‘Midwives Overboard!’ Inside their hearts are breaking, their makeup may be flaking but their smile still stays on

Pezaro, S. , Clyne, W. , Turner, A.P. , Fulton, E.A. and Gerada, C

Original citation & hyperlink:
Pezaro, S. , Clyne, W. , Turner, A.P. , Fulton, E.A. and Gerada, C (2015) ‘Midwives Overboard!’ Inside their hearts are breaking, their makeup may be flaking but their smile still stays on. Women and Birth, volume 29 (3): e59 - e66
http://dx.doi.org/10.1016/j.wombi.2015.10.006

DOI 10.1016/j.wombi.2015.10.006
ISSN 1871-5192
ESSN 1878-1799

Publisher: Elsevier

Abstract

Problem

Midwifery practice is emotional and, at times, traumatic work. Cumulative exposure to this, in an unsupportive environment can result in the development of psychological and behavioural symptoms of distress.

Background

As there is a clear link between the wellbeing of staff and the quality of patient care, the issue of midwife wellbeing is gathering significant attention. Despite this, it can be rare to find a midwife who will publically admit to how much they are struggling. They soldier on, often in silence.

Aim

This paper aims to present a narrative review of the literature in relation to work-related psychological distress in midwifery populations. Opportunities for change are presented with the intention of generating further conversations within the academic and healthcare communities.

Methods

A narrative literature review was conducted.

Findings

Internationally, midwives experience various types of work-related psychological distress. These include both organisational and occupational sources of stress.

Discussion

Dysfunctional working cultures and inadequate support are not conducive to safe patient care or the sustained progressive development of the midwifery profession. New research, revised international strategies and new evidence based interventions of support are required to support midwives in psychological distress. This will in turn maximise patient and public safety.

Conclusions

Ethically, midwives are entitled to a psychologically safe professional journey. This paper offers the principal conclusion that when maternity services invest in the mental health and wellbeing of midwives, they may reap the rewards of improved patient care, improved staff experience and safer maternity services.

Key Words: Midwifery; Patient Safety; Health Services; Mental Health; Psychological Distress; Midwives

Summary of Relevance:

Problem

There is potential for midwives to experience work-related psychological distress. This is of salience, as poor psychological wellbeing in midwives is linked to poorer maternity care.

What is Already Known

There is a paucity of support for midwives, who could be at an increased risk of psychological distress due to the fact that they are exposed to poor organisational cultures and traumatic professional events.

What this Paper Adds

This paper illuminates the scale of work-related psychological distress within midwifery populations. It also outlines the salient issues in practice, and highlights the need for effective staff support for safer maternity care.

Introduction

Depression, burnout, anxiety and stress, account for one quarter of all episodes of sickness absence in National Health Service (NHS) staff [1–3]. The Francis report demonstrates the extent to which poor staff wellbeing directly relates to poor quality services [4]. Poor staff health can lead to an increase in medical errors[5], infection rates[1], and mortality rates[6]. This is not compatible with safe and effective patient care.

As with other health service staff, midwives are known to experience higher levels of stress and trauma than the general working population due to the nature of their work relating to human emotions, patient suffering and, in the developed world, relatively infrequent death[7–13]. Therefore, midwives in psychological distress may display behaviours that are out of character, and experience symptoms of burnout, depression, secondary trauma, Post-Traumatic Stress Disorder (PTSD) and compassion fatigue in line with other nursing populations [14–16].

Much emphasis is placed upon providing support for the patients and carers who become a part of a traumatic clinical incident. However, limited attention has been paid to the 'second victim', the healthcare professional involved, who may experience similar levels of psychological and emotional distress[17–19]. Many of the same symptoms can be identified in patients, families and midwives during the aftermath of trauma. These include initial numbness, detachment, depersonalisation, confusion, anxiety, grief, depression, withdrawal, agitation, and flashbacks of the event[20]. These symptomologies are not compatible with quality patient care.

Recent position papers have set out clear visions for improved staff wellbeing [21–23]. Yet the emotional trauma of caring often remains unrecognised, undervalued, and staff are often left unsupported [24–28]. This paper focuses on midwives' experiences of work-related

psychological distress. We refer to the concept of psychological distress as a general state of maladaptive psychological functioning, which occurs in response to prolonged or acute exposure to stressful occurrences [29,30]. We further define it by its attributes of a perceived inability to cope, a negative change in emotional status, actual and/or communicated discomfort and/or harm[31]. Midwives have been known to suffer in silence whilst working in cultures which may prioritise service and sacrifice above self-care [28,32–36]. As such, it remains important to collate an overview of current understanding and identify any opportunities for change, and gaps for further research to explore.

Background

Midwives could be at an increased risk of work-related psychological distress due to the fact that they are independent practitioners, working in an area of high litigation[37,38]. Yet the incidence of psychologically distressing episodes is sometimes seen as an inconsequential and normal part of the job[39]. Challenging work environments can also expose the midwife to prolonged periods of stress[40–42]. This is significant as a prolonged exposure to occupational stress can result in significant physical symptoms as well as poor self-care, and may also impact upon a midwife's family life[43–45]. Midwives suffering psychological distress may also be more likely to emotionally withdraw from their support network, patients and colleagues. This both affects patient care and makes it even more difficult to identify those in need of help[39].

Currently, there is a paucity of structured support designed to address the psychological well-being of midwives[37]. This has been identified as a missing response to the management of adverse events around the world[46–48]. In addition to a lack of support, some midwives may experience ostracisation, bullying and inferences of incompetence, which may, in turn, exacerbate their psychological distress[49,50]. As midwives' experiences of witnessing

traumatic events is under researched, appropriate support remains unlikely to be available or provided[51].

Healthcare guidance dictates the delivery of person centred care[52,53]. Yet if midwives fail to prioritise their own psychological wellbeing, their compassion for patients may deteriorate. This is of concern, as compassion and empathy are both essential elements of good maternity care, and are listed as key priorities for the NHS[4]. This warrants further attention as patients and policy makers continue to demand accountability for the quality of healthcare provided, in which cracks are beginning to appear[54,55].

The assumption that midwifery work is joyful and a privilege to be a part of, may not allow midwives to acknowledge the emotionally demanding reality of their work[56,57]. This is concerning when psychological symptoms of traumatic stress can quickly overwhelm those affected [58]. Following any traumatic incident, midwives may begin to shield themselves from any stimuli that serve as reminders to the incident, avoid activities which they used to find pleasurable, experience cognitive deficits such as reduced concentration, and feel emotionally detached from others[59]. This dissociation is not compatible with quality maternity care, yet healthcare professionals rarely seek help or do so only after years of suffering[48].

The most extreme consequence of psychological distress is death by suicide. UK healthcare professionals have been identified as having high suicide rates [37,60]. Yet a recent situational analysis of suicide by clinicians involved in serious incidents within the NHS failed to identify any sources of support, specifically designed for midwives [37]. 28 doctor suicides were reported between 2005 and 2013, all of whom were under investigation by the UK's General Medical Council at their time of death. Some received diagnoses of alcohol-related illnesses, depression, bipolar depression and substance misuse disorders[60]. Similar data remains unavailable for midwifery populations, and yet midwives have reported similar levels of

stress. Therefore the risk of death by suicide may be equally apparent in midwifery professionals.

The NHS has committed to providing a positive working environment for staff and to promote supportive cultures that help staff to do their job to the best of their ability [22,61]. In many NHS trusts, stress and mental health issues are now overtaking musculo-skeletal disorders as the main reason given for sickness absence[3], yet just 57% of these Trusts have a plan in place to support the mental health of their staff [23,62]. Sadly, occupational health departments may not be adequate to support the clinical needs of midwives, nor be accessed when required[63]. This calls for the development of new strategies and innovations to drive remedial actions forward into practice, as what is now needed may go beyond previous recommendations[45,64].

Categories of Psychological Distress

Work-related psychological distress may occur as a result of hostile behaviour towards staff, either from other staff or patients[65–67], workplace bullying[65,68], poor organisational cultures[24], medical errors[69], traumatic 'never events'[70], critical incidents[37], occupational stress[71], workplace suspension[38,72], whistleblowing[73], investigations via professional regulatory bodies and employers[60,74,75], and/or pre-existing mental health conditions[60,75]. This list is far from exhaustive.

Midwives may experience different types of psychological distress in response to challenging clinical events and/or work environments. 'vicarious compassion fatigue', 'vicarious traumatisation' and 'secondary traumatic stress' are all terms used to describe the potential emotional impact that working with traumatised families may have upon healthcare professionals[10,76]. These are a normal consequence of helping others over time, to deal with an emotional, sometimes abnormal, and/or traumatising situation.

In the most extreme cases, Post-Traumatic Stress Disorder (PTSD) can develop following a traumatic event. Symptoms can include the display of reckless or self-destructive behaviour, memory flashbacks, hypervigilance, emotional numbness and avoidance[20]. However, the risk of Acute Stress Disorder following an indirect, or direct traumatic event is far greater, and can result in symptoms of shame, guilt, anger and self-doubt[77]. Significantly, PTSD is often accompanied by depression, substance abuse disorders, and/or other anxiety disorders, which may result in a display of unethical behaviour [77,78]. Should these symptoms remain unmanaged, patient safety could be put at risk.

Those in psychological distress may also experience depression. Symptoms of major depression include feelings of worthlessness, chronic fatigue, a sense of guilt, reduced concentration and poor decision making[20]. These symptoms may cause clinically significant distress or impairment in areas of occupational functioning. This is pertinent to midwifery populations as we begin to understand the co-morbidities of psychological distress and the impact it may have upon a midwife's fitness to practise.

As health care professionals' emotional reserves run low, 'burnout' may eventually take hold. Midwives have been identified as a group at risk of exhibiting high levels of emotional exhaustion and burnout[79]. Burnout is a syndrome consisting of emotional exhaustion, depersonalisation and negative thinking towards others[80]. Symptoms are closely associated with psychological trauma, and occur when a midwife's emotional resilience becomes depleted. In midwifery practice, burnout results in poorer patient care and increased staff turnover[23]. Saliently, 60%-70% of healthcare professionals admit to having practised at times when they have been distressed to the point of clinical ineffectiveness, and as such are more at risk of enacting unnecessary medical errors[1,81,82]. These disclosures illuminate a situation which is clearly incompatible with safe and effective clinical care.

As emotional stores run low, midwives may also exhaust their ability to care compassionately. Compassion fatigue refers exclusively to those in the caring professions, and weakens the capabilities of the midwife to provide effective care[39]. Midwives will be vulnerable to compassion fatigue, and yet they must continue to deliver emotional interactions to ensure a healthy emotional journey for the families they care for [64,83]. This suggests an urgent need to support midwives to remain emotionally responsive and clinically effective in order for them to provide quality care.

Sustained psychological distress can result in adverse behavioural symptoms, which may include drug and alcohol disorders [20,84–86]. Yet the vast majority of healthcare professionals who develop substance abuse disorders are not doing so for recreational pleasure[84]. The use of substances becomes a symptom of mental ill-health, as the user employs maladaptive coping strategies to medicate a deeper distress [75]. It will be important to identify, remedy and understand the many origins and experiences of work-related psychological distress in midwifery populations in order to ameliorate professional suffering and improve the safety of midwifery care. A narrative literature review was chosen to do this, so that the relevant literature in this field could be consolidated into narratives, which review the state of psychological distress in midwifery populations from a contextual point of view[87].

Methods

The literature was reviewed narratively in order to gain a broader perspective with regards to the aetiology, experiences, symptomology and epidemiology of midwives in psychological distress.

Search Strategy

AMED - The Allied and Complementary Medicine Database, CINAHL with Full Text, MEDLINE and PsycINFO were searched simultaneously, using a combination of terms used in tandem with the defining cohort of ‘midwives or midwife’ within the TI (Title) search field.

Searches included ‘midwives or midwife’ and ‘psychological distress’, and ‘bullying in nursing workplace‘ and ‘bullying in the workplace’ and ‘bullying in nursing’ and ‘traumatic stress’, and ‘vicarious trauma’, and ‘compassion fatigue and burnout’, and ‘secondary trauma’, and ‘depression and anxiety’, and ‘PTSD or post-traumatic stress disorder’, and ‘workplace stress’ and ‘resilience’ and ‘Emotion Work’ and ‘secondary traumatic stress’. This resulted in 14 separate searches, which generated 264 results. 98 duplicates were then removed, leaving 166 papers to review.

Searching was widespread in scope, in line with the ESRC Methods guideline for generating Narrative Synthesis[88]. Papers had to be written in the English language and focus upon work-related psychological distress in relation to the aetiologies, experiences, symptomology and epidemiology of midwives in psychological distress, rather than in relation to the women they cared for or any other professional group. Papers were limited to those published after the year 2000 in order to generate a more contemporary overview of current understanding. Papers selected for inclusion were limited to cohort studies, systematic reviews, meta-analyses, and randomised controlled trials in order to unite best evidence[89].

76 papers were primarily excluded as they related to issues affecting childbearing women rather than midwifery populations. 25 articles were removed, as they were editorial or discursive in nature. A further 36 articles were excluded, as they did not relate to the subject of midwives in work-related psychological distress. 12 papers related to workplace interventions, and although we considered these to be of general interest, they were excluded from this review so that a focused depiction of psychological distress could remain paramount. One study was rejected as it related to nurses providing care to labouring women, and two studies were added through a snowballing of the literature, whereby reference lists were assessed for absent papers [90]. 30 papers were eventually selected for inclusion.

The research team then went through the iterative process of reading and rereading these papers, noting themes and narratives throughout a discursive process of review. Anonymous peer reviewers also became a part of influencing the finalised report of findings.

Limitations

Midwifery is a nursing profession. As such, professionals who practise as midwives are frequently referred to as obstetric nurses or nurse-midwives, and may be amalgamated within nursing cohorts, or referred to as general healthcare staff [91]. Therefore, a large number of studies may have avoided retrieval by omitting to identify their cohorts as midwives.

Results

Overview of studies

The studies selected for review took place in Nigeria[92], America[58], Ireland[93], the United Kingdom[25,51,94–99], Australia[44,100–103], [104], France[105], Poland[106], Croatia[107],Israel[57], Italy[108], Japan[26,109], Uganda[7,110], Turkey[111] and New Zealand[102]. Study designs included convergent, parallel mixed-methods, critical literature reviews[8,112–114], online professional discussion groups[94,95], individual and group interviews[25,51,57,96,108104] narratives[115], diary-keeping[115] and questionnaires[6,26,58,92,97,99,101–103,105–107,109,111,115–118]

Findings

The literature retrieved illuminates that distressed midwives may carry on working in distress, and use this persistence as a maladaptive coping strategy. This dysfunctional endurance may not allow them to recognise psychological ill health in themselves. Long hours, the introduction of new technologies in healthcare, job security, emotion work, trauma exposure, dysfunctional working cultures and a lack of career progression have become strong predictors of work-related psychological distress in midwives[112,113,116,119]. Additionally,

the overarching superhuman philosophy that midwives should be able to cope with anything does nothing to promote healthy, or help seeking behaviours.

Occupational Sources of Stress

Midwives remain at risk of developing secondary traumatic stress as they care for childbearing women [8]. Risk factors for the development of traumatic stress in midwives include an increased level of empathy and organisational stress[113]. Secondary traumatic stress in midwives is reported at high to severe levels as they engage empathetically with the trauma experienced by those in their care [58]. These high levels of distress mean that a midwife's ability to professionally engage with childbearing women and their families may be compromised. This may also make them more likely to leave the profession all together. Within the labour and delivery rooms of the United States, midwives most frequently cited neonatal demise/death, shoulder dystocia, and infant resuscitation as being the incidents in which their secondary traumatic stress had originated[58]. This becomes significant as specific interventions of support are developed in response to the most salient adverse events.

Midwives report having difficulties in functioning professionally during the unexpected reality of a stressful clinical situation [57]. This may lead to distressing feelings of guilt, rumination and diminished professional confidence. 33% of 421 UK midwives surveyed have been found to develop symptoms of clinical posttraumatic stress disorder following a traumatic event[99]. These symptoms included feelings of fear, helplessness and horror. Following clinical investigations and traumatic births, midwives in the United States expressed a need for a safe forum to share their experiences with colleagues, as they had no place to talk and unburden their souls [58]. Some of these midwives lost their belief in the birth process, developed PTSD, and many left the midwifery profession altogether. The development of PTSD symptoms is associated with burnout, and as such, the exposure to trauma may impact significantly upon the wellbeing of the workforce [99]. This becomes significant as the

world tries to recruit a high quality midwifery workforce in the face of a global shortage of midwives [120].

Upon providing ethically complex and emotive clinical tasks such as the Termination of Pregnancy (TOP), many midwives report significant emotional distress[105,108,121]. How the midwife manages emotional midwifery work is crucial in determining the quality of patient experiences, as the stressors involved in conducting a TOP are associated with the development of compassion fatigue[112,121]. Equally, the psychological distress experienced by midwives caring for families experiencing stillbirth, neonatal loss and miscarriages remains high, as midwives continue to provide emotionally intense and deeply empathetic care[114]. This is significant as the demanding task of providing empathy may often conflict with the midwives need to protect themselves psychologically, and yet empathy and compassionate care have been identified as fundamental tenets of the nursing professions[4,122].

Midwives working within resource poor, developing countries experience traumatic incidents and death more frequently[123,124]. In a survey study of 238 midwives working in two rural districts of Uganda, many have displayed moderate to high death anxiety (93%), mild to moderate death obsession (71%) and mild death depression (53%) [7]. Furthermore, 74.6 % of 224 midwives working again, in rural areas of Uganda, developed moderate or high death anxiety following prolonged exposure to maternal death[110]. This becomes significant as the midwifery profession looks to maintain a healthy workforce globally in order to make their contribution towards achieving goal 4 and 5 of the Global Millennium Development Goals in achieving safer childbirth[125].

Midwives who provide antenatal care to families with complex social needs have reported cumulative feelings of frustration, inadequacy and vicarious trauma over time[104]. This emotional and stressful work, which often requires long working hours has led to some of

these midwives utilising unhealthy coping strategies and harmful daily drinking[102]. This is significant as we begin to understand the consequences of cumulative exposure to complex and emotive maternity work.

Student midwives also experience work-related psychological distress. As they narrate their most distressing placement related event, their beliefs about the uncontrollability of thoughts and danger, beliefs about the need to control thoughts, and rumination over that traumatic incident were all significantly associated with posttraumatic stress symptoms[117]. Despite this, student midwives have reported feeling unable to speak out and ask for help within hierarchical midwifery workplaces[115]. This becomes significant as we seek to empower a new generation of midwives to effectively manage their mental health whilst carrying out demanding and emotional midwifery work.

Organisational Sources of Stress

Midwifery cultures are hierarchical, and this may lead to the subordination of midwives, bullying, ineffective team working and a reduction in professional autonomy [115]. It has also been proposed that midwives form elite 'clubs' in the workplace and exclude those of lesser ranking [115]. As the obstetrician takes the most senior position within the hierarchical structure, the medical takeover of birth could restrict the midwives ability to innovate and develop optimal levels of confidence [115]. This dysfunctional working culture may not allow midwives, or the midwifery profession to thrive, as midwives remain persistently worried about workplace aggression and bullying [119]. Inhibited professional progression, bullying and subordination are key predictors of psychological distress [116,126,127]. This becomes important as we begin to understand and address these predictors in order to construct collaborative working cultures in maternity services, to ensure safer care for patients [128].

In one study of 58 Australian midwives, almost 30% of the sample experienced moderate to high levels of burnout, and their levels of personal and work-related burnout were found to

be higher than any burnout related to giving care to women [103]. Midwives may experience burnout as a result of dysfunctional working cultures, work stress, and poor job satisfaction [111]. This suggests that the origins of burnout may be rooted within organisational sources of stress, however more research in this area is required so that the origins of burnout in midwives can be comprehensively acknowledged and defined.

Burnout, emotional exhaustion and depersonalisation levels have been found to be higher in midwives than in general nurses and hospice nurse populations, yet the latter two populations sometimes receive a higher level of support in the workplace [106]. This indicates that the reality of burnout in midwives may not be adequately recognised. Should midwives continue to receive inadequate support in comparison to other professional groups, they may come to feel that they are a less valued profession. This is significant, as low morale does nothing to ameliorate the challenges associated with recruitment and retention. This situation may also fuel a midwife's belief that their own wellbeing remains inconsequential, which does little to promote help seeking behaviours.

In a sample of 60 Croatian midwives, over three-quarters (76.7%) reported that their job is stressful [107]. Another study has cited that 80–90% of 556 Japanese midwives have been highly stressed by qualitative job overload, with one out of every three to five displaying a psychological disorder[109]. Those who express high levels of job satisfaction, and those who perceive that others have a positive opinion about the midwifery profession are observed to have lower levels of work-related stress and burnout [111]. This may indicate that raising the professional profile of midwifery and placing more value upon midwives in practice should play a part in any strategy designed to remedy psychological distress in midwifery populations.

The culture that student midwives observe is sometimes spiteful and cruel [98]. They also observe a lack of care towards themselves and other midwives in a culture permissive of bullying [97]. The reality is that workplace aggression and bullying from both staff and patients has been seen as a frequent occurrence within the maternity workplace [101]. This becomes significant as we nurture and recruit the new generation of midwives to become high quality professionals for the future advancement of maternity services. Such disruptive working cultures in maternity services also threaten patient safety [67].

Student midwives may also feel despondent upon the realisation that childbearing women do not get the care that they expect due to organisational pressures and excessive workloads [98]. Sadly, they understand why midwives may not want to come into work as they too see the stresses of the job. Some midwifery students who identify with these feelings of stress display unhealthy coping strategies such as excessive smoking, drinking or eating [98]. This introduction to the midwifery profession is not conducive to a positive inaugural experience, and may have serious implications for future retention and recruitment strategies, as new students in training may assume some of the negative perspectives and behaviours communicated via their qualified mentors[115].

Emotion work (emotional work) can be defined as the emotional regulation required of the employees in the display of organisationally desired emotions[129]. Emotion work remains less understood as a concept in midwifery work. Yet challenging models of midwifery care, high expectations, working intimately with women in pain, and managing the emotions of other staff all place emotional burden upon the midwife [112]. Negotiating inter-collegial conflict in UK midwifery is a major source of emotion work, which is likely to exacerbate workforce attrition and psychological distress [96]. Interactions with colleagues and healthcare organisations requires effective emotion management. This is significant as we begin to understand the

contradictory ideologies that present in midwifery practice, and the conflicts between ideals and practice, which often result in frustration, psychological distress and anxiety [96].

When a traumatic birth occurs, midwives find it difficult to work between the medical model of care and the midwifery model of care as turf wars continue between midwives and doctors [51]. Midwives value the compassionate support given from their obstetric teams, yet many feel betrayed and abandoned in an unsupportive, 'toxic' and unsafe working environment [58]. It will be important to understand the nature of these tensions in practice in order to ensure safe care for women, remedy low morale and improve staff retention rates [67,130,131]. Midwives continue to report feeling bullied, undermined and intimidated because of the power imbalances currently at play [51,96]. Interpersonal conflict has been positively correlated with hostility, depression, anxiety, fatigue and physical complaints in midwifery professionals [109]. As such, the origins of tension in the work place requires further attention before these maladaptive cultures present further concerns in relation to effective collaborative working, patient safety and staff wellbeing.

Discussion

The findings of this review illuminate a global and contemporary picture, where midwives are suffering in work-related psychological distress and yet at times, carry on working regardless. Some are frustrated when they cannot practice to the best of their ability due to organisational inadequacies and obstructive working cultures. A multitude of organisational pressures and features of emotional work have been identified as predictors of psychological distress in midwifery professionals. In addition to the clinically significant impacts of direct trauma exposure, inter-professional conflicts, bullying and unsupportive organisational cultures are repeatedly highlighted as threats to the midwife's psychological wellbeing. Midwives working within rural areas of developing countries, and those caring for women with complex social needs may present with specific symptomologies which relate to their

particular area of midwifery practice. In any case, this review has highlighted that midwives in psychological distress often feel that sources of support are inadequate, and that there is nowhere go to unburden their distress.

Midwives are faced with a multitude of workplace pressures which show no sign of alleviating. Increased population growth, midwife shortages, a rising birth rate and increased numbers of complex births have become part of the modern realities of midwifery[120,132] Yet in addition to these pressures, toxic, hierarchical, time pressured and unsupportive workplace cultures only serve to reverse any gains made in supporting midwives in psychological distress[67,96,115,133]. These pressures may also result in midwives further neglecting their own wellbeing. Effective clinical mentorship, clinical supervision, the reorganisation of maternity care models, wellbeing strategies, positive leadership and the creation of positive working cultures, where maternity staff feel valued and motivated to drive the midwifery profession forward have all been suggested as ways in which to address these issues within the midwifery workforce[35,103,134–138]. Midwifery cultures may benefit from further research in this area, as new proposals for change are required.

Midwives remain unsatisfied with the support programmes and management interventions currently on offer [101]. This presents future research, healthcare leaders and policy makers with new opportunities to develop effective, evidence based interventions designed to support midwives in work-related psychological distress. Midwives often seek out their own effective coping strategies, access support, develop self-awareness, reflect, vent, positively re-frame events, cultivate a professional identity and employ self-distraction techniques in order to increase their own resilience towards workplace adversity[7,94,139]. However, more research will be required in order to evaluate which strategies may be most effective. There may also be an opportunity to turn new, online visions of support into practice.

Future interventions should predominantly focus upon placing more value on midwives and empowering the midwifery profession to resolve professional conflicts. They should also help midwives to recognise that they are not alone and provide safe platforms of support where midwives can share their experiences with colleagues and unburden their distress[58]. Proactive support should focus upon those midwives engaged in situations most frequently associated with distress. Ultimately, the shared goal should be the repudiation of psychologically unsafe workplace cultures and the provision of appropriate psychological support.

Midwives are entitled to a psychologically safe professional journey, and caring for them is not an optional issue, it is an ethical one. As evidenced by this review, midwives are likely to benefit from a sound work-life balance, autonomy, models of maternity care that maximise their emotional wellbeing, sensible working hours, psychological support, professional respect, safe platforms where midwives can unburden their distress, and processes to deal with dysfunctional working cultures and bullying the most[34,58,140]. New guidance, and the development of novel interventions tailored to the needs of midwives have the opportunity to turn this vision into practice.

In order to protect and empower our valuable midwifery workforce to provide excellent quality care, forthcoming international initiatives could:

- Acknowledge the emotional consequences of midwifery practice.
- Promote the need to prioritise self-care and inter-professional support [141,142]
- Acknowledge the need to prioritise the emotional wellbeing of midwives [45]
- Promote psychologically safe working cultures [41,143].
- Explore alternatives to discipline, which include non-punitive and non-blame-focused approaches towards:

1. Medical error [17]

2. Concerns raised by healthcare staff[73]
3. Behavioural symptoms displayed whilst staff are unwell [46,48,63,75].

Conclusions

This narrative review of the literature demonstrates that globally, there is not enough attention assigned to the seriousness and prevalence of work-related psychological distress in midwifery populations. Midwifery is seen as a pleasurable and privileged job by society and by midwives themselves [56]. Yet the needs of those in psychological distress have not been understood, prioritised or comprehensively acknowledged. In the future, it will be important to identify the causes of problematic working cultures in order to reverse the adverse consequences sometimes seen as part of the problem when catastrophic failings within maternity services occur [144].

Exposure to trauma and psychologically distressing events could adversely affect the wellbeing of midwives, the care provided to women and contribute to adverse climates in healthcare [113]. Future research has the opportunity to explore and develop evidence-based solutions to support midwives in work-related psychological distress. Further research may also generate a deeper understanding in relation to the aetiologies, experiences, symptomology and epidemiology of midwives in psychological distress. This will be significant, as in facilitating psychologically safe professional journeys for midwives, we will in turn augment the quality and safety of maternity services[23,67,145–149].

Midwifery care aims to support optimal outcomes in childbearing[53]. If, when caring for women, the potential consequences for midwives are ignored, we risk their capability to provide midwifery care to the high levels they aspire to. This threatens the very eminence of midwifery as a profession. So as the gargantuan ‘Maternity Service Ship’ sails on, proudly flying the flag of being ‘with woman’, look out for those who have been left behind, silently shouting ‘Midwife overboard’.

Acknowledgments and Disclosures: Ethical approval has been given for this literature review by Coventry University, UK. Project [P32836].

This literature review has been funded by a full time research scholarship provided by the Centre for Technology Enabled Health Research at Coventry University.

References

1. Boorman S. Health and well-being of the NHS workforce. *Journal of Public Mental Health* 2010; **9**(1): 4-7.

2. Boorman S. The Final Report of the independent NHS Health and Well-being review,(2009). Department of Health. *NHS health and well-being review–the government response* 2009; .

3. NHS Employers. Reducing sickness absence in the NHS using evidence-based strategies. Summary report. 2014; .

4. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary. *The Stationery Office. London* 2013; .

5. Harrison R, Lawton R, Stewart K. Doctors' experiences of adverse events in secondary care: the professional and personal impact. *Clin Med* 2014; **14**(6): 585-90.

6. Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. NHS; 2013.

7. Muliira RS, Bezuidenhout MC. Occupational exposure to maternal death: Psychological outcomes and coping methods used by midwives working in rural areas. *Midwifery* 2015; **31**(1): 184-90.

527 8. Leinweber J, Rowe HJ. The costs of 'being with the woman': secondary traumatic stress in
528 midwifery. *Midwifery* 2010; **26**(1): 76-87.

529 9. Thomas RB, Wilson JP. Issues and controversies in the understanding and diagnosis of
530 compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder. *Int J Emerg*
531 *Ment Health* 2004; **6**(2): 81-92.

532 10. Klein M. The stork and the phoenix: birth, burnout and rebirth. *Midwifery Today Int Midwife*
533 2009; **(92)**(92): 44,6, 67.

534 11. Clarke J, Mander R. Midwives and loss: the cost of caring. *Pract Midwife* 2006; **9**(4): 14-7.

535 12. Kirkham M. Traumatised Midwives. *AIMS Journal* 2007; **19**(1).

536 13. Kenworthy D, Kirkham M. Midwives Coping with Loss and Grief: Stillbirth, Professional, and
537 Personal Losses. Radcliffe Publishing; 2011.

538 14. Wilkinson S. How nurses can cope with stress and avoid burnout: Stephanie Wilkinson offers a
539 literature review on the workplace stressors experienced by emergency and trauma nurses. *Emergency*
540 *Nurse* 2014; **22**(7): 27-31.

541 15. Rice V, Glass N, Ogle K, Parsian N. exploring physical health perceptions, fatigue and stress
542 among health care professionals. *Journal of multidisciplinary healthcare* 2014; **7**: 155.

543 16. Clarke E. Toasted, Fried or Frazzled? Burnout and stress in midwifery practice. *MIDWIFERY*
544 *MATTERS* 2013; (139): 15-6.

545 17. Wu AW, Steckelberg RC. Medical error, incident investigation and the second victim: doing
546 better but feeling worse? *BMJ Qual Saf* 2012; **21**(4): 267-70.

547 18. Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too.
548 *BMJ* 2000; **320**(7237): 726-7.

549 19. Denham CR. TRUST: the 5 rights of the second victim. *Journal of Patient Safety* 2007; **3**(2):
550 107-19.

551 20. DSM-5 American Psychiatric Association. Diagnostic and statistical manual of mental
552 disorders. *Arlington: American Psychiatric Publishing* 2013; .

553 21. Black C. Why healthcare organisations must look after their staff. *Nurs Manag (Harrow)* 2012;
554 **19**(6): 27-30.

555 22. Department of Health. Health Sector Staff Wellbeing, Service Delivery, and Health Outcomes.
556 A Compendium of Factsheets: Wellbeing across the Life Course'. *2014* 2014; .

557 23. The Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to
558 patient care. 2015; .

559 24. Wilkinson E. UK NHS staff: stressed, exhausted, burnt out. *The Lancet* 2015; **385**(9971): 841.

560 25. Hunter B. Conflicting ideologies as a source of emotion work in midwifery. *Midwifery* 2004;
561 **20**(3): 261-72.

562 26. Mizuno M, Kinefuchi E, Kimura R, Tsuda A. Professional quality of life of Japanese
563 nurses/midwives providing abortion/childbirth care. *Nurs Ethics* 2013; **20**(5): 539-50.

564 27. Kirkham M. The midwife-mother relationship. Palgrave Macmillan; 2010.

565 28. Calvert I, Benn C. Trauma and the Effects on the Midwife. *International Journal of Childbirth*
566 2015; **5**(2): 100-12.

567 29. Abeloff M, Armitage J, Lichter A, Niederhuber J. Clinical Oncology. New York, NY: Churchill
568 Livingstone. 2000; .

30. Ryrie I, Norman I. The origins and expression of psychological distress. *The Art and Science of Mental Health Nursing: A Textbook of Principles and Practice.Open University Press, Maidenhead* 2004; : 3-34.

31. Ridner SH. Psychological distress: concept analysis. *J Adv Nurs* 2004; **45**(5): 536-45.

32. Deery R, Kirkham M. Supporting midwives to support women. In: Page L, McCandish R, editors. The new midwifery: science and sensitivity in practice. . London: Churchill-Livingston; 2006.

33. Kirkham M. The culture of midwifery in the National Health Service in England. *J Adv Nurs* 1999; **30**(3): 732-9.

34. Prowse J, Prowse P. Flexible working and work–life balance: midwives' experiences and views. *Work, Employment & Society* 2015; : 0950017015570724.

35. Dixon-Woods M, Baker R, Charles K, et al. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Qual Saf* 2014; **23**(2): 106-15.

36. Kirkham M, Stapleton H. Midwives' support needs as childbirth changes. *J Adv Nurs* 2000; **32**(2): 465-72.

37. Strobl J, Sukhmeet S, Carson-Stevens A, McIldowie B, Ward H, Cross H, Madhok R. Suicide by clinicians involved in serious incidents in the NHS: a situational analysis. . *NHS Clinical leaders network* 2014; .

38. Anderson A. Ten years of maternity claims: an analysis of the NHS Litigation Authority data–key findings. *Clin Risk* 2013; **19**(1): 24-31.

39. Wallbank S, Robertson N. Predictors of staff distress in response to professionally experienced miscarriage, stillbirth and neonatal loss: A questionnaire survey. *Int J Nurs Stud* 2013; **50**(8): 1090-7.

591 40. Mollart L, Skinner VM, Newing C, Foureur M. Factors that may influence midwives work-
592 related stress and burnout. *Women and Birth* 2013; **26**(1): 26-32.

593 41. Campling P. Reforming the culture of healthcare: the case for intelligent kindness. *BJPsych*
594 *Bulletin* 2015; **39**(1): 1-5.

595 42. Holmes D. Mid Staffordshire scandal highlights NHS cultural crisis. *Lancet* 2013; **381**(9866):
596 521-2.

597 43. Kordi M, Mohamadirizi S, Shakeri MT. The relationship between occupational stress and
598 dysmenorrhea in midwives employed at public and private hospitals and health care centers in Iran
599 (Mashhad) in the years 2010 and 2011. *Iranian Journal of Nursing & Midwifery Research* 2013;
600 **18**(4): 316-22.

601 44. Mollart L, Newing C, Foureur M. Midwives' emotional wellbeing: impact of conducting a
602 structured antenatal psychosocial assessment (SAPSA). *Women Birth* 2009; **22**(3): 82-8.

603 45. Copp E, Morton N. Attention: calm and relaxed midwives at work! *Pract Midwife* 2011; **14**(4):
604 21-3.

605 46. Austin D, Smythe E, Jull A. **Midwives' well-being following adverse events – what does the**
606 **research indicate?**. *Journal of the New Zealand College of Midwives* 2014; **50**: 19 - 23.

607 47. Seys D, Scott S, Wu A, et al. Supporting involved health care professionals (second victims)
608 following an adverse health event: a literature review. *Int J Nurs Stud* 2013; **50**(5): 678-87.

609 48. Ullström S, Andreen Sachs M, Hansson J, Øvretveit J, Brommels M. Suffering in silence: a
610 qualitative study of second victims of adverse events. *BMJ Quality & Safety* 2014; **23**(4): 325-31.

611 49. Cresswell K, Sivashanmugarajan V, Lodhi W, Yoong W. Bullying workshops for obstetric
612 trainees: a way forward. *The clinical teacher* 2015; **12**(2): 83-7.

613 50. Carter M, Thompson N, Crampton P, Morrow G, Burford B, Gray C, Illing J. Workplace
614 bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to
615 reporting. *BMJ Open* 2013; **3**(6): e002628.

616 51. Rice H, Warland J. Bearing witness: Midwives experiences of witnessing traumatic birth.
617 *Midwifery* 2013; **29**(9): 1056-63.

618 52. Richards T, Coulter A, Wicks P. Time to deliver patient centred care. *BMJ* 2015; **350**: h530.

619 53. Officers UCN. Midwifery 2020 Delivering Expectations. *London: Department of Health* 2010;
620 .

621 54. Collins KJ, Draycott T. Measuring quality of maternity care. *Best Practice & Research Clinical*
622 *Obstetrics & Gynaecology* 2015; .

623 55. Quality Watch. Cause for concern: Quality Watch annual statement 2014. 2014; .

624 56. Knapp R. Where there was love... Compassionate midwifery as protection against trauma. . *The*
625 *Practising Midwife* 2015; **18**(4).

626 57. Halperin O, Goldblatt H, Noble A, Raz I, Zvulunov I, Liebergall Wischnitzer M. Stressful
627 childbirth situations: a qualitative study of midwives. *J Midwifery Womens Health* 2011; **56**(4): 388-
628 94.

629 58. Beck CT, LoGiudice J, Gable RK. A Mixed-Methods Study of Secondary Traumatic Stress in
630 Certified Nurse-Midwives: Shaken Belief in the Birth Process. *Journal of Midwifery & Women's*
631 *Health* 2015; **60**(1): 16-23.

632 59. Horowitz MJ, Reidbord SP. Memory, Emotion, and Response to Ttauma. *The handbook of*
633 *emotion and memory: Research and theory* 2014; : 343.

634 60. General Medical Council (GMC). Doctors who commit suicide while under GMC fitness to
635 practise investigation: Internal review . 2015; Available at: http://www.gmc-
636 uk.org/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf. Accessed 08/05, 2015.

637 61. Department of Health. Policy paper Healthy Staff, Better Care for Patients: Realignment of
638 Occupational Health Services to the NHS in England . 2011; .

639 62. The Royal College of Physicians. Implementing NICE public health guidance for the
640 workplace: a national organisational audit of NHS trusts in England, round 2. 2014; .

641 63. Munro R. Sick day scrutiny. *Nurs Stand* 2011; **25**(18): 24-5.

642 64. Wilkinson E. UK NHS staff: stressed, exhausted, burnt out. *The Lancet* 2015; **385**(9971): 841.

643 65. Demir D, Rodwell J. Psychosocial antecedents and consequences of workplace aggression for
644 hospital nurses. *J Nurs Scholarsh* 2012; **44**(4): 376-84.

645 66. Woodrow C, Guest D. Workplace Bullying, Patient Violence and Quality of Care: A Review.
646 *NIHR and King's Patient Safety and Service Quality Centre (PSSQ) Workforce Programme, Working*
647 *Paper* 2008; **1**.

648 67. Veltman LL. Disruptive behavior in obstetrics: a hidden threat to patient safety. *Obstet Gynecol*
649 2007; **196**(6): 587.e1,587.e5.

650 68. Carter M, Thompson N, Crampton P, Morrow G, Burford B, Gray C, Illing J. Workplace
651 bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to
652 reporting. *BMJ Open* 2013; **3**(6): e002628.

653 69. Wu A. Medical error: the second victim. The doctor who makes the mistake needs help too. .
654 *British Medical Journal* 2000; **320**: 726-7.

655 70. Harrop-Griffiths W. Never events. *Anaesthesia* 2011; **66**(3): 158-62.

656 71. Lindberg I, Christensson K, Öhrling K. Midwives' experience of organisational and
657 professional change. *Midwifery* 2005; **21**(4): 355-64.

658 72. Hood L, Fenwick J, Butt J. A story of scrutiny and fear: Australian midwives' experiences of an
659 external review of obstetric services, being involved with litigation and the impact on clinical
660 practice. *Midwifery* 2010; **26**(3): 268-85.

661 73. Francis R. Report on the Freedom to Speak Up review. *The Stationery Office. London* 2015; .

662 74. Edwards N, Murphy-Lawless J, Kirkham M, Davies S. Attacks on midwives, attacks on
663 women's choices. *AIMS Journal* 2011; **23**(3): 3-7.

664 75. Brooks SK, Del Busso L, Chalder T, et al. 'You feel you've been bad, not ill': Sick doctors'
665 experiences of interactions with the General Medical Council. *BMJ Open* 2014; **4**(7): e005537,2014-
666 005537.

667 76. Naturale A. HOW DOWE UNDERSTAND DISASTER-RELATED VICARIOUS TRAUMA,
668 SECONDARY TRAUMATIC STRESS, AND COMPASSION FATIGUE? *Vicarious Trauma and*
669 *Disaster Mental Health: Understanding Risks and Promoting Resilience* 2015; : 73.

670 77. National Institute of Mental Health (NIMH). What is post-traumatic stress disorder, or PTSD?
671 2015; Available at: http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-
672 ptsd/index.shtml. Accessed 08/05, 2015.

673 78. Kouchaki M, Desai SD. Anxious, threatened, and also unethical: How anxiety makes
674 individuals feel threatened and commit unethical acts. 2014; .

675 79. Borritz M, Rugulies R, Bjorner JB, Villadsen E, Mikkelsen OA, Kristensen TS. Burnout among
676 employees in human service work: design and baseline findings of the PUMA study. *Scand J Public*
677 *Health* 2006; **34**(1): 49-58.

678 80. Yoshida Y, Sandall J. Occupational burnout and work factors in community and hospital
679 midwives: A survey analysis. *Midwifery* 2013; **29**(8): 921-6.

680 81. Romani M, Ashkar K. Burnout among physicians. *Libyan Journal of Medicine* 2014; **9**(1).

681 82. National NHS Staff Survey Co-ordination Centre. NHS staff survey for England. 2014; .

682 83. Hunter B. The heart of the job: emotion work in midwifery. *ESSENTIALLY MIDIRS* 2011; **2**(2):
683 17-21.

684 84. Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for misuse of prescription
685 medication among physicians undergoing monitoring by a physician health program. *J Addict Med*
686 2013; **7**(5): 349-53.

687 85. Cleary M, Horsfall J, Baines J, Happell B. Mental health behaviours among undergraduate
688 nursing students: Issues for consideration. *Nurse Educ Today* 2012; **32**(8): 951-5.

689 86. Dorrian J, Paterson J, Dawson D, Pincombe J, Grech C, Rogers AE. Sleep, stress and
690 compensatory behaviors in Australian nurses and midwives. *Rev Saude Publica* 2011; **45**(5): 922-30.

691 87. Green BN, Johnson CD, Adams A. Writing narrative literature reviews for peer-reviewed
692 journals: secrets of the trade. *Journal of Chiropractic Medicine* 2006; **5**(3): 101-17.

693 88. Popay J, Roberts H, Sowden A, et al. Guidance on the conduct of narrative synthesis in
694 systematic reviews. *A product from the ESRC methods programme.Version* 2006; **1**.

695 89. Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB. How to practice and teach
696 EBM. *Edinburgh: Churchill Livingstone* 2000; .

697 90. Choong MK, Galgani F, Dunn AG, Tsafnat G. Automatic evidence retrieval for systematic
698 reviews. *J Med Internet Res* 2014; **16**(10): e223.

699 91. Faucher MA. Most labor and delivery nurses experience secondary traumatic stress. *J*
700 *Midwifery Womens Health* 2013; **58**(1): 114-5.

701 92. Afolayan JA, Dairo BA. Stress in the workplace of Nurses and Midwives in Nigeria. *Journal of*
702 *Behavioural Sciences* 2009; **19**(1-2): 1-21.

703 93. Begley CM. 'Great fleas have little fleas': Irish student midwives' views of the hierarchy in
704 midwifery. *J Adv Nurs* 2002; **38**(3): 310-7.

705 94. Hunter B, Warren L. **Midwives′ experiences of workplace resilience**. *Midwifery* 2014; **30**(8):
706 926–934.

707 95. Hunter B, Warren L. Midwives' experiences of workplace resilience. *Midwifery* 2014; **30**(8):
708 926-34.

709 96. Hunter B. Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery*
710 2005; **21**(3): 253-66.

711 97. Gillen P, Sinclair M, Kernohan G, Begley C. Student midwives' experience of bullying. *EVID*
712 *BASED MIDWIFERY* 2009; **7**(2): 46-53.

713 98. Davies S, Coldridge L. 'No Man′s Land': An exploration of the traumatic experiences of student
714 midwives in practice. *Midwifery* 2015; .

715 99. Sheen K, Spiby H, Slade P. Exposure to traumatic perinatal experiences and posttraumatic
716 stress symptoms in midwives: Prevalence and association with burnout. *Int J Nurs Stud* 2015; **52**(2):
717 578-87.

718 100. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: a
719 descriptive survey (the SWAB study). *Int J Nurs Stud* 2012; **49**(11): 1423-31.

720 101. Hutchinson M. Around half of nurses and midwives report workplace aggression in the past
721 month: 36% report violence from patients or visitors and 32% report bullying by colleagues. *Evidence*
722 *Based Nursing* 2014; **17**(1): 26-7.

723 102. Schluter PJ, Turner C, Benefer C. Long working hours and alcohol risk among Australian and
724 New Zealand nurses and midwives: A cross-sectional study. *Int J Nurs Stud* 2012; **49**(6): 701-9.

725 103. Jordan K, Fenwick J, Slavin V, Sidebotham M, Gamble J. Level of burnout in a small
726 population of Australian midwives. *Women and Birth* 2013; **26**(2): 125-32.

727 104. Mollart L, Newing C, Foureur M. Midwives' emotional wellbeing: impact of conducting a
728 structured antenatal psychosocial assessment (SAPSA). *Women Birth* 2009; **22**(3): 82-8.

729 105. Garel M, Etienne E, Blondel B, Dommergues M. French midwives' practice of termination of
730 pregnancy for fetal abnormality. At what psychological and ethical cost? *Prenat Diagn* 2007; **27**(7):
731 622-8.

732 106. Kalicińska M, Chylińska J, Wilczek-Różyczka E. Professional burnout and social support in
733 the workplace among hospice nurses and midwives in Poland. *Int J Nurs Pract* 2012; **18**(6): 595-603.

734 107. Knezevic B, Milosevic M, Golubic R, Belosevic L, Russo A, Mustajbegovic J. Work-related
735 stress and work ability among Croatian university hospital midwives. *Midwifery* 2011; **27**(2): 146-53.

736 108. Mauri PA, Ceriotti E, Soldi M, Guerrini Contini NN. Italian midwives' experiences of late
737 termination of pregnancy. A phenomenological-hermeneutic study. *Nurs Health Sci* 2015; **17**(2): 243-
738 9.

739 109. Sato K, Adachi K. Occupational stress experienced by Japanese midwives. *British Journal of*
740 *Midwifery* 2013; **21**(11): 801-6.

110. Muliira R, Sendikadiwa V, Lwasampijja F. Predictors of Death Anxiety Among Midwives Who have Experienced Maternal Death Situations at Work. *Maternal & Child Health Journal* 2015; **19**(5): 1024-32.

111. Oncel S, Ozer ZC, Efe E. Work-related stress, burnout and job satisfaction in Turkish midwives. *Social Behavior and Personality* 2007; **35**(3): 317-28.

112. Hunter B. Emotion work in midwifery: a review of current knowledge. *J Adv Nurs* 2001; **34**(4): 436-44.

113. Sheen K, Slade P, Spiby H. An integrative review of the impact of indirect trauma exposure in health professionals and potential issues of salience for midwives. *J Adv Nurs* 2014; **70**(4): 729-43.

114. Wallbank S, Robertson N. Midwife and nurse responses to miscarriage, stillbirth and neonatal death: a critical review of qualitative research. *EVID BASED MIDWIFERY* 2008; **6**(3): 100-6.

115. Begley CM. Great fleas have little fleas': Irish student midwives' views of the hierarchy in midwifery. *J Adv Nurs* 2002; **38**(3): 310-7.

116. Afolayan JA, Dairo BA. Stress in the workplace of Nurses and Midwives in Nigeria. *Journal of Behavioural Sciences* 2009; **19**(1-2): 1-21.

117. Bennett H, Wells A. Metacognition, memory disorganization and rumination in posttraumatic stress symptoms. *J Anxiety Disord* 2010; **24**(3): 318-25.

118. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: A descriptive survey (the SWAB study). *Int J Nurs Stud* 2012; **49**(11): 1423-31.

119. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: a descriptive survey (the SWAB study). *Int J Nurs Stud* 2012; **49**(11): 1423-31.

120. Oulton JA. The global nursing shortage: an overview of issues and actions. *Policy Polit Nurs Pract* 2006; **7**(3 Suppl): 34S-9S.

121. Mizuno M. Confusion and ethical issues surrounding the role of Japanese midwives in childbirth and abortion: A qualitative study. *Nurs Health Sci* 2011; **13**(4): 502-6.

122. The Nursing and Midwifery Council (NMC). The Code: Professional standards of practice and behaviour for nurses and midwives. 2015; .

123. World Health Organization, UNICEF, United Nations Fund for Population Activities. Trends in Maternal Mortality: 1990 to 2010: WHO, UNICEF, UNFPA, and The World Bank estimates. World Health Organization; 2012.

124. Oestergaard MZ, Inoue M, Yoshida S, et al. Neonatal mortality levels for 193 countries in 2009 with trends since 1990: a systematic analysis of progress, projections, and priorities. *PLoS Med* 2011; **8**(8): e1001080.

125. Poverty E. Millennium development goals. *United Nations.Available online: http://www.un.org/millenniumgoals/(accessed on 23 August 2011)* 2015; .

126. Schluter PJ, Turner C, Huntington AD, Bain CJ, McClure RJ. Work/life balance and health: the Nurses and Midwives e-cohort study. *Int Nurs Rev* 2011; **58**(1): 28-36.

127. Skinner N, van Dijk P, Elton J, Auer J. An in-depth study of Australian nurses' and midwives' work-life interaction. *Asia Pacific Journal of Human Resources* 2011; **49**(2): 213-32.

128. Prosser-Snelling E. Safer Births Through Better Teamworking. *The Health Foundation* 2015; .

129. Zapf D, Vogt C, Seifert C, Mertini H, Isic A. Emotion work as a source of stress: The concept and development of an instrument. *European Journal of work and organizational psychology* 1999; **8**(3): 371-400.

784 130. Johanson R, Newburn M, Macfarlane A. Has the medicalisation of childbirth gone too far?
785 *BMJ* 2002; **324**(7342): 892-5.

786 131. Reiger K. Domination or mutual recognition? Professional subjectivity in midwifery and
787 obstetrics. *Social Theory & Health* 2008; **6**(2): 132-47.

788 132. The Royal College of Midwives. State of Maternity Service Report. 2011; .

789 133. Fenwick J, Hammond A, Raymond J, et al. Surviving, not thriving: a qualitative study of
790 newly qualified midwives' experience of their transition to practice. *J Clin Nurs* 2012; **21**(13-14):
791 2054-63.

792 134. West M, Dawson J, Admasachew L, Topakas A. NHS staff management and health service
793 quality. *London: Department of Health* 2011; .

794 135. Blake H, Zhou D, Batt ME. Five-year workplace wellness intervention in the NHS. *Perspect*
795 *Public Health* 2013; **133**(5): 262-71.

796 136. Wallbank S. Effectiveness of individual clinical supervision for midwives and doctors in stress
797 reduction: findings from a pilot study. *EVID BASED MIDWIFERY* 2010; **8**(2): 65-70.

798 137. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus
799 other models of care for childbearing women. *Cochrane Database Syst Rev* 2013; **8**(8).

800 138. Newton MS, McLachlan HL, Willis KF, Forster DA. Are caseload midwives more satisfied
801 and less burnt out than standard care midwives? Findings from two cross-sectional surveys conducted
802 in Victoria, Australia. *BMC Pregnancy & Childbirth* 2014; **14**(1): 463-91.

803 139. Warren L, Hunter B. Reflecting on resilience in midwifery. *Pract Midwife* 2014; **17**(11): 21-3.

804 140. Scott A, Witt J, Duffield C, Kalb G. What do nurses and midwives value about their jobs?
805 Results from a discrete choice experiment. *J Health Serv Res Policy* 2015; **20**(1): 31-8.

141. Wickham S. Caring for ourselves. *Pract Midwife* 2014; **17**(11): 37-8.

142. Byrom S. Feeling the pressure: what can we do? *Pract Midwife* 2014; **17**(2): 46-.

143. Holland M. Intelligent Kindness: Reforming the Culture of Healthcare. *The Psychiatrist* 2012; **36**(10): 399-.

144. Kirkup B. The Report of the Morecambe Bay Investigation. 2015; .

145. Illing J, Carter M, Thompson N, et al. Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision-making in the NHS. 2013; .

146. Longo J. Combating disruptive behaviors: Strategies to promote a healthy work environment. *OJIN: The Online Journal of Issues in Nursing* 2010; **15**(1).

147. Haigh R. The quintessence of a therapeutic environment. *Therapeutic Communities: The International Journal of Therapeutic Communities* 2013; **34**(1): 6-15.

148. Downe S, Finlayson K, Fleming A. Creating a Collaborative Culture in Maternity Care. *The Journal of Midwifery & Women's Health* 2010; **55**(3): 250-4.

149. King TL, Laros RK, Parer JT. Interprofessional collaborative practice in obstetrics and midwifery. *Obstet Gynecol Clin North Am* 2012; **39**(3): 411-22.