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The erratic pathway to regaining a professional self-image after an obstetric work-related trauma: A grounded theory study

Åsa Wahlberg[a,b,*], Ulf Högberg[a], Maria Emmelin[c]

[a] Department of Women's and Children's Health/Obstetrics & Gynaecology, Uppsala University, Sweden
[b] Department of Obstetrics and Gynaecology, Ystad Hospital, Sweden
[c] Department of Social Medicine and Global Health, Lund University, Sweden

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ABSTRACT

Background: It is known that healthcare providers might be affected by severe medical events in which patients are badly hurt. In birth care, escalating situations can result in death or injury to a mother or new-born child.
Objective: To explore the process that Swedish midwives and obstetricians go through after a severe event in the maternity unit.
Design: A modified Constructivist Grounded Theory analysis, based on fourteen in-depth interviews with birth care professionals.
Participants: Seven midwives and seven obstetricians.
Results: A core category, 'regaining of a professional self-image', was constructed and interpreted as being constituted of six main categories illustrating a frequently erratic pathway to the regaining of a professional self-image. The process included a search for external acceptance for the re-establishment of belongingness by obtaining corroboration from the woman, work colleagues and manager, and the medico-legal system.

Media exposure was invariably seen as something negative. Internal processes involved coping with emotions of guilt and shame and the vulnerability that the work entails, as well as contemplating future work. The possibility to fully regain one's professional self-image depended on having a sense of confidence and an urge to support others in similar situations by sharing gained insights. However, the process could also result in reconsidering one's professional self-image by setting up boundaries, creating a better work-life balance, or creating mental back-up plans in case of similar recurrences. For others, the process led to a change of professional identity and a search for roles away from emergency obstetrics or the specialty as such.
Conclusions: Many midwives and obstetricians will experience severe obstetric events that might affect them, sometimes severely. The vulnerability that healthcare professionals are exposed to should not be underestimated and preparedness in terms of collegial support, as well as an awareness in the workplace of how badly affected employees might be, is important. Growth as well as leaving birth care can be the results of the process following a severe event.

What is already known about the topic?

- Healthcare providers might be psychologically affected by severe events resulting in the injury or death of a child or mother
- The way in which providers are affected can bear consequences for their ability to perform high quality care
- Support from colleagues is important after severe events or errors resulting in patient injury

What this paper adds

- Health care providers strive to regain their professional self-image after a work-related trauma
- The regaining process involves external as well as internal factors
- External factors include acknowledgement by affected women, colleagues and the medico-legal system
- Emotions of guilt and shame are prominent, resulting in questioning future work
- Professional birth care entails a vulnerability that needs to be acknowledged

* Corresponding author at: Kristianstadsgatan 37, 3 tr, S-214 35, Malmö, Sweden.
E-mail address: asa.wahlberg@kbh.uu.se (Å. Wahlberg).

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1. Introduction

In 2000, Wu coined the term'second victim', describing the agony that healthcare providers can feel after having made an error, causing injury or death to an individual for whom they have provided care (the first victim). Since then, knowledge in the field has increased substantially (Wu, 2000; Edrees et al., 2011; Wu et al., 2017). Throughout the history of medicine, similar experiences have likely been a reality for healers but their stories have rarely been told. A strong notion within medicine is the idea of perfectionism, which is still vivid today (Christensen et al., 1992; Coughlan et al., 2017). There is also an expectation that healthcare providers should remain above the emotional pull that is experienced in clinical encounters (Schmidt et al., 2017). When Hilfiker submitted a paper to *The New England Journal of Medicine* in 1994, discussing the boundaries and limits of help and knowledge in relation to his own experience of making errors, he was warned by the editor that its publication might damage his future career (Hilfiker, 1998). Hilfiker's openness about how heavily the weight of accountability burdened him was provocative in those days. Being a physician, nurse or midwife has always entailed an element of responsibility and trust being expected by the patient. Navigating modern medicine and society as a healthcare provider takes its toll. A three-fold increase in suicidal ideations among surgeons after a perceived medical error, generally high suicide rates for physicians, and depression or burnout among midwives and physicians after severe events, indicate that these complex matters are not fully acknowledged (Shanafelt et al., 2010, 2011; Fahrenkopf et al., 2008; Schroder et al., 2016).

The public notions of modern birth care in Western societies encompass healthy babies, negligible risks for mothers, and that deaths are "never events", which increase the complexity of negative obstetric outcomes (Coughlan et al., 2017). Changes in society result in altered expectations, norms, and cultural values, in women as well as among healthcare providers. Midwives and obstetricians today face the challenges of rising caesarean section rates that create new risk evaluations, new rules regarding patient autonomy, and threats of litigation (Johanson et al., 2002; Larsson et al., 2009). Nuzum et al. (2014) described in a qualitative study how medico-legal fear might reduce obstetricians' level of empathy and that experiencing severe events such as stillbirths may make them consider leaving the field, an issue also described in quantitative surveys (Heazell et al., 2016; Gold et al., 2008). In a previous study we found that 43% of midwives and obstetricians had experienced emotions of intense fear, helplessness, and horror in conjunction with the worst event experienced during their work on the maternity ward. Fifteen percent had symptoms of partial and probable post-traumatic stress disorder (PTSD) after the same event, and 28% of the midwives and 47% of the obstetricians indicated that they had felt guilty for something they had done or not done in relation to the event (Wahlberg et al., 2017b).

How healthcare providers experience and react after a severe obstetrical event has not been thoroughly described. This knowledge may help to explain why some professionals can cope with their own faults and mistakes and yet remain open and empathetic, while others become cynical or detached. Understanding the situation of professionals as second victims can also elucidate what is needed for healthcare organizations to provide better support to midwives and obstetricians after severe events, which might subsequently improve the retention of staff.

The aim of this study was to explore the process that midwives and obstetricians experience in the aftermath of a severe event on the delivery ward and to discuss the possible implications for birth care.

2. Data and methods

2.1. Overall study design

The study used a modified Constructivist Grounded Theory approach (Charmaz, 2014), aiming to produce a theoretical understanding of social processes and relational conditions involved in the studied phenomenon. An underlying assumption was that people understand and interpret their experiences a posteriori in order to build cognitive maps (Dahlgren and Winkvist, 2004). Individual in-depth interviews were chosen for data collection to capture individual experiences and to cater for the sensitive nature of this study (Dahlgren and Winkvist, 2004). The interviews for this study have previously been analyzed to capture how midwives and obstetricians experience severe events, focusing on organizational structure and emotional reactions in connection with the event (not published), while the focus in this paper is placed on the experiences, strategies and actions taken after the event.

2.1.1. Context

In Sweden, with 110–115 000 births annually, home births are very rare and there are few alternatives to traditional hospital-based birth settings (Social Board of Health and Welfare, 2017; Hildingsson et al., 2013; Larsson et al., 2009). Healthcare in Sweden is publicly funded and available to all citizens. Pregnancy and birth care involves no private insurance and there are at present no private healthcare organizations that provide birth care.

According to Swedish regulations, all avoidable, serious adverse events must be reported to the National Board of Health and Welfare (NBHW) or, from June 1, 2013, to the Health and Social Care Inspectorate (IVO). These agencies are subordinate to the Ministry of Health (Nilheim and Leijonhufvud, 2013). There is also a system by which patients or family members can make complaints to the IVO. This system has some resemblance to the British system of reporting clinical negligence claims to the National Health Service Litigation Authority (NHSLA), but in Sweden, no financial compensation can be claimed through the IVO. To gain financial compensation in the Swedish system, an appeal must be made to an insurance company (generally, The Swedish National Patient Insurance Company) or, in rare cases, a lawsuit can be filed in a civil court.

2.2. Study setting

Participants were recruited from birth care settings limited to the geographic area of the Southern and Middle regions of Sweden and included professionals who had no working relationship with the first author.

2.3. Sampling and recruitment of participants

The participants were purposively sampled among midwives and obstetricians who had earlier participated in a survey about severe events in the labour ward and potential post-traumatic stress symptoms (Wahlberg et al., 2017a,b). In connection with completing in the survey, the participants had indicated their willingness to share their experiences in an individual interview. To reach additional potential participants for interviews, the study invitation was also presented in two journals that are circulated to members of the Swedish Association of Midwives and the Swedish Society of Obstetrics and Gynecology.

The described approach rendered 23 potential participants. From the list, 13 were purposively selected to represent both genders (all midwives were women), varying lengths of working experience, and those with present and previous work experience from both smaller and larger maternity units. One participant was recruited using the snowball sampling technique, i.e., through recommendation from another participant.

2.4. Data collection

All interviews were conducted by the first author (ÅW) from May to December 2015. Potential participants who had previously received written information about the study were contacted through e-mail.

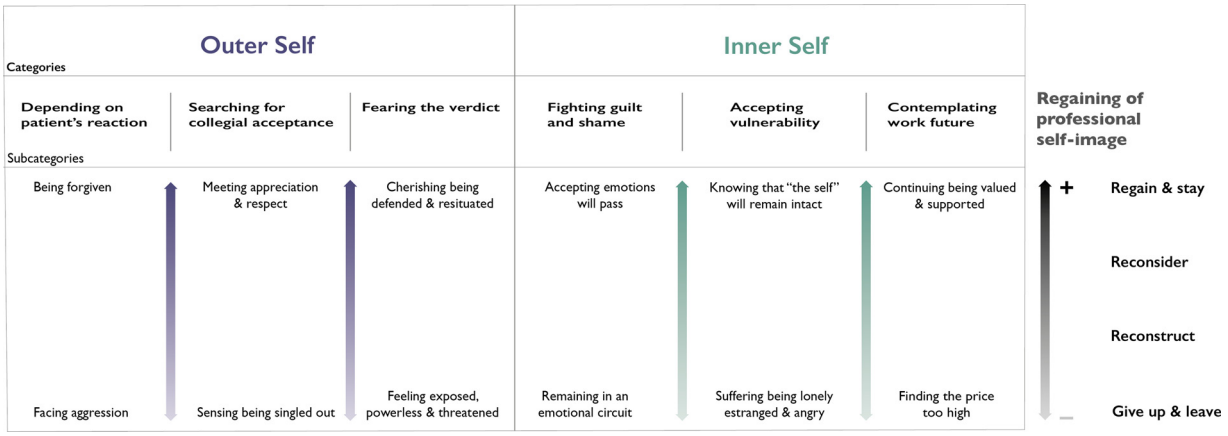

Fig. 1. Conceptual model of the process of regaining a professional self-image for midwives and obstetricians following a severe obstetric event.

Two were no longer interested in participating and one did not reply. The time and place for the interviews were chosen by the participants (secluded places in hospitals or libraries or in private homes). Prior to the actual interview, participants received a written version of the information letter and signed a consent form.

A thematic interview guide was used, focusing on the experiences of one or several severe events and the aftermath of the events. The guide covered all aspects of their experiences of severe events, but, for this paper, the questions regarding the participants' experiences of received support, the medico-legal procedures, and their own strategies and actions taken were in focus. During most of the interviews, these areas were covered "narratively" with the interviewer only probing after the initial question; "Can you tell me about a severe event that you have experienced during your working life on the labour ward?" had been raised. The interviews lasted from 63 to 133 min (mean 76 min) and were audiotaped and transcribed verbatim.

2.5. Data analysis

The analysis was carried out according to Charmaz' Constructivist Grounded Theory (2014), including initial, focused, and theoretical coding. Memos were written after each interview and during the coding process. These memos were crucial for developing emerging categories and were continuously discussed among the research group, as were codes, categories, and the emerging conceptual model, in order to increase the trustworthiness, credibility, and confirmability of the analysis. The data were constantly compared and contrasted throughout the data collection and analysis process. Finally, a core category was constructed with supporting main categories and with subcategories that describe dimensions and variations within each category. The analysis process was characterized by an oscillation between the event descriptions (the text) and the developing categories until they were regarded as being saturated. The final analysis led to a theoretical model describing the components of the process that follows after having experienced a severe event. Formal member checking was not performed, but, during the study period, the preliminary results and the emerging conceptual model were presented to both midwives and obstetricians on several occasions. The responses during these sessions were mainly those of recognition.

2.6. Ethical considerations

Prior to the interview, the participants were informed that their participation was voluntary and that they could end the interview at any time. Due to the sensitivity of the questions, the participants were reassured that the information they provided would be treated confidentially and that the presentation of the results (interpretation and quotes) would not be possible to trace back to any individuals. The study was approved by the Regional Ethics Board of Uppsala University on November 8, 2013 (2013/351).

3. Results

Of the fourteen participants, seven were midwives, all women, and seven were obstetricians, four men and three women. The midwives had varying work experience, ranging from two to about thirty years. One had changed from birth care to out-patient care, and one was about to change. All obstetricians were specialists; the most junior for about five years. One obstetrician was about to become a double specialist in another specialty while still working in obstetrics, one had changed specialty fairly recently, one obstetrician was on sick-leave, and another was retired (being the most senior). In both professional groups, the participants had work-experience from both university and district hospitals.

3.1. The erratic pathway to regaining a professional self-image

The analysis was developed around the core category, 'Regaining a professional self-image', which was characterized by an aspiration as well as by a potential or an attained outcome of the process after having experienced a severe obstetric event. This process was dependent on external (outer self) key factors constituted by three main categories; *Depending on patient's reaction*; *Searching for collegial acceptance;* and *Fearing the verdict.* Three main categories; *Fighting guilt and shame*, *Accepting vulnerability,* and *Contemplating work-future,* illustrated the internal (inner self) processes. Fig. 1 provides an overview of the conceptual model.

The main categories should not be perceived as one pathway or steps happening in a sequential order, but as important aspects that play a vital role and give higher or lower chances of regaining a professional self-image in the aftermath of a severe event on the labour ward. *The erratic professional pathway* indicates that the key categories might vary widely in importance and that perceptions can fluctuate within the same category during the process. The descriptions, or subcategories, indicating higher or lower chances of regaining a professional self-image should be seen as ideal or negative "extremes" with all possible variations in-between. At the end of the process the different levels of regaining a professional self indicate alternative choices relating to the work future within the field of obstetrics. It should be recognized that the strategies and solutions described as higher or lower levels of *regaining of a professional self-image* are not static, nor are they necessarily "better" or "worse" than others.

3.1.1. Outer self

3.1.1.1. Depending on patients' reactions. The woman, and sometimes her partner, was crucial for the midwife's or the obstetrician's experiences of the aftermath of the severe event. Despite their diverging roles, the woman and the healthcare provider shared a profoundly important experience. *"I was disconnected from everything else by the unit coordinator. I had a huge need to be with this couple, this child. That was essential."* (Participant 6, Midwife)

Depending on who was involved in the event, the outcome could differ significantly. If the woman and her partner allowed for continued contact and there was no disruption or upfront hostility, a relationship could evolve that eventually gave the midwife or obstetrician a feeling of *being forgiven*. *"The patient said, 'I forgive you for this and I understand why you did it' … while crying she said, 'I want you to tell me all the details about what happened.'"* (Participant 10, Obstetrician)

A direct apology was not always given, but rather, an acknowledgement of the profound loss that also affected the healthcare provider.

> *"I spent all lunch breaks with them. It was a hard week. But in the end I got positive feedback for being the only person they trusted, even though I was the one who had made the error. When I discharged them she told me, 'You should know that I did not want to see you in the eyes when you came in to us the first time after the event. But I am a Christian and I want you to know that I have forgiven you. And thank you for having spent all this time with us.' That rendered some tears.*" (Participant 5, Obstetrician)

When the contact with the woman or her family was characterized by negative connotations the process was affected in a different way. *Facing aggression* from the woman was disconcerting and initially bewildering, resulting in an unfamiliar experience of being out of control and a need to protect oneself by creating a mental distance towards the woman. Mental turmoil was sensed when feeling sorry for the bereaved woman, while at the same time being met by anger, frustration and agony when the woman or relatives deliberately tried to cause harm through persistent communications, reports, or through the media.

> *"The woman had parents with a vocabulary that I did not quite recognize. Abusive language all the time … And the parents [woman and her partner] were so extremely aggressive! It would not have been the same with another couple. They were very, very negative. I had a good relationship with the woman, for quite a while but then I could not take it any longer … In a way one does understand them. But acrimony and aggression. There was nothing else … I understand their situation. Their reactions, but it gets so drastic when they handle it like that."* (Participant 2, Midwife)

The woman also played a vital role in the aftermath of the severe event in cases where an actual, physical meeting never took place. The woman could refuse to meet the midwife or obstetrician, either directly after the event or after having returned from the referral hospital to which the injured child had been sent. In such cases the participant described regret for not having approached the couple in the few hours between the incident and their hasty departure. *"I regret bitterly that I did not have contact with the parents before the child died. Then maybe they would have seen me differently."* (Participant 11, Midwife)

3.1.1.2. Searching for collegial acceptance. How the colleagues and managers acted towards the midwife or obstetrician who had been involved in a severe event mattered greatly. Being a part of the collective group was important, and both the immediate reaction from colleagues and managers, as well as the long-term support offered, affected the process of regaining a professional self-image.

The midwives and obstetricians who received immediate and profound support felt *met by appreciation and respect*. Colleagues would arrive earlier at work to help out, and managers would make sure they could spend time with the woman and get back to their other responsibilities and work tasks in their own time. *"I felt love from my colleagues. Got loving support, phone calls home, checking again and again. From midwives and close managers."* (Participant 10, Obstetrician)

Feeling a valued part of the team allowed the obstetrician or midwife to search for and accept an honest evaluation of the actions that he or she had taken during the event.

> *"I think it is necessary both to get absolution for what you did right but also to get justified critique. Not something to do in a group but privately. With somebody who knows obstetrics and the local [culture] and has integrity. And can communicate and know how to lift and support. Getting people back on track."* (Participant 5, Obstetrician)

It was important that the workplace had a culture in which it was possible to make errors or wrong decisions and at the same time feel highly respected and trusted.

> *"It is the usual mechanisms behind it. The usual shame or failure. How tolerant are we at the clinic? How much are we prepared to share? … You want a colleague to say this was not correct, but you are a human being. You make errors. Can you tolerate that?"* (Participant 1, Obstetrician)

Being met by avoidance or silence from colleagues and managers created a sense of being singled out. "It is not good when you have a feeling that your colleagues consider you a poor physician. You feel guilty and bad. It is hard finding a way out of that feeling." (Participant 3, Obstetrician)

> Sometimes there was a strong notion or worry that people were talking behind their backs. *"You know from situations where others have been involved that people talk … There is a lot of gossip and people are not always fair. It matters greatly what people say."* (Participant 12, Midwife)

The normalization of severe events among professionals was seen as a problem for acknowledging own or colleagues' emotional and psychological needs.

> *"The problem is that we are so accustomed. We no longer accept our needs. They are of lower priority. Sometimes they bring somebody from the hospital church [to lend support]. But usually nobody shows up."* (Participant 6, Midwife)

Occasionally, healthcare professionals were offered professional counselling with an external psychologist or counsellor, but these contacts seemed harder to accept when they were the only support offered.

> *"The [hospital] staff manager contacted me and asked if I needed any help. I said I did not. I guess it was self-defense. One has this strong feeling of discomfort in the belly and one wonders what would get better by talking to a psychologist … I would have wished for personal talks with my clinical manager."* (Participant 9, Obstetrician)

3.1.1.3. Fearing the verdict. The possibility to regain a professional self-image was also dependent on how the "world outside the hospital" viewed and responded to the severe event. This "other world" was partially constituted by the private sphere, close family and friends. The official parts included the NBHW or the IVO, representing the "*official medical opinion*" and the media, expressing the "*public opinion*". Midwives and obstetricians experienced *fearing the verdict* from these institutions of power, situated outside the scope of the healthcare provider's influence.

There were participants who expressed a strong belief in the medico-legal system which was intact or enhanced by the response from the NBHW or the IVO following the severe event. They found the evaluations valuable, the critique to be correct, and something to bring into future work. This resulted in a feeling of having been understood. *"I have read and learned more. Now I know about the errors I did … I am*

mentally prepared and try not to make it [the same mistake] again." (Participant 3, Obstetrician)

Other physicians and midwives felt that they *cherished being defended and resituated by their manager* when receiving unfair critique from the NBHW or the IVO, or when being exposed in the media. In cases where the hospital or clinic manager had expressed their persistent trust in their employee, this was highly appreciated.

> *"My boss tried to defend me. He went out in the [local] newspaper because there was a small notice there and said we support our doctor. He did exactly everything he could."* (Participant 10, Obstetrician)

However, the event analysis and the reporting to the NBHW or the IVO by the hospital or the woman were mainly described in negative connotations, even though it was acknowledged that some sort of controlling function was necessary. For some, the NBHW or the IVO report was a painful blow, affecting their self-esteem and view of themselves as professionals.

> *"As a doctor you consider yourself to be knowledgeable enough so that what you do is reasonable. But when one gets to know from the scientific board that one's actions were not reasonable, it is hard on your self-esteem."* (Participant 9, Obstetrician)

The participants perceived the managers to sometimes be naïve and arrogant about how difficult and painful it was to participate in these investigation procedures. They described how other persons involved (often the responsible midwife or obstetrician) had been "covering their own back". *"She [the obstetrician] wrote herself out of the situation in the medical chart afterwards. She created her own truth, I would say."* (Participant 6, Midwife)

Experiencing dishonesty gave rise to a huge distrust and *feelings of being exposed, powerless and threatened*. These feelings were sometimes strengthened by an impression of managerial lack of jurisdictional knowledge and fear of an arbitrary outcome from the NBHW or the IVO, depending on who had been their medical expert. *"I got caught in a political game and everybody understood that. But they did not do anything because the IVO has the power. It is corrupt."* (Participant 10, Obstetrician)

The lengthy time of the investigation procedures was described as problematic. Participants had been told that the investigations should formally focus on organizational insufficiencies rather than personal shortcomings. This was, however, perceived as a joke and the participants had experiences of the opposite, i.e., that the investigations were focusing mainly on finding out what went wrong questioning their personal judgement or actions. *"His [the medical expert's] statement was very critical. One doctor had heard he tended to be particularly critical … The critique was directed only towards me."* (Participant 11, Midwife)

Among the participants there was consensus that media attention brought nothing positive for those involved.

Midwives and doctors, who had been involved in situations that were reported by either traditional or social media, expressed *feeling exposed, powerless and threatened*; like being under public attack. Anger and resentment were common reactions related to incorrect narratives reported by the media. *"The journalist is not interested in diving deep searching for the truth. He or she is only after the emotion. Selling a 'scoop'."* (Participant 1, Obstetrician)

Being unable to give their own version of the incident, or to correct faults and errors in the reporting due to professional confidentiality, created a strong sense of defenselessness. The participants described how entire clinics could be affected by severe events being publicly reported in the traditional media or on the internet. This could, for example, result in a sudden rise in caesarean sections rates due to irrational but nevertheless prominent feelings of fear.

> *"It was like terror on social media. Names were mentioned. Internet harassment. And the midwife [who had been responsible for a severe event] was spreading fear around her … I was the senior consultant in charge that summer and we had a C.S. rate of 25%. Everybody was scared. So fearful."* (Participant 5, Obstetrician)

3.1.2. Inner-self

3.1.2.1. Fighting guilt and shame. In the middle of the process of facing the woman, meeting colleagues and managers, managing reporting to authorities, and facing exposure in social or traditional media, the obstetricians and midwives described how they struggled with a torrent of conflicting emotions of guilt and shame. Guilt for what had been done, for the suffering and pain inflicted on the woman and the child, and shame for not being a better, more insightful and knowledgeable professional.

The healthcare professionals who were very aware of the power of these emotions, still present after the event, seemed to be able to create a distance between these effects and their perception of "self". They were *accepting the emotions,* knowing they *would pass* and also seemed to be aware of what they needed in terms of practical and psychological support, after the event. Even if they did not have previous experience of severe events themselves, they appeared to be prepared to accept their strong emotions and tried to find strategies for how to cope with immediate and long-term reactions.

> *"I am suturing and I tell them to call the senior surgeon on call because my hands are tired and I need someone to make sure I do not miss something … She [senior surgeon on call] arrives and she is crying. She got tears in her eyes when walking down the corridor [and passing the infant resuscitation desk outside the theatre]. She asks how she can help. I tell her I want her to keep an eye on me and every time she has a question I want her to say it out loud. Her eyes are less subjective … And I am very sad. My husband picks me up and for five hours I sit with my animals, watching the sea and cry. I give myself that time."* (Participant 10, Obstetrician)

Other participants were mentally less prepared for their own reactions. They *remained in an emotional circuit* and were hence less aware of personal strategies to cope with these strong emotions. *"… when I felt at worst, I was so terribly full of shame. God, why did I put myself in this situation? Was I daft? There was no limit to my self- blame."* (Participant 7, Midwife)

A similar statement around intense reactions was shared by an obstetrician who stated:

> *"When I left the theatre, I will never forget, my tongue was stuck in my mouth … I was so affected by stress. And I noticed when driving home that I had bad judgement … When I am going back to work and I see the hospital I have to throw up in a shrub. I do not want to enter … My entire body is screaming no! I do enter and join the morning meeting and work that first day … It was probably the first time [in my life] that I had an anxiety attack."* (Participant 8, Obstetrician)

Sometimes this could partly be compensated for by them being provided close support from insightful colleagues who would listen and validate the experiences, hence acknowledging that the force of the emotional surge would fade out.

> *"One colleague who had worked with me during the night called me [that same day] and forced me out on a walk to dwell. I really did not want to! I only wanted to hide under a blanket and struggle with my thoughts. I felt I was never ever going to work on a delivery unit again."* (Participant 11, Midwife)

3.1.2.2. Accepting vulnerability. In general, the powerful emotions would gradually fade, becoming less intense. At some point the midwife or obstetrician would realize that the process might have changed them for life, but that nothing more was to come. *"The self" had remained intact* in spite of the guilt and shame and their experiences could be shared to support others.

"When one does not have to worry. Nothing more will happen … I keep my license. I got some critique, but nothing worse what I had already given myself plenty of. Now there will be no next step … And time plays in and [bad] things happen to others and I feel I can back them up because I know what it is all about." (Participant 11, Midwife)

The time it took for midwives and obstetricians to reach an acceptance of their own emotions and vulnerability linked to their profession varied greatly. Their vulnerability was, to some extent, connected to how they managed their feelings of guilt and shame. Those who were more emotionally prepared for bad things to happen were also more actively acknowledging their professional vulnerability.

"I have this ability to feel safe within myself. I tend to think that bad things happen in this specialty. You never make things perfect. Optimally. For Christ's sake, we are human beings." (Participant 5, Obstetrician)

For some, the awareness of having managed to get through the rough times created a sense of confidence.

"Then it was very hard! You are in the process more or less all the time in one way or the other. You do not forget … and when somebody else is experiencing something similar it all comes back. So, you make a choice. This can break you to the extent that you cannot continue or you decide that this happened and I have to live with it and move on." (Participant 14, Midwife)

The participants were all aware that bad things always would happen in obstetrics, regardless of routines and protocols. The unexpected, luck or "faith", would inevitably play their role, something they wanted to be acknowledged and possibly accepted. Preventive actions taken after an event were sometimes considered *window-dressing*, creating imaginary safety. There were participants who described that they felt a discrepancy between the actual risks that birth work entailed and the outside world's unrealistic desire for infallible birth care. A conscientious awareness of this circumstance was sometimes already present before the severe event, but, in many cases it was a hard-earned insight.

Participants recalled how they used to think "that will never happen to me" when hearing about a birth that had gone badly. They saw this as a defense, acknowledging their own as well as everyone else's inherent wish to be protected from painful professional events. After the events, however, they became aware of the unattainable character of this longing.

"I believe it will always happen. Somewhere, sometimes. But that you cannot state publicly, in the newspaper! You can't. I think we will not get away from it, ever, actually. Independently of guidelines and whatever we do … If we are really honest everybody in this field have been lucky. Maybe you did something where you felt you could have done this slightly better, but it went fine. And it could just as well have gone the other way." (Participant 2, Midwife)

In the process of regaining a professional self-image, there were midwives and obstetricians who kept *suffering; being lonely, estranged and angry* for a longer period of time than others, emotions that could be so influential that they affected their view of their future.

"I feel in my brain that I have the best job in the world. But when I go into society I do not feel that. Then I feel I merely have tons of responsibility … Now that they have started civil proceedings then it is given that one feels do I really have to stand here as a target? Because if something terribly bad happens I will be standing there entirely on my own." (Participant 1, Obstetrician)

3.1.2.3. Contemplating work future. How midwives and obstetricians viewed their work future varied depending on their experiences of the severe event and what had happened during the aftermath. They had also gained some hard-earned but valuable insights and experiences that they could pass on to others. *"Now I feel I can stand there for you [others] because I have been there … I know exactly what it's like."* (Participant 11, Midwife)

Another midwife shared a similar feeling: "I feel strengthened. I have gone through all this hardship and have become more observant. Aware of the structures and of my reactions." (Participant 7, Midwife)

There were also participants for whom the event had entailed proof to themselves that they could live through a work-related crisis and that people had stood up for them. This feeling of *continuously being valued and supported* at their work places made it possible for them to continue, making some minor changes in work duties

"[I ask my boss] 'how are we going to make sure this does not happen again?' 'It will happen again,' he said, 'Because we are not perfect. I have gone through it and there is nothing we can do to avoid this type of situation in the future. Apart from you not having to be on call as often. Because that makes you tired.' Can you imagine what a wonderful boss I have had?" (Participant 10, Obstetrician)

Other midwives and obstetricians were *finding the price too high* and their experiences of the severe events and the aftermath had resulted in more drastic changes in their work-related worldview. They described that they had lost their naivety, security or faith in "the system", represented by women, colleagues, managers, the medico-legal system and the media. Their previous belief that as long as one works really hard and does one's best things will be fine had been replaced by a harsher insight that they would never be the same again.

"But it has affected [me]. Subconsciously it has affected, even though I try to resist. I will never be quite the same. And I do not feel that exuberant joy of going to work. And I am very, very afraid from time to time." (Participant 2, Midwife)

The participants described how their experiences of the severe event and the process afterwards had made them reflect and also make some work-related changes. *"I have started working with other things on the side. I feel it is important for me doing things that I really enjoy. I enjoy this but not 100 percent."* (Participant 7, Midwife)

Seeing the fear of making mistakes in older colleagues also resulted in contemplating about their professional future.

"I have colleagues who have worked for very, very long. And when I look at them when they work I can see that they too are afraid! Do you get that? They are afraid! Those who have worked for a long time, like fifteen to twenty years!" (Participant 1, Obstetrician)

There were also those who, when scrutinizing how the present working situation affected them, started to think about or actively search for new working environments.

"I kept working but I did not enjoy it like before. But I kept going. Then I visited T [a colleague with another specialty] with my daughter and he asked, 'How is work?' I did not know him that well but responded something like, 'I don't enjoy it as much as I used to.' I did not say more than that but when we were about to leave he said, 'Why don't you come and work with us?' … The next day his boss called me; 'Why don't you come and have a look?' So I went there. And they were nice and seemed happy so I decided to go for it." (Participant 4, Obstetrician)

3.1.2.4. Staying or searching new ways. Based on the experience of outer and inner factors, the outcome was interpreted as varying between fully regaining or even further developing the professional identity based on experiences of having gone through professional hardships, with backing and support. It could also imply leaving birth care because the price was too high. Leaving birth care or work altogether was sometimes out of necessity rather than by choice. Reconsidering future work was another possible outcome. Changing from a larger birth unit to a smaller one with a potentially better working climate and collegial support was one of the strategies. The process could also result in

reconstructing professional identity through working part-time as a way of creating a better work-life balance. There might also be a desire for mental back-up plans, such as the possibility of changing roles, or taking early retirement, in case something similar might happen again.

4. Discussion

The findings of this study illustrate some key concepts in the complex process of regaining professional self-image after having experienced a severe obstetric event. The process was erratic and stumbling, and contained a search for re-established belongingness from external, outer-self contacts, i.e., the woman, colleagues and managers, and the medico-legal system. Media exposure was described as severely threatening, inflicting feelings of powerlessness unless being defended by managers or hospital media representatives. An inner process involved a struggle with feelings of guilt and shame, accepting the vulnerability that the work entails, as well as contemplating one's future work. The regaining of a professional self might entail a "full" regaining, and sometimes even psychological growth or considering significant mental and practical changes concerning the workplace worst scenario.

For the healthcare organization and for the midwifery and obstetric professions, the retaining of staff is important. It is both a personal and organizational loss if experienced professionals leave the field due to the consequences of experiencing severe events. Wu states that "some of them might be the most reflective and sensitive colleagues, perhaps most susceptible to injury from their own mistakes" (Wu, 2000, p. 727). For occupations built around cognitive, emotional and empathetic competence, with working tasks described as error-ridden, resilience ought to be in focus, both on an organizational as well as on an individual level (Schroder et al., 2017). The high levels of psychological ill health among healthcare providers after severe events illustrate that these matters have not been fully recognized (Wahlberg et al., 2017b; Shanafelt et al., 2010; Fahrenkopf et al., 2008; Schroder et al., 2016). Our results add to the knowledge by exploring the complexity of the interaction between inner and outer processes related to the reactions of women, colleagues, organizations, and the medico-legal community for further understanding the work-related consequences of being a second victim. The results were unifying in terms of gender and professions, with no obvious differences found between groups. Schroder et al. (2016) found that Danish midwives reported higher rates of psychosocial problems, following a severe event, than obstetricians and related this to gender differences. In a study on symptoms of post-traumatic stress disorder following a severe event we found no differences regarding gender or profession (Wahlberg et al., 2017b).

A comprehensive review of the literature reveals that a healing power lies within the process of disclosure to the woman, providing an honest apology and creating the potential for forgiveness (O'Connor et al., 2010). This was also clear from our results. However, it was also evident that this part of the process, for which mutual recognition and acceptance is a prerequisite, did not always work out well. This emotionally challenging meeting did not always happen or the woman was unwilling or unable to accept an apology. Berlinger (2005) elaborates on the concept of "cheap grace" (p. 82) but also points to the pressure that the healthcare system can place on injured patients or their families by letting them know that nobody meant any harm or that offering forgiveness will bring them closure. Healthcare providers ought to strive for an "off-guard" meeting in which they can genuinely express their sorrow for the patient's losses. However, if not successful, this failure can become a "double burden" for the midwife or obstetrician. Not only have they inflicted injury or death, but they have also not lived up to the expectation of a disclosure and potential recognition from the woman, which could be a starting-point for healing on both parts. Schroder et al. (2017) claim that self-forgiveness could be independent of patient-forgiveness. The results from this study imply a necessity for healthcare providers to be able to accept that the woman might not forgive them and that the contact is broken. To acknowledge the burden that this inflicts might be one way of mitigating the effects of contempt or anger, something that is also important for colleagues and managers to be aware of.

The media's interest in healthcare services has increased and there has been a shift of focus from giving attention to structural aspects to focusing on aspects of personal agency (Wramsten Wilmar et al., 2014). Wramsten Wilmar et al. (2014) show that one way for healthcare managers to cope with media attention is to be tough on subordinates, expecting everyone to mind their own business and not offering them support when they have problems during times of intense media focus. This could also be seen in our results, with severe disruption of trust as a consequence. An organizational preparedness for such media attention by providing support to individual healthcare providers as well as managers has been recommended (Wramsten Wilmar et al., 2014).

The personal responsibility approach has a longstanding tradition in medicine, and blaming individuals rather than institutions is emotionally more satisfying for the affected individuals, as well as being legally more convenient (Reason, 2000). This human idiosyncrasy was also seen in our study, among the responsible healthcare providers themselves, as well as among representatives of the outer-self categories. In Sweden, complaints from patients and reports from hospitals should give attention to the healthcare institution in which the event took place (system approach) rather than to the involved individuals (person approach), according to a regulation that has been in place since 2011 (Nilheim and Leijonhufvud, 2013). This seemed to play a minimal role for those healthcare providers who had experienced severe events after this date, indicating that the system approach might need some time to reach its full impact.

Resilience can be defined as "an outcome of successful adaptation to adversity" and is a complex, dynamic and multi-dimensional phenomenon (Reich et al., 2010; Rees et al., 2015). Experiencing adversity in life can lead to growth (Reich et al., 2010), an observation that was also seen in our results. Regaining professional self-image could actually imply gaining a higher level of professional self-image than before the event. The types of support that might contribute to this growth can be divided into emotional, instrumental (reflecting concrete actions), and informational (reflecting guidance or advice) (Reich et al., 2010). In addition, self-disclosure to other network members and receiving emotional support is associated with growth (Reich et al., 2010). Self-disclosure initiates a cognitive processing for the affected individual where words become organized in a coherent story that provides a sense of the experience (Reich et al., 2010). Hence, as Reich et al. suggest, meeting the patient, as well as colleagues, provides opportunities for growth, but this entails high risks in terms of exposure and vulnerability, also seen in our study. The profound importance of belongingness and the pain inflicted upon people when being socially excluded are important issues to consider. Both implicit and explicit exclusion generate a social pain that is analogous in its neurocognitive function to physical pain and can trigger aggression, pro-social behavior and self-regulation (Eisenberger et al., 2003; DeWall et al., 2011). In this study, this was evident in the participants' descriptions of dealing with guilt and shame.

Some people have an ability to take a "psychological time-out" in the face of severe stress, which enables them to see the "big picture" (Reich et al., 2010). In this study this "time-out" was seen in the "gap" between the self and the surge of emotions that made the effects easier to cope with for some participants. Accepting feelings of guilt and shame as well as acknowledging the joint vulnerability was also important for regaining professional self-image. This is also proposed by Schroder et al. (2017) when they illustrate the benefits of retaining the notion of medical work's inherently fallible nature and the deceptive illusion of a failsafe system.

The desire for acceptance, i.e., social inclusion, might be reflected through the woman, within the organization, and possibly in relation to society. Cooley's (1902) looking-glass self provides a description of how humans are constantly "mirrored" (p. 152) by others, giving rise to

emotions ranging from pride to shame. A healthcare organization that responds to a situation of crisis with flexibility, trust, and confidence is reinforcing a culture that encourages resilience, which will also be grounded in the organization's collective consciousness (Cooley, 1902). Reich et al. (2010) suggest that the social environment contributes to growth, emphasizing the role of support and self-disclosure. For individuals, learning and growth demand an undistorted view of reality, common aspirations and recognition of the interconnectedness between individuals (Reich et al., 2010). This suggests that a reconstruction of a professional self-image, resulting in leaving the field of emergency obstetrics, can be a sign of personal growth rather than of personal loss. For the healthcare organization, however, the goal must be to provide support for growth, leading to the retaining of midwives and obstetricians who are able to provide future insightful backing to other colleagues. Scott et al. (2009) describe the possibilities for professionals after a severe event as dropping out, surviving, or thriving. Our study indicates the need for the organization to be aware of the importance of the interaction between the patient and the responsible professionals after a severe event, as well as a desire for collegial acceptance and support if being exposed in the media. For healthcare providers, a recognition of the inherent vulnerability of working with obstetric care and preparedness for emotions of guilt and shame is helpful for a resilient and sustainable working life.

4.1. Methodological considerations

This study is a continuation of a quantatative project on severe events and subsequent symtptoms of PTSD, in which 2165 Swedish midwives and physicians participated (Wahlberg et al., 2017a,b). Of these, a small number were interested in participating in an interview study, which limited our possibilities of theoretical sampling. However, the data collected were rich, resulting in the construction of categories illustrating variation in experiences. The aim of the study was to generate analytical generalizations and a model that could be applied in scenarios that might be identified among other healthcare providers (Dahlgren and Winkvist, 2004). Intimate familiarity with the setting and topic was achieved and systematic comparisons between observations and categories were made in order to enhance credibility. The data collection and data analysis processes were continuously discussed and reflected upon within the research group. Quotes were included in the description of the results in order to illustrate how categories and sub-categories were grounded in the data.

In this study we focused on processes common to both professions and found no differences regarding gender, which might be due to the sample size not allowing for these.

The sensitive nature of the topic and the risk of re-traumatization was acknowledged by making efforts to create an empathetic atmosphere during the interviews, enabling the participants to retain control over the process (Corbin and Morse, 2003). They described a positive experience of telling their story to somebody who listened and expressed that they found the aim of the study important. Corbin and Morse (2003) describe that the very act of talking to another person who shares a common interest, is genuinely interested in your viewpoint, and is not critical can be a rewarding experience. The insider perspective of the interviewer (specialist in obstetrics and gynecology) might be considered problematic, but was also beneficial in that terminology and pre-understanding made it easier for the participants to talk without having to give thorough explanations.

5. Conclusions

The developed model illustrates the vulnerability that working on a birth ward entails; which is also applicable to other healthcare professionals. The results have implications for further research on resilience and support and show a need for education regarding expectations and preparedness among maternity care professionals. There is a necessity to see healthcare organizations as social constructs with a potential for acknowledging the profound emotional consequences that severe events and errors can cause for women and healthcare providers, which encompasses the fundamental human need for acceptance, inclusion, and belonging.

Disclosure of interests

There are no financial relationships relevant to this article. The authors have no conflict of interest to disclose.

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