PRACTICE ISSUE

Midwives' wellbeing following adverse events – what does the research indicate?

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ABSTRACT

This paper explores the current influences and expectations in relation to adverse events in New Zealand's maternity setting and the affect these have on midwives. Midwives, like other health professionals, have the potential to become the second victim, a term used to encompass the health professional's feelings of despair following an adverse event. Insights from international research and reports are related back to midwifery and a growing number of New Zealand qualitative studies that identify the effect of adverse effects on midwives are highlighted. The evidence indicates that the current tools or support measures that are implemented at the individual or group level may be limited in their effectiveness. Common principles emerge from the literature that could facilitate a midwife's safe journey through the emotional distress when there is an adverse event. These are: understanding the nature of midwifery practice, the midwife's own emotional well-being, providing safe environments, seeking and receiving professional reassurance, and a willingness to learn from the adverse advent. An action research study is planned by the primary author to work with midwives about their experiences of successfully navigating adverse events with the aim of facilitating accessible support to reduce the trauma of adverse events. For midwives to be able to support women and their families they too need to be supported.

KEY WORDS

Adverse Event, Emotional Impact, Support, Second Victim, Midwife

INTRODUCTION

When a midwife is involved in an adverse event, how does she deal with the emotions and consequences? How well is she supported? This paper will explore the international literature related to adverse events, asking, "how does this research relate to midwifery practice in New Zealand?" Much of the literature directly related to New Zealand focuses on a wider group of health professionals. The insights from such research and reports will be related back to midwifery. For example, the concept of health professionals being the 'second victim' will be explored for the purpose of thinking through strategies that might help midwives reduce the emotional trauma implied above, that some sustain. There is a growing body of qualitative research by New Zealand midwives which affirms the emotional impact of adverse events on practice. While qualitative studies by their nature have small numbers of participants, the echo of emotional distress that is revealed in these studies draws attention to the stress experienced by these midwives in both caseload and hospital based midwifery practice. The paper concludes by describing the next steps planned in this action research project towards enacting helpful strategies and tools to support midwives who find themselves involved in an adverse event.

The paper starts with a reflection from the primary author that provided the initial impetus for her proposal to embark on an action research project:

> *When I returned to midwifery practice several years ago, I was scared. What if I made a mistake? Having previously worked in Quality Improvement I was aware of the many safety processes and best practices to prevent harm but sometimes I ran out of time or was distracted and 'forgot' to do them. I found myself taking the less than ideal moments of the day home, to replay, to wonder if I was good enough to still be a midwife. I thought I would have grown out of this behaviour by now, but I haven't. The dread of something I've done (or left undone) stays with me. As I open up this conversation with others, I find they too are scared. They too struggle to make peace with memories of moments that others label as 'adverse events'.* (Diana, primary author)

An adverse event can be described as "an incident which results in harm to a consumer" (Health Quality and Safety Commission, 2013b, p. 4). An adverse event may or may not be preventable. If preventable it can be considered as a result of an individual or a systems error. In New Zealand, in 1998, the rate of hospital admissions, where a preventable in-hospital adverse event occurred during the admission, was 5%. This was determined following a comprehensive chart review (Davis, Lay-Yee, Briant, & Scott, 2003). A more recent, smaller study, undertaken during 2010 – 2011 by Auckland District Health Board, found that 48% of severe maternal morbidity was preventable (Sadler et al., 2013). In a review of maternal deaths in New Zealand 35% were identified as potentially avoidable by an expert panel (Farquhar, Sadler, Masson, Bohm, & Haslam, 2011). The New Zealand Health Quality & Safety Commission reported 437 serious adverse events (including maternity cases) from District Health Boards and 52 from other healthcare providers across New Zealand during 2012-2013 (Health Quality and Safety Commission, 2013a). Serious events were defined as "those

which have resulted in serious harm or death to consumers of health and disability services (Health Quality and Safety Commission, 2013a, p. 5). This number is the result of voluntary reporting and is predominately healthcare facility based; therefore may not be representative of the actual number of adverse events in New Zealand. It is important to note that the number of complaints upheld against midwives is small; however they may have been involved in the care and thus affected by the event (Health and Disability Commissioner, 2009a).

When midwives are involved in the care of women and there is an adverse event midwives live with these memories and can become the second victim, a term used to describe the feelings and experiences of healthcare professionals following an adverse event (Scott et al., 2009). The term 'second victim' was introduced by Wu (2000) in relation to doctors but is applicable to other health professionals, with the patient being the first victim and the health professional the second. The term encompasses the health professional's feelings (which have been described as despair) and relates to a realisation that they were involved in an error, a consequent feeling of isolation and exposure to the often unsupportive response by colleagues and the health system.

WHAT DOES SOCIETY EXPECT OF MIDWIVES?

For the woman and her baby, any adverse event is personal, and she may consider that the health practitioner has failed to deliver the outcome the woman expected when they entered the healthcare relationship. The woman and her family want the issue addressed from their perspective. For example, following the lifting of name suppression in the high profile New Zealand Barlow case (Health and Disability Commissioner, 2013), it was acknowledged that public identification of the practitioner(s) involved would be challenging for that person(s) but, according to a lay reporter, "experiencing the consequences of one's actions is natural justice in action" (Jachin, 2011, para 2). Several recent events from the broader New Zealand health sector also highlight the expectation that name suppression will be lifted. For example, a father, whose son died of meningitis following several presentations to Whangarei Hospital, had a concern that the individuals responsible had not been held accountable, despite an external review being done and recommendations implemented. His reaction is summed up in this quote: "It's unbelievable the HDC [Health and Disability Commissioner's office] don't take them to task. The way the HDC have dealt with the hospital is all pretty soft really" (Johnston, 2012, para 4). Midwives need to be aware that not only will the media name them but there is a growing impetus for mistakes/misinterpretations of practice to be dealt with in more punitive ways.

In another case of meningitis, where a medical student died, the family won the battle in court to have the health professionals, involved in the care, publically named despite the death being identified as a systems issue. The family stated that naming of health professionals involved was "a victory for open justice and freedom of speech"(Johnston, 2013b, para 3). Ron Paterson, New Zealand's former Health and Disability Commissioner, acknowledged the benefit of openness but identified its incongruence with a no-blame, systems approach to improvement, "…it's a tick for transparency and open justice, it raises a question mark for accountability ... and it has the potential to slow our progress in quality improvement and patient safety" (Johnston, 2013a, para 2). A court ruling sets precedents. What happens in practice is shaped by such consequences. Will midwives feel safe in acknowledging mistakes when there is a societal expectation that they will be publically named?

Only months later, with the launch of the National Patient Safety Campaign *Open for Better Care,* New Zealand health care workers are being challenged by the Associate Health Minister, "to be open to acknowledging mistakes and learning from them, open to working closely with patients and consumers, and open to change, improvement and innovation" (Goodhew, 2013, May 17, para 2). Midwives, along with other health professionals, are caught in this tension. It is conceivable that when practice is examined and causes identified that the learning from this could lead to safer care for families. However, we also know that there are differing interpretations of optimal practice and that retrospective analysis can identify issues that are not easily identified at the time. Additionally, there are many situations when midwives have provided optimal care but an adverse outcome has eventuated. But is there a danger that, despite that conclusion, those exonerated individuals are named and shamed in the process? Could it lead to performance management by an employer, appearing before a disciplinary body, or even a loss of employment? The tension between honest openness towards change and secretive avoidance of public disclosure is likely to be at the heart of many practice encounters. Practitioners may already carry a burden of guilt or blame when they are involved in an unexpected outcome or an adverse event. A study of over 700 Australian and New Zealand midwives identified that, for 24% of the respondents, what they feared most was "missing something that caused harm and being blamed for it" (Dahlen & Caplice, 2011, p. s9).

Disclosing adverse events to women and their families is a requirement in New Zealand; however, reporting them within the health system is only mandated if they relate to particular situations such as perinatal and maternal mortality (Health Quality & Safety Commission, 2011). The New Zealand policy on reportable events defines open disclosure or open communication as, "the timely and transparent approach to communicating with, engaging with and supporting consumers, their families and whanau when things go wrong" (Health Quality and Safety Commission, 2013b, p. 5). Disclosing adverse events to women and their families is strongly promoted by the Health and Disability Commission as the ethical and right thing to do (Health and Disability Commissioner, 2009b).

In recent years the serious and sentinel events have been made public in a national report which lists events by District Health Boards. All events that meet the criteria for the report are required to be forwarded for inclusion; however the practice of voluntary reporting varies (Health Quality and Safety Commission, 2013a). Despite health professionals emphasising that a high rate of incidents may reflect the accuracy of reporting the media continue to interpret it differently. Following the 2012 report release Prof Alan Merry was reported as saying, "in some tragic cases errors resulted in serious injury or death. Each event has a name, a face and a family, and we should view these incidents through their eyes" (Cooke, 2012, October 21, para 7). New Zealand research confirms midwives and other health professionals do view these events in relation to the effect they have on the individual woman and relive the events, mostly internally, emotions buried while they continue with their work, hoping that they will not be faced with further adverse events (Jones, 2012; Young, 2011).

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THE EMOTIONAL IMPACT OF ADVERSE EVENTS ON MIDWIVES

Midwifery is focused on facilitating the arrival of new life, not morbidity or death. A study of 12 National Health Service UK (NHS) midwives' experiences, of caring for women and their families following stillbirth, identified that all found the events deeply disturbing, "resulting in them experiencing highly negative emotions and, in some instances, deep unjustified feelings of culpability' (Kenworthy & Kirkham, 2011, p. 17). A small British study concluded that the midwife's experience of a maternal death was comparable with that of "emergency personnel attending large-scale disasters" (Mander, 2001, p. 248). Intense responses to traumatic events were identified in a New Zealand study of 16 midwives, with emotional stress causing illnesses such as anxiety and post-traumatic stress disorder (Calvert, 2011).

Cox and Smythe (2011), in a New Zealand study exploring why midwives leave self-employed midwifery practice, describe midwives as having a feeling of being excessively responsible for outcomes and that impacts their practice. Young's (2011) qualitative study, of the experience of 12 midwives and of the partners of four of those midwives, revealed burnout was often following an adverse event such as being in a situation where the midwife thought the baby would die, that took its toll, ultimately resulting in burnout. Jones's (2012) study on a midwife's first experience of a stillbirth again reflects the deep angst that follows such an episode of practice. "When a baby dies, there is always the question of what could have been done differently. Was the risk already there, or was this unsafe practice (Smythe, 2003). Midwives agonise over such questions in relation to their own involvement, and also in terms of how others may perceive the standard of care. The worry pervades" (p. 20).

The international literature is more extensive for other health professional groups in relation to adverse events. A study involving semi-structured interviews of 20 surgeons in Canada demonstrated the effect of adverse events on a professional group who are perceived as emotionally strong. Surgeons interviewed, who acknowledged emotional trauma following an adverse event, described themselves as "more sensitive and more affected than most surgeons" unlike other surgeons who are "absolute rocks" (Luu et al., 2012, p. 1182). The researchers then interviewed these 'rocks' and discovered they had similar, significant reactions with one stating, "'You didn't think this bothered me as much as it did right?' And there may be a tendency for men to look or appear to be more aloof and not be bothered" (Luu et al., 2012, p. 1182). This was further confirmed by the female interviewees, claiming to be harder on themselves than the male surgeons in the study. Another study involving 7905 surgeons reported that 501 (6.3%) of participants had suicidal ideation during the previous 12 months related to an error (Shanafelt et al., 2011; Varjavand, Nair, & Gracely, 2012). A survey of health professionals in America found that about one in seven staff (175/1160) had anxiety, depression or concerns about being able to perform their job following a patient safety incident and this was irrespective of the type of health professional. Of concern is that "68% of these reported they did not receive institutional support to assist with this stress" (Scott et al., 2009, p. 325). The evidence appears to indicate strongly that all health professionals, including midwives, are affected by something going wrong and can be considered to suffer as the second victim.

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The lack of attention to the wellbeing of the health professional has been identified as a missing response in the management of adverse events in countries such as America, United Kingdom and Sweden (Conway, Federico, Stewart, & Campbell, 2011; Mander, 2001; Seys et al., 2013; Ullström, Andreen Sachs, Hansson, Ovretveit, & Brommels, 2014). Although the data from New Zealand are limited, a survey of thirteen paediatric emergency departments across Australia and New Zealand indicated that they had no policy or programme to provide debriefing despite it being viewed as important for support and learning (Theophilos, Magyar, & Babl, 2009). Calvert's (2011) New Zealand narrative inquiry study, drawing on data from 16 midwives, highlighted that, not only did midwives interviewed fail to be supported after a traumatic or adverse event, but there was evidence of behaviour by other health professionals and organisations involved that exacerbated the trauma. Some participants of the study reported being ostracised by midwifery colleagues with inferences of incompetence. In Calvert's analysis, informed by the sociological writing of Bourdieu, she states: "The form of symbolic violence instigated a breach of relational trust for the midwife arousing emotional effects that created harm for the practitioner, destroying relationships and disrupting lives" (Calvert, 2011, p. 201). In Young's (2011) phenomenological study of 16 participants, there was one instance where a midwife, who was involved with a woman who became life-threateningly ill, was offered formal support, but still she felt misunderstood and chose not to continue with what she experienced as an unsupportive strategy. In another New Zealand phenomenological study (Jones, 2012), there are examples from the five midwives, interviewed about their first experience of dealing with the aftermath of a stillbirth, of both exemplary support and of feeling alone and abandoned. Support mechanisms are variable, with some midwives needing to establish their own network of safe, trusted colleagues to turn to for an opportunity to debrief.

PROMOTING MIDWIVES' WELLBEING

Strategies currently utilised in healthcare in response to adverse events include: debriefing or Critical Incident Stress Management (CISM), peer support, supervision, referral to Employment Assistance Programme (EAP), professional counselling, and support of a colleague. The College of Midwives booklet, 'Unexpected outcome?' also provides guidance on support strategies for midwives (New Zealand College of Midwives, 2008). There is a lack of research that has assessed these tools as effective support strategies for midwives, although there is some research within other disciplines indicating that the current strategies of debriefing may cause potential harm (Dufresne, 2007; Rose, Bisson, Churchill, & Wessely, 2002). From reviewing this literature common principles emerge that could facilitate a midwife's safe journey through the emotional distress when there is an adverse event. These are: understanding the nature of midwifery practice, the midwife's own emotional well-being, providing safe environments, seeking and receiving professional reassurance, and a willingness to learn from the adverse advent (Devilly, Varker, Hansen, & Gist, 2007; Scott et al., 2009; Smythe, 2003; Ullström et al., 2014).

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Understanding the nature of midwifery practice

It is important that midwives recognise the complex nature of healthcare. A New Zealand hermeneutic study of 19 participants explored the meaning of being safe in practice among midwives, women and medical staff. It revealed "a world of practice that is often disordered, where the practitioner is caught up, trapped, and can only do what is possible at the time" (Smythe, 2003, p. 203). During a busy duty the midwife can still only be in one place at one time, even though she knows other women may need her (Fergusson, 2009). Amidst this dynamic flux, woman, midwife, and other practitioners are all caught up in the 'thrownness' of what comes, to circumstance beyond control, being able to neither control feelings nor the configuration of the situation (Wrathall, 2005). Thus, while the midwife may have a commitment to bring a "spirit of safe practice" (Smythe, 2003, p.198), the midwife never carries a guarantee that the outcomes of her practice will be, and remain, safe. The nature of practice is such that even when the midwife and her colleagues are providing safe, competent care, there can still be an adverse event.

Midwife's own emotional wellbeing

Midwives and other health professionals identify a need to talk about a traumatic event, to be listened to and shown empathy (Calvert, 2011; Ullström et al., 2014). It is acknowledged however that despite such a need there are barriers. A midwife's previous, unresolved feelings of grief may lead to an inability to provide effective support to others. The studies by Calvert (2011), Young (2011) and Jones (2012) provide New Zealand examples of avoidance of unpleasant situations by midwifery colleagues when the support was most required. An individual needs to assess their own unresolved traumatic responses. The findings of Smythe's study (2003, p. 202) suggest "that each practitioner needs to monitor the state of their own spirit of safe practice, and to make others aware when they feel the possibility of indifference or neglect is likely to affect their 'being safe'".

Providing safe environments

A further barrier to speaking openly to others, in any setting about an adverse event, is the fear of being stigmatised and judgement that may follow (Ullström et al., 2014). In an American study which interviewed 31 clinicians of varying professional groups a common concern raised was "not knowing who was a 'safe' person to confide in" resulting in a third of participants turning to family members (Scott et al., 2009, p. 328). Speaking up in group situations can also feel unsafe. A study by Devilly et al. (2007) found that misinformation overheard in a debriefing session was later likely to be considered as their eye witness account and used as evidence. Midwives need to provide safe environments where colleagues can talk freely. If, for whatever reason, a midwife is unable to be provided with such collegial support, then referral to an appropriate person, as fitting to the circumstances, is essential to avoid aloneness and suffering in silence (Ullström et al., 2014).

Professional reassurance

'Should I still be a midwife?' Following an adverse event a midwife may question her ability to still be a midwife or whether to continue with the ongoing emotional strain of the trauma. As revealed in all three studies—the study of New Zealand midwives leaving self-employed midwifery (Cox & Smythe, 2011), Young's (2011) study on midwives' experience of burnout, and Calvert's study on midwives' experience of trauma (2011)—it may be that some experienced midwives feel like they have no other option but to leave. Fergusson's (2009) phenomenological study of the experience of five charge midwives in three different New Zealand delivery suites indicated that core midwives are also at risk of facing adverse events and choosing to resign. Professional insecurity can also occur with events where the outcome is good but there is still fear about what could have happened and the midwives can't help but question their own judgement (Ullström et al., 2014). The "what if?" lingers. After an event midwives need to hear of their continuing professional worth as a midwife. They need to know they are still trusted. Or, perhaps more importantly, they need to still have trust in their own skills and integrity of practice.

Need to learn

Reflecting on practice—what happened, why, and what can be done differently—is integral to New Zealand midwifery practice. The New Zealand College of Midwives provides the opportunity for a special review to allow reflection on a specific case if required (New Zealand College of Midwives, 2008). Following an adverse event midwives' need the opportunity to be able to reflect on the actions that seemed sensible at the time, either in their own quiet space or with the safe company of others. Formal review processes aimed at identifying systems for improvement provide an avenue for learning if conducted in a manner that does not add to the emotional trauma (Calvert, 2011). Anecdotal evidence shows midwives and other health professionals can be excluded from the review team and subsequently wait months for feedback, if at all. To avoid the emotional anxiety that grows amidst such silence, those in leadership positions are encouraged to facilitate communication channels to keep the involved midwives informed of the facts rather than allowing needless speculation.

CONCLUSION

So why are we scared? Because we know it only takes a moment's inattention, a lapse into forgetfulness, a distraction, for something to go wrong. We already carry the scars of the past. Do we trust ourselves, our colleagues or the system to get us through the 'adverse event' still to come? What does it take to keep us safe in the aftermath of our all too human lapse? Or to help us see that there was nothing we could have done to change the outcome? Perhaps it is the memories of the times when others gathered around us; listened; understood; helped us to re-find our courage (Diana, primary author).

The significant effect of adverse events on midwives needs to be acknowledged. Midwives can be affected by the fear of adverse events occurring, fear of being blamed for an event and this may be more profound if there is a subsequent lack of support (Calvert, 2011; Cox & Smythe, 2011; Dahlen & Caplice, 2011; Young, 2011). There are a variety of tools or support measures that may be implemented at the individual or group level but none may be successful in easing the emotional distress of the second victim. The next step in this action research journey is to interview midwives about their experiences of successfully navigating adverse events. What helped? What steps did they initiate themselves? How did others support them in a way that helped them to come to a realistic understanding of what happened? What worked in terms of calming the emotional anxiety and relieving the stress? It is anticipated that the phase of the research following the interviews will be to work with stakeholders identifying and developing accessible, helpful strategies to minimise the impact upon the second victims. Having support structures, tools and strategies that prevent or minimise the impact of emotional trauma following involvement in adverse events, is to the benefit of quality care for women and their families, and will help sustain midwives' commitment to practice.

REFERENCES

Calvert, I. (2011). *Trauma, Relational Trust and the Effects on the Midwife* (Doctoral Thesis, Massey University, Palmerston North, New Zealand). Retrieved from http://hdl.handle.net/10179/4081

Conway, J., Federico, F., Stewart, K., & Campbell, M. (2011). *Respectful Management of Serious Clinical Adverse Events.* Cambridge, Massachusetts: Institute for Healthcare Improvement. Retrieved from www.IHI.org

Cooke, M. (2012, October 21). 'Increasing trend' in delayed hospital treatment. Retrieved from http://www.stuff.co.nz/national/health/7978429/Increasing-trend-in-delayed-hospital-treatment

Cox, P., & Smythe, L. (2011). Experiences of midwives' leaving Lead Maternity Care (LMC) practice. *New Zealand College of Midwives Journal, 44*(44), 17.

Dahlen, H., & Caplice, S. (2011). What do midwives fear? *Women and Birth, 24*(Journal Article), S9-S9. doi:10.1016/j.wombi.2011.07.044

Davis, P., Lay-Yee, R., Briant, R., & Scott, A. (2003). Preventable in-hospital medical injury under the "no fault" system in New Zealand. *Quality & Safety in Health Care, 12*(4), 251-256. doi:10.1136/qhc.12.4.251

Devilly, G. J., Varker, T., Hansen, K., & Gist, R. (2007). An analogue study of the effects of psychological debriefing on eyewitness memory. *Behaviour Research and Therapy, 45*(6), 1245-1254. doi:10.1016/j.brat.2006.08.022

Dufresne, R. L. (2007). *Learning from critical incidents by ad hoc teams: The impacts of team debriefing leader behaviors and psychological safety* (Doctoral Thesis, Boston College, Boston, United States of America). Retrieved from http://aut.summon.serialssolutions.com

Farquhar, C., Sadler, L., Masson, V., Bohm, G., & Haslam, A. (2011). Beyond the numbers: classifying contributory factors and potentially avoidable maternal deaths in New Zealand, 2006-2009. *American Journal of Obstetrics and Gynecology, 205*(4), 331.e331-331.e338. doi:10.1016/j.ajog.2011.07.044

Fergusson, L. (2009). *Working as a coordinator midwife in a tertiary hospital delivery suite: a phenomenological study* (Masters Thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://hdl.handle.net/10292/725

Goodhew, J. (2013, May 17). *New national patient safety campaign launched.* Retrieved 21 October, 2013, from http://www.hqsc.govt.nz/news-and-events/news/916/

Health and Disability Commissioner. (2009a). *Decisions and Case Notes.* Retrieved 25 September, 2014, from http://www.hdc.org.nz/decisions--case-notes

Health and Disability Commissioner. (2009b). *Guidance on Open Disclosure Policies.* Wellington, New Zealand. Retrieved from http://www.hdc.org.nz/media/18328/guidance%20on%20open%20disclosure%20policies%20dec%2009.pdf

Health and Disability Commissioner. (2013). *Decision 12HDC00876* Wellington, New Zealand: Health and Disability Commissioner. Retrieved from http://www.hdc.org.nz/media/254684/12hdc00876.pdf

Health Quality & Safety Commission. (2011). *Perinatal and Maternal Mortality Reveiw Commitee - Terms of Reference.* Retrieved 25 September, 2014, from http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/about-us/terms-of-reference/

Health Quality and Safety Commission. (2013a). *Making health and disability services safer: Serious adverse events reported to the Health Quality & Safety Commission 1 July 2012 to 30 June 2013.* Retrieved 7 April, 2014, from http://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Making-health-and-disability-services-safer-Serious-Adverse-Events-Nov-2013.pdf

Health Quality and Safety Commission. (2013b). *New Zealand Health and Disability Services – National Reportable Events Policy 2012.* Wellington, New Zealand. Retrieved from http://www.hqsc.govt.nz/our-programmes/reportable-events/

Jachin. (2011, February 11,). *Baby Adam Barlow inquest: midwife's identity revealed.* Retrieved from http://mandenomusings.wordpress.com/2011/02/11/baby-adam-barlow-inquest-midwifes-identity-revealed/

Johnston, M. (2012, September 18). Saving Lives: family denied justice over son's death - Dad. *The New Zealand Herald.* Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10834727

Johnston, M. (2013a, March 21). Naming of health workers raises fears. *The New Zealand Herald.* Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10872524

Johnston, M. (2013b, March 19). 'Zac will rest easier' after naming. *The New Zealand Herald.* Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10872142

Jones, K. (2012). *A heavy heart and a pocket full of grief: an interpretive enquiry of midwives' first experiences of still birth as a community based midwife* (Masters Thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://hdl.handle.net/10292/5466

Kenworthy, D., & Kirkham, M. (2011). *Midwives Coping with Loss and Grief: Stillbirth, Professional and Personal Losses.* London, United Kingdom: Radcliffe Publishing Ltd.

Luu, S., Patel, P., St-Martin, L., Leung, A. S. O., Regehr, G., Murnaghan, M. L., ... Moulton, C. a. (2012). Waking up the next morning: surgeons' emotional reactions to adverse events. *Medical Education, 46*(12), 1179-1188. doi:10.1111/medu.12058

Mander, R. (2001). The midwife's ultimate paradox: a UK-based study of the death of a mother. *Midwifery, 17*(4), 248-258. doi:10.1054/midw.2001.0275

New Zealand College of Midwives. (2008). *Unexpected Ouctomese? Legal & Professional Advice for Midwives.* Retrieved 25 September, 2014, from http://www.midwife.org.nz/quality-practice/unexpected-outcome

Rose, S., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews (Online)* (2), CD000560. doi:10.1002/14651858.CD000560

Sadler, L., Austin, D., Masson, V., McArthur, C., McLintock, C., Rhodes, S., & Farquhar, C. (2013). Review of contributory factors in maternity admissions to intensive care at a New Zealand tertiary hospital. *Am J Obstet Gynecol, 209.* doi:doi.org/10.1016/j.ajog.2013.07.031

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Brandt, J., & Hall, L. W. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Quality & Safety in Health Care, 18*(5), 325-330. doi:10.1136/qshc.2009.032870

Seys, D., Vanhaecht, K., Scott, S., Wu, A., Van Gerven, E., Vleugels, A., ... Sermeus, W. (2013). Supporting involved health care professionals (second victims) following an adverse health event: a literature review. *International Journal of Nursing Studies, 50*(5), 678. doi:10.1016/j.ijnurstu.2012.07.006

Shanafelt, T. D., Balch, C. M., Dyrbye, L., G, B., Russell, T., Satele, D., ... Oreskovich, M. R. (2011). Special report: suicidal ideation among American surgeons. *Archives Of Surgery, 146*(1), 54-62.

Smythe, E. (2003). Uncovering the meaning of 'being safe' in practice. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 14*(2), 196-204. doi:10.5172/conu.14.2.196

Theophilos, T., Magyar, J., & Babl, F. E. (2009). Debriefing critical incidents in the paediatric emergency department: current practice and perceived needs in Australia and New Zealand. *Emergency Medicine Australasia: EMA, 21*(6), 479. doi:10.1111/j.1742-6723.2009.01231.x

Ullström, S., Andreen Sachs, M., Hansson, J., Ovretveit, J., & Brommels, M. (2014). Suffering in silence: a qualitative study of second victims of adverse events. *BMJ Quality & Safety, 23*(4), 325. doi:10.1136/bmjqs-2013-002035

Varjavand, N., Nair, S., & Gracely, E. (2012). A call to address the curricular provision of emotional support in the event of medical errors and adverse events. *Medical Education, 46*(12), 1149-1151. doi:10.1111/medu.12074

Wrathall, M. (2005). *Heidegger.* London, United Kingdom: Granta Publications.

Wu, A. W. (2000). Medical error: The second victim. British Medical Journal, 320(7237), 726.

Young, C. M. (2011). *The experience of burnout in case loading midwives* (Doctoral Thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://hdl.handle.net/10292/2447

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Austin, D., Smythe, E., Jull, A. (2014) Midwives' wellbeing following adverse events – what does the research indicate? N*ew Zealand College of Midwives Journal, 50,* 19-23 http://dx.doi.org/10.12784/nzcomjnl50.2014.3.19-23