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Beyond emotional support: predictors of satisfaction and perceived care quality following the death of a baby during pregnancy

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Abstract

Objectives: To investigate which objective (actions/interventions) and subjective (perceptions of care quality) outcomes of care following stillbirth or termination of pregnancy predict perceived care quality.
Methods: A cross-sectional descriptive study using an anonymous online survey. The population was women who had experienced a stillbirth or termination of pregnancy from ≥16 weeks of gestation, in the Spanish health system. Multiple sequential regression analysis was used to identify predictors of perceived care quality (satisfaction, willingness to recommend, competence and ability to provide loss-focused care).
Results: Results from 610 women were analysed. A significant regression equation ($p<0.001$) was found in each of the objective only and objective-subjective models. In the case of overall care (satisfaction-recommend composite), 72.0% of variance (adj. R2) was explained. In general, subjective evaluations of care are more potent predictors of perceived care quality than objective care interventions (e.g. autopsy performed). Feeling free to 'express emotions', 'teamwork between doctors and nurses/midwives', and 'being well-informed of all steps and procedures' were the three strongest predictors, followed by perception of 'medical negligence'. Information provision and loss-focused interventions had the weakest influence, except in the specific 'loss-focused' model.
Conclusions: The results indicate that the 'atmosphere' of care is a transversal dimension related to the context of loss and trauma and has the single greatest influence on perceptions of care quality. It is necessary to use a specific 'loss-focused' care variable to adequately capture perceptions of the quality of bereavement care and a custom scale to measure the influence of care interventions on perceived quality.

Keywords: bereavement care; satisfaction with care; fetal death; perinatal death; stillbirth; termination of pregnancy.

Introduction

Assessing quality from the perspective of patients is a crucial part of delivering effective care that complements measures of health related quality of life and biological outcomes [1, 2]. Measuring patient satisfaction and perceptions of care quality can be effective ways of assessing health subjectivities, particularly as part of mixed-method designs and when placed in social and cultural context [3–6]. Although considerable work has been done on the measurement of care outcomes in perinatal bereavement, there has been relatively little quantitative research on the underlying components and predictors of satisfaction and what constitutes quality of care from the perspective of women, or their partners. Partly, this relates to the underuse of established techniques and, in parallel, the lack of area-specific instruments to do so. This is an important gap because healthcare following perinatal loss is understood to have an important impact on grief and health outcomes [7]. This article describes the development of a preliminary scale to measure women's subjective evaluations of care following late pregnancy loss – second and third trimester stillbirth and termination of pregnancy for medical reasons – and the results from its application through an online survey.

To date, most work on care outcomes following stillbirth has focused on the implementation or effectiveness of care interventions and patients' subjective experiences. Through surveys, patient-reported outcomes have been used to measure the implementation or offer of particular care interventions, which can be divided into two categories: a) clinical and structural aspects of care (e.g. autopsy, mode of birth, accommodation), and b) care related to bereavement and loss (e.g. contact with the baby, memory objects) [8, 9]. Other studies have measured the effectiveness of bereavement care interventions, such as 'the mother saw/held the

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baby', in terms of mental health outcomes or satisfaction [10–17]. While the experiences of women and their partners in hospitals have been widely assessed through both qualitative and quantitative research [18–20], only a few studies are based on established constructs of care satisfaction and perceived quality.

The studies that have used such constructs are problematic for a number of reasons. Firstly, the use of single-item measures of satisfaction [13, 21, 22] is an issue because perceptions of care are made up of various sub-components, meaning that the specific aspects of care that patients are assessing remain unknown, and, furthermore, satisfaction tends not to capture the full range of subjective evaluations [23, 24]. This is highly limiting as a guide to practice. Even when multidimensional scales are used, their appropriateness is questionable. For example, the PSQ-18 [25] and MPSQ [15] have been employed to assess perinatal bereavement care, but are designed to measure continuous primary care from doctors. While some studies are based on area specific scales, they are mostly published with little information on their development and validation [10–12, 26]. Recent work by Wool et al. in the related area of perinatal palliative care provides an interesting contrast [27, 28]. This indicates a twofold problem: lack of knowledge of the underlying components of subjective care quality and an absence of area-specific scales to carry out such measurement.

Studies on the dimensionality of 'satisfaction' or 'perceived quality' show that patients are principally evaluating functional, technical and physical (comfort, privacy, etc.) components of their subjective experience [5, 24, 29–36]. On one side, the functional dimension relates to empathy and emotional care/support, including perceptions of being treated respectfully and as individuals. This also includes decision-making and equity in care encounters, which encompasses information provision, feeling listening to and respect for patient preferences. In perinatal bereavement care, emotional support and decision-making are the cornerstones of good practice, but are specifically oriented toward affirmation of identities (mother/father/child) and decisions that parents will most likley never have considered (autopsy, post mortem contact, etc.) [18–20]. The technical dimension of care relates to the technical competence of health professionals, administrative and structural competence in relation to coordination of care, and perceptions of health outcomes. In perinatal bereavement care, aspects such as continuity and coordination of care have been highlighted as important [18–20]. However, there is a lack of consideration for possible health outcomes beyond mortality and evaluations of technical aspects of care (task-directed skill related to clinical and loss-focused care), and how these may fit into overall perceptions of care, as well as considering how doctors and midwives work together to provide care.

Developing more detailed knowledge of the meaning of patient satisfaction and subjective quality in perinatal bereavement care could have significant advantages for learning more about patient needs and the ongoing development of care practices. In addition, at a methodological level, it may help to ensure that these constructs are better understood and that measurement is more reliable. This exploratory study aims to investigate: (1) if satisfaction alone is a sufficient measure of care quality in the context of loss; (2) what objective and subjective outcomes predict satisfaction; (3) what components of care are most important to women. The study included the development of a detailed questionnaire, including a custom scale to measure subjective evaluations of various aspects of care, and its application to a large sample in Spain.

Materials and methods

The population was defined as women who had experienced a late miscarriage, stillbirth, intrapartum death, or termination of pregnancy for medical reasons from 16 weeks of gestation and within the Spanish healthcare system. A cross-sectional descriptive study was carried out using an anonymous online survey, the only practical means to reach the population at a national level. The study took place as part of a broader ethnographic and mixed-methods research project that included participant observation and qualitative analysis of narrative style interviews [37].

The anonymous online questionnaire sought to collect five main types of data: (1) *socio-demographic*; (2) *reproductive history and details of the loss/death*; (3) *objective measures of care* focused on care interventions related to: the diagnosis, accommodation, birth and mode of delivery, administration of sedatives, investigation of the cause of death, disposition of the body, contact with the baby, memory objects; (4) *intensity of contact with support charities*; and (5) *subjective evaluations of care* through the development of a custom battery called the Pregnancy Loss Care Quality Scale (PLCQ scale), which uses a 5-point Likert agreement scale. As well as the PLCQ, a separate five-item scale was developed to measure specific types of information. Finally, respondents were also asked if they believed there had been medical negligence in their case (response options: No; Yes, a claim was made; Yes, no claim was made).

The questionnaire was developed through a review of the literature, exploratory qualitative interviews with four healthcare professionals and six parents, and content and face validation [32, 38, 39]. For the PLCQ scale development, a panel of 15 expert health professionals were presented with 57 items, broadly related to the care dimensions outlined in the introduction, as well as items related to diagnosis and decision-making on *post mortem* contact. The panel rated and qualitatively evaluated the items. Following a second round, 29 items were retained in the final questionnaire.

In addition, six global measures or dependent variables (DVs) were included. Firstly, both 'satisfaction' and 'willingness to recommend' the hospital to other couples were included as standard, yet differentiated, measures of care performance [40]. In the analysis, these two items were first compared and subsequently collapsed into one overall global measure of care (GLB1). As the study was also concerned with patients' perception of professional competence, two items were added that sought to evaluate doctors and nurses/midwives individually: 'the doctors were competent in their work' (GLB2); 'the nurses/midwives were competent in their work' (GLB3). At a hypothetical level, it was thought that both 'competence' and 'satisfaction/willingness to recommend' might not capture evaluations of loss-focused care. This conjecture was based on exploratory interviews and theory on satisfaction measurement which suggests that patients rate the difference between their expectations and performance [29, 41]. As most women, and their partners, are not prepared for this experience or have knowledge of appropriate care, it was posited that they may differentiate between standard expected care and loss-specific aspects of care. Therefore, two further items were introduced: 'the doctors knew how to deal with cases of loss' (GLB4); 'the nurses/midwives knew how to deal with cases of loss' (GLB5). A mixed panel of 11 health professionals and eight bereaved women validated the draft questionnaire, which was subsequently piloted by 18 women. A full list of the socio-demographic data, reproductive/loss variables, care interventions and the full questionnaire has been published elsewhere [37].

Fieldwork took place between June 2013 and June 2016. Respondents were recruited using convenience sampling (snowballing), including advertisements on support associations' websites, social media and through direct contact with parents and health professionals. In total, 796 women, whose baby had died within the previous 5 years, completed the survey. However, to give greater stability to the regression analysis, only the 610 cases occurring within 24 months previous to participation, and which had no more than one missing data point, were analysed. Further detailed information on sampling procedures, fieldwork and data purification are available elsewhere [37].

As the analysis was concerned with care practices, variables related to socio-demographics, pregnancy history, details of the loss, and intensity of contact with support associations were not included. It should be noted, however, that exploratory analysis indicated that, of these, only second trimester loss had strong predictive value over satisfaction. For the purpose of the regression analysis, objective variables were converted to dummies (0,1). Prior to performing the regression, Mann-Whitney 2-tailed tests of independence ($p<0.05$) and Cohen's effect size [42] were used to test the 51 objective independent variables (IVs) against the DVs and to screen for inclusion in the initial objective regression model. Multiple sequential (forward method) regression was used to assess the ability of objective and subjective IVs to predict the five global measures of care (GLB1, GLB2, GLB3, GLB4, GLB5). The sample size was sufficiently large to meet a recommended IV to DV ratio of 18:1 [43]. In order to reduce contributions from weak or unstable variables, the alpha criteria for inclusion in the regression model was set at $p<0.1$. Missing data was substituted by mean scores. Analysis of tolerance (IVs<0.1) and inflation (VIF > 10) found that multicolinearity was not present in any of the models and Durbin–Watson scores were all acceptable (≥1.5 and ≤ 2.5). Residual scores were within the acceptable range (3.3–3.3) and plot analysis and Mahalanobois and Cook distance tests indicated no significant issues [43, 44].

Results

Basic sample data

Data on the sample characteristics are presented in Table 1. Basic frequency data for all the objective and subjective variables used in the analysis are available in Table 2. Notable from the results, 'willingness to recommend' scores almost 8 points lower than satisfaction, while general 'competence' scores (GLB2, GLB3) are higher than satisfaction or willingness to recommend, but ability to provide loss-focused care (GLB4, GLB5) scored much lower.

Characteristics of the dependent variables

Analysis of the inter-correlations between the seven DVs (see Table 3) shows that all were significantly correlated ($p<0.001$). Satisfaction and willingness to recommend overlapped very strongly. Although they showed some differences in exploratory regression analysis, to simplify, they were combined to an aggregate score: overall care (GLB1). In general, competence (GLB2, GLB3) showed a higher correlation to overall care (GLB1) than ability to provide loss-focused care (GLB4, GLB5).

Objective outcomes of care: regression models

In total, 51 objective IVs were identified as potentially relevant to the study (e.g. an autopsy was performed). Following screening with 2-tailed test of independence ($p<0.05$) and Cohen's effect size (>0.15), 30 objective IVs were retained for exploratory regression analysis (identified in Table 2). A significant regression model ($p<0.001$) was found for all DVs, each composed of six to seven variables, but the amount of variance explained (adjusted R^2) was not strong, ranging from 18 to 26% (see Table 4). Of the 30 objective IVs entered, 14 were retained for the combined subjective-objective analysis as they contributed to at least one of the models.

Selection of the subjective measures of care (scale items and perceived negligence)

All 29 items from the PLCQ scale (SB1-SB29) were included for initial screening. Based on correlations to the DVs and

Table 1: Characteristics of the survey sample.

Age at the time of the loss	**n**	**%**	**Type of pregnancy**	**n**	**%**
< 25 years	16	2.6	Singular	571	93.6
25–29 years	84	13.8	Multiple	39	6.4
30–34 years	268	43.9			
35–39 years	190	31.1	**Type of loss/death**		
≥40 years	52	8.5	Spontaneous intrauterine	476	76.7
			Termination of pregnancy	145	21.0
Education level			Intra partum	14	2.3
Up to intermediate second level	57	9.3			
Second or lower diploma	196	32.1	**Gestational age at the time of the loss**		
Diploma, university degree or higher	357	58.5	16–19 weeks	97	15.9
			20–25 weeks	150	24.6
Nationality			26–33 weeks	116	19.0
Spain	579	94.9	≥34 weeks	247	40.5
Foreign national	31	5.1			
			Year of the loss/death		
Geographic location			2009–2011	31	5.1
City, suburbs or large town	440	72.2	2012	105	17.2
Small town or rural area	169	27.8	2013	157	25.7
Missing	1		2014	148	24.3
			2015–2016	169	27.7
Type of hospital					
Public	454	74.4	**Previous contact with support assoc.**		
Private	156	25.6	No	272	44.9
			Yes	334	55.1
Pregnancy history			Missing	4	
First pregnancy	290	47.5			
Not first pregnancy	320	52.5			
Total	610	100.0	Total	610	100.0

inter-correlation between subjective IVs, seven items were removed: five because of low contributions (SB2, 3, 4, 5, 17) and two because of over performance: ‘HPs were respectful’ (SB10) and ‘feeling listened to’ (SB12). The remaining 22 items were entered into the five regression models, along with the five information items (INF1-INF5) and perceived negligence (NEG1).

A significant regression ($p<0.001$) was found for each DV (these results are not presented). Following this analysis, six further items that made no contribution were dropped (SB7, 8, 9, 19, 24, 25), leaving 16 items. Two information items (INF2, INF5), and the perceived negligence IV (NEG1) were also retained for the final analysis, giving a total of 19 subjective IVs.

Combined subjective-objective multiple regression models

The 19 subjective IVs and 14 objective IVs were entered into each of the five models. A significant regression equation ($p<0.001$) was found for each model (see Table 5), accounting for a high proportion of variance that ranged from 58.7% in the case of ‘doctors’ competence’ (GLB2) to 72.0% for the overall rating of care (GLB1). Across all five final models, contributions were made by 13 IVs from the PLCQ scale; one item from the information scale (INF5: information on pathology studies); ‘perceived medical negligence’ (NEG1); and two objective IVs (‘no pathology studies conducted’ [OB28]; ‘a doctor explained pathology study options’ [OB26]). Commonalities are evident across all models (particularly the strongest predictors), as well as differences, notably between overall care evaluation (GLB1) and ability to provide loss-focused care (GLB4, GLB5), and between doctor (GLB2, GLB4) vis-à-vis nurse/midwife models (GLB3, GLB5).

Exploratory scale analysis

To finish, the 13 PLCQ scale items that made some contribution to the final five models (SB1, 11, 13, 15, 16, 18, 20, 21,

Table 2: List of objective and subjective variables included in the analysis (following preliminary screening).

	Objective measures	%	Missing		Subjective measures	Agreeing, %	Mean	SE	Missing
	Diagnosis				**Postmortem contact and memories**				
OB1	Doctor communicated diagnosis[a]	88.8	2	SB1	Enough information for decisions[c]	43.5	3.00	0.07	5
OB2	Nurse/midwife communicated diagnosis[a]	8.4	0	SB2	Advised to not see the baby	19.8	2.06	0.06	4
	Accommodation			SB3	Help keeping memory objects	17.6	2.09	0.06	2
OB3	Private room[a]	78.8	0		**Diagnosis**				
OB4	Could hear babies crying (strong)[a,b]	32.8	0	SB4	Doctor took a long time to see	21.3	2.29	0.05	4
	Birth and mode of delivery			SB5	Treated with priority	57.5	3.50	0.06	3
OB5	Vaginal birth	84.1	1	SB6	Clear explanation[c]	68.6	3.70	0.06	2
OB6	Vaginal birth (induction)	73.9	1	SB7	Opportunity to ask questions	62.1	3.59	0.06	3
OB7	Caesarean birth	14.9	1	SB8	Empathetic	61.6	3.57	0.06	0
OB8	Programmed cesarean	2.0	1	SB9	Accompanied by HP(s) after	57.5	3.41	0.06	0
OB9	Emergency cesarean	10.5	1		**Emotional support/interpersonal**				
OB10	Cesarean for failed induction	2.5	1	SB10	Felt listened too	66.5	3.68	0.05	1
OB11	Instrumentalised birth	13.3	1	SB11	Could express emotions[c]	61.1	3.55	0.06	1
OB12	Accompanied during birth[a,b]	73.2	2	SB12	HPs were respectful	76.1	3.99	0.05	0
OB13	Partner not allowed to accompany[a,b]	15.6	2	SB13	HPs sensitive with language[c]	67.5	3.73	0.05	0
	Sedative administration			SB14	Treated like a mother[c]	49.8	3.30	0.06	3
OB14	Administration after diagnosis	22.5	0	SB15	Emotional support – doctors[c]	60.4	3.54	0.06	1
OB15	Administration during labour/birth	13.3	0	SB16	Emotional support - nurses/midwives[c]	75.4	3.98	0.05	0
OB16	Administration after birth	22.0	0	SB17	Some HPs good others bad	46.9	3.01	0.06	2
OB17	Sedatives admin. at least once	47.9	0		**Information and decision-making**				
OB18	Sedatives admin. twice or more	7.7	0	SB18	Birth process explained[c]	52.4	3.24	0.06	1
OB19	Sedatives admin. on patient request	16.9	0	SB19	Information on disposition	24.4	2.47	0.06	8
OB20	Sedatives admin. on HP indication	24.9	0	SB20	General information for decisions[c]	47.0	3.12	0.06	0
OB21	Sedatives admin. without consent[a]	8.7	0	SB21	Could ask questions[c]	69.1	3.80	0.05	2
OB22	Admin. without explaining side-effects[a,b]	32.5	0	SB22	Control decisions – medical[c]	45.4	3.09	0.06	0
	Pathology			SB23	Control decisions – ritual[c]	39.3	2.95	0.06	2
OB23	No pathology studies offered[a]	12.1	0		**Coordination of care**				
OB24	Autopsy offered[a]	67.4	0	SB24	Paperwork presented at a good time	30.1	2.72	0.06	11
OB25	No one communicated options[a]	19.2	0	SB25	Room peaceful	74.8	3.90	0.05	3
OB26	Doctor communicated options[a,b]	68.0	0	SB26	All staff aware of situation[c]	63.7	3.68	0.05	2
OB27	Nurse/midwife communicated options	16.1	0	SB27	Teamwork personnel[c]	68.6	3.78	0.05	2
OB28	No postmortem test conducted[a,b]	14.1	13	SB28	One HP guided care[c]	47.8	3.14	0.06	1
OB29	Autopsy conducted	62.1	13	SB29	Well informed steps[c]	53.6	3.30	0.06	0
	Language used to refer to the baby								
OB30	Doctor used baby's name[a,b]	12.5	0		**Information scale (% some/a lot)**	**Some/lot %**	**Mean**	**SE**	**Missing**
OB31	Doctor used 'baby'[a,b]	34.8	0	INF1	Keeping memory objects	14.1	1.47	0.04	2
OB32	Doctor used 'foetus'[a,b]	33.6	0	INF2	Grief[c]	16.8	1.60	0.03	0
OB33	Doctor – do not recall	19.2	0	INF3	Puerperal care	32.6	2.11	0.04	0
OB34	Nurse/midwife used baby's name[a,b]	18.4	0	INF4	Disposition	19.5	1.73	0.04	10
OB35	Nurse/midwife used 'baby'[a,b]	37.5	0	INF5	Autopsy and pathology studies[c]	33.5	2.18	0.04	4
OB36	Nurse/midwife used 'foetus'[a,b]	22.8	0						
OB37	Nurse/midwife – do not recall	22.5	0		**Negligence (reported or unreported)**	%			
	Post mortem contact/memories			NEG1	Perceived medical negligence	26.2			7
OB38	Mother saw the baby[a]	56.7	0						

Table 2: (continued)

	Objective measures	%	Missing		Subjective measures	Agreeing, %	Mean	SE	Missing
OB39	Father saw the baby[a]	61.1	0		**Global**	**Agreeing %**	**Mean**	**SE**	**Missing**
OB40	Family/friend(s) saw the baby[a]	36.4	0		Satisfaction with care	69.1	3.69	0.05	1
OB41	Mother held the baby[a]	38.4	0		Willingness to recommend to other	61.4	3.58	0.06	3
OB42	Father held the baby[a]	23.3	0	GLB1	Satisfaction-recommend composite	65.3	3.63	0.05	4
OB43	Have at least one memory object[a]	34.3	0	GLB2	Doctors competence	72.9	3.84	0.05	2
	Disposition			GLB3	Nurses/midwives competence	76.9	3.99	0.05	3
OB44	No one communicated options[a,b]	33.9	0	GLB4	Loss-focused care ability – doctors	47.6	3.21	0.06	1
OB45	Doctor communicated options[a,b]	31.3	0	GLB5	Loss-focused care ability – nurses/ midwives	56.3	3.46	0.06	1
OB46	Nurse/midwife communicated options[a,b]	19.5	0						
OB47	Funeral home communicated options	15.4	0						
OB48	Private disposition (cremation or burial)[a]	40.0	0						
OB49	Hospital managed disposition[a]	45.7	0						
OB50	Hospital disposition only option[a]	34.3	0						
	Psychological support								
OB51	Was visited by a psychologist[a]	21.0	0						
	Total	610			Total	610			

[a]Objective variables retained following screening with 2-tailed test of independence. [b]Objective variables retained following initial regression modelling of objective variables. [c]Subjective variables retained following initial regression modelling of subjective variables.

Table 3: Correlations on the dependent variables.

				GLB1	GLB2	GLB3	GLB4	GLB5
	Satisfaction with care	1	0.961	0.965	0.705	0.665	0.647	0.624
	Willingness to recommend to other women/couples	0.961	1	0.855	0.710	0.673	0.645	0.627
GLB1	Satisfaction-recommend composite	0.965	0.855	1	0.651	0.610	0.603	0.577
GLB2	Doctors' competence	0.705	0.710	0.651	1	0.621	0.648	0.475
GLB3	Nurses/midwives' competence	0.665	0.673	0.610	0.621	1	0.481	0.665
GLB4	Loss-focused care ability – doctors	0.647	0.645	0.603	0.648	0.481	1	0.635
GLB5	Loss-focused care ability – nurses/midwives	0.624	0.627	0.577	0.475	0.665	0.635	1

n=599 and all correlations are statistically significant at $p<0.001$.

23, 26, 27, 28, 29) were combined to a global score in order to test it against the objective variables. A significant equation was found that included nine objective IVs that explained 38.9% of the variance, around double that of the single-item global models (GLB1, GLB2, GLB3, GLB4, GLB5); see Table 6 for details. Cronbach's alpha scores for the 29, 22, 16 and 13-item PLCQ were all above 0.9.

Discussion

The models produced by this exploratory study are robust and provide important insights to hospital care, one of the main social spaces for defining the meaning of pregnancy loss and for providing appropriate resources for grieving. The study has implications for both the provision of care and quality assessment. Before discussing the results it should be taken into account that the non-probabilistic online sampling procedure means that the study has coverage limitations that reduce its generalizability. However, some confidence can be gained from the knowledge that the sample is a very close match to national data in terms of gestational age, autopsy rate and caesarean section rate [37, 45], and that exploratory analysis of socio-demographics found only very small predictive values. The results should also be interpreted as situated within a particular set of cultural values and expectations, which may be similar to or differ from other countries. Finally, the limitations of surveys themselves should be considered as they tend to reduce complex

Table 4: Regression models – objective care outcomes.

		Stand. co-eff. beta	Part (semi-partial)	Change statistics				
				Adjust. R^2	Std. error of est.	R^2 change	F change	Sig. F change
	Global evaluation of care[a] (Adj. R^2 = 24.6%)							
OB34	Nurses/midwives referred to the baby 'by his/her name'	0.273	0.262	0.097	1.359	0.098	61.478	0.000
OB44	No one communicated options for the disposition	−0.189	−0.178	0.155	1.314	0.060	39.820	0.000
OB34	Nurses/midwives referred to the baby as 'baby'	0.167	0.162	0.189	1.288	0.035	24.156	0.000
OB22	Administration of sedatives without explaining side-effects	−0.112	−0.111	0.203	1.276	0.015	10.927	0.001
OB12	Accompanied by partner/other during birth	0.125	0.124	0.216	1.266	0.015	10.721	0.001
OB4	Could hear babies crying (strong)	−0.111	−0.110	0.227	1.257	0.012	8.807	0.003
OB34	Nurses/midwives referred to the baby 'by his/her name'	0.273	0.262	0.097	1.359	0.098	61.478	0.000
	COMPETENCE – DOCTORS[b] (Adj. R^2 = 18.3%)							
OB26	Doctor explained pathology studies options	0.238	0.235	0.076	1.188	0.077	46.897	0.000
OB31	Doctors referred to the baby as 'baby'	0.194	0.192	0.119	1.160	0.045	28.476	0.000
OB30	Doctors referred to the baby 'by his/her name'	0.142	0.141	0.140	1.146	0.023	14.703	0.000
OB22	Administration of sedatives without explaining side-effects	−0.134	−0.133	0.159	1.134	0.020	13.563	0.000
OB4	Could hear babies crying (strong)	−0.122	−0.121	0.172	1.124	0.015	10.341	0.001
OB13	Partner/support person not allowed to accompany during birth	−0.110	−0.110	0.183	1.117	0.012	8.335	0.004
	COMPETENCE – NURSES/MIDWIVES[c] (Adj. R^2 = 18.4%)							
OB36	Nurses/midwifes referred to the baby as 'foetus'	−0.198	−0.190	0.078	1.109	0.079	48.337	0.000
OB34	Nurses/midwifes referred to the baby 'by his/her name'	0.161	0.155	0.111	1.089	0.035	21.980	0.000
OB22	Administration of sedatives without explaining side-effects	−0.128	−0.127	0.131	1.077	0.022	14.175	0.000
OB12	Accompanied by partner/other during birth	0.116	0.115	0.148	1.066	0.019	12.234	0.001
OB4	Could hear babies crying (strong)	−0.115	−0.114	0.161	1.058	0.014	9.533	0.002
OB26	Doctor explained pathology studies options	0.129	0.126	0.173	1.051	0.013	8.792	0.003
OB46	A nurse/midwife explained disposition options	0.114	0.111	0.184	1.044	0.012	8.475	0.004
	LOSS-FOCUSED CARE – DOCTORS[d] (Adj. R^2 = 23.4%)							
OB44	No one communicated options for the disposition	−0.147	−0.135	0.086	1.345	0.087	53.861	0.000
OB26	Doctor explained pathology studies options	0.195	0.188	0.129	1.313	0.044	28.630	0.000
OB4	Could hear babies crying (strong)	−0.164	−0.162	0.165	1.285	0.038	25.430	0.000
OB30	Doctors referred to the baby 'by his/her name'	0.204	0.197	0.195	1.262	0.032	22.195	0.000
OB31	Doctors referred to the baby as 'baby'	0.143	0.138	0.214	1.247	0.020	13.975	0.000
OB22	Administration of sedatives without explaining side-effects	−0.111	−0.110	0.225	1.239	0.012	8.877	0.003
OB12	Accompanied by partner/other during birth	0.105	0.104	0.234	1.231	0.011	7.937	0.005
	LOSS-FOCUSED CARE – NURSES/MIDWIVES[e] (Adj. R^2 = 25.3%)							
OB44	No one communicated options for the disposition	−0.191	−0.179	0.103	1.353	0.104	65.548	0.000
OB34	Nurses/midwives referred to the baby 'by his/her name'	0.263	0.252	0.162	1.307	0.061	40.746	0.000
OB34	Nurses/midwives referred to the baby as 'baby'	0.149	0.141	0.198	1.279	0.037	25.746	0.000
OB4	Could hear babies crying (strong)	−0.120	−0.119	0.215	1.266	0.018	13.182	0.000
OB13	Partner/support person not allowed to accompany during birth	−0.124	−0.124	0.229	1.254	0.016	11.586	0.001
OB22	Administration of sedatives without explaining side-effects	−0.129	−0.128	0.243	1.243	0.015	11.142	0.001
OB28	No pathology studies conducted	−0.110	−0.107	0.253	1.234	0.011	8.623	0.003

[a] Durbin–Watson: 1.994 (F(7, 610) = 29.78, p<0.001). [b] Durbin–Watson: 1.939 (F(6, 610) = 23.37, p<0.001). [c] Durbin–Watson: 1.860 (F(7, 610) = 22.19, p<0.001). [d] Durbin–Watson: 2.022 (F(7, 610) = 26.48, p<0.001). [e] Durbin–Watson: 1.940 (F(7, 610) = 28.39, p<0.001).

Table 5: Regression models – subjective and objective care outcomes.

		Stand. co-eff. beta	Part (semi-partial)	Change statistics				
				Adjust.R^2	Std. error of est.	R^2 change	F change	Sig. F change
	Global evaluation of care[a] (Adj. R^2 = 72.0%)							
SB11	I felt I could express myself emotionally in front of the HPs	0.198	0.125	0.492	1.859	0.493	591.782	0.000
SB27	The doctors and nurses/midwives seemed to work well as a team	0.200	0.138	0.613	1.623	0.121	190.688	0.000
SB29	Kept me/us well-informed of all steps and procedures	0.132	0.086	0.655	1.534	0.042	74.053	0.000
NEG1	Perceived negligence (reported or not)	−0.175	−0.159	0.685	1.464	0.031	59.864	0.000
SB16	I felt emotionally supported by the midwives/nurses	0.136	0.090	0.700	1.430	0.015	30.052	0.000
SB13	The HPs were sensitive in their use of language	0.122	0.077	0.708	1.411	0.008	17.508	0.000
INF5	Amount of information received on autopsy and medical tests	0.063	0.052	0.713	1.397	0.006	12.915	0.000
SB20	Received enough information to help us with the decisions we had to take	0.094	0.065	0.717	1.388	0.004	8.903	0.003
OB28	No pathology studies conducted	−0.061	−0.058	0.720	1.381	0.003	7.298	0.007
	COMPETENCE – DOCTORS[b] (R^2 = 58.7%)							
SB15	I felt emotionally supported by the doctors	0.235	0.150	0.435	0.936	0.436	469.758	0.000
SB27	The doctors and nurses/midwives seemed to work well as a team	0.250	0.177	0.530	0.854	0.095	123.298	0.000
SB29	Kept me/us well-informed of all steps and procedures	0.136	0.091	0.556	0.830	0.027	36.517	0.000
NEG1	Perceived negligence (reported or not)	−0.136	−0.125	0.574	0.813	0.019	26.808	0.000
SB13	The HPs were sensitive in their use of language	0.125	0.082	0.582	0.805	0.009	12.750	0.000
SB18	Received a clear explanation of the birth process in cases of loss	0.100	0.074	0.587	0.801	0.005	7.962	0.005
	COMPETENCE – NURSES/MIDWIVES[c] (R^2 = 60.8%)							
SB16	I felt emotionally supported by the midwives/nurses	0.441	0.285	0.537	0.790	0.538	707.299	0.000
SB27	The doctors and nurses/midwives seemed to work well as a team	0.163	0.113	0.580	0.752	0.043	63.007	0.000
SB29	HPs kept me/us well-informed of all steps and procedures	0.085	0.061	0.592	0.741	0.013	19.605	0.000
SB21	I felt that I could ask questions if I wanted to	0.109	0.069	0.599	0.735	0.007	10.745	0.001
NEG1	Perceived negligence (reported or not)	−0.081	−0.074	0.603	0.731	0.005	8.159	0.004
SB26	All the personnel on the ward were aware of my situation	0.084	0.069	0.608	0.727	0.005	7.475	0.006
	LOSS-FOCUSED CARE – DOCTORS[d] (R^2 = 66.2%)							
SB15	I felt emotionally supported by the doctors	0.462	0.305	0.578	0.916	0.578	834.156	0.000
SB20	Received enough information to help us with the decisions we had to take	0.222	0.159	0.641	0.845	0.064	108.582	0.000
SB23	Had control over decisions related to ritual (e.g. seeing the baby)	0.098	0.082	0.652	0.832	0.011	19.152	0.000
SB18	Received a clear explanation of the birth process in cases of loss	0.096	0.074	0.658	0.824	0.007	13.137	0.000
SB13	The HPs were sensitive in their use of language	0.098	0.065	0.662	0.820	0.004	7.619	0.006

Table 5: (continued)

		Stand. co-eff. beta	Part (semi-partial)	Change statistics				
				Adjust.R^2	Std. error of est.	R^2 change	F change	Sig. F change
	LOSS-FOCUSED CARE – NURSES/MIDWIVES[e] (R^2 = 62.1%)							
SB16	I felt emotionally supported by the midwives/ nurses	0.478	0.319	0.538	0.968	0.539	710.866	0.000
SB1	Received enough information on the decision to see/or not see the baby	0.182	0.145	0.587	0.915	0.049	72.938	0.000
SB20	Received enough information to help us with the decisions we had to take	0.112	0.079	0.605	0.895	0.019	28.552	0.000
SB28	There was one HP who guided me/us through the whole process	0.108	0.084	0.612	0.887	0.008	12.365	0.000
OB26	Doctor explained the options for pathology studies	−0.079	−0.075	0.617	0.881	0.005	8.731	0.003
SB21	I felt that I could ask questions if I wanted to	0.107	0.068	0.621	0.877	0.005	7.351	0.007

[a]Durbin–Watson: 2.012 (F(9, 610) = 174.98, p<0.001). [b]Durbin–Watson: 1.778 (F(6, 610) = 145.03, p<0.001). [c]Durbin–Watson: 1.922 (F(5, 610) = 158.22, p<0.001). [d]Durbin–Watson: 1.846 (F(5, 610) = 239.723, p<0.001). [e]Durbin–Watson: 1.908 (F(6, 620) = 167.43, p<0.001).

Table 6: Regression model – objective care outcomes as predictors of the exploratory 13-item Pregnancy Loss Care Quality (PLCQ) Scale.

		Stand. co-eff. beta	Part (semi-partial)	Change statistics				
				Adjust.R^2	Std. error of est.	R^2 change	F change	Sig. F change
	Pregnancy loss care quality scale[a] (Adj. R^2 = 38.9%)							
OB44	No one communicated options for the disposition	−0.196	−0.177	0.159	12.154	0.160	115.725	0.000
OB34	Nurses/midwifes referred to the baby ‘by his/her name’	0.218	0.210	0.222	11.686	0.065	50.589	0.000
OB26	Doctor explained pathology studies options	0.208	0.200	0.269	11.329	0.048	39.854	0.000
OB31	Doctors referred to the baby as ‘baby’	0.165	0.157	0.313	10.981	0.045	40.120	0.000
OB4	Could hear babies crying (strong)	−0.150	−0.148	0.342	10.751	0.029	27.140	0.000
OB22	Administration of sedatives without explaining side-effects	−0.155	−0.154	0.362	10.581	0.021	20.498	0.000
OB13	Partner/support person not allowed to accompany during birth	−0.098	−0.097	0.374	10.483	0.013	12.380	0.000
OB32	Nurses/midwifes referred to the baby as ‘foetus’	−0.107	−0.098	0.383	10.408	0.010	9.641	0.002
OB3	Accommodated in a private room	0.086	0.084	0.389	10.357	0.007	7.013	0.008

[a]Durbin–Watson: 2.074 (F(9, 610) = 44.17, p<0.001).

patient experiences to simplistic and impersonal dimensions [3, 46]. In this project, the results of the survey are triangulated with qualitative methods, showing good convergence and some divergence [47, 48].

The results make it clear that when women rated ‘satisfaction’ or ‘willingness to recommend’ the hospital they were not evaluating the totality of loss-focused care. This fits with the disconfirmation thesis [23, 41] and suggests a ‘halo’ effect [49] whereby patients assess aspects of care that fall within their frame of reference or expectations. So, while useful, the results suggest that satisfaction tends to provide overly positive evaluations and should be balanced by a measure such as 'willingness to recommend' and, much more importantly, a specific item to measure loss-focused care. In addition, single-item global evaluations had limited analytic capacity, making a strong argument for the need to use constructs that capture the broad range of underlying components/dimensions of care following pregnancy loss. The PLCQ scale developed in this study, for example, provided a much better measure of the value of specific care interventions to women.

It is also apparent that when the participants were rating care they were largely, though not exclusively, evaluating the process of care rather than the outcomes themselves. This reinforces the idea that the human aspects of interactions with health professionals are crucial to care and experiences of grief/loss. However, in this study, these interactions were much broader in scope than the expression of empathy and emotional support, encompassing the organisation of care, teamwork, technical competence (including perceptions of fault) and bereavement related interactions. The rating of 'emotional expression' over 'emotional support', 'being well informed' over 'information', and the novel inclusion of 'teamwork between doctors and nurses/midwives' point to a number of important findings for care practice.

At a general level, the results suggest a transversal dimension related to the 'atmosphere of the care setting' and its significance in the unique situation of death/loss. As women commonly experience great sadness, trauma, fear and anxiety in the period after diagnosis [50–52], it should be considered that the primary goal of many women may be to just get through a threatening situation that seems to exceed coping capacity [53]. On this basis, being 'well informed' of the process of care before it happens may help to reduce the anxiety and fear that women often feel. Similarly, the participants seemed to readily detect harmony or tension between health professionals, which appeared to reinforce or undermine confidence in the quality of care. Lack of teamwork may relate to conflict between obstetricians and midwives on what constitutes appropriate care [54, 55]. This finding highlights the extreme importance of collaborative teamwork and a unified approach during encounters with patients. It is also noteworthy that the importance of teamwork was not as evident in the qualitative research [37], showing the benefits of mixed-method approaches. Finally, as the highest ranked predictor, feeling free to 'express emotions' in front of health professionals is differentiated from 'receiving' emotional support and suggests an atmosphere of care that creates a space for loss and reduces feelings of shame and stigma. Collectively, these three predictors seem to define a dimension of care that traverses functional and technical components and that creates security and confidence in carers. It might be said to represent the basis or groundwork of good care. Each of these predictors also gives a sense of women as astute observers of healthcare provision rather than just receivers of care. This questions the directionality of traditional thinking on care provision, which tends to focus on direct provider actions, for example, when examining trauma in childbirth [56].

The results also demonstrate considerable variations in expectations of the roles of nurses/midwives compared doctors, whose actions had a greater influence over ratings. In this sample, doctors not only held greater clinical authority – e.g. in expectations of the provision of clinical information – but they also seemed to have greater power to define social identity [6]. This was seen in the way that insensitivity with language was more influential in doctors' models and highlights the challenge to doctors to be empathetic and supportive of the emotional experience of loss, as observed elsewhere [57]. Nurses/midwives, on the other hand, were assigned to subordinate positions associated with traditional caring and support roles. From the perspective of implementing 'midwife-led' bereavement care in Spain this is problematic. It indicates a requirement for stronger teamwork between professionals and that doctors validate or reinforce the role of midwives during initial interactions with women and their families.

Finally, the study helps our understanding of how women view and assess technical-professional competence, in particular evaluations of how care is managed and organised and whether fault for the death is attributed to health professionals. This contradicts any notion that patients are incapable of making technical assessments [58, 59]. Given the impact of 'perceived negligence', future studies may consider including it as one way of measuring health outcome. On the other hand, the relatively low ranking of 'information' shows that other aspects of care are prioritised in the peritraumatic period. It seems relevant here that parallel qualitative research found that low cultural expectations of equity in decision-making and naturalised paternalism are common in obstetric care following pregnancy loss in Spanish hospitals [37].

To conclude, the results indicate that a transversal dimension 'atmosphere of care' is the single greatest influence on satisfaction/quality, which probably relates to the unique context of loss, grief and trauma. It is necessary to use specific loss-focused global variables to adequately assess bereavement care and a custom scale to measure the influence of care interventions. Future work will focus on further development and testing of the PLCQ scale.

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