

“Death is a sensitive topic when you are surrounded by life”: Nurses experiences with pregnancy loss

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ABSTRACT

Objective: Although there is increasing evidence on the psychosocial adjustment and experiencing pregnancy loss from the patient’s perspective, few studies have investigated the nurses’ experience perceptions. This study aimed to understand the experience of nurses involved in pregnancy loss care based on the self-fulfillment model of communication.

Methods: A qualitative approach was developed through semi-structured interviews to 16 nurses working in an Obstetrics and Maternal-Fetal Department of a local hospital. Based on grounded theory approach, data was analyzed with NVivo 12 software.

Results: The analysis revealed three major themes and 11 sub-themes: i) stressful work conditions, comprising care management and institutional practices; ii) personal characteristics, including discomfort with loss, communication skills, work experience and empathy; and iii) the patient’s journey, containing the partner’s ambiguous role, timing, respect for the patient’s individuality, viewing the fetus and facilitating grief rituals.

Conclusion: Nurses daily involved in providing care to patients suffering pregnancy losses have a demanding challenge in trying to assure that patients get the appropriate and better care and ensuring they keep their level of engagement in their profession. Interventions to improve communications skills with patients and with other health professionals are needed to enhance professional realization.

Introduction

The World Health Organization (WHO) describes fetal death as the absence of vital signs before expulsion from the mother’s body, regardless of gestational age [1]. Almost 25 % of known pregnancies end in loss, with psychosocial consequences for the health and well-being of women and couples [2]. Pregnancy loss is commonly accompanied by shock, failure, guilt, and a search for explanations [3]. These cognitions can lead to social isolation, anxiety, depression, and psychosomatic diseases [4].

Adequate care from health providers can ease this burden and improve patients’ well-being, relationships, and adjustment to future pregnancies [5]. The first recommendations for establishing contact and

providing supportive care in pregnancy loss have over 50 years [6], and since then, obstetrical societies have been developing specific guidelines within this context. Nonetheless, patients still report abusive behaviors from health professionals that, besides resulting in low levels of trust in the medical team, can add additional trauma and inhibit the grieving process [7].

Nurses are usually the first providers to contact patients in this context and often the most frequently seen [3]. There is still mixed evidence about the positive impact that nurses can have in pregnancy loss situations. While some recent studies showed that nurses could facilitate the grief process [10], others have emphasized a lack of empathy and support that can lead to patient dissatisfaction and increase their distress [11]. Moreover, there is insufficient knowledge of the perspective of

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obstetric nurses on this impact [12].

An involuntary pregnancy loss conceptual framework for healthcare professionals is still to be developed. While grieving models seem to have been adopted by research, healthcare professionals' loss related to patients' deaths differs from the loss of a loved one [12]. Additionally, pregnancy loss is often not recognized as death or a real loss. The self-fulfillment model [8] sees pregnancy loss as simultaneously a privilege and a challenge in nurses' careers and includes four central concepts: (i) the therapeutic use of self; (ii) interpretation of event; (iii) facilitation of grieving; and (iv) nurse's self-fulfillment. The therapeutic use of self is the intentional use of communication skills and knowledge to provide care. Using the self therapeutically involves observing subtle changes in patients, critically thinking in complex situations, and consistently reaching for the correct treatment, intuition, communication, altruism, and comfort with loss. Interpreting the event involves helping to build meaning to the surrounding circumstances, including negotiation with the hospital hierarchy to satisfy the patient's needs, providing physical and emotional care and comfort to facilitate the transition from life to death, and enable privacy and dignity in honoring the individual's body and soul. Facilitating grief can be enabled by providing normalcy, bonding, and closure, treating the loss as real, and allowing the creation of bonds, thus facilitating the end of the birth experience and the beginning of grief. Performing these tasks will lead to self-fulfillment determined by the patients' positive emotional feedback or expression of gratitude. As such, pregnancy loss has a large potential for job satisfaction and personal growth [9].

However, the self-fulfillment model was developed through the evaluation of a single case. To the authors' knowledge, there is no evidence of how this model is applicable according to the professionals' perspectives and using a larger sample.

The present study adds to the literature by gaining an in-depth understanding of how obstetric nurses integrate the self-fulfillment communication model into their daily routines. We aimed to explore nurses' experiences dealing with pregnancy loss, communicating with patients, and facilitating grief. A better understanding of these nurses' emotional experiences overloaded with loss and grief will allow to pinpoint specific skills or work conditions needed in this context. Ultimately, the patient's experience will also be more agreeable when encountering a more patient-centered care.

Methods

Participants and procedure

This study was approved by the Faculty of Psychology and Education Sciences - University of Porto and S. João Hospital Ethics Committees. This is the largest hospital of the northern region of Portugal and one of the largest of the country, with more than 5000 workers. Our target population was nurses working in this hospital's Obstetrics and Maternal-Fetal Department. These nurses work in all perinatal stages including pregnancy and labor, and losses can be diagnosed via a routine appointment or obstetrics' emergency. We sent an open invitation to the head of the department, who approached all the department nurses. Written information about the study was given, and informed consent was obtained. All accepted to participate. Interviews were taken in an isolated room at the hospital, audio recorded and transcribed verbatim. The average duration was 15 min. Information that could identify participants was omitted.

The final sample was composed of 16 nurses. Of these, 15 were women, and six had an advanced specialization in obstetrics recognized by the Board of Nursing. Participants had a work experience between three to 15 years.

Measures

A semi-structured interview was conducted using a script developed

by the research team. The initial version went through several modifications and was reviewed by two experts in the fields of obstetrics and reproductive health. The final script had five open questions aimed at understanding nurses' perception of given care in pregnancy loss and difficulties during the process (see [supplementary files](#)).

Data analysis

A continuous analysis was made based on Grounded theory's guidelines [13]. Using NVivo 12 software, each interview was listened to become familiarized, highlighted, and coded by a microanalysis line by line of relevant information. Then, coded data was compared and labeled through a focused coding process. This constant comparative analysis method [13] included line-by-line and in vivo coding, categorizing, and creating of main subconcepts and concepts. The first author examined the transcripts line by line and organized the initial thematic analysis. Then, the first and last authors went over the contents of each theme and subtheme and compared to confirm exclusivity. Several reviews were done until the codification was considered clear and consistent to team members. All authors confirmed the final thematic tree. The analysis stopped when no new information could be coded, facing a "saturation" phenomenon [13]. We calculated the relative frequency (rf) of references for each theme and subtheme with the total number of interviews (Fig. 1).

Results

Three themes emerged during the analysis: stressful working conditions; impact on personal life; and personalization in nurse-patient communication. These themes and respective subthemes are discussed below; examples can be found in [Table 1](#).

Stressful work conditions

Care management

This sub-theme involves interpersonal relationships within the hospital. The need for specialized education in pregnancy loss was the most frequently cited topic and the one cited by most participants. Nurses want to learn more about "How to approach the couple, give bad news, support them, knowing what to say" (I02) and be able to transmit "scientific comprehension of what happened" (I12).

The need for patient follow-up was the second topic more frequently talked about. Most participants reported the need to screen patients and refer to psychological support after discharge. Some nurses suggested this support should occur at the hospital or primary care services, and others wanted a self-report tool or a structured interview script to facilitate referral. Even though psychological support is available at the hospital at the patient's request, several participants underlined that a direct referral and being involved in the decision was perceived as means to alleviate the sense of guilt and blame underlying the current system.

Three-quarters of the participants disclosed the need to promote positive relationships between employees. Although sharing experiences was recognized as happening informally, regular meetings were considered a helpful tool for debating topics collectively. "Sharing cases" (I03) would allow to "share feelings" (I12) and acknowledge how others cope. Mentoring was also reported as a way for new nurses to learn with more experienced ones. The need for multidisciplinary teams and meetings involving nurses, mental health professionals, social workers, and obstetricians was often mentioned, and participants felt that these regular meetings should be a part of their work routine. The possibility of professionals having individual emotional and psychological support to help manage emotions and develop defense and coping mechanisms was also mentioned.

Two participants also referred to the importance of having patients' feedback regarding their role and communication. Even though there is

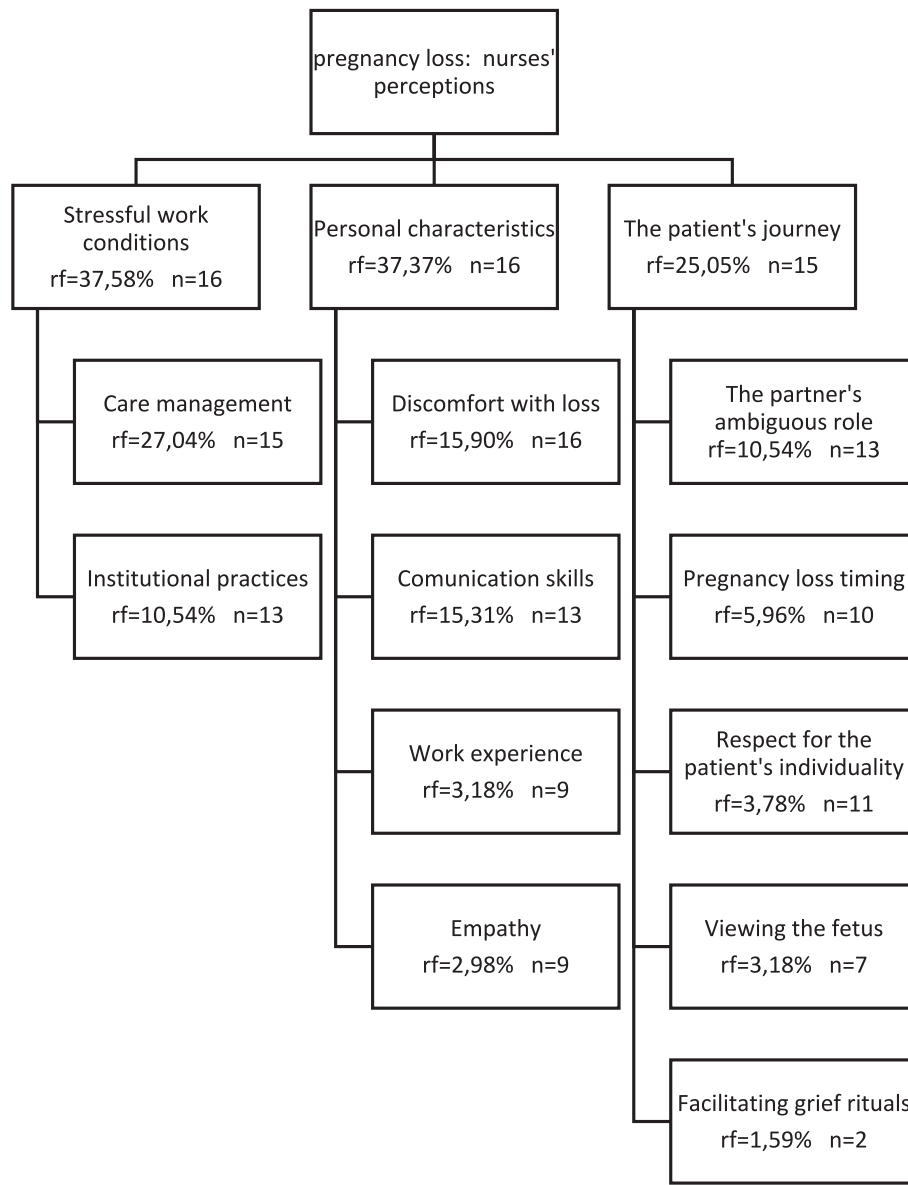


Fig. 1. Overview of themes and categories.

a positive perception of patients' satisfaction in moments of support, nurses expressed the need to have "written feedback [...], good or bad" (I03).

Institutional practices

This sub-theme includes topics related to the structure, rules, and governance that indirectly influence caregiving. Participants described the need for patients to have more privacy to ensure a safe and silent place for caregiving success. Several suggestions for improvement were made, such as giving couples a room to grief and acknowledging space and time to process the event and decision-making. Nurses admit that working space conditions hinder their efforts, such as pregnancy loss patients "sitting beside women in labour" (I02). The minimization of auditory stimuli was reported as urgent, including music, babies' cry, and monitors' heartbeats.

Besides privacy, the other topic that emerged was availability. Participants were very aware that care could be enhanced if the patient could always report to the same nurse. This would facilitate nurses' work and help patients to avoid the repetition of information. The high

number of patients, administrative tasks, and insufficient time to address sensitive and complex issues were also pointed out as reasons for limited availability. Nurses perceived that these limitations could lead to attitudes that patients often perceive as rough and incomprehensive.

Personal characteristics

Discomfort with loss

All participants shared discomfort with the paradox of working in "a department associated with life and not death" (I01, I10, I11, I14). The loss was perceived as difficult to accept and deal with in such an environment - "Death is a sensitive topic when you are surrounded by life" (I15). Some nurses admit their daily struggle to simultaneously provide direct medical care and emotional support (I04, I07, I08). Escape behaviors such as not looking at screens or avoiding face-to-face contact during intrusive procedures were mentioned (I02, I15, I16), with more than half of the sample admitting an effort to hide emotions. Nurses described that these emotions were nevertheless oftentimes perceived by patients through facial expression or even by abruptly leaving the room with torn eyes (I03, I04, I10). Pregnancy loss was described as traumatizing,

Table 1
Themes and examples of categorized meaning units.

Themes and categories	Examples of meaning units
Stressful work conditions	
Care management	“More education in this area, because talking about death is hard” (I05); “Sharing cases would help as professionals and in assisting our patients” (I10)
Institutional practices	“Space working conditions are not the best. Most times, patients hear babies crying” (I04); “We don’t have enough time to give them the appropriate support” (I06)
Personal characteristics	
Discomfort with loss	“Professionals have a rough time going through this situations” (I02)
Communication skills	“We talk with the patient, we explain everything, I think lies should not be used, we should give clear information” (I11)
Work experience	“My ability in these cases has improved with time” (I03); “The frequency I dealt with it helped” (I09)
Empathy	“I’m not a mom, but I put myself in their place because I want to be” (I09); “I was trying to get pregnant and I couldn’t, still can’t. Maternity is a goal, so I identify myself with them” (I14)
The patient’s journey	
The partner’s ambiguous role	“Men are neglected, we focus on women because it is her body” (I11)
Pregnancy loss timing	“We kind of devalue this situations (first trimester losses) because of its frequency” (I03); “I consider a fetal death more traumatic (...), when it is a medical interruption there is a reason (...).” (I11)
Respect for the patient’s individuality	“There are women who like to be left alone and I try to respect that. There are those who need their husbands and I leave them in the room even if they were not supposed to be there” (I04)
Viewing the fetus	“I always ask if they want to see [the fetus], even in earlier losses” (I02)
Facilitating grief rituals	“If all diagnoses are done, the body can be donated or have a funeral” (I02)

exhausting, and painful (I01, I02, I04, I05, I07, I08, I09, I11, I15), and patients’ emotions were recognized as having an impact on nurses’ professional and personal contexts (I07).

Communication skills

Most participants considered communication skills necessary to nurses’ personal characteristics when working with pregnancy loss. Seven participants described the importance of respecting the patient’s timing or pausing for silence (I01, I03, I04, I07, I14, I15, I16). Taking time is not always easy because it has to be balanced with the need to give accurate and truthful information about the possible causes and ways on how the event occurred (I02, I04, I05, I12), all this while medical procedures are taking place (I03, I13). Even when there is the feeling that patients are prepared to listen to the information, the information often has to be repeated with different words to facilitate assimilation (I09, I11, I12). Two nurses discussed the importance of avoiding delays in confirming the loss and promoting informed decision-making (I05, I13).

Work experience

More than half of the participants talked about how their care provided to patients improves with time “for me, as I have had so many situations, I ended up learning to deal with them” (I05). Facing these patients and their losses was recognized as very important as nurses tend to “run away” (I02). Seven nurses considered a previous personal experience of loss as helpful (I09, I11, I12, I13, I14, I15, I16).

Empathy

More than half of the sample considered empathy an essential characteristic, particularly emphatic listening (I01, I09, I10) - “supporting them is more at the level of listening”. Interestingly, a quarter of participants reported motherhood as a facilitator to empathize.

The patients’ journey

The partner’s ambiguous role

Although participants portrayed men as important in their narratives, answers were inconsistent. Women were reported as “protagonists” (I14), and men were identified as left out (I01). However, nurses also try to ensure the presence of the male partner when giving bad news (I02, I05, I10, I14) and instructing on misoprostol’s administration (I02, I15, I16). Although men were recognized as suffering and grieving (I04, I14, I15), the loss was perceived as less shocking to them (I13, I16). This devaluation of their feelings was justified by the fact that pregnancy occurs in the female body (I04, I05, I11, I16). Men were also described with similar roles to professionals (I07), assuming a supporter role. However, nurses recognized that male partners suffer later and alone (I02, I06, I07, I12, I13, I14, I15, I16), with references to men crying in the absence of their partners (I14, I15).

Pregnancy loss timing

Almost two-thirds of nurses reported that it was essential to consider the timing of pregnancy loss. Later losses were found harder to deal with, associated with body changes and investment in preparations (I02, I03, I09, I11, I13, I14, I15, I16). Earlier losses were more often described as “natural selection of nature” (I13), banalized by the argument that some women do not even know that they were childbearing (I07). Medical interruptions were perceived as easier due to health justifications (I09), but were also portrayed as more challenging in older gestational ages (I03, I11). The first loss in the patient’s obstetric history was considered easier (I09), but the event was described as harder for nulliparous women due to expectations and unfulfilled maternity projects (I15).

Respect for the patient’s individuality

All participants pointed to adapting to each patient’s needs and personality as necessary to the caregiving process. Perceiving if the patient wants to be emotionally supported was described as not always easy (I06), so nurses have to come up with ways to show availability (I14). Additionally, nurses often advocate for patients’ rights and needs (e.g., expansion of visiting hours), and altruistic gestures such as spending the night with a patient that was perceived as more vulnerable (I04) were found. Being open to flexible visiting hours and letting others stay in the room or stayovers were also referred several times (I01, I13, I15).

Viewing the fetus

A quarter of respondents referred to viewing the fetus and how this has to be handled with care. The usual routine for fetal loss was described as maintaining the procedure of measuring and weighting (I11). However, opinions seem to diverge on earlier losses: while some reported never presenting the opportunity at earlier gestational ages (I04), others reported always asking (I02). Four participants indicated that seeing the baby should be the patient’s decision, and nurses should respect it. Two nurses also mentioned the importance of approaching patients’ religious or spiritual beliefs (I05, I12). Preparing the patients for what they will look at was mentioned as important when they choose to view the fetus or products of miscarriage (I02, I03, I04, I10). Narratives of this moment included nurses holding the fetus and showing it to the couple (I04), giving patients the fetus or baby to hold and providing privacy (I03), and patients taking pictures (I10). One participant mentioned that some of the patients choosing not to view contact the department after discharge inquiring on the possibility of having other mementos such as ultrasound pictures (I03). Viewing seemed to be associated with facilitating grief and its’ resolution (I02, I03).

Facilitating grief rituals

Even though a funeral is not allowed at early gestational ages, participants mentioned that discharging patients before initiating

medication to terminate the pregnancy safely is also acknowledged as a way of starting the grieving process and returning to normalcy (I05). Two participants mentioned their involvement in supporting patients with advanced gestational age losses in deciding to donate the body for scientific research or having a funeral after autopsy (I02, I05).

Discussion

This study aimed to explore how nurses perceive the impact of pregnancy loss on patients and themselves regarding communication and caregiving. Our results showed several suggestions for practical intervention points to be applied in order to accomplish both nurses' self-fulfillment and better care and communication with patients who go through pregnancy loss. The central notion of duality between privilege and challenge underlying the nurse's self-fulfillment model [8] seems to be present throughout all the experiences reported by participants. However, this model's concepts were more often referred to as improvements that are still needed for an adequate routine instead of factors that underlie motivation.

In effect, nearly 40 % of the analyzed content in the present study is related to the struggle nurses dealing with pregnancy loss face in their daily work. Importantly, care management variables were mentioned more often and perceived as more critical than infrastructural factors. Almost all participants referred the need for additional or continued education, which would enable them to apply the therapeutic use of self and enhance critical thinking to improve the provision of comfort with loss. Advanced learning on grieving and death counselling can improve nurses' adaptation to loss [4] and avoid the involvement of nurses in escaping behaviors when facing patients' emotional suffering. Sharing and supervision or intervision were also mentioned as more informal but productive ways to improve nurses' personal well-being and communication, particularly in the case of novice clinicians. The presentation of difficult cases would help better interpret events and offer those interpretations to patients as preconized by the nurses' self-fulfillment model. Although only suggested by two of our participants, having patients' feedback on how they felt supported would certainly also improve event interpretation and honoring individuality [8].

Interestingly, most nurses were aware of this individuality and patients' needs and reported that their care should only be the start of a therapeutic process for a significant part of patients. Our findings suggest that nurses would feel more empowered if they could refer patients for psychological support. Although the referral to counselling by other professionals has been recommended [2,14], further studies should address whether it is feasible and acceptable for patients and professionals to have referrals done by nurses since they are the ones more directly involved in care in this case. This would ease the process of addressing in a single moment family planning and the impact of the loss on possible future pregnancies [15,16]. The need to screen at-risk patients was reported previously as crucial to identify pathologic grief [17]. Patients have pinpointed this as necessary for their emotional recovery [18], mainly because they lack acknowledgment from their social supporters [19]. Huttu et al. [20] suggested that this work could be done through scales like The Perinatal Grief Intensity Scale.

A less expected finding was related to the lack of infrastructure conditions and the discomfort associated with women or couples who have suffered pregnancy losses, sometimes side-by-side with child-bearing or puerperal women. Treatment in urgency or treatment rooms was also mentioned, and previously reported in other studies [5,18]. Focus on privacy and giving space to those affected by pregnancy loss is essential [21,22], and this study demonstrates that patients are not the only ones affected. In addition to the fact that the hospital environment per se is a trigger to elicit negative emotional responses [23], nurses reported spending their energy and efforts in minimizing auditory stimuli. More action to give a more tranquil experience to every-one involved in pregnancy loss was identified to provide more humanized and adequate care, including the ratio of patients per nurse, the need to

have more time to discuss loss and grieving, availability, and the establishment of a relationship with a single nurse. The availability of a single nurse has been previously detected as important to the patient [18] and would eliminate the distress and misunderstandings caused by repeating information to several professionals [23,24].

Based on nurses' narratives, the experience of working regularly with pregnancy loss means that personal characteristics and personal development are very much implied. Within this theme, discomfort with loss was the category most often mentioned and referred to by all participants. Although dependent on cultural values, personal history of losses, and experiences of death and grief resolution [24], it is only natural that this discomfort should be present in this profession. Human care systems are based on the fact that nurses assume the role of caregivers by expressing emotions and not omitting them [16,25,26]. While the presence of this feeling in most nurses is positive, it is undoubtedly related to the narratives associated with a stronger desire for specialized education and sharing between professionals. Most participants felt that how they communicate affects the patient's ability to make informed decisions and better cope with loss. Our findings reinforce the need to be aware of the quality and quantity of information while avoiding medical jargon [18,19]. Specifically, nurses addressed the importance of respecting personal needs and beliefs, giving information about the procedures involved, and avoiding delays in confirming the loss. Addressing the causation of loss was also referred to, and this might be particularly important in first-trimester pregnancy losses where normalizing miscarriage can have a negative impact [19]. Accumulating experience with pregnancy loss and being empathetic were found to improve care. Interestingly, professional experience has been identified as an indication of nurses' reliability by patients [24]. Patients also value emotion validation, understanding, and sensitivity [23]. These characteristics are associated with adequate facilitation of grief [8], leading to nurses' self-fulfillment. Our study suggests that nurses should particularly avoid placing the focus of care solely on women, physical condition, or type of loss and devaluating earlier losses and medical interruptions.

Our results revealed that the experiences of nurses working with pregnancy loss revolve around the patient, and five particular categories were identified as underlying the patients' journey. Participants were aware that when the couple is the focus of care, male partners have an ambivalent role as grief sufferers and caregivers. This is supported by the fact that hospitals still have a women-centered process leaving men as observers and not participants [24]. Previous evidence about men's perceptions of pregnancy loss showed that they devalue themselves in favor of the process happening in women's bodies [18]. However, men also perceive this lack of attention from society and health professionals as a reinforcer of their secondary role, which can negatively impact emotional and grief responses [24]. Our findings reinforce the urgency to involve men as patients and not only partners, as nurses perceive this. We also found a prevalent devaluation of earlier losses compared to later ones, which is corroborated by previous studies [5]. Professionals should be reminded of the non-linearity relationship between pregnancy duration and grief intensity [16]. However, more research is needed on differential approaches to pregnancy loss according to duration, as research points to more complicated grief in the third trimester [27]. Studies focusing on the differential care for patients in different trimesters (e.g., time spent with patients) and impact on nurses are needed. Nevertheless, all participants mentioned the need for a personalized approach to patients, per established guidelines [5,26], and associated with individualized approaches to decision-making related to viewing the fetus and performing rituals. As professionals with more direct contact with patients at the time of loss, the responsibility to inform about the possibilities of viewing the fetus and performing rituals is crucial [28]. Depending on the gestational age, preparing patients for their expectations regarding viewing the fetus and creating mementos facilitates the grief process [16,23]. This study shows that nurses seem to be aware of the importance of allowing the creation of memories,

particularly at later gestational ages. However, it is worth noting that less than half of the participants mentioned the importance of approaching the viewing of the fetus. Only two nurses reported the facilitation of grief rituals in their narratives. Although the components of the self-fulfillment model seem to be present in the reports of nurses, it is clear that several suggestions for improvement arise from this analysis. Even though well-known international guidelines seem to be increasing the focus on patient-centered care [e.g.,29,30], directives addressing skills to face the professional stress of perinatal loss seem to be missing on recommendations for best practice. Our results revealed that the most frequent categories emerging from the nurses' narratives were stressful working conditions and impact on personal life. Addressing the need for continuing education on stress management and self-care skills in perinatal loss guidelines at an institutional level might be fruitful.

Using a qualitative methodology to investigate the experiences of nurses working with pregnancy loss seems to capture the differences between what is known theoretically and what is effectively applied by these professionals. By using the grounded theory method we allowed collected data to guide our analysis. Another strength of this study is the 100 % acceptance rate, allowing representativeness of that hospital and detection of variability in narratives. On the other hand, the fact that participants are based in one sole hospital constitutes a limitation of the present study. Further studies are needed with different contexts, including private centers, and more heterogeneous samples, including male nurses and a higher percentage of nurses with advanced education in pregnancy loss. Future qualitative findings using grounded theory will allow sufficient evidence for theory creation. The fact that participants were informed beforehand about the study goal might have created a social desirability bias. While it is possible that some participants gave a more positive view of their work, this bias seems mitigated by the high frequency of complaints and stress that emerged in the analysis.

Future research is needed to address the gaps in care pointed out by our participants and improve the experience of nurses working with pregnancy loss. An example is comparison studies of nurses' and patients' experiences between obstetrics departments, with at least one having a separate room or aisle for pregnancy loss care. Randomized controlled studies testing the efficacy of nursing education interventions for developing specific communication skills and coping with gestational loss are another example. Exploring the possibility of patients having contact with one nurse of reference or better communication between professionals when passing shifts seems also needed to improve pregnancy loss care.

Conclusions

The experiences of pregnancy loss are challenging and complex for nurses in obstetric care. Although the components of the self-fulfillment model are present in nurses' reports, several factors that hinder this realization and that can be improved were mentioned. Most of our participants' narratives regarding these factors are institutional, and several suggestions to improve care management and clinical practice were given. The care of nurses dealing with gestational loss is clearly patient-centered. However, continued education and supervision of practices will promote not only better care but also greater resilience in the face of testifying emotional suffering. Soliciting patient feedback may also help achieve self-fulfillment, but this was not a common practice referred by participants. Future research will be conducted to provide a greater understanding of the risk and protective factors of pregnancy loss nursing. It will further confirm if specialized education and communication skills will improve the experience of nurses and, ultimately, patients.

Authors' contributions

[blinded for review].

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.srhc.2023.100817>.

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