Women and Birth xxx (xxxx) xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth

A qualitative study of early career Australian midwives' encounters with perinatal grief, loss and trauma

Annabel Sheehy *, Kathleen Baird

Centre for Midwifery, Child and Family Health; University of Technology Sydney (UTS), Australia

ARTICLE INFO

Keywords:
New graduate midwife
Perinatal death
Maternal death
Clinical competence
Clinical debriefing
Maternal grief

ABSTRACT

Problem: The health of women is dependent on midwifery workforce stability. Retaining new midwives is paramount, however without support, the early career can be a vulnerable time for midwives.
Background: Midwives care for women who experience poor perinatal outcomes like stillbirth and neonatal death. Midwifery care in these sentinel events is complex. There is limited understanding of early career midwives' experiences within these encounters.
Aim: To understand the experiences of Australian early career midwives' clinical encounters with perinatal grief, loss and trauma.
Methods: A qualitative descriptive/exploratory study using in-depth interviews.
Findings: Four themes were identified from interview data: (1) all eyes on the skills; (2) support is of the essence; (3) enduring an emotional toll; (4) at all times, the woman. Most participants had minimal exposure to perinatal loss as a student. As a result, most felt unskilled and unprepared for this as a new midwife.
Discussion: Types and degrees of support varied in these encounters. Early career midwives who were well supported reflected positively on working with grief and loss. In contrast, inadequate or absent support had detrimental effects on participant wellbeing. Poorly supported encounters with death (intrapartum fetal, early neonatal, and maternal) in the early career period were significantly distressful, giving rise to mental and emotional distress.
Conclusion: Pre-registration perinatal loss skill development and supported experiences are necessary for preparedness. Continued education, formalised debriefing and mentoring, institutional philosophies which promote collegial ethics of care, and the expansion of continuity of midwifery care models will improve new midwives' experiences.

Statement of significance

Problem or issue

New midwives are more vulnerable to distress, have a bigger risk of burnout, and a greater desire to exit the profession than their more experienced colleagues. Understanding the impact of working with women experiencing perinatal grief, loss, and trauma on the new midwife is valuable.

What is already known

Some new midwives have educational training and student experience with perinatal grief, loss and trauma prior to employment. To provide this care requires preparedness, training and emotional competence due to the complexity of clinical needs in these encounters.

What this paper adds

Participants' access to pre-registration experiences with perinatal grief, loss and trauma was limited. Adequate practical training with support improves new midwives' experiences and personal outcomes.

1. Introduction

Considering the specialised nature of midwifery [1], there is concern that the Australian and international midwifery workforce will be inadequately staffed for future requirements [2,3]. Compounding this concern are the current challenges that the Australian midwifery profession is facing regarding workforce retention [4], with indications that the number of midwives considering leaving are increasing [4–6]. The early career period is a vulnerable time for a midwife, during which they are susceptible to leaving the profession [4]. It has been proposed that the inclination to leave midwifery in less experienced and younger

* Corresponding author.
E-mail address: annabel.sheehy@uts.edu.au (A. Sheehy).

https://doi.org/10.1016/j.wombi.2022.01.009
Received 8 August 2021; Received in revised form 19 January 2022; Accepted 20 January 2022

midwives is due to their greater likelihood of experiencing work-related burnout, depression, anxiety, and stress [7]. Reduced workforce numbers because of early career midwifery attrition are detrimental to the profession and the health of the community.

One factor influencing occupational vicissitude is stress arising from the midwifery role. Although rewarding, being a midwife is also demanding [8] and several elements of the role have been referred to as taxing emotion work [9]. It is now evident that the emotional cost of being a midwife may contribute to workforce attrition and the desire to leave midwifery due to psychological stress, occupational burnout, and job dissatisfaction [10]. Also associated with waning job satisfaction and diminished emotional health are institutional pressures and hospital directives impeding midwives in their provision of safe woman-centred care [11,12]. Role dissatisfaction and eroding wellbeing have consequences for women and babies [13] due to the potential of these to undermine the quality and safety of midwifery care [14–16]. Both midwifery workforce stability and the safety and efficacy of care are therefore reliant upon an emotionally well and adequately staffed midwifery workforce [17]. One means of promoting workforce stability is by new midwives remaining in their employment and being in possession of their health and emotional wellbeing. The early career period is a critical interval for the health and wellbeing of midwives as additional responsibilities and previously unencountered tasks can contribute to emotional and professional distress [18,19].

2. Background

Not all new midwives will have had exposure as a student to the wide gamut of clinical experiences that encompasses maternity care. It is not until the early career period, when autonomous practice and stressors within the role are wholly comprehended [20] and that true comprehension of what it is to be a midwife is fully appreciated [21]. The steep learning curve and newfound responsibilities that greet new midwives can lead to work stress and impact upon employment decisions [22], particularly when clinical and emotional support is lacking [23].

One aspect of the role that early career midwives may not be familiar with, owing to deficient or absent exposure during clinical placement, is perinatal grief, loss and trauma-related events [24]. These encounters can be defined as working with women and their families in stressful and traumatic life events, and which have significant morbidity and mortality as their outcome. The high income status and universal health system in Australia means that childbearing is safer than in many other countries. Even so, midwives across Australia care for six stillbirths and two neonatal deaths per day [25] and experienced midwives may encounter these events with frequency [26,27]. Other components of clinical care comprising perinatal loss include prenatal diagnosis of fetal abnormalities [28], medical terminations of pregnancy [29], maternal death [30] and assumption of care [31,32]. Perinatal loss has enduring impacts on the future wellbeing of women and their families [33] and the care requirements in these encounters are numerous and require clinical, medical, communicative and psychological expertise [34]. Midwives competent in these complex skills have the potential to improve maternal health outcomes during and after perinatal grief and loss events. Improved outcomes for women require exemplary midwifery care, which itself requires educated, skilled and competent staff in sufficient numbers [35].

Australian midwives have a responsibility to provide care for all women, even when the experience or outcome may be difficult and demanding. Notwithstanding this professional duty, such clinical encounters are emotionally stressful for those involved [36,37] and without support can lead to occupational burnout [38]. Midwives bear an immense emotional and psychological burden from witnessing and working with childbearing-associated trauma [39]. Given the emotive power of the role in times of joy, the capacity for exposure to perinatal loss to generate distress [19,39] may lead to secondary traumatic stress of midwives [26,37,39]. Known as vicarious traumatisation, secondary traumatic stress can arise when clinicians are involved in maternal and family bereavement, grief and loss [40,41]. Midwives may encounter these events frequently, unexpectedly, or unpredictably and this recurrent, erratic, or random nature of trauma can compound clinician distress [34]. Cumulative exposure to traumatic experiences, particularly when the work environment is unsupportive, may result in the development of longstanding psychological distress [17].

The potential for perinatal grief and loss to generate distress in midwifery students [42] and the pre-registration educational supports required by them [43] have been examined in the literature. However, research is lacking about early career midwives' experiences and their support in these encounters. Some studies infer that not all students have encountered death during their midwifery placement [34]. The unpredictable nature of mortality and the competing demands of clinical placement mean that students may not have encountered death at any point during their midwifery program. Limited student exposure and hands-on training of midwifery skills required in events with significant consequences detract from clinician competence and confidence, as identified by a study examining competence and confidence with domestic violence screening [44]. New midwives who feel emotionally unequipped for working with the intense emotional gravity that accompanies perinatal death [24,42] may not provide quality midwifery care, which may potentially contribute to long-term negative consequences for women [45].

Newly qualified midwives are yet to develop sophisticated strategies required for coping with perinatal loss [46]. The early career period is a time when competence is still progressing, resilience skills are in their nascency, proficiency with high-level communication skills are developing, the appropriate expression of empathy is yet to be learned, and close-knit collegial support networks are still being discovered. The significance for the new midwife is that they may be providing care with minimal or absent training [24] and incomplete self-restorative mechanisms. Therefore, novice midwives may be susceptible to developing distress and negative outcomes when providing midwifery care in grief, loss and trauma-related events [47].

3. Research aim

The aim was to explore whether early career midwives' encounters with perinatal grief, loss and trauma impact wellbeing and job satisfaction. In view of the vulnerability of new midwives to endure distressful events, their heightened potential for burnout, their greater desire to exit the profession, and the limited data in this sub-population, this project focused on the first five years of employment.

4. Methods

Due to the dearth of research in early career midwives, this was a descriptive/exploratory qualitative study, drawing on a convenience sample of self-selected participants across Australia. Descriptive and exploratory methodology has been identified as valid and appropriate for research which seeks insight into a poorly understood phenomenon [48].

4.1. Participants and recruitment

Midwives who had undertaken their pre-registration education and had commenced working as a registered midwife in Australia, and were within their first five years of practice, were eligible to participate. Participants were included even if they had left midwifery, but only if the data collection was within five years of commencing midwifery employment. An advertising flyer was distributed via the Australian College of Midwives (ACM) research opportunities newsletter in May 2021. A flyer was also distributed amongst midwifery academic and clinician networks by social media, leading to snowball sampling. Decisions regarding the adequacy of the sample size were made by

collectively evaluating the processes of participant sampling, data collection and data analysis [49]. The included number of participants had to supply enough raw data to permit the development of themes and be representative of their experiences. Rather than predicting a set sample size at the outset of the study, participant recruitment ceased when both data saturation and variation in participant composition occurred [50]. Composition variety was measured by demographic and workforce differences amidst the sample and when the raw data allowed for an adequate analysis, including comparison and contrasting of experiences within the phenomenon under study.

4.2. Ethics

Approval was provided by an accredited university ethics committee [UTS HREC ETH20-5659]. The flyer and associated participant information sheet provided eligibility criteria and contact details if a potential participant wanted to discuss the study or wished to participate. Participation was entirely voluntary. Initial correspondence was by email, instigated by the potential participant and eligibility was established. Verbal communication by telephone followed if the potential participant permitted. A suitable time for a telephone interview was organised. Written and verbal informed consent was gained prior to data collection and participants were assured of confidentiality. Due to the potentially traumatising subject matter, a distress protocol was developed to follow should a participant become distressed, and participants were aware they could cease the interview at any time without consequence. Data was stored via secure data management software and will remain confidential until it is destroyed in due course.

4.3. Data collection

One-off in-depth semi-structured qualitative interviews were undertaken with individual participants via telephone. Although an interview question list was developed, the interviews were participant-led using open-ended questions, allowing participants to provide in-depth accounts of experiences. Interview duration therefore varied, ranging between 50 to 90 min, which provided a total of 955 min of raw data. Telephone interviews maintained participant anonymity and privacy, which aided the generation of in-depth data about this sensitive topic [51]. Interviews were digitally recorded then transcribed verbatim. Emotions and nonverbal communication were included in analysis. Any preconceived notions about the topic held by the interviewing researcher (first author) were minimised by concentrating on participant's language and narrative and by verifying meaning with participants. Extensive field notes were written immediately post interview.

4.4. Data analysis

An iterative data analysis approach for the identification and development of emerging thematic patterns was undertaken, which is congruous to the inductive exploratory methodology, often utilised in studies that aim to understand experiences within a complex phenomenon [52]. Braun and Clarke's (2006) demarcated, yet flexible, process guided data analysis [52]. Using both the transcripts and field notes, data analysis was initiated by the first author via a repeated close reading of the raw data. This step aimed for initial comprehension and familiarisation and the creation of preliminary codes. Transcripts were read multiple times to ensure concepts were emerging from the content, rather than memory of the interview. Due to the broad and exploratory subject matter and sizeable transcripts, the process of reading was circular and re-reading and researcher reflection on perceived insights was necessary. The concepts embedded within the narratives were preliminarily coded when patterns were established firstly within one transcription, then across the whole data set. Collaboration between the two researchers allowed for finalisation of code names and these were used in a further re-reading of data to identify concepts within an individual's data set, which were tabulated in a Word Document. Themes were generated through the collating of the coded data and reviewed repeatedly in a systematic fashion, with names being formed, revised, and retitled through researcher discussions. The process required moving back and forth amongst the data for the interpretation of the phenomenon to emerge as coherent and distinctive themes and sub-themes. Visual mapping provided a modifiable visual representation of the process and aided thematic structuring and how data interrelated. Thematic nomenclature was conceived by using participant language to augment faithfulness of themes to the essence of the data. Developing meaning and the verification of findings was determined by reflexive, shared discussions between the researchers and repeated examination of the raw data. Thematic findings were also shared with five participants to ensure fidelity to their experiences, further adding to the trustworthiness of the research.

5. Results

Interviews were undertaken in June 2021 ($n = 15$). Data saturation was reached and the decision to cease recruitment was made when interviews had supplied adequate raw data to allow for comparison and contrasting of participant experiences [50]. Table 1 shows participant characteristics. All but three participants were in their twenties. Three had left midwifery altogether and two had moved out of birthing care, all quoting traumatic experiences as grounds for their decision. These participants had no current plans to return to midwifery employment or to intrapartum midwifery. Another two participants were on maternity leave and intending to return to practice. Employment locales varied amongst metropolitan, regional, rural and remote settings. Pre-registration clinical placements were diverse, including secondary and tertiary care levels and the private sector. Employment roles ranged from transitional midwife, rotational midwife, antenatal clinic, postnatal clinic, caseload midwifery in a midwifery group practice including publicly funded homebirth.

Table 1
Characteristics of the study population.

Variable	Study participants
n	15
Gender (*n*, %)	
Female	15 (100)
Male	0 (0)
Other	0 (0)
Age in years (mean (range))	26.7 (22–42)
Pre-registration education program (*n*, %)	
Grad Dip	5 (33.3)
BMid	6 (40)
MMid	3 (20)
BM/BN	1 (6.6)
Duration of practice in years (mean (range))	2.4 (0.5–5)
Currently working as a midwife (*n*, %)	
Yes	10 (66.6)
No	5 (33.3)
Sector of current employment (*n*, %)	
Public	10 (66.6.)
Private	0 (0)
n/a	5 (33.3)
Current employment role (*n*, %)	
Clinical	10 (66.6.)
Non-clinical	0 (0)
n/a	5 (33.3)
Place of residency (*n*, %)	
ACT	3 (20)
NSW	5 (33.3)
VIC	1 (6.6)
NT	2 (13.3)
WA	2 (13.3)
QLD	2 (13.3)

6. Findings

Findings emerged as four themes (Table 2) and each will be illustrated by participant quotes which exemplify each theme. A code reveals interview order ('P' denoting participant). The research findings and titles of the themes and sub-themes resonated with the five participants confirming experiences. Encounters considered perinatal grief, loss and trauma-related events included: miscarriage, medical and late-term termination, antenatal and intrapartum fetal death, neonatal death, poor neonatal outcomes, maternal death, maternal collapse and obstetric emergencies.

6.1. Theme one: all eyes on the skills

Once practicing, many participants possessed an increased focus on clinical skills and administrative procedures when tasked with perinatal grief and loss encounters. This hypervigilance was due to their perception of not having adequate education and hospital practice of the required technical skills. This meant many felt they had to learn on the job, with one saying:

> *I think there was probably a small module on it somewhere but there were no specific assignments. There were no specific lectures. There were no specific days, there was nothing specifically on it, so I've learnt a lot of the stuff on-the-job as a midwife* (P1).

Many felt there was "a ghost of a chance" (P15) for new graduates to have prior clinical exposure to perinatal loss prior to employment. Eleven participants felt they possessed an undeveloped skill set for this care. One participant related their unpreparedness to reality shock:

> *There's a very small unit at uni where they talk about death and how that's a part of midwifery. It seemed not enough really, when it came to me going through it at work, I didn't really feel very well-prepared to deal with it. I just had never experienced an adult die, let alone a baby. It was a huge shock and a big reality check about what midwifery involved* (P2).

6.1.1. Sub-theme: protectionism, but of whom?

Deficient student exposure to grief and loss events was perceived by some participants to be due to a form of student protectionism. The subject requiring protection was twofold.

Firstly, participants considered student exclusion from perinatal loss encounters was authoritative and purposive. Perceptions were of intentional defending of women against the incursion of students into women's grief by midwives "trying to minimise the amount of people who enter their room" (P5). Participants considered their exclusion from these encounters was due to their lack of required skills, which could worsen an already awful experience for women:

> *It is hushed away a little bit, and obviously not just to protect the students, but obviously for the families, I think having a student in there observing could be a bit too much for them* (P2).

Student involvement was also thought to not be desired by women, with one participant reflecting:

> *I'm not sure* every *birthing woman would want a student, but especially in a moment of grief, in that kind of situation. Maybe they want more privacy* (P10)*?*

Secondly, midwives were perceived to be protecting students from the 'realities' of midwifery practice and psychological harm arising from inexperience:

> *"Oh no, don't come in you don't want to see this, you don't want to experience this yet, don't look". A lot of students get nervous and don't know what to say, how to talk to women. Midwives often discourage students from going into those rooms (*P12*).*

Many considered there to be absent opportunities for hands-on student learning within the safety of the student-midwife relationship. As a result, those participants believed they were "thrown in the deep end" (P15) once graduated. One participant stated that new midwives were then unprepared for employment:

> *They hide you away from it and then once you're qualified then they just chuck you in the deep end. They don't expose you to it – you don't hear anything about it until you're a new grad* (P4).

Being the primary midwife in these encounters once employed was nonsensical considering they felt unprepared for this work due to student protectionism. One participant said:

> *When you're a student people say we'll keep you away from that, and then you get that magic registration that suddenly changes everything and people say, right you're out there now, you're one of us, you've got to just go and do it* (P9).

6.1.2. Sub-theme: actively seeking preparedness

For many, a hyper-focus on arming themselves with perinatal loss skills resulted from fears of making clinical and administrative mistakes due to a lack of pre-registration training. Perceptions of unpreparedness related to under-developed communication and technical skills, with many stating it was 'confronting', 'terrifying', and 'frightening' when undertaking this care.

> *What if I do something wrong with handling the baby? Because the baby feels different, and I was freaking out when a woman asked me to bath and dress the baby. All these little technical things were difficult because you don't know whether you're doing the right thing or not* (P5).

Student involvement in these cases was not perceived as the norm. Only one reported their experience being actively organised by their educator. Active self-promotion and "putting up my hand" (P3, P8) and "advocating to get into those rooms" (P12) was required for experience, "otherwise you won't gain the exposure" (P3). Underlying these efforts was a belief they would benefit from being involved, one said:

> *I was someone that put my* hand *up and said, "look, this is something that I really want to know before I'm out there as a brand new grad and having to do this all by myself"* (P8).

Many of the participants raised their concerns that their hyper-focus on clinical and communication skills as a new midwife in these encounters detracted from their ability to emotionally care for women:

> *During the actual process I didn't – I wasn't able to connect with her which I really regret not being able to* (P2).

Only one participant reported having had a dedicated university subject. All others reported that theory and learning was threaded through numerous subjects. Many suggested that university focused only on women's emotional experiences of loss, forsaking practical skill development, with one stating:

> *I think what uni does very well is talk about how to be with women and I think what is done less well is the clinical care* (P7).

Table 2
Study findings as themes and subthemes.

Themes	Sub-themes
All eyes on the skills	Protectionism, but of whom? Actively seeking preparedness
Support is of the essence	Wheel of fortune A blueprint of support
Enduring an emotional toll	Anticipated grief Unwarranted guilt
At all times, the woman	

On the other hand, some felt unprepared for the emotional work associated with these encounters, with one participant saying:

> *There was nothing on how to support those women or what support staff get and how to look after yourself* (P12).

In contrast to perceptions of skill inadequacy, this participant indicated feeling prepared due to adequate university learning, saying:

> *I am satisfied with how the uni approached that, and I did feel quite prepared for a lot of that side of things* (P9).

Feeling well-equipped despite skill illiteracy was due to woman-centred education and the understanding that women's needs are paramount. Despite not feeling technically confident, they felt sufficiently developed in their empathy and inter-relationship skills:

> *I could communicate well with the woman in this clinical encounter. Despite not having the clinical skills, you felt that your skill level was high enough that you could undertake this care even though you hadn't done the tasks before* (P5).

6.2. Theme two: Support is of the essence

Supported practice was perceived to be crucial. The type and degree of support was a contributing factor to how effective participants were when providing care in these situations as a new midwife and how participants responded in the aftermath of grief and loss encounters. Supportive midwives were perceived as being exemplary, with one participant reflecting on her positive experience with one such midwife:

> *I think it is important to have some exposure with amazing support. I received support from a midwife who had herself experienced pregnancy loss. She was the most sensitive, empathetic and beautifully kind* woman*, she was so supportive, she showed me the morgue, the cold cots and their set up, the memory boxes and the little angel dresses. She showed me how it worked, the paperwork, the swabs and tests and wanting to be able to provide care for women in that position. She taught me a lot about being able to step back. Being able to breathe with people. Being able to step back as a midwife. She was an amazing woman* (P10).

6.2.1. Wheel of fortune

This subtheme refers to the random chance of the availability, accessibility and provision of support. Receiving support was not considered routine, but "fortunate" (P9) or "lucky" (P8), with some suggesting it was related to staffing levels. Those with pre-registration experience considered themselves lucky, with one revealing:

> *I was lucky enough to experience – fortunate enough to experience a medical termination during my student year, so to me it was seen as part of midwifery and normal to practice, whereas other students didn't get that opportunity. Once they were midwives, they had to learn on their feet, and it was a rather strange way for them to learn* (P2).

Various care approaches based on midwives' degree of comfort with loss was perceived to lead to varying levels of expertise amongst senior staff. Therefore, only certain midwives were "happy" (P12) or "skilled enough" (P15) to provide support to new midwives, as explained by this participant:

> *There's a good portion of our staff that just refuse to be involved when it comes to fetal death. Potentially it is due to clinical skills and not feeling confident in their clinical skills, so therefore not feeling able to support and perform the job* (P1).

Assuming responsibility without senior support was difficult. There were references to senior midwives refusing to take part in perinatal loss care. One participant said:

> *We've got a lot of senior midwives on the antenatal ward who have been there for years. They believe that they've done their fair share of perinatal losses, and so they will often refuse to help with that or to take care of a woman if there's a new grad or a junior who is available to take care of that woman. When I was asking for help, I felt that their opinion was, well, it's not my patient. I've done this. It's your job now. And the only support that I felt I could receive was from my fellow new grads who had dealt with it the week before and could give me some advice on that* (P13).

6.2.2. Sub-theme: a blueprint of support

The importance of and desire for support was universally reported, often arising in discussions relating to its reported absence. One participant noted that new midwife support was important due to their inexperience:

> *It was harder as a new grad because you're already trying to get all your skills consolidated and then also having to encounter these new death experiences that you haven't experienced before* (P4).

Support was sustaining and it came in various forms, practical and otherwise, mainly as informal support from midwifery colleagues, often as simple as "a cup of tea" (P5). Practical assistance, skill advice, stepping in to lend a hand, reassurance and kind words were all considered informal midwifery supports to the newly employed:

> *But when you get support from a more* senior *midwife around those task-y skills, you're not just getting provided those skills support. It's a bit more. If a midwife says, "Do this form and do that form and do this form," and she says it in a nice way, it feels like you're getting a big hug from her at the same time* (P6).

Another source of support was noted to be relationships forged within midwifery group practices:

> *The closer friendships in caseload are more supportive when you have experienced, say, a traumatising experience like a stillbirth. Talking is debriefing. And the constant relationships in caseload mean your experience is not forgotten and you can deal with it better* (P15).

Formal supports were perceived to be structured, organised and top-down provided by management and institutional processes. These were regarded by most to be hard to access. Interactions with managers were desired but were reported to be largely absent, with one participant stating:

> *My manager didn't reach out to me for about two weeks. Having a conversation, a lot earlier would've been supportive, and there was no debrief after it either. I think having my manager come to me sooner and check in and see if I needed to take time off or tell me how to access the hospital counsellor would've been a lot more supportive. I had to seek everything out myself and it wasn't very clear cut, even for the managers. They didn't even tell me what leave to use and to get a certificate or anything. I feel like looking after staff should be their number one priority* (P2).

However, accessing formal support from managers was not illusory for all:

> *The unit manager that would set up the meetings* and *the debriefs and send out emails and say "anyone affected or who wants to come and sit in or participate, you know, please do so"* (P10).

Similarly, this participant considered her manager to be supportive, saying:

> *She takes time to see how you're all going, what your thoughts on it are, how you're feeling about it, rather than just going, "OK, this is your caseload, get on with it," like others might* (P1).

6.3. Theme 3: enduring an emotional toll

All participants endured an "emotional toll "(P4) from caring for perinatal grief, loss and trauma. The degree of support was crucial to the extent of this emotional toll. Supported experiences were important to acquaint the inexperienced with strategies for resilience:

> *I think having that exposure as a student, of having the support as a new grad to be able to learn that and not let it be overwhelming or all-consuming, is so vital. You know, to be able to learn that, yes, it's trauma and grief and pain, but it's not your trauma or your grief, your pain, you can put it down. You must be able to put it down otherwise you'd burn out (P10).*

6.3.1. Sub-theme: anticipated grief

Those who received synchronous, early and continued support were more likely to experience *anticipated grief*. This grief is sadness within normal limits, is brief in duration and does not negatively impact one's personal life. In anticipated grief, blame was not directed to the self and guilt was not considered theirs:

> *I was sad for them, I still think back, and my heart breaks a little bit for her now, but it's finding that line where it's OK, that it's not your trauma* (P10).

Another factor associated with anticipated grief was the type of clinical encounter experienced. When an adverse pregnancy outcome was perceived to be because of natural causes rather than clinical decisions made in practice, participants experienced *anticipated grief*. Certain encounters appeared not to be related to participant experiences of prolonged and deep grief. These included preterm birth, medical termination, or antepartum stillbirth:

> *Some situations are so sad but are easier to swallow, when you reflect on them and can see that it had absolutely nothing to do with your midwifery practice, like a woman presenting to birth unit with a stillbirth* (P15).

6.3.2. Sub-theme: unwarranted guilt

Participants who received no support during and after a traumatic encounter experienced deep remorse. *Unwarranted guilt* refers to guilt being forged and felt by the participant. One participant said:

> *I think being new and not having gone through that all before was hard because I just felt so guilty* (P2).

Clinical events leading to *unwarranted guilt* were associated with intrapartum fetal death, neonatal demise at or soon after birth, or maternal death, especially when the case underwent protracted root cause analyses. Unfortunately, even when serious adverse events occurred there were instances of participants receiving no support:

> *We stayed around until we knew she'd survived the surgery and went to ICU, which was midday after a night shift. And no one offered me any support. I didn't turn up for work the next night. I didn't know if she'd survived in ICU or not. I didn't know what had happened. When I had to work next there was no support for it* (P9).

Participants spoke of being culpable, or possessing blameworthiness, for the outcome. One participant, through tears, remembered:

> *I sat in the shower for an hour crying wondering if I'd killed the baby* (P9).

Repeated exposure and objectionable participation in medically-induced trauma arising from the medicalisation of birth was also a cause of accumulative trauma, with this participant saying:

> *One in three women in Australia are traumatised by their birth experience. But if one in three women are traumatised, imagine how many midwives are traumatised repeatedly. We're dealing with all these births, and nobody gives us any chance to process that. We are repeatedly subjected to things that I think in a lot of places would be almost considered torture. It's traumatic and it's just compounded, one on top of another. I feel like I'm constantly watching car crashes that I know are going to happen. I know this is what's going to happen. I feel like, as midwives, it's like we're being gaslighted. We know what's going to happen* (P14).

Personal consequences for those who reported traumatic clinical experiences without support were significant, resulting in disengagement and withdrawal from midwifery. Those who were traumatised by these perinatal encounters had significant negative outcomes of poor emotional and mental health, reporting anxiety, depression and post-traumatic stress disorder. The following quote highlights the emotional toll of unsupported experiences:

> *I started having nightmares. I was dreaming that I was drowning, I was on the floor and the quantity of thick mec was building up and building up and I was drowning in it. I kept dreaming that I had dead babies that I couldn't resus and I was stuck in a room with them, and I'd have these dreams multiple times a night. I dreamt that I was in the corner of a room and the team leader, who was never anything but nice to me, she was screaming at me, "this is all your fault, you did this. Do you see that mother without a child, you did this"* (P9).

6.4. Theme four: At all times, the woman

Interweaved throughout and underpinning the narratives was a strong ethic of woman-centred care. Perinatal grief work was perceived to be private, unseen midwifery work. Involvement in these events was considered an honour, with participants paying tribute to women. Participants were determined to actively undertake true women-centred care for grieving women, by:

> *Putting yourself into their shoes, understanding where they're coming from and taking the time to hear their stories, because everybody* has *a story that needs to be heard* (P1).

Participants spoke of the midwife's duty to work their hardest to observe the honour bestowed upon them by being admitted into this space of grief. Attempting to honour the unique authority that maternal grief deserves, participants described safeguarding women from hospital processes which curb women's autonomy, noting that women's memory of the event endures:

> *I think it's an incredibly emotive time and to walk alongside women during what is a very traumatic time in their life, it's hugely important that we're able to stand there to support those women. I think midwifery is a privilege. An honour, I think particularly in this space how we care for those women is profound and they will remember it forever* (P7).

Perinatal loss care triggered reflection on the strengthening effect these encounters had upon their philosophy of woman-centred care. This was especially true for participants who encountered supported experiences as a student. These positive experiences contributed to feeling comfortable in this care as a new graduate and being able to focus on the woman:

> *I had the privilege and the honour to be present* [as a student] *and it made me a stronger midwife because I had practised it at uni, and it made me think it is so important to be woman-centred* (P8).

At all times, the woman refers to the idea of memory, with part of the midwife's role consisting of bearing witness and remembering. Participants who experienced *anticipated grief*, acknowledged the rightful owner of the grief. Grief required honouring and then relinquishment. However, this did not mean that memories vanished:

> *There was a particular woman I will never forget, she will never leave me* (P11).

All participants wanted their midwifery care in these experiences to be a respectful and good encounter for the woman within the woman's sad experience of loss. They did not wish to exacerbate pain by delivering poor care, "because of her experience she's already been harmed" (P3) from grief and loss. This participant explained:

> *Birth is the most pivotal moment of a woman's life, but stillbirth also is. They're going to remember that for ever and ever and you don't want it to be a bad experience. You don't want to make it any worse than it already is* (P10).

Participants whose job satisfaction specifically emerged from these grief and loss encounters articulated that midwifery was an astonishing and rewarding career which integrates both joy and tragedy. It was considered necessary to learn of this spectrum of pregnancy outcomes early through involvement. Then over time, grasping clinical skills meant participants were more able to focus on the woman, with one participant saying:

> *I then felt more comfortable, over time I felt I could do it. Once I did, I wanted to be with woman and focus only on her needs within her experience* (P15).

7. Discussion

This discussion locates participant experiences with grief and loss, favourable or otherwise, as being related to their state of clinical preparedness and the quality of provided support. Absent physical and emotional support for new midwives negatively compounded their lack of experience with perinatal grief and loss. Some participants were traumatised from these clinical encounters. Conversely, despite limited experience in providing clinical care in these encounters, well supported early career midwives reflected positively on these experiences and their occupation as a midwife. Student experiences with perinatal loss were considered most beneficial when encountered in the latter stages of education. At this stage of study, accumulated knowledge and skills could be employed within the safety of the student-midwife relationship.

Preparation is important in potentially traumatising clinical encounters [53]. A scoping review of university and hospital education has revealed there to be many technical, communication and self-care skills required to prepare clinicians for perinatal loss care [35]. Participants acknowledged the importance of being prepared and clinically competent for these responsibilities prior to employment. Comparable with other research [54] most participants in the study felt to some extent unprepared for these significant events, resulting in them having *all eyes on the skills* once in practice [27]. Having limited exposure as a student prior to managing these events once registered, and the complexity of the midwifery care required, induced varied perceptions of apprehension and unpreparedness. Significant findings of this study were a perceived paucity of experiences with loss and death during clinical placement and a lack of cohesive pre-registration education on the topic. Most participants encountered piecemeal education on perinatal loss at university which hindered the acquisition and strengthening of essential skills. Many recommended the inclusion of a dedicated perinatal loss subject in midwifery curriculum to establish and consolidate foundational skills. Undoubtedly, skill acquisition is delayed with limited or inadequate student opportunities [55,56]. Focused education has been shown to enhance student knowledge and confidence for this element of midwifery care [57,58] and practical hands-on learning is widely known to be effective for developing student competence [55]. Many participants felt that clinical simulations with realistic environments and case scenarios of death and loss would have been beneficial in their university program, to help students develop the numerous technical and communication skills required for this care. An increased preparedness for practice was expressed when perinatal loss was encountered within a continuity of midwifery care student placement. This correlates with Australian research which identifies these models to be valued for their ability to support students, instil confidence and prepare students for practice [59].

Research has suggested that pre-registration education, however, does not adequately respond to the clinical practice requirements of perinatal loss; there being a disproportionate focus on the 'normal', which may prohibit new-grad preparedness for pathological events [60]. Participants considered the prevailing representation of perinatal loss in both university and clinical learning was it being an anomaly of childbearing, rather than a potential outcome in the spectrum of birth. Participants considered this to be a form of student protectionism, a safeguard from encountering death until they were midwives. In view of studies about students and midwives acquiring secondary trauma from traumatic clinical experiences [39], there is compassion and workforce savviness in protecting the student and the inexperienced. However, comparable to Coldridge and Davies' (2017) findings, depriving the inexperienced from these commonplace experiences contributed to most participants feeling they lacked contextual understanding of these complex encounters [61]. Many in this study felt they were lacking in technical competency, ways to access and claim essential support and positive coping strategies for managing vicarious trauma.

Early career midwifery preparedness was regarded as being a holistic undertaking of 'what to do' and 'how to be'. Participants expressed a predominant concern for knowing the correct steps and execution of 'what to do' in perinatal loss encounters in the early career period. Apprehension regarding technical and administrative processes was present even in those who were prepared for the sophisticated psychological and emotional care requirements. Task orientation has been shown to be an avoidance strategy employed by midwives who are less able to withstand stress in the role [62] in a bid to cope with emotional stress. Yet, maternal distress may be heightened when midwives predominantly focus on clinical tasks [63]. A focus on the 'doing' may emotionally disengage the midwife from a woman's distress, but it also distances the midwife from the woman and her needs. Most participants mentioned that a concentrated focus on tasks was detrimental in care provision, and some spoke of diminished woman-centredness being an unintended consequence of task hypervigilance. In the main, participants had not practised the foundational skills for perinatal loss and there was apprehension that this lack of experience could further traumatise an already distraught woman. Task-orientation in this study, therefore, was not an avoidance tactic or site of emotional refuge. Rather, hypervigilance stemmed from participants' meticulous assurance that all professional tasks were completed without error. Not wishing to cause harm or elicit additional trauma, all participants desired to safeguard the woman from further distress.

Distress is not felt by the woman alone. A systematic review of the potential consequences from witnessing traumatic births noted these to be adverse emotional and psychological outcomes for the midwife [64]. Longitudinal nursing research has indicated an association between a lack of pre-registration clinical preparedness for these likely encounters with death and an increased risk of heightened stress reactions and mental health problems [65]. Distress resulting from encountering perinatal loss as a new midwife whilst being clinically and emotionally unprepared may give rise to the fear of birth. Fearing birth jeopardises the quality of midwifery care and midwives' confidence in, and protection of, the normality of birth [26,64]. The key, therefore, is to have supported learning experiences [24,38], with comprehensive grief and loss training in conjunction with and not in lieu of the much-needed advocacy of normal birth. Participants reported minimal impacts on psychological wellbeing if they had received supported learning as a new graduate or student.

Support is of the essence because when participants were supported, they felt able to provide the required care as a new midwife and considered perinatal loss a rewarding element of being a midwife. Valuing midwifery as one's profession and possessing job satisfaction

has been observed in other studies to be associated with midwives receiving support in these instances of care [24,64]. Sources of support desired by participants were midwifery colleagues, management and the hospital, however support was not ubiquitously received. Perceived as fortunate to obtain, support was contingent on multiple workplace factors: 1) being rostered with a kind midwife who was happy to help and provide support; 2) the other midwife having extensive perinatal loss experience; 3) adequate staffing and skill mix; and 4) the shift not being too busy. Other early career research has identified that antagonistic workload and staffing factors limit the amount and type of support new midwives receive [23].

Absent support is significant as it can contribute to workplace stress and emotional distress and may increase the risk of midwifery burnout, intentions to leave midwifery and poor emotional and mental health [14,64,65]. Unfortunately, a recurrent picture of perceived ill-support, inadequate leadership and insufficient communication with management surrounding grief and loss events, were highlighted by most in the study. Many indicated that management were unaware of the complexity and challenges of clinical care in these events. A lack of acknowledgement and managerial understanding of clinician responsibilities in these instances has been identified as a basis for job dissatisfaction and distress in midwives [27,66].

Substandard job satisfaction and emotional health in midwives are likely to undermine workforce stability and the delivery of safe and quality midwifery care [14,15,26]. Distress was accredited by some in this study to witnessing and taking part in unnecessary medical interventions, with some feeling distressed from the knowledge that they were instrumental in the birth trauma of women. Perceptions of complicity in disrespectful and authoritative maternity care have been shown to contribute to the development of professional trauma in midwives, job dissatisfaction and diminished professional confidence [26]. In this study, when an adverse pregnancy outcome was perceived to result from clinical practice decisions and not solely from natural causes, midwifery psychological wellbeing was greatly impacted. Feelings of long-term guilt and blameworthiness, although unwarranted, were evident in those *enduringan emotionaltoll*. Comparable to other research was the finding that the most traumatic event as a midwife was the death of someone in their care [37,67]. Narratives of self-perceived responsibility were evident in participants who spoke of instances of care resulting in intrapartum fetal, early neonatal and maternal deaths, particularly when timely and continued support had not been provided to them. Akin to other literature [68], self-doubt of clinical competence, distrust of role proficiency, risk aversion and skill hypervigilance were a consequence of experiencing *unwarranted guilt*.

Unsupportive colleagues and deficient mentorship, and absent supervision and debriefing impacted on the health and wellbeing of those who experienced self-reported long term psychological trauma. The lack of support reported by these new midwives is an inglorious characteristic of, and a blight on, midwifery and has been demonstrated elsewhere [8]. Without adequate support, traumatic experiences involving death resulted in disengagement and attrition from the midwifery profession and substantial mental health effects including anxiety, depression and post-traumatic stress disorder, as also shown in a Dutch study [67]. Also shown elsewhere is the traumatic personal and professional impact for those participants who experienced prolonged clinical investigations after an adverse neonatal outcome [69]. Work-related psychological-injury has been shown to disproportionately occur amongst health professionals [70]. Outside-of-work, real-world outcomes of psychological-injury, such as adverse impacts upon personal finances, were reported consequences in this study when traumatic experiences and absent support converged. These included depleted leave without pay, expenditure of all sick and annual leave allowances, use of workers' compensation benefits, turning to unpaid stress leave, having medical, medication and psychological therapy expenses related to experiences of perinatal loss in their midwifery role, unhealthy alcohol use, loss of income, the inability to work and the loss of a much sort after career.

Due to the emotional complexity of care involving loss, participants drew strength from relationships with other early career midwives who were experiencing similar circumstances, and from exemplary midwives. Like other research exemplifying good midwifery care [71], exemplary midwives were most important to participants. Such midwives provided compassionate care, were very experienced and comfortable working with women's loss, felt at ease with students and possessed a teaching approach of 'being' rather than one of verbal tuition. The collegial relationships within midwifery group practices were also valuable in these encounters. Strength and resilience were fortified from the strength of the woman. Woman-centred convictions of participants were strongly evident with their primary focus *at all times, the woman*. Continuity of midwifery care was largely seen to be protective and supportive of women experiencing grief and loss, and like other research, was beneficial and curative for midwives [72].

8. Conclusion

This study identified that adequate pre-registration education and sufficient exposure to perinatal grief and loss and positive experiences within these encounters were associated with being better prepared and ready for these experiences once graduated. The perceived shortcoming of pre-registration education of the disproportionate emphasis on normal birth can be rectified by including targeted perinatal loss preparation into curriculum. Support should be provided for all midwives; however it is especially important if exposure to loss occurs as a new student due to limited knowledge and experience. Those who had clinical exposure to these events as a well-supported student or received adequate, quality and timely support as a new graduate, did not experience prolonged negative health and wellbeing outcomes after traumatic perinatal loss experiences.

One reason presented by participants for their minimal exposure to these events during midwifery clinical placement was because they are considered not amenable to teaching. Clinical midwives frequently use a verbal didactic approach when teaching technical skills to the less experienced. Midwifery care in grief and loss events was noted to be verbally quieter. Observational education strategies which support student learning through bearing witness are necessary to enhance perinatal loss training. An understanding that the core skills used in perinatal loss are the same as those for normal live births is also a necessary learning experience. Skills that are firmly established in midwifery philosophy help promote midwifery care that can adapt to and meet the needs of individual women. These skills include being with woman, woman-centeredness, empathy and communication and technical capabilities, those very skills utilised when looking after women experiencing grief and loss.

Working with women experiencing adverse pregnancy outcomes has the potential to negatively impact job satisfaction, midwifery wellbeing and workforce attrition. This is exacerbated from the lack of clinical preparedness and absent workplace and collegial support structures. Access to support positively impacted personal outcomes of midwives despite the emotional weight of grief and loss care. Supports desired by early career midwives included working with an experienced and kind midwife during initial encounters with perinatal loss, having empathetic midwifery colleagues who provide guidance and practical support, access to timely debriefing, adequate staffing and skill mix and receiving recognition from management.

9. Strengths and limitations

The rationale for employing descriptive/exploratory methodology was the desire to generate in-depth findings on a complex phenomenon through a comprehensive interview method. Intensive and detailed work resulting from many iterations of thematic development require a small sample. Although fitting for the sensitive nature and the subtleties

and complexities of midwifery encounters when caring for women experiencing grief and loss, this was a small-scale qualitative study in one country. Therefore, findings cannot be generalised to a larger population. Furthermore, self-selection bias must be considered in view of the recruitment method. Notwithstanding these limitations, data achieved saturation and evidence of sample variation was present. A strength of the research was data collection occurring within the first five years of practice, therefore minimising participant reliance on long term memory.

10. Implications for future research

This study illuminated the requirement to adequately prepare new graduates for the full scope of midwifery practice through targeted university education and supported exposure to these encounters in the clinical setting. Further research on educational and clinical placement strategies which augment clinical preparedness is required. To ensure the inclusion of all stakeholder perspectives, co-design is essential for this scholarship. Midwifery student, academic, early career midwife, midwifery educator and managerial collaborative involvement is essential. Women's' perceptions of student and early career midwifery involvement in their perinatal loss experiences is important future research.

11. Implications for practice, education, and policy

Pre- and post-registration educational strategies to ensure midwifery students and midwives, early career and otherwise, can participate safely and compassionately in perinatal grief and loss encounters is vital. Institutional support in the form of written policies, formal debriefing processes, practical training for positive coping strategies, paid positions for midwifery supervision and workplace philosophies which espouse a collegial ethic of care would benefit the Australian maternity sector. The expansion of continuity of midwifery care and midwifery group practices is also perceived as valuable for midwifery skill development and collegial support.

Declaration of Competing Interest

The authors have not identified any competing interests.

Ethical approval

University of Technology Sydney Human Research Ethics Committee [UTS HREC ETH20-5659].

This manuscript has adhered to the guideline: Standards for Reporting Qualitative Research

Funding source

Early Career Researcher grant from the School of Nursing and Midwifery, University of Technology Sydney, for recruitment advertising and interview transcription.

CRediT authorship contribution statement

Annabel Sheehy: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Validation, Visualization, Writing – original draft, Writing – review & editing. **Kathleen Baird:** Methodology, Formal analysis, Visualization, Validation, Writing – review & editing, Supervision.

Acknowledgements

Thank you to the generous participants for sharing their experiences.

The first author is grateful for the support provided from the ECR grant received from the School of Nursing and Midwifery, University of Technology Sydney.

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