal lives |
| Being with the woman and her family         | • Understanding that it is their loss, not ours
• Listening to, caring for and supporting mother and family |
| Finding a new purpose                       | • Being inspired to evolve their practice and strive to be a better midwife
• Finding personal and professional fulfilment |
| Strengthened through support                | • Listening to, caring for and supporting each other
• Encouraging the organisation to evolve their support role |
| Developing the courage to care              | • Engaging coping strategies
• Drawing on the expertise of midwives and mothers who have travelled this road
• Empowered through professional development
• Realigning the pieces through reflection and meaning making
• Healing through the telling and the listening |
Each major theme is presented in turn and identified as a heading in bold text. The sub-themes concerned with the major theme are highlighted and italicised followed by the elucidation of that sub-theme. Examples of verbatim quotes from the transcripts have been included as supporting evidence for the findings. These direct quotes from the transcripts are italicised and opened and closed with quotation marks to identify a quote as being extracted from a transcript. Quotes have been referenced by a code that identifies whether it is from the blog, a focus group or an interview; the participant’s research code number; and the paragraph within the source transcript. Text from the blog and email interviews was taken directly as typed by the participant.

When an audio interview is transcribed verbatim, the spelling and punctuation is transcribed according to the transcriber. With this in mind, I have also corrected basic spelling and inserted punctuation into these written transcripts to make them more readable. Some quotes were edited to remove repetition and this is indicated by the use of ellipses (...). To clarify the intended meaning of a quote where I thought that it was unclear, additional words have been added in parenthesis (for example). On occasions when a participant mentioned names and places, I have removed the name and replaced it with a description of the name; for example [Participant name], in square parenthesis to maintain anonymity. In the transcripts from the focus groups that were transcribed from audio, when a participant has used a manner of speech such as ‘uhm’ or ‘aah’, these have been included in the quote.

4.3.2 Theme one: Grappling with the reality of perinatal death. The first major theme to be described in this chapter is “Grappling with the reality of perinatal death”. Participants identified that perinatal death broke with expectations around pregnancy and birth, leading to the first sub-theme, “Shattering of expectations”. Acquiescing the “unexpectedness” was reported by participants to be influenced by having unanswered questions around why perinatal death has occurred, leading to the second sub-theme, “Needing answers”.

4.3.2.1 Shattering of expectations. During the blog discussions, a number of participants described how the unexpected nature of perinatal death was a factor that
exacerbated the feelings of grief, heartache and devastation. This was elucidated further by participants in all four focus groups. The first response to the opening question from participants, when asked to write down and then talk about what contributed to the catastrophic nature of perinatal death, was about expectations and the unanticipated nature of the event.

“the first thing that came uhm to my mind was the unexpected nature of things in our society; that uhm perinatal death is not something that people expect.” (FG3.1a)

“I had mine cross over with [Participant name] very similarly, but I had unexpected because, as she said, you know you’re going along with a normal labour and then all of a sudden this thing just ... (pause)... it’s not what people expect.” (FG2.1c)

When prompted to expand on the impact of “the unexpected”, participants went on to explain:

“just that everything was going to be normal and that you were, you know, when you get pregnant you just expect to bring home a baby and that’s not really part of antenatal education. Nobody ever sort of says to you, so, you know, you might not end up with a live baby. As you go through your pregnancy it’s just about what milestones you’ve reached and what ultrasound you need and what not. There’s not much talk about, you know, I mean we talk about fetal movements and things like that, but we don’t ever, you know, you don’t say (the word) ‘stillbirth’ in an antenatal visit; it’s just not done. So (for) most people it’s a really unexpected event that this would happen for them.” (FG2.1b)

“it’s the unexpectedness that the pregnancy isn’t perfect and this isn’t what women have dreamt about. And women often, in my experience, have very strong beliefs and ideas of what their experience of becoming a mother is going to be, long before perhaps they’ve even conceived a baby, so they are not expecting it to happen.” (FG1.1l)
“It is not meant to be. Little ones are meant to grow up and be loved. This little one does not have that joy; the parents do not have that joy. I see the parents’ heart break. I empathise with them; probably too much for my own good. Those sad, devastated faces. That sheer pain; words cannot express the pain that they are going through. No hope is seen on their faces. We are there at the worst time in their life. It is not meant to be.” (I4.1a)

I wanted to gain a deeper understanding of what participants meant by this “unexpectedness” that had been spoken about in the focus groups. In the email interviews I encouraged participants to explain how they felt at the time.

“The short answer is devastated! The long answer would be that having come from a nursing background, specifically Emergency Department, where death did happen, sometimes several times a week, it was a more expected or acceptable outcome. Usually people who died on my shift were elderly or very unwell because they (had) something wrong with them. No-one expects a well, healthy person with no disease or accident or dramatic threat, to die, and if it is unexpected there are due legal processes and investigations to understand why. Babies are usually healthy in utero and well protected from insults; they are also remarkably resilient and have excellent coping mechanisms. They don’t have degenerative diseases or worn-out bodies. Birth is seen as a happy event, where new life arrives and in our technological age in well-off, middle-class Australia, we expect a healthy baby at the end, and very few people talk about death in association with pregnancy. If we lived in the Sudan it would be a completely different expectation. We have the most amazing knowledge and technology that can save a baby born at 23 weeks or so. How can a term, healthy baby with no underlying complications, just die without a cause and without someone realising?” (I6.2a)

In one of the focus groups a participant mentioned that perinatal death was “a taboo subject”. When asked to clarify what she meant, the participant explained:
“Perinatal death is very much a taboo subject in the wider community as babies are meant to bring joy and promise of continuing life. Most people who are not involved in a healthcare situation, and sometimes even some healthcare providers, only see old people as the ones who die. They can’t deal with the idea that anyone can die and have trouble dealing with a young adult dying yet alone one dying inside its mother, or shortly after birth.” (I2.1c)

Midwives related that when talking to friends and family, it seems that people only want to hear, and to believe, that a midwife’s work is only all about joy and life, and people do not want to believe, accept or have to admit to the fact that babies do die.

“How many times have you been told that being a midwife would be such a happy job by family and friends? They say, you see new life brought in to the world and that it is joyous, and it is most of the time, but to tell people that 1 in 5 pregnancies results in fetal loss and they would think that you are crazy as no one talks about this side of it. When I talk about my job I too talk about the happy occasions rather than the sad ones, although I can’t help myself sometimes when I say the most beautiful baby I ever saw was stillborn.” (B10q2)

“They seem to believe that modern science can fix things that it absolutely can’t … they have the belief that medicine can perform miracles, although sometimes they do occur, and that they don’t have to think about the possibility of that baby dying … I find that when I talk to people about my job I am very selective of who I talk to about perinatal death. Many people say it is a happy, wonderful job filled with so much joy and to tell them about the unhappy times seems cruel to them so I tend not to discuss the nitty gritty parts of my job and usually say that yes, it is a happy job most of the time and then not expand on the unhappy parts. In some ways this probably means I also make it a taboo subject as I don’t discuss it very much with many people.” (I2.2a)

Even midwives, as this one participant admitted, had not fully accepted that babies do die.
“babies aren’t expected to die, they’re usually healthy and little and well-formed and we don’t, as [Participant name] said you know, we just don’t expect babies to die. I know when I started my midwifery training I was horrified that babies still died; I thought that every baby lived these days.” (FG2.1c)

One midwife explained why perinatal death is seen as so unexpected by seeking cultural or societal reasons as to why this is so.

“we still are in a culture that doesn’t accept perinatal death; we are in a culture that expects that every pregnancy will end in a live, healthy baby. That’s our culture, you know. A death of a 90-year-old is acceptable, but a death of a baby uhm with congenital abnormalities is uncomfortable, and the death of a baby who is uhm well-formed and normal and supposed to be a part of a family for, you know, until well after the parents are dead is not acceptable. It’s just not acceptable and I think that’s what as a profession we have to understand; that’s the cultural environment we live in, so it’s, we have to acknowledge that our emotions are okay” (FG3.13a)

Not being prepared for the unexpected nature of perinatal death was explained by some midwives to be associated with not having everything in place to make the delivery and care go smoother.

“I guess if you are prepared and expecting a dead baby you would, you know, you’d have all of that in the front of your mind, but when it all happens unexpectedly uhm there’s a lot to get your head around quite quickly, so yeah.” (FG2.11a)

A participant: “I have to say in, I don’t know if you have the same thing at your hospital, but we do have a checklist.”

Another participant: “Yeah, we do too, but I didn’t have it anywhere near me, you know, before the baby was born because this was an unexpected event and so, you know. So certainly, if people are going through terminations or known stillbirths, you’ve got all that in front of you when it all happens but, and it’s not a big deal, but it’s just something that uhm I remember feeling a bit confused about at the time; just
thinking, aah, now hold on, there’s a whole lot of other stuff here that I’ve got to get my head around as well.” (FG2.11d&e)

Even though midwives talked about how they knew in the back of their minds that death was a possibility, they also felt that when it did occur, it was not something they could feel fully prepared for, no matter how well organised they were.

“as a midwife you are always aware that uhm an IUFD (intrauterine fetal death) is always a possibility and, but the day you actually come face-to-face with it it’s so surreal that you, it’s like you have been planning for it your whole training, but then it’s just suddenly in your face and you’re not quite ready for it yet.” (FG3.7a)

4.3.2.2 Needing answers. Midwives have identified that the “unexpectedness” of perinatal death adds to the trauma and heartache of the situation. Additionally, as participants explain, perinatal death conjures up unanswered questions around what has happened, compounding the feelings of distress and grief.

“I think one of the reasons this was such a deeply distressing situation was because I feel that we have not had a clear outcome or a reason for this baby’s death and even now the obstetricians do not agree in their opinions. I feel that she didn’t give us enough clues that something was wrong and I did, and do, ask myself why and what did I miss every day.” (B7o1)

“I immediately felt numb and just wanted to know all the answers. I had so many whys and hows running through my mind. … I wanted answers.” (B21a-b)

Participants expressed immense frustration at not knowing why this has happened and the inability to do anything about it.

“there was no sense of fairness and justness. … clinically I’m confident it was just a case of too bad, and I found it really hard to deal with that, you know, a little baby could just be there one second and gone the next.” (FG3.7a)
A participant reported her concern and frustration when, in the team meeting to discuss what had happened, answers were not consistent and agreement was not reached.

“The meeting where [Baby’s name] was discussed there was lots of discussion among the medical staff, but nothing that identified what actually happened. The neonatology staff were happy with their resuscitation, and the pathologists stated that [Baby’s name] was well grown and perfectly normal. There was meconium staining of her skin, the placenta and the membranes. One of the obstetricians concluded from the CTG, that was only on for the last hour after the first decal (deceleration) was heard, that the baby had died ‘sometime’ before and was actually dead when I first came in. The rest of us find this hard to believe because, as described, the decels I heard and the fetal heart (beat) we heard sounded very fetal to the rest of us. The concerning thing about this, as well, is that if he was correct, three midwives and the registrar who saw the trace, didn’t recognise it as maternal. The neonatologist also argued that a baby who had been dead for more than an hour before birth would not have been able to be resuscitated at all and would never have regained a heart rate.” (B7j2)

In response to other participants’ stories on the blog, participants felt that the absence of answers would lead to feelings of self-blame even when a midwife knows that she has conducted everything competently.

“I would have still felt very responsible for the outcome, regardless of knowing that I acted in best practice. It is very difficult when case-loading (when a woman is cared for by the same midwife throughout pregnancy, birth and in the early weeks after birth), as you feel that there must have been something that you missed. Being a primary caregiver gives you an enormous sense of responsibility.” (B7e2)

“The main points being made by the author in relationship to herself is one of helplessness and profound sorrow. Helplessness in the very fact that there never will be an answer that allows her to feel completely guilt-free. The question of why will always be there.” (B7t1)
Participants expressed this frustration from a sense of unfinished business when responding to the experiences of other participants on the blog.

“This story in many ways makes me feel uncomfortable. The midwife/s (and) doctors all acted appropriately and still there was a bad outcome. There are too many questions, why? What makes it worse is that those questions will not be answered.” (B7a1)

And this inability to find answers could be seen by some as potentially overwhelmingly preoccupying

“At the same time, I would have been screaming silently in my head – why, why, why?” (B7f1)

Parents and families also react to not knowing why perinatal death has occurred and participants recounted the reactions of parents and families to this need for answers.

“The doctor told them this was not their fault, that it was nothing that they had done and that nature sometimes ended pregnancies this way for no discernible reason. During all this, the woman was quiet and composed. She looked like she had known all along and was ready for the diagnosis. The father, however, looked dumbfounded. He was shocked and became loud and aggressive seeking answers and reasons why” (B15d)

“Guilt is a sad reaction to losing your baby, and for them, with their limited medical knowledge, they would have felt, incorrectly, that they should have known better. The only thing to say is no one knew that this was going to happen, as I am sure the doctor and midwives that saw her at the antenatal appointment are also feeling guilty about the baby dying. Retrospect, unfortunately, does not help and we all wish we had a crystal ball to predict and stop bad things from happening … Hopefully they may get answers from the autopsy on why their baby died, but (in) 80% of these
cases there is no identifiable cause which often makes dealing with the baby’s death so much harder.” (B19l)

However, one participant related that when there is an explanation it can bring some relief for the midwife and the parents.

“I was also very glad to be able to tell them that the umbilical cord was tied in a tight knot just before the baby’s abdomen, and had been blanched. The consultant doctor felt this was a cord accident and not the result of anything more complex. The parents took great comfort in this and, since they had decided not to have an autopsy, felt this gave them at least the possibility of a reason for this tragedy.” (B15j)

Despite the search for answers, in the end, participants appeared to have rationalised the absence of an explanation and reached an acceptance that answers cannot always be found.

“No one can understand why such heartbreaking things happen” (B21g)

“If, as we all know, you know, often unexpected stillbirths, you won’t get an answer, you won’t know the cause of it because there is no scientific cause that we can point our finger at.” (FG3.15h)

And one midwife was quite philosophical in her acceptance that answers could not always be found.

“Medicine has achieved so many things over the years, but 1 in 5 pregnancies still end in loss. We know so little about why fetal death in-utero occurs, so we can do very little to improve the statistics. In fact, it seems at times that we improve our overall care when we discover a possible cause, such as the discovery of MTHFR (referring to a gene mutation), and prevent some losses, but the overall numbers don’t drop. It is nearly like this number is what is supposed to be and when we fix one problem, another cause replaces it to keep those numbers static.” (I2.2a)
Attempting to come to terms with such significant and unexpected loss, whilst being unable to find and provide definitive answers for either themselves or the parents often resulted in a challenge to their personal identities as midwives and an internal struggle to manage their own emotional responses, as seen in the second theme: Struggling with personal and professional heartache.

4.3.3 Theme two: Struggling with personal and professional heartache. This theme developed out of participants’ expression of the personal and professional effects on themselves as a result of caring for a woman and her family through perinatal death. The midwives reported being impacted to the extent that practice direction and personal philosophy were contemplated, and in some cases, altered. The telling of their stories and the language used to describe the “crushing impact” demonstrated the lasting effect that these experiences had upon these midwives’ lives. This theme will be told through the sub-themes: “Challenging their view of them self as a professional”, “Feeling the trauma personally” and “Living with the enduring impact”.

4.3.3.1 Challenging their view of them self as a professional. Midwives participating in this study revealed that they questioned their abilities as a midwife to deliver a new life when things have gone wrong and resulted in perinatal death.

“where you see yourself as a professional who cares for and protects a woman and her baby through her labour and her birth and when that goes wrong you question your own competence.” (FG2.1d)

“for me it was the loss of that child, that overwhelming pain, and the unexpectance of that as well for the family and for me with a feeling of failure and incompetence.” (FG4.1a)

One participant suggested that she felt unqualified in these situations without having had formal education in how best to provide care during perinatal death.
“This case was a particularly hard one for me. I feel somewhat unqualified in the area of providing care for people in these situations as no real 'formal' education has ever been given to me on how best to do so. I have mainly gained knowledge from other staff, a friend who has had a stillbirth.” (B19c)

Midwives reported that when a baby dies it makes them question their competence as a midwife, losing some confidence in their skills and abilities. This was manifested through expression of having lost trust in themselves as well as the normal birth process.

“The event completely rocked my trust in myself as a midwife and my trust in birth as normal and I had to have another midwife with me for several births afterwards just to be there.” (B7o1)

Participants felt responsible,

“I felt that, you know, as a midwife that, you know, that I maybe had missed something and that if I maybe had picked something up earlier that it wouldn’t have happened.” (FG4.1b)

“I guess I feel that I could have prevented the death of their baby. Following are several things that I feel I could have done: Sought additional advice regarding my concerns over the CTG trace, following several reviews by reg (the registrar); listen to (the) fetal heart during the unusually long time that (the) epidural took to insert.” (I7.1a)

And articulated these feelings of self-blame and loss of confidence in terms of doubting their skills or thinking they are not qualified to do this

“I think it makes you say, am I good at my job? And if I was good at my job, could I, if I had been better at my job, could that baby have, could I have prevented that outcome or changed that outcome?” (FG2.2c)
The blow to the participants’ confidence was reported to have led to a fear of the ability to manage subsequent labour and births.

“it made me afraid of that aspect of my job, i.e. the actual birth, and made me stop trusting my own judgement and need lots of reassurance that yes, everything is OK and all is well. I think we have a picture of ourselves where we can say, “Yes, I am good at my job and I did that well”, and it is hard to think that this baby died because I missed something. I know the reality is not the case but the thought is still there.” (I6.3a)

And one participant explained how the fear returns with each delivery.

“but I never have gotten over my fear of uhm basically that time from when you can see the baby’s head to the birth of the baby. I can just feel my adrenaline just going and sometimes I wonder, is that just, do all midwives experience that or is that just me because I have this, I have this overwhelming feeling of this baby can’t die? That’s what I think for every single woman that has a birth; I just think this baby can’t die, and it’s just like my adrenaline is just pumping and yeah. ... I just wonder if I will ever get over my fear, uhm and I don’t know. Do other midwives experience that? Uhm, it’s kind of that you don’t want to ask people that because you don’t want them to think you’re silly (another participant: oh God, so true) yeah, you don’t want them to think that you’re somehow scared of birth.” (FG4.10c)

One midwife’s self-blame was manifested in her feelings of inadequacy and vulnerability when a woman, whom she had previously cared for through perinatal death, chose to go to a private obstetrician rather than returning to the birth centre for a subsequent pregnancy.

“I had a hitch after your last question because, in the meantime, I had coffee with "Beth" and she tells me she is pregnant which I (am) thrilled for her about. She has, of course, elected to go to a private obstetrician who is providing her ‘proper’ surveillance in a private hospital. I am sad that this makes my care and the birth
Commenting on others’ experiences from the stories on the blog, participants considered how their confidence may have been affected had they been in the same situation.

“I think I would have had my confidence shattered because she wasn’t listened to and her judgements and requests were ignored ... I think this takes a while to rebuild confidence after this kind of event.” (B10g1)

“The thing that strikes me most in this narrative is the way this death affected Midwife 21’s practice. I can definitely relate to her feelings of being anxious around birth, and being ‘antsy’ when things are moving away from normal. I still find myself needing reassurance with some births and wonder whether I have become more interventionist since my experience. I am still on high alert at every labour, and struggle to find a balance between trusting birth and being hypervigilant.” (B21p)

After reading other midwives’ experiences on the blog, participants pondered the impact each experience might have on a midwife’s practice and how they might compensate for these effects.

“This incident would definitely make me more cautious. This could lead to being overly interventionist which goes against the ethos of keeping birth normal.” (B7f2)

“I would not be so trusting of ‘normal’ childbirth and I would distance myself ever so slightly from the women I care for, so as not to be so badly affected next time it might happen.” (B7y1)

One participant reflected on what it could mean for a midwife to be so intimately involved when caring in a caseload model (when a woman is cared for by the same midwife throughout pregnancy, birth and in the early weeks after birth).
“Perhaps you could say that providing such intimate care, as midwives do in a caseload model, is too taxing on a midwife when things go tragically wrong. Are the consequences too great?” (B7u1)

And others contemplated whether their experiences could be a catalyst for midwives to leaving the profession.

“some midwives had only sort of had one or two experiences and had been poorly supported and had been truly traumatised, and I wonder if that leads to midwives leaving the profession.” (FG1.9b)

This belief was confirmed by a participant who related how leaving the profession had been something she had considered.

“I had a similar uhm feeling, I just, when I came home from work that day, I just thought this is the worst day of my life and I just didn't want to be a midwife. I just thought I can't do this job, uhm yeah, but I stuck with it.” (FG4.7e)

Whilst others actually acted to remove themselves from potentially having to manage such situations again.

“I actually left midwifery for about 4 years; I was never ever going to be a midwife again ...” (FG4.6d)

“I had been the only one from my graduating class that felt ready to take on the preceptorship, which resulted in me being allocated these cases (of pregnancy loss) very frequently ... . When I had become a little overwhelmed with the number of cases I was getting, I did discuss with my ANUM (Acting Nurse Unit Manager) how this was an increasing burden and explained I needed a bit of relief. She simply asked who I would ask to take over my role ... . It was a particularly bad run, to have this number of cases at once, but it was also the fact I was working full-time and it was
invading my personal life a lot to carry this around with me. I began to see all pregnancies as potential losses and lost some of the satisfaction in my work.

... (following another fetal death my preceptor) looked at me and said, "You are too young to know how to birth a dead baby better than an alive one." ... . This was birth number nine.

Three more fetal deaths later, I was exhausted and arrived on the morning shift to be allocated a woman having a mid-trimester abortion of a baby with Down Syndrome. As I volunteered with children with Down Syndrome as a recreational program coordinator at this time, I knew I could not participate in this birth adequately. I made this known at hand over and was basically told to get on with things. I did work with this family, and they were lovely and devastated by the enormity of their decision, but I cried all day. I held the little boy for 40 minutes while he passed away and sobbed the entire time. I then took him back to his parents, left them together for some family time and went directly into my NUM office. I wrote my resignation on her computer while she sat beside me, taking my name off the birth suite roster.”

(I9.7a-c)

### 4.3.3.2 Feeling the trauma personally.

The Australian College of Midwives explains that midwife means ‘with woman’, and this underpins midwifery’s philosophy, work and relationships. The nature of this work explains the intimate relationships that participants report to have developed and the personal grief that they have described experiencing when caring for women through perinatal death. One participant explained this relationship and connection:

“As a midwife, I am with women in labour & birth. I care for all women as if they are my sister, daughter, niece or friend. It is an intimate, personal experience for women, as we know, which profoundly affects them & how they function in society & their family. So when [baby’s name] died, she was part of my family & I mourned her as I would if I lost my own. Therefore, I feel empathy when caring for women & their families whose babies are stillborn. I understand the enormity of their pain. Women know when you are genuine.” (I3.3b)
Other participants also confirmed the connection that is formed between midwives and the families they care for and alluded to the positive impact this can have when perinatal death is involved.

"that's actually a really important thing, to bond with your families. I've got a lady who's just now had a 30 weeker who has lost a 21 weeker and a 20 weeker previously, and looked after her for both of those two and she feels like she is a part of my family. You've seen her before, you've seen her grieve, her whole family, when I walk into her room she just, when she lost both of her babies she just cried, her losses are like my losses as well because it's not fair for them." (FG1.5d)

"Your story of one family and their loss of their precious baby shows how compassion for these people can build a relationship that lasts, not for the short-term of their delivery and immediate postnatal period, but also later as they go on with their lives. Sometimes I feel that I build a stronger bond with the family who has lost their baby than with those that take home a live baby as most of the families are so grateful for anything that you can do for them when their baby has died." (B20j)

Participants explained that “it affects you on a personal level as well, it's not just your job.” (FG2.2b); as a midwife, you are personally affected by these events.

“it is extremely emotional and, you know, you go as far as you want into it, you give everything that you've got to give them, the best care, but it is like that does affect you.” (FG1.7b)

And this can continue beyond just the immediate postnatal period, as one participant voiced:

“as a midwife there'll be, you know, past after 6 weeks you start to, grief starts to subside, but for that parent, you being their care provider, that grief's never going to subside and they will always want to revisit it and that can be emotionally draining
for a midwife having to go back through something that you have tried to close.”
(FG3.7c)

Participants recognised that the nature of the relationship means that they too experience grief as a result of the baby’s death.

“it’s also hard because you’ve got that relationship to have to separate, you know. Your feeling of, you know, absolute devastation for the woman and your professional role and trying not to cross them although they easily cross when it comes to perinatal death. And you’re really, you become a close friend, I guess, in the end and just trying to deal with your own grief of caring for this baby that you’ve looked after throughout the antenatal period and you expect it to be born perfectly healthy like all the others. Uhm, so as a midwife, I guess you grieve too, and that’s kind of hard to not grieve in front of the parents.” (FG3.4a)

“Then the funeral came around and all I could do was cry uncontrollably. That day was one of the saddest days of my life – coffins should not be that small.” (B21c)

At times in a midwife’s career there may be occasions where there is a blurring of the lines between professional and personal experiences. In one of the stories on the blog, a participant described her care of a woman whose baby died while the midwife herself was also pregnant.

“As I was also currently visibly pregnant, I approached my colleagues to take over care for this family, feeling my pregnancy may make the woman or her support people uncomfortable … I then informed them that another midwife would be in to start the induction with the doctor as soon as possible. The woman asked if I was qualified and able to care for her. I was slightly taken aback and confirmed that yes, I was a qualified midwife capable of caring for her, but felt it was best to remove myself from the case. The woman put her hand on my belly and felt the kicks of my baby. “I was hoping you would be able to stay with me,” she said. “You have been upfront and honest with me and I feel I can trust you. I know this is an awful thing to
ask you but please stay.” I was unable to say anything but I nodded and had a little tear... 4 months’ later, I got a card from the woman. She expressed her gratitude for me staying with her overnight and told me how much it had meant to her that I could put everything else aside and meet her needs in the moment. She hoped that the card would find me with my own baby, safe and well. Little did she know I had a premature baby at 29 weeks gestation exactly a week after her birth.” (B15f, g, l)

Other participants responded to this account, pondering the possibility of a connection to the midwife’s pre-term labour and her caring for a woman through perinatal death.

“wondering to myself whether this event had such a psychological impact on midwife 15 that it sent her into prem (premature) labour herself. I hope your baby is well now.” (B15h1)

“I hope I would have responded in the same way and I found it an interesting point to wonder if this labour had an effect on midwife 15’s subsequent prem labour and am glad it did not seem to. I think I would have been quite scared delivering my own premmie so soon after this experience and could imagine myself visualising this little 27 weeker when contemplating birthing my own 29 weeker.” (B15o1)

The participant who had shared this experience on the blog reflected further on the other midwives’ responses to her story during the focus group:

“reading other people’s comments and things was really interesting because I did have a prem baby just afterwards and uhm I hadn’t even thought that that experience could impact on my own experience of birth. And, you know, looking back through it, and I really think that it did because I did have that image of, not necessarily of that particular baby, but of that gestation and things while I was going through my own experience and I hadn’t connected the two before. So for me it was really enlightening to go through all of that again and bring it all back to see what point of view we can get now.” (FG1.13e)
For these participants, the experience of caring through perinatal death was a catalyst to challenge their belief system and personal philosophy.

“I have never lost a baby and can’t imagine what they are going through, even though I have cared for so many families that have also been there before them. I try not to influence their beliefs, but if asked, will tell them mine. I do not believe in a god and say this to my family with the reason being that I have placed too many dead babies into their mothers’ arms and if there was this all powerful being, how could he be so cruel to take away something so small and precious? But I do believe that there is somewhere that we go when we die, not heaven as such, but a place where there is no more pain or suffering and that these angels watch over us as we continue in this world. I know that I said I have a logical mind and I cannot prove this, but it is that thing that you hope is out there so that the ones that have died before you are somewhere far better than where we are. I guess it is the optimism that keeps you going. This also helps now that Australia is such a multi-cultural society, as I explain in, not as religion, but as hope, and it seems to help families no matter what religion they have.” (I2.6a)

“The oddest part of this situation for me was that during the funeral, religion was heavily incorporated into the service and this made me angry. I had never been a religious person but I had always had faith. That day is the day I became an atheist. I guess I was always going to be one, but I just could not comprehend there being a higher power when the most beautiful, loving parents in the world had their daughter taken away at 36 weeks without even getting to really meet her – that was just not fair. I found comfort in the fact that I wholeheartedly believed there is no God, just good and bad luck.” (B21c)

One of these participants explained further in the interview:

“This experience actually shaped my personal philosophy. I guess I was always borderline but then as soon as this happened I just knew religion was just some bullshit (I couldn’t think of a better adjective, sorry) excuse to try and give purpose or
a reason behind the tragedy of neonatal death. I hated how people would say she’s
an angel looking down on you and God needed her. I felt like saying, no she is dead,
she’s never coming back to life and her parents needed her, not some made-up
figure. I also knew the parents held the same beliefs as me, but I never voiced my
opinion on the matter to the parents or their family / friends because I knew it would
not do any good. I guess I always have this thought in my head; when I enter a
birthing suite, I know that no divine intervention is going to help me or save the mum
and baby, but that I have to have the knowledge to be able to give them the best
possible care to try and achieve a good outcome. I don’t think it negatively impacts
my philosophy of practice, or how I care for women at all. If anything it enhances it
because I’m not blinded by religion or faith. The only faith I hold is within my own
abilities and the mother’s ability to birth. But inevitably, religion will always be
brought up when there is a neonatal death / stillbirth and I’m happy to organise for
pastoral care workers to be present if the parents wish, or to have their own priest /
pastor come in to do a christening or some counselling post-birth because if that is
what is going to help those parents cope with enormous grief, then that is what they
need, and I’m happy to help facilitate that.” (I11.2c)

The emotional intensity and long-lasting effects of these experiences on other personal
relationships was highlighted during one interview where, in a follow-up question to the
participant: “How have these experiences shaped your sense of yourself as a person and as
a midwife?”, there was a long break before she responded. The participant had explained
prior to me asking this question that it was coming up to the birthday of the baby who had
died; she would have been 12 years old.

“Sorry I was not able to continue, couldn’t even bring myself to reply. That time of
year is always so distressing.
This is a difficult question for me because it makes me really acknowledge the change
that has occurred in me, & I don’t like me as much as I once did. There is a verse in a
song by Harry Chapman when he said, “I finally learned to like myself”. I loved that
line & achieved it. But that changed... I am not the happy person I was once, too
serious, angry, frustrated and fighting depression. Intolerant of what doesn’t really
matter; that applies to work & my personal life, so I tend not to have many close
cfriendships as I find them shallow & self-indulgent. I’m a great pretender and always
making everything right for others. As the years have gone by, I have become more
willing to talk to colleagues & family. It has been as difficult for my family. [Partner’s
name], my partner of 22 years, is not a good communicator. He figures -if you
pretend it’s not there it will go away. That’s his way of dealing with difficult
situations. But he has & is always there for me quietly. So unfortunately I haven’t
been able to talk it out with him. I did resent him for that for some time, then
eventually acknowledged & accepted him for him. After all, none of this was his fault.
So personally it has been quite detrimental.” (I3.3c)

4.3.3.3 Living with the enduring impact. A number of the midwives participating in
this study told stories about caring through perinatal death as first experiences as students
or newly qualified midwives up to 30 years ago. The way in which their stories were
recounted exemplified how these experiences were still clearly etched in their memories.
The passage of time and being involved in subsequent deliveries does not appear to have
rendered the memory of the events to be less acute for these midwives.

“It was a long time ago so I don’t know why I was so impacted - yet I remember it.”
(I5.1a)

“I have cared for so many families that have lost their babies, too many to count;
some I remember very well, some not as much but all of them will always leave an
impact on me.” (B18b1)

“thanks so much for sharing your story [Participant name]; this scenario obviously
left a deep impression on you as it was several years ago, but you describe it
acutely.” (B8p)

The way in which one midwife described the moment she could not hear the heartbeat left
no doubt as to how she felt and that she will always remember this time.
“I’ll never forget the terrible cold, prickly sensation I felt when I was unable to hear the heart beat.” (B8a)

For some midwives, it is in the way in which they recount the trauma of the situation for the mother and family that gives the impression that this will live on in the participants’ memories.

“I was worried, because she kept on completely passing out, but continued to wake up and scream with contractions. I had not seen this reaction to morphine before – I am still a newish midwife. Her partner was there the whole time looking really stressed. I tried to relieve his and her anxiety as much as I could – however I’m not sure of my success because I was anxious myself. The screaming was traumatic; the whole situation was traumatic.” (B10d)

“the woman that I looked after, she was uhm 42 and having her first baby, and so it wasn’t just the loss of that baby to her, it was the loss of her never being able, you know. I worked in [Place name] for uhm, probably 7 years now, and I’ve never heard of her coming back to have another baby, so it was that enormous loss of her never having a family and that really sticks with me now and I think gee, that, you know, I could have changed that scenario for her if, yeah. So that’s a real grief that sticks with me that they never had children as far as I know.” (FG4.1g)

One midwife related the effects of the experience on her to be what she thinks could have been post-traumatic stress disorder.

“I sort of have had an understanding how, what post-traumatic stress disorder was because it was pretty much I’m sure the same, not being able to sleep, you know, that’s when you thought about” (FG4.6a)

And in the individual interview, this same participant revealed some of the extent to which she has been affected by this tragic experience.
"My faith in God is all that has kept me from not taking my own life. I still hope one day I’ll just die early. I could never do that. Time heals & I’ve learned to forgive my human self. I prayed for years for forgiveness, then God told me one day (that) it was only myself who failed to forgive. It (is) still taking a long time. Maybe after I go overseas & do voluntary work it may help also." (I3.2b)

Some of the memories were reported to have carried special significance for participants, as this midwife shared being able to find meaning through the experience.

"There is special meaning for me in the baby dying in her mother’s arms; the sacred moments of birth and death are so precious. Possibly I feel strongly about this because of having been involved in a situation where a very premature babe died on the bench; her mother couldn’t face holding her while she gasped – moments like this get etched deeply into memory. If I could bring that moment back, I would cradle that babe myself.” (B7v)

The personal and professional trauma experienced by these participants is expressed in the deep impact that the experiences of perinatal death have had on their lives and careers. The powerful and, at times, unexpected emotions have also led participants to question the extent to which they should grieve as a midwife.

4.3.4 Theme three: Seeking the space to grieve as a professional. In the previous themes, participants identified the nature of the caring relationship and the emotions generated by this heartbreaking event. Participants spoke about how they grieve for the baby and the parents’ loss, as well as their own inability to change what has happened. This theme, “Seeking the space to grieve as a professional”, developed out of these participant accounts of their own grief and grief reactions in the presence of the family, as well as in their private lives when they leave the workplace. There is an impression of participants becoming more active with a greater sense of personal agency, in this theme, as participants move toward doing something, changing something in their personal and professional lives. The sub-themes that describe this theme are “Confronting personal grief” and “Managing grief across professional and personal lives”.
4.3.4.1 Confronting personal grief. The midwives participating in this study spoke about the grief that they experience as a result of a family in their care losing their baby. There was a mixed stance from participants around whether it was acceptable as a professional to grieve in front of the family and whether indeed it was okay for the midwife to grieve at all. Participants who expressed that it was acceptable to grieve with and in front of the family believed that this helped to validate their sense of loss.

“any time that you are working with these families it is extremely emotional and, you know, you go as far as you want into it. You give everything that you’ve got to give them, the best care, but it is like that does affect you, But I think that you know, when you can cry with a family and actually be a part of that grief process while you are helping them, it shows, not only that you know you’re human and that losing a baby is tragic in any circumstances, but it lets them acknowledge that this is a real loss and the community, the maternity community especially, will actually view this as their baby and it is sad and it gives them permission to grieve as well.” (FG1.7b)

“I think as well that for, about clinicians being affected as well, I had been trained in a very traditional nursing framework and that, you know, nurses shouldn’t cry or show their emotions, and I’d never sort of practised like that, that wasn’t really how I was as a person, but, but allowing families to see that you’re upset and that this is sad for you, I think that that does really give them a sense that there has been, that the loss is not just contained to them, but this is a loss to a community.” (FG1.8e)

Participants considered that it would not be a natural occurrence for a midwife not to feel and express emotions under such tragic circumstances

“it is okay to cry with the families, you know babies die; it’s like something really horrible has happened, it's okay to cry with them if you feel it.” (FG1.7d)

And the way in which the midwife responds and reacts may influence the grieving process for the mother and family
“I think if we don’t show our emotions, the family, you know, we must seem to be removed from them and you can’t be removed from that situation because uhm that event will affect them for the rest of their lives, and so what we do at that time has a huge impact on how they deal with it uhm, and I think that’s what I learned from uhm my first experience with that. The way I dealt with it, and my input had a huge impact on them, and that was really vital for them uhm coping, even though they probably coped better than I did, really, in the end.” (FG4.3g)

Although these participants agreed that crying and showing grief in front of the family is acceptable, participants also articulated that there does need to be a time when the midwife must “be the strong one”; the professional who will move on from this grief and be able to provide care.

“Well I think it's uhm important to show some type of grief or loss and sincerity and it's okay to cry in front of the parents and it's okay to be upset at the funeral and, but I think at some point you also have to be the strong one to have to be still doing all your clinical work that you would normally do.” (FG3.4b)

“you do have to kind of experience that with them and then move on, you know; you do take a bit of it home, but you are also able to live a normal life afterwards and not cry every time you see a baby or anything, I guess.” (FG2.9c)

As this one participant conveyed, there is a belief that the midwife needs to demonstrate a degree of restraint in her expression of grief in front of the family

“I had one midwife who brought over a lady from our assessment unit with no fetal heart and needed to console them as they sobbed in the room and were nearly hysterical, so much that I needed to get them out of the room as they were upsetting the mother, who dealt so much better with losing her baby than the midwife did; a little bit embarrassing, but OK in the end. Caring for these families can be stressful, but it is their loss, not ours and we need to remember that. We have all cried while looking after these families, something that most families appreciate that we care
enough to feel their loss, but the breakdown hysterics has to be away from them.”
(I2.13a)

Other participants voiced the need to separate their own personal grief so that they could remain professional in front of the family, even if it is difficult.

“it’s also hard because you’ve got that relationship to have to separate, you know, your feelings of, you know, absolute devastation for the woman and your professional role and trying not to cross them, although they easily cross when it comes to perinatal death. And you’re really, you become a close friend, I guess, in the end and just trying to deal with your own grief of caring for this baby that you’ve looked after throughout the antenatal period, and you expect it to be born perfectly healthy like all the others. Uhm, so as a midwife, I guess you grieve too, and that’s kind of hard to not grieve in front of the parents.” (FG3.4a)

“Although I felt so devastated for the couple, and I was so sad for days, I couldn’t cry, and I’m a really emotional person. This made me feel so heartless that, as sad as I felt, I couldn’t cry. I felt I needed to be strong as the professional, but I couldn’t find a release and that was really difficult for me.” (B21c)

This participant described her struggle not to go “absolutely hysterical” as she believed that she did not have the right to grieve as a midwife:

“and I felt that I couldn’t grieve, I didn’t have the right to grieve as a midwife, uhm and it wasn’t until the funeral where I, uhm I almost went into hysterics and uhm, my partner came with me that day and he just looked at me and I knew that I couldn’t fall apart at this funeral that was for this baby of this whole family, so I just quietly sat at the back and cried with everyone else, so uhm, on the inside I just wanted to be absolutely hysterical.” (FG3.7a)

And another participant, during a focus group, expressed the need to put her personal needs on hold in order not to appear unprofessional.
“when it first happened, and I guess this is a situation where I was very involved, and uh I was embarrassed and ashamed of my own grief response to this situation because I was overwhelmed by it ... but I was able to step outside and not show that to the family, like I went and kind of just dealt with that or something until I was ready to go back. ... I think in the actual situation I was worried about how I was responding because I didn’t want to be unprofessional. I wanted to be calm and empathetic and just focus on meeting their needs and not overwhelmed by my own fear, like my own just grief, but also fear that I had done something wrong and done something to prevent, like to make this baby, or to let this baby die when I should have done something else. Uhm, so I think next time I would be better at just being calm and professional in front of the woman. Not that I wasn’t; I’m confident that I wasn’t unprofessional this time, but next time I would be able to just put my own stuff aside better and say, you know I’m here to kind of meet your needs for the time being and I’ll process my own stuff later, basically.” (FG2.3d&e)

A participant in the same focus group provided some support, explaining that families would expect that a midwife would also be affected by the family’s tragic loss.

“I just have to say, in support of you, I think sometimes families even appreciate the fact that the wider community see it as a devastating event, like, don’t be too hard on yourself. I think for a family to see that it has upset you as well, you know, isn’t always a bad thing. I know you are saying it’s sort of a professional thing, but I’m just saying, like on a personal level, you know, to be upset by an event like that is only a natural thing and for them to see you have a tear, or you know, whatever.” (FG2.4a)

To regard a grief response as a normal reaction was encouraged by some participants. These participants also agreed that, under different circumstances, people will have differing responses and reactions.

“the important thing for your own self-preservation is to understand that whatever emotional response you’re having, it’s normal. You’re not a freak, it’s normal, you know. You can’t be, I mean we all, you know, we all as midwives understand the joy
of a birth and, you know, some births affect us differently. This is, you know, live babies, normal live babies and some of them affect us differently on different days with different people, you know, depending on the amount of sleep we’ve had, depending on the circumstances, depending on the busyness of the day and depending on the family, whether you’ve got a connection with them or not, and I think we’re in a profession where we have to acknowledge that that’s just part of our daily lives and that uhm it’s okay, you know.” (FG3.12f)

And another midwife described how sharing comfort with the mother helped the midwife to address her fears of rejection and blame from the mother.

“Being close to grief, visiting the family the following day and being involved in their grieving process, I felt that the woman was stronger than me. She almost gathered me in her arms and held me tightly and we both cried. We held that embrace for a long time and it felt like she was actually comforting me rather than the other way around. It was then that I knew she didn’t hate me.” (I7.3b)

As a result of gaining experience in caring for women during this time, participants reported that they would be able to separate their own feelings of grief better for subsequent perinatal death cases.

“more confident because having been through that one where I was terribly involved uhm I think if it was to happen again I know more about the actual process and what happens and I know what worked, what helped that family last time, so I would be, I guess better able to just, uhm yeah, sort of stop worrying about my own grief so much and just kind of feel a bit more prepared. Even though I never want it to happen again I think I’ve learned from the experience about how to help women going through that.” (FG2.3c)

4.3.4.2 Managing grief across professional and personal lives. In theme two, participants explained how caring through perinatal death takes its toll on a midwife
personally. In dealing with that grief and emotion, participants admitted that it is a struggle to keep work and their personal life apart.

“it affects you on a personal level as well; it’s not just your job, you know, you kind of, yeah, you take it home with you, you look at your own family, you know. It affects you more than, you don’t just leave your job and go oh well, another day done, off we go.” (FG2.2b)

“I know that empathising can help the grieving parents, and it is something I naturally do; however, it does affect me too much. I find it hard to separate my work from my personal life. I grieve at work, and then I continue to grieve at home. I find it takes a long while to get over something like perinatal death. It still gives me a jab of pain when I think about it. I know that this is not healthy, but I do think it is life—well, my life anyway.” (I4.1d)

Participants described how, because they viewed midwifery as being a part of who they are, it was not possible to prevent taking this experience home, where it would then also impact their family.

“What probably has had a major impact on my family. I think that probably uhm what’s underestimated really is that as midwives we, well for me anyway, I live, midwifery is part of me. It’s not something that’s, you know, removed, it’s sort of part of everything you are, so of course uhm it also had huge impact, I think, on my relationship with my family.” (FG4.14a)

“My uhm husband doesn’t really want to listen to things about my work either. ... it’s really hard to get that balance right, of not taking too much home, uhm yeah, but I just, yeah, I think it’s very hard for, uhm you know, family to understand what you do and how intense an experience it can be.” (FG4.14c)

This participant explained how her family no longer allow her to speak about work when at home and she feels that it has been an improvement for her family.
“I’m not allowed, I don’t talk about work as much at home as I used to, which is definitely an improvement because I would tend to bring too much of my work home all the time and my family found that uhm overwhelming and they didn’t want to hear about it, they were sick of hearing about it, so I tend not to. I discuss work with my colleagues, uhm but don’t really talk about it much at home at all. It was so enormous, I think, in my life that uhm it did have a huge impact on our relationship, [Husband’s name] and my relationship. We are still together though. Uhm, he at the time, he didn’t want to hear about it at all and I really needed to talk about it, so I was quite angry with him about that, uhm but now I see that that was pretty unfair that I expected that of him.” (FG4.14b)

It is difficult to discuss their experiences outside of work, according to these participants, as they feel that friends and family do not understand and don’t want to know about it.

“when people say, “ah you’re a midwife, how lovely”, and you’ve just been with a family who’s lost a baby and you think, yeah, really lovely, had a great day, thanks; and you can’t really discuss it with friends or family because they don’t understand and they kind of go, oh well but, you know, they’ve got another baby or whatever, and you think well no, that doesn’t really work either” (FG2.2e)

“I talk to some family members/friends and will say things like, ‘the most beautiful baby I have ever seen was a stillborn baby’, and how the flower her mum placed with her in her cot has made the Princess Lily one of my favourite flowers, and I love to grow them, I think of [Baby’s name] when I see them flower, but outside of work I would not talk about holding 19 week twins, that had a genetic termination, in my arms in the dirty utility until they died as their family just wanted them out of the room and I couldn’t bear to let them die alone in a dish. People in general don’t want to hear this type of information and can think that you are weird if you mention what you do in your job if it is something like that.” (I2.2a)

Some participants stated that they do try to keep work and home separate as much as possible.
"I am not really sure how I separate my work from my home life, but I guess that is something that I have perfected over all my years of nursing. For me, both my home and work are separate identities, and I try as much as possible to keep them apart, even though, in reality, they are intertwined. I have times where what is happening in my personal life reflects on my work practice and vice-a-versa, but I try to not let either influence the other too much. ... but, as stressful as it was, I did not spend that month full of doom and gloom. Each shift was giving your all to those involved and then leaving work and dealing with family and friends with other problems, and I guess, just living life before coming back to the next shift and dealing with the next tragedy. Mind you, I am not saying that you forget about these people, I can somehow put it to the back of my mind. This does not mean that I don't reflect on shifts that I work; I just tend to do this when I am alone.” (I2.4a)

However, maintaining separation between personal and professional lives for these participants was reported to be difficult. Indeed, some participants feel that this separation was not necessary, as long as the midwife remains professional in her focus of care of the woman and her family.

4.3.5 Theme four: Being with the woman and her family. The woman and her baby and partner were central to what participants shared throughout data collection. The caring nature of midwifery has been expressed by participants in the preceding themes and this theme, ‘Being with the woman and her family’, demonstrates this more specifically. The sub-themes that underpin this theme are: “Understanding that it is their loss, not ours” and “Listening to, caring for and supporting mother and family”.

4.3.5.1 Understanding that it is their loss, not ours. When speaking of the grief that they experienced as a result of perinatal death, participants reported that even though it was a heartbreaking event for them and they did experience grief as a result of the loss, they needed to remember that it is the family's loss and the context for the grief being experienced is different for the family than for the midwife.
“You are allowed to feel uncomfortable and upset, but as long as you remember that it is their loss and not yours, you need to keep everything in context. Your day may be bad having to care for someone who has lost their baby, but you haven’t lost your baby, so their day is a lot worse than yours.” (I2.15c)

“I felt that they were in a really good place, you know, that they moved on really well, and they, I don’t think they ever had any understanding of how I felt, because I didn’t want them to have any understanding of that, because it wasn’t about me, it was about them.” (FG4.4b)

In one of the focus groups, participants discussed the necessity for the midwife to be able to recognise that a midwife needs to separate their own emotions in order to help others to get through their life-changing experience; the midwife being able to manage their own emotions in order to appropriately approach the care that the family requires.

“each birth experience is as important as every other birth experience and isn’t uhm diluted by the number that we have, and so for me uhm the most important thing that I try and do when I’m in that situation uhm, to manage my own emotions, is to understand that that’s not my life experience, that that’s that family’s life experience. And I suppose that’s, and so when I hear what [Participant name] says about the little 22 weeker, that’s the sort of stuff that I like to do as well. So it’s to make that very special moment a special moment so to be able to uhm help that family have those special moments and to put the focus so, you know, to manage my emotions by ensuring that I do a very good job for that family. (FG3.11b)

This participant explained that everyone reacts differently to their circumstances and that, as a midwife, she should not make assumptions around the woman’s needs based on the midwife’s personal sense of loss.

“I suppose when I take the experience forward, when I think about my work life, it’s been about sort of recognising that there are common elements that, you know, with every woman that I have seen who’s had a loss, you know, they would follow a
similar kind of trajectory, but everybody has individual differences to their story as well. So I suppose it’s, for me it’s, just being mindful to not make assumptions, you know, about what they might need. And in relation to that sort of tension between your own personal sense of loss and remaining professional, I suppose I’ve come to the position where my job really is to hold the space for them, and if I know those parents well, it’s much easier to do that.” (FG3.4d)

4.3.5.2 Listening to, caring for and supporting mother and family. Although participants expressed feelings of grief, frustration and heartache as a result of perinatal death, their accounts return to the effect on mothers and what they, as midwives, can do to care for the woman and her family. One of the participants described her immediate impression of a woman on admission and explained how, as a result of her initial misconception about the woman, she learned to support rather than be judgemental of people’s choices.

“I felt every emotion possible including shame for my quick judgment and my entire outlook on life changed in that single case experience. It was this experience that showed me that women need to make the choices that best suit their circumstances and you can never know what their home life is like so we cannot judge anything they do. I held onto that belief tight as I was introduced to the world of pregnancy loss.” (I9.4c)

Participants explained that women need to be listened to and care must be delivered according to their individual needs and wishes.

“My response is coloured by my own experiences. Too often women are rushed by health workers to go ahead, get it over with etc. ... sometimes families do want it over with as soon as possible but there are families who want more time. I will never forget a couple on finding out that their baby had died choosing not to be induced until after Christmas as they wanted to have that Christmas with their baby. I am reminded again that often women ‘know’ ... we health professionals must take time to listen, to really hear what women are saying. I have learnt that sometimes we
don’t ask questions of women because we are afraid that we won’t know what to do with the answer.” (B8e)

“just being able to just sit with a family and pick up those things about a mum, just glancing over towards the cot where her baby is and, instead of me suddenly being like, okay would you like to hold the baby now, uhm, was able to sit there and sort of be guided a little bit more by those really subtle soft signs that families will show you ... take the time to, for them to set the tone and sometimes you do need to say to families, what about we do this now, but really letting them, letting them guide where you’re taking the conversation or where you’re taking what needs to come next.” (FG1.8c)

A midwife needs to go the extra mile, and sometimes even bend the rules a bit, so that you can give women good clinical, emotional and practical care that makes a difference and may go some way to ease some of the trauma of the situation.

“whenever I care for a woman with a fetal loss, I try very hard to improve their difficult situation. I try to go the extra mile, find things that they need, bend some rules, such as the number of visitors, and try to make life a little bit easier if I can. I think that they have enough to contend with that any assistance will make their traumatic experience a little bit less.” (I2.3d)

It is not always necessary to know exactly the right thing to say to grieving parents. As participants explained, simply being there can make a difference for the woman.

“we can make a huge difference to women experiencing the loss of a baby. The midwife doesn’t have to know how to say just the right thing; just her presence and caring attitude can make a big difference.” (I7.3a)

And being able to acknowledge the baby validates their life.
“I also feel like caring for these babies validates their life, no matter if only lived in utero, and gives them respect and honour in their death. I do not allow any baby to pass away alone; I was mortified when I found a baby placed alone in a dish in the pan room post induced mid-trimester abortion, still breathing. No matter what the situation, everyone deserves a "good" death and I aim to ensure all babies are given this, to the best of my ability. It has caused a little friction with the shift coordinators at times, when I take myself to a private room and sit with a baby, sometimes for long periods, when parents cannot bear to see their baby alive (usually in the case of induced late abortions for fetal anomalies), but I have now had so much positive feedback from families that the staff understand how important this is and are more supportive.” (I9.6b)

“Acknowledging that there is a baby and that they are a mother regardless of if their baby is with them or not makes a difference and, yeah, and this woman pointed out just by me saying his name and by talking to him, regardless of the fact that I didn't notice I was doing it, just made such a huge difference and like you said, the little things can really alter their experience and that gives you such a reward, knowing that you have been able to ease a little bit of their pain.” (FG1.7b)

A participant told a story of how the setting can be carefully created to try to leave good memories for the woman.

“I guess it was beautiful because uhm we kept the environment relaxed and we dimmed the lights and we were so woman-centred uhm and the woman was able to make jokes and laugh about life, and then uhm the baby was actually born alive which none of us expected, uhm and we asked her if she would like to, you know, hold her baby while it passed away. And the baby lived for 30 minutes and this mum got to nurse her baby and I remember looking in on the situation as an outsider and just thinking how, you know, this baby has only ever experienced love, and now that's all it's ever going to feel. It's never going to have nastiness or anger or hate towards it, it's just experiencing love as it passes away, and I thought that was kind of beautiful. … it's about creating memories for parents whose memories won't be as
good as someone who has just had a baby. It is easy to create a memory to last a lifetime with someone who has a healthy, happy baby, but to be able to create memories that they can look back on fondly in years to come is such an important part of midwifery.” (FG3.10d, 11c)

Considering how the woman will be supported once they leave the maternity unit is also important, as participants reported:

“to actually provide some support to those people that are around the mum, because the mums are so numb at that point in time. It’s hard to yeah, and the carer, so by providing some support strategies to the carers, uhm or people who are going to be around them in the short, you know, raw time ahead, to actually have that, and to provide some form of contact for them, so that’s the other thing, that experience has shown me that it’s, it is really important to have some follow-up with mums who have had perinatal losses just so that they know they’ve got a, you know, someone who’s involved in that care period that might be a safe ear for them to have a little talk with, that’s all.” (FG3.3a)

“and you can make a big difference in that situation, like in that transition from hospital to home to the community too, can’t you? Like if you are doing that adult care, you can be the kind of safe comfort, like the safe one after that hospital environment and before they then start to embark back into life into the community.” (FG2.5b)

Not all scenarios played out in the best possible way. One participant told a story on the blog about a woman who had been admitted at 23 weeks’ gestation with pre-term rupture of membranes. The woman had been in hospital for a few weeks to reduce the chance of pre-term labour, but in the end delivered a baby who died shortly after delivery. The midwife shared this harrowing experience which illustrates that, no matter how good the intention of midwives, an interdisciplinary approach is required.
“Some of the staff seemed to indicate that she was a bit ‘precious’. ... I had on handover that she had been complaining of contractions all night; however, they did not think that it was anything significant. Eye rolling was seen. I went and saw her, and determined through palpation that she was having some tightening. She had taken pain relief (including Endone), with not much effect. Heat packs were continually used in this time. When I saw her, she continued to complain of pain. She had taken the maximum that had been charted. I put in the Dr’s book for them to review her pain relief, as the doctors were not in the ward. I asked a Dr to review her; I was ignored due to the Dr being busy. Soon afterwards her obstetric team visited her, and were not happy to increase her pain relief – I got the impression that they did not think she was in labour. They said they will do a spec, but not now because they were busy.” (B10c)

In acknowledging their own pain, participants expressed that, as a midwife, it is important to remember that this loss belongs to the mother and family. The woman needs to be the centre of care and the midwife will find even simple ways to help her at this time. Some of these methods of care develop over repeated experiences as the midwife seeks ways to best care for her mothers.

4.3.6 Theme five: Finding a new purpose. Participants’ accounts suggest that the experience of caring for women through perinatal death initiates and inspires a desire to improve their skills, knowledge and practice. Participants report that this pursuit of learning from a difficult incident not only leads to development professionally, but to personal and professional satisfaction from their work. This theme is described through the sub-themes “Being inspired to evolve their practice and strive to be a better midwife” and “Finding personal and professional fulfilment”.

4.3.6.1 Being inspired to evolve their practice and strive to be a better midwife. Participants have described experiencing emotions such as anger, guilt, frustration and grief as a result of perinatal death. They have, however, also reported that caring for women through these often-traumatic circumstances was the catalyst for participants to evolve their practice and to seek opportunities for growth, right from the first experience.
“This was my first ever experience and one that I was unprepared for, but made me want to improve what I did for these families.” (B18f)

“I guess my first bad experience of fetal death laid the foundations for me to provide better care to the next family.” (I7.3a)

And they have reported being motivated to research their further education needs.

“I guess for me, through dealing with these sorts of situations I’ve got quite an interest in it, like I’ve sort of looked into sort of how I can further my education.” (FG2.4g)

First time experiences that were perceived by others to be negative, proved to be positive learning experiences for the participants.

“I wrote about my first experience and lots of people wrote comments as in they thought that I was unsupported and because that was my first experience and the other midwives just rolled their eyes at me at the time, and I think that people saw that I saw that as a negative experience, but I actually saw it as an experience where it wanted me to improve, it wanted me to get, I wanted to get better. I wanted to be not like that, I wanted to help people rather than feel that I was inadequate at the time. So it was, I saw it as my first experience, but saw it as a learning experience rather than a negative experience.” (FG1.12e)

“It may not have come across like it, but as scary as this experience was, at the time for me, it has laid a foundation to improve my knowledge about caring for people who have lost their baby and hopefully help them with their grief, so I see it as a positive. My lack of experience meant that I needed to ask questions, so although they treated me as I was an idiot, I am glad that I asked and even today ask whenever I am not sure about what is happening in all aspects of my midwifery, even if that makes me look like an idiot to those who I ask. I try to always answer questions from those around me in a positive manner and hopefully help those who
ask not (to) feel like they are dumb, although sometimes I am sure that I don’t always succeed at this.” (B18y)

As a result of being involved in caring for women through perinatal death, participants describe becoming more confident and competent:

“I now consider myself a careful, competent midwife. I utilise evidence in my practice & ensure the women I care for are well informed and the centre of their care. I am an enthusiastic educator and a positive change maker to improve women centred care. … I’m totally dedicated & committed to improving outcomes for mothers & babies – but I think my family would see that as an obsession, possibly some of my colleagues as well. However, for me to return & practise as a midwife I had to ensure I was competent; the confidence took much longer & I had to work hard to control my anxiety & keep birth normal, not over react. Thankfully, so many of my colleagues have often unknowingly supported me along this rough track.” (I3.2d, 4a)

One participant’s story illustrates her professional growth following her own personal loss experience.

“I’ve worked in neonatal care and as a midwife for 12 years and so I was very young when I started, so my response to perinatal death has really changed over the last 12 years, uhm and I think, because I started my career in a neonatal intensive care unit, so you know there was a lot of babies that never went home, I’ve been able to build on those experiences to be able to provide different, and sometimes, I think, better care to families. And the loss of a family member myself a few years ago really did change the way that I communicate with families. I have never had a baby, so it wasn’t a death like that, but it’s being able to, yeah, I guess it changed the way I communicate with families, changed the time that I spend with families, uhm but I have a real sense of pride in being able to provide good care to families at a really really difficult time in their lives … I just emotionally couldn’t be there for anyone else, and really to come to work every day was enough without that. And then it was just one particular day, he’d passed away a few months previously and I was allocated to
a birth centre and there was a family who had lost a baby, and just suddenly that day I thought no, actually I want to care for them and I really want to be there for someone else like many people had been there for us. But I think the difference was around some of the language that I used, uhm, and I think I was much more aware of sitting with a family and working out where they were at. ... just being able to just sit with a family and pick up those things about a mum just glancing over towards the cot where her baby is and instead of me suddenly being like, okay would you like to hold the baby now, uhm, was able to sit there and sort of be guided a little bit more by those really subtle soft signs that families will show you. And also closing the door and knowing that however long this takes with the family, the rest of the birth centre will continue. But if I need to be there with the family for 5 minutes or an hour, then to them they will remember that time forever. And I think when my dad was very unwell and actually when he’d passed away, people really rushed us at that time for lots of different reasons, and I was not, well I won’t do that to another family. I will really take the time to, for them to set the tone and sometimes you do need to say to families, what about we do this now, but really letting them, letting them guide where you’re taking the conversation or where you’re taking what needs to come next.” (FG1.6a, 8c)

Participants acknowledged the need for continual growth for the profession.

“We have improved but we can always get better and having midwives that care and want to get better will improve the situation for the next generation of stillborn babes that unfortunately are still happening at the same rate as 20-30 years ago, I hope that the numbers will decrease but so far this is not happening.” (B19m)

Sharing their stories served as inspiration and motivation for some midwives.

“Thank you Midwife 18 for sharing this beautiful story, I am inspired and encouraged that one day maybe I could be a wise and experienced midwife too!” (B18e1)
“What a wonderful story you have told. My first thoughts were that; I can do what you have done. Thank you for inspiring me to do better, and not shying away.” (B20e)

One participant declared that she has already changed her practice.

“I have already changed my practice. I have made myself more available for colleagues. I know it is very important that they debrief, so I’m happy to listen, and give supportive feedback if they want it.” (I4.7b)

4.3.6.2 Finding personal and professional fulfilment. Participants expressed the desire to build on their skills, confidence and competence as they emphasised that midwives need to have the knowledge and skills to be able to provide good care. Participants also spoke about how they have found it rewarding to care for women and their families through difficult circumstances; however, they felt that people who are not midwives do not understand how this kind of care can be rewarding.

“it sounds a bit strange and people who aren’t in the profession don’t understand it, but I quite enjoy looking after those people. Like, I feel like there’s a real purpose to your job, and it’s not, you know, it’s not their fault these things have happened, and you know, you look at people like Deb de Wilde (a well-known Australian social worker within pregnancy loss support for women) who do such amazing work in these sort of situations and I think that it would be really good to have all that knowledge and be able to provide really good care, but in order to do that, you really, like midwifery doesn’t give you, your university degree doesn’t give you all the skills that you need. And I’ve been a midwife for a long time, but I’ve also been on maternity leave for half of my life as a midwife, so you know, uhm I just think like, I really quite enjoy looking after these women, you know, which sounds strange to somebody who doesn’t understand it, but I do enjoy it and I like being able to provide good care and I guess I just want to make sure that my, what I think is good care, is good appropriate care, but you don’t really know that.” (FG2.4g)
The professional reward from being needed and making a difference during such difficult circumstances was highlighted as being an integral part of the experience.

“and found something, not enjoyable, but really really rewarding professionally in knowing that you can make a difference in those families regardless of how bad things have gone if you provide good care, then you can give them a positive, as positive as possible experience in that kind of field. ... it is a really rewarding experience to be able to care for a family, uhm, at a time of loss for them.” (FG1.6b, 6c)

“although we all want things to be perfect for families, if it’s all perfect a midwife is important, but if it’s all going wrong a midwife is absolutely vital, and if you can be there through something that has gone really wrong for a family and still provide them good care and some positive parts about whatever, that might have been, you know, that to me is true midwifery.” (FG1.9d)

This ability to turn such a traumatic occurrence as perinatal death into a positive experience was also seen as more rewarding than the joy associated with normal births.

“although a lot of midwives would tell you that the highlight of their career is being with a woman who has a normal birth and breastfeeds and goes home in 6 hours, I’m not sure if that’s for me. I think I’ve had plenty of highlights of actually where things have gone wrong for families, but I’ve been able to redirect care to be able to find some joy in a real experience that has gone wrong.” (FG1.10b)

Participants report that they find the appreciation shown by women under devastating situations, such as perinatal death, to be profoundly special.

“It is heartbreaking to see babies die, but you find that the majority of women are grateful for any small thing you can do for them. ... I think that they can sense how much you want to help. Sometimes you don’t realise that what you do has such a big impact. ... I feel like I am helping them and that makes me feel good. You don’t need
to get accolades from management and the rest of the world if the person that you are looking after thinks that you have helped them, even in the smallest way. This counts for all patients, as nothing feels better than a thank you. Seeing a lady that you looked after in labour the day before, but delivered on the next shift, wanting to show you her baby, so that you are part of her birth, is special. Looking after women who have lost their babies and are devastated, but saying thank you non-stop, is a different type of special.” (I2.7b, 8b)

Although draining and potentially traumatic, caring for women through this devastating and vulnerable time is, according to the participants, fulfilling and offers a sense of purpose.

“I’ve heard one midwife say ‘she doesn’t like that kind of thing!’ I’m not sure if anyone does like it, but I find caring for families experiencing loss heartbreaking, rewarding, a privilege and personal taxing all at the same time.” (I8.4a)

“I know it seems like a horrible job, but in reality, it is some of the most rewarding/fulfilling work I have ever done. It’s not enjoyable, but the knowledge that you are helping women and families through the single most devastating event in their lives and helping to make it bearable in some small way, really gives me a sense of purpose.” (I9.4d)

The participant who described in theme two how she had wanted to leave midwifery said:

“It makes me feel that I’m glad I didn’t leave the profession despite the stressors of the job.” (I7.3a)

Participants expressed the need to be able to grow professionally following this difficult and emotional experience, and described ways in which they sought to develop their knowledge, skills and confidence. A part of this growth helped participants to discover that this type of work can be rewarding. However, to be able to grow and achieve personal and professional fulfilment in this aspect of their work as a midwife, it is necessary to have the appropriate support.
4.3.7 Theme six: Strengthened through support. The responses from participants show how important support is to a midwife when they are caring through a devastating event such as perinatal death. Participants indicated that the type of support received can be a strong determinant of how a midwife copes with the situation, then and in the future. Professional support for a midwife comes from her colleagues, team leaders and from the institution where she works, and is described in the sub-themes “Listening to, caring for and supporting each other” and “Encouraging the organisation to evolve their support role”.

4.3.7.1 Listening to, caring for and supporting each other. Having access to non-judgemental support and being able to provide support to colleagues was expressed by participants to be integral to emotional survival for a midwife, as well as the capacity to care for women and families through perinatal death.

“to be able to really acknowledge any form of loss in midwifery is a really great thing for a practitioner to be able to do, and I think that we do need to be able to be supported to support women.” (FG1.9c)

“There is much to be gained in sharing wisdom among colleagues; having awareness of the need for self-care and peer support, and sharing the load of caring for families experiencing loss. Some midwives seem to carry the load more than others; maybe they do have a special gift. These midwives need to be given the option to say ‘no, not today, not this time’.” (I5.6b)

One participant used a good analogy to illustrate what she considers to be effective support from colleagues.

“What's made it easier for me in the past to do that work is where my colleagues have been standing on the fringes and looking and keeping a really protective eye on me. Uhm I suppose it's when I think of it, I think of the mother in the middle, the mother and father in the middle, their family are in the next circle around them, I'm sort of circling the outside of that sort of group and then there is a group circling the outside of all of us and that's my colleagues just keeping an eye and making sure you
know, and they're really, really great at stepping in where it looks like I need some help and standing back where I don't, and they're the times I recall as being uhm this horrible situation but there's definitely some growth in there, you know.” (FG3.7b)

And other participants described how it is good to have colleagues believe in one’s capabilities.

“I guess what kept me going as a midwife was that my colleagues believed in my capabilities as a good midwife and they supported me through my grief. Other midwives also opened up to me about adverse events that had happened in their practice and these were really good midwives.” (I7.5b)

Participants expressed how much it helped to receive support and reassurance from colleagues after the fact.

“the first case that I ever looked after I guess she went through it kind of systematically and she called me at home the next day to see how I was going and stuff, uhm and she really reassured me that the care I provided was the uhm quality that she would expect and what the hospital would expect and she encouraged uhm the way that I dealt with the loss especially because I haven't done my nursing, I guess death was kind of a new concept. All I had seen was life, so her being able to, that reassurance that she was there if I needed her but at the same time that I was capable of doing it. That really helped.” (FG3.12c)

One of the participants expressed how teams need to be supportive of each other while remaining protective over the women in their care. She explained that sometimes, in circumstances such as when care has been transferred to another team, there can be friction and disagreement between teams. The participant postulated the reason behind this to be as a result of each team trying to do what is best for the woman.

“I think what happens is, because midwives are so protective of mums, that sometimes when more than one team has looked after the mum there's sometimes in
both teams’ uhm defence, a trying to find some reason or rational reason behind an event that none of us, you know; it might never come up, there might be no cause that we can point a finger to for an event happening, uhm but because there's no relationship, there's very limited relationship between teams, then I think both teams are trying to do the right thing by the mum, so uhm it's important for us, for me as a midwife, to make sure that that doesn't affect the mum, you know, directly affect the mum when that is going on.” (FG3.6d)

Although participants have explained the importance of support and the need for a team approach, not all participants reported having received support when they needed it most. In theme four, I introduced the story told by a participant who described the events around a 23-week gestation baby whose mother had been in hospital for pre-term rupture of membranes. This participant described a devastating scenario where lack of teamwork and a blatant deficiency in support left this midwife feeling insecure, unsupported and traumatised.

“A decision was made to transfer her to the delivery suite so that she could get more pain relief. The ward doctor that was hanging around, however was not able to help in any way, indicated that it was a good idea. I think the doctor was new and junior. The doctor had tried to get further support, with no success, even with a PACE call being alerted. No other doctor came. I was worried, because she kept on completely passing out, but continued to wake up and scream with contractions. I had not seen this reaction to morphine before – I am still a newish midwife.... We got down to the delivery suite. The woman was given gas straight away, and the baby was delivered by DS staff soon afterwards – I remained there. The mother and father were screaming and crying when they held their baby, who was not breathing, other than one breath at birth, but had a heart rate. I went out of the room sometime later to do some paperwork, after a tear, only to have the DS staff say how stupid it was that she was brought down to the DS (delivery suite). A conversation of the same lasted at least 10 minutes. They said that she should have just delivered on the ward. The same conversation was continuing every time I came out of the delivery room. I was questioned by more than one person about ‘my’ decision. I tried
to explain why the decision was made. It made no difference; I felt attacked by many
midwives, including a student midwife. I did agree with the decision to go to the DS
at the time, because the woman really wanted some more pain relief when she was
contracting, of which we could not provide on the ward. I do question if it was the
right decision now.

I soon took the mother, father and baby back to the ward, on their request. I made
every effort to be sensitive to their needs. I had a wide-eyed year 10 student look at
me when I got back. I had a quick debrief with her; she had stayed out of it, but heard
all the commotion, and had seen her while she was being transferred. I remember
thinking – I need to debrief. I was feeling unsure of my skills as a midwife and
traumatised by the whole birth. ...

The day continued with two Met Calls on the Mother, with traumatised extended
family watching on. ... I continued to support the mother, her partner and her
family, to the best of my ability.

The shift finished soon afterwards. I had no one to talk to. I sobbed all the way to the
car. I rang my husband and told him very briefly what happened, as he does not like
me talking about my work. I am still traumatised by this event.” (B10i)

In response to hearing this story, other participants were horrified by the way in which this
midwife had been treated.

“I agree with your comments here, sometimes midwives aren’t very kind to each
other and it’s something we could do better.” (B10v)

“that a midwife should be in such an awful situation with not much support, (the)
other T/L (Team Leader) sounded supportive, but to have to deal with the horizontal
violence shown to her by the D/S staff (delivery suite staff) and the lack of support
shown by the medical team. No wonder we have a shortage of midwives if this type
of event is considered acceptable.” (B10w1)

And during the focus groups, participants reflected further on the need for midwives to be
kind to each other and provide collegial support.
“what saddened me most was not about the stories in themselves, but more, often how the midwife was treated in the midst of those stories, and uhm, I just think as midwives we should be there to support one another, and sometimes we don’t do that so well. And sometimes it’s not midwives so much, it’s about the system not supporting a circumstance.” (FG1.9a)

4.3.7.2 Encouraging the organisation to evolve their support role. Support from colleagues and team leaders was reported to be important in helping participants to care for women through perinatal death. Additionally, participants indicated that the organisation had a responsibility to provide support. Participants specified that resources and processes need to be in place for better care; however, as in the story told about the 23-week gestation baby, sometimes this was not the case.

“As a midwife reading this story I am ashamed to be part of a system that provides this sort of care; however I know that many times I have been part of similar pictures; busy ward, competing demands, miscommunication, and lack of planning all conspiring together to further traumatise the persons intimately involved.” (B10n)

“The baby had not a hope in hell of being treated with dignity and respect in this out of control situation. (B10s1) ... The hospital obviously provided a facility, but not much else. Administration should have taken this up as totally unacceptable. I think an IMMS should have been done.” (B10u1)

“Is there a developing culture due to staff shortages whereby the degree of our care is being compromised? It sounds like the incident may not be an isolated one??” (B10z1)

And that effective communication was a key component for good care.

“In this story there seems to be a lack of planning or failure to communicate the plan for the high probability that this woman would labour. Miscommunication is one of the key components to inadequate care.” (B10p)
Participants felt that the organisation has a responsibility to provide support for midwives and is responsible for the resultant feelings of mistrust that can develop as a result of unfortunate incidents.

“The other major factor here from the midwife’s perspective is the lack of organisational support she received and the subtle and implied opinions that this was somehow the Birth Centre midwife’s fault as birth centre midwives can’t be trusted.” (B5b1)

This participant explained further, citing skill-mix, open communication and avoiding a blame culture to be factors that need to be addressed by the organisation.

“Perinatal death has a devastating impact on the lives of women, their partner & their families. But that impact can be as devastating for their carers, especially the midwife who births their term, stillbirth or 20-week baby. This needs to be recognised & professional help arranged for carers, & not on an ad hoc basis or organise themselves, but a structured process by our employers. Skill mix must be safe & junior midwives need to have organised access to a senior midwife. A culture without blame that encourages open discussion & debriefing needs to be fostered within our workplaces. These measures may help to reduce the perinatal rate related to suboptimal care.” (I3.4d)

Despite the existence of such negative work cultures, midwives believed that adequate education provided by the organisation would be of benefit to the midwife when caring for women through adverse events, as well as helping to support their colleagues during and following these difficult occurrences.

“I think there should be in-services on ‘what you can do in a crisis’. (I4.8a) ... This education should be done regularly, say every 6 months/year. You need this information so that you can do your best when you are faced with the issue. It would all be available if there was an incident.” (I4.8c)
“I agree with you, we need better education regarding supporting women, men and their families after loss. We also need to be educated on how to support each other.” (B19h)

This belief was confirmed by reports of settings where education and support were well established.

“So the hospital I work at has a structured support with uhm a reproductive loss coordinator. We’re very lucky; we’re one of only 4 hospitals in Australia to have a reproductive loss coordinator, and she runs sort of structured education programmes and she runs drop-in sessions, and then we have very ad hoc kind of debriefing mentoring.” (FG1.11f)

Participants explained the importance of education in keeping up to date with skills, particularly for incidents that may not happen regularly or with any warning. One participant also expressed the need for midwives away from practice to have the opportunity to keep their skills up to date and be supported on their return.

“I found that so often uhm education was lacking and we were always so under staffed that people wouldn’t be rostered off to, you know, attend the fetal surveillance monitoring, and because they would have to travel away to do it, of course. And uhm the same with attending any other, the MaCRM (Maternity Crisis Resource Management) or any other of our courses... that has really improved greatly, thank God, with the change in registration having to have CPD (Continuing Professional Development) points... we can’t be registered if we haven’t got the education, so it puts some onus back on the places that we work at, that they give us time where we can have that education. But to me that’s really, really vital that we are allocated time and we’re paid for it where, and it ensures that all midwives have got their education up to date... even when they are on maternity leave, we should still be supporting them to make sure that they have access to education when it’s available, uhm because that’s a big problem when people come back and they haven’t had a chance to have any education, .... I think always when they come back
because you never know what's going to happen on that next shift really. You don't know what could face you, and that could be the time that you needed to have. You make sure that you are up to date with your CTG interpretations and you may not be, and uhm you know, yeah. So for me education is extremely important.” (FG4.12d)

Participants considered that adequate facilities and services must be available for women and their families.

“It was also difficult because the photos they had of the baby were of pretty poor quality and I was sad the hospital had not yet become aware of the Heartfelt organization. I feel through this experience I really want to learn more on how best to care for these women and their families in such a time of need.” (B19c)

Although there was an acknowledgement that services were better than in the past.

“Thankfully we are better at this than what we were 20-30 years ago when women were sent home and told to forget about it, have another baby and move on. Talk to an older midwife or Registered Nurse and we could tell you of the women who delivered their fully formed fetus in a gynae ward and it being left in the kidney dish in the pan backs and then being thrown out. One of the other midwives in this blog talked of a grandmother holding her grandchild as she did not get to hold her own child, something that was very common back then. Now we encourage families to do as much, or as little, depending on what they want, as they possibly can.” (B19m)

One midwife admitted that the organisation does make programmes and opportunities for debriefing or counselling accessible, but the availability of time to take part in these can prevent access.

“I work in the public health department and they've got lots of programmes you know, you can go and get, see people and counselling and all that type of thing, but there really isn't time in your life. You have to go in on your day off and blah blah and you think, no, I'll be fine. So there is the opportunity for debriefing and, you know, my
manager, if I was distressed, would always say, you know, come in (and) we’ll have a chat and blah blah, but in real life, it doesn’t always work like that, but there is the opportunity for it, it’s probably just more that you just kind of get on with your day, you know.” (FG2.5e&2.6a)

Participants detailed the importance of support for the midwife by her colleagues and team leaders, as well as the organisation. Having support structures in place may facilitate the development of strategies for midwives to manage their grief and to advance their knowledge and skills to deliver the care needed for women and their families in the future.

4.3.8 Theme seven: Developing the courage to care. To be able to manage their own grief and feelings of devastation and insecurity, participants reported making use of strategies that help them to come to terms with what has happened and use the experiences to improve their practice. These methods will be explored through the sub-themes: “Engaging coping strategies”, “Drawing on the expertise of midwives and mothers who have travelled this road”, “Empowered through professional development”, “Realigning the pieces through reflection and meaning making”, and “Healing through the telling and the listening”.

4.3.8.1 Engaging coping strategies. Participants explained some of the strategies that they use to help them to continue with their personal and professional lives. They reported that being able to move on and get on with their lives allows the pain to subside.

“It doesn’t affect you forever, you know, you do kind of forget about them, which is horrible, but, you know, you do get a new set of patients and a new lot of things to deal with, so you, I don’t know, I kind of, you know, it hangs on for a little while and you think about it, and you do tend to sort of think back on those situations every now and then, but because it’s not your family, so much as, you don’t think about it every day or anything like that. I guess that’s just a part of human survival; if you dwelled on all those catastrophic events in your life you wouldn’t get through.” (FG2.3a)
Previous experiences have been used by participants to prepare them to be able to put up barriers to protect themselves.

“I think if it was to happen again I would be able to protect myself a bit better from the emotions that I felt at the time because I think I’m, because I’ve been through it I think; there’s just some, it’s a bit weird but, I’ve said barriers, like just ways to protect myself from my own kind of emotions around it.” (FG2.3c)

In a similar way, one participant described how her experiences as a new midwife in a large maternity unit not only helped in developing her skills, but also helped her to maintain some emotional distance.

“when I looked forwards with how I was going to do it, uhm the experience I gained in that big centre helped me develop some very good, I believe, very good strategies to be able to uhm assist mums and to provide a level of support for them uhm without, and I suppose without, this is probably going to sound a bit blunt to others on the phone, but uhm just without having to take on the emotional burden.” (FG3.8f)

Participants felt that once they had experience in caring for a family through perinatal death, participants were better prepared for subsequent experiences.

“I wouldn’t say it’s easier, I just think you feel better prepared in a way uhm. Like being a mother I suppose, you know the more children you have it just becomes easier, it just becomes sort of uhm you’re just more experienced at it I suppose, so sort of in that same element, I don’t think ever, I don’t think ever dealing with someone’s grief and loss is uhm easy. I just think you feel more comfortable with it or you don’t have to, it sort of flows, it just flows better if that makes sense.” (FG4.3e)

And even felt that subsequent experiences helped them heal from their first experience.
“I felt uhm that it was quite a cathartic experience caring for a woman maybe about 6 months after the death of uhm the baby that I was looking after ... another woman, a woman came in with a stillbirth and I was able to, I wasn't frightened of looking after her uhm and I felt that I could, because I'd had that experience, I wasn't scared of it as much anymore.” (FG4.3c)

“So the foundations were laid by experiencing grief up close, so that the next time I encountered it, it was somewhat familiar.” (I7.3b)

One participant explained that even the administrative requirements become less overwhelming with experience.

“Strange as it might sound, uhm the paperwork involved with uhm a stillbirth or uhm you know perinatal death can be quite overwhelming and I think once you've done that a few times the fear of dealing with the whole situation, not just the emotional side of it but also the administrative side of it, I think even the administrative side can be quite overwhelming and I know when I was a new grad as a midwife I just tried to avoid anything to do with stillbirth because I thought it's too much, I don't know what to do, uhm but I think once you've been through that experience a few times uhm yeah you build a level of confidence in your abilities.” (FG4.4d)

Participants described in previous themes the way in which experiencing perinatal death had an influence on their spiritual beliefs. In a similar way, participants also felt that spiritual beliefs and practices helped them to process events and feelings.

“Prayer, sounds weird, but that's probably, that's how I got through it.” (FG4.6b)

“Prayer is really my form of yoga/mediation. When I am unavailable to anyone except God. It is peaceful, loving & honest. ... Sadly, I feel our materialistic world lacks or misses the depth of our spiritual being. Possibly it enables me to isolate feeling from over thinking everything & find solution to what I am concerned about in my life & what is worrying me. God is my go to person.” (I3.2e)
Developing a bond and maintaining contact with the family was a strategy used by participants.

“A really important strategy that can be helpful is to maintain some form of contact with the family who have had an unexpected outcome. Whilst this can initially be very daunting it can be very helpful to both the midwife and the family. Continuity of care and carer models encourage this contact.” (I1.4c)

“I find that I cope better with these babies’ demise because I bond with them and because of the amount of work I do for them. I feel like I am helping and that is what I think nursing/midwifery is about, helping people and making things a bit better makes me feel better.” (I2.3e)

And speaking out to get it off one’s chest is practised by participants to relieve the frustration.

“At times I can get quite frustrated with what is happening in the obstetric/midwifery world in general and will have a little rant or sometimes a not so little rant, get whatever I have on my chest off and then go on with what I need to do. If you want to use your imagination and a more professional term I guess you could say I debrief with anyone who will listen, then I go back to my work. I have never felt that I needed a break from fetal losses, mainly due to the rewards I get from caring for the families that I don’t feel like it is a burden.” (I2.7c)

One participant made use of good analogy to illustrate the way in which one can choose to process one’s experiences when ready to, rather than allowing them to get in the way of everyday life.

“I think if you’re willing to reflect and process, the experiences don’t stack up on one another, (it is) more (like) a previous experience can inform (your) response to another. I wonder if ‘closure’ is a modern construct – what does closure really mean? I give the following picture to clients- it’s a different take on ‘closure’; where events
are not processed; it is like a set of photos (images) strewn across the floor – you risk tripping up over them. The images are intrusive. The alternative is to pack the photos up in to a box and to put them on the shelf then to choose when you will take the lid off the box and look at the photos again. Viewing the picture is intentional. This is a process.” (B5u)

4.3.8.2 Drawing on the expertise of midwives and mothers who have travelled this road. Participants articulated the value in having the opportunity to listen to and learn from women and midwives: “I learn from women, midwives and colleagues every day.” (I3.2d), as well as learning from practice they witness and would not like to repeat themselves.

“I think the opportunity to spend lots of time with families and ‘see what works’ and get feedback from families has been invaluable. I have also seen poor practice which has at times made it very clear how I don’t want to practice! ... For me it was getting almost a set of lines often which I’d heard other health professionals use. Things like, ‘your baby (will) always be a special part of your family.’ They kind of make up a script which you can use when you’re having difficult conversations with families. It (is) not about taking the individual care away .... For me it’s about being able to deliver, that I’m thinking clearly at a time of great emotion.” (I8.3a-b)

One participant described a time when she was being guided by a preceptor and how important that was in assisting her in learning the details around the special care required in such a situation.

“I did a preceptorship with a woman who was a very, very experienced midwife, uhm and she’d also had stillborn babies herself, and so she took me under her wing and we spent a lot of time together working in these cases and working as a team, and you know it was her who let me know that it is okay to cry with the families. You know, babies die, it’s like something really horrible has happened, it's okay to cry with them if you feel it, just let them see it and to do those sorts of things, so it was little things like that, that I picked up from her that you can’t learn from reading in a text book, and you know learning the ideals, she really showed me by doing it and I
was just observing her and speaking to her about it and learning those little things. And one of the biggest things was how to present a baby that's passed to its parents who weren't sure if they wanted to see the baby or not and letting them, you know, she taught me a special way to wrap the baby so that you can show the baby in stages, you know, show them the perfectly formed foot, or show them the hands and gradually let them see their baby if they're not ready to see the baby as a whole yet, just showing the things that are perfectly formed and, yeah, all of those little things just make a huge difference.” (FG1.7d)

Participants explained that by listening to more experienced midwives they can learn a range of valuable approaches, even down to the detail of what to say to women.

“more experienced staff just telling me how they do things and how they find, you know, what they find helps in dealing with the family and, you know, even what to say, like you know you walk into a room and you've got to do a postnatal check on somebody who has lost a baby and you kind of walk in and go, you know, do I say sorry about your baby, do I say nothing, do I just pretend it didn't happen, do I talk about them like they're still here, do I know use the baby's name, what do I do? And just being led by the staff who, you know, sort of talk about it. And also, I've had a friend who had a stillbirth and she's very open about it and she's like, oh you know I love it when people use his name, so you know I guess just talking to other people, other women who've been through it, I don't know.” (FG2.6d)

A participant shared the impact that the experience of having the opportunity to be able to talk, question and discuss care with other midwives, had on her and how this still holds emotional value even after so much time has passed.

“the hospital that I trained at uhm was very much about the mums and very much about uhm minimalist care, so creating the right environment, ... creating the nice space for the mums to labour in their own space, and so being a bit minimalist, so being out of the room in the early stages of labour. So we spent a lot of time in the tearoom playing cards on night shift, and in those days smoking cigarettes and
drinking coffee ... I believe that what I learned from that experience was the talking, so the, you know, talking about cases uhm in a comfortable, safe environment with uhm experienced staff that uhm provided you that support to be able to talk about anything in a frank and honest way. And that was something that the, it was mainly on night shift because that was the time when you had the opportunity to sit quietly and allow the mums to labour by themselves and there wasn't anyone else to, you know, come in the room and want to know how many VEs you'd done and what her progress was and everything, so for me those night shifts taught me a lot. It taught me a lot about honesty, it taught me a lot about the importance of talking through cases where you thought things could have happened differently and, uhm I think, the other thing that it taught me was that it is okay to have a bit of a cry, it is okay uhm, it's important to uhm share and it's, I think, the other thing I have learned over the years is, it is about recognising uhm those emotional responses in yourself and managing them when you need to manage them. Sorry” (became tearful and needed a break). (FG3.11g to 12a)

Having contact with women who had previously experienced perinatal death, and hearing these women’s personal experiences, was also important feedback that allowed midwives to improve their care.

“we actually had a mum come and speak to us who'd uhm had a uhm stillbirth, and so she could actually talk to all of our staff about how she felt about how we had uhm cared for her and what we’d missed and what would have made a difference to her afterwards. And it was really interesting, the things she said, uhm. For instance, she said at night time, on night shift, the staff hardly came near her, but the staff didn’t not go near her because they didn’t want to, but because they thought that they wanted to have time by themselves, but she actually wanted them to come and sit with her. And so, what she was saying to us, was you need to ask us what we want because we’re all so different, you know, so one person might want you there, but the next person won’t. And uhm she said, the thing, every single memory, that’s the only memory that they will ever have, and I really took that away with the next uhm time I cared for another lady ... that actually having that feedback from that
woman was really, really so important to us, you know, to improve the next woman’s experience, really.” (FG4.5c)

4.3.8.3 Empowered through professional development. The pursuit of knowledge and openness to learning new things are described by participants as being a valuable trait.

“Knowing where to find answers is much more important than knowing all the answers, something that I tell those around me every day. I feel that every day you learn something new, but that may only be that I am getting older and keep forgetting things.” (I2.9c)

Inspired to develop their knowledge and skills further, participants report the inability to find courses specific to what they need for these special circumstances.

“I've looked into what sort of degrees you need to be uhm sort of specialist in the area, and you need a social work degree. And uhm, there's some sort of grief counselling sort of things, but the social work degree, I think, is 4 years or something, and I think, well you don't really need that, you know; I don't need the whole shebang. There needs to be something more suited to this area, I don't want to go and talk to people whose grandfather died, you know, it really, you know, I've got the midwifery training. It's more just focussing on the you know, surrounding loss of a child which is, I think, a very different part of grief counselling to any other loss.” (FG2.5e)

Participants demonstrated having actively sought sources to educate themselves.

“As a new clinician I found working with families, at times (well a lot of the time), overwhelming, especially in the setting of loss. After 12 years I have built a set of ‘tools’ and strategies to help me care better from families. This has been done via observation of excellent clinical practice, professional development days, reading, formal education and simply time with lots of families. (I8.3a)
“As a profession, I think midwives have heard from grieving families what could have supported them better - I have appreciated Jane Warland’s book ‘The midwife and the bereaved family’ - one example she gives: “They asked me if I wanted a hospital funeral and I didn't know what it meant so I agreed. It was a mass grave. I regret that no one explained what ‘a hospital funeral’ meant.”” (15.2f)

4.3.8.4 Realigning the pieces through reflection and meaning making. Expectations have been shattered, confidence has been questioned and personal and professional identities have been challenged, but by looking back and reflecting on the passage of their experiences, even from as a student, participants have pieced together strategies to be able to continue attending to cases of perinatal death.

“I was a student midwife back in the 80s and uhm at a, you know, a tertiary hospital where we had probably more uhm perinatal loss than, you know, in a smaller centre. ... and so I think, uhm honestly when I was in the bigger centre as a student midwife being protected by uhm all of those around me, I saw a lot of uhm perinatal losses, a lot of uhm, I suppose, unexpected outcomes for mums, and some that mums were aware of prior to delivery, as well as, you know, uhm things that were, so you know, congenital anomalies that were terminated and things like that. So I sort of had a, I suppose I had a different view of things then uhm, as a student midwife, in (that) I wasn't really, I suppose, switched on with how, uhm, how much that affected a mum, because it was pretty much a volume, you know, was getting through the day managing a big amount of, you know. My motivation was to get my, you know, uhm 20 deliveries, 100 witnesses (and) all that sort of stuff. But I think what that experience, for me, and the way that uhm some of the midwives, when I look back, actually did manage these mums in a very busy uhm environment, I think that did help me in developing how I managed mums uhm with perinatal losses in the future. So I'm not saying when I looked back on how I did it, I think when I looked forwards with how I was going to do it, uhm the experience I gained in that big centre helped me (to) develop some very good, I believe, very good strategies to be able to uhm assist mums and to provide a level of support for them uhm without, and I suppose without, this is probably going to sound a bit blunt to others on the phone, but uhm
just without having to take on the emotional burden uhm of, I mean, it affects all of us, but what I'm trying to say is the exposure I had as a student may well have made me a little bit more objective about the way I managed those situations for the mums and allowed me the ability to uhm recognise that that emotional reaction is quite normal ... So uhm, although it affected me, I feel that it may have helped me” (FG3.9a)

Participants mentioned the way in which spiritual beliefs have been affected and have helped. One participant voiced that attending church provides her with the opportunity for reflection.

“I attend mass most weeks & find an enriching solitude to share with others in prayer. It is a precious time for reflection; what sort of person have I been? How can I improve this week? How might I approach this? What good have I achieved? A weekly debrief, I suppose. I truly believe we are here to make difference; that I have been given talents to share for the benefit of others.” (I3.2e)

A participant spoke about not experiencing the same level of emotion when reading others’ stories on the blog. She explained that through reflection, she has come to accept her own experience and has therefore been able to move on and not be affected to the same extent as she would have previously.

“...I think it's an experience that you reflect on naturally more because it somehow, it touches you more, I don't know, uhm so I think that you sort of put, you know, once you have reflected on something and you sort of come to a decision about how you feel about it, or you've reconciled it, or, then perhaps reading other people's experiences doesn't have such an impact, I don't know.“ (FG3.8e)

Being able to reflect on experiences has allowed participants to look back at “which ones worked well and which ones didn't work well and why things were different.” (FG3.13a)
“I think that every experience helps with the next. I think that the best attitude is to accept that life isn’t perfect and things rarely go exactly as we have visualised they will. I know that during reflection there are always improvements in processes, communication etc. that can be identified. I also accept that if things aren’t going the way I want them to, then continuing to do things the same way will not result in my desired outcome. So change and growth is always positive. I try not to beat myself up about anything. I accept what has happened and look forward to what is next. In saying that though, I do try and live the moment. If I am feeling sad I cry, laugh if I am happy and cuddle when that feels right. I also understand that I cannot change other people; all I can change is my approach and reaction to them.” (I1.5d-g)

And through reflection, participants have described finding meaning in the experiences of caring through perinatal death.

“I believe that only by experiencing the full spectrum of pregnancy/birth experiences can we appreciate the good moments we are privileged to be part of. It is then you can give fully of yourself, respect the woman, family and our work and be in the moment for the birth of a healthy baby and see it for what it truly is - a miracle! If you only have the happy experiences, it becomes ‘just work’ and you can miss the true value in our work.” (I9.9b)

“I know that my experiences with women and families have allowed me to develop a tolerance of what is different to my understanding of (what) ‘normal/average’ is. We all judge the world through our own eyes and our experiences definitely help to shape all of us. I see myself as someone who has been very privileged to have been able to share so many ‘highs and lows’ in life. I look at my adult children and know that [Husbands name], my husband of 31 years, and I have done a great job in getting them all safely to this point in their lives and seen them develop into such great individuals. I do believe that my exposure to others in their special times has allowed me to develop a level of tolerance that equips me to live my life with contentment. I am very comfortable with who I am and trust that I can go to bed each night and sleep well. And so I do try and accept those things that I have no ability to control ’at
this time in my life’. I have definitely developed this through my experiences with women and families. This acceptance does not stop me from reconsidering challenges at a later time when circumstances change. But what I do try and do is not to struggle with what has happened and to move through things.” (I1.2d – 3a)

4.3.8.5 Healing through the telling and the listening. Participants described the telling of their story on the blog, reading others’ experiences and receiving feedback on their own experiences, as helpful and therapeutic. One participant expressed that it was the first time that she has been given the opportunity to speak to another midwife who has had a similar experience.

[Participant a]: “Thanks for giving us the opportunity to talk about it (this study).” [Participant b]: “Well actually yeah [Participant name], I’m really grateful, uhm Robert I don’t know if you, what made you decide to do this because you’re the first uhm midwife I’ve ever spoken to actually who’s had an intrapartum death as well, so it’s really been lovely; it’s been really fabulous actually, thank you. It has been really, really helpful.” (FG4.15d&e)

Drawing on similarities to other midwives’ experiences provides comfort and a sense of not being alone in these experiences.

“it’s kind of therapeutic to read through other people’s experiences and just go, ah yeah, okay, I get that you know. ... my friends certainly don’t understand; you can’t debrief with a friend because they don’t get it at all. So it was kind of therapeutic to read through peoples’ things and get support; the feedback sort of on my own story sort of validated and you know probably more experienced midwives are saying, ah you know, wow, I think you did a really good job and that must have been hard and you think, ah thanks, you know, I thought I did an alright job but it’s nice to hear from someone else. And you can’t go back and change what you did either, so you know it’s nice to have that support in that situation I guess.” (FG2.7a-b)
Participants were able to get insight into the way in which another midwife cares for women and for herself to help participants to understand how to adapt and care for others in the future.

“the midwife's grieving pattern, how she dealt with it and how individualised care really is. So how each midwife not only deals with her own grief but how she strategically helps uhm women come to terms and their family come to terms with grief and it really made me realise how individualised care uhm needs to be.” (FG3.5c)

Having the opportunity to share experiences amongst midwives, who have had similar experiences, through involvement in this research has been cathartic for participants.

“Do you feel like you are a better midwife since you have gone through this? You hint this in your last sentence. I know with myself, I have learnt from my situation; I still grieve when I think about it, however I am glad that I have been able to voice my pain in this research.” (B21h)

And participants stated that they have used what they have learned through this research to help them feel calmer, more confident and that they are not alone in what they are doing.

“I have used what I learnt from being in this research. It was weird – it was like the research made me feel calmer. I had it in my head that everything is going to go ok. I was looking for opportunities to debrief, and took advantage of it when I could. This time I knew that I was not alone. I don’t think I would have had this feeling if I had not been involved in this research.” (I4.4e)

“I had some great feedback on my previous experience, and I got some ideas from other people’s experiences. This has helped me to be more confident in what I do for these women and their families, and how I take care of myself as well.” (I4.4g)
Participants have discovered and developed strategies to help them to reconcile the experience of caring for women through perinatal death and the emotions that they have lived through as a result. Participants’ descriptions of their stories indicate that they will not forget, but they do have a desire to grow personally and professionally.

This chapter has outlined the perceptions of participants to what makes perinatal death a catastrophe, their experiences of caring for women through perinatal death, and their thoughts around what can be and what has been learned. Participants’ viewpoints emerged as seven main themes, each with a number of subThemes. These findings shed new light on midwives’ experiences and highlight assumptions and new realities regarding education, learning, knowledge, emotional responses, competence, support and development. A number of important points arose from these findings which will be discussed in the next chapter.
Chapter 5: Discussion

5.1 Introduction
This study set out to explore midwives' experiences of caring for women during perinatal death, and what participants may have learned from their involvement. The overall aim was underpinned by four research questions. The first, what are midwives' perceptions of the catastrophic elements of perinatal death? The second research question asked, what do midwives learn following their involvement in perinatal death and how did this learning influence their practice? The third question, what does a midwife need personally and professionally to improve their capacity to care for a mother and her family through perinatal death? And finally, how does reflection and the reconstruction of meaning of the experience of perinatal death influence midwives' learning and their ability to examine and evaluate developmental needs for future events?

The methods used in this study to gather data yielded information that has allowed comprehensive interpretation of participants’ perspectives on these questions. With 17 midwife participants from different midwifery practice areas across Australia, the results may not be generalisable to all midwives, but have still revealed valuable considerations that may contribute towards preparing midwives for this difficult aspect of their role. As shown in Table 4, seven major themes revealed a rich picture of participants’ experiences of caring for women through perinatal death and the resultant perceptions of their learning, as well as personal, professional and educational needs. There are experiences and characteristics that were congruent with what has been previously published, while some findings are unique to this study. The findings, reported in the previous chapter, will be discussed in relation to the research questions and current literature, with consideration to using a critical realism lens to the interpretation of midwives’ experiences. This chapter will also introduce a model, based on outsider witness practices, which may be used to facilitate online and remote support, knowledge sharing or data collection activities in the future. Finally, the chapter closes with recommendations, limitations and conclusions.
5.2 Characteristics of the Sample
The sample of 17 midwives in this current study provided a wide representation of years of midwifery practice, from different geographical areas across Australia, and is comparable to Australian midwifery workforce statistics (Nursing and Midwifery Board of Australia, 2017) and to the samples in similar studies (Alghamdi & Jarrett, 2016; Cholette & Gephart, 2012; Jonas-Simpson et al., 2013; Jones & Smythe, 2015; McCreight, 2005; Montero et al., 2011; Roehrs et al., 2008). Similarities include a predominantly female workforce with an age range of 26 to 55 years, with most midwives having dual registration as both a nurse and midwife. The ratio of representation from the states and territories of Australia in this current study was also similar to national figures with one exception; that being the Australian Capital Territory (ACT), where participant representation was 11.8% (n=2) compared to 2% (n=646) in the Australian midwifery population.

When considering the sample of this study in relation to similar studies of midwives, obstetric nurses and doctors caring for women through perinatal loss, comparisons were made with studies that collected data using focus groups and/or interviews (n=12) (Alghamdi & Jarrett, 2016; Begley, 2003; Cholette & Gephart, 2012; Jonas-Simpson et al., 2013; Jones & Smythe, 2015; McCool et al., 2009; McCreight, 2005; McKenna & Rolls, 2011; Modiba, 2008; Montero et al., 2011; Petrites, Mullan, Spangenberg, & Gold, 2016; Roehrs et al., 2008). Sample sizes of these studies ranged from one to 50 participants (mean = 16.4). The majority, (n=10) had a sample size of five to 22 (mean = 14.6). Midwives, labour nurses and/or obstetric nurses made up the participants in nine of these studies, three of which were studies of only student midwives. The remaining studies were a combination of midwives and doctors (obstetricians and/or paediatricians). Interestingly, in those studies providing sample details, the range of age and years of experience were similar across all studies, including this current study. The majority of studies that included midwives only, collected data from female participants, with the exception being one male student midwife in one of the studies.

5.3 Experiencing the Catastrophe of Caring for Women Through Perinatal Death
Midwives in this study described their experiences of perinatal death in terms that reflected the catastrophic nature of the event, where the initial turmoil and impact of their losses
were significant for both the midwife and the woman. The notion of unexpectedness in connection to the concept of catastrophe was often raised by the participants and was multifaceted. Firstly, it related to the predictability of circumstances in which death can occur. Midwives in this study referred to perinatal death as being unexpected in so far as it was seen to be something that is not in the natural order of things. Moreover, midwives pondered whether society’s expectations, linked to cultural norms and technical and medical advances, add to this unexpectedness. Secondly, midwives in this study found perinatal death to be heartbreaking and devastating, describing a raft of raw emotions that they did not feel personally prepared for, and a depth of emotional response that was unforeseen. Thirdly, midwives in this study viewed perinatal death as a break from the expectations of the passage of life and parenthood. They regarded perinatal death to be a catastrophic loss of the family’s expectations related to pregnancy, birth and subsequent family unit.

5.3.1 The unexpected nature of perinatal death. A prominent theme throughout the findings in this study, and in the reviewed literature, was related to the experience of an unexpected death rather than the predictability or inevitability of death that is most often experienced in healthcare settings (Begley, 2003; Fenwick et al., 2007; Jones & Smythe, 2015; McKenna & Rolls, 2011). Midwives participating in the current study felt that they had been taken by surprise as they had an expectation of new life according to what is considered to be the correct sequence of birth, life and death. Although experiencing the death of any person under a health professional’s care may elicit a grief response, there is a greater likelihood for patient death to occur when caring for the severely injured, sick or elderly, making it an inevitable part of work. Babies, on the other hand, were viewed by study participants as resilient and well protected in-utero, making it difficult to comprehend or expect that a healthy person with no disease, accident or trauma can die.

The society in which we live has deemed perinatal death unacceptable, according to the participants in this current study. Participants believed the cultural expectation is one in which sick or old people will die, but a pregnancy will end in a live, healthy baby. The idea that perinatal death is determined by society to be unacceptable may cause additional conflict for the midwife. Similar concerns around cultural expectations were raised by Beck
et al. (2015) and McCool et al. (2009) who reported the way in which midwives expressed concern for the possibility of lawsuits following perinatal death. In a comparison of midwives’ experiences in developed and developing countries by McCool et al. (2009), midwives in developing countries held a fear that was centred around a loss of livelihood, humiliation and a risk of public exposure in the media as retribution for what society views as impermissible, rather than lawsuits noted in their counterparts in developed countries.

Participants in this current study speculated that society’s attitude toward the occurrence of perinatal death may be linked to living at a time of considerable technological advancement. Participants considered that living in a wealthy developed nation such as Australia, where medical science has advanced exponentially over the last 100 years, society finds it unacceptable that a well-developed baby with no congenital abnormalities does not outlive the parents, let alone they should die in the perinatal period. A similar expectation of cure was highlighted by Trankle (2014). Although his participants were doctors reporting on experiences of death in an Intensive Care Unit (ICU) setting, Trankle (2014) expressed the need to consider education at a cultural level to dispel this unrealistic anticipation of cure, a view also taken by Smith-Han et al. (2016). This apparent denial by society that perinatal death occurs is however contrary to statistics that shows that in 2015 there were 2849 perinatal deaths (9 in every 1000 births) (Australian Institute of Health and Welfare, 2017) and 2.6 million perinatal deaths globally (Lawn et al., 2016). Further investigation into the effects on midwives, as a result of society’s beliefs, may help to determine whether this denial of occurrence is a factor that influences the support offered, as well as sought by midwives. It is also conceivable that the perception that perinatal death should not happen may be an aspect to consider when exploring whether perinatal death is adequately addressed during initial entry to practice midwifery education and ongoing professional development opportunities. These two questions regarding support and midwifery education will be further considered later in this chapter.

5.3.2 Feeling unprepared for the depth of emotion. The unexpected nature of perinatal death appeared to exacerbate the myriad of emotions felt by midwives in this study, and enhanced the catastrophic aspect of the experience. The lack of personal preparation for dealing with perinatal death not only exposed midwives to raw emotions,
but the range and depth of their responses appeared to take them by surprise, leaving midwives in this current study in a position where they struggled to understand and cope with their responses. Similarly, midwives in a study by Jones and Smythe (2015) that explored the impact on midwives of caring for women through stillbirth also described finding that their emotions were difficult to contain and these participants felt overwhelmed by the depth of their grief and shock. An alternate consideration by McCreight (2005) in a study that examined nurses’ feelings and experiences when caring for parents who have experienced pregnancy loss was that, although their emotions were intense and needed to be managed, nurses saw these emotions as a resource rather than a weakness. This may be the case in the long term, however close to the event, midwives may be struggling to understand and cope with the intense extent of their responses, as indicated in a study by Fenwick et al. (2007), where participants, in sharing experiences of providing perinatal loss care, expressed the need to distance themselves from the woman in order to give themselves the time to deal with the acuteness of their affective reactions.

Emotional preparedness for perinatal death, or being better prepared for accurately forecasting emotional reactions, may be influenced by the notion of good deaths and bad deaths. In chapter two, I examined literature by Costello (2006); Jackson et al. (2005); Sorensen (2009); and Trankle (2014) in which nurses and doctors reported their experiences of death to be different if death was considered to be good (anticipated, tranquil, in comfort and control with time for care goals) (Costello, 2006; Sorensen, 2009; Trankle, 2014) or bad (unexpected, shocking, traumatic and lacking control) (Costello, 2006; Jackson et al., 2005). Participants in this current study confirmed this suggestion as they compared their experiences in other areas of nursing where death occurred, but was more expected, to the unexpected deaths that they had experienced in the perinatal period.

A number of highly emotionally descriptive adjectives and expressions were used by participants in the current study to relate the impact that caring for women through perinatal death left on midwives’ lives. Similarly, in other studies, midwives, nurses and obstetricians have expressed the impact as sad and distressing (Alghamdi & Jarrett, 2016; Beck et al., 2015; Fenwick et al., 2007; Jonas-Simpson et al., 2013; McNamara et al., 2017; Montero et al., 2011), regardless of the level of the midwife’s clinical experience (Alghamdi
Emotional responses reported by participants in this current study have also been documented in the majority of studies, reviewed in chapter three, of midwives’ experiences of perinatal death and other traumatic birth events. The most intense and frequent of these reactions were stress and shock, with other responses including sadness, guilt, self-blame, inadequacy, helplessness, withdrawal, depression, denial, anxiety, fear and lack of meaning (Beck et al., 2015; Jones & Smythe, 2015; McCool et al., 2009; McKenna & Rolls, 2011; McNamara et al., 2017; Montero et al., 2011). Additionally, the presentation of Post-Traumatic Stress Disorder (PTSD) and Secondary Traumatic Stress (STS) symptoms, also described in first responders and other health professionals who are exposed to death and dying, have been reported by midwives (Beck et al., 2015; Ben-Ezra et al., 2014). Although this current study did not specifically assess participants for symptoms of PTSD or STS, participants did describe reactions, such as anxiety, depression, guilt, sleep disturbances and hypervigilance, which support the presentation of these stress disorder related symptoms.

5.3.3 Breaking the natural order of birth, life and parenthood. Midwives in this study identified that, for parents, perinatal death broke with expectations around pregnancy and birth, resulting in a loss of the parents’ hopes, dreams and plans that had been made for the passage of pregnancy, birth and the future with a child as a part of their family. Participants described perinatal death as the worst time in a mother’s life; the pregnancy and beyond has been believed in, planned and dreamed about. Parents are expecting a baby, parenthood, to become a family unit and to enjoy and experience all of the associated growth and developmental milestones; similar thoughts to those expressed by midwives, nurses and obstetricians in a study by Montero et al. (2011) that explored these professional’s action strategies and difficulties faced in their approach to perinatal loss.

The lack of explanation for the occurrence of perinatal death added to the frustration and catastrophic quality of the experience for midwives in this current study. Participants reported feeling unprepared, both in terms of personal and professional responses, contributing to feelings of self-blame, self-doubt, role conflict, questioning of their professional ability and a loss of confidence and trust in the birth process. Consequently, midwives experienced vulnerability in their professional capacity, where their view of
themselves as midwives felt challenged, and for some, losing their desire to continue to practise as a midwife. Midwives in this study rationalised the absence of an explanation and acknowledged that answers cannot always be found; however, they remained frustrated and helpless in that, no matter what has been done right, a bad outcome resulted and some questions will never be answered, feelings also recounted by the midwives in studies by Fenwick et al. (2007); McCool et al. (2009); and Montero et al. (2011). A number of studies described midwives’ experience of role conflict as a result of attending to death and loss (Alghamdi & Jarrett, 2016), shaking their belief in midwifery and the birth process (Beck et al., 2015; McKenna & Rolls, 2011), and realising the unpredictable nature of midwifery (McKenna & Rolls, 2011). Conversely, Petrites et al. (2016) reported midwives proclaiming perinatal death to be unexplainable, but inevitable. This study by Petrites et al. (2016) was, however, conducted in Ghana, in a high perinatal death rate and low resource setting, which may explain why these midwives did not consider perinatal death to be unexpected.

The unavoidable reality of loss through perinatal death and the subsequent emotions experienced by a midwife are described by Cholette and Gephart (2012) using a case study design, in-depth examination of a single midwife’s experiences through observation, field note analysis and interview. The likelihood of encountering perinatal death as a midwife is high, according to Cholette and Gephart (2012), and one needs to be able to grieve and then continue on with providing care. This study, however, is drawn from the experiences of only one participant. Midwifery students also indicated that they believe that coping with and responding to stressful challenges is a part of being a midwife (Alghamdi & Jarrett, 2016), however, personal feelings of guilt do still remain even in the knowledge that it is not the midwife’s fault (Jones & Smythe, 2015; Nallen, 2007; Schröder et al., 2016; Wahlberg et al., 2017). Midwives in this current study reported holding themselves personally responsible, questioning themselves, their knowledge, skills, acts and beliefs; leading to self-blame even when a midwife has been competent in their practice.

The loss of confidence and feeling vulnerable in their competence as a midwife can result in repercussions for future practice. In this current study, midwives contemplated leaving the profession, and one participant did leave, although she returned to practise some years later. Midwives and obstetricians in the study conducted by McNamara et al. (2017) also
questioned their career choice as a result of caring for women through perinatal death, and some midwives also left midwifery following traumatic birth experiences (Beck et al., 2015). Participants in this current study expressed concern about becoming too interventionist, “struggling to find a balance between trusting birth and being hypervigilant” (Participant on the blog, B21p). This was also a concern considered by midwives and obstetricians in Ireland (McNamara et al., 2017). On the other hand, student midwives declared that the ability to endure stressful and traumatic situations was a ‘rite of passage’ in becoming a midwife; it is a part of a midwife’s professional identity and role (Alghamdi & Jarrett, 2016, p. 718). Midwives in this current study did agree to some extent, stating that there was the need to grow, develop and learn through the experience, to “learn to recognise those emotional responses in yourself and managing them when they need to be managed” (Participant in Focus Group 3).

On the whole, midwives do know and accept that perinatal death can happen. It is also likely that midwives would have learned about perinatal death in training/education, through experience or observation. However, there remains this real or perceived unpreparedness and opposition of expectations that adds to the turmoil felt by the midwife, leading midwives to question their professional view of themselves and of the birth process. Subsequently, participants in this current study were motivated to search for answers and strive toward better practice. Thereupon, midwives made steps toward developing an understanding of loss and grief in themselves and others, as well as realising that these experiences can be professionally motivating. Initially, midwives expressed the concern that there are gaps in their education, but once they began to recognise the normality of their emotions and reactions, growth and learning was realised. Further discovery through reflection on theirs and others’ stories helped the midwives in this study to discover the cathartic nature of sharing experiences with other midwives who have had the same experience.

5.4 Travelling the Road to Acceptance and Learning

The findings from narratives of midwives in this study has helped to provide an understanding of what can be learned from their experience of perinatal death, how this learning takes place and the outcomes of this learning. It is reasonable to expect that
participants will have travelled a personal learning journey before, during and after an experience of caring for a woman through perinatal death. Recounting their story as a part of this study, together with alternate views revealed by other participants, has built onto existing knowledge to emerge as new learnings and understandings; effectively evolving their learning and highlighting what has previously been learned or known. On analysis of the transcripts and field notes from this study, the manner in which new insights and learning transpired became evident. Firstly, as participants progressed in the telling of their stories through the blogs; secondly, by reading and elaborating on comments made in response to their own and others’ stories, and then finally, as they synthesised their learning when discussing their experiences in greater depth during focus groups and email interviews. For the most part, through these data collection activities, evidence emerged that participants had grown profoundly in their understanding of the bereavement suffered by parents. In like manner, they also reflected on their own grief as a person and a professional as they fostered greater comprehension and acceptance of their own loss and reactions to perinatal death. On reflection and acknowledgment of the normality of their reactions, participants described, in the focus groups and email interviews, the extent of how professionally satisfying it can be to care for women through perinatal death.

5.4.1 Acknowledging the depth of their attachment and loss. Caring for women in labour and through birth is an intimate and personal experience for both the woman and midwife. Participants in this study described caring for women as if they were their sister, daughter, niece or friend. As a result, midwives mourned the loss as if it was their own loss. Midwives are not always prepared for the extent of this personal attachment, loss and grief; however, midwives in this study have expanded their understanding of loss for the parents and for themselves, discovering the nature and depth of their personal philosophy and/or spirituality. The midwives in this study explained that midwifery is not just their job, it is a part of their lives, and they realised that consequently, something like perinatal death will affect them on a personal level as well. Midwives in this study recognised that the stress of the situation appeared to be compounded by midwives having to face the emotions of parents as well as their own, a discovery that supports similar findings by Fenwick et al. (2007) and Montero et al. (2011).
There was no doubt that the experience, for the midwives in this study, of caring for women through perinatal death, left an enduring impact. The way in which stories were told and the details recalled, whether they happened recently or over 30 years ago, revealed the extent of the impact, and subsequent enduring memories. Participants in this study learned of this significance when, at times, the grief and emotion was brought back to the surface when participants were talking about their own and others’ stories. Midwives established that they experience a grief that is not seen as belonging to them, is not their loss to openly grieve about. However, their own sense of loss was real, intense and deeply personal. Public sorrow, explains Jonas-Simpson et al. (2013), is for the woman and her family, while private sadness is for the midwife. On the other hand, participants in this current study contemplated that, for a midwife, the grief does subside in time; for the parent however, the grief will always be there in some form. Participants in this study also reiterated that although they are devastated and heartbroken, as a midwife they need to learn to be the strong one. Caring for families can be stressful, but in essence, the midwife must separate their own emotions in order to help parents get through their life-changing experience.

Similarly, Fenwick et al. (2007) noted that midwives found it necessary to separate from the mother initially so that the midwife could address their own emotions before being able to return and provide professional midwifery care. Although the midwife is exposed to intense emotions, McCreight (2005) also determined that midwives need to learn to manage these visceral reactions.

5.4.2 Learning to acknowledge compassionate care within a professional role.

Participants in this study discussed their understandings and feelings about whether it was acceptable or not, as a professional, to express one’s grief; displaying emotions in front of and together with the family. Some participants questioned whether it was a blurring of the lines between professional and personal experiences, and others expressed how difficult it is when a relationship with the woman has been developed and the midwife must separate their feelings of absolute devastation from their professional role. There were some participants who believed that the two should not cross; the midwife can grieve, but not in front of the parents.
Compassionate care is a cornerstone of health professionals’ work (Fry et al., 2013), however emotional resilience is paramount to protect healthcare professionals’ well-being and emotional coping (Kinman & Leggetter, 2016). Although compassionate care is an integral role for midwives, in some studies, and indeed according to some participants in this current study, it appears that there are midwives who consider compassionate care and professionalism to be polar opposites. Participants admitted that it was a struggle to keep professional and personal life apart. Achieving balance between compassionate and empathetic care while maintaining clear professional boundaries is believed to be an important aspect of professional practice, according to Wuthnow (2012). Midwives in the studies by Jones and Smythe (2015) and Puia et al. (2013) felt torn between dealing with parents’ emotional devastation while containing their own personal shock responses, trying to keep their feelings under wraps, but not always successfully. In contrast, compassionate care has been described as a deep awareness of, and desire to relieve, another’s suffering (Chochinov, 2007), a concept that has resonated throughout the narratives of midwives in this current study. Not all participants in this current study felt that grieving and professionalism had to be separated. In fact, some midwives in this study insisted that it was important to show grief and loss as it demonstrates a sincerity and authenticity to the bereaved parents. It communicates to the parent that it is tragic, it is a loss to the whole community and it is appropriate to be devastated and to grieve.

In my field notes, from the focus groups, I wrote, “it was almost like a sigh of relief”. This related to when there was uncertainty around whether it was professionally appropriate to cry and display emotion in front of the parents. Participants appeared to be relieved when they discovered that they were not alone in these thoughts, becoming more eager to discuss it further. There were similar responses to discussions around participant’s own grief. It was in such a way that the solidarity of similar experiences, insecurities and questions had given participants the permission to recount their feelings and experiences; subsequently learning that they are not alone in these thoughts and concerns. Participants were able to consider each other’s opinions and experiences to realise that the boundaries need not be so rigid.
In the literature, a range of responses is recorded as to whether it is professionally acceptable to show personal emotions in front of the family or not (Gardner, 1999), including contested understandings within studies (McCreight, 2005), as was the case in this current study. Some midwives were not sure that crying in front of parents was appropriate (McKenna & Rolls, 2011), while others suggested that one should detach, disconnect feelings, setting aside personal emotions and remaining strong for the family (Cholette & Gephart, 2012; Petrites et al., 2016) as it would be inappropriate to show emotions in front of the grieving parents (McCreight, 2005). Some midwives considered that feeling sad is a normal reaction to perinatal loss (Alghamdi & Jarrett, 2016), and felt that they could care for the family and openly show the grief that they are feeling (Gardner, 1999; Jonas-Simpson et al., 2013; McCreight, 2005); while others preferred to withdraw and avoid the woman (Begley, 2003; Jones & Smythe, 2015; Modiba, 2008), or just focus on physical care to avoid the emotional aspect and reduce anguish (Montero et al., 2011). Setting aside personal emotions to remain strong, or withdrawing and avoiding, may be defence mechanisms to guard against compassion fatigue that becomes easier with experience. However, as expressed by some midwives in this current study, withdrawing or maintaining professional distance is difficult due to the emotional involvement and personal relationship that develops between midwife and mother, a notion also depicted by McCreight (2005).

Looking after one’s self by distancing slightly from the woman being cared for, according to Cholette and Gephart (2012), is an important part of supporting bereaved parents; the ability to switch off one’s own emotions in order to manage providing care and support to families. Equally important, the midwife needs to acknowledge their emotions, take time to heal and grieve for the losses that have been witnessed, use self-care techniques such as reflection and access support systems (Cholette & Gephart, 2012). This concept of self-care and developing self-compassion was considered by Beaumont, Durkin, Hollins Martin, and Carson (2016) and Sorenson, Bolick, Wright, and Hamilton (2016) to be instrumental in reducing stress, and equipping midwives and other health professionals to provide compassionate care with reduced risk of compassion fatigue. Systems of self-care, such as mindfulness stress reduction training (Cacciatore, 2012; Foureur, 2013; Manzella & Papazoglou, 2014) and compassionate mind training (Beaumont et al., 2016; Beaumont & Martin, 2016), were described in chapter two. Embedding self-care programmes across initial midwifery education and ongoing professional development may prove, following
evaluation, to be beneficial in strengthening compassionate care, reducing compassion fatigue and resisting stress related conditions.

It was interesting to note the reaction to a more intricate mixing of personal and professional lives when a midwife is pregnant and caring for a woman through perinatal death. A story on the blog detailed one participant’s experience while pregnant herself. This participant felt the need to withdraw from caring for the woman so that her own pregnant state would not cause further distress to the woman. The opposite eventuated with the woman preferring to be cared for by the pregnant midwife. This participant was surprised by the subsequent questions and comments to her story by other participants who asked if the stress of this event had been influential in her own pre-term onset of labour. It is consequential to consider the care and concern toward the woman experiencing perinatal death as well as the protectiveness toward a colleague and apprehension that exposure to such stress may have been influential in the outcome of the midwife’s own pregnancy.

A similar protectiveness toward colleagues was described in a study by Hutti et al. (2016). Participants explained that some maternity units have an unwritten policy to shield pregnant colleagues from the pain of perinatal death, excluding them from caring for women through perinatal death. In this same study, labour and delivery nurses described how emotionally draining it was when having to switch between a grieving family in one room to a joyous one in the next (Hutti et al., 2016). Nurses in a study by Roehrs et al. (2008) conveyed the importance of not getting mixed up between the room in which to be happy and the one in which to be sad. This too suggests maintaining a strict separation between women who have birthed live babies and those who have lost theirs; not even letting the one see the emotion that the midwife is experiencing with the other. These examples further illustrate the importance of the concept of emotional labour as a part of a midwife’s role, as discussed in the reviewed literature in chapter two, and may also be intensified by midwives’ concerns regarding the boundaries between professionalism and displays of emotion. Perhaps the realisation of a freedom to express emotion as a part of compassionate care may enable midwives to manage their own grief, fear, guilt and questioning of competence; or as Beaumont et al. (2016) described, midwives would benefit from being kinder to themselves. One could also contemplate whether the mistrust in the
birth process expressed by participants may be an underlying factor in midwives’ attempts to protect pregnant midwives and women who have lost a perinate from each other.

5.4.3 Learning about support. Midwives in the current study realised the importance of support to a midwife when caring for a woman during a devastating event such as perinatal death. By the agency of sharing experiences, participants in this study learned that the type of support received can be a strong determinant for the manner in which a midwife copes with the situation, both then and in the future. The most effective and meaningful support came from colleagues, and participants in this study agreed that midwives who had experience in similar encounters had the understanding required to provide more effective support. Midwives participating in this study learned that not all midwives received support, and some were left to fend for themselves under difficult circumstances. Participants were horrified to learn of some midwives’ experiences, expressing the need for midwives to learn to be kinder to each other and offer collegial support. Participants discovered that not all organisations offer the same level of support, but all agreed that it was vital.

An interesting factor to consider could be in what determines availability of, and engagement in support. Considering cultural denial of perinatal death that was posited to be an influence on the support received by midwives, together with participants’ suggestion that friends and family and people in general only want to hear and believe that a midwife’s work is about joy and life, support for midwives may not be forthcoming. Midwives expressed finding it a struggle to explain the poignant aspects of midwifery to others and contemplated whether it was because they were struggling to make sense of it themselves or, as Jones and Smythe (2015) suggested, because telling others makes it more real. Perhaps these factors all have an influence on support. Not only in terms of the expectation of friends, family and society in general that perinatal death does not and should not happen, rendering support unnecessary, but also from midwives themselves. If midwives do not see the loss as theirs to grieve; feel that they must be professional and carry on; cannot describe experiences to family and friends and admit to needing support, then midwives are unlikely to seek support.
Irrespective of the rationale, support for midwives following their care of a woman through perinatal death is mixed. In this current study, all participants mentioned varying degrees of inability to talk to friends or family, citing the explanation to be that people who are not midwives just do not understand. Support in this study ranged from good and caring support from colleagues and supervisors, to a rather unpleasant experience of overt hostility and blame. Participants in this study valued support from colleagues on the occasions that it occurred. Similarly, obstetric nurses in the study by Puia et al. (2013) valued informal support from peers, and Beck et al. (2015) explained that support from the entire obstetric team was helpful; however, not all midwives received support and reported feeling abandoned and betrayed. Literature does show a mixture of support (Cholette & Gephart, 2012; Fenwick et al., 2007; Jonas-Simpson et al., 2013; McKenna & Rolls, 2011) that is often absent or insufficient (Begley, 2003; Chan, Chan, & Day, 2004; Fenwick et al., 2007; McNamara et al., 2017) resulting in a call from midwives for a safe forum to be able to “unburden our souls” (Beck et al., 2015, p. 21).

Support is one of the coping strategies reported by midwives in this current study as vital to enable a midwife to care for women who experience perinatal death. The midwives in this study spoke of the necessity of other coping mechanisms, such as reflection and debriefing, strategies also highlighted by Alghamdi and Jarrett (2016); Gardner (1999); McNamara et al. (2017). Moreover, what I found noteworthy was the discovery by participants of the cathartic nature of their participation in this current study, which indicated sharing and reflecting on their and others’ stories has aided the discovery of new realities and meaning. All participants, either at the end of the focus group or during the email interview, described the study as invaluable to their journey to learning and acceptance. No specific question elicited this response. For the most part, it was expressed on closing the focus groups and interviews when participants were asked if there was anything further that they wanted to share. One participant stated that this was the first time that she had spoken about her experience and several participants mentioned that it had been their first opportunity to talk to others who have had similar experiences. Other participants found that it was “kind of therapeutic to read through other people's experiences and just go ah yeah, okay I get that”. (Participant in Focus Group, FG2.7a). Participants in this study suggested that, although the resources and availability for support is known, the time to engage in these
support or development activities is often not available. One could contemplate whether the idea of support and debriefing may be something that a midwife knows they need, but the requisite conditions to actually seek out and engage in support are required. Perhaps the factors discussed, such as confidence in competence, guilt, denial, cultural denial, fear of others not understanding or preference for withdrawal, may influence the midwife’s decision not to actively seek and engage in supporting and debriefing activities.

5.4.4 How midwives envisage learning taking place. A focus, both in literature and for the participants in this current study, remains on education and training being the ‘go to’ solution. In reality, death on any level is not something that can be fully prepared for in the classroom. The perception of unpreparedness in this way may render a midwife ill-equipped to face their resultant raw emotions, and leaves the midwife searching for meaning, and for validation of both themselves and their midwifery practice (Jones & Smythe, 2015). Perhaps this is why midwives consider that further education will be of benefit. Midwives in the current study have contemplated their own and others’ stories and have described the value of learning which has taken place through observation, through their own experiential learning, and in the sharing of experiences between midwives.

Participants in this current study considered that their midwifery education had not adequately prepared them to care for women through perinatal death, a sentiment that echoes a number of other studies (Begley, 2003; Gardner, 1999; Modiba, 2008; Roehrs et al., 2008). Participants in the current study stated that, within their midwifery education, there was discussion around what can go wrong in pregnancy and labour, but they felt that there was a lack of education in knowing what to expect, how to respond and how to express one’s own grief; the social aspect of care or bereavement counselling were also lacking, similar findings to those by Chan et al. (2004); Chan et al. (2005); Chan et al. (2007); Gardner (1999); Jonas-Simpson et al. (2013); McCreight (2005) and Montero et al. (2011).

A positive attitude was displayed toward bereavement care by Chan et al. (2008), with age, experience in caring for grieving clients and bereavement care education identified as significant factors in predicting attitudes. In the study by Chan et al. (2008), 40% of obstetric nurses in Hong Kong reported having received bereavement care education. Although this
may be true, 90% of these obstetric nurses still indicated a need for further skills, knowledge and understanding in the care and support of bereaved parents. Similarly, McNamara et al. (2017) reported that 82% of midwives and obstetricians had received no education in intrapartum death and 94% had no education in self-care strategies, with 84% advocating for this to be offered. Participants in this current study all agreed that their education in the care of women through perinatal death was based on how they observed other midwives’ approaches to these cases.

Midwives participating in this current study actively sought further education subsequent to their experience of caring for a woman through perinatal death. To demonstrate, one midwife reported having looked into what sort of degree she would need in order to become more of a specialist in the area of perinatal death. She concluded that a social work degree was required. Ultimately, relevant grief counselling skills focusing specifically on the loss of a baby would be relevant to midwifery, a unique area of health care. These skills could be taught to midwifery students in the same way as is provided in the social work degree. Participants’ observations were that a midwife’s first encounter with perinatal death occurs predominantly as a student or early in practice. Correspondingly, topics such as bereavement care, general information on what to expect, what the baby or fetus may look like, services that can be offered and accessed, should be addressed in the initial midwifery education. The majority of midwives and obstetricians in a UK study by Heazell et al. (2016) postulated similar suggestions, emphasising the requirement for education and professional support, particularly in psychosocial care and communication skills. In their evaluation of the effectiveness of an interactive workbook in equipping student midwives with perinatal bereavement care knowledge, Hollins Martin et al. (2014) also noted a difference when midwives have been exposed to real-life experiences. The mean Understanding Bereavement Evaluation Tool (UBET) scores were higher in third year students compared to second year students, suggesting an influence as a result of greater experience in the clinical practice environment (Hollins Martin et al., 2014). Although participants in this current study supported the need for further education in perinatal death care, they also accentuated the necessity for support afterwards to help a midwife to make sense of and grow from the experience.
Even with a good theoretical background, participants in this current study believe that it is not real until after one has personally had the lived experience of caring for a woman through perinatal death. Midwives in New Zealand explained that these types of practice experiences cannot be taught and will be interpreted by each midwife in their own unique way (Jones & Smythe, 2015). The disquiet surrounding the paucity of education and training received in the midwifery courses of participants in this current study were mostly discussed in the blog and early parts of the focus group. As the focus group discussions progressed, and then into the interviews, participants admitted that the theoretical preparation for death would have been attended to in their initial midwifery training. In this light, participants reflected and contemplated the means by which learning had taken place as a result of their own and others’ experiences. Significantly, participants described opportunities where they learned from more experienced midwives, as well as subsequently teaching inexperienced midwives and students themselves.

Once midwives in this current study had gained more experience and confidence for themselves, they reported having positive teaching opportunities with other midwives. One participant recounted encouraging student midwives to join her at a time with the baby when she could educate them about pregnancy loss without parents present, allowing them to ask the questions that they need to without offending the families. In this way, the midwife was also able to let novice midwives see and hold the baby, getting used to the sight in a gentle way, rather than in the heat of the moment in a birth that they may not be prepared for. Other participants described more experienced midwives doing similar for them, sharing a wealth of knowledge and experience in a hands-on approach that cannot always be gained from a textbook or classroom. Student midwives revealed that they considered the only way to be more prepared for perinatal death was through experience; through direct observation and participation (Alghamdi & Jarrett, 2016). Labour nurses in a study by Roehrs et al. (2008) explained that they felt comfortable in providing care for grieving families due to their extensive experience in caring for those suffering loss. Participants in this current study illustrated alternate sources valuable to learning, such as parents who have experienced perinatal loss returning to describe to midwives the positive and negative aspects of care that they received. All participants reported growth, learning and development of their practice owing to their experiences, reiterating that what a
person learns when something truly horrible has happened, helps in all aspects of midwifery practice.

5.4.5 Harnessing the experience of others. Participants in this study affirmed the requisite for a person to have undergone similar experiences to be able to fully appreciate and understand all that is involved in caring for women through perinatal death. Confidence improves in the light of experience; correspondingly, participants in this study outline learning by virtue of exposure to and involvement in this devastating area of care. The most valuable learning depicted by participants in this study appears to be based on interacting and communicating with midwives who are experienced in caring for women through perinatal death, a similar discovery to that by Rondinelli, Long, Seelinger, Crawford, and Valdez (2015) and by McCreight (2005) who determined that collective bodies of knowledge already inherent in practicing health professionals could be shared by practitioners for the good of those in their care.

Participants in the current study did not explicitly state that this was their best learning, but the profundity of narrative descriptions in the focus groups and email interviews disclosed the value placed on this method of learning, as well as the evident respect shown towards more practised colleagues and mentors. Markedly, nurses in the study by Rondinelli et al. (2015, p. 161) placed significant emphasis on the processes of “experiential knowing”. The experiences acquired professionally while providing bereavement care, as well as personally as a result of their own loss, allowed nurses to better understand role expectations and provide perinatal bereavement care more comfortably and confidently. The descriptions shared by participants in this current study, as well as those in prior studies, suggests that with experience comes confidence, the ability to recognise that one’s emotional reaction is normal, attainment of understanding of the loss and grieving process, and less apprehensiveness in offering support to women; to the end that a sense of satisfaction in one’s ability to competently care under catastrophic circumstances is achieved.

It is apparent that the experience, this collective body of knowledge, must be harnessed to be able to expertly help midwives to, not only provide care amidst such catastrophes, but for themselves to be prepared both personally and professionally. The question however is,
how can this be done? In chapter two the possibilities of simulated learning were explored. In reality, catastrophic situations are often unexpected, stressful and complex occasions involving individuals who may respond quite uniquely according to their own psychological, physical, emotional, and spiritual characteristics, as well as based on previous experiences and personal traits (Borodicz & Van Haperen, 2002; Williams, 2005). Foreseeably, perinatal death would be the type of scenario that is fraught with difficulties when set up as a simulated learning experience. Simulated mortality was, however successfully implemented as a learning tool for resident anaesthetists, as reported by Goldberg et al. (2015).
Conceivably, the exploration of how to harness midwives’ experiential knowledge in a manner based on the concept of simulation using storytelling and actors, should be considered as one of the possible next steps to follow this current study.

5.4.6 The outcomes of learning. In the sharing of their story and talking about their and others’ stories on the blog and in the focus groups, participants contemplated the positive and negative effects of their experiences on future practice. Encountering perinatal death, re-telling the experience and listening to the experience of others appeared to help midwives to reflect on their own experience more thoroughly. Henceforth, participants reported being inspired to improve their skills, knowledge and midwifery practice. Accordingly, a proactive search for learning and professional development was kindled. Participants revealed that their pursuit of learning, as a result of perinatal death, not only led to them becoming more confident and competent, but also to personal and professional satisfaction. In like manner to when participants first broached the question of displays of grief and professionalism, initial mention by participants of caring for women through perinatal death being professionally rewarding was tentative. When a participant alluded to considering the provision of care to a woman through perinatal death as professionally fulfilling, they began with phrases along the lines of: “this may sound a little strange, but ...”. Thereupon, participants realised that they were not alone in feeling this way, and discussions regarding professional satisfaction became more comprehensive.

Midwives explained that it is a privilege to be able to support parents enduring the death of their baby, a sentiment also expressed by Heazell et al. (2016). It is a rewarding experience that inspires change and growth, seeking answers and aspiring to develop the knowledge
and skills that midwives considered they lacked (Jonas-Simpson et al., 2013; Petrites et al., 2016). Midwives in another Australian study by Fenwick et al. (2007) voiced similar sentiments of professional satisfaction, stating that as the primary carer in a continuity of care model, it allowed them to work to the full extent of their skills and qualifications. These same midwives extrapolated further, regarding it to be a privilege to be a part of this unique life and death journey, making a difference in the lives of those in their care (Fenwick et al., 2007).

Participants have learned as a result of their experiences of caring for women through perinatal death and found new understandings and meaning in the undertaking of this study. In chapter two, I described the phases of learning outlined by Mezirow (2009), reviewed the transformational learning in online environments findings of Dirkx and Smith (2009), and detailed how storytelling, according to Tyler (2009), meets the conditions for critical discourse and learning (Mezirow, 1991). Storytelling and subsequent learning and discovery of new understandings and meaning by participants in this study not only confirms the outcome of transformational learning through storytelling, but also demonstrates the value of an online environment to recognise, harness and share the learning that has taken place. Equally important, participants in this study questioned the extent to which they had been prepared educationally to be able to care for women through perinatal death. As a result, each participant explained a process of seeking further knowledge and skills following their experiences of caring for women through perinatal death.

One has to consider to what extent the shock, stress and unexpectedness, and subsequent insecurity in ability, is an influencing factor on the initial consideration for midwives that they have not had sufficient education in this area. The fifth condition for critical discourse and learning described by Mezirow (1991) centres on a person’s ability to reflect critically on presuppositions and their subsequent effects. As a part of the storytelling, reflection and exploring of participants’ experiences in this study, midwives came to understand the inevitable limitations of initial education and the importance of continued learning and development through their own and others’ experiences. Perhaps this realisation will drive a
desire in novice practitioners to procure as much experiential learning from others as possible.

5.5 Learning Through the Research Process

I found it consequential that across the sequence of data collection methods, respondents appeared to progressively provide thicker descriptions of their experiences when having the time, space and confidence to re-examine their realities. A concept first described by Gilbert Ryle in his series of lectures, papers and essays published in 1971 (Ponterotto, 2006), thick descriptions are not merely an outline of an occurrence, but “our own constructions of other people's constructions of what they and their compatriots are up to” (Geertz, 1973, p. 9). Thick descriptions have subsequently been described as going beyond just the surface appearances to include detail, context and emotion to establish the significance of an experience; interpreting within the context, and ascribing thinking and intentionality (Braun & Clarke, 2013; Denzin, 1989; Ponterotto, 2006). The initial telling of experiences by participants, as stories that were presented in the blog, tended to be a presentation primarily of facts and sequence of events in a fairly clinical manner. Thicker descriptions of the questioning, self-doubt and raw emotions began to emerge as the other participants commented and empathised. The focus groups that followed also revealed thick descriptions, as defined by Denzin (1989) and Braun and Clarke (2013), of the unexpectedness and emotional turmoil, as well as consequences and outcomes, as participants discussed and re-told stories and commented on similarities, differences and how others’ stories made them feel.

5.5.1 A model for data collection based on outsider witness practices. Data collection for this study using an online discussion forum was built around the critical incident task described by Francis (2004), which is based on double loop learning theory proposed by Argyris (2002). The decision to follow up the blog discussion with focus groups grew from the need for greater engagement in the stories from participants to explore their experiences and thoughts in more depth. I considered that the opportunity to engage more personally with fellow participants who have similar experiences would encourage thick descriptions (Denzin, 1989). Individual email interviews concluded data collection as further elucidation, clarifying details shared on the blog and during the focus groups. When
planning and implementing data collection for this study, the practices of reflecting teams and outsider witness practices was not drawn upon. On analysis, however, the findings revealed connections that may be drawn to outsider witness practices. This serendipitous perspective may offer new ways of seeing problems and potential solutions and has the capacity for development into a model for support, debriefing, knowledge sharing and development, as well as data collection strategies.

Outsider witness practice has been drawn from the practices of reflecting teams and narrative therapy. Reflecting team practice grew out of family therapy practices and more recently have been applied to a variety of settings, including training (Cox, Bañez, Hawley, & Mostade, 2003), academic support (Morrison, 2016), supervision (Fox, Tench, & Tench, 2002), and helping nursing students to go beyond the stereotypical beliefs of mental illness (Morrison, 2009). There is congruence in reflecting team practice with social constructionist theory (Biever & Gardner, 1995; Cox et al., 2003), described in chapter two, where perceptions of reality are constructed through one’s interactions with others (Cox et al., 2003). Thereupon, the interactions with outsider witnesses serve as a stimulus for reflection on one’s stories from alternate perspectives that may result in new answers and realities.

Outsider witness practice, described by Fox et al. (2002) and Morrison (2009, 2016), begins with a story narrated to another person (interviewer; step 1), and witnessed by a small group of others (outsider witnesses). The interviewer asks the outsider witnesses about aspects of the story that they have heard, and the person who told the story witnesses this re-telling of the original story (step 2). This process often elicits new layers and meanings to the story. The interviewer re-interviews the original story teller (step 3), who reflects on the new ideas that have emerged from the outsider witnesses. Using this description, and illustrated by figure 5, a model for remote data collection can be described, drawn from outsider witness practice and based on the data collection for this current study.

Participants were asked to write their story of an experience of caring for a woman through perinatal death, to be made available on the blog (a telling; step 1; narratives shared and discussed on the blog and in focus groups - spirals in figure 5). The rest of the participants (outsider witnesses) reflected on the story using the key questions described by Francis (2004). These reflections were written as comments on the blog to that particular story
(step 2; first spiral in figure 5). On completion of the group blog activity, focus groups were conducted in which participants had the opportunity to reflect further on their own and others’ stories, as well as on the feedback and comments that had been made to the stories (extension of step 2; second spiral in figure 5). This exploration of the stories in greater depth by all participants through blog comments and focus groups, illustrated by the spiral in figure 5, can be related to the re-telling of the story by the outsider witnesses (step 2), enabling adaptation and learning. Finally, individual interviews were conducted with participants by email (step 3), allowing the researcher to ‘re-interview’ the original story teller, reflecting on the new ideas and realities (three arrows in the model in figure 5), resulting in emergence.

Figure 5. Model of data collection related to outsider witness practice. This figure illustrates a model for remote data collection based on outsider witness practices.
One of the benefits of outsider witness practice is the creation of new answers and possibilities (Andersen, 1987). Reflecting on the findings in this study, I can see that the participants have described a situation of perceived chaos that may have shattered their current perspective; they progressed through processes of adaptation borne on the recall of bare emotions, frustrations, anger, helplessness and self-doubt. Participants discovered that they were not alone in this experience and realised that they had emerged with new ideas, realities and understandings. Participants were able to consolidate the experience and find meaning; even finding it to be a rewarding aspect of their work despite the intense emotion and self-doubt. Participants learned that they have personal strength and courage, and the desire to strive to further develop their knowledge and skills. Along the journey the nature and degree of support received varied, a reality that would be present in most of life’s situations and has been shown to be comparable in other professions in similar situations. The realisation for participants of the cathartic nature of involvement in this research appeared to cultivate acknowledgment and resonance with the lives of others. In essence, perinatal death will remain a catastrophe. Nonetheless, the potential for facilitated emergence and understanding for midwives may be key to ensuring that the short existence of the lives of these babies has been instrumental in midwives’ personal and professional development.

5.6 Recommendations

5.6.1 Recommendations for policy makers. Support was mooted to be vital at all stages of midwives’ care for women through perinatal death. Organisational policy should not only explicitly reflect the support opportunities available, but actively encourage the provision of support as well as engagement by midwives. The findings from this study suggest that factors such as society’s attitude toward perinatal death, midwives’ considerations of their own confidence, competence and culpability, as well as time and opportunity to engage, may influence provision and acceptance of support. These factors could be counteracted through a culture of support instilled within organisational policies and procedures.

The personal and professional reactions of midwives are based on a caring and protective philosophy toward women with whom an intimate and like-minded relationship, in terms of
childbearing, has developed. As has been evident in this current study, as well as other studies, this is not restricted to women in a midwife’s care, but to colleagues too. It may be necessary for organisational policy to guide and structure these professional, protective and nurturing attitudes to enable midwives to provide compassionate care within organisational codes and values as well as midwives’ own professional expectations. In effect, fostering an environment that allows midwives to be with the woman in the moment, provide practical and emotional support to colleagues, and be mindful of compassion fatigue.

Participants in this current study outlined a coordination system that has been implemented in some maternity units to varying degrees, sometimes officially, but mostly just by an experienced midwife who feels passionately about care through difficult birthing related situations. Piecing together the roles and help offered, as explained by participants, there may be scope to suggest the establishment of the availability of an experienced midwife or group of midwives who can mentor novice or less confident midwives. Possibly a coordinated approach may establish the availability of further education, formal and informal debriefing, procedure tips, tools and resources, the arranging of cover to allow time for counselling, debriefing or further education, follow-up care for the family, and further research. As the story telling approach used in this study proved to be effective in promoting reflection and finding new understandings and meaning for the midwives in this study, perhaps engaging in similar activities, such as debriefing and professional development, may also prove beneficial to other midwives. The online forum approach implemented in this current study could be replicated to counteract the administrative difficulties associated with time, place and opportunity. The model proposed as a result of combining the data collection strategies employed in this study with the principals and practices of outsider witness practice may prove to be valuable as a debriefing forum, research method or professional development platform. Participants mentioned limitations of time and place as instrumental to engagement in support, debriefing and professional development; and yet, an online forum would allow midwives to access these at their convenience with other midwives nationally and even internationally.

5.6.2 Recommendations for education and research. A prominent concern expressed by midwives in this current study, as well as in previous studies, centres on a
perceived lack of preparatory education and training in perinatal death and bereavement care. When looking beyond these surface (or empirical strata) considerations to gain a deeper understanding (the actual strata), it could be considered that the gap lies in the conversion from theoretical knowledge and skill development to authentic lived experience. Further research would be beneficial in determining a way to promote an awareness of a collection of knowledge and experience already available and to harness these lived experiences of practising midwives, instilling a sense of preparedness in novice midwives. Although not a replacement for the learning that occurs through experience, it may be valuable to investigate the potential for simulation into perinatal loss education. Only a few studies have explored the possibilities that simulation could hold for students and novice practitioners to learn about situations where death occurs; perhaps extending simulation into perinatal death would reap benefits across professions.

Simulation traditionally evolves around the reproduction of real life scenarios or situations in a controlled and secure environment. This could be problematic on a few levels for perinatal death. Perhaps simulation based on events such as perinatal death could take on a narrative approach influenced by a model similar to this study’s suggested outsider witness adaptation. For example, the wealth of experiential knowledge of practising midwives could be disseminated following the proposed model in either an online or face-to-face forum. Combinations of experienced, novice and student midwives would enable new understandings to emerge as well as existing knowledge to be shared. The sharing and discussion of narratives need not be restricted to midwives, but can also tap into the experiences of mothers.

5.6.3 Recommendations for clinical practice. Preparation to manage perinatal death should be an ongoing process based on contemporary research and educational principles. The recommendations for education and research discussed may provide a starting point for dissemination and implementation into the clinical practice area. The expertise and experiences of midwives has been noted in this study to be highly valued by participants. Harnessing and sharing this knowledge and skill could be achieved through debriefing forums, simulation, mentoring and supervised rehearsal.
The irregularity and inconsistency in provision of support for midwives participating in this study suggests the requirement for the development of a referral pathway for support. The findings from this study, as well as other research findings, demonstrates variance in support of positive, absent and unsatisfactory experiences. Further analysis and interpretation of midwives’ narratives from forums, debriefing and mentoring sessions may yield data to establish a consistent referral pathway that could direct a midwife to the most appropriate formal and/or informal supports. The type and method of support, for example, de-briefing, mentoring, counselling, further education or clinical supervision, could also be gleaned from analysis of midwives’ experiences.

Taking into consideration the cathartic effect of involvement in this study noted by participants, and the successful implementation of an online forum that may be adapted for use as debriefing, group experience sharing, further research data collection or professional development, an online support hub may prove beneficial. An online platform that is easily accessible from work or home could hold information, pathways for support and professional development, self-diagnosis and screening of stress related conditions using psychometric scales to help staff make sense of their own mental state. There are multiple brief assessment and screening tools with established reliability and validity available for free or at low cost (Beidas et al., 2015). These brief psychometric scales include instruments to assess for symptoms of anxiety, depression, overall mental health and screening for symptoms of trauma (Beidas et al., 2015). A pack of self-diagnostic psychometric tools could help midwives to identify relevant referral pathways and enable midwives to connect to appropriate resources or sources of support.

5.7 Limitations

This study has provided insights into potential learning that may take place for a midwife caring for a woman through perinatal death. Valuable understandings have been highlighted to consider what may be impeding the recognition of learning and how this obstruction could be overcome. The findings have also added support to the body of knowledge of midwives’ experiences of, and reactions to, perinatal death. There are, however, limitations within the study related to response, sample and methodological design.
It must be acknowledged that this study is just a snapshot of the experiences of midwives in their care of women through perinatal death. A number of extraneous factors may influence a midwife’s experience and recall of the experience. Some examples of extraneous factors may include the number of times this has occurred, experience level as a midwife, personal factors that may influence a midwife at the time, the possibility that time may change the memory of events, organisational cultures and the model of midwifery care followed within the organisation. Although it would be beneficial to evaluate the influence of these factors, it is not within the scope of this study.

Midwives described losing their desire to continue to practise as a midwife, and one participant left the profession for a number of years. This participant had however returned to midwifery practice before taking part in this study. All of the participants were practicing midwives, therefore precluding the experiences of midwives who have left the profession. This is an important group and their experiences and reasons for leaving midwifery must be recognised and explored. Greater understanding as to why midwives leave the profession may contribute to better support for midwives, particularly those who provide care to women experiencing a perinatal death but, due to the experience, actually leave midwifery.

This study was limited to midwives practising in Australia, a developed country with relatively similar rates of perinatal death to equivalent developed countries (Flenady et al., 2016; Lawn et al., 2016). Be that as it may, this study’s sample was representative of the national midwifery workforce of Australia. Previous studies have indicated similarities and differences between midwives’ experiences in developed and developing countries (McCool et al., 2009; Modiba, 2008; Petrites et al., 2016), and comparisons have been drawn with the findings from this current study.

5.8 Conclusion
Midwives have a profound desire to be able to provide effective support to women who have endured perinatal death. For this reason, midwives in this study sought the tools to accomplish their personal and professional intention. Midwives in this study believed that they did not have adequate education or training in perinatal death. On the other hand, midwives discovered a wealth of learning and learning opportunities from within their own
experiences and from the experiences of more accomplished midwife colleagues. If we can peel back the layers of the grief response, there is an abundance of knowledge and learning to be found. The devastation of the circumstances, concerns about behaving professionally and competently, and having an awareness that this is the parents’ loss and not their own is not conducive to seeking the learning that midwives may have achieved amidst such a catastrophic event. Providing the space for a midwife to reflect on and observe their experience from different perspectives has the potential for the discovery of new meanings, new understandings, and for the realisation of learning and growth that has facilitated understanding and emergence. Further investigation into the harnessing of this experiential knowledge may benefit midwives in developing the manner in which they learn about caring for women through perinatal death, as well as their own and others’ support and learning.


Australian Copyright Council. (2017b). *Websites and user-generated content*. Australian Copyright Council Retrieved from


Black, D., Hardoff, D., & Nelki, J. (1989). Educating medical students about death and dying. *Archives of Diseases in Childhood, 64*(5), 750-753. doi:10.1136/adc.64.5.750


Emmett, D. J. (2011). *Student engagement with an eportfolio: A case study of pre-service education students*. (PhD), Queensland University of Technology.


Kim, Y., Huang, J., & Emery, S. (2016). Garbage in, garbage out: Data collection, quality assessment and reporting standards for social media data use in health research, infodemiology and
digital disease detection. *Journal of Medical Internet Research*, 18(2), e41. doi:10.2196/jmir.4738


Laing, R. E. (1999). *The experience of registered nurses nursing patients after intra-uterine death*. (Bachelor of Arts Honours in Psychology), University of Port Elizabeth, Port Elizabeth.

Laing, R. E. (2004). *Accompaniment needs of nursing students related to the dying patient*. (Magister Curationis), University of Port Elizabeth, Port Elizabeth.


Muessig, K. E., Nekkanti, M., Bauermeister, J., Bull, S., & Hightow-Weidman, L. B. (2015). A systematic review of recent smartphone, internet and web 2.0 interventions to address the...


Pezaro, S., Clyne, W., Turner, A., Fulton, E. A., & Gerada, C. (2016). ‘Midwives Overboard!’ Inside their hearts are breaking, their makeup may be flaking but their smile still stays on. Women and Birth, 29(3), e59-e66. doi:http://dx.doi.org/10.1016/j.wombi.2015.10.006


Thomas, D. R. (2016). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology, 1*-17. doi:10.1080/14780887.2016.1219435


List of Appendices

Appendix A: ACM e-bulletin and Facebook expression of interest to participate
Appendix B: Personal Inventory Questionnaire (PIQ)
Appendix C: ACM Midplus CPD points approval
Appendix D: Participant Information Letter
Appendix E: Participant Consent
Appendix F: Murdoch University Human Research Ethics Committee Study Approval
Interested in sharing

your experiences around perinatal death

whilst also receiving 5 CPD points?

I will be conducting a study that aims to examine midwives' learning responses to perinatal death and help you to reflect on how you learn through stressful incidents.

If you would like to participate you would be required to take part in an online blog activity and an interview by email.

To take up this opportunity please contact Robert at midwife.learning@gmail.com or on 0415351687.

If you think this project may be of interest to other midwives please feel free to either circulate or place a copy of the invitation in your workplace.
Appendix B: Personal Inventory Questionnaire (PIQ)

Personal Inventory Questionnaire

Responding to catastrophe: Learning from perinatal death

Please answer the following by placing a ✓ in the most appropriate box (left double click on the box and select ‘checked’, then click ‘OK’)

I am Registered as a Midwife with the following:

☐ Australian Health Practitioner Regulation Agency
☐ Midwifery Registration Authority in another country. If yes, please specify:

Country: __________________________

Sex
☐ Female
☐ Male

Age
☐ 18 to 25
☐ 26 to 35
☐ 36 to 45
☐ 45 to 55
☐ over 55

I have been a Registered Midwife for

☐ 2 to 5 years
☐ 6 to 10 years
☐ 11 to 15 years
☐ over 15 years

Are you currently practicing as a Registered Midwife?

☐ yes
☐ no

Approximately how many patients have you cared for through perinatal death

☐ 1
☐ 2 to 5
☐ more than 5
The last patient in my care whose baby died before, at or just after birth was

☐ in the last 6 months
☐ in the last 12 months
☐ in the last 2 years
☐ over 2 years ago

Please answer the following by typing your response under the question:

Please reflect on one particular experience of caring for a patient through perinatal death and describe how this experience changed you (if it has).

Please describe the support you received through this experience.

How would you like to have been supported?

Please describe what you have taken from this experience and put into your working and/or life relationships.

What would you like others to know about your experience?

Please tell me whether there are any areas that you feel you would like to develop further before encountering a similar experience in the future.

Please return this questionnaire by email to: midwife.learning@gmail.com

Thank you
Appendix C: Australian College of Midwives (ACM) Midplus CPD points approval

Robert Laing
1649 Wilmot Road
LOWER WILMOT TAS 7310

Dear Robert,

Re: Application for endorsement of the CPD activity: “Responding to catastrophe: Learning from perinatal death”

Thank you for your application to the Australian College of Midwives (ACM) for endorsement of this continuing professional development (CPD) activity under the ACM’s MidPLUS program.

Your application has been carefully considered by the Professional Development Committee and endorsement by the Australian College of Midwives has been approved. An allocation of 5 MidPLUS Points has been approved for midwives who complete this activity (equivalent to the number of actual activity hours).

The purpose of the endorsement process is to promote the provision of high quality, relevant and appropriate CPD activities that meet the ongoing educational needs of Australian midwives. You may advertise this activity as “Endorsed by the Australian College of Midwives” and use the ACM MidPLUS logo on advertising material for this endorsed activity.

Please ensure that attendees are provided with a certificate of attendance which may be used by the midwife as evidence of participation for the purpose of claiming points with the MidPLUS program.

The ACM is happy to assist with promoting your activity if you would like us to do so. We maintain information about endorsed activities on our website, and inform members of events in their state (or nationally where appropriate). Please let us know if for some reason you would prefer us NOT to publicise this event.

Endorsement with the MidPLUS program entails a responsibility on the part of the CPD provider to demonstrate a commitment to ongoing evaluation and continuous improvement of the content and delivery of their activity.
Please send us a summary of the attendee’s evaluations of the activity within one month. We would be happy to provide you with a template that you can use or adapt to assist with evaluating the activity if you are interested.

Endorsement of this activity is granted for one time only.

Yours sincerely

Rachel Smith
Education Officer
Australian College of Midwives
Appendix D: Participant Information Letter

Information Letter

Project Title: Responding to catastrophe: Learning from perinatal death

Investigators
Robert Laing
Professor Paul Morrison
Associate Professor Catherine Fetherston

We are inviting you to participate in a study into the midwife’s learning following care through perinatal death.

Background
The loss of a baby during the perinatal period can be a catastrophic event for not only the parents but also the health professionals involved in their care. So far there is limited research focusing on the midwife’s experiences and attitudes through these often unpreventable events. This study aims to explore midwives’ perceptions of the learning that occurs during, and as a result of, being involved in the care of a mother where there is a perinatal death. This research will also assist you to reflect on the experience and explore different aspects of the context in which the event occurred and your responses to these. This will help to generate a rich understanding of your experiences and what you learned both professionally and personally. As a participant, you will be able to tell your story of how you have experienced perinatal death and your experiences will help us to elicit areas where we could help and support others. The research will lead to greater understanding of the midwife’s role in caring for her patient through perinatal loss, how and what she learns through this difficult process, and how this can be of benefit to midwives in focused professional and personal development. Ultimately, the benefit gained by midwives through this study will be passed on to benefit patients and will lead to quality improvement for the institution charged with their care.

Aim of the Study
We would like to know what you as a midwife have learned through the experience of caring for a patient through the death of their baby before, at or just after birth, and how this has influenced your personal and professional development.

What Does Your Participation Involve?
Participation in this study will be conducted on-line through blogs and email. In return for the time that you spend contributing to the study the Australian College of Midwives have awarded 5 MidPLUS points to your participation. Your involvement will be to complete a personal inventory questionnaire that will take approximately 30 to 40 minutes to complete and will be returned by email. This questionnaire will help you to start gathering your thoughts around the incidents that you may have experienced and will be a starting point for the group blog activity that will follow. This will consist of an online group activity blog with other participants who will all have had some experience in caring for mothers and their families through perinatal death. This task will require you to discuss and analyse your own experiences as well as those of other participants. As this will be completed on a blog, you may contribute a little over a longer time or larger amounts over a shorter time period. You will spend approximately five hours on this activity for which you will receive 5 MidPLUS points. The time limit for these conversations will be three months. All contributions to this blog will remain confidential and anonymous and you will be able to edit or delete your own entries at any time.

On completion of the blog discussion we will arrange to conduct a personal interview with you by email. This interview may be conducted over either a short period of one to two hours, or extend over a few weeks depending on your choice of the use of either immediate or delayed responses.
Voluntary Participation and Withdrawal from the Study

It is important that you understand that your involvement in this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. If you decide to discontinue participation at any time, you may do so without providing an explanation. If you withdraw, all information that you have provided will be destroyed. However, if you withdraw once analysis has taken place we may not be able to withdraw your data from the final findings.

Your privacy

Your privacy is very important to us. Your participation in this study and any information will be treated in a confidential manner. Your name and identifying details will not be used in any publication arising out of the research. Following the study, the data will be kept in a de-identified format electronically in a password protected file. Each participant will have a username not related to their real name to maintain anonymity amongst participants. Each participant will sign a confidentiality agreement as a part of their consent, committing to keep all disclosures within the blog confidential and to not use any identifying names, places or occasions in their posts.

Possible Benefits

While there is no guarantee that you will personally benefit, the knowledge gained from your participation may be of benefit to you and the profession. The study may help to gain a better understanding of the resources deployed by midwives in maintaining professional compassion and an ability to care for the mother whilst both her own and the mother’s coping mechanisms are exposed to extreme challenge. There is evidence to suggest that exploring tricky experiences and writing about them helps people, so your participation may benefit you personally in this way.

Your participation in the online blog activity will attract 5 MidPLUS points.

Possible Risks

There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed or uncomfortable due to what you may be recalling in either the blog or interview, the researchers will assist you in seeking support from your established support networks such as your local GP or existing local health service.

Research Findings

The research outcomes will be available as a thesis and through journal articles published during and on completion of the thesis. In addition to this a summary of these results will be made available on the School of Nursing Midwifery website for you to access.

Questions

If you would like to discuss any aspect of this study please feel free to contact Robert Leang on (03) 6492 1356 / r.leang@murdoch.edu.au, Paul Morrison on (08) 9582 5504, or Cathy Fetherston on (08) 9582 5516. You are welcome to contact Robert, Paul or Cathy to discuss any issue relating to the research study.

We would like to thank you in advance for your assistance with this research project. We look forward to hearing from you soon.

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval 2012/083). If you have any reservation or complaint about the ethical conduct of this research, and wish to talk with an independent person, you may contact Murdoch University’s Research Ethics Office (Tel. 08 9360 6677 or e-mail ethics@murdoch.edu.au). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix E: Participant Consent

Consent

Responding to catastrophe: Learning from perinatal death

1. I confirm that I meet the criteria for participation in this study:
   □ I am over the age of 18 years.
   □ I am a Registered Midwife with the Australian Health Practitioner Regulation Agency (AHPRA), or
   □ I am a Registered Nurse with the Australian Health Practitioner Regulation Agency (AHPRA)

2. I agree voluntarily to take part in this study.

3. I have read the Information Sheet provided and been given a full explanation of the purpose of this study, of the procedures involved and of what is expected of me. The researcher has answered all my questions and has explained the possible problems that may arise as a result of my participation in this study.

4. I understand I am free to withdraw from the study at any time without needing to give any reason.

5. I understand I will not be identified in any publication arising out of this study.

6. I understand that my name and identity will be stored separately from the data, and these are accessible only to the investigators. All data provided by me will be analysed anonymously using code numbers.

7. I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law. I understand that all postings to the blog will be accessed by other participants in the study and that I can remove my own entries at any time.

8. I agree to maintain the confidentiality of all information shared in the blog by other participants.

9. I agree to remain anonymous in all of my contributions to the blog and ensure that no identifying names, places or occasions are included within any of my blog contributions.

10. I am happy to be interviewed by email and for the interview to be stored electronically. I understand that I do not have to answer particular questions if I do not want to and that I can withdraw at any time without consequences to myself. If I do decide to withdraw I understand that I may not be able to withdraw my data from the study if it is at the stage where analysis of the data has taken place.

Signature of Participant: ___________________________  Date: ……/……/……
(Name)

Signature of Investigator: ___________________________  Date: ……/……/……
(Name)
Appendix F: Murdoch University Human Research Ethics Committee Study Approval

Tuesday, 5 June 2012

Prof Paul Morrison
School of Nursing and Midwifery
Murdoch University

Dear Paul,

Project No. 2012/083
Project Title Responding to catastrophe: Learning from perinatal death

Thank you for addressing the conditions placed on the above application to the Murdoch University Human Research Ethics Committee. On behalf of the Committee, I am pleased to advise the application now has:

OUTRIGHT APPROVAL

Approval is granted on the understanding that research will be conducted according the standards of the National Statement on Ethical Conduct in Human Research (2007), the Australian Code for the Responsible Conduct of Research (2007) and Murdoch University policies at all times. You must also abide by the Human Research Ethics Committee’s standard conditions of approval (see attached). All reporting forms are available on the Research Ethics web-site.

I wish you every success for your research.

Please quote your ethics project number in all correspondence.

Kind Regards,

Dr. Erich von Dierze
Manager of Research Ethics

cc: A/Prof Catherine Fetherston
    Robert Laing

HREC Outright Approval Letter 16012012
Human Research Ethics Committee: Standard Conditions of Approval

a) The project must be conducted in accordance with the approved application, including any conditions and amendments that have been approved. You must comply with all of the conditions imposed by the HREC, and any subsequent conditions that the HREC may require.

b) You must report immediately anything which might affect ethical acceptance of your project, including:
   - Adverse effects on participants
   - Significant unforeseen events
   - Other matters that might affect continued ethical acceptability of the project.

c) Where approval has been given pending copies of documents such as letters of support / consent from other organisations or approvals from third parties, these must be provided to the Research Ethics Office before the research may commence at each relevant location.

d) Proposed changes or amendments to the research must be applied for, using an Amendment Application form, and approved by the HREC before these may be implemented.

e) An annual Report must be provided by the due date specified each year (usually the anniversary of approval) for the project to have continuing approval.

f) A closure report must be provided at the conclusion of the project.

g) If, for any reason, the project does not proceed or is discontinued, you must advise the committee in writing, using a Closure Report form.

h) If an extension is required beyond the approved end date of the project, an extension application should be made allowing sufficient time for its consideration by the committee. Extensions cannot be granted retrospectively.

i) You must advise the HREC immediately, in writing, if any complaint is made about the conduct of the project.

j) Any equipment used must meet current safety standards. Purpose built equipment must be tested and certified by independent experts for compliance with safety standards.

k) Higher degree students must have both Candidacy and Program of Study approved prior to commencing data collection.

l) You must notify the Research Ethics Office of any changes in contact details including address, phone number and email address.

m) The HREC may conduct random audits and/or require additional reports concerning the research project.

Failure to comply with the National Statement on Ethical Conduct in Human Research (2007) and with the conditions of approval may result in the suspension or withdrawal of approval for the project.

The HREC seeks to support researchers in achieving strong results and positive outcomes.

The HREC promotes a research culture in which ethics is considered and discussed at all stages of the research.

If you have any issues you wish to raise, please contact the Research Ethics Office in the first instance.