

Original Article

Midwives' emotional distress over maternal death: The case of Ashanti Region

Anita Fafa Dartey (PhD, M Nursing, BTech OHNP, RN)¹
Ellemes Phuma-Ngaiyaye (PhD, RN, RM)²
Rene D. Phetlhu (PhD, MCur, BA)³

Abstract

Emotional distress associated with the death of human beings cannot be underestimated. Much as it affects the immediate family members, midwives who witness death of pregnant patients are not spared the emotional distress. Emotional distress affects the general health, behaviour, productivity and job satisfaction of nurses and midwives. However, there is inadequate literature on how midwives in the Ashanti Region of Ghana become emotionally distressed after they experience maternal death. This study sought to explore and describe lived experiences of midwives' emotional distress over maternal death at work using a qualitative approach. The study consisted of 57 participants (18 supervisors and 39 ward midwives) selected using the purposive sampling technique. Data collection was done through focus group discussions using semi-structured interviews. The responses collected were managed by qualitative computer data analysis package (Atlas.ti version 7.1.7) and the Thematic Content Analysis was used for analyzing the data. Four major themes emerged from this study: feeling sad or bad, traumatised, disorganised, and death seen as unpleasant, painful and inhumane. Main recommendation embodied institution of support programmes in hospitals without them, to help workers cope with such distress, help lessen the distress that midwives go through, improve quality of services provided, as well as provide job satisfaction.

Keywords:

Emotional distress; midwives; maternal deaths; job satisfaction

1. School of Nursing and Midwifery, University of Health and Allied Sciences, Ho, Ghana
2. Department of Nursing & Midwifery, Mzuzu University, Malawi.
3. School of Nursing, University of the Western Cape, South Africa

Corresponding Author:

1. School of Nursing and Midwifery, University of Allied Sciences, Ho, Ghana
PMB 31, Ho, Volta Region-Ghana
Email: fadartey@uhas.edu.gh

Introduction

Globally, there are occupational distresses in every organization, and different jobs produce different occupational distresses. A healthy distress-free healthcare environment is important for the quality of healthcare services received by patients as well as for job satisfaction of the care provider. However, unexpected deaths of pregnant women are not only occupationally stressful but also emotionally stressful experiences for midwives. Such experiences intensify the already dire situation contributing to 'job distress' (Dagget, Molla, & Belachew, 2016). According to Khan Aqeel, and Riaz (2014), emotional distress, resulting from job distress is believed to have a direct impact on job performance and job satisfaction. Distress, from the perspective of Bickham (2009) is any response to an event, which overpowers one's coping skills. Similarly, distress is seen as the psychological strain resulting from experiencing unusual or demanding situations, known as stressors (Finney, Stergiopoulos, Hensel, Bonato & Dewa, 2013). Emotional distress can therefore, be defined as a situation that causes an individual to respond to sudden and painful psychological experience. The overwhelming characteristics manifest as anger, guilt, nightmares, suffering, resentment, sorrow, helplessness, powerlessness and loss of self-worth (Zuzelo, 2007).

Moreover, emotional distress leads to emotional burnout and frustration, which can cause an imbalance between occupational and household roles. In a similar situation, emotional job distress is perceived as the unpleasant condition or position at the workplace, with a negative impact on an individual's overall well-being and performance (Khan, et al, 2014). Emotional distress also causes fear, depression, exhaustion and isolation (Bickham, 2009). The initial reactions of healthcare professionals to a patient's death have an obvious impact on them and these impacts are grouped into emotional, physical, cognitive, social and moral distress (The American Association of Colleges of Nursing (AACN), 2008).

Similarly, when emotional distress occurs repeatedly within the working environment of midwives, it can lead to withdrawal and a flight response (De Villers, 2010; Austin, Kelecevic, Goble & Mekechuk, 2009). Edo-Gual, Tomás-Sábado, Bardallo-Porras and Monforte-Royo (2014) reported that nurses and midwives frequently rated dealing with 'death and dying' as one

of the major emotionally stressful events, and the impact on them included burnout, health complaints and decreased quality of patient care. Bickham (2009), therefore, concluded that if the distresses experienced in stressful healthcare environments are not dealt with, they might lead to mental symptoms such as depression, anxiety, depersonalisation and dissociation. Bickham (2009), however, did not deny the fact that nurses and midwives are expected to cope with emotional and other stressful circumstances, such as patient deaths, though such situations appeared to be difficult for some nurses and midwives, notwithstanding that the two professions are fundamentally demanding enough.

Core characteristics expected of midwives include respect, compassion, empathy and accountability (Lewis, 2014). Therefore, any midwife who is unable to justify the cause of a maternal death would be stigmatised, and blamed for the death. Lewis (2014) recalls instances where incidences of maternal death have been reported to the police for criminal investigations, resulting in the placing of a health staff in custody until proven innocent. Such experiences eventually create gaps in job satisfaction and negatively affect midwives who face such situations making them not enjoy doing their job any longer (Dagget, Molla, & Belachew, 2016). Khan et al., (2014) posited that job satisfaction is "a stable and balanced arrangement of environmental, psychological and physiological situations at workplace" (p. 270). Alnems Aboads, Alyousef, AL-Yateem, and Abotabar (2005) further argued that job dissatisfaction of midwives may occur due to emotional distress and is found in non-supportive work environments. It is evident that emotional job distress and job dissatisfaction are the most significant causes of job turnover among nurses and midwives (Zuzelo, 2007). Job dissatisfaction of employees can lead to high turnover, less work commitment, physical withdrawal, and emotional or mental retreat from the organisation (Pathak, 2012). Midwives who witness maternal death initially experience a sense of emotional distress and disbelief. The situation is becoming a serious problem in midwifery practice; moreover, people with serious emotional distress carry the remnants of the experience for many years, if not for a lifetime (De Villers, 2010). However, what is not clear is how emotionally distressed midwives in Ashanti Region of Ghana get when they experience maternal deaths at

their workplaces. This paper therefore seeks to explore and describe the midwives' emotional distress over maternal death in the Ashanti Region of Ghana.

Research Design and Methods

A qualitative approach with exploratory and descriptive research design was employed in the study. An exploratory research design has the advantage of uncovering many aspects of the phenomenon under investigation and aims at examining the full nature of comparatively unfamiliar phenomenon (Polit & Beck, 2008). Furthermore, Polit and Beck (2012), define descriptive research design as a study of the main objectives of describing an accurate representation of the characteristics of persons or situations. With regard to the current study, the descriptive research design brought out the meaning of the problem under investigation through a detailed description of the lived experiences of midwives at their workplaces. The research setting for the study was within the Ashanti Region of Ghana, where maternal death has been very high (usually above 100 per 1000 live births) since 2009 (Ghana Health Service Annual Report, 2014). The study was conducted in nine health facilities including one teaching hospital, one regional referral hospital, four district referral hospitals and three health centres. The region has a high number of healthcare facilities as well as high number of health workers, yet a low number of supervised deliveries in the country (Ghana Health Service Annual Report, 2014). Purposive sampling was used to select participants who met the inclusion criteria: having worked continuously as midwives for at least two years before the date of data collection, who have experienced maternal death, and have gone through the maternal death review process. Participants were recruited through the principal midwifery officers in charge of the wards. Data saturation was attained after 18 semi-structured interviews and 8 focus group discussions, where no new information was coming from the participants. A total of 57 ward midwives and ward supervisors took part in the study. Interview guides were used. All focus group discussions and the semi-structured interviews lasted between 40-60 minutes each. The ethical clearance for the study was obtained from the Senate Research Committee of the University of Western Cape, South Africa, where the lead researcher was studying, and the Ministry of Health/Ghana Health Service.

Data Management and Analysis

Data analysis was done after audio recordings were transcribed. The data analysis followed Holloway & Wheeler's (2013) stages of Thematic Content Approach in analysing data. Through validation of data, data transcribing, and data cleaning. Coding was done to categorise and group similar information into families and later into themes (Polit & Beck, 2012). The analysis was assisted by the use of computer software called Atlas.ti version 7.1.7. Participants were identified with alphabets and numbers: M2 (midwife manager number 2) and FG2M5 (focus group 2 midwife 5).

Rigour

Qualitative trustworthiness was accomplished through credibility, confirmability, transferability and dependability. Trustworthiness of the current research was based on Lincoln and Guba's (1985) position, which states that rigour in qualitative research should not suffer information loss. Therefore, there was no sacrifice of relevant information in the study. Credibility was ensured by peer debriefing, triangulating the different methods of data collected, prolonged engagement with participants as well as member checking while using official data analysis methods. Research audit was one of the processes of confirmability used under this study. Transferability was achieved through the provision of detailed descriptions of the participants' characteristics for any researcher who wishes to do so. Dependability puts emphasis on the need for the researcher to describe any changing context within which the research occurs and that which the researcher observed. Dependability was also achieved through external audits. Participants' confidentiality and privacy were preserved throughout the study by using a number of measures, such as the signing of focus group binding forms and individual consent forms.

Results Background of Participants

All participants were females since there were no male midwives at the time of data collection. Participants ranked from the lowest rank (Staff midwife) to the highest rank (Director of Midwifery). There were more junior ranked officers (52.6 %). Participants' ages ranged between 22 and 61 years with the majority (56.1%) under the age of 46 years, implying that there are younger midwives who are likely to be exposed to

maternal death in their work life without proper support in the form of Employee Assistance Programme (EAP). The participants had post qualification work experience ranging from three (3) to more than 25 years. About 58% of the participants had more than 10 years of experience as midwives, which meant more than half of the participants had appreciable working experience. Most of the participants had repeated exposure to maternal death and the processes that follows.

Findings

The findings of the study revealed that midwives are emotionally distressed whenever they witness maternal death cases at the healthcare facilities, and this influences their wellbeing and ability to function efficiently in the performance of their responsibilities to other patients. Four themes emerged from the study: feeling bad or sad, traumatised, disorganised, and seeing maternal death as unpleasant and inhuman.

Feeling Sad or Bad

Feeling sad or bad meant midwives were unhappy about the death of patients they cared for. While some participants used the phrase "feeling sad" to describe their experience with maternal death, other participants simply put it as "feeling bad". Feeling sad or bad was an emotional feeling of loss and helplessness. The expression "feeling sad" and "feeling bad" was used by the majority of the participants in expressing their experience with maternal death. This is illustrated by the following quotes;

"I always feel very sad when I hear that a patient died on the ward. I feel so sad. You know one cannot revive a dead person. It is so sad when we record maternal death because we are all trying to support maternal health, not to encourage maternal death". FG1M3

"It is so bad to hear that someone expecting a baby is dead. I think I have experienced it three times. It is very sad because nobody expects it but it happens, and when it happens like that, one feels bad as a caregiver". FG1M4

"If a mother dies during my care, I feel very bad, what I pray for is to always deliver mothers safely. It is a bad experience". FG4M4

"It affected me badly and it made me think that maybe I didn't do my work well". M13

Traumatised

Some participants reported that they were traumatised anytime they experienced maternal death. To be traumatised entails experiencing a disturbing event. Participant FG1M3 expressed the experience quite well stating,

"When there is maternal death the midwife herself is in shock, traumatised so I think the hospital chaplain can help break the news and console the relatives....."

FG1M2 also presented with the same position

"... if the patient expires, you the midwife you are traumatised, there is the possibility of even forgetting to document though it was done."

Disorganised

When an individual is traumatised, the individual is likely to be disorganised, not knowing what to do or say. This was experienced by some participants and Participant M3 said

"I feel very sad and disorganised when I experience or hear of a maternal death. It is not a good thing. It feels very sad and am disorganised anytime it happens"

while Participant FG1M3 stated

"When I hear or experience of maternal death, I feel disorganised for some time...."

Participant M13 also expressed the sense of disorganisation this way:

"I was so disturbed that night. Psychologically I was disturbed. Human being dying in our hands is not easy, not good."

while Participant FG1M4 also said

"I put myself in the deceased's shoes for that moment and you cannot even do things right because it affects one emotionally."

Unpleasant and Inhumane

In another instant, some participants expressed their experience with maternal death as unpleasant, painful, and inhuman. Participants are of the view that maternal death is neither a good nor a pleasant experience for human beings.

"It's... unpleasant and is very painful to experience maternal death. Why because a woman is pregnant, expecting to deliver in a healthy and beautiful way and all of a sudden something will come up concerning the situation then she dies, so it's not something good." M5

"Sometimes [it] is very inhumane to experience maternal death. Oooh we are human beings and a human being's life taken away is not good, who is going to look after the baby, and all these things go into consideration when you experience Maternal Death." FG6M5

Some participants reported that maternal death distresses everybody. The participants in this study largely shared the view that maternal death is everybody's business. This was expressed quite well in the following quotes:

"Maternal death is something that affects everybody. Looking at the baby and the other people that the woman left behind, automatically affect you." M16

"When maternal death happens, it does not matter if you are a relative or not, male or female healthcare provider. As far as it's our client, we build a relationship, establish rapport, so you will be able to manage and communicate with the client well." M6

Furthermore, the findings present a situation where the midwives as a team feel helpless in their distress when unable to save a woman's life.

"...Maternal Death is something I think we all need to address because emotionally we (midwives) all don't seem fit when we lose a client"

and confirmed by FG4M3 saying 10

"Death is something nobody wishes to happen, not

even to the enemy because it's an emotional thing. So when it happens to a pregnant woman it is very sad especially since there might be two or three lives involved at the same time. It is something you do not wish for your own self. It affects midwives psychologically. The mention of death everybody becomes emotionally distressed. This is the same thing that happens to us all in the ward. We also feel about it very much. So why the pregnant woman should die as a result of delivery it is not something we wish for." M8

Similarly, individual midwives acknowledged that though they are not related to the clients, they still feel pain and are emotionally distressed. Participant FG1M4 explained that though patients who die might not be related to her, emotional distress is experienced:

"The fact that the deceased person is not my relative does not mean I don't feel the pain that the relatives go through or I don't care about how the relatives feel. It affects me emotionally".

While M5 said the same thing in a different way

"HMMMMM, when we (midwives) record maternal death, emotionally I am disturbed. Although I am able to do some work, I am emotionally unstable."

Emotional distress was also observed in some participants by their colleagues. According to these participants, colleagues who experience maternal death whilst on duty are mostly seen to be in deep distress. The distressed midwives are mostly seen to be by themselves, asking themselves what actually happened for the woman to die as reported by M14:

"Yes, the midwives are normally affected emotionally: particularly when we are marking their reports. They say maternal death occurred and it affects everybody's emotional feelings and we become emotionally distressed. The midwives come out and say, 'aah somebody died this morning or at this particular time, in fact it is pathetic."

We wished it has [sic] not happened but it has

happened and women are suffering but what else can we do?' we just have to support them. Most of the time, their expressions show that they are emotionally affected but they have to work by bringing the emotions down."

FG1M also remembered what happened to one close colleague,

"It actually affects us (midwives) emotionally because I do remember a colleague had gone through that situation (emotional distress) where a mother died while she was on duty and it was tough for her. She was repeatedly and sadly questioning herself why such an incident (maternal death) happened to her and I had to support her psychologically."

On other hand, few participants (particularly supervisors) were of the view that emotional distress should not be entertained too long or it would disrupt the work. These participants said that they were able to work, despite the distress, to prevent further reoccurrence of maternal deaths. These participants felt responsible as ward supervisors on whom the care of other patients rested and some expressed their views on the need to continue working as in the case of M11;

"I shouldn't say this woman is dead so I won't attend to others."

Meanwhile, M4 was of the opinion that life needed to go on in spite of any sad occurrence

"Life must go on and the work; you cannot leave the work like that, you cannot stay at home because of that situation."

Discussion

The analysed data indicated that midwives were emotionally distressed when they experienced maternal death at their workplaces. Participants described different ways in which they expressed the emotional distress they went through because of the death of their clients. They alluded to the fact that all midwives in the wards became unfit emotionally when they experienced maternal death. Nickerson, Liddell, Maccallum, Steel, Silove and Bryant (2014) are of the view that there is always emotional distress whenever people experience the death of others no

matter the relationship. Emotional distress was experienced by all participants, notwithstanding age, position or number of years of experience on the job as a midwife or the type of health facility they worked in. One participant put it as *"none of us (midwives) seem fit"* whenever maternal death occurred at the workplace. Emotional distress affects behaviour, productivity and performance as well as job satisfaction (Center for Prevention and Health Services, 2008). Participants in this study alluded to the fact that they experienced sadness whenever maternal death occurred. They felt the goal of assisting a patient to a safe delivery and going home happily after delivery was forever missed. According to Cain and Ter-Bagdasarian (2003), midwives who experience maternal death go through gloom and psychological distress. The distress in the hospital setting threatens the physical and mental well-being of health workers and goes beyond the existing stage into the future. Peters and others (2013) also stated that it compromises patient care and safety (Peters, et al., 2013). Some participants in the current study indicated that they became disorganised when they experienced maternal death. This is in line with the literature, where Bozarth (2013) mentioned that, people who experience grief tend to forget what to say or do, making such people have personal problems such as low self-esteem. Such state of disorganisation is not helpful in healthcare and especially in midwifery, because concentration is paramount in order to observe and give the best care to the clients as in the case of midwifery, two or more people might be involved at any other time (Sjöblom, Idvall, & Lindgren, 2014).

Furthermore, other participants expressed experiencing maternal death as unpleasant and painful. To these midwives, it was a nightmare when they experienced maternal death in the hospital. From the point of view of Hugenschmitt, Souquet, Lefort, Bagur, and Gueugniaud (2015), death experience faced by some health staff, especially nurses and midwives, does not appear to protect them from trauma, pain or other unpleasant feelings resulting from grief; they still struggle to deal with new death cases that they encounter (Kellogg, Barker & McCune, 2014; Wilson, 2014). As a result, Sliter, Sinclair, Yuan and Mohr (2014), suggest that midwives' working environment should be conducive and stimulating enough to discourage any compromise on the quality of healthcare and to help improve wellness being of such workers.

In contrast to the fact that most participants were sad or felt bad, traumatised and disorganised, few participants overlooked the perceived negative effects of maternal death. Their emotional experiences made them work harder and they became more careful attending to other clients in order to prevent a possible recurrence of the situation. Midwives do not want to experience maternal death for the second time since it is a painful experience to them (Wilson and Kirshbaum, 2011). A study by Tan, O'Connor, Howard, Workman and O'Connor (2013) confirms that some nurses and midwives who deal with death most often have diminished levels of emotional distress and death anxiety. Midwives therefore, use the bad situation as a learning event to make necessary corrections or amendments to prevent future occurrences. In addition, Lange, Thom and Kline (2008) have observed that midwives with a number of years of work experience exhibit positive attitude towards death and dying patients than those just beginning. In 2004, the World Health Organisation (WHO) prescribed for all healthcare providers of pregnant women the use of Maternal Death Review (MDR) which entails an "in-depth investigation into the causes and circumstances surrounding maternal death" (FIGO-LOGIC, 2013, p, 13). According to WHO (2004), MDR should be done for all maternal deaths so that mistakes by the healthcare providers can be used as a learning process to avoid similar situations in the future.

The results from the current study indicate that participants were emotionally distressed collectively as a group (of midwives), ward members or a team on duty. This depicts the esprit de corps amongst nurses and midwives, which can be turned into a useful opportunity to address maternal mortality. For example, normally during emergencies in the maternity wards or units, all experts (midwives and others with midwifery skills) are called on board to assist (Flohr-Rincon, & Tucker, 2012; Wrammert, Sapkota, Baral, Ashish, Målqvist, & Larsson, 2017). Such display of teamwork can positively affect the Sustainable Development Goal 3, which seeks to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. From the findings of the study, emotional distress varies with the individual midwives. Individual midwives directly involved in nursing the patient before death are usually drenched in emotional distress as identified by colleagues at work. A survey conducted by May (2009), confirms

that nurses who were unable to deal with their reactions to death, might have compromised their professional position in a way. This, according to Peters, and others (2013), is a professional reaction, which leaves the midwives under no control over the situation, but rather vulnerable and distracted in their environment. Some participants indicated that they had observed colleagues in deep emotional distress, where they always tried to find answers to the reasons for their clients' death and why it happened during the time, they were on duty. These colleagues according to participants were seen always very sad and in bad mood, mostly by themselves and quite often absent-minded. According to Bickham (2009), midwives get emotionally distressed on the death of their clients, since caring for pregnant mothers to the safe delivery of their babies is their ultimate goal and as such, maternal death is considered as a kind of failure of the entire healthcare system.

Implication for midwifery practice and policy

The study has brought to light the emotional distress, affecting midwives as a result of maternal death, which may negatively affect the quality of health care services rendered to other patients. The study also unearthed a positive practice – teamwork – among midwives amidst the sad experience they go through that can be fallen on as an opportunity to address maternal deaths.

Conclusion

In conclusion, the study established that institutional maternal deaths bring about emotional distress among midwives. The research was conducted in only one region and therefore might not be representative of the full opinion of all midwives in Ghana. Further research on how emotional distress can be dealt with and the effects associated with maternal deaths is recommended. More research is also recommended on how to harness the esprit de corps expressed by midwives in their emotional distress to encourage more teamwork to address maternal deaths as aimed in the SDG 3.

Conflict of Interest

The authors of the manuscript declare that no conflict of interest exists.

Acknowledgement

The authors thank Dr. Gladys Dzansi at the School

References

- Alnems, A., Aboads, F., Alyousef, M., AL-Yateem, N., & Abotabar, N. (2005). Nurses' perceived job related stress and job satisfaction in Amman private hospitals. Retrieved from faculty.ksu.edu. Sa/msawalha/Documents/My's, 20. On June 15, 2014.
- Austin, D., Smythe, E., & Jull, A. (2014). Midwives' wellbeing following adverse event – what does the research indicate? *New Zealand College of Midwives Journal*, 50, 19- 23.
- Austin, W., Kelecevic, J., Goble, E., & Mekechuk, J. (2009). An overview of moral distress and the paediatric intensive care team. *Nursing Ethics*, 16(1), 57-68.
- Bickham, A. M. (2009). *Distress in nurses following patient death: A local response to the need for debriefing*. Thesis- Montana State University.
- Bozarth, A. R. (2013). A journey through grief: Gentle, specific help to get you through the most difficult stages of grieving. Retrieved from <http://books.google.com/books?isbn=1592859380> on June 15, 2014.
- Caine, R. M., & Ter-Bagdasarian, L. (2003). Early identification and management of critical incident stress. *Critical Care Nurse*, Vol. 23, pp. 59-65.
- Center for Prevention and Health Services (2008). An employer's guide to employee. Retrieved on April 09, 2013 from <http://www.businessgrouphealth.org/pub/f3137a542354-d714-51c7-3c18b5cf5959>, on April 09, 2013.
- Dagget, T., Molla, A., & Belachew, T. (2016). Job related stress among nurses working in Jimma Zone public hospitals, South West Ethiopia: a cross sectional study. *BMC nursing*, 15(1), 39.
- Dartey, A. F & Ganga-Limando, M. (2014). Contributions of midwives in the implementation of facility-based maternal death review (MDR) in selected health facilities in Ashanti Region, Ghana. *International Journal of Research in Health Sciences*. 2(2):614-20.
- De Villers, M. J. (2010). Moral Distress and Avoidance Behavior in Nurse Working in Critical Care and Noncritical care Units. Loyola University Chicago, Dissertation, Paper 195. Retrieved from on June 15, 2014.
- Edo-Gual, M., Tomás-Sábado, J., Bardallo-Porras, D., & Monforte-Royo, C. (2014). The impact of death and dying on nursing students: an explanatory model. *Journal of Clinical Nursing*, 23(23-24), 3501-3512.
- Finney, C., Stergiopoulos, E., Hensel, J., Bonato, S., & Dewa, C. S. (2013). Organisational stressors associated with stress and burnout in correctional officers: A systematic review. *BMC Public Health*.
- Flohr-Rincon, S., & Tucker, L. (2012). "Many Hands Make Light Work": Using a Kaizen Approach to Ignite Innovation While Increasing Patient Safety and Productivity on an Obstetric Triage Unit. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 41(s1). Ghana Health Service Annual Health Report (2014). Policy, Planning, Monitoring and Evaluation. Accra, Ghana. Retrieved from https://www.ghanahealthservice.org/downloads/Ghana_Health_Service_2014_Annual_Report.pdf on 25.05.2017.
- Holloway, I., & Wheeler, S. (2013). *Qualitative research in nursing and healthcare*. John Wiley & Sons.
- Hugenschmitt, D., Souquet, M. L., Lefort, H., Bagur, J., & Gueugniaud P. Y. (2015). Emergency nurse faced with death in pre-hospital setting. *Revue de l'infirmiere*, (211), 41-43.
- Kellogg, M. B., Barker M., & McCune, N. (2014). The lived experience of paediatric burn nurses following patient death. *Paediatric Nursing*, 40(6), 297-302.
- Khan, E. A., Aqeel, M., & Riaz, M. A. (2014). Impact of job stress on job attitudes and life satisfaction in college lecturers. *International journal of information and education Technology*, 4 (3), 270- 273.
- Lange, M., Thom, B., & Kline, N. E. (2008). Assessing Nurses' Attitudes towards Death and Dying Patients in a Comprehensive Cancer Center. *Oncology Nursing Forum*. 35, 955.
- Lewis, G. (2014). The cultural environment behind successful maternal death and morbidity reviews. *BJOG, An International Journal of Obstetrics and Gynaecology*, 121, 24-31.
- Lincoln, Y.S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
- May, T. (2009), Nurses deeply affected by young patient death. *Nursing Times*, Retrieved from <https://www.nursingtimes.net/nurses-deeply-affected-by-young-patientdeath/1981751> on 01.05.2017
- Muliira, S. R., Sendikadiwa, B. V., & Lwasampijja, F. (2014). Predictors of death anxiety among midwives who have experienced maternal death situations at work. *Maternal and child Health Journal* 19(5), 1024-1032.
- Nickerson, A., Liddell, B., Maccallum, F., Steel, Z., Silove, D. & Bryant R. A. (2014). Posttraumatic stress disorders and prolonged grief in refugees exposed to trauma and loss. *BMC Psychiatry*, 14(1), 106.

- Pathak, D. (2012). Role of perceived organisational support on stress-satisfaction relationship: An empirical study. *Asian Journal of Management Research*, 3, 153-168
- Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., Morphet, J., & Shimoinaba, K. (2013). How death anxiety impacts nurses' caring for patients at the end of life: a review of literature. *The Open Nursing Journal*, 7, 14.
- Polit, D.F., & Beck, C.T. (2008). *Nursing Research. Generating and assessing evidence for nursing practice*. (8th edition). Philadelphia: Lippincott Williams & Wilkins. United Kingdom
- Polit, D.F., & Beck, C.T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Ninth Edition. Wolters Kluwer/Lippincott Williams & Wilkins.
- Sjöblom, I., Idvall, E., & Lindgren, H. (2014). Creating a Safe Haven—Women's Experiences of the Midwife's Professional Skills during Planned Home Birth in Four Nordic Countries. *Birth*, 41(1), 100-107.
- Sliter, M. T., Sinclair, R. R., Yuan, Z., & Mohr, C. D. (2014). Don't fear the reaper: Trait death anxiety, mortality salience, and occupational health. *Journal of Applied Psychology*, 99(4), 759.
- Tan, H. M., O'Connor, M. M., Howard, T., Workman, B., & O'Connor, D. W. (2013). Responding to the death of a resident in aged care facilities: Perspectives of staff and residents. *Geriatric Nursing*, 34(1), 41-46.
- The American Association of Colleges of Nursing (AACN), (2008). Moral Distress, Public Policy statement. Retrieved on June 15, 2014, from www.aacn.org.
- Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in Health care: a systematic review of reviews. *BMC health Services Research*, 14(1), 99.
- Wilson, J. (2014). Ward staff experiences of patients death in an acute medical setting. *Nursing Standard*, 28(37), 37-45.
- Wilson J, Kirshbaum M. Effects of patient death on nursing staff: a literature review. *British Journal of Nursing* 2011; Vol. 20 (9).
- World Health Organization (2004). *Beyond the numbers: Reviewing maternal deaths and complications to make pregnancy safer*. Geneva, Switzerland.
- Wrammert, J., Sapkota, S., Baral, K., Ashish, K. C., Målqvist, M., & Larsson, M. (2017). Teamwork among midwives during neonatal resuscitation at a maternity hospital in Nepal. *Women and Birth*.
- Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, 14 (3), 344-359.