

# Experiences of Maternity Healthcare Professionals Returning to Work Following a Personal Perinatal Loss: A Scoping Review of the Literature

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## Abstract

**Background:** In Australia, midwives care closely for women during pregnancy and birth and the immediate postnatal period. This scoping review aimed to explore the experiences of female maternity healthcare professionals when they return to work following a personal pregnancy loss or neonatal death.

**Methodology:** A scoping review was carried out on published and unpublished research and grey literature looking at how maternity healthcare professionals who have had a personal perinatal loss experience working in a maternity setting following the loss. A search of the literature was performed between October and December 2018, with no set limitations. A search for relevant references from included papers was also carried out. The literature was analysed thematically. The types of perinatal loss were defined as per Australian guidelines.

**Results:** 10 articles were included in this scoping review. Four themes emerged from the literature and these were: 1) Impact of being asked, “have you got

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children?"; 2) Impact on professional practice; 3) Impact of pre-existing professional knowledge; 4) Importance of collegial support on return to work.

**Conclusions:** Return to work in a maternity setting following a personal perinatal loss is emotionally challenging and requires a range of supports. Further research is needed in this area.

### **Keywords**

bereavement, healthcare professional, midwife, perinatal loss, return to work

In Australia, midwives and others care closely for women during pregnancy and birth and the immediate postnatal period. These professionals also care closely for women who have lost a baby due to stillbirth or neonatal death. This care includes practical and emotional support during this difficult time. It has been said that the midwife's role in bereavement care is "to walk next to women and their families and guide them and protect them to ensure they have safe and respectful care while they create precious memories of their baby" (Dahlen, 2017, p. 182). According to the Australian Institute of Health and Welfare, 98.6% of midwives are female (Australian Institute of Health & Welfare, 2015). Many of these midwives will be or are planning to become mothers. Many female midwives and other maternity healthcare professionals (HCPs) will fall pregnant or give birth during their professional careers, meaning there is a chance that these women will also experience a personal pregnancy loss, as around one in four pregnant women experience a miscarriage, and there are at least six stillbirths per day in Australia (Australian Institute of Health & Welfare, 2018). It can be argued therefore that we need to explore the experiences of these HCPs to better understand the effect on them and the potential effect on the women they care for, as well as identifying ways in which to support them on their return to work.

### **Background**

There is a large body of literature reporting on the experience of pregnancy loss for women and their families. Perinatal loss is expressed in different ways, and it is considered to be unique, in that losing a pregnancy can be seen as losing a part of oneself (McCoyd & Walter, 2016, p. 38). The concept of disenfranchised grief was first developed by Dr Kenneth Doka, an American sociologist, who defined disenfranchised grief as "*grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, socially sanctioned or publicly mourned*" (Doka, 1989, p. 4). According to Doka (1999), perinatal loss can bring about

strong grief reactions, but many still consider this type of loss to be insignificant. This point has been echoed in other studies. For example, Lang et al. (2011, p. 184) state that many parents who suffer a perinatal loss feel disenfranchised because their grief is not considered as significant as the grief of those mourning in traditionally recognised circumstances of death. With miscarriages, the lack of rituals of mourning, and the lack of acknowledgement of the baby by the extended family, can also impact negatively on the grief process (Kersting & Wagner, 2012; Tseng et al., 2017).

Indeed research has identified that grief may vary according to the type of perinatal loss. Schaap and colleagues (Schaap et al., 1997) looked at couples who had experienced a stillbirth and those who had experienced neonatal death and found that couples who had experienced a stillbirth showed more avoidant behaviour, such as throwing away mementos or avoiding talking about their pregnancy loss, more so than those in the neonatal death group. In terms of the time of loss, the study by Tseng et al. (2017) found that couples who lost a baby over 20 weeks' gestation had significantly higher grief scores than those who lost a baby at earlier gestations. However, other studies have reported no difference in grieving at different gestational ages of the loss (McSpedden et al., 2017). It has also been found that childlessness can exacerbate perinatal loss grief (McSpedden et al., 2017; Tseng et al., 2017) and grieving decreases significantly when there is a subsequent successful pregnancy (Kersting & Wagner, 2012; McSpedden et al., 2017). Another study showed that parents may harbour feelings of guilt regarding events surrounding the pregnancy or perinatal loss (Burden et al., 2016; Nuzum et al., 2018).

It can be argued that maternity HCPs who experience personal perinatal loss will also experience similar expressions of grief to those discussed above but will also be required to work in an environment that is a constant reminder of what they have lost. Some maternity HCPs may be forced to return to work early at a time when the grief is still intense; for example, when they do not qualify for maternity leave. Very little is known about the experiences of maternity HCPs who have lost their own babies when they provide care for a woman who has had a baby or a woman who has lost a baby.

Some studies have been undertaken exploring the experiences of maternity HCPs caring for families who have experienced perinatal loss. Maternity HCPs experience grief when they care for families going through perinatal loss (Jonas-Simpson et al., 2013; McCool et al., 2009; Pastor Montero et al., 2011) and they can feel overwhelmed by this grief (Jones, 2012; Wallbank & Robertson, 2008). Ben-Ezra et al. (2014) also found that obstetric nurses had higher levels of psychiatric symptoms such as Post Traumatic Stress Disorder (PTSD) and depression three months after exposure to perinatal death. Collegial support appears to be of great importance to health professionals who experience perinatal loss in the workplace. According to McCreight (2005) nurses reported that they received emotional support mostly from their colleagues. Similar findings

were reported by Roehrs et al. (2008) where nurses stated that talking to other nurses helped them cope. In light of these studies and the deeply emotional issue of HCPs returning to a maternity setting following the loss of their own baby, the question arises of the impact and consequences of this return to work for maternity HCPs.

The aim of this scoping review was to explore the experiences of maternity HCPs when they return to work in a maternity unit following a personal pregnancy loss or neonatal death. For the purposes of the review, the terms “pregnancy loss” and “perinatal death” will follow the Australian definitions, where miscarriages are pregnancy losses before 20 weeks’ gestation, stillbirths are foetal deaths at and beyond 20 weeks’ gestation and neonatal deaths are deaths of babies within the first 28 days of life (Australian Institute of Health & Welfare, 2018).

## **Methods**

The initial intention of the literature search was to explore documented experiences of midwives when they return to work in a maternity unit following a personal pregnancy loss or neonatal death. However, there was a lack of research on midwives’ experiences of personal pregnancy loss or neonatal death, and most of the papers retrieved using the search criteria centred on experiences of various types of HCPs caring for families who have experienced perinatal loss. The literature search was then expanded into a scoping exercise in order to identify available evidence and assess any gaps in research about maternity HCPs who have experienced personal perinatal bereavement, and the impact of personal perinatal loss on maternity HCPs’ subsequent return to practice. The search question directing the scoping review was: “What are the experiences of maternity HCPs who work in a maternity setting when they return to work following a personal pregnancy loss or perinatal loss?”. Scoping reviews are valuable in assessing gaps in research by reviewing broader areas of research and grey literature (Peters et al., 2015).

### ***Literature Search Strategy***

A search of the literature was performed between October and December 2018. The following search engines and selected databases were used to search for literature on, and related to, the experiences of midwives, when they return to work following a personal pregnancy loss or perinatal loss: OVID (Medline R All, Books @Ovid, All Ovid journals, Joanna Briggs, CAB Abstracts, Embase, Embase classic, Ovid Emcare), EBSCO host – (CINHAL plus with full text, MEDLINE, eBook collection, E-Journals, Health source, Historical abstracts with full text, psych articles, psych books, psychology and behaviour sciences collection, psych INFO, SocINDEX with full text, The serials Directory, Open

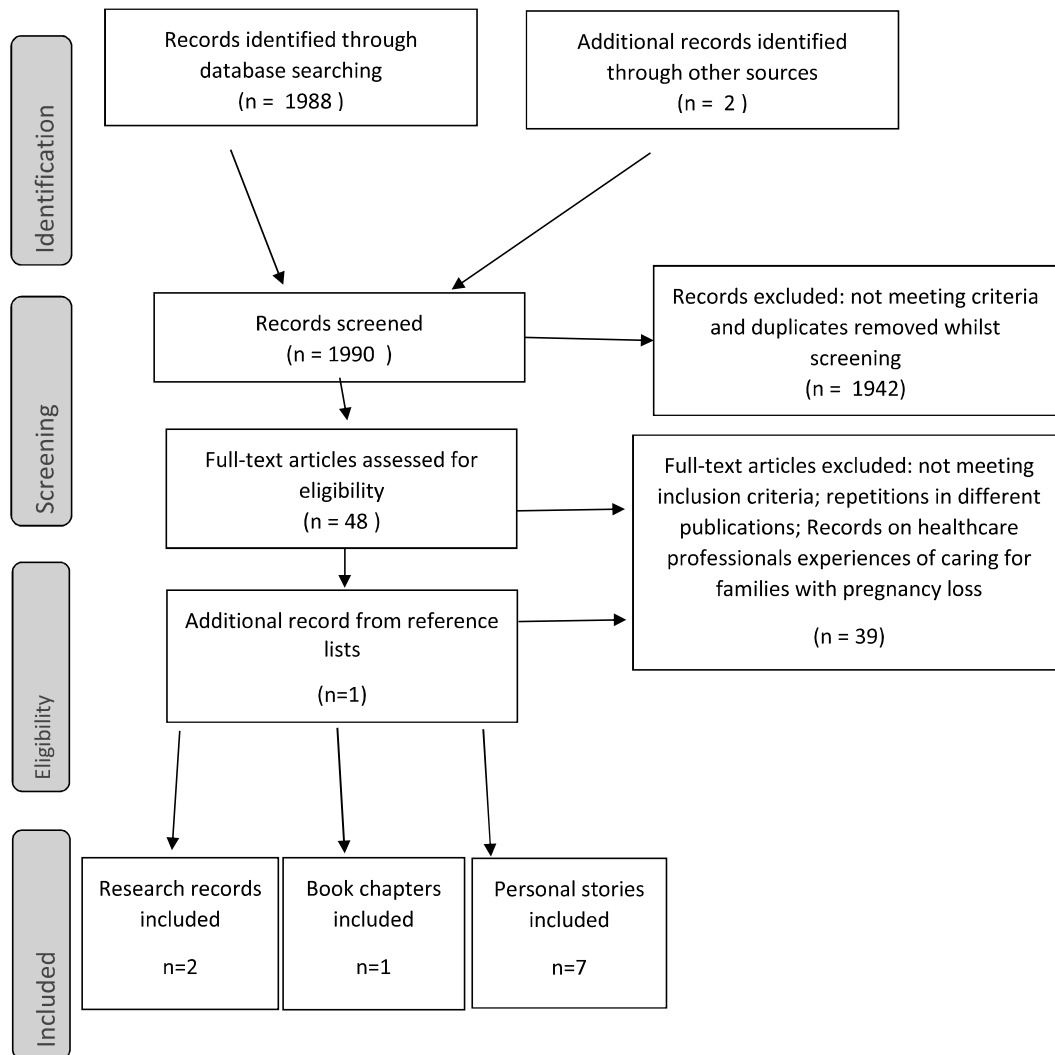
Dissertations), Google Scholar, Research Direct Western Sydney University, Research Gate and Google.

The initial main search terms used were as follows: (midwife, midwives); (perinatal loss, pregnancy loss); (miscarriage, stillbirth); neonatal death; (return to work, back to work); (personal experiences, personal loss, personal impact). Due to lack of literature specific to midwives, the following variations of the initial search terms were also used, but were not limited to: obstetric nurse, nurse-midwife, labour nurse, healthcare professional, return to practice, and perinatal bereavement. The keywords *doula*, *obstetrician* and *childbirth* were added to further expand the search and include literature on other maternity HCPs experiences when they return to work following a personal perinatal loss. The search terms were combined using Boolean operators “OR” and/or “AND”. The electronic search was performed with no time, language or any other limitations, as a means of gauging the extent of the literature published on the topic.

Meetings were held by the authors to discuss search results and determine papers for inclusion and exclusion. Included in this review were papers written in English which were directly related to the above stated research question. Grey literature was also included in this review, such as personal stories, videos and book chapters. Excluded from the review were papers which set out to address the experiences of HCPs not working in maternity units (e.g., sonographers), or HCPs still in training (e.g., student midwives). Other exclusions were blog entries, articles in non-professional journals, magazines or websites, and papers not written in English. Inclusion/exclusion criteria were applied whilst scanning the papers found and duplicates of relevant papers were manually removed during the scanning process.

## Results

Initially, 1988 records were found online with two other records found from other sources. A total of 1942 of these articles clearly did not meet the criteria, leaving 48 articles for assessment. Following a reading of the full text, a further 38 articles were excluded due to not meeting the inclusion criteria for the review. An additional potential record was located when checking the reference lists, but it did not meet criteria and was therefore also excluded. This left a total of 10 articles which were included in this review, exploring maternity HCP experiences of personal pregnancy loss, including personal stories. Only two of the 10 articles were research papers. The articles included in this scoping review were from the following locations: Australia, the United States of America, the United Kingdom and Isle of Man, and Sweden. Figure 1 summarises the literature search strategy. Details of each study are shown in Table 1. Rigour of the studies was not assessed, following the tenets of scoping reviews and the fact that grey literature was included (Peters et al., 2015; Peterson et al., 2017).



**Figure 1.** Literature Search Flow Chart.

## Findings

This review follows a narrative form and highlights the experiences of HCPs who have experienced a personal perinatal loss. In total, 10 articles were included in this review (two research papers, one book chapter and seven personal stories). The two pieces of research on midwives' personal pregnancy loss were carried out by the same author in the United Kingdom (Bewley, 2000, 2005). The seven personal stories of personal pregnancy/child loss experienced by maternity HCPs were from two doctors, one nurse and four midwives. The seven personal stories included a video documentary by Caplice and Copeland (2005) entitled "Hannah's story", which was obtained from a different source. The documentary portrays the neonatal losses experienced by a midwife named Hannah. One of the seven personal stories mentioned above was part of

**Table 1.** Summary of Literature Included in the Scoping Review.

Studies and book chapters	Author/year/Country	Aim	Methodology/Sample/ Measures	Main findings	Comments
Bewley (2000) UK	To determine the effects of a negative response to the question, 'Have you got children?', on the midwife's perception of herself in the midwife/mother relationship	Quantitative and qualitative data collection from questionnaire respondents 184 midwifery respondents included in study, of which 10 were follow up interviews	Some midwives do not want children at that specific time, some do not want them at all, and some want children but are unable to have them. Some found the question, 'Have you got children?', legitimate and conversational; others found it annoying, implying a deficit in either themselves as women, or as midwives. Midwives who experience pregnancy loss, or the loss of potential motherhood through age or medical reasons, need specific support as they go through a grieving process.	Wide variety of gestational ages and reproductive circumstances Some midwives here were childless by choice or childless but considering motherhood in the future.	
Bewley (2005) UK (Bewley, 2008, 2010a and 2010b all are based on this thesis: no new information offered.)	The aim of the study was to explore the experiences of midwives who were having problems with any aspect of reproduction, and relate this to their approach and attitude to their work with pregnant and childbearing women, and to their colleague	Grounded theory 40 participants, and from 10 follow up, in-depth, semi-structured interviews. Constant comparative technique	-Pregnancy related losses, including infertility, miscarriage, termination of pregnancy, stillbirth and neonatal death, influenced the participants' personal and professional relationships. -Colleagues were helpful in terms of support but some would say unhelpful things. -Being a midwife was an advantage	Wide range of pregnancy loss including adoption and infertility Literature review prior to GT data collection	

(continued)

**Table 1.** Continued.

Studies and book chapters			
Author/year/Country	Aim		
Methodology/Sample/Measures	Main findings		
Comments			
Donnolley and Dahlen, 2019 Australia	Reproductive loss and grief: Hannah's story- A love that never ends	Book chapter written by 2 women (Hannah Dahlen, a midwife, and Natasha Donnelley a health information manager) who have experienced the loss of a baby/babies.	for some as care and treatment was prioritised, but a disadvantage as they were expected to know more than they knew. -Some midwives found it difficult being with pregnant women or babies, although most differentiated between longing for their own baby, and envy of any other baby. -Some found difficulty working in particular areas, for example labour ward, or in the rooms in which they had delivered their own babies, although there seemed to be no link between the type of loss, and problematic areas The Donnolley and Dahlen (2019) book section compares Hannah's story -a love that never ends, to Natasha Donnelley's story – a fractured future (Natasha is a consumer who is not an HCP) <i>Hannah's story can be viewed under the personal stories table of summaries</i>

Personal stories	Author/year/country	Title	Main points	Comments
Caplice and Copeland (2005) Australia	DVD video- Hannah's story	Midwife, mother of four, 2nd and 3rd children were neonatal deaths within first 2 weeks, 1 year apart.	<ul style="list-style-type: none"> <li>- Found comfort and hope in her first child who was a young girl at the time of the losses</li> <li>- Her pre-existing medical knowledge made her aware of the gravity of her son Luke's condition</li> <li>- Found herself wondering what would be worse, between a disabled child or a dead baby</li> <li>- Felt no need to attend a support group, stating that as a midwife she was surrounded by other wonderful midwives who met all her needs.</li> <li>- Talks about returning to work after her losses to find some midwives going out of their way to hug her and share in her grief and others made efforts to avoid her.</li> <li>- Hesitates when asked how many children she has</li> </ul>	
Jennings, 2012 UK	<i>Delivering Hattie...</i>	Midwife, 1st child, "textbook pregnancy", laboured at home to limit intervention and allow the baby "time to turn" as baby was Occiput Posterior position.	<ul style="list-style-type: none"> <li>- Foetal death in labour</li> <li>- Regrets not listening to foetal heart at home and questions if that would have changed the outcome</li> <li>- Now she "struggles between mother and midwife" constantly questioning her own practice</li> <li>- Felt a strong urge to discuss her experience to the last detail</li> <li>- Through her profession as a midwife she had many friends and colleagues who lent an ear and also openly discussed her loss with her.</li> <li>- Talking about it made her feel like a mother but she also felt like a failure going home without a newborn baby</li> <li>- Returned to work in a few months because of lack of financial entitlements beyond maternity pay.</li> </ul>	

(continued)

Table 1. Continued.

Personal stories			
Author/year/country	Title	Main points	Comments
Johnson, 1972 Sweden	<i>Stillbirth- a personal experience</i>	<ul style="list-style-type: none"> <li>- Hopes her experience will add to her life's learning and role as a midwife</li> <li>- Support from her colleagues was "immeasurable"</li> </ul> <p>Nurse educator; Intrauterine death 1 week postdates, 1st child Induction of labour, PPH</p> <ul style="list-style-type: none"> <li>- Within 24 hours of her loss, a "business as usual attitude prevailed" among people around her</li> <li>- Despite asking for a public health nurse visit whilst she was pregnant (before IUD), she did not get one and felt it was because the nurses thought she did not need any outside help as a "well educated nurse"</li> <li>- Both lay people and professionals said unhelpful things e.g. you can try again or the still born baby was perfect therefore high chances of perfect baby next time</li> <li>- Constantly asked "why me"-especially when she saw pregnant friends and acquaintances</li> <li>- Rationalised that had the "respiratory distress" been discovered 1 time to deliver a live baby the baby may have been brain damaged which would be "certainly undesirable"</li> <li>- 2-years later (at time of writing the story) she still had episodes of anger and depression</li> </ul>	
Kelley, 2017 USA	<i>Full disclosure: An OB/GYN's personal story of pregnancy loss</i> Questions if full disclosure	<p>Reproductive endocrinology and infertility doctor;</p> <ul style="list-style-type: none"> <li>- 1st child, miscarriage at 8 weeks</li> <li>- Difficult conception, was a patient in the clinic where she worked</li> <li>- Found it hard to review ultrasounds after her miscarriage</li> <li>- Realises she has little insight into the patient experience with pregnancy loss</li> <li>- Depression was her first stage of grief</li> <li>- The "doctor part" of her rationalised about reasons for the miscarriage</li> </ul>	

(continued)

Table 1. Continued.

Personal stories	Title	Main points	Comments
Kelly, 2014 Isle of Man	<i>Do you have any children?</i>	<ul style="list-style-type: none"> <li>- Wondered if sharing her loss with patients would make it better for them</li> <li>- When he had been trying to conceive it was difficult seeing other pregnant people make it look so effortless</li> <li>- She decided that under the right circumstances if the patient asked she would share a glimpse of her own struggles</li> <li>- Midwife, 1st child died in an accident in 2008</li> <li>- Experiencing motherhood made her become a midwife</li> <li>- Felt comradeship with women under her care as a fellow mother too</li> <li>- After child's death the question "do you have any children?" became difficult to answer</li> <li>- Fears that question everyday as still unsure of how to answer</li> <li>- Experiences physical and emotional reactions to the question</li> <li>- The only time she feels comfortable revealing her son's death is when the woman has also lost a child.</li> </ul>	
Oglethorpe, 1983 UK	<i>Stillbirth: a personal experience</i>	<ul style="list-style-type: none"> <li>- Child psychiatrist and husband is also a doctor, intrauterine death, 1st child – gestation not specified but likely viable gestation as she mentions registering the baby.</li> <li>- Author states she had a "handicapped" brother therefore she felt dead is better than brain damage</li> <li>- States she had "release of tension when diagnosed IUD"</li> <li>- Felt sense of achievement when son was born</li> <li>- Pictures of baby were a great comfort</li> <li>- Was placed in postnatal ward after delivery and feels strongly that she should have been placed elsewhere in the hospital</li> <li>- She felt a strong urge to tell people about her ordeal</li> <li>- Return to work boosted her morale</li> <li>- Colleagues tactful encouragement helped</li> </ul>	Does not state whether there was a known abnormality but statement within the story would suggest so

(continued)

**Table 1.** Continued.

Personal stories			
Author/year/country	Title	Main points	Comments
Stanfield-Porter (2009) Australia	<i>Clare's story</i>	<ul style="list-style-type: none"> <li>- Someone commented (does not specify if colleague or not) "I don't know how 2 doctors could have allowed their baby to die"- which was unforgettably hurtful</li> <li>Clare, a midwife and grief counsellor whose story was included within a self -help book for people coping with pregnancy loss, rationalised that she was part of the "one in four" statistics with her first miscarriage, and was devastated with her second miscarriage, worrying that this would keep happening. Clare stated she had more empathy at work due to her experience</li> <li>Supported husband through his grief in the first few weeks and when he "moved on from that stage" she was 'able to fall in a big heap"</li> <li>After her 2 miscarriages she had many tests and scan, and from her "hospital experience" she knew how fragile pregnancy is right up to delivery.</li> </ul>	

a book chapter also detailing Hannah's story (Donnolley & Dahlen, 2019). The video had additional information and was therefore included in this review in addition to the book chapter. The following four themes were revealed and are discussed below: 1) Impact of being asked, "have you got children?"; 2) Impact on professional practice; 3) Impact of pre-existing professional knowledge; 4) Importance of collegial support on return to work.

### *Impact of Being Asked "Have You Got Children?"*

Bewley (2000) carried out a study exploring the experiences of midwives without children when asked the question "have you got children?" by women under their care. The sample of 184 participants included midwives who were childless by choice and midwives who had experienced pregnancy loss and pregnancy related loss (for example, infertility). All participants responded to a survey questionnaire and 10 were randomly selected for follow up interviews. Bewley (2000) reported that midwives who had experienced pregnancy loss or infertility found it hard to respond to the question "have you got children?" Midwives who had experienced personal perinatal loss were not keen to discuss their experiences with the women and would therefore steer the conversation regarding whether or not they had children to other topics. Midwives who had lost their own babies found it painful to hold a baby, as did those who were unable to have children. A midwife in this study disclosed her fleeting thoughts of abducting a baby after her own miscarriage but stated she did not act on these thoughts due to the repercussions for herself and the baby's family.

Within the grey literature, the question "have you got children?" brought out physical and emotional reactions from one author (Kelly, 2014). Kelly, a midwife, spoke about how she encountered that question regularly from women in her care. After the loss of her child in a car accident the question became loaded with anxiety and sadness. Kelly found herself in a dilemma where answering truthfully meant making her clients uneasy and lying meant denying her child's existence. Kelly stated that the only time she felt comfortable telling the truth was when the client had also lost a baby (Kelly, 2014). The shared experience of having had a child and then losing a child may have made her more comfortable. In the chapter by Donnolley and Dahlen (2019), Hannah (a midwife), mentions how she hesitates when asked how many children she has. She had four children in total, and she states that she selects who she shares this with.

### *Impact on Professional Practice*

The loss of a baby was also reported as having an impact on professional practice. A midwife in the study by Bewley (2000), who had experienced a neonatal death, was angry and sorrowful when upon return to work she assisted a woman to give birth who was unhappy with the sex of the baby. The midwife

said she could not continue caring for the woman, and after handing over care to a colleague she broke down crying. Similarly, some midwives found it difficult to be with women who put their pregnancies at risk by lifestyle choices such as smoking and illicit drug taking. Some midwives in Bewley's study found it difficult to be around pregnant women or women who had recently given birth, and others even left midwifery because of it. However, many also stated they did not allow their own feelings to impact the care they gave to women. Bewley (2000) ultimately concluded that counselling outside the workplace, and sensitive clinical placements or avoiding those areas which lead to constant contact with babies, would be beneficial for midwives who had experienced pregnancy loss.

Bewley went on to complete a PhD and studied the experiences of midwives who had problems with any aspect of reproduction in relation to their work with childbearing women (Bewley, 2005). In her PhD study she interviewed 40 participants with 10 follow up in-depth semi structured interviews. A constant comparative technique was used to analyse data. The thesis was unpublished, but the research was reported in a book chapter (Bewley, 2008). Two further publications in 2010 were a revisit of her PhD thesis (Bewley, 2010a, 2010b). For the purposes of this review the 2005 thesis will be specifically referenced as it contains all of Bewley's data and in-depth analysis.

### *Impact of Pre-Existing Professional Knowledge*

Bewley (2005) found that the reactions to personal pregnancy loss mirror the reactions of the general population reported in parental grief literature. In addition to experiencing the same reactions as the general population, Bewley also found some midwives felt they were expected to know certain things when they themselves were pregnant, with one midwife stating she felt she was not given enough information when she had rupture of membranes following amniocentesis and a subsequent termination of pregnancy. Some midwives spoke about being in a privileged position when it came to treatment, although this was counterproductive for one midwife whose colleagues expedited her appointments for a termination of pregnancy after a spina bifida diagnosis. The midwife felt this did not allow her time to think before the intervention. One of the articles found in the grey literature showed a stark difference in the midwife's and consumer's experiences, where the midwife's story was mostly positive (she had her own private midwives) but the consumer's story was an unfortunate example of fragmented, substandard perinatal bereavement care (Donnolley & Dahlen, 2019). The midwife's knowledge led her to seek out care that was protective.

The healthcare professionals' use of their pre-existing medical knowledge to rationalise issues surrounding their losses was a common theme emerging from the HCP personal stories. For example, Johnson (1972) (a nurse educator) and

Oglethorpe (1983) (a child psychologist) both mentioned how having a brain damaged child from “respiratory distress” would be undesirable: “I personally had no doubts that a dead child would be easier to accept than a brain damaged one” (Oglethorpe, 1983). In the video mentioned earlier, “Hannah’s story”, the midwife’s pre-existing medical knowledge made her aware of the gravity of her son’s condition when, whilst on the operating table soon after his birth, she heard someone ask for adrenaline and knew at that point that the outcome would most likely be poor (Donnolley & Dahlen, 2019). She goes on to say in the video that she found herself wondering what would be worse, a disabled child or a dead baby.

Jennings (2012), another midwife, talked about how she regretted not listening to the foetal heartrate when she was in labour at home and wondered if it would have made a difference. Kelley (2017), a fertility doctor, rationalised the reasons for her miscarriage at eight weeks based on her experience. Kelley (2017) also reported how she found it hard to review obstetric scans after she had her miscarriage, and how her own loss made her realise she had little insight into the “patient experience”. Clare, a midwife and grief counsellor whose story was included within a self-help book for people coping with pregnancy loss, rationalised that she was part of the “one in four” statistics with her first miscarriage, and was devastated with her second miscarriage, worrying that this would keep happening (Stanfield-Porter, 2009).

### *Importance of Collegial Support on Return to Work*

Some issues found in the literature were specific to how the maternity HCPs were treated by their colleagues on their return to work, which directly or indirectly affected their relationships with women. The bereaved midwives valued practical and emotional support from colleagues, where sensitive approaches included being asked where they wanted to work (Bewley, 2005). There was, however, a thin line between the sensitive and insensitive approaches, with the midwife in charge of the shift making assumptions about whether or not they could work with mothers experiencing loss instead of asking the midwife what she wanted (Bewley, 2005). One midwife recollected how she was traumatised when she was allocated to work with a mother whose labour was being induced for foetal loss (Bewley, 2005). Other issues midwives found distressing were assisting a woman to give birth on the day their baby would have been due, working on the anniversary of the death or the due date, returning to the room where they had birthed their stillborn (for those who gave birth where they work), and insensitive things said by colleagues such as “just relax, it will happen naturally” (comments directed at a midwife who was finding it hard to conceive) (Bewley, 2005).

Insights from the personal stories showed that HCPs felt they generally received good support from their colleagues, (Donnolley & Dahlen, 2019;

Jennings, 2012; Oglethorpe, 1983) except for Johnson (1972) who felt community nurses thought she did not need any outside help as a “well educated nurse”. In the book chapter (Donnolley & Dahlen, 2019), the midwife felt no need to attend a support group, stating that as a midwife she was surrounded by other wonderful midwives who met all her needs, whereas the consumer found comfort in attending support group meetings as she felt her family and friends could not relate to her pain and grief. The midwife talks about returning to work after her losses to find some midwives going out of their way to hug her and share in her grief whilst others made efforts to avoid her. She came to the conclusion that the colleagues who avoided her were probably just out of their depth and did not know what to say.

## **Discussion**

The aim of this scoping review was initially to look at the documented experiences of midwives returning to work after a personal pregnancy loss or neonatal death. Due to the very limited literature available on midwives experiences it was expanded to include maternity HCPs experiences of returning to work after a personal pregnancy loss or neonatal death. Research and anecdotal literature indicate that personal pregnancy loss can have a lasting impact on the HCP’s professional life.

### *Impact of Vicarious Grief*

Findings from literature on HCP experiences of caring for families experiencing a perinatal loss suggest that healthcare professionals can be negatively impacted when caring for women and families who have experienced perinatal loss. The grief experienced by maternity HCPs can be personal even when it is not the HCP who has experienced the loss (Jonas-Simpson et al., 2013). Cacciatore (2013) asserts that “compassion fatigue” and “vicarious traumatisation” can occur when healthcare professionals experience unexpected deaths at work. It follows that maternity HCPs who return to work after a personal perinatal loss may have additional vulnerabilities related to vicarious grief whilst still experiencing their own grief. It may take time before a maternity HCP is emotionally able to care for a grieving family after she returns to work following the loss of her own baby.

It has been identified that depressive symptoms related to miscarriage can continue for up to three years after the loss (deMontigny et al., 2017). Some losses, such as perinatal loss, may not be acknowledged by society (Doka, 2017). The disenfranchisement of perinatal grief can complicate the grief process and maternity HCPs can consequently experience prolonged grief (Lang et al., 2011). This means that maternity HCPs who have lost their own baby may need support from their managers and colleagues when they return to work and for years

after, with consideration given to the HCP's preferred area of work and work requests; for example, if the HCP needs to be off duty on the anniversary of her loss.

### *Post-Traumatic Stress and Coping Mechanisms*

In a meta-ethnographic study of midwives' and nurses' experiences of adverse labour and birth events, Elmir et al. (2017) found that midwives and nurses experienced feelings of shock, fear, horror and apprehension after witnessing adverse labour and birth events, and the memories of these events lingered for years, haunting them. Leinweber et al. (2017) identified a risk of post-traumatic stress disorder (PTSD) in midwives witnessing traumatic birth events at work. It is unknown how a maternity HCP returning to work following her own possible trauma of personal pregnancy loss would cope with traumatic events at work. The literature on HCPs who returned to work following their own pregnancy or perinatal loss showed that the HCPs valued support from their colleagues and managers/employers. Therefore, colleagues and managers of maternity HCPs who are grieving a loss need to be aware of the possible additional support that they may require when faced by adverse events at work. Managers should be mindful of the grieving professional's ability/inability to take on complex cases.

### *Knowledge and Skills*

Midwives in the study by Bewley (2005) felt they were not given enough information at the time of their loss and/or during the time leading up to their losses as they were expected to already know more than others. Similarly, whilst exploring midwives' experiences of personal pregnancy and childbirth, Church (2014) found that a midwife's assumed midwifery knowledge appeared to limit information-giving by care givers, and discussions of the significance of any medical tests or test results were also limited, thereby limiting support and information given to the pregnant/birthing midwife. Healthcare providers therefore need to fully engage in information-giving and education even if the woman they are caring for is a maternity HCP, and not assume she knows everything. This can be helpful in allowing the maternity HCP the time to process her perinatal loss and make informed decisions on the follow-up management of her situation, for example when a foetal anomaly has been detected.

Several researchers have noted education and training as a factor impacting maternity HCPs' experiences of caring for bereaved couples (Agwu Kalu et al., 2018; Fenwick et al., 2007; Gandino et al., 2019; Horiuchi, 2016; Modiba, 2008; Shorey et al., 2017; Wallbank & Robertson, 2008), stating that HCPs felt inadequately trained to provide emotional care to bereaved families. It is unclear how such education can impact the response of the grieving professional when she cares for a grieving family. However, one can surmise that learned skills such

as general concepts of loss and grief and strategies for facilitating the grieving process, which can be incorporated into bereavement training, can in turn help the grieving HCP with personal grief management and possibly help the HCP cope better when caring for grieving families. It may well help the colleagues who surround her to be more responsive as well.

### *Returning to Work After a Personal Pregnancy Loss*

Both research projects by Bewley reported that it was difficult for the midwives to return to caring for pregnant women and babies (Bewley, 2000, 2005). Whilst several authors have written about pregnancy and/or child envy, where bereaved parents experience feelings of jealousy and painful memories of their loss when they see pregnant women or parents with well babies (Kersting & Wagner, 2012; Lee, 2012; Nuzum et al., 2018), the literature does not indicate how long this may last. For a maternity HCP returning to work within a few months of her pregnancy loss, being around babies may well still be an emotional trigger for them. This means the maternity HCP may need additional support from colleagues and managers in coping with these emotions.

A two-track model of bereavement developed by Simon Rubin provides a clear understanding of grief and how people respond to loss, with track 1 focusing on biopsychosocial functioning of the griever, and track 2 focussing on the nature of the relationship with the deceased (Rubin et al., 2018). This model was based on research on bereaved mothers who had lost children to Sudden Infant Death. One main finding from his research was that there was no end to the mothers' relationships with their deceased children (Rubin et al., 2018). It is quite possible then, that when a maternity HCP loses her baby, the grief response can become complicated, where her biopsychosocial function (track 1) is constantly impacted by being in an environment that is a constant reminder of her loss. This biopsychosocial impact can be in the form of fractured interpersonal relationships and inability to meet demands at work, coupled with possible traumatic responses and anxiety when faced with certain emotional triggers.

The grief and bereavement literature have seen a move from the belief that grief resolves when the bereaved reaches a level of detachment from the deceased, to the idea that grief can still be in the process of resolution in cases where those grieving maintain a lasting connection with the deceased (Klass, 1993). Working through the grief using the continuing bonds framework assists the bereaved person in developing a way to continue living with the memories and emotions associated with the deceased (Klass, 1997). Given the nature of perinatal loss, where the loss is construed as a loss of part of oneself, and where the maternal bond to the developing baby and/or newborn baby may continue even after the baby's death (Rubin's track 2 domain), one could argue that maternity HCPs receiving psychological support would benefit from

support that incorporates the continuing bonds element of grief and Rubin's two-track approach to bereavement.

### *Implications for Future Research*

It is clear from this review that there is inadequate research into the experiences of midwives and other professionals when they return to work in a maternity unit following a personal loss. Maternity HCPs experience negative emotions when caring for families experiencing perinatal loss or traumatic births. This means that maternity HCPs who have had their own losses could be at an increased risk of negative emotional and psychological impacts when they are faced with adverse events at work. Performing skills such as neonatal resuscitation may trigger negative emotions, thus impacting on the care the professional gives to women. In further support of this observation Aschenbrenner et al. (2016) reported that labour nurses' attitudes to providing professional labour care were affected by the nurse's own experience of childbirth. Midwives, as the most common health provider for childbearing women around the world, could be affected in an even greater way. Given the critical nature of this issue, more research is required to further explore the complexity of experiences. Some of these complexities are outlined in the following section on limitations.

### **Limitations**

There are limitations to this scoping review. There is extremely limited data on maternity HCPs (including midwives) who experience a personal perinatal loss and return to work, which was the aim of the review. As a result, the review mainly comprises of insights from personal stories of maternity HCPs' experiences. Furthermore, studies not in English were excluded, meaning some valuable information may have been missed. Cultural considerations were only referred to in the PhD project by Bewley (Bewley, 2005), but the participants in that study were predominantly of similar cultures. Cultural beliefs and practices surrounding grief and bereavement can impact on a person's experience of grief and bereavement, and this has implications for how grief is understood within different cultures: the meaning(s) which can be ascribed to death and mourning. This important issue of meaning per se was beyond the scope of the current review but is certainly evident as a subtext when addressing different perspectives.

### **Conclusion**

The review of the literature identified only two studies (both from the UK) that explored the experiences of midwives who have had a personal pregnancy loss or neonatal death. This review was thus extended to include maternity HCPs and

there was still limited peer reviewed literature. The unique position of being both a maternity HCP and a bereaved mother brings to light issues for further exploration, such as the impact of professional knowledge, the relationship between the bereaved HCP and her colleagues, the impact of personal grief on maternity care and job satisfaction, and the support from healthcare employers and managers when the bereaved HCP returns to work. Specific studies are needed as they have the potential of informing employers, managers, midwives and other maternity healthcare professionals who may return to work following a personal pregnancy loss.


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