Royal College of Obstetricians & Gynaecologists

Prevention and Treatment of Work-Related Post-Traumatic Stress Symptoms in the Maternity and Gynaecology Workforce

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This is the first edition of this guidance. This guidance is for healthcare professionals who care for women, non-binary and trans young people and adults, as well as their carers and families.

Within this document the terms woman and women's health are used. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

1. Purpose

To provide a framework for the prevention, identification and treatment of post-traumatic stress symptoms (PTSS) in the maternity and gynaecology workforce. This framework purposely focuses on PTSS rather than the disorder because the wider term incorporates those with symptoms that would not meet the threshold for diagnosis, but are nevertheless distressing.

2. Introduction and background

Staff within women's health services are commonly exposed to psychologically traumatic events at work.[1–6] Attention to staff wellbeing has appropriately risen in recent years, as recognised in the UK-wide NHS People Plan,[7] NHS guidance for patient safety incidents,[8] and the General Medical Council's recommendations on caring for doctors.[9] The Royal College of Obstetricians and Gynaecologists (RCOG) supports these reports and recommends they are supplemented with programmes to prevent, recognise and treat work-related PTSS. Full details of resources for wellbeing, mental health and legal advice can be found on the RCOG wellbeing resources hub [www.rcog.org.uk/careers-and-training/starting-your-og-career/workforce/supporting-our-doctors/wellbeing-resources-hub].

The definition of events that are psychologically traumatic using the World Health Organization International Classification of Diseases 11th Revision (ICD-11) are those where a person is aware of an actual or perceived threat to life which is experienced as threatening or horrific; this threat can be objective or subjective.[10] Such events can be characterised by an extreme sense of powerlessness as well as a disruption of beliefs and expectations.[11] In a national survey of obstetricians and gynaecologists, conducted as part of the INDIGO study (Investigation into the experience of traumatic work-related events in gynaecologists and obstetricians), two-thirds of respondents had experienced a traumatic work-related event during their careers.[2] Within midwifery the rate appears similar, or even higher, with 68% experiencing psychologically traumatic events in the previous 5 years.[12]

In most cases, the healthcare worker will process these events (sometimes with the support of their wider community) and any short term distress will naturally resolve. However, this is not always the case and exposure to traumatic events may trigger the development of post-traumatic stress disorder (PTSD). This is characterised by four symptom groups:

1. intrusions (e.g. flashbacks, intrusive thoughts or images);
2. avoidance of reminders, which may be places, people, procedures, etc.;
3. arousal (e.g. feeling 'on edge' and constantly under threat); and
4. negative alterations to beliefs or mood (e.g. anger, guilt).[1]

A postal survey of midwives working in the UK in 2011–12 found that 33% (138/421) of midwives were experiencing symptoms commensurate with clinical level PTSD.[1] An online survey in 2017 of RCOG Fellows, Members and Trainees found that 18% reported clinically significant PTSD symptoms.[2]

Of concern for the quality of care, both surveys found that staff members suffering from PTSD had higher levels of depersonalisation for the women they were caring for; 'depersonalisation' refers to the act of treating recipients of services as objects rather than as human beings.[2,12] This is in direct contradiction to the call for compassion and kindness for all women in maternity care, and likely to worsen both the experience and outcome of care for women.[13]

PTSD symptoms have been shown to be linked to 'burnout', although whether PTSD symptoms increase the risk of burnout or vice versa is yet to be determined.[1,2] A survey of UK O&G doctors, carried out in 2017–18, reported that 36% met the criteria for burnout.[14] Ideally both conditions would be prevented in parallel by systems focused at national, organisational and individual levels.[15] In essence, "Health-care organisations should move beyond a culture of endurance, which overvalues stoicism and dismisses complaints as signs of weakness",[16] and embrace long-term support of the workforce.

Healthcare workers with PTSD have lower job satisfaction, more emotional exhaustion and are more likely to consider changing their place of work, or leaving the profession entirely.[2,17] As a result of psychological trauma, 60% of trainees* and 30% of consultants† seriously considered leaving the specialty in a 2017 survey of UK O&G doctors.[2] Furthermore, the 2017–18 survey of UK O&G doctors found that 23% of those with burnout reported an increase in defensive practice, compared with 7% without burnout.[14] PTSD and burnout lead to stress-related sick leave. While attrition from obstetrics and gynaecology training has improved from 12% to 3% between the years 2013 and 2019, it is now estimated that 12% of O&G doctors leave the UK within 3 years of completing training, the highest level of any specialty.[18] It is clear that reported levels of PTSD symptoms are highly detrimental for individuals, for patient care and more broadly at organisational and specialty level.

Knowledge of events that are more likely to cause PTSD symptoms can be helpful to target systems of support. A 2017 survey of UK O&G doctors identified sudden and unpredictable events, especially those with perceived preventability, acute sensory experiences and high emotionality as most frequently associated with trauma perception.[19] Moral injury is also likely to increase psychological trauma in staff. This is defined as: 'the psychological distress which results from actions, or the lack of them, which violate someone's moral or ethical code'.[19,20] Staff trauma can be compounded by an absence of support, involvement in investigation procedures and pre-existing relationships with the recipient of care.[19] Of note, reviewing documentation or hearing recounts of traumatic events can also act as a form of exposure and be traumatising, as well as direct exposure to the incident.

Table 1. Events most frequently associated with psychological trauma.[19]

Patient death (maternal or gynaecological)
Stillbirth or neonatal death
Major haemorrhage
Cardiac arrest/resuscitation
Difficult childbirth
Intra- or post-operative complications

If PTSD symptoms develop, there is good evidence that interventions focused on psychological trauma can help recovery.[21] To receive such treatments staff need access to clinical psychologists, with expertise in exposure-based therapies and eye movement desensitisation and reprocessing (EMDR).[22] EMDR involves using side to side eye movements or other bilateral stimulation combined with a review of trauma in a specific and structured format.[23] It is recognised by the National Institute for Health and Care Excellence (NICE) as a treatment for PTSD.[21]

* Specialty and Locally Employed Doctors (LED) included as 'trainees'.

† Associate Specialists included as 'consultants'.

The COVID-19 pandemic had enormous effects on all aspects of healthcare workers' lives.[24] We recommend that Trusts/organisations and Health Boards learn from the COVID-19 pandemic to prepare not only for the physical health of their staff, but also their psychological wellbeing in any future pandemics. Measures described in this document are still applicable to a pandemic environment, with appropriate adjustments for containment of the infection according to its mode of transmission.

Evidence suggests the cause of PTSD is not solely the nature and experience of the events, but that personal and organisational responses also play an important role. In January 2021, the Healthcare Safety Investigation Branch (HSIB), published a national learning report into support for staff following patient safety incidents.[25] The RCOG and the Royal College of Midwives (RCM) endorse these findings and present recommendations below for use within our specialties (see section 3), with additional focus on prevention and management of work-related PTSS. In line with the views expressed in the HSIB report, it is recognised that the ideal mode of staff support has yet to be determined, and it is unlikely that 'one size fits all'. Therefore, programmes to support staff should be subject to formal evaluation, and guidelines adjusted in light of this.

3. Recommendations

Each organisation delivering maternity and/or gynaecology services should commit to a programme to prevent and provide early intervention for work-related PTSS in all staff members.

The programme should have an organisational focus and operate at a multilevel, consistent with recognised models of staff support, and utilise the best available evidence in this field.[26,27] Evaluation should be inbuilt to further expand the limited knowledge base, and a budget made available to facilitate appropriate intervention.

3.1 Facilitating a supportive culture

Staff working in maternity and gynaecology services are likely to be subject to distressing events in the workplace. Exposure to traumatic events in maternity and acute gynaecology settings should now be recognised workplace hazards for which employers hold a duty of care to their workforce. A workplace culture should be developed in which some distress in response to such events is viewed as humane, not a weakness. This can be supported by four elements:

1. Staff should be encouraged and supported to discuss events in a professional manner; mindful of the effect of such discussions on other staff members. Following a work-related traumatic event, all staff should be encouraged to generate a culture of support rather than blame, and to destigmatise the need for access to psychological help.[2]
2. Individual Trusts/organisations and Health Board guidance after patient safety incidents should recognise the potential for work-related PTSS and incorporate support for staff in the immediate aftermath, in the longer term and in relation to investigative processes.[28] The investigative process should be conducted with compassion and civility, and be cognisant of the potential to re-traumatise staff. Support systems should be separate from the review process.
3. Healthcare workers should be routinely and proactively supported to develop their understanding of normal responses to trauma, and how to manage the impacts of distressing events.
4. Healthcare workers should be facilitated to attend sessions related to psychological support within their work schedule, this should include providing flexible support around shift patterns.

3.2 Universal training on prevention of PTSS

Workforce training programmes should be made available across all levels of seniority to include, but not limited to: midwives, gynaecology nurses, healthcare support workers, theatre staff and doctors. It should also include students of these disciplines.

Training should incorporate awareness, knowledge and confidence in dealing with the normal emotional response to trauma, thereby enhancing basic self-care, as well as a culture of reflection, self-forgiveness and moving on after the index event. Examples include the Programme for the Prevention of Posttraumatic Stress Disorder in Midwifery (POPPY),[12] and the Trauma Risk Management (TRiM) programme.[29]

3.3 Routine provision of a system of support after both patient safety incidents and self-labelled traumatic workplace events

Each Trust/organisation and Health Board providing O&G services should develop a non-stigmatising system of support appropriate to the situation. This could include access to confidential support from trained peers, seniors or external organisations. The support should be separate from both the incident investigation process and the process to evaluate staff member performance or career progress.

The support system should be automatically offered when a patient safety incident is identified (in particular those listed in Table 1), but also made accessible for self-referral. A network of supporters should be developed so that staff can also obtain support from those in other hospitals if they prefer. While regional supporters may be easiest to organise in the short term, the increasing familiarity with video conferencing may facilitate remote supporters in the longer term. Teams introducing online support must ensure adequate confidentiality is provided. Supporters should be trained to identify PTSD and burnout, as well as symptoms of mental ill health. External organisations may be considered to provide training for the supporters, for example, through the TRiM programme[29] or POPPY peer support training.[12] Supporters should be able to signpost staff so they can receive prompt treatment (see section 3.4), and have access to trauma-focussed psychological intervention.

3.4 Easy access to trauma-focussed psychological intervention

For staff members who find that support from colleagues is not sufficient to prevent the development of symptoms indicative of PTSD, rapid confidential access to a course of trauma-focused psychological assessment and intervention should be provided. All staff should be aware of its availability and how to access this input for reactions to work-related events. As previously noted, PTSS are themselves linked with moral injury and burnout. The programme outlined above should be embedded in a wider system of staff support, including access to external organisations not limited to:

- Healthcare Workers' Foundation (healthcareworkersfoundation.org/counselling/)
- BMA Counselling and peer support service (bma.org.uk/advice-and-support/your-wellbeing#wellbeing-support-services)
- Frontline19 (www.frontline19.com)
- Mind: Mental Health at Work Commitment (www.mind.org.uk/news-campaigns/campaigns/mental-health-at-work-commitment/)
- DocHealth (www.dochealth.org.uk)
- NHS Practitioner Health (www.practitionerhealth.nhs.uk/)

3.5 Formal evaluation of programmes to support staff

As recommended in the HSIB report, programmes of support for staff should be subject to formal evaluation.[25] This would assist understanding of what is good practice in terms of support delivered and resource required. As part of the evaluation process, both availability of support, but more importantly effectiveness, and remaining psychological morbidity should be assessed.

4. Conclusion

Recognition of the importance of staff wellbeing within healthcare is a relatively recent development, and the optimal mode of supporting staff is yet to be determined. By recognising the vulnerability of staff within maternity and gynaecology services to PTSD, the RCOG and the RCM are aiming to identify the key elements that need to be

present to optimise the psychological health of our workforce, and by extension, their families. In turn, this should also improve the safety and experience of women and families in our care.

5. Tools for reconfiguration/implementation

Trusts/organisations and Health Boards should concentrate on three main themes for implementation which are: building a culture and leadership – safety first; providing support during a healthcare investigation; and delivery and availability of support services. Examples of how to do this are provided in Table 2 and in the RCOG Workforce Report 2022.[18]

Table 2. Examples of how Trusts/organisations and Health Boards can implement systems to reduce staff PTSS.

Develop an organisational approach to workplace trauma	Appoint a staff wellbeing champion. This role may be combined with other components of wellbeing, or standalone, dependent on the requirements of the organisation and personnel.
Create a workplace culture of safety – safety first	Staff-led huddles, Schwartz Rounds. Symbols of caring, such as rest spaces and free food and drink. Build a programme that is safety-centric. Ensure resources to deliver the programme.
Boost an atmosphere of trust	Ensure an atmosphere of empathetic listening, validation, non-judgmental curiosity, and problem solving is embedded. Establish a culture of psychological safety where staff can speak up without fear of retribution.
Embed care of staff within trust policy documentation	Review all Trust/organisation and Health Board policy documentation to ensure this recognises the potential for staff trauma and provision for care.
Recognise additional vulnerability of specific staff groups	Staff from communities that experience racial inequality and those who have lower levels of perceived support in the workplace may be particularly vulnerable to PTSS symptoms.[2] This may include staff who are new to the role. Provide additional support to overcome such vulnerabilities, e.g. by creating awareness among the staff groups with additional vulnerability to PTSD symptoms about the availability of support and preventive measures.
Ensure staff understand how to manage normal responses to trauma exposure	Provide universal PTSD prevention workshops.
Always report	Support staff to use an incident reporting system so that events can be identified and followed up.
Ensure built in opportunities to process work place traumatic experiences	Provide a network of trained peers, or seniors to provide supportive discussion of events perceived as traumatic.
Support a 'Just Culture'	Treat staff involved in patient safety incidents in a consistent, constructive and fair way. Utilise the processes developed by the 'Just Culture' initiative.[28]
Allow easy access to safety information and wellbeing champions	Signpost individual, group, peer, external support that is available. Ensure wellbeing champions are visible and accessible.

Hold regularly scheduled meetings on safety in the workplace	Hot debrief, safety huddles, wellbeing months.
Support staff recovery if suffering from work place post-traumatic stress symptoms	Provide rapid confidential access to trauma-focussed psychological intervention.
Learn from other organisations – collaborate	Learn from other organisations or set up within Local Maternity and Neonatal System (LMNS). Utilise resources such as Yorkshire Quality and Safety Research Group, Improvement Academy, and NHS Resolution.
Evaluate the programme	Obtain user feedback for evaluating the programme that has been instituted and remaining psychological morbidity.
Fund the programme appropriately	It is anticipated that such programmes will primarily be funded by Trusts/organisations and Health Boards, with additional local top-ups as a result of savings made from reduced absenteeism.

6. Future considerations

Future work should aim to further develop tools (e.g. toolkits or training courses) to facilitate the implementation for these recommendations. Both the overall programme and individual components should be formally evaluated.

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The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in 2027, unless otherwise indicated.

