The impact of stillbirth on consultant obstetrician gynaecologists: a qualitative study*

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Objective To explore the personal and professional impact of stillbirth on consultant obstetrician gynaecologists.

Design Semi-structured in-depth qualitative interviews.

Setting A tertiary university maternity hospital in Ireland with a birth rate of c. 9000 per annum and a stillbirth rate of 4.6/1000.

Sample Purposive sample of eight consultant obstetrician gynaecologists (50% of consultant obstetrician gynaecologists in the hospital).

Methods Semi-structured in-depth interviews analysed by Interpretative Phenomenological Analysis. (IPA) IPA is a methodology for exploring human experience and its meaning for the individual.

Main outcome measures The lived experiences, personal feelings and professional impact of stillbirth on consultant obstetrician gynaecologists.

Results Stillbirth was identified as amongst the most difficult experiences for consultants. Two superordinate themes emerged: the human response to stillbirth and the weight of responsibility. The human response to stillbirth was characterised by the personal impact of stillbirth for consultants and, in turn, how that shapes the care they provide. The weight of professional responsibility was characterised by the sense of professional burden and the possibility of a medico-legal challenge—mostly for those who are primarily gynaecologists resulting in the question ‘what have I missed?’.

Conclusions Despite the impact of stillbirth, no consultant has received formal training in perinatal bereavement care. This study highlights a gap in training and the significant impact of stillbirth on obstetricians, professionally and personally. The provision of support, ongoing education, bereavement training and self-care is recommended. Medico-legal concerns following stillbirth potentially impact on care, warranting further research.

Keywords Bereavement care, consultant, gynaecologist, obstetrician, qualitative, stillbirth.

Introduction Consultant obstetrician gynaecologists are primarily associated with the safe birth of healthy babies and the resultant joy for new parents. Parents place high expectations on the professional capacity of their consultant to monitor their baby through pregnancy to a successful birth. The diagnosis that a baby will not survive or has already died in utero brings with it a bewildering array of emotional distress where birth and death collide with life-lasting impact for the parents.1–3 How parents are cared for during this delicate time can have long-lasting consequences, both positive and negative.3,4 This is a distinctive journey, where consultants are required to care for life through the lens of death.

Consultants do not enter this profession to care for those who are dying, yet each has to face the reality that not every baby will survive. In the recent drive to examine the

prevalence of stillbirth as a global phenomenon, the lived experiences of bereaved parents have been researched and have contributed much to the published literature. The impact of emotional burden in the wider healthcare field is well documented and acknowledged. Silver and Draper have identified that ‘obstetricians... often feel awkward or uncomfortable spending time with grieving families’. Gold et al., in a questionnaire study of US obstetricians in 2008, identified that 75% of respondents acknowledged that caring for women following stillbirth took a large emotional toll on the obstetrician.

Researching the impact of stillbirth on consultants contributes to the published literature by bringing to light the experiences of consultants themselves and, in turn, how that experience influences the care provided to bereaved parents. In a professional culture in which death and the expression of emotion can be seen as a negative, the recognition of the emotional burden of stillbirth is an important step towards fostering a more supportive professional environment, reducing burnout, stress and compassion fatigue, and increasing professional engagement and satisfaction.

The objective of this study, the first of its kind of which the authors are aware, was to explore the impact of stillbirth and to research the lived experience of consultants working in a tertiary university maternity hospital as they care for women who have been given the news that their baby has died or will die before birth.

Methods

Qualitative methods are used to understand complex social processes, to capture essential aspects of a phenomenon from the perspective of study participants, and to uncover beliefs, values and motivations towards care and service provision, and were therefore seen as appropriate for this study. As the study focused around the common experience of stillbirth impact and care, Interpretative Phenomenological Analysis (IPA) was the appropriate qualitative method to capture the lived experiences of participants. IPA is a well-established qualitative research methodology that has grown from the field of health psychology and is being used increasingly in health science research to understand how people make sense of their experiences.

Phenomenology is concerned with the study of experience and how experiences—in this case stillbirth—are understood. IPA focuses on the specific and particular nature of a phenomenon or experience at depth and what it means for each individual participant.

A semi-structured interview topic guide with open questions was developed by the authors to ascertain personal demographics, professional and personal experience of stillbirth, the impact of stillbirth and coping mechanisms following loss. Open questions were used to gather qualitative data and included questions such as:

‘What is the hardest part about being an obstetrician?’
‘What is it like for you to care for parents following a stillbirth?’
‘Have you received any training in perinatal bereavement care?’
‘How would you describe what it is like for a couple to be told that their baby has died?’

In addition, a scene was presented to each consultant about receiving a telephone call to attend to a couple at 38 weeks of gestation to confirm a stillbirth, and to describe what that was like for them and how they would care for the couple.

Recruitment

Following ethical approval from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Ref. No: ECM 4 (pp) 06/03/12), a purposive sample of eight consultants (50% of consultants in the hospital) was invited to participate in the study. Inclusion criteria were that the subjects were permanent consultant staff and provided care for parents following stillbirth.

All consultants received a personal email invitation to participate in a semi-structured in-depth interview with the researcher, with the stated aim to explore how they care for women and their partners during stillbirth and what were their experiences. One consultant did not respond to the invitation to participate or to a subsequent reminder, and was replaced in the sample by inviting another consultant.

Sample

Interpretative Phenomenological Analysis as a research methodology focuses on the depth of data and, by their nature, IPA studies have small sample sizes to allow experience to be studied at depth. The participants represent an experience rather than a population.

The sample of eight consultants consisted of equal gender balance, equal balance between those who were primarily specialised as obstetricians and those who were primarily gynaecologists and an equal balance between those who had an academic portfolio and those who worked exclusively in clinical practice. The research team included a healthcare chaplain (DN), a social scientist (SM) and a consultant obstetrician (KOD).

To safeguard anonymity and to facilitate a high level of trust in a sensitive area, the co-investigator (KOD; who is a consultant obstetrician) was not aware of the names of the individual consultants invited to participate in the study. The identity of the participating consultants was known only to the researcher (DN).
Data collection
Semi-structured interviews were conducted to ensure a consistency of topics covered and also to allow for the lived experiences of the consultants to be captured. This ideographic approach invites the sharing of important insights from the world of the participant and facilitates the emergence of topics of importance to the participant that might not have been thought of by the researcher.

Each interview took place in a private office environment without interruption at the participants’ place of work at a time of the participants’ choosing. Interviews lasted between 27 and 58 minutes, were digitally recorded and subsequently transcribed verbatim. Transcripts were anonymised to protect the identity of the participants. Following transcription and before analysis, each transcript was checked for accuracy against the original recordings by the researcher.

Analysis
The data were analysed using IPA. IPA is ideographic and, as a methodology, has the dual aim of providing both an in-depth exploration of people’s lived experiences and a close examination of how people make sense of those experiences. The researcher is tasked with entering as far as is possible into the world of the participant in an empathic way.

As a methodology, the participant is the ‘experiential expert’. This fosters a trusting environment and allows the participants to direct the conversation and share what is of most significance to them. The strength of qualitative analysis is that the focus is on depth and quality; this is particularly evident during analysis, as themes are chosen based on the richness of a particular account that highlights both the meaning and significance for the participant.

Data analysis is thorough and is undertaken in five steps: (1) familiarisation of the transcripts—listening to recordings, reading transcripts, reviewing notes of initial impressions; (2) preliminary themes identified—this is performed on a case-by-case basis; it involves focusing on key words and phrases that were coded; (3) themes are grouped together as clusters—related themes are arranged together; (4) the creation of a master table of themes—which themes have commonalities or contradictions?; these can then be developed into superordinate themes which are made up of subordinate themes; (5) the integration of cases—this is where one moves from the individual to the whole sample; as one moves from one transcript to the next, compare and contrast the themes; is there a pattern emerging from the sample as a whole?

The data were analysed by the research team and consensus was formed on the emergence of superordinate and subordinate themes. Data were managed using NVIVO Version 10 (QSR International, Warrington, UK).

Following analysis, the data were presented locally and the participants were invited to attend. Participants were also invited to view the results privately on an individual basis.

Results
Following the analysis of the data, two superordinate themes emerged: the human response to stillbirth and the weight of professional responsibility. The human response to stillbirth was characterised in two ways: the personal impact on the consultants and how that, in turn, shapes the care they provide to parents. The weight of professional responsibility was characterised by professional burden and medico-legal concerns.

Direct quotes are used in the article to demonstrate the results of the study. However, as the study involved a small number of participants who are known to each other, we have opted not to reference each quotation to protect the identity of participants who might be revealed by the connecting of particular quotes.

All consultants spoke openly about their experiences of breaking bad news, caring for families following stillbirth and what that was like for them. In response to the question, ‘what is the hardest part of being a consultant obstetrician?’, six consultants identified stillbirth as one of the most difficult parts of their job; the other two identified ‘the hours’ and ‘paperwork and management’.

Human response to stillbirth: personal impact
All consultants interviewed care for parents following stillbirth as part of a wider multidisciplinary bereavement team that includes specialist midwives, chaplains and social workers, in addition to support provided to parents by two support organisations: ‘A Little Lifetime Foundation’ and ‘Féileacáin’.

None of the consultants had received any specialist training in perinatal bereavement care. All learned ‘on the job’ and from senior colleagues during their training years. Most consultants considered stillbirth to be the worst outcome for parents; however, two felt that lifelong disablement was an outcome worse than death.

Consonant with the literature, there was a strong sense of the personal impact of stillbirth for each consultant. Consultants spoke about how stillbirth impacted them at a human level. The interviews were emotional for six consultants, requiring the interviews to be paused for a time in some cases. Emotions expressed were of sadness, fear, anger, disappointment and personal grief.

The experience of recalling particular situations opened up painful and vivid memories for some of the care that the consultants had provided following stillbirth.

My first night on call [as a Senior Registrar] ... I was looking after a woman who came in ... in full blown...
labour … the baby was a stillborn normal baby and I remember being absolutely devastated. This is my first night, first time … I was so devastated … I cried my eyes out.

The impact of stillbirth extended beyond the working day and the hospital environment for a number of consultants.

I find it difficult to separate the job at work … and coming home and just switching off.

Some consultants referenced the reality of the personal impact of stillbirth in terms of being parents themselves.

Sometimes it would be something as simple as just holding one of them [children] in a hug … might be enough to get me through what was a horrible day.

Six of the eight consultants had experienced pregnancy loss in their close family and spoke about the impact of this. Three said that their personal experience of loss had shaped how they care for bereaved parents in their professional practice.

I guess you compare the situations you’ve been in … and how they would feel and what they would like to hear and often they don’t want to hear the clinical stuff they just want somebody human … they remember for the rest of their life a few people associated with that. It’s more your expression, your body language and … how you are with them.

The depth and complexity of the personal impact of stillbirth revealed feelings of loss, fear, remorse, sadness, discomfort and anger for the participants, as outlined in Table 1.

These are strong feelings that are often experienced in personal and professional isolation. This isolation was demonstrated by the inability of some consultants to discuss it at work and unable to bring it home. No consultant identified any support structure that they used and only three said that they would discuss their personal emotions with colleagues in an informal way. This raises challenges as to where personal impact is recognised or addressed. One consultant said:

I don’t get upset at work … but usually on the way home I end up pulling over [in the car].

Another described the sense of isolation experienced as a junior clinician and the lack of recognition of the impact of stillbirth.

There was no recognition that it might be difficult … there was no training … there was no debriefing … and I think that’s bad. You did it yourself … nobody cared if you got so psychologically disturbed you threw yourself off the roof the following week.

**Human response to stillbirth: how it shapes care**

Every consultant displayed a high level of awareness of the devastating impact of stillbirth and perinatal bereavement for parents. Participants were asked to describe what they thought it was like for parents to be told that their baby had died (see Table 2).

Recognising the impact for parents, each consultant in turn expressed that giving time to bereaved parents is important and that there should always be an acknowledgement of their loss. All consultants said that they try to visit bereaved parents and their baby before they are discharged from hospital. Every consultant felt that bereaved parents should receive the direct care of a consultant, but two qualified this by acknowledging that, at times, another member of the team might be more appropriate if they had had primary contact with parents. In one case, a consultant recognising the personal emotional impact of stillbirth felt that some colleagues were not good at caring empathically, and that in sensitive and emotional situations it would be better for parents if another member of the team were primarily involved. One consultant described caring empathically as:

giving them a little bit of you and it would be draining if you did that the whole time. I think they are scared to

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**Table 1. Personal impact of stillbirth**

|  It’s a real sense of loss for me as an obstetrician… it is something that tugs, really tugs at my heart strings |
|  …it’s horrible |
|  It gives you a heaviness in your heart |
|  There is nothing nice about it |
|  You’ve got anger, huge anger … especially where a mistake has been made or something has been missed |

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**Table 2. What is it like for parents?**

|  I can only imagine it. I don’t think anything can compare with it, I mean it’s the loss of the highest order … it’s unimaginable |
|  …the situation is destroying their dreams |
|  It must be devastating |
|  It’s probably the most devastating thing that’s going to happen to them … their worst nightmare |

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give, to give that bit of themselves ... or maybe they've never thought what it would be like to be in that position themselves ... some people have had a very blessed life that they just don’t know what personal trauma is like.

Every consultant expressed the importance of ‘humanised’ care, where parents should be cared for sensitively and compassionately. The importance of recognising the baby as an individual was an strong subtheme in this area, characterised by a recognition of the importance of caring for the baby as they would with a live baby. One consultant described the importance of a baby’s name and always using it:

... the importance of the name, giving them an individuality, an importance.

This corresponds with best practice in this area, as outlined in various professional guidelines. How consultants expressed this human aspect of their care is illustrated in Table 3.

The data reveal a high level of sensitive and empathic care. This is best revealed by one consultant who expressed what he or she thought was needed by parents.

They don’t want to hear the clinical stuff, they just want somebody human and they remember your face rather than what you say.

Concern was expressed that the emotional impact of stillbirth is such that all consultants should share the load, and it was recognised by one consultant that, for a clinician specialising in this area:

it would take more of an emotional toll if you did it twice a week ... that’s just too many stories to take on board ... too many lives to get involved in ... I think that is too much for one clinician.

One consultant finds the expression of strong emotion by bereaved parents difficult to endure, and so says, 'I'll come back in 10 minutes', and leaves the room.

The reality of the personal impact of stillbirth on consultants means that some consultants remain emotionally distant from bereaved parents. The comments in Table 4 demonstrate this.

**Weight of professional responsibility: professional burden**

The sense of responsibility was a dominant theme for all consultants. Every consultant spoke about the professional reality that parents have high expectations that they will receive the highest level of care, and in a tertiary referral centre consultants are seen as having particular expertise. When a stillbirth occurs, it carries with it a sense on the part of the consultant that he or she might have missed something.

Being a fetal medicine expert, I suppose we probably should have less stillbirths.

Being a consultant brings with it a responsibility to be an expert clinician. For one consultant, this was one of the hardest parts about being an obstetrician. In a tertiary referral centre, those who specialise in fetal medicine care for parents who have more complex pregnancies, including those who will have a poor outcome, however expert the care. This can place an unrealistic expectation on consultants. One expressed this as:

the hardest part now is that your name is at the top of the chart and when it all goes wrong even if you’re not involved ... it all comes back to the consultant ... you’re ultimately responsible.

Professional responsibility extends to the expectations that consultants have of themselves as specialists in their field where, in addition to the expectations they feel from parents, their own professional expectations are also high.

As a fetal medicine specialist you’re not allowed to miss anything which is completely nonsense, but you don’t allow yourself to miss anyone [mother/baby].
Some consultants became very animated and expressive about the sense of professional responsibility they felt and, in turn, how they felt some of their colleagues evaded their responsibilities by not getting involved and referring to ‘experts’ on the team and thereby not discharging their responsibilities.

Sometimes we make it too easy for them.

This feeling of collegiality or lack of it was also conveyed by a competitive undercurrent expressed by some consultants about how stillbirth care should be managed. Some felt that every consultant should share the case-load, whereas others felt that those with particular expertise were best placed to provide care. Those who are primarily gynaecologists and who recognise that this is not their area of expertise were positive about the facility to refer bereaved parents to a colleague with specialist interest and expertise in pregnancy loss. One consultant articulated:

I don’t see myself as the expert; with a stillbirth I’ll see them [parents], I’ll have … all the information but I’ll be thinking I’d much rather X or Y would be doing that bit because they would be able to say more definitively what the cause was … but I accept that it’s my job if they are my patient … but I feel as though I’m doing a half-hearted job because I’m going to be sending them to somebody else.

Coupled with the importance of all consultants sharing the case-load of stillbirth care was the tension of acknowledging that some consultants may not have the knowledge and skills to deal with stillbirth care in a sensitive way. This was expressed by the statements in Table 5.

However, there was also a strong sense that all consultants need to be able to provide good care to bereaved parents and not to evade responsibility. One consultant, whilst acknowledging the importance and role of the multidisciplinary team, expressed this as:

…often you find people feel out of their depth and so it would be nice to say to the couple ‘Oh, we have a professional counsellor, we’ll get them to talk to you.’ … If we lose our ability to comfort another human being, even if we’re not that skilled at it, if we lose that ability we actually lose our ability to be good clinicians.

Weight of professional responsibility: medico-legal concerns

The medico-legal reality associated with obstetric practice is well documented by the Clinical Indemnity Scheme which manages clinical negligence claims and associated risks on behalf of the Irish State. In Ireland, one-third of all reported claims are from the discipline of obstetrics, resulting in one-quarter of all medico-legal financial awards annually.21 The proportionate claims are even higher in the UK.22 This is further compounded by the widespread media reporting of medical negligence cases: medical negligence invites public comment and concern.

At a personal and a professional level, the potential exposure of a medico-legal case weighed heavily on some consultants.

For one consultant, this was a dominant theme throughout the interview. The sense of a ‘blame culture’ and litigious environment following a perinatal death heightened the sense of nervousness associated with the outcome of stillbirth. The following sentiments were expressed in one interview:

There’s always someone to blame.

and if I’m not to blame they’ll [the media] certainly have a good go at it.

we’re working in a very suspicious environment.

For one consultant, the first thought on hearing of a stillbirth diagnosis was about professional credibility:

what’s the post-mortem going to show here?

you’re only one bad baby away from the front page of The Irish Times, and that’s the bottom line.

Medico-legal worries following stillbirth were predominantly, but not exclusively, expressed by those who are primarily gynaecologists. This was characterised by the question ‘what have I missed?’ It carried with it a sense of guilt that they or a junior colleague might have ‘missed something’ and professional fear about the potential public and legal outcome.

Discussion

Main findings

The emotional burden associated with stillbirth is considerable and the study reveals the emotional complexity for
consultants as they lead the multidisciplinary team. The fact that most consultants were emotional during interview highlights the significant and lasting impact of this work and, for some, this has potentially reduced their capacity to be emotionally present to bereaved parents which, in turn, may have a negative impact on the overall experience of parents at an already difficult time. The level of emotion expressed by some consultants when speaking about their own personal losses and grief suggests that they are carrying unprocessed loss. This is likely to impact on the level of emotional availability to other bereaved parents.

Caring for death in the midst of life is demanding. It became evident during the interview process that most consultants do not have a support structure in which they can process the personal and professional impact of death in particular, and work-related stresses in general. This has the potential to reduce the ability of consultants to care, and could lead to professional burnout. It is recommended practice that there should be a support structure for staff working in this area. There is no evidence from the consultants interviewed that they are aware of support structures or that they would feel comfortable accessing such services or revealing the impact of death. This area warrants further research, as it has the potential to negatively impact on the emotional health of consultants and affect the overall experiences of bereaved parents if left unattended. Participation in this study will, in itself, have increased the awareness of the importance of stillbirth for consultants as they reflected on their experiences. Consultants expressed that they did not find that the experience of stillbirth got easier over time.

The depth of feeling conveyed around professional burden and responsibility was considerable for some consultants. The question ‘what have I missed?’ was one that arose for those who are primarily gynaecologists, and raises questions about their level of professional confidence as they care for parents following stillbirth. If a medico-legal fear is uppermost in the mind of a consultant, this is likely to reduce the level of empathic availability. Further research is required to explore whether this fear impacts negatively on the ability of consultants to care empathically.

The high level of awareness expressed by consultants about the impact of stillbirth on expectant parents will be of interest to bereaved parents and the important role they have in sharing their stories as part of ongoing education for professionals in this area. However, the fact that no consultant could recall having received any formal training in perinatal bereavement care highlights a significant educational deficit that deserves immediate attention, both for consultants and for those who shape undergraduate and postgraduate medical curricula.

Strengths and limitations
The strengths of this study are that it is the first study to focus specifically on the effect of the experience of stillbirth on consultants as a specific group. In our study, the lived experiences of consultants following stillbirth are named and explored, contributing an important insight to the broader global discussion concerning stillbirth. As this was a qualitative study, the results pertain to a particular group from one facility. The data are particular to the participants and cannot be generalised to a global population; however, the insights and experiences are likely to have commonalities for other obstetricians and gynaecologists who care for families following stillbirth, and have importance beyond the sample studied.

As the study was exclusively focused on consultant obstetrician gynaecologists and did not research the wider obstetric team, a similar study of non-consultant hospital doctors is warranted.

Interpretation
The personal and professional burden of stillbirth is consonant with the published literature in the wider medical sphere. Our study brings to a deeper level the most recently published study by Menezes et al., which researched the ‘toll’ of working in maternal–fetal medicine for various healthcare professionals. In addition, our study confirms a congruence with the experience of parents in the published literature and the awareness of consultant obstetrician gynaecologists about the devastation experienced by parents when their baby dies.

Conclusions
In addition to acknowledging the pain of stillbirth for bereaved parents, it is also time to acknowledge the human and professional impact of stillbirth on consultants. This study describes the multifaceted experiences of stillbirth for consultants, revealing a very human insight into the personal burden of stillbirth. It highlights an awareness on the part of consultants of what bereaved parents experience when faced with this tragedy. Our results represent both an invitation and a challenge to consultants and to health service managers to acknowledge the clinicians’ burden of loss and to manage parents’ sometimes unrealistic expectations. Following our study, we recommend that consultants are encouraged to avail of existing professional and personal support structures, and that the importance of support and self-care is included in medical curricula and continuing professional development. Our study highlights the need for specialist training in perinatal bereavement care for all obstetricians and gynaecologists. As a result of this study, a local course on bereavement training has been scheduled by hospital management.
Following training, quantitative research should be carried out to measure the impact and effectiveness of training in this area.

As IPA focuses on a particular group with a shared phenomenon, further research into the impact of grief amongst non-consultant obstetricians and gynaecologists is recommended to expand this knowledge base. The impact of medico-legal fear and how it affects care provided following stillbirth also warrant further research.

This study builds on previous studies by bringing the experiences of consultants out of the shadows, revealing unacknowledged burdens associated with stillbirth care for consultant obstetricians and gynaecologists.

Disclosure of interests
The authors declare that they do not have any conflict of interest in regard to this article.

Contribution to authorship
KOD and DN designed the study. SM determined the methodology and supervised the transcription and interpretation of interviews. DN identified the cases, performed and transcribed the interviews, analysed the data and wrote the paper. KOD and SM assisted with data analysis and writing of the paper.

Details of ethics approval
This study received ethical approval from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Ref. No: ECM 4 (pp) 06/03/12).

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We need bereavement training and support for stillbirth providers

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Mini commentary on ‘The impact of stillbirth on consultant obstetrician gynaecologists: a qualitative study’

The reduction in stillbirths since 1935 is a major public health and obstetric success story (Woods R. Bull World Health Org 2008;86:460–6). Yet stillbirth still happens, and the cost to the mother and her family is enormous; however, we should not overlook the fact that the cost to the care providers can also be significant. Using a sound and validated methodology, the authors elegantly demonstrate not just that there is a psychological cost to caring for women with stillbirths, but also the specific qualitative nature of this cost for the care providers.

Regardless of whether or not the care provided is adequate, regardless of whether or not the workup to determine a cause is adequate and regardless of whether or not the psychological support in the hospital is adequate, it has been my belief in recent years that the grief that occurs for the mother after a stillbirth can be reduced by a few simple interventions. First, give the mother time to air her feelings. Second, allow the mother or couple the option of saying goodbye—to hold the infant’s body, to keep a picture of the infant or in some other way create a positive memory. Third, schedule a time of ‘closure’ later where they will hear from a knowledgeable individual or team about the probable cause of death. This meeting may not result in closure, because the cause is not known in many cases, but this can be tempered by emphasising two things: the expectation soon after the birth that, at the time this meeting is scheduled, no true cause may have been determined in many cases; and the knowledge that the team has done its best to determine a cause. This means that there must be a (Perinatal Bereavement) team at each tertiary centre. However, the difficult nature of dealing with stillbirth means that few individuals have the temperament to lead this kind of endeavour at each institution. Thus, often it does not materialise. I must now include a fourth link in the chain—that of dealing with the clinicians’ burden of loss.

Armed with the knowledge provided by the current study, we can begin to educate the care providers so that it does not seem so thankless and overwhelming a task to care for these women. Baltasar Gracian, a Jesuit priest, wrote in 1647, ‘Hope is the great falsifier. Let good judgement keep her in check.’ Hope doesn’t get us very far. Good judgement can. In this circumstance, good judgement is responding to the challenge of the authors: ‘Our results represent both an invitation and a challenge to consultants and to health service managers to acknowledge the clinicians’ burden of loss and to manage parents’ sometimes unrealistic expectations.’

My first inclination was to describe this study as a drop in the bucket that may presage a downpour that fills the bucket. On second thoughts, I hope that this study can be seen for the catalyst that it is, generating additional studies and policy changes that focus on dealing with the psychological cost of stillbirth for both patients and providers.

Disclosure of interests
I have no conflict of interest to disclose.