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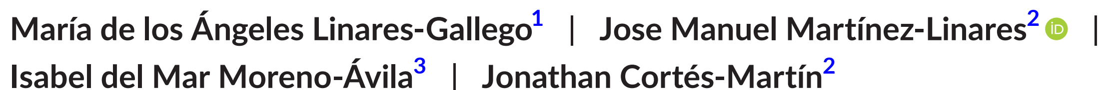
Midwives' support for parents following stillbirth: How they practise and resources they need from a phenomenological perspective



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Abstract

Aim: To explore the perceptions and experiences of midwives caring for couples who experience a stillbirth.

Design: Qualitative study based on Gadamer's hermeneutic phenomenology.

Methods: This study was conducted with midwives ($n=18$) at the birth unit of a third-level public hospital in Jaén (Spain) in 2023. Personal semi-structured interviews were recorded in audio for later transcription by two researchers following steps described by Fleming.

Results: Two themes were identified as important aspects of the practise of midwives in a situation of the birth of a stillborn child: (1) the importance of each action of the midwife, and (2) the availability of resources determines the care provided.

Conclusions: Having a stillbirth is a very complex experience, in which the psychological support and human and material resources involved are the basic tool for the care of these families. Acknowledging limitations of the available resources, the assistance and care provided by midwives are in line with the clinical practice guidelines, which can have an emotional impact on them.

Implications for the Profession and/or Patient Care: The care to be provided in stillbirth requires appropriate human and material resources for these families. Midwifery and nursing professionals are in a unique position for acting in cases of families with a stillbirth, updated protocols and, in general, the coordination of the different agents involved within the healthcare system.

What Problem Did the Study Address?The midwives´ experiences in cases which end with the delivery of a stillborn.

What Were the Main Findings?Each action of the midwife is as important as the availability of resources to offer the most appropriate care.

Where and on Whom Will the Research have an Impact?In each woman who receives the care of a midwife who attends the birth of a stillborn.

Reporting Method: COREQ checklist.

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Patient or Public Contribution: No patient or public contribution occurred for this study as this research focused on exploring staffs' perspectives from the specific viewpoint of their personal experience.

KEYWORDS
family care, healthcare personnel, lived experiences, midwife, perinatal care, qualitative research, staff attitudes, stillbirth

1 | INTRODUCTION

The birth of a stillborn child is a moment that will leave a mark on both the families that experience it and the midwives who provide the necessary attention and care (Horey et al., 2021). Due to its potential repercussions, it can be a traumatic experience (Abiola et al., 2022; Westby et al., 2021). Stillbirth affects 1:200 pregnancies in high income countries (Murphy et al., 2021). This situation occurs every 16 s worldwide, that is, there are 2 million stillborn babies every year. There are huge differences in stillbirth rates in the world, with a risk that is 20 times higher in the country with the highest stillbirth rate compared to the country with the lowest stillbirth rate (UNICEF, 2023). For example, this rate varies between 3.22% in Guinea-Bissau and 0.19% in Iceland (United Nations, 2020). Risk factors associated with stillbirth are maternal, family, community, health system and structural risk factors, and they may interact with one another in complex ways, potentially amplifying risk (UN-IGME, 2022). Although stillbirth rates have decreased globally, prevention needs are required (Hug et al., 2021).

It is important for nursing and midwifery staff to be well prepared because they are the healthcare professionals who most closely experience these events (Peracchini et al., 2023).

2 | BACKGROUND

A baby who dies after 28 weeks of pregnancy, but before or during birth, is classified as a stillbirth (WHO, 2023).

The psychological effects of losing a child are huge, in terms of anxiety, depression, post-traumatic stress disorder and obsessive–compulsive disorder for the families who suffer such, a loss as well as its social and economic repercussions (Murphy & Cacciatore, 2017; Westby et al., 2021). Studies reveal that professional support could affect family adjustment after stillbirth: taking bereavement photography (Oxlad et al., 2023), acknowledging the baby as a unique person even though their baby was born dead (Persson et al., 2023) or creating a memory box (Salgado et al., 2021) and providing continuity of midwifery care after the stillbirth (Mills, Roberts, et al., 2022). Mothers and fathers who suffer this loss often require some of these care practices. Failure to do so, may affect their lives for years (Farrales et al., 2020). These recommendations are included in the existing clinical practice guidelines (Royal College of Obstetricians and Gynaecologists, 2010; Institute of Obstetricians and Gynaecologists, 2013; Flenady et al., 2020; Leduc, 2020; American College of Obstetricians and Gynaecologists et al., 2020). Thus, these guides can serve as useful resources to improve the quality and outcomes of clinical practice (Zhuang et al., 2022).

Healthcare professionals can also experience an emotional and psychological impact as a result of dealing with cases of stillbirth, such as burnout and post-traumatic stress disorder (Ravaldi et al., 2022), particularly, in early career nursing and midwifery staff (Sheehy & Baird, 2022). To avoid this, health systems should prioritize the health and well-being of midwives and nurses (Fernández-Basanta et al., 2022), because these professionals, also, have shown that they can effectively prevent and reduce maternal and neonatal mortality and stillbirths (Nove et al., 2021).

In cases of stillbirth, it is important to have healthcare professionals who can offer a higher level of support, who are competent, confident and compassionate (Donegan et al., 2023). Also, it is necessary to provide timely, individualized and compassionate care (Watson et al., 2019). Lack of recognition of manifestations of grief following stillbirth by healthcare professionals exacerbates negative experiences of stigmatization, blame, devaluation and loss of social status (Shakespeare et al., 2019). Therefore, it is important to apply protocols related to perinatal loss and ensure that staff are adequately trained and equipped to care for parents during this experience (Berry et al., 2021).

The midwife is the healthcare professional who can provide the best support, although not all experiences were positive with them

What does this paper contribute to the wider global clinical community?

- The birth of a stillborn child has psychological, social and economic repercussions for the families who experience it.
- There is no conclusive scientific evidence about the practice guidelines in a situation of stillborn.
- The psychological support and human and material resources involved are the basic tool for the care of these families.

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(Martínez-Serrano et al., 2019). That is why healthcare professionals directly involved need to be encouraged, with organizational support and enough time to process their experiences before caring for other families giving birth (Persson et al., 2023).

In such cases, a sudden and potentially traumatic breach of the bond of attachment exists (Bowlby, 1979). Swanson's Theory of Caring is the best theory that suits stillbirth practice (Swanson, 1991). According to this theory, in stillbirth, it is necessary to maintain respect for beliefs of who has suffered the loss (maintaining beliefs), striving to understand the meaning of an event in the life of the other (knowing), being emotionally present to the other and in person (being with), to do for others what one would do for self if at all possible (doing for), facilitating the other's passage through life transitions and unfamiliar events (enabling).

The evaluations of the interventions that have been carried out, to improve bereavement care for parents after a stillbirth (National Bereavement Care Pathway, 2022), have shown positive results in the support received by health personnel during the hospital stay, but there is still room for improvement (Pekkola et al., 2022). For this, a clinical trial is currently being developed (Loughnan et al., 2022).

Healthcare professionals´ perceptions and needs while caring for bereaved parents was not examined until 1999, when Gardner studied it in healthcare professionals working closely with parents: midwives and nurses (Gardner, 1999). However, there is a need to improve knowledge of these perceptions and needs (Siassakos et al., 2018).

Research conducted to date has shown the impact of the work of midwives to reduce maternal and neonatal mortality (Nove et al., 2021), the effectiveness of the care provided to the families who suffer the loss of a child (Ellis et al., 2016) and the need for healthcare staff training to address their needs in these situations (Ravaldi et al., 2018).

In Spain, stillbirth rates are below the European average (Euro-Peristat Project, 2018). The province of Jaén, southern Spain, has approximately 110,000 inhabitants and around 4500 births per year. This province has presented a perinatal mortality rate above the national average, according to the figures from 2021: 3.89 in Spain and 6.67 in Jaén (National Statistical Institute, 2022). There is no explanation for this difference. These data reveal a greater impact of this phenomenon. Although almost all maternity hospitals have recommendations on stillbirth, fewer studies have focused on the healthcare professionals´ experiences who attend them. A recent study has determined the midwives´ degree of adaptation to international standards in southern Spain (Martínez-García et al., 2023), but at the moment, no one has focused on the impact that stillbirths have on these healthcare professionals in this region.

The healthcare professional who experiences such a tragic event most closely is the midwife (Peracchini et al., 2023). It is therefore important to know what are the experiences of midwives in a situation of foetal death. Accordingly, the research question was: What are the experiences of midwives who work in hospitals in relation to the care they provide to a family in a situation of foetal death?

3 | THE STUDY

The aim of this study was therefore to explore the perceptions and experiences of midwives caring for couples who experience a stillbirth.

4 | METHODS

4.1 | Design and theoretical framework

A qualitative study based on Gadamer's hermeneutic phenomenology was conducted. This type of study allows us to understand a phenomenon by questioning the preconceptions that people have about it (Gadamer, 2013). Language is the tool that allows us to understand the human experience. For it, the researcher's viewpoint ('horizon of pre-understanding') has to come to a dialogue with the participants' horizon of pre-understanding, through the so-called hermeneutic circle (Gadamer, 2013). As a result, a 'fusion of horizons' occurs and the phenomenon is understood (Gyollai, 2020). In order to provide greater consistency to Gadamer's hermeneutic phenomenology, Fleming's et al. (2003) developed a qualitative data analysis method based on Gadamer's hermeneutics. The two first steps were: Firstly, the researchers reached a spontaneous understanding through the dialogue in the interviews. To do this, the researchers repeatedly re-read the transcripts of the interviews, until they had a mental framework of each of the interviews. The second step was for the researchers to undergo a period of reflection, establishing preconceptions related to stillbirth in relation to midwives´ work. The researchers jointly discussed the preconceived ideas they had about different aspects of midwives' actions in cases of stillbirth. The report was written following the COREQ criteria (Tong et al., 2007).

4.2 | Study setting

This study was conducted in the Maternal and Child Hospital in Jaén (Spain), a public hospital of the Andalusian Health Service which has an average of 2000 births per year (Cazalilla-Parras et al., 2022). This is a tertiary hospital, and therefore, the referral hospital in the province of Jaén, in the event of any risk from pregnancy. There, midwives work in the obstetric and gynaecology emergency unit, delivery room and maternity unit. In the delivery room, midwives provide care for at least two or more women who are in labour. Inside the delivery room, women spend the following 2h after birth in a common room. Here, they are under the supervision of the same midwives. After the first 2h, if

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there are no alarm signs or symptoms, women are transferred to postnatal maternity units.

4.3 | Participants and recruitment

The participants were selected and in person contacted individually through purposeful sampling, in order to achieve greater variability in their characteristics (Moser & Korstjens, 2018). Thus, using inclusion criteria, midwives of both sexes were selected, as well as both midwives who had delivered a stillborn child and midwives who had not. This study included midwives who had attended to at least one stillbirth and had a minimum of 3 years of professional experience. None of the contacted midwives declined to participate in this study. With this number of participants ($n = 18$), we achieved the theoretical sufficiency (Dey, 1999) through the use of intentional sampling, having studied all aspects of the phenomenon studied, having taken into account more and less relevant data for the analysis, and the theoretical knowledge and the existing scientific literature on the topic of study. (Morse, 2015). The participants did not have a previous relation with the researchers. Their sociodemographic characteristics of the participants are shown in Table 1.

4.4 | Data collection

Researchers with previous experience gathered the data through an in-depth interview designed ad hoc to respond to the objectives of this study. The questions were prepared to respond to the aim of this study: exploring the course of action of the participating midwives in situations of stillbirth, the possible changes that had been incorporated in these action guidelines and the needs they had detected to improve the care provided (Table 2). The interview was pre-tested with three people to verify the clarity and relevance of the questions. For one of the authors, it was her first time as interviewer, although she received training in phenomenological philosophy, bracketing and pilot interviews and guidance of research (Thomas, 2021). Data collection was carried out after receiving approval from the ethics committee.

The interviewer had no previous contact or relation with the participants. The interviews were conducted outside of the participants' workplace, in a comfortable place (a room in the university or the participant's own home), and they lasted approximately 45 min each (between 41 and 52 min). They were carried out by an interviewer with no others present. The aim of this interview was previously explained to the interviewee, and data about the sociodemographic characteristics of each participant were gathered. One interview at a time was conducted and were recorded in audio and later transcribed. The transcriptions were not returned for correction. Field notes were gathered and incorporated into the data analysis. The interviews were conducted between January and March 2023.

4.5 | Data analysis

In order to understand the phenomena from the data and complete the processes of data interpretation and analysis, the steps described by Fleming et al. (2003), were completed. The third step

TABLE 1 Sociodemographic characteristics of the participants ($n = 18$).

Code	Age (years)	Sex	Number of children	Own foetal death	Professional experience (years)	Number of stillbirth cases attended to
M1	47	Male	4	No	25	9–12
M2	43	Female	3	No	11	10
M3	48	Female	2	No	23	12–15
M4	43	Female	2	No	19	3–4
M5	47	Female	5	Yes	22	5
M6	54	Male	2	No	32	7–10
M7	58	Female	2	No	36	10–12
M8	40	Female	2	No	5	2–3
M9	47	Female	2	No	19	6
M10	40	Female	2	No	17	2
M11	41	Female	1	No	5	1
M12	47	Female	2	Yes	22	10
M13	42	Female	0	No	6	2
M14	58	Female	0	No	35	5
M15	38	Female	1	No	12	4
M16	42	Male	2	No	16	8–10
M17	35	Female	2	No	9	4–6
M18	51	Female	2	No	25	15–18

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TABLE 2 Protocol of the interview.

Stages of the interview	Theme	Question content/example
Presentation	Reasons Intentions	Belief that their perspectives provide a unique teaching that must be known globally To conduct an investigation with the aim of showing the real situation
Beginning	Kick-off question	Tell me about your experience. How has a stillborn baby affected you?
Development	Conversation guide	How did you act during birth? Explain it in detail. Tell me, what sensations and emotions did you experience in that situation? Were you satisfied with your way of acting? Have you needed to seek support from your co-workers or professional help?
End	Final question Appreciation Offer	Is there anything else you would like to tell us? Thank you for your attention. Your testimonies will be very useful We want to remind you that you can call us or send us an email regarding any doubts you may have. We will send you the results of this investigation

achieved a spontaneous understanding of the phenomenon through dialogue between the researcher and the participants. In this phase, the participants were contacted again to clarify terms or expressions that could make it difficult to understand the phenomenon. The fourth step allowed us to understand the phenomenon in the reading of the transcriptions. Each interview was read several times again to identify the main content of interest. At this time, themes, sub-themes and units of meaning could be identified (Table 3).

Forty-nine codes were used, which were grouped into units of meaning, based on the relationship between them. The seven sub-themes and the two themes that are exposed in the Results section were identified. More representative quotations of the shared understandings between the researcher and participants were selected. ATLAS.ti 7 software for Windows© (Scientific Software Development GmbH, Berlin, Germany) was used. The researchers agreed on the coding, its definition and the identification of the themes.

4.6 | Ethical considerations

This study was carried out respecting the ethical principles of the Declaration of Helsinki. Before starting data collection, approval from the Ethics Committee of the University of Jaén (reference number: ENE.20/4.TFG, date: 24 Jan 2020) was obtained. Before conducting the interview, each participant received all the necessary information and signed the corresponding informed consent. The European regulations were applied for the protection of personal data and the informed consent documents. Midwives answered the questions freely and were able to leave the study if they deemed it convenient. If needed, an appointment in the mental health unit would have been arranged for participants and researchers. In data analysis and writing this paper, to ensure anonymity and confidentiality, participants cannot be identified by descriptions or citations and a code replaces their name in the final publication. Only the researchers were able to access the data, guaranteeing their custody and subsequent destruction.

4.7 | Rigour and reflexivity

To ensure the scientific rigour of the study, the criteria of Schwandt, Lincoln and Guba (2007) were applied: credibility, transferability, dependability and conformability. The exchange of information, through open questions, was carried out in a relaxed atmosphere, in a room of the university, which allowed the perceptions of the participants to be freely expressed. A neutral and non-critical position was adopted by the researchers during the interviews, listening carefully to participants and incorporating the pre-conceived ideas they had about the topic of study as part of field notes. Before the interviews were transcripted, researchers listened to the recordings several times to ensure an accurate transcription. Moreover, they were then listened to once again after they were transcribed. Two experienced researchers independently conducted the analysis of the data, and in a second step, they reached an agreement to select the codes that best identified

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TABLE 3 Example of the analytical process.

Quote	Initial codes	Meaning units	Sub-theme	Theme
'At first you can't give them much information, you have to be very clear about that moment, how hard it is for parents to hear that their child, with all the hope they've had, is gone. And then after the first phase you inform them of what is going to be done, how we can do it, what they want,...' (M7)	Diagnosis Information. Location of the pregnant woman. Delivery route Possibility of induction Analgesia for childbirth Communication between professionals	Information on the possible options during the development of childbirth	All necessary care during childbirth and postpartum	The importance of each action of the midwife
'No, the hospital is not prepared for these cases. It is prepared on the fly, that the woman is in a room as far away as possible, that she is as quiet as possible, ... We have to adapt within what we have to try to help her to be the best she can be'. (M4)	Insufficient resources Human resources: non-exclusive midwife Low turnover of healthcare staff. Material resources: no isolated dilatation room. Resource improvization	It is about preventing the family from having contact with other families and their newborns, but not abandoning them	Families need intimacy and isolation	Even in these cases, the availability of resources determines the care provided

the themes which were then generated. A detailed description of the context of this study, and how the data collection and the analysis that was conducted is provided in this paper. As an important element of Gadamer's phenomenological hermeneutic approach, in order to improve the understanding and interpretation of the phenomenon, the authors incorporated their personal prejudices.

To ensure reflexivity, an examination of prior understanding and motivation of the research question was conducted. Two of the researchers are midwives, but they had never directly attended any stillbirth case. A reflective journal was completed during fieldwork and data analysis methods that incorporated reflexivity were used (Green & Thorogood, 2018).

5 | FINDINGS

Based on the perceptions of the participating midwives, two themes were identified as important aspects of the attention and care provided to families who go through a situation of stillbirth: (1) the importance of each action of the midwife, and (2) the availability of resources determines the care provided.

5.1 | The importance of each action of the midwife

The participants highlighted the care that must be taken in cases of stillbirths. This category shows that each gesture, each word or each silence can be transcendental so as not to contribute to increasing the pain of the family. At all times, the objective was to minimize the impact of this experience and transmit to the family the availability of the midwives.

5.1.1 | It all starts with having to communicate the worst news

Upon suspicion of foetal death, the midwife performs a cardiotocographic test in the obstetric emergency unit room, although the diagnosis confirmation is given by the obstetrician or gynaecologist through ultrasound in the same room. Therefore, the midwife is present when the mother or partner of the mother is informed about the foetal death. This professional stays with the mother or partner of the mother in silence and is available to provide the information that the family may ask for, always respecting their silence and maintaining physical contact, if accepted. In these cases, the midwife accompanies the woman to the delivery room when she is ready to begin labour.

'At this point, it is very important to stay with the mother and family, to let them know that you are there, and maintain some physical contact'. (M1 and M12).

From that moment, midwives try to offer holistic care to the woman and her partner. From their experience, they perceive that this loss generates a very painful grief for the parents, regardless

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of the week of pregnancy in which it occurs. In the opinion of the participants, at the moment of communicating the foetal death, in a hospital environment, unknown and technological, a mixture of physical and emotional pain is generated, as well as a feeling of emptiness that invades the family.

'It is a very hard moment for the parents that causes them indescribable pain, time stops and their whole life falls apart. You have to try to care for them holistically'. (M7).

5.1.2 | All necessary care during childbirth and postpartum

After the initial moment of shock, when time is given to the family, the midwife provides the information about the birth process. An induction is performed in the delivery room, and the birth is conducted vaginally, unless the state of the mother indicates that a C-section should be carried out. All existing measures of pain relief are offered, including epidural anaesthesia, as well as all the attention and care available to ensure maximum well-being. In these cases, women choose epidural anaesthesia as a pain relief method if it is not contraindicated since, according to the midwives, the pain is more intense.

> 'Women are offered all available resources for labour pain relief, including epidural analgesia. Normally almost all of them accept it because the pain in these cases is magnified even more'. (M3).

Both in the birth room and later in the postpartum unit, the mother is taken to a dilation room or any room as far as possible from other women and their newborns.

> 'We take them to a dilation room, as isolated as possible, so that they are not in contact with other mothers in labour, and we try to preserve their privacy and the trust environment in this regard'. (M10).

According to the midwives, these births have a greater emotional impact, and the physical pain of the birth itself is intensified by the emotional pain from the loss. Therefore, midwives try to minimize the interventions, as in the delivery room as in the postpartum unit, limiting these to the essential interventions for the evolution of the birth and trying to make this experience the least traumatic possible.

> 'We try to make the birth the least traumatic possible for the mother, avoiding episiotomies among many other things, especially pain, both physical and mental'. (M8).

In these situations, the minimum possible number of people attend to the mother and her partner in order to minimize their exposure. Similarly, communication is increased between the professionals who provide the care to prevent giving contradictory messages to the family.

> 'It is crucial to ensure their privacy, especially regarding the number of people present and who they are'. (M13).

During the labour and to provide emotional support and avoid pathological grief, midwives offer the parents the possibility, without forcing, of creating a memory of their child by taking a picture, making a footprint and keeping a lock of hair. Likewise, they are offered the possibility of seeing and holding their child, saying goodbye, giving them time alone and expressing their feelings. In the participants' opinion, these measures allow the parents to 'keep a memory of their stillborn child as a person and not as a ghost'. The experience of the midwives indicates that, although some parents initially refuse to take these steps, after some time, they thank them for encouraging them to do so, and thus the mourning is less traumatic for them.

> 'If they wish to keep something, such as the blanket we gave them, pictures, the child's footprint…'. (M9).

5.1.3 | Knowing what to do and what to say is just as important as what not to do and what not to say

The midwives highlighted the importance of communicating with the mother and family who go through this difficult situation, during the hospital stay: respecting their silence, showing their availability to provide the information they require and encouraging the expression of emotions in these moments. Moreover, they avoid the use of topical phrases that minimize the importance of stillbirth or try to justify it, which, in the participants' opinion, can even be counterproductive for the experience of such loss and the corresponding mourning.

> 'We should never undervalue the feeling of loss, which is very important; to this end, in order to avoid mistakes and the use of topical phrases, it is best to remain quiet, and let them speak, and let them cry if they need to'. (M1).

As an additional resource, the midwives provide the parents with contact data of some self-help organization, association or group in the area and specialized in perinatal loss.

> 'There are support associations of mothers and families who have gone through the same situation, where help is offered'. (M8).

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5.1.4 | At that moment, the family's emotional storm cannot be ignored

The emotions identified by the midwives in the parents of a stillborn child range from initial apathy to emotional shock, going through sadness or anxiety as the most common feelings. In these situations, there is a mourning process in which great pain is experienced from the loss of a wanted child. In this regard, the participants highlighted the importance of giving the parents the necessary time to assimilate the news of the diagnosis before starting to give them information about the entire process, as well as the benefit of encouraging and allowing them to express their emotions.

> 'We try to let them see what is happening, that they are entitled to express their feelings. This is important because we can't deny that they are going through a traumatic situation'. (M11).

The parents are advised to have a follow-up through the primary care midwife or their general practitioner for the detection of a possible depression or a pathological mourning that would require referral to and evaluation by mental health professionals.

> 'I recommended them to go to their health centre, to contact the midwife there because in the puerperium, you can imagine how it is if you add the whole issue of stillbirth …'. (M7).

Despite all this, the midwives stated that the families were grateful to them for the attention provided although, in a few cases, the parents tried to find someone to blame among the professionals who attended to them during the pregnancy to justify their loss.

> 'The parents are usually very grateful for everything that we do for them in this situation; obviously, if we provide good care to people who go through this, they will be grateful'. (M6).

5.2 | The availability of resources determines the care provided

This category reflects the experiences of the participants about the non-existence in the unit of a specific care protocol for these cases, and the limitation of resources. Midwives use the available resources to provide the best possible assistance to the families in these situations, following the existing scientific evidence on this topic. However, despite the appreciation of the families, they are aware of their limitations, which prevent them from optimizing the attention required by the families in these situations.

5.2.1 | Families need intimacy and isolation

The participants stressed the lack of a room where these women can do dilation and birth, and that would allow isolating these families to provide them with the privacy they need, avoiding contact with other families and their newborns. They considered that the second and third stages of labour are critical for these families. Therefore, it is now when it is very important to ensure adequate privacy and isolation, as the scientific evidence suggests. In some cases, if there is more privacy in the labour area, the delivery takes place here and not in the delivery room. When one of these cases occurs, it reveals the lack of preparation that hospitals have to offer the necessary care and attention.

> 'This situation is always dealt with on the go, taking the woman to a separate room so that she is isolated from other families, but the hospital is not prepared for this in advance'. (M4).

5.2.2 | The midwife in a dichotomous situation

In these situations, there is never a single midwife who can fully attend to the family who goes through the stillbirth, as would be desirable. Thus, midwives have to attend both to women having a normal birth and women giving birth to a dead child, at the same time and in adjoining labour rooms. This reality is perceived as complex and difficult to manage emotionally.

> 'These women need much more, much more space and see things in a much calmer manners'. (M9).

5.2.3 | Facing this experience in spite of difficulties

The protocol for these situations does not include, during or after the hospital stay, adequate psychological assistance to these families, limiting such assistance to those cases in which the parents show signs or symptoms of depression or pathological mourning after the loss.

> 'Psychological help by protocol isn't provided either … and that should be a basic service'. (M8).

For the midwives, these situations are considered as 'very tough' experiences that affect them emotionally, leading some to even cry together with the family. In addition to this, the midwives also suffer the inability to quickly mitigate the pain of the family, as well as dealing with the result of the birth of a stillborn that cannot be resuscitated. The tokens of appreciation from the families are a reward for the attention provided.

> 'In these deliveries we feel bad, weird … we feel like just leaving the birth room, because we are used to

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life, to seeing happiness in the birth room, and not that … sadness'. (M9).

In these cases, in the absence of professional support provided by the hospital, the midwives search for emotional support from their co-workers to share the experience.

'No, I never required professional help, but we can't restrain ourselves from commenting on situations like these with our co-workers'. (M13).

6 | DISCUSSION

This study explored the perceptions and experiences of midwives in a situation of foetal death. Swanson's Theory of Caring (Swanson, 1991) has allowed us to understand stillbirth as a very traumatic event for the families who suffer it, and midwives are healthcare professionals who respect the loss, understand the meaning of this event in the life of each woman and each family, being emotionally present during delivery and postpartum, to do for these women and their families what one would do for themselves if possible and facilitating their passage through this sudden and unexpected bereavement. Understanding the factors involved in the attention and care needed in these situations, can give information about barriers and facilitators in its management.

Participants were present when the woman or the family received the news. Likewise, the importance of the presence of the midwife in these situations was highlighted in the study by Gold et al. (2017), which indicates that 62% of women with a stillbirth were told by a doctor or midwife that their baby had died. The importance of being physically, emotionally and spiritually available for their patients (Willis, 2019) makes it possible to provide the holistic care needed by these families, as participants in this study highlighted. This approach to care has been universally indicated as the most appropriate in Ethiopia (Tura et al., 2020), in the USA (LoGiudice & O'Shea, 2018) or in Papua New Guinea (Cheer et al., 2021).

To provide emotional support and avoid pathological grief, midwives offer the parents the possibility of creating a memory of their child. For example, bereavement photography has been recognized as an important tool to create memories and as a support service for parents experiencing perinatal loss (Vivekananda et al., 2023). But, these memories can be built when there is good communication throughout the care received, shared decisions, the chance to see and hold the baby, as well as collect memories (Salgado et al., 2021). However, in a quantitative study (Ravaldi et al., 2018) carried out in Italy with healthcare providers in which 72.8% were midwives, 44.4% immediately took the babies away without allowing parents to properly say goodbye to them. Healthcare professionals could initiate and support the parents' memory creation and enable and strengthen the parental relationship with the baby (Persson et al., 2023). Similarly, to limit the number of healthcare staff present or restrict the essential interventions during the labour, are findings and recommendations from inquiry reports related to Irish maternity services (Helps et al., 2020). And it is recommended to offer intrapartum analgesia to all parturients with stillbirth (Tsakiridis et al., 2022). It is important to note that, in these cases, behaviours and actions of staff have a memorable impact on parents (Ellis et al., 2016).

Another aspect emphasized by midwives was the importance of what to say, to do, or not. It shows the importance of constant support for the families who go through such an experience. And just as important is the language used. A UK study (Smith et al., 2020) discovered that parents who were told they were 'losing a baby' rather than 'having a miscarriage' were more prepared for the realities of labour, the birth experience and making decisions to see and hold their baby. Appropriate terminology validated their loss and impacted on parents' health and well-being immediately following bereavement and in the longer term. In a study (Cassidy, 2022) carried out in Spain with women who had experienced a stillbirth to investigate which actions/interventions and subjective outcomes of care following stillbirth or termination of pregnancy predict perceived care quality, the three strongest predictors were feeling free to 'express emotions', 'teamwork between doctors and nurses/midwives' and 'being well-informed of all the steps and procedures', followed by the perception of 'medical negligence'. These measures reduce the psychological impact and generate better future well-being for the parents. In this regard, the role of the professionals to inform and give advice on this matter is very important (Kingdon et al., 2015).

Additionally, midwives recommended these families to contact the loss support group. However, although recent studies have evaluated the feasibility of these groups (Gold et al., 2021, 2022; Sullivan et al., 2022), there is no conclusive data showing the effectiveness of this support. A clinical trial on this subject is currently underway (Loughnan et al., 2022). Mothers and fathers of a stillborn child have highlighted the importance of various types of support ranging from follow-up phone calls, medical support, support groups, counselling and connecting with other bereaved families. In addition to these gaps, there is a lack of specialized skills in individual and group settings to meet their needs (Farrales et al., 2020). Along the same lines, in an international study (Wojcieszek et al., 2018), only 10% of parents who suffer the loss of a child received psychosocial care such as additional visits to a bereavement counsellor or access to a named care provider's phone number (27%). The lack of social support is one of the greatest predictors for complications in grief and for the development of mental health problems (Cassidy, 2021) that can complicate the situation.

All the midwives who participated in this study highlighted the importance of providing constant emotional support to the parents from the moment they receive the news of the foetal death until a follow-up is performed during puerperium after hospital discharge. Respecting their expressed feelings, providing parents clear information, giving the parents the necessary time to assimilate the news and trying to make the experience the least traumatic possible, are the main guidelines that direct the course of action of these professionals. As in other studies (Christou et al., 2021), the protocol does not offer psychological assistance to the family, although

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they are given contact data of support groups in the area (Flenady et al., 2020). This approach agrees with the recommendations included in clinical guidelines (Flenady et al., 2020; Leduc, 2020), and form part of the respectful and supportive perinatal bereavement care must be provided.

Due to the limitations regarding the available physical and human resources, it is not always possible to have a separate dilation room isolated from other women in labour and their babies during the birth as is recommended, although there are individual rooms for puerperium. The lack of provision of separate wards for women whose baby had died, and they were in the same room as all women, illustrates how distressing this can be in this situation (Christou et al., 2021). Healthcare providers agreed that separation was needed, recommended and would be beneficial (Boyle et al., 2020).

The importance of adequate hospital infrastructure was highlighted in a Spanish study too (Cassidy, 2018), in which female participants provided a quality benchmark and identified a number of areas where hospitals could make improvements to care practices that should have important psychosocial benefits for women and their families. In the opinion of these women, intrauterine deaths at earlier gestational ages received poorer quality care, due to the lack of infrastructure needed. And, in addition to the inadequate hospital infrastructure, the fact of not having enough human resources, contributes to not providing the attention needed by these families. In a recent study carried out in Spain, which assessed the attitudes and care practices of midwives and nurses in relation to death care and perinatal bereavement, only 57.3% of midwives participants, could provide a one-to-one assistance (Martínez-García et al., 2023), as indicated in most recent clinical practice guidelines (Flenady et al., 2020; Leduc, 2020; Zhuang et al., 2022).

Midwife participants perceived that families who suffer a stillbirth, should have continuous psychological attention during the hospital stay and after they were discharged, not only when parents showed psychological symptoms. In this regard, consistent, individualized stillbirth care facilitates a seamless transition for these families from diagnosis through the hospital stay to discharge and follow-up, allowing them to focus on their baby, their stillbirth and their family's well-being (Helps et al., 2020). Thus, according to other studies, hospitals should adopt protocols adapted to the needs of parents and a midwifery-led model policy based on psychological and psychiatric support for mothers and couples who have experienced a stillbirth, as well as increased follow-ups (Peracchini et al., 2023).

In general, the lack of human resources and adequate infrastructures to provide the care needed by these families, was another important perception highlighted by midwives participants. Another Spanish study agrees with this result, but from the point of view of parents who suffered the loss. To them, in-hospital logistic barriers that complicated the process, as well as the fact that these births occurred in the same areas of the hospital as the births of live, healthy children (Martínez-Serrano et al., 2019). A previous study performed in an Anglo-Saxon environment agrees too (Kelley & Trinidad, 2012). With this in mind, among the most important factors are the training of health staff and other professionals, the preparation of the maternity ward to support bereaved families and the continuous support to the professionals involved in the bereavement (Salgado et al., 2021).

Midwives carry out very special tasks after the death of a baby. These tasks are also difficult because they involve not only professional but also personal skills (Ravaldi et al., 2018). The importance of this type of event can be seen in the fact that, after a traumatic perinatal, more than a third of midwives had seriously considered leaving the midwifery profession (Sheen et al., 2015). As reported by the participants in this study, healthcare professionals should have access to peer-to-peer and professional support to avoid burnout (Flenady et al., 2020). The BLOSSoM study (Ravaldi et al., 2022) suggests that midwives are at risk of developing professional burnout, with particular reference to reduced personal accomplishment at work, after only 5 years of work, and this is not significantly correlated with the number of events assisted but with the psychological impact exerted by these events. There are no resources to offer help to midwives, so they turn to their peers. This lack of help was also revealed in the study (Mills, Ayebare, et al., 2022) in which care and psychological support were acknowledged as often inadequate. A caring organizational culture and supportive leadership will facilitate care continuity between specialized and primary healthcare and promote the welfare of midwives (Fernández-Basanta et al., 2021).

6.1 | Strengths and limitations

The results of this study must be considered in the context of its design, strengths and limitations. Firstly, this study belongs to a larger research project, whose aim is related to this topic, although it is different from the research question of this article. Thus, we did not include data of the entire sample; however, the study includes the experiences of the midwives, who are the professionals that accompany the woman and the family throughout the entire process of delivering a dead child until hospital discharge. Secondly, the data gathering was conducted after the SARS-CoV-2 pandemic. The participants could not be interviewed during the lockdown or during the most critical stage of the pandemic, although the scientific evidence of the care that must be given in these situations has not been modified by the pandemic.

6.2 | Recommendations for further research

The role of midwives in terms of the best guidelines for action in the event of a stillbirth suggests that it would be beneficial to conduct research on the effectiveness of the different recommendations for action. Furthermore, it would be very useful to carry out research that would reveal the perceived benefits that these actions generate for families in the short, medium and long term, as well as the improvement in the quality of care provided when these action guidelines are applied through protocols developed specifically for these situations.

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6.3 | Implications for policy and practice

Having a stillbirth has psychological, social and economic repercussions for the families who experience it. Further studies should provide more information about the effectiveness of cares that, at this moment, midwives and nursing staff apply in these cases. The findings of this study may help improve the care provided to women and families with a stillbirth. This is however a very complex experience, in which the psychological support and human and material resources involved are the basic tool for the care of these families.

As this study shows, from a nursing practice perspective, nursing and midwifery professionals are a reliable source for detecting potential barriers when identifying and managing these patients, and essential for finding possible alternatives and coordinating quality care. Midwifery and nursing professionals are in a unique position for acting in cases of families with a stillbirth, updated protocols and, in general, the coordination of the different agents involved within the healthcare system. It is the responsibility of healthcare systems, and hospital managers, to provide needed resources in order to be able to offer care for women and families, during and after a stillbirth, based on the newest and best evidence.

7 | CONCLUSION

This qualitative research highlights the complex nature of delivering a stillborn child. Midwives said that they provide emotional support by accompanying the family, favouring the expression of feelings and giving the necessary information at the right time. Moreover, the aim was to provide all the possible comfort measures during the birth, offer the possibility of creating memories of the stillborn, ensure the privacy of the family throughout the entire hospital stay and offer resources to continue the support after discharge. However, due to the lack of human and material resources, it is not always easy for midwives to take this course of action. All this has an emotional impact on these professionals.

Midwives and maternal units nurses are in a unique position to provide care needed by these women and families to overcome this difficult experience, using the existing scientific evidence. Further research is required to explore factors that facilitate both physical and emotional closeness to achieve it.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE): (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the author(s).

DATA AVAILABILITY STATEMENT

The data required to reproduce the study findings cannot be shared as the participants did not provide written consent for their raw data to be publicly distributed.

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