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Which events are experienced as traumatic by obstetricians and gynaecologists, and why? A qualitative analysis from a cross-sectional survey and in-depth interviews

Kayleigh Sheen 1, Laura Goodfellow,2 Katie Balling,3 Janice Rymer,4 Andrew Weeks,2,5,6 Helen Spiby,7 Pauline Slade3


ABSTRACT

Objectives To explore the events perceived as traumatic by obstetricians and gynaecologists (O&G), and to examine factors contributing to the perception of trauma.

Design Mixed methods: cross-sectional survey and in-depth interviews.

Sample and setting Fellows, members and trainees of the Royal College of Obstetricians and Gynaecologists (RCOG).

Methods An online survey was distributed to 6300 fellows (May–June 2017), members and trainees of RCOG; 1095 (17%) completed surveys were returned. Of these, 728 (66%) reported work-related trauma experience, with 525 providing a brief description of an event. Forty-three participants with trauma experience were purposively sampled and completed an in-depth interview (October 2017–March 2018), which were analysed using Template Analysis. Information regarding the scale and impact of trauma experience is presented elsewhere. The present analysis provides new information describing the events and perceptions of why events were traumatic.

Primary outcome measures The nature of traumatic events in this clinical setting, taken from survey descriptions of perceived traumatic events and information from the in-depth interviews.

Results Events perceived as traumatic by O&G were similar between consultants, trainees and other RCOG members no longer working in O&G. Maternal or neonatal death/stillbirth, haemorrhage and events involving a difficult delivery were most frequently reported. Sudden and unpredictable events, perceived preventability, acute sensory experiences and high emotionality contributed to trauma perception. Respondents’ trauma was compounded by an absence of support, involvement in investigation procedures and pre-existing relationships with a recipient of care.

Conclusions Identification of events most likely to be perceived as traumatic, and wider circumstances contributing to the perception of trauma, provide a basis on which to focus preventative and supportive strategies for O&G. Training on the nature of traumatic events, self-help for early stress responses, processing support and rapid access to trauma-focused psychological input (where required) are needed.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A large number of obstetricians and gynaecologists provided descriptions of which events they had perceived as traumatic that fulfilled criterion A of the Diagnostic and Statistical Manual of Mental Disorders 4th Edition, Revision.

⇒ In-depth interviews enabled exploration of why specific events were traumatic providing a basis for evidence-informed preventative and supportive strategies.

⇒ The initial response rate to the survey (17%) is a limitation yet aligns with research conducted in this context.

⇒ Attrition from the survey may limit generalisability of findings.

INTRODUCTION

Obstetricians and gynaecologists (O&G) commonly experience events while providing maternity care that they perceive as traumatic, and some will develop symptoms of post-traumatic stress disorder (PTSD).1–4 In this context, traumatic events involve actual or perceived threat to the mother or her infant, and where the doctor experiences intense fear, helplessness or horror.5 Perception of trauma is subjective, influenced by appraisals of an event and its consequences.6 While it is an individual’s appraisal that will determine if an event is experienced as traumatic, employers need to develop an understanding of the events that place their staff most at risk of psychological trauma and subsequent PTSD. This may enable potential mitigation of circumstances that can compound the perception of trauma. It could also form part of a package of care to increase awareness among teams regarding the experience and impact of trauma, and facilitate timely
identification of individuals who may benefit from additional support.

Identification of the types of events that are experienced as traumatic is limited and has not yet been explored in the UK. A qualitative investigation with obstetricians in Ireland identified that stillbirth was unsurprisingly experienced as a very difficult event. In a survey of 683 Dutch obstetrician-gynaecologists, the most commonly reported adverse events included neonatal and maternal death, severe neonatal or maternal complications, patient aggression, medical errors and conflicts with colleagues. An investigation with obstetricians and midwives involved in a severe obstetric event in Sweden reported that the pace of patient deterioration, organisational deficiencies in staffing or resources and an absence of support increased difficulty.

Methods of measuring trauma experiences have varied. Some studies use the Diagnostic and Statistical Manual of Mental Disorders 4th Edition, Revision (DSM-IV) criterion A, which takes into account appraisal (whether the obstetrician responded with fear, helplessness or horror during the event). The appraisal criterion was removed from the subsequent revision of the DSM. However, for contexts where exposure is virtually universal the appraisal element is clearly important. Indeed, it has been shown to be the strongest predictor of subsequent PTSD in the context of childbirth. Other studies ask respondents whether they have experienced a severe event, or provide a list of predetermined events to select. Provision of a predetermined list of events may limit the breadth of events reported, and will not necessarily capture events that have been appraised as traumatic.

The INDIGO study (Investigating experiences of traumatic work-related events in gynaecologists and obstetricians) examined the scale and impact of traumatic work-related events reported by O&G in the UK. In collaboration with the Royal College of Obstetricians and Gynaecologists, the INDIGO study identified individuals who may benefit from additional support.

### Table 1: Demographic (gender, marital status) and employment details split by level of responsibility (n=525)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Trainee/Staff grade (n=208)</th>
<th>Consultant/Associate specialist (n=301)</th>
<th>RCOG members working outside of clinical O&amp;G (n=16)</th>
<th>Overall (n=525)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age*</td>
<td>M (SD) range</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>M (SD) range</td>
<td>34.92 (5.40) (27–58)</td>
<td>48.98 (8.09) (33–73)</td>
<td>49.19 (11.23) (34–72)</td>
<td>43.39 (10.00) (27–73)</td>
</tr>
<tr>
<td>Gender (n, %)</td>
<td>Male</td>
<td>28 (13.5)</td>
<td>79 (26.2)</td>
<td>4 (25.0)</td>
</tr>
<tr>
<td>Gender (n, %)</td>
<td>Female</td>
<td>179 (86.1)</td>
<td>219 (72.8)</td>
<td>12 (75.0)</td>
</tr>
<tr>
<td>Prefer not to say (n, %)</td>
<td>1 (0.5)</td>
<td>3 (1.0)</td>
<td>0</td>
<td>4 (0.8)</td>
</tr>
<tr>
<td>Marital status (n, %)</td>
<td>Single</td>
<td>40 (19.2)</td>
<td>25 (8.3)</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td>Marital status (n, %)</td>
<td>Married/Cohabiting</td>
<td>161 (77.4)</td>
<td>252 (83.7)</td>
<td>13 (81.3)</td>
</tr>
<tr>
<td>Marital status (n, %)</td>
<td>Divorced/Separated</td>
<td>4 (1.9)</td>
<td>20 (6.6)</td>
<td>1 (6.3)</td>
</tr>
<tr>
<td>Marital status (n, %)</td>
<td>Widowed</td>
<td>0</td>
<td>4 (1.3)</td>
<td>0</td>
</tr>
<tr>
<td>Marital status (n, %)</td>
<td>Other</td>
<td>3 (1.4)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ethnicity (n, %)</td>
<td>White or white British</td>
<td>145 (69.7)</td>
<td>208 (69.1)</td>
<td>13 (81.3)</td>
</tr>
<tr>
<td>Ethnicity (n, %)</td>
<td>Mixed or multiple race</td>
<td>8 (3.8)</td>
<td>6 (2.0)</td>
<td>0</td>
</tr>
<tr>
<td>Ethnicity (n, %)</td>
<td>Asian/Asian British</td>
<td>31 (14.9)</td>
<td>59 (19.6)</td>
<td>3 (18.7)</td>
</tr>
<tr>
<td>Ethnicity (n, %)</td>
<td>Black/Black British</td>
<td>13 (6.3)</td>
<td>8 (2.7)</td>
<td>0</td>
</tr>
<tr>
<td>Ethnicity (n, %)</td>
<td>Other ethnic group</td>
<td>11 (5.3)</td>
<td>20 (6.6)</td>
<td>0</td>
</tr>
<tr>
<td>Current employment† (n, %)</td>
<td>NHS</td>
<td>194 (93.3)</td>
<td>261 (86.7)</td>
<td>10 (62.5)</td>
</tr>
<tr>
<td>Current employment† (n, %)</td>
<td>University</td>
<td>15 (7.2)</td>
<td>18 (6.0)</td>
<td>0</td>
</tr>
<tr>
<td>Current employment† (n, %)</td>
<td>Other</td>
<td>10 (4.8)</td>
<td>34 (11.4)</td>
<td>6 (37.5)</td>
</tr>
<tr>
<td>Current clinical practice‡ (n, %)</td>
<td>Yes</td>
<td>196 (94.2)</td>
<td>295 (98.0)</td>
<td>9 (56.3)</td>
</tr>
<tr>
<td>Current clinical practice‡ (n, %)</td>
<td>No</td>
<td>12 (5.8)</td>
<td>6 (2.0)</td>
<td>7 (43.8)</td>
</tr>
</tbody>
</table>

Total n=525.

*N=2 missing.

†Not mutually exclusive.

‡Whether currently working clinically. Individuals not currently working clinically were still in their role but primarily on maternity/sick leave.
and Gynaecologists (RCOG), 1095 fellows, members and trainees of RCOG completed an online survey about their experiences of work-related trauma. Telephone interviews were conducted to explore in-depth the nature of traumatic experiences and associated impacts. Paper 1 provided information on the prevalence and predictors of PTSD and associated impacts. Two-thirds of respondents had experienced a work-related traumatic event, and of these 18% reported clinically significant PTSD symptoms. Furthermore, 91% of respondents felt that specific support in relation to trauma experiences was needed.

However, in order to develop a support system for PTSD it is crucial to understand what type of events are experienced as traumatic, and factors that influence this. The current paper focuses on cause rather than impact using information from INDIGO, not previously published, to identify both the types of events that are perceived as traumatic and wider elements contributing to the perception of trauma by UK practising O&G. This manuscript presents new information examining what events are experienced as traumatic, and why.

**Study objective**

To explore the events perceived as traumatic by O&G and to examine factors contributing to the perception of trauma.

**METHODS**

Data collection involved two stages: (1) a national survey of members and fellows and (2) in-depth interviews with a subsample of survey respondents.

**Patient and public involvement statement**

As a staff-focussed project, INDIGO included from conception a study management group with consultant and trainee representatives and an elected RCOG representative; all shaped the design of the study, interpretation of results and dissemination of findings.

**Stage 1: national survey**

A national survey (INDIGO) was conducted in collaboration with the RCOG, inviting fellows, members and trainees to provide information on the frequency and impact of traumatic work-related experiences. Membership of the RCOG is awarded following successful completion of specialist training in obstetrics and gynaecology. Fellowship of the RCOG is an honorary position awarded following long distinguished service (typically in excess of 12 years.) The survey was emailed to all 6300 doctors (excluding retired members) on the RCOG membership database in May-June 2017 (online supplemental file 1). This included 4750 consultants/associate specialists, and 1550 trainees/staff grade doctors.

Demographic and professional designation details were recorded. Work-related trauma experiences were defined using criterion A of the DSM-IV for PTSD, including (1) events involving perceived or actual threat to the mother and/or infant and (2) where the doctor had experienced fear, helplessness or horror in response. In this context of almost universal exposure, it was deemed advantageous to record experiences that were both objectively severe (A1) and subjectively appraised as such (A2). This also aligns with the recently updated WHO International Classification of Diseases 11th revision definition of a traumatic event involving perceived or actual threat to the mother and/or infant and (2) where the doctor had experienced fear, helplessness or horror in response. In this context of almost universal exposure, it was deemed advantageous to record experiences that were both objectively severe (A1) and subjectively appraised as such (A2).

**Table 2** Overview of categorised events as reported by consultant, trainee and ‘other’ groups, presented by frequency within each professional group (total n=525)

<table>
<thead>
<tr>
<th>Consultant (total n=301)</th>
<th>Trainee (total n=208)</th>
<th>Other (total n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient death (105, 35%)</td>
<td>1. Patient death (59, 28%)</td>
<td>1. Haemorrhage (6, 38%)</td>
</tr>
<tr>
<td>2. Haemorrhage (71, 24%)</td>
<td>2. Haemorrhage (41, 20%)</td>
<td>2. Patient death (4, 25%)</td>
</tr>
<tr>
<td>3. Difficult delivery (30, 10%)</td>
<td>3. Difficult delivery (40, 19%)</td>
<td>3. Poor neonatal outcome (4, 25%)</td>
</tr>
<tr>
<td>4. Involvement in cardiac arrest/resuscitation (23, 8%)</td>
<td>4. Involvement in cardiac arrest/resuscitation (23, 11%)</td>
<td>3. Pre-eclampsia (3, 19%)</td>
</tr>
<tr>
<td>5. Intraoperative/Postoperative complications (18, 6%)</td>
<td>5. Poor neonatal outcome (20, 10%)</td>
<td>5. Sepsis (2, 13%)</td>
</tr>
<tr>
<td>6. Poor neonatal outcome (17, 6%)</td>
<td>6. Sepsis (11, 5%)</td>
<td>6. Intraoperative/Postoperative complications (1, 6%)</td>
</tr>
<tr>
<td>7. Venus thromboembolism (12, 4%)</td>
<td>7. Uterine rupture or inversion (9, 4%)</td>
<td>7. Uterine rupture or inversion (9, 4%)</td>
</tr>
<tr>
<td>8. Maternal/Fetal intrapartum complication (8, 3%)</td>
<td>8. Intraoperative/Postoperative complications (8, 4%)</td>
<td>8. Sepsis (3, 13%)</td>
</tr>
<tr>
<td>9. Sepsis (10, 3%)</td>
<td>9. Venus thromboembolism/Amniotic fluid embolism (6, 3%)</td>
<td>9. Sepsis (10, 3%)</td>
</tr>
<tr>
<td>10. Pre-eclampsia (3, 1%)</td>
<td>10. Pre-eclampsia (5, 2%)</td>
<td>10. Pre-eclampsia (3, 1%)</td>
</tr>
<tr>
<td>11. Uterine rupture or inversion (2, 1%)</td>
<td>11. Fetal anomalies in labour (2, 1%)</td>
<td>11. Fetal anomalies in labour (2, 1%)</td>
</tr>
</tbody>
</table>

Categories are not mutually exclusive. N=7 (consultant) and n=1 (trainee) descriptions not included in the analysis as they related to ‘general’ feelings or experiences in relation to work-related trauma. An additional 24 (consultant) and 15 (trainee) events were categorised as ‘miscellaneous’ and did not fall into any of the categories as identified across all descriptions. Death includes gynaecological patients, maternal, fetal and neonatal deaths. Percentages denote proportion of respondents within each professional group.
event. Participants were asked to describe an event that they had experienced as traumatic. Where multiple events were reported, respondents described the event that they had found most difficult. Descriptions were analysed (KB, LG) using content analysis, focusing on the characteristic of the event that appeared to be traumatic. For this analysis, doctors were split into three groups: those working in O&G as consultant or associate specialist; those working as trainee or staff grade and RCOG members working outside of clinical O&G.

PTSD symptoms were recorded using the Impact of Event Scale-Revised (IES-R). Although not a diagnostic tool, a cut-off of 33 and above was used to indicate symptoms occurring at levels commensurate with a clinical diagnosis. The extent of perceived impairment to work, social and family/home life (following a work-related traumatic event) was recorded using the Sheehan Disability Scale (SDS). Details of survey telephone interviews with purposefully sampled respondents were conducted (October 2017–March 2018) with participants asking to be interviewed. Forty-three, 1:1 semi-structured telephone interviews were conducted (October 2017–March 2018) with purposefully sampled respondents forming two groups:

### Stage 2: qualitative interviews

Survey respondents were asked to indicate their willingness to be interviewed. Forty-three, 1:1 semi-structured telephone interviews were conducted (October 2017–March 2018) with purposefully sampled respondents forming two groups:

<table>
<thead>
<tr>
<th>Category</th>
<th>Illustrative quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death</td>
<td>“An antenatal patient had a cardiac arrest while I was on call as a registrar, she had a perimortem section but died”. (C)</td>
</tr>
<tr>
<td>Haemorrhaging</td>
<td>‘Patient with vaginal delivery and PPH. There were extensive vaginal tears and vagina was friable and unable to control bleeding with suturing or packing’. (C)</td>
</tr>
<tr>
<td>Poor neonatal outcome</td>
<td>‘Unwell new-born who survived several months but had sequelae’. (O)</td>
</tr>
<tr>
<td>Maternal/Fetal intrapartum</td>
<td>“CS at fully with a previous section as an ST3. I was assisted by an ST1 and deroofed the bladder. I saw the Catheter balloon drift into view and was mortified”. (T)</td>
</tr>
<tr>
<td>complication</td>
<td>“I was crash called to A&amp;E when she was having sustained seizures. She was deeply unconscious and her GCS was 3. There was no fetal heart beat on scanning and her blood results showed severe HELLP syndrome”. (C)</td>
</tr>
<tr>
<td>Eclampsia/HELLP</td>
<td>‘Labour ward triage, acutely unwell septic patient presented desaturating and hypotensive’. (T)</td>
</tr>
<tr>
<td>Sepsis</td>
<td>‘Emergency caesarean section with deeply impacted fetal head. Severe difficulty delivering baby’. (T)</td>
</tr>
<tr>
<td>Difficult delivery</td>
<td>‘Early pregnancy patient attending for TOP had cardiac arrest in outpatient’s department while I was only doctor present (secondary to massive PE). Needed CPR for over an hour and several weeks in ITU”. (T)</td>
</tr>
<tr>
<td>Peri-arrest/cardiac arrest</td>
<td>‘A patient had bilateral PES after hysterectomy and was quite ill for a time but survived’. (C)</td>
</tr>
<tr>
<td>Venus thromboembolism</td>
<td>‘An injury of bowel at laparoscopy, laparotomy needed, bleeding and bowel damage needing repair’. (C)</td>
</tr>
<tr>
<td>Intraoperative/Postoperative</td>
<td>“bled heavily and on examination had an inverted uterus which we were unable to reduce”. (T)</td>
</tr>
<tr>
<td>complications</td>
<td>“(The baby) had massive hydrocephalus and in order for its head to fit through the maternal pelvis it had to have fluid drained. This involved inserting a large needle directly through the mother’s abdominal wall/uterus and into the baby’s brain where I then had to remove as much fluid as possible with a syringe, which was attached to the needle”. (T)</td>
</tr>
</tbody>
</table>

A&E, accident and emergency; CPR, cardiopulmonary resuscitation; CS, caesarean section; GCS, Glasgow Coma Scale; HELLP, Haemolysis, Elevated Liver enzymes and Low Platelets; ITU, intensive care unit; PE, pulmonary embolism; PPH, postpartum haemorrhage; TOP, termination of pregnancy.
in managing the impacts what helped, (4) what hindered and (5) what was wanted. Analysis of event impacts and perspectives on helpful strategies (2–5) were presented in a paper focused on need for and provision of care. This paper presents an analysis from a complementary perspective by providing staff perceptions of the environmental context that triggers these responses in the key theme of what made the events traumatic (1), which was not previously reported.

The primary analysis was conducted by KB using Microsoft Word and checked throughout the process by the team (KS, LG, PS) to ensure appropriate identification, evidencing and labelling of themes with repeated comparison to data. Strong parallels in perspectives from participants were identified indicative of data saturation. Finally, the PTSD and no PTSD groups were compared for similarities and differences in emergent themes and subthemes.

RESULTS
Stage 1: survey—what are the characteristics of events perceived as traumatic?
A total of 525 respondents (of 728 reporting work-related trauma experience) provided a description of the most difficult traumatic event they had encountered. This included 301 consultants, 208 trainees and 16 RCOG members no longer working in O&G. Respondent details included in the analysis of events are presented in table 1.

There were strong parallels in the characteristics of events perceived as traumatic across each of the staff groups (table 2). The predominant features of events that were perceived as traumatic were poor patient outcome and sudden deterioration in the clinical situation, such as in difficult deliveries and venous thromboembolism. There was a high representation of events in which the doctor was involved in resuscitation or management of haemorrhage. Exemplar quotations are displayed in table 3.

Table 4  Overview of themes and subthemes from stage 2: interviews—what made the event so distressing?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maybe it was preventable</td>
<td>1.1. A busy (night) shift with competing demands (and less support)</td>
</tr>
<tr>
<td></td>
<td>1.2. Lack of experience/new to the role or team</td>
</tr>
<tr>
<td></td>
<td>1.3. Misjudgements/Potential errors by the doctor and the team</td>
</tr>
<tr>
<td></td>
<td>1.4. A feeling of self-blame and a sense of responsibility (potentially due to a mistake)</td>
</tr>
<tr>
<td>2. Lack of support during and after the event</td>
<td>2.1. During the event: feeling alone with the responsibility (not knowing what to do next)</td>
</tr>
<tr>
<td></td>
<td>2.2. After the event</td>
</tr>
<tr>
<td></td>
<td>2.2.1. Poor or no support offered</td>
</tr>
<tr>
<td></td>
<td>2.2.2. Criticised, gossiped about and blamed by the team</td>
</tr>
<tr>
<td>3. The unpredictable nature of obstetrics and gynaecology</td>
<td>3.1. The event was unexpected (still do not understand what happened)</td>
</tr>
<tr>
<td></td>
<td>3.2. A sudden emergency situation/rapid deterioration/having to move and think quickly</td>
</tr>
<tr>
<td></td>
<td>3.3. Try and do everything right but sometimes drills/procedures and usual manoeuvres sometimes do not work</td>
</tr>
<tr>
<td>4. High emotion around the event</td>
<td>4.1. High emotion of the patient, family and team</td>
</tr>
<tr>
<td></td>
<td>4.2. Doctor’s empathy for the patient and their family</td>
</tr>
<tr>
<td>5. Investigation processes that compound the trauma</td>
<td>5.1. A long investigation process, sometimes without closure/feedback on the case</td>
</tr>
<tr>
<td></td>
<td>5.2. Blaming and unfair investigation process</td>
</tr>
<tr>
<td>6. Pre-existing relationships with the woman/identification with the woman</td>
<td></td>
</tr>
<tr>
<td>7. Sensory aspects of the event</td>
<td>All themes and subthemes were reported by interviewees in the high and low/no PTSD groups.</td>
</tr>
</tbody>
</table>
The systemic factors included: (1.1) *the busyness of the shift coupled with the competing demands of high-risk patients.* Human factors included: (1.2) *lack of experience/being new to the role or team,* (1.3) *misjudgements/potential errors by the doctor and/or the team* and (1.4) *a feeling of self-blame and a sense of responsibility for something having gone wrong.*

1.1 System factors: a busy (night) shift with competing demands (and less support)

Some experiences emphasised the stressful wider circumstances of the shift; a high number of births occurring at the same time, patients with complex medical needs or night shifts where support was less accessible.

And… the board was completely full with lots of high risk patients (L24)

1.2. Lack of experience/new to the role or team (human factors)

This sub-theme highlighted how reduced familiarity (with a hospital, a role or a particular clinical situation) contributed to difficulty, especially in the context of the unusually severe events as highlighted in table 3:

and you know, I was a year one registrar, never run a labour ward on my own before, and all these awful things were happening (H23)

1.3. Misjudgements/Potential errors by the doctor and the team (human factors)

These events involved situations where doctors attributed the weight of responsibility to a mistake they or their colleagues had made. Inherent within this was a sense that ‘human error’ led to the situation or outcome that occurred.

There was lots of human factors involved, lots of different people looking after her, lots of things that in retrospect she should have picked and then there’s lots of disjointed care (L13)

1.4. A feeling of self-blame and a sense of responsibility (potentially due to a mistake) (human factors)

Although not attributed to a mistake or error, others reported self-blame either for not ‘speaking up’ to challenge decisions that were made, or where an alternative course of action could have prevented the event occurring held a lasting impact.

I still feel very … sad when I think about that case, and I, and you know to my dying day I’ll think ‘oh my god I wish we’d just done a section’ (H16)

2. Lack of support during and after the event

In this theme, difficulty during the event related to (2.1) feeling alone with the responsibility and not knowing what to do next. After the event, difficulty centred around (2.2.1) feeling unsupported (because poor support is offered/no support at all) and (2.2.2) feeling criticised, gossiped about or blamed by other members of the team.

2.1. During the event: feeling alone with the responsibility (not knowing what to do next)

Feelings of isolation were identified, sometimes from being the only doctor available at the time. On a broader sense, doctors reported that the responsibility attributed to their role contributed to a sense of loneliness. Underpinning these accounts was a sense of fear from not knowing what to do to improve a situation, and feeling alone.

...as doctors you have these moments from time to time where you are solely responsible for that thing and nobody else can help you out, there’s only you. And those moments can be pretty, pretty lonely and pretty terrifying (L18)

2.2. After the event

2.2.1. Poor or no support offered

An absence of support compounded difficulty, with some participants reporting that nobody had spoken to them about what had happened, despite this being ‘normal’ following an adverse event. Others felt that any discussion they did have was not supportive, or that in general there was no support available.

...absolutely nothing … yeah and to be honest with you, if the same situation happened again I don’t think anything would be offered either… (H30)

2.2.2. Criticised, gossiped about and blamed by the team

Vulnerability from external criticism, likened to gossip, contributed to a sense of being blamed or judged for the decisions that had been made. Some reported that this led to a need to defend themselves, for others this enhanced feelings of guilt.

you know when people start whispering about you, and you know, and start gossiping about you and then they form this opinion about you and then you, and then you, whatever you do, nothing’s ever right... and that’s basically what happened to me (H23)

3. The unpredictable nature of obstetrics and gynaecology

This theme included: (3.1) *the event was unexpected,* encapsulating the notion that routine/straightforward processes can be unpredictable and the unexpected change or outcome can have an impact, (3.2) *a sudden emergency situation/rapid deterioration/having to move and think quickly,* demonstrating the speed at which things can change (in obstetrics particularly) requiring the doctor to make rapid complex decisions and (3.3) *try and do everything right but sometimes drills/procedures and usual manoeuvres do not work* reflecting the helplessness when knowledge and skills are exceeded.

3.1. The event was unexpected (still do not understand what happened)

The unpredictability of events contributed to a sense of shock, especially where ‘warning signs’ were not apparent.
3.2. A sudden emergency situation/rapid deterioration/having to move and think quickly
Witnessing rapid deterioration requiring immediate action was also a feature of several reported events.

And it [the liquor] wasn’t offensive or anything like that … Just as we were about to go into theatre, we got her blood back, and her white cell count was 30, so you’re thinking, ‘oh god ... get to theatre’ (L11)

3.3. Try and do everything right but sometimes drills/procedures and usual manoeuvres sometimes do not work
Instances where usual procedures did not work contributed to feelings of helplessness where despite ‘doing everything’ that a doctor had been trained to do, the situation did not improve.

I think it was that it felt as though the baby was going to die in front of me, that I was powerless, I was doing my very best to rectify the situation but it was sort of that feeling that the baby is going to die right in front of my eyes, this baby is going to die and I can’t seem to do anything about it [...]. (L18)

4. High emotion around the event
This theme includes high emotions expressed by anyone involved in the event including, the patient, the family and the team (4.1). It also includes the empathy for the patient and family at the time, or following the event (4.2).

4.1. High emotion of the patient, family and team
Bearing witness to the trauma and horror experienced by patients was a ‘harrowing’ experience. Other experiences involved witnessing other colleagues visibly upset.

it was just the patient herself was… I mean obviously understandably very traumatised but the difficult thing... the mother of the patient who just screamed and then ran through the hospital saying that we’d killed her baby. (L13)

4.2. Doctor’s empathy for the patient and their family
For some doctors, recognition of the implications of a situation for the family contributed to difficulty.

and obviously it was … a Daddy left with (number) children and no mother… (H20)

5. Investigation processes that compound the trauma
This theme concerned the investigation process that can often follow a traumatic work-related event, and how, when not managed well, can compound the impact; including (5.1) the length of the investigation process coupled with a lack of closure on the case and (5.2) a blaming and unfair investigation process.

5.1. A long investigation process, sometimes without closure/feedback on the case
For some, difficulty attributed to involvement in an investigation was underpinned by the inability to obtain closure. Not being able to see the family afterwards, or know of the long-term outcome was reported. Others reported that not hearing the outcome of the case contributed to the long-term impact of their experience.

Yes, it does, and you know, particularly if you’re a Junior. Patients are more litigious than they used to be and most of them there isn’t a case but that destroys our lives for about 3 or 4 months you know. (H1)

5.2. Blaming and unfair investigation process
A sense of unfairness in the details presented as part of an investigation, where doctors felt undermined or information presented in a way so as to paint them in ‘the worst possible light’ prolonged the difficulty that had been experienced.

…I was being hung out to dry when I felt I’d failed in that the particular skill that I had... and you know I know that you have to stand up and be counted but I think there’s a difference between you know being negligent and held to account and being struck off which is what they were trying to do. (L12)

6. Pre-existing relationship with the woman/identification with the woman
This theme highlights the impact of the pre-existing relationship with the patient, which involved both positive and more challenging relationships, and instances where the doctor identified with the patient; that is, the doctor was pregnant or had experienced a miscarriage.

I knew the lady because you do four nights in a row basically, so I had met her the night before and interestingly she had the same first name as me (laugh) it’s funny how you remember those things (H20)

Having a pre-existing relationship led to a stronger personal impact for the doctor following an adverse event.

and because we’d built up a bit of a relationship you know, she said ‘oh it would be really nice if you could deliver my baby’ and all this stuff (L32)

7. Sensory aspects of the event
This theme includes the sensations around the event, including the touch of a baby that has died, the image of the amount of blood in the room, the colour of the baby as it was delivered; all of which compounded the impact.

yeah the baby did die in my arms, in my hands to be honest. (H31)
DISCUSSION

The most frequently cited events described by all groups involved patient death (including maternal, gynaecological, fetal and neonatal), haemorrhage, difficult delivery and involvement in cardiac arrest and resuscitation attempts. The general similarity in event types across each of the professional groups highlights the commonality of perceptual experience regardless of level of training or responsibility. This holds utility for the development of support systems, especially in relation to raising awareness about specific events that are more likely to be perceived as traumatic. The consultants/associate specialists reported proportionally more intraoperative/postoperative complications; likely reflecting the level of seniority of the samples.

Despite being among the most frequently reported trauma events, maternal and neonatal mortality and stillbirth are rare in the UK. It is likely that these events featured frequently as traumatic for respondents due to their finality. Another common feature in events that were perceived as traumatic was the doctor’s involvement with clinical situations that were sudden, dramatic and visually horrific, such as massive haemorrhage and involvement in resuscitation attempts.

There were strong parallels between the high and low PTSD groups in the seven features influencing the perception of trauma. This further highlights commonalities in the events perceived as traumatic irrespective of psychological sequelae, and can provide a basis on which to inform systems of support. Many factors influencing the perception of trauma involved those around the event itself, that is, whether this was viewed as a result of unnecessary systemic or ‘human factors’. Recognition of human factors underpinning patient safety are widely recognised. In the context of the current manuscript, their role in the perception of an event and subsequent impact on practitioners is highlighted.

Where there were issues about busyness and competing demands these may relate to the concept of moral injury, where professionals cannot deliver a service according to their expected standards. Specific investigation into the concept of moral injury in maternity care providers, especially in the context of trauma exposure, is limited. However, the role of moral injury in predicting subsequent PTSD has been identified in contexts outside of maternity care. This is a concept of particular relevance in the current COVID-19 pandemic.

The suddenness and unpredictability of the event was also a factor. Clinicians who personally identified with the patient or who had a pre-existing relationship with them reported that this increased difficulty. This is aligned with previous research exploring midwives’ experiences of work-related trauma. Emotional experiences during the event were important, with the sensory nature reported together with a feeling of responsibility aloneness and isolation. Following the event, a lack of support or indeed active criticism and gossip intensified difficulties. Other postevent factors concerned the slowness and lack of communication about any investigation. Some findings resonate with those from previous qualitative investigations and studies with midwives, particularly, feeling ‘talked about’ afterwards, blame and involvement in litigation procedures, suggesting cultural issues within maternity settings play a key role.

Implications

O&G during their training and careers can expect to be exposed to events that they experience as potentially traumatic. The wider elements contributing to the perception of trauma as described by clinicians with and without high levels of PTSD symptoms are consistent with the concept that the cause of PTSD is not so much the nature of the event itself, but the personal and organisational procedures that follow. As previously reported, key differences between the high and low PTSD groups included (for those in the low group) having time to process the event, finding a positive in a negative and using the experience to train other doctors. Contextual aspects that may intensify risk could be routinely addressed within organisations to meet employers’ duty of care. These include adequate staffing, and integrated trauma prevention and intervention systems.

Given the unpredictability and severity of events, this would allow staff to be well prepared rather than focussing only on postevent supportive care. Universal prevention workshops could prepare individuals for such exposure both in training and in qualified roles and facilitate trauma awareness (including awareness of the nature
of traumatic events, early responses), and training in self-help strategies to reduce translation of trauma exposure into PTSD. Such workshops have demonstrated encouraging impacts following feasibility testing for midwives.33

The availability of support for doctors around the time of experiencing a traumatic event was clearly important, together with movement towards a more compassionate staff culture, normalising the availability of and access to support and not tolerating what could be experienced as disrespectful and unprofessional ‘gossip’ postevent.34 Appreciation for the subjective nature of trauma perception,6 where the outcome of a situation does not necessarily predict or mitigate a trauma response, may further contribute to a culture of support among staff. Where needed, the ability for doctors to access appropriate psychological input, including trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing therapy is essential.35

Recognition of the impact of investigative procedures both at Trust level and those of the Healthcare Safety Investigation Branch is required, including clarity in processes and timeline and the availability of appropriate staff support throughout.32 Modification or scrutiny of Trust guidance as indicated by Slade et al8 is needed to ensure routine attention to staff needs and prevention of trauma escalation. Findings have informed the development of a new Good Practice Paper for maternity staff support, currently under review with the RCOG, with recommendations for PTSD prevention and treatment directly drawn from the INDIGO study and previous research specifically with UK midwives.428 31 33 36

CONCLUSIONS
The nature of events perceived as traumatic by O&G were similar across roles and training. Themes identified about why events were traumatic were unaffected by whether or not the person was currently suffering with PTSD. Aspects that influenced the perception of trauma related to the event itself and how it occurred, the high level of emotionality and sensory experience of the event and personal identification with the patient. Also implicated was an absence of support during or after the event and length and lack of communication related to any investigation. The workplace circumstances triggering traumatic experiences in O&G are now clear and a systematic approach to preventing and intervening is urgently needed.

Author affiliations
1School of Psychology, Faculty of Health, Liverpool John Moores University, Liverpool, UK
2Department of Women’s and Children’s Health, University of Liverpool, Liverpool, UK
3Department of Primary Care and Mental Health, Institute of Population Health, University of Liverpool, Liverpool, UK
4School of Medical Education, Faculty of Life Sciences and Medicine, King’s College London, London, UK
5Liverpool Women’s Hospital Foundation Trust, Liverpool, UK
6Liverpool Health Partners, Liverpool, UK
7School of Health Sciences, Faculty of Medicine and Health Sciences, University of Nottingham, Nottingham, UK

Twitter Kayleigh Sheen @kayleighsheen

Contributors KS contributed to the funded proposal, contributed to qualitative analysis and led the development of the paper. LG contributed to implementation, qualitative analysis, interpretation and drafts of the paper. KB implemented the survey, completed all qualitative interviews and analyses and contributed to the paper. HS was instrumental in design, obtaining the funding, implementation, interpretation and the paper. JR facilitated the running of the project via the Royal College of Obstetricians and Gynaecologists and contributed to interpretation and the paper. AW contributed to the design, obtaining the funding, interpretation and the paper. PS (guarantor) was responsible for design, led the bid for funding and oversaw all aspects of the project and paper.

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Patient consent for publication Not applicable.

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Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available. No data are available. In the participant information sheet and therefore our ethical agreement, we have stated: ‘access to data from this study will be strictly limited to University members of the research team only’. Therefore, participants consented to their data being used for this project only.

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ORCID iD
Kayleigh Sheen http://orcid.org/0000-0003-1254-1763

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Investigating experiences of traumatic work-related events in Gynaecologists and Obstetricians (INDIGO) Questionnaire

Please read each of the following questions through carefully and respond by clicking your answer. There are no right or wrong answers; we are interested in your experiences and the way you feel about them. Sometimes you may wish to provide a short description in response; however, it is up to you how much detail you provide.

This questionnaire can be divided into four sections:
- **Section one** begins by asking for some demographic details
- **Section two** includes some questions about your professional experiences of trauma, some work-related questions, and your personal experiences of traumatic events
- **Section three** includes a series of short questionnaires that measure responses and feelings associated with experiences of traumatic events and work-related stress
- **Section four** includes some questions on what you think would be helpful to support you in dealing with workplace traumatic events

All responses you provide will be strictly confidential and returned directly to the University members of the research team.

### Section one

1. **What is your age?**
   - Age: [ ] .......................... [ ] years

2. **What is your gender?**
   - Male
   - Female
   - Prefer not to say

3. **What is your ethnicity?**
   - White
   - British
   - Irish
   - Other
   - Mixed
   - White and Black Caribbean
   - White and Black African
   - White and Asian
   - Other
   - Asian or Asian British
   - Indian
   - Pakistani
   - Bangladeshi
   - Other
   - Black or Black British
   - Caribbean
   - African
   - Other
   - Other ethnic group
   - Chinese
   - Other

4. **What is your current marital status?**
   - Single
   - Married/cohabiting
   - Divorced/separated
   - Widowed
   - Other
   - [ ] ........................................

5. **What level do you currently work at?**
   - ST1-2
   - ST 3-5
   - ST6-7
   - Post CCT
   - Consultant
   - Other: Please Explain

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6. **Who are you currently employed by?**

<table>
<thead>
<tr>
<th>NHS</th>
<th>University</th>
<th>Other (please specify):</th>
</tr>
</thead>
</table>

7. **Are you currently, or have you in the past, completed an advanced competency qualification?**

<table>
<thead>
<tr>
<th>Name of advanced competency:</th>
<th>Completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes/ No</td>
</tr>
</tbody>
</table>

8. **Are you currently involved in clinical practice on at least a monthly basis?**

<table>
<thead>
<tr>
<th>Yes (see a)</th>
<th>No (see b)</th>
</tr>
</thead>
</table>

   a) If yes, which clinical area(s) do you currently work in?

<table>
<thead>
<tr>
<th>Early Pregnancy Care</th>
<th>Outpatient Gynaecology</th>
<th>Maternal Medicine</th>
<th>Fetal Medicine</th>
<th>Adolescent Gynaecology</th>
<th>Labour ward</th>
</tr>
</thead>
<tbody>
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<td></td>
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<thead>
<tr>
<th>Benign Gynaecology</th>
<th>Urogynaecology</th>
<th>Reproductive Medicine</th>
<th>Forensic Gynaecology</th>
<th>Gynaecological Oncology</th>
<th>Sexual Health</th>
</tr>
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<thead>
<tr>
<th>Antenatal Care</th>
<th>Other:</th>
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</table>

   b) If no, where do you currently work?

<table>
<thead>
<tr>
<th>Academic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Other:</th>
</tr>
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</table>

9. **What is your personal experience of giving birth or of your partner giving birth?**

   a) I have given birth

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4+ times</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

   b) My partner has given birth

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4+ times</th>
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</thead>
<tbody>
<tr>
<td></td>
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10. **Have you ever consulted a healthcare professional about issues to do with your mental health, including problems with sleep or ‘nerves’?**

<table>
<thead>
<tr>
<th>Yes (see b)</th>
<th>No</th>
</tr>
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</table>

   a) If yes, who did you speak to? Please circle all that apply:

<table>
<thead>
<tr>
<th>GP</th>
<th>Occupational Health</th>
<th>Practice Nurse</th>
<th>Other: Please Specify</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

   b) If yes, were you referred to any of the following? Please circle all that apply:

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>Psychiatrist</th>
<th>Mental Health Nurse</th>
<th>Counsellor</th>
<th>I was prescribed medication</th>
</tr>
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<tbody>
<tr>
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</table>

I was referred to someone else:  I wasn’t referred to anyone:

<p>| | |</p>
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</table>

   b) Please explain in a few words (i) your previous difficulties, and (ii) how long you were experiencing them (iii) and how many phases of life this has been a problem for you

   (i)
11. Are you currently receiving any input for psychological difficulties that you think in part relate to your work?

<table>
<thead>
<tr>
<th>Yes (see b)</th>
<th>No</th>
</tr>
</thead>
</table>

a) Please explain in a few words your current difficulties:

<p>| |</p>
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<th></th>
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</table>

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Section two

The next questions ask about experiences you may have had whilst working as an obstetrician or gynaecologist that you may have personally found to be traumatic, upsetting or emotionally difficult.

We are particularly interested in events you have encountered at work, where you believed:

1. That a person in receipt of care could be in danger of serious injury or death

AND

2. Where you experienced a sense of intense fear, helplessness or horror in response.

You may have witnessed this event (i.e., being present when it was happening and/or providing care to that person.)

We understand that it may be difficult to recall the exact number of events you may have experienced. Where you are uncertain, please give your best estimate.

1. This question asks about traumatic work-related experiences where you were physically present. You may have been involved as a care provider, or been present at the time. For example "I was there and I believed somebody else to be in danger of serious injury or death"

   a) How many times during your Obstetrics and Gynaecology career have you witnessed an event at work that was traumatic for you?

   ..........................(N)

   b) How many of these events occurred in the last 5 years?

   ..........................(N)

   c) How long ago did the last traumatic work-related event happen?

   ...........................(years) ~.....(months)

   d) For how many of the events mentioned in question 14a did you experience a sense of the following emotions? You may feel one or more of the emotions on each occasion.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Intense fear</td>
<td>..........................(N)</td>
</tr>
<tr>
<td>(ii) Horror</td>
<td>..........................(N)</td>
</tr>
<tr>
<td>(iii) Helplessness</td>
<td>..........................(N)</td>
</tr>
</tbody>
</table>
e) In relation to the events mentioned in question 14a

(i) What was the most difficult event for YOU, that you have been physically present at whilst working as an obstetrician or gynaecologist? Please describe briefly below:

(ii) What made this event so difficult for you? Please describe briefly below:

(iii) How long ago did this particular event happen?

…………..years ………..months ………..weeks ………..days

2. a) Have there been any (i) beneficial or (ii) adverse effects for you, from experiencing a traumatic work-related event(s)?

Yes (see b) No

b) If yes, please describe these in the space below:

(i) Beneficial:

(ii) Adverse:

3. AS A CONSEQUENCE OF a traumatic work-related experience, have you ever:

a) Asked to amend your clinical allocation to avoid a specific clinical area or situation on a short term basis (e.g., a couple of shifts)?

Yes No Considered

b) Asked to amend your clinical allocation to avoid a specific clinical area or situation on a long-term basis (e.g., more than a couple of shifts)?

Yes No Considered
### c) Taken time off (e.g., sickness absence)?

| Yes | No (go to d) |

If yes, how much time?

| Up to 1 week | Up to two weeks | Up to one month | Up to 6 months | Over 6 months |

### d) Seriously considered changing your clinical speciality? Please circle all that apply:

- Yes leaving Obstetrics
- Yes leaving Gynaecology
- Yes leaving the Specialty
- No

### e) Seriously considered moving away from clinical practice?

| Yes | No |

### f) Seriously considered leaving the medical profession?

| Yes | No |

### g) Reduced working hours, taken a career break or a secondment?

| Reduced working hours | Career Break | Secondment |

### h) If you answered yes or considered yes to any of the questions above, please describe the instances below (indicating which questions you are referring to) in terms of the duration of the requested changes, what they involved, and how long ago this was:

### 4. These questions ask about your general life experience (non-work) trauma.

#### a) Have you ever experienced an event (outside of work) where you believed yourself or someone else to have been in danger of serious injury or death?

| Yes | No |

#### b) Did you experience a sense of extreme fear, helplessness or horror in response to what happened?

| Yes | No |

#### c) If yes, give a brief outline of the event, including when it happened, in the space below. If you have experienced multiple events, please describe one which you feel was most stressful.

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5. These questions ask about your personal experience(s) of giving birth or being present when your partner was giving birth. If you have never given birth before, please move to Section 3.

   a) When you (or your partner) gave birth to your baby, did you ever believe yourself (your partner) or your baby to be in danger of serious injury or death?
      
      |   |   |
      | Yes | No |
      |-----|----|

   b) If yes, did you experience a sense of extreme fear, helplessness or horror in response?
      
      |   |   |
      | Yes | No |
      |-----|----|

Section three

Section three consists of a series of short questionnaires that ask about different responses that are associated with the experience of traumatic events and work-related stress. There are also some questions measuring empathy and how you perceive your experiences to be affecting different areas of your life. Each set of questions has a small description and information on how to record your response. There are no right or wrong answers. Please do not think too long about each question, just give your first response.

Questionnaire 1.
The following questions list some difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty is for you by circling your response. Please refer to your feelings about work-related traumatic experiences in the last 7 days. How much were you distressed or bothered by these events?

Please use the following key:

0= Not at all
1= A little bit
2= Moderately
3= Quite a bit
4= Extremely

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Any reminder brought back feelings about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>I had trouble staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Other things kept making me think about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>I felt irritable and angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>I avoided letting myself get upset when I thought about it or was reminded about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>I thought about it when I didn’t mean to</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>I felt as if it hadn’t happened or wasn’t real</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>I stayed away from reminders about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>Pictures about it popped into my mind</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
10. I was jumpy and easily startled 0 1 2 3 4
11. I tried not to think about it 0 1 2 3 4
12. I was aware that I still had a lot of feelings about it, but I didn’t deal with them 0 1 2 3 4
13. My feelings about it were kind of numb 0 1 2 3 4
14. I found myself acting or feeling like I was back at that time 0 1 2 3 4
15. I had trouble falling asleep 0 1 2 3 4
16. I had waves of strong feelings about it 0 1 2 3 4
17. I tried to remove it from my memory 0 1 2 3 4
18. I had trouble concentrating 0 1 2 3 4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart 0 1 2 3 4
20. I had dreams about it 0 1 2 3 4
21. I felt watchful and on guard 0 1 2 3 4
22. I tried not to talk about it 0 1 2 3 4

**Questionnaire 2**

Please read the statements written below, and circle the number to show the extent to which you agree with them by using the scale.

**“My experiences of traumatic work-related events have disrupted my work”**

Not at all 0 1 2 3 4 5 6 7 8 9 10
Mildly
Moderately
Markedly
Extremely

**“My experiences of traumatic work-related events have disrupted my social life”**

Not at all 0 1 2 3 4 5 6 7 8 9 10
Mildly
Moderately
Markedly
Extremely

**“My experiences of traumatic work-related events have disrupted my family or home life”**

Not at all 0 1 2 3 4 5 6 7 8 9 10
Mildly
Moderately
Markedly
Extremely
**Questionnaire 3** (Maslach Burnout Inventory) redacted for copyright purposes

**Questionnaire 4.**
The following statements ask about your thoughts and feelings in a variety of situations. For each item, show how well it describes you by choosing the appropriate number on the scale (1= does not describe me well, 5= describes me very well). Read each item carefully before responding. Answer as honestly and as accurately as you can.

Please use the following scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Does not describe me well</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Describes me very well</td>
<td></td>
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</tbody>
</table>

1. I often have tender, concerned feelings for people less fortunate than me
2. Sometimes I don’t feel very sorry for other people when they are having problems
3. When I see someone being taken advantage of, I feel kind of protective towards them
4. Other people’s misfortunes do not usually disturb me a great deal
5. When I see someone being treated unfairly, I sometimes don’t feel very much pity for them
6. I am often quite touched by things I see happen
7. I would describe myself as a pretty soft-hearted person
**Questionnaire 5**

Please read the following statements carefully, and indicate how much you agree with each one by circling your response.

Please use the following key:

1 = Strongly agree  
2 = Agree  
3 = Not sure  
4 = Disagree  
5 = Strongly disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally speaking, I am satisfied with my current role as an obstetrician/gynaecologist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel I am in a rut</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel frustrated with my current role</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have enough opportunities to make decisions about care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have limited opportunities for professional development</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am confident that I have the skills for my current role</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have enough time to give others the care they need</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I get professional support from my medical colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I get enough support from other clinical colleagues (e.g., GP, midwives)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There is not enough time to do my job properly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My current role is very stressful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My current role allows me to provide women with choice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My current role allows me to plan care with women</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I need greater scope to provide women with information about their care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have limited opportunities to provide women with individualised care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have limited opportunities to provide continuity of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have enough professional independence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have few opportunities to develop my skills as an obstetrician/ gynaecologist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have plenty of opportunities to further my professional education</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I lack professional support from my managers</td>
<td>1</td>
<td>2</td>
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</table>
Section Four.

Views on what, if anything, needs to be provided

1. Do you feel there should be more specific support for Obstetricians and Gynaecologists following a traumatic event?

Yes    No

If Yes, what do you think would be helpful to support you in dealing with workplace traumatic events? Please describe:

2. We are currently piloting a stepped package of care for midwives to create a ‘trauma aware workforce.’ We would like to assess whether this package would be useful for obstetricians and gynaecologists, and if so how it could be adapted to meet your specific needs.

The POPPY package is organised as follows:

**Element 1.** This is an *educational workshop* for all midwives to:

(i) increase understanding about normal responses to psychological trauma
(ii) know how to best manage these responses through self-help strategies, to facilitate healthy thinking and prevent the development of posttraumatic stress symptoms
(iii) know when to seek further help
(iv) know how to help colleagues

An *information leaflet* is provided summarising the workshop information.

If self-help is insufficient the package also includes two further resources available for midwives to use in sequence if needed.

**Element 2 Peer support system.** We have trained a small group of midwives to provide confidential telephone peer support.

**Element 3 Psychological assessment and input.** Midwives who continue to experience difficulties 6-8 weeks after a traumatic perinatal experience are offered psychological assessment. This could result in trauma-focused structured psychological input provided by a specialist clinical psychologist.

1. How useful would these elements be for Obstetricians and Gynaecologists?

   a. *Workshop:*

   1  2  3  4  5
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<tr>
<th></th>
<th>Not Useful</th>
<th>Not Useful</th>
<th>Neutral</th>
<th>Somewhat Useful</th>
<th>Extremely Useful</th>
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</thead>
<tbody>
<tr>
<td><strong>At all</strong></td>
<td></td>
<td></td>
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b. **Peer support:**

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<tbody>
<tr>
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<td>Not Useful</td>
<td>Neutral</td>
<td>Somewhat Useful</td>
<td>Extremely Useful</td>
<td></td>
</tr>
<tr>
<td>At all</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
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</table>

c. **Easy access to trauma psychological intervention:**

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<td>Somewhat Useful</td>
<td>Extremely Useful</td>
<td></td>
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<tr>
<td>At all</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
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</table>

d. **The package as a whole:**

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<td></td>
</tr>
<tr>
<td>At all</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
<td>Useful</td>
</tr>
</tbody>
</table>

2. Are there other elements that could be considered? Please suggest:

- 
- 
- 

3. How would you improve this package to better meet the needs of obstetricians and gynaecologists?

- 
- 
- 

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V5_06022017_survey
The survey is now complete

This study is being conducted in two stages. Thank you for completing Stage 1.

Stage 2 involves a 30 minute telephone interview to explore in greater detail your personal experience of a traumatic experience at work. If you would be willing to hear more about taking part, please leave your details below and our researcher will contact you.

Are you interested in learning more about Stage 2?

YES    NO

If you have answered YES please complete the contact information

Name:  
Email:  
Telephone Number:  
Alternative phone number

Are you interested in receiving a summary of the work you have contributed to?

YES    NO

If you would like to receive a summary of this work please provide your email address on the next page. Your contact details will be stored separate to any of the responses you have provided in this survey.

If you would prefer to conclude your participation here, we would like to take this opportunity to thank you for your time.

We are aware that thinking about traumatic events can be difficult. If you feel you need further support in relation to these issues then the following organisations may be of help:

- BMA Counselling - available 24 hours a day Tel: 0330 123 1245
- Support4Doctors – www.support4doctors.org
- Samaritans – available 24 hours a day Tel: 116 123 or email: Jo@samaritans.org

Alternatively, you can contact the researcher, Dr Katie Balling, who will be able to signpost you to appropriate support services:

Dr Katie Balling (Research Associate and Clinical Psychologist)  
Ground Floor Whelan Building, Psychological Sciences, Institute of Psychology, Health and Society University of Liverpool, Brownlow Hill, Liverpool, L69 3GB  
Tel: +44 0151 7955537  Email: Kballing@liverpool.ac.uk
Investigating the impact of traumatic experiences in obstetricians and gynaecologists
(INDIGO)

Interview guide

INTRODUCTIONS

The interviewer will thank the participant for agreeing to take part in the research and will attempt to make them as relaxed as possible. The following details will be covered:

- The aims and purpose of the study (including a reminder of the definition for a traumatic work-related event)
- Explanation of tape recording and transcription
- Explanation of procedures to ensure confidentiality (inc. study numbers)
- Explanation that names will not be used and that personally identifiable information will be removed upon transcription
- Explanation that the interview can stop at any time, that the participant can refuse to answer any question, and that it is entirely up to them how much detail they provide in their answers
- Opportunity to ask questions prior to beginning
- Consent will be taken
- Check that the tape is working
TOPIC GUIDE

1. Part one: the event
   a. Can you tell me about the most traumatic work-related event that you have experienced over the last few years, in as much detail as you would like to?
      i. What was your role during this?
      ii. How long ago did this happen?
   b. What was it about this event that was particularly stressful for you?
   c. Can you tell me about what it was like for you [during this event]?

2. Part two: responses and impact
   a. What was it like for you initially after this event?
      i. Can you give me any examples?
   b. In what way, if at all, do you think that this experience affected you or your clinical practice?
      i. Can you think of any specific examples?
         1. Prompt: professional / personal

3. Part three: Helpful and supportive strategies
   a. Is there anything you did to manage your feelings or thoughts after this event?
      i. Prompt: internal/ external
      ii. In what way were these [effective/ not effective]?
   b. What did you want, if anything?
   c. Were you offered any support after this event?
      i. Can you tell me about these?
      ii. Can you comment on how helpful these were?
   d. Did you have any input from others?
      i. How helpful was this?
   e. Can you think of anything else that may have helped you more?
      i. Looking back, is there anything different you would do?
         1. Can you tell me more about this?
   f. Was there anything that made the situation more challenging?

4. Part 4: Reflections
   a. Did anything change after the event?
      i. Professional/ personal
   b. In what way, if at all, have things [thoughts/ feelings) changed since then?
      i. What do you think influenced these changes?

5. Discussion of support provision
   a. What do you think would be the most appropriate support for Obstetricians and Gynaecologists who have experienced a difficult work-related event?
   b. [describe the programme currently in development for midwives; educational workshop and training in self-management of initial stress responses, information leaflet, peer support system, psychological input]
      i. How useful do you think these resources would be for [obs/gyn]?
      ii. What barriers can you see in providing this for [obs/ gyn]?
      iii. In what way do you think that these could be better suited?
         1. What elements would you change, if at all?

6. Is there anything else important relating to this that you would like to comment on?