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Fears associated with maternal death: Selected midwives' lived experiences in the Ashanti Region of Ghana

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Abstract
Like the fear associated with the demise of loved ones, maternal deaths at any health facility equally illicit fear among midwives. This jeopardises their ability to achieve the quality of work expected of them. There is a depth of literature on midwives and fear associated with maternal death. Therefore, this paper seeks to explore the lived experiences of midwives who, in the discharge of their professional duties, have come face-to-face with maternal death in selected hospitals of Ashanti region in Ghana. The study applies a qualitative research paradigm and exploratory descriptive design in the overall collection and analysis of data. Purposive sampling was used to select 57 participants (18 supervisors and 39 ward midwives). The data was collected through semistructured interviews and focus group discussions, and managed by computer data analysis package (Atlas ti version 7.1.7). Content analysis was employed to analyse the data. Six themes emerged from the analysed data, namely fear of death, recurrence of death, fear of the Maternal Death Review (MDR) Process, fear of deceased family members' reactions, fear of stigma from community members and fear of lawsuit/withdrawal of license. The study established that fear experienced by midwives as a result of maternal death may affect their quality of work life and the quality of services provided to patients under their care. It is therefore recommended that, all health facilities in the Ashanti Region should institute support programmes to assist midwives cope with challenges associated with death of patients.

Introduction
Maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (World Health Organization [WHO], 2007: 134). Maternal death includes the demise of a woman in early pregnancy from complications of abortion and ectopic pregnancy (WHO, 2004). From the definition, maternal death is crucially a significant issue globally and can be a frightening experience for midwives whenever there is maternal death. More so, Ghana as a country failed to meet the Millennium Development Goal 5 in 2015 which targeted a reduction in maternal death by three quarters (WHO 2004). This suggests that, more maternal deaths occurred in the country compared to the global trend. This picture is not different from that of the Ashanti Region since 2011 (Ghana Health

Service, 2014), resulting in more exposure to these deaths and MDR process, leading to fear among midwives as they occur and Maternal Death Review (MDR) process. The MDR is a qualitative and in-depth investigation of the situations surrounding maternal deaths that occur at health care facilities, at home or anywhere else (Pearson, de Bernis & Shoo, 2009).

Jan (2011) describes the nature of nursing and midwifery practice as exposure to unpleasant, nauseating, frightful and traumatic scenery. The fear of death is innate and a natural common response exhibited when confronted with death (Wilson & Kirshburm, 2011: Penson, Partridge, Shah, Giansiracusa, Chabner, & Lynch, (2005). However, some researchers with a different school of thought have argued that the fear of death is not necessarily innate to the individual, but rather it is a learned reaction (Moore & Williamson, 2003). According to Lewis (2014) fear is toxic to both safety and improvement among humans. This kind of fear experienced can negatively impact the wellbeing of the midwives, especially when there is the lack of psychological support for them at the workstation where that fright is actually experienced (Chróinín, Haslam, Blake, Ryan, Kyne, & Power, 2011; Jowett, 2003). Studies have shown that nurses and midwives are known to have more contact hours with patients at the hospital than any other group of health care professionals (Chróinín et al., 2011).

Due to the nature of the midwifery profession, the work of the midwife involve caring for the well-being of patients. As a result, a therapeutic relationship naturally develops between the midwife and the patients. These relationships might also extend to family members of the patients who in turn may be a source of concern for health-workers (Wilson & Kirshburm, 2011). Consequently, midwife-patient relationships are a likely source of fear for the midwife if a patient who is being cared for suddenly dies. However, the degree of relationships would depend on the length of stay of patient at the hospital, the gender and also the age of the patient. It is understood that the longer the patient stays at a hospital, the stronger the attachment (Costello, 2001). The stronger the bond, the more likely and severe the experience of trauma among the midwives in the event of a patient's demise.

The 'starring' role of a midwife during the labour process cannot be over-emphasized. It is a moment when the patient is expecting to be made to feel safe enough to wholeheartedly trust the midwife (Dartey & Ganga-Limando, 2014). A midwife is supposed to ensure that the delivery environment is conducive, the temperature of the delivery room is appropriate, monitor vital signs and intervene when necessary (Ghana Health Service, 2009). In most cases, during severe contractions, the patient may become unaware of her environment and may not care who is around her until after delivering (Reed, 2012). The midwife is expected to aid the restless patient—applying a cold compress to a patient's forehead, clean sweat, monitor foetal heart beats and movements, and check for the physiological changes of labour in general while encouraging the patient to bear down when it is time to do so (Reed, 2012). It is for this reason that when patients care outcome is unfavourable, the midwife is burdened with the responsibility of loss which is often emotionally, psychologically and

physically traumatic. The purpose of this paper is to explore and describe fears experienced by midwives in the Ashanti Region of Ghana as they witness maternal death at work.

Research Design and Methods

A qualitative study that employed exploratory descriptive research design. An exploratory research design helps the researcher to discover the dimensions of a phenomenon, or a relationship between phenomena. This design aims at examining the full nature of comparatively unfamiliar phenomenon (Polit & Beck, 2008). A descriptive research is designed to provide a complete and truthful description of a particular situation, social setting or relationship in everyday life (Sandelowski, 2010). Contextual research design examines behaviours, organizational culture and perception of the phenomenon under investigation (Wendy & McMillan, 2009). The study took place in the Ashanti Region of Ghana, which recorded the highest maternal mortality in the country above the world target of 185 per 100,000 live birth since the year 2011 (Ghana Health Service, 2014). For example, Ashanti Region recorded 253 maternal deaths in 2011, 315 in 2012 and 200 in 2013 against 165 in 2010 (Ashanti Regional Annual Report, 2012). This research was conducted in nine health facilities—one teaching hospital, one regional referral hospital, four district referral hospitals and three health centres. A purposive sampling was employed to select participants who have worked for at least two years as midwives and had experienced maternal death during the course of work. The participants who took part in the study were identified by the ward managers in the selected health facilities after meeting the inclusion criteria of the study.

The study used two main methods of data collection: focus group discussions and semi-structured individual interviews. Data collection started from the 11th January, 2014 and ended in December, 2014. The focus group discussions were guided by Focus Group Discussion schedule while the semi-structured interviews were guided by interview guide. All Focus Group Discussions and Semi-structured individual interviews were conducted at the hospitals. The participants identified various places at the hospitals where interviews took place since they found it more convenient. The individual semi-structured interviews took between 40 - 50 minutes while the Focus Group Discussions were up to one hour. Tape recorders were used to collect data and transcription done within 24 hours. Data saturation was reached after the 8th discussion for the Focus group discussions and 18th interview for semi-structured individual interviews. The researchers obtained ethical clearance from the Senate Research Committee of the University of the Western Cape, South Africa, where the lead researcher was studying and the Ghana Health Service Research Committee, Accra. Additional permission was received from the Ethical Clearance Committee of the Ghana Health Service, Ashanti Region as well as Komfo Anokye Teaching Hospital Ethics where the study was conducted.

Data management and Analysis

Letters and numbers were used to identify participants. For example, F1M1 (Focus group 1 Midwife 1) in the case of focus group discussions and M1 (Manager 1) in the case of individual semi-structured interview with managers. The managers were made up of unit and ward managers who were also midwives. In this study, the Thematic Content Analysis was adopted in data analysis. The various ideas that emerged during an interview were better managed under the mechanism of thematic content analysis. Thematic content analysis is a research method easy to use with a vibrant process because it brings a basic understanding of the research methodology when it comes to analyzing the interview data. Therefore, data analysis follows Holloway and Wheeler's (2010) idea of data analysis procedures. This procedure starts with validation of recorded data, transcription of data, then cleaning data to denote unsound information in the data collected. Coding of data follows to sort the different information. The analysis was assisted by the use of computer software, Atlas ti version 7.1.7 for qualitative data analysis. Similar codes that emerged were used to create families and similar families grouped together as themes (Polit & Beck, 2013).

Rigour

In qualitative research, trustworthiness of the quality of data collected is measured in terms of confirmability, dependability, credibility and transferability (Patel, 2008). In this study, credibility was ensured by member checking and peer debriefing while confirmability was attained when the research results represented the precise account of midwives' experiences as they lived and perceived them. Transferability was reached by the rich and thorough description of research setting and of observed transactions and processes provided in the research, and dependability was achieved through ensuring data consistency and usability. Audit trails were observed as reflective journal was done, and audio-tape recordings and transcripts are preserved, while field notes were also kept.

Results

All the participants in this study were females because currently, males do not practice midwifery in Ghana. Participant position/rank range from Staff midwife to Director of Nursing, ages between 22 and 61 years with work experiences ranging from 3 to 25 years post midwifery qualification.

In all, six themes emerged from the analysed data. These themes demonstrated that fear is an emotional reaction to maternal death that has the possibility of occurring anytime. The participants' fears were related to the following: fear of death, recurrence of death, fear of the Maternal Death Review (MDR) process, fear of deceased family members' reactions, fear of stigma from community members and fear of lawsuit/withdrawal of professional license. These different fears were reported to have been experienced by almost all 57 participants in the current study.

Fear of death

This was expressed by participants anytime maternal death occurred. This is confirmed in the following quotes by the participants:

"As humans, the mention of death will always bring fear" **M16**

"Death is inevitable; you cannot do nothing to stop it so putting that information in my mind.....and someone still dies under your care you would be affected [and] there will be fear". **FG4M3**

Recurrence of death

Another type of fear experienced by the midwives was the recurrence of death as they cared for their patients. This can be seen in the following quotes from the participants:

"It affects the midwife very much because sometimes when a pregnant mother dies while you are on duty, and then you have a different pregnant woman with that same condition, you would think that if you help that person [new patient] or you try to care for that person, that person might die in your care as in the case of the deceased patient. And then you don't have a sound mind to work; because you are always thinking and afraid of the consequences." **FG6M4**

"Yes, you would be scared if the person has a bad obstetric history and will panic with thoughts of it happening all over again." **M1**

Fear of the Maternal Death Review (MDR) Process The participants in the current study were scared of going through the MDR process. This is demonstrated in the following quotes from some participants:

"The death will be audited and I have to travel to Accra [Ministry of Health Headquarters] to answer questions about what happened and the woman died" **M13**

"We also have to answer so many questions about the death of a patient. So we always want to prevent it." **M8**

Fear of deceased family members' reactions

The deceased family members' reaction to the death of the beloved one brings fear to these midwives as presented in the following quotes:

"When you come to work and you deliver someone and at the end of the delivery process, say mother dies, the patient family will not [say] ... that you have killed their relative but the way they will behave [react]; cry and roll on the floor ..., it [would] affect(s) you" **FG4M3**

"Sometimes when relatives come and we have to inform them, it is not easy at all as the [manner] they accept it is a burden on us. You are afraid of their reactions" **M7.**

Fear of stigma from community members

Fear of reactions from members of the community who associate the death of the pregnant woman to the attending midwife was evident in the data collected:

"If somebody comes to deliver and dies. The community members, who saw you attending to the patient before her death, will point accusing fingers at you whenever and wherever they see you". **M5**

"In this community, sometimes you go to town, some of them who identify you will be pointing accusing fingers at you that this is the nurse livered my relation and I lost her or the baby". **M4**

Fear of lawsuit/withdrawal of license

Fear of a lawsuit against the individual midwife of the hospital for negligence and also withdrawal of professional license by the governing body was evident in the data as presented in the quotes that follow:

"The hospital or the ministry [of health] will suspend you, ask you to go home for investigations to be done and you may not return." **M14**

"The Nursing Council will withdraw your licence to practice". **M8**

Discussion

The purpose of this paper was to explore and describe fear among midwives resulting from maternal death. The results demonstrated how fear engulfed the participants after their experiences with the death of patients left under their care. Fear is seen as an emotional effect of maternal death in this study and affected midwives' personal and work life. All participants expressed some form of fear whenever they experience maternal death regardless of age, type of health facility they work for, nursing ranks/positions or years of working experience.

Fear of death was prominent in this study. This may be because death terminates dreams, ambitions and goals of individuals. Kübler-Ross (2009) confirms that death is always distasteful to man and will continue to cause fear. The fear of own death in the finding was not surprising as all participants were females and majority within the reproductive age group (12-55) and therefore could get pregnant and experience similar situations. As such they felt it could be anyone of them dying. Furthermore, elderly participants (above reproductive age group), identify with this theme because they have children in their reproductive age

who could be victims of maternal death. This finding is congruent with literature. For example, Kübler-Ross (2009) describes the difficulties nurses and midwives go through in nursing patient with same gender as themselves and also same age groups or younger. The deceased pregnant woman did not prepare for death, and midwives were not expecting death either.Similarly, Lehto and Stein (2009) observe that health care workers often feel unprepared for their personal death and therefore death of patients' in the hospital bring deep fear to the people involved. It is a negative emotion that can also prevent an individual from achieving a set goal.

In addition, the fear of own death may cause emotional feeling among midwives. It could prevent some of them from achieving their dreams of becoming mothers. This has also been observed by Beckstrand, Callister and Kirchhoff (2006) that the experience of patient death by health workers made them fear how they could die, compared to death. Continuous imagination of one's own death can cause some of them to stop practicing midwifery and move to other areas of health or leave the health services entirely. This in effect, has consequences on the healthcare system as it affects healthcare delivery. For midwives to work effectively in such environments, Peters, Cant, Payne, O'Connor, McDermott, Hood, Shimoinaba, (2013) suggest that they need skills to manage the fear they experience when maternal death occurs. It is therefore appropriate to develop employee support programmes at healthcare facilities to assist these participants and all other midwives, deal with the fear they experience.

Another dimension of fear that emerged was fear of recurrence of other patients' death, especially, those with the same diagnosis or similar conditions on admission. Fear of recurrence of death was also prominent among midwives in the health centres, where resources were limited. These participants prefer to refer patients to other healthcare facilities for the fear that even if they could manage such cases. This may be because some of those patients on admission may have some signs and symptoms that reminded the midwives of the death that they experienced previously. This stand is supported by Papadatou, Martinson and Chung, (2001) who observed that nurses who experience the death of close relations have challenges nursing patients with some features that reminded them of their grief. The possibility of the fear recurring makes midwives nervous and uncomfortable. This type of fear may cause lack of interest; no zeal to work since the focus would be on what happened previously. As such, patients and family suffer due to poor quality of care which may in turn lead to other maternal deaths if the referral health-care facilities are farther in distance.

Fear of MDR process and the possibility of being blamed for the death of a patient was one of the concerns of the participants. As pointed out earlier, MDR is a process for auditing the death of each expectant mother who become victims of maternal death (WHO, 2004). The process of MDR is a complex one, requiring time, patience, and some form of tolerance. It is at the review process that the individual midwife is seen to be "guilty or otherwise" for the

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death of a patient. The fear of the outcome of the reviews increases participants' anxiety. Consequently, according to WHO (2004), MDR is not to be conducted as a blame game review but to learn from the lessons that might have caused the death of the patient especially if it was preventable.

Meanwhile fear of blame and punishment is still seen worldwide among health professionals especially the ex-Soviet states, cities and rural communities of Asia, Africa and Far East still adhere to the Draconian laws (Parker, 2007). The law is deemed to punish the health caregiver (the midwives) in charge of the dead patient. In sum, these midwives are used as scapegoats whenever a maternal death occurs. This would lead most of them to become demoralised and neglect responsibilities (Lewis, 2014). Nurses and midwives are expected to give account of their actions and justify their decisions (Floyd, 2013), but failure to give a reasonable account shows professional incompetence or negligence (Savage & Moore, 2004). Therefore, any midwife who is unable to justify the cause of a maternal death would be labelled with a stigma of being responsible for the death. From the study findings, it appears that the process is sometimes regarded as a 'fault finding' exercise which in effect puts pressure on midwives. This finding is supported by Kongnyuy and van den Brock (2008) who observed that MDR is under no circumstances conducted without health workers blaming each other, leading to major health challenges like depression, lack of concentration and at the same time cause job dissatisfaction.

Fear of bereaved family members' reaction upon disclosure of death was a major concern to participants in this study. It was evident from the study that, disclosure was particularly difficult for the young midwives. They admitted the ward managers must help in such situations. The fear of disclosure and family members' reaction tie with the view of Valante and Saunders (2002) who observes that care takers worry over the response of the death of patients. This worry and fear may be because midwives are often not ready to face patient families because their reactions are often painful to hand. They are also unsure of how to handle their own emotions when family members react. The responses of family relations may be physical (strongly holding the midwife by the neck, hand) or emotional (show anger, rolling on the floor, crying aloud with hands over the head or even verbal abuse). Family members could also run into shock or get sick suddenly. This study corroborates that of Rassin, Levy, Schwartz and Silner (2006) who contend that health care professionals experience helplessness when disclosing bad news to patients' family, mainly due to the fact that they are not trained in disclosure of bad news to the patients' relatives. This can cause midwives to flee the ward, leaving the grieving family with unqualified staff.

In the current study, participants from the teaching and regional healthcare facilities were not affected by community stigmatisation arising out of maternal death. This is because the facilities they work for are large in size and operation. However, participants in the smaller district health facilities and centres are subject to stigmatisation. This situation may be frustrating to midwives since it reminds them of the sad event and also make them feel

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like they caused the death of another person. This can affect their health and well-being in general, as well as, the quality of work life. The current situation can equally prevent them from socializing since one would not know where she might encounter an accusatory public. The above finding is in agreement with Keene, Hutton, Rushton (2010) who found out that nurses side-stepped other patients and families because of the impact of earlier death of a patient. On the contrary, some participants are very happy when introduced for safe delivery of family members. They are happy for being the first to see and care for the newly born. These are positive things that enhance the quality of work life.

Fear in relation to malpractice or lawsuit either for the hospital or individual, even both, also emerged as disquiet in the study. Participants in this study experienced fear because maternal death could cause them their jobs: lose their license to practice or even be suspended from the hospital. According to Duddle and Boughton (2007) this kind of situation in the hospitals may cause work-related stress issues such as burnout, psychological, and somatic health challenges. Withdrawal of practicing license by the Nursing and midwifery Council of Ghana does occur when a nurse or midwife on duty is found guilty of malpractice. Gündoğmuş, Özkara and Mete (2004) admitted that malpractice cases among nurses and midwives can be tried as civil or criminal cases involving the regulatory bodies, other stakeholders and the law courts. The mere thought of this happening could make midwives uncomfortable, thereby affecting their quality of work life and heightened level of job insecurity.

Implications for midwifery practice and policy
The study has established that, due to fear, the quality of work life and the quality of midwifery care provided to patients are compromised. Participants have narrow thoughts in terms of innovations in attending to their patients and therefore, reducing their ability to plan and provide the needed care to patients. This is so because fear reduces the ability for ingenuity and forestalls the desire to go beyond one's duty call. According to Lachman (2009) fear can cause nurses and midwives to compromise on ethical issues. Quality of work life does not only relate to remuneration workers get as a reward but also job satisfaction that comes with caring for the sick. The quality of the work life of these midwives is indeed compromised and so is the quality of health care services required by their patients. It is therefore important that, policy makers use the findings in this study to fully establish Occupational Health Services and Programmes such as Employee Assistance Programme at the health institutions in order to assist all health care professional who might have work-related challenges that may affect personal lives as well as work performance.

Conclusion
The study suggests that midwives experience fear when they witness maternal death while on duty. The research also brings to bear the different types of fears experienced by midwives. It must be understood that, the study was conducted in only one region of Ghana and therefore may not represent the wider view of midwives in the country. Further

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research is needed to ascertain how these fears can be vigorously addressed in order to ensure a good quality of work life amongst midwives and the quality of health care service rendered to pregnant women and babies.

Conflict of Interest Statement

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

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References

Ashanti Regional Health Directorate (2012). Annual health report: Kumasi, Ghana (Unpublished).

Beckstrand, R. L., Callister, L. C., & Kirchhoff, K. T. (2006). Providing a "good death": critical care nurses' suggestions for improving end-of-life care. *American Journal of Critical Care, 15*(1), 38-45.

Chróinín, D. N., Haslam, R., Blake, C., Ryan, K., Kyne, L., & Power, D. (2011). Death in long-term care facilities: Attitudes and reactions of patients and staff. A qualitative study. *European Geriatric Medicine, 2* (1), 56-59.

Costello, J. (2001). Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards. *Journal of Advanced Nursing, 35*(1), 59-68.

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.* Vol. *2* (2):614-20.

Duddle, M., & Boughton, M. (2007). Intraprofessional relations in nursing. *Journal of Advanced Nursing, 59* (1), 29-37.

Floyd, L. (2013). Helping midwives in Ghana to reduce maternal mortality. *Afr J Midwifery Women's Health, 7*(1), 34-38.

Ghana Health Service, (2014). *Annual Health Report.* Policy, Planning, Monitoring and Evaluation. Accra, Ghana.

Ghana Health Service, (2009).*Annual Health Report.* Policy, Planning, Monitoring and Evaluation. Accra, Ghana.

Gündoğmuş, Ü. N., Özkara, E., & Mete, S. (2004). Nursing and midwifery malpractice in Turkey based on the higher health council records. *Nursing Ethics, 11*(5), 489-499.

Holloway, I., & Wheeler, S. (2010). *Qualitative Research in Nursing and Healthcare:* John Wiley & Sons.

Jan, M.T. (2011). Effects of job stress on job performance & job satisfaction. *Interdisciplinary Journal of Contemporary Research in Business. 3*(7), p. 453.

Jowett, S. (2003). When the" honeymoon" is over: A case study of a coach-athlete dyad in crisis. *Sport Psychologist, 17*(4), 444-460.

Keene, A. E., Huttin, N., Hall, B., & Rushton, C. (2010). Bereavement debriefing sessions: an interview to support health care professionals in managing their grief after the death of a patient. *Pediatric Nursing,* Vol. 36.

Kongnyuy, E. J., & van den Broek, N. (2008). The difficulties of conducting maternal death reviews in Malawi. *BMC Pregnancy and Childbirth*, 8(1), 1.

Kübler-Ross, E. (2009). *On death and dying: What the dying have to teach doctors, nurses, clergy and their own families:* Taylor & Francis.

Lachman, V. D. (2009). *Ethical challenges in health care: Developing your moral compass:* Springer Publishing Company.

Lehto, R. H., & Stein, K. F. (2009). Death anxiety: an analysis of an evolving concept. *Research and Theory for Nursing Practice, 23*(1), 23-41.

Lewis, G. (2014). The cultural environment behind successful maternal death and morbidity reviews. BJOG: *An International Journal of Obstetrics & Gynaecology, 121*(s4), 24-31.

Moore, C. C., & Williamson, J. B. (2003). *The Universal Fear of Death and the Cultural Response* (Vol. 1): Thousand Oaks. Cambridge: Sage Publications.

Papadatou, D., Martinson, I. M., & Chung, P. M. (2001). Caring for dying children: A comparative study of nurses' experiences in Greece and Hong Kong. *Cancer Nursing, 24*(5), 402-412.

Parker, D. B. (2007). Risks of risk-based security. *Communications of the ACM*, *50*(3), 120.

Patel, S. (2008). Qualitative Research: An introduction to reading and appraising. *British Medical Journal*, Volume 337, No. 7666.

Pearson, L., deBernis, L.,& Shoo, R. (2009).*Maternal death* review in Africa. Retrieved on February 14, 2013, from: www.ncbi.nlm.nih.gov/pubmed/19428010.

Penson, R. T., Partridge, R. A., Shah, M. A., Giansiracusa, D., Chabner, B. A., & Lynch, T. J. (2005). Fear of death. *The Oncologist, 10*(2), 160-169.

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., 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*(1).

Polit, D.F.,& Beck, C.T. (2013). Essentials of nursing research: *Appraising Evidence for Nursing Practice*. Wiley-Blackwell: United Kingdom

Polit, D. F., & Beck, C. T. (2008). *Nursing Research:Generating and Assessing Evidence for Nursing Practice*: Lippincott Williams & Wilkins.

Rassin, M., Levy, O., Schwartz, T., & Silner, D. (2006). Caregivers' role in breaking bad news: patients, doctors, and nurses' points of view. *Cancer nursing, 29*(4), 302-308.

Reed, S. K. (2012). Cognition: *Theories and Applications:*CENGAGE learning.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77-84.

Savage, J., & Moore, L. (2004). Interpreting interpreting: an ethnographic study of practice nurses, accountability and multidisciplinary team decision making in the context of clinical governance': *Research Report of Royal College of Nursing*.

Valente, S. M., & Saunders, J. M. (2002). Nurses' grief reactions to a patient's suicide. *Perspectives in Psychiatric Care*, *38*(1), 5-14.

WHO. (2004). Work organization and stress: *Systematic challenges approaches for employers, managers and trade union representative.*

World Health Organization (2004). *Beyond the numbers: Reviewing maternal deaths and complications to make pregnancy safe*r. Geneva, Switzerland.

WHO. (2007). *International Statistical Classification of Diseases and related Health Challengess*. (10th Revision) 10, 2:134. WHO Press, Geneva, Switzerland.

Wilson, J., & Kirshbaum, M. (2011). Effects of patient death on nursing staff: A literature review. *British Journal of Nursing, 20*(9), 559-563.