Original article

Zuzanna Mucha[1], Beata Szlendak[2], Joanna Krzeszowiak[3], Natalia Anuszkiewicz[4], Urszula Tataj-Puzyna[4]

[1]Medical University of Warsaw, Warsaw, Poland
[2]Foundation for Supporting Midwives, Warsaw, Poland
[3]District Hospital Complex in Oleśnica, Oleśnica, Poland
[4]Department of Midwifery, Centre of Postgraduate Medical Education, Warsaw, Poland

Midwives' experience of delivering women with a life-threatening foetal diagnosis

Abstract

Background: Taking care of a woman in the delivery room who is giving birth to a baby affected by a life-limiting foetal condition is a difficult experience for a midwife.

Participants and methods: In a qualitative study, semi-structured interviews were conducted with 10 midwives who are actively working in delivery rooms at four hospitals in various regions of Poland. The interviews were recorded, and then transcribed and analysed using the content analysis method with the MAXQDA tool.

Results: From the experiences of midwives who deliver babies for women after an unfavourable prenatal diagnosis for the baby, two main themes and four sub-themes were identified. Within the first theme, "Impact in the scope of personal experience", identified sub-themes included "Difficult but positive experiences" and "Confronting one's own emotions". Within the second theme, "Impact in the scope of interaction with others", identified sub-themes included "Empathising with the woman" and "Community with other midwives".

Conclusions: Taking care of a woman giving birth to a baby affected by a life-limiting fetal condition is for midwives an experience that is difficult, but ultimately positive and enriching for their personal and professional identity. Midwives need to be prepared through education to effectively deal with the problems which appear in their everyday practice. Psychological support for midwives is insufficient; an opportunity to participate in training courses would enable them to develop their skills related to handling difficult situations, coping with stress, and above all the ability to talk to mothers and fathers of the babies in those situations that are so difficult for the parents.

Palliat Med Pract 2023; 17, 3: 144–151

Keywords: life-limiting foetal condition, midwifery, midwife, stillbirth, perinatal loss

Address for correspondence:
Beata Szlendak
Foundation for Supporting Midwives, Bagno 7/156, 00–112 Warsaw, Poland
e-mail: szlendakb@vp.pl

Palliative Medicine in Practice 2023; 17, 3, 144–151

DOI: 10.5603/PMPI.a2023.0012

Received: 28.02.2023 Accepted: 2.03.2023 Early publication date: 22.03.2023

Introduction

Midwives usually attend births that involve emotions of the women described as positive: happiness and joy, but they can also witness difficult and distressing events when taking care of a woman in labour [1]. In Poland, according to the organisational standard for perinatal care issued via regulation of the Minister of Health, midwives take care of women during normal pregnancies, but also in extraordinary situations, which include: diagnosis of a defect in the baby during pregnancy, giving birth to a stillborn baby, giving birth to a baby incapable of surviving, giving birth to a sick baby or giving birth to a baby with congenital defects [2]. Taking care of a woman who is giving birth to a baby affected by a life-limiting foetal condition (LLFC) is a very difficult experience for a midwife. In the last decade, researchers have devoted much attention to the experiences of women giving birth to a baby affected by a life-limiting foetal condition [3–10]. On the other hand, the perspective of midwives who deliver babies affected by a lethal foetal diagnosis has been addressed only in a small number of publications [11–14]. Researchers point out that empathetic medical care received by parents experiencing the loss of a baby has a long-term impact on their mental health and determines the course of the grieving process [15, 16].

The philosophy of work carried out by midwives, associated with care based on a close relationship with the parturient, focused on "being with the woman", can lead midwives to experience stress in situations of difficulties and problems during delivery. Research indicates that the commitment of midwives to support the parents throughout the entire delivery, in welcoming and saying goodbye to a baby with fatal defects, a baby who dies after birth, may lead to them feeling sadness, frustration and strong emotions related to empathising with the pain and loss experienced by the parents [12, 13]. Emotions related to taking care of a woman who gave birth to a stillborn baby in many situations linger in the minds of midwives for many years [14]. Research also suggests that such events can reduce the efficiency of work carried out by midwives who are trying to manage such stressful situations. Said research indicates that such situations lead to a higher risk of post-traumatic stress disorder, depression, and occupational burnout, and can even trigger the decision to leave the profession [17–20].

The goal of the work whose results are presented in this article was to examine the experiences of midwives who delivered babies affected by a life-limiting foetal condition (LLFC). The research was meant to answer the question "How does witnessing a difficult birth affect midwives and what kind of support should they receive?". The results of this research will contribute to the creation of educational programmes adapted to the needs in the scope of supporting midwives in coping with difficult emotions, which will directly affect the comfort of work of midwives taking care of women who are giving birth to a baby affected by a life-limiting foetal condition.

Participants and methods

Participants

Recruitment of midwives began by sending information about the study via e-mail to several secondary and tertiary referral hospitals in Poland. The response was received from 12 midwives from four hospitals (Warsaw; Łódź; Katowice; Wrocław), who, in their professional practice, have had experience in delivering babies affected by a lethal foetal diagnosis. All participants received detailed information about the goals and course of the study. An informed consent form was obtained from each participant before the commencement of the interview. Two midwives quit the study, stating that the subject matter was too difficult and stressful for them and that they did not wish to discuss it. The sociodemographic data of the participants are presented in Table 1. The youngest midwife was 30, and the oldest was 62. The lowest number of years worked as a midwife was 7, the highest was 38. All midwives completed tertiary education; two midwives had no specialisation.

Methods

A qualitative study makes use of the semi-structured interview method. Content analysis was performed by coding and building themes during iterative team meetings using the MAXQDA tool.

Conducting the interviews and data analysis

The interviews were conducted between July 2022 and January 2023. They were recorded either online using the Zoom platform at the home of the participants at a time most convenient for them or using a voice recorder during face-to-face meetings at a place indicated by the midwives. Recordings were done by the last-named author (a midwife with a PhD and 37 years of professional experience) using an interview guide with open-ended questions prepared in advance. Interviews focused on the subjective experiences of the midwives who delivered babies affected by a life-limiting foetal condition (LLFC). Each conducted interview took between 45 and 90 minutes.

The interviews were anonymised and then compiled using content analysis, without relying on exist-

Table 1. Sociodemographic data of participants of the study

Interview	Age	Personal experience in motherhood	Marital status	Education	Specialisation	Years worked as a midwife	Number of delivered babies with LFD	Hospital — city
1	50	Yes	Married	Bachelor's degree in obstetrics	*(OB/GYN) **(Family)	16	10–15	Warsaw
2	62	Yes	Married	Master's degree in obstetrics	*(OB/GYN)	38	20	Łódź
3	36	No	Married	Master's degree in obstetrics	*(OB/GYN) **(Family)	26	10	Warsaw
4	40	Yes	Married	Master's degree in obstetrics	*(OB/GYN) **(Family)	19	10	Warsaw
5	53	No	Married	Master's degree in obstetrics Master's degree in family studies	*(OB/GYN)	27	10–15	Warsaw
6	54	No	Married	Bachelor's degree in obstetrics	*(OB/GYN)	33	30	Katowice
7	44	Yes	Married	Master's degree in obstetrics	**(Family)	23	10	Warsaw
8	36	Yes	Married	Master's degree in obstetrics	*(OB/GYN)	14	10	Warsaw
9	50	Yes	Married	Bachelor's degree in obstetrics	None	34	20	Wrocław
10	30	No	Married	Master's degree in obstetrics	None	7	5	Warsaw

* — specialisation in the field of obstetrics and gynaecology nursing (OB/GYN);
** — specialisation in the field of family nursing (family)

ing frameworks and theories [21]. Three independent co-authors of the work performed coding using the MAXQDA software (a midwife, PhD; a midwife-psychologist, PhD; a licensed midwife). Several meetings were held to increase the credibility of the study; once consensus was reached, the coding tree was accepted by all co-authors. The work was written by the Standards for Reporting Qualitative Research (SRQR) [22]. The study was approved by the Bioethics Committee of the CMKP no. 7/2021. The study was conducted in accordance with the Declaration of Helsinki.

Results

Analysis of the content of the conducted interviews concerning experiences of midwives related to delivering babies affected by a life-limiting foetal condition lead to the identification of two main themes: (1) "Impact on the scope of personal experience" and (2) "Impact on the scope of interaction with others", as well as four sub-themes: "Difficult but positive experiences", "Confronting one's own emotions", "Empathising with the parturient" and "Community with other midwives" (Figure 1).

Impact on the scope of personal experience

Difficult but positive experiences

When asked about their personal experiences related to attending births after an unfavourable prenatal diagnosis concerning the life of the baby, the midwives emphasised the positive aspect of such events. Even though it was very difficult, nine

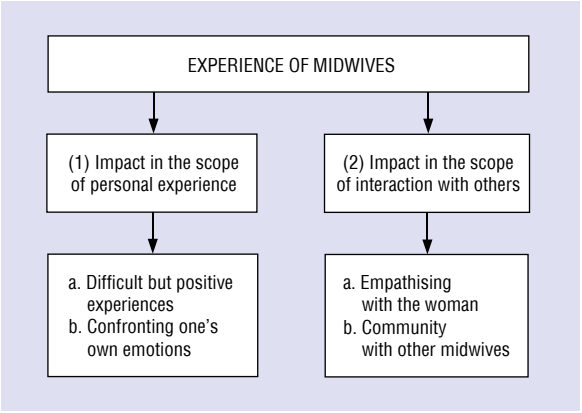

Figure 1. Diagram of the impact of experiences related to taking care of a woman who is giving birth to a child affected by a life-limiting foetal condition on midwives

midwives stressed that taking care of a family which awaited the birth of a baby affected by a life-limiting foetal condition was a positive experience, with no negative connotations:

— "Putting aside the feelings of the woman, putting aside the story of her life, putting aside what it means to her, for me, it is a positive experience" (W4).

— "Some deliveries are certainly traumatic, dramatic. But going a step further, as I now look at these deliveries, it is something positive for me. I can't say that this is a negative experience. Because then I would delete all these positive situations. That is certainly not the case. For me, it is a positive experience, albeit a very, very difficult one" (W8).

Accompanying families in going through difficult emotions related to the birth of a baby affected by a life-limiting foetal condition can also change the way midwives perceive the world. The participants stressed that taking part in such experience gives them mental strength, changes their perspective, and makes it easier to deal with personal difficulties:

— "This is because attending such births somehow gives you a kind of strength to appreciate the human life, to appreciate being healthy, to appreciate the good situations that we experience in life, while the more difficult ones become a kind of a challenge, there is no longer such great fear of going through them" (W6).

Emotions related to taking care of this group of women led to reflection which affected both the personal and professional development of the midwives. Four respondents expressed an opinion that delivering a baby affected by a life-limiting foetal condition was an experience that enriched them in the scope of professional work:

— "[…] I'm happy that I was able to witness these moments and experience them as a midwife. But, on the other hand, these are not easy experiences… I have always said that if you work in this profession, it is probably a good thing if you go through all its chapters. It is enriching. And ultimately I don't regret that I had the opportunity to be with these women during these deliveries" (W10).

Delivering a baby that will most likely not survive is a very difficult experience for the entire delivery ward. Midwives who are in close contact with a woman awaiting the birth of a sick baby may experience various emotions, including concerns about the quality of their medical care. Upon retrospective analysis of their experiences, most midwives concluded that thanks to parents who appreciated their empathetic care, the experience reinforced their sense that they had done something good, despite the pain and suffering felt by the parents:

— "[…] fortunately, this experience probably makes you stronger. But that's only because these people gave me good feedback. And this gave me this sense that I had done something good (…); because I was fortunate to receive good feedback, I feel that I had done good work, that I perform my work well" (W7).

— "[…] this experience definitely makes you stronger, although it does weigh on you, maybe just a little. Because, obviously, this is a difficult experience. But it definitely makes you stronger. These are wonderful people who are affected by this experience during these deliveries. And it is this exceptional nature in these decisions, not only when it comes to the delivery itself, that strengthens my conviction in the value of life so much… in the value of people, in the hierarchy of these values, in the fact that if there are people like these mothers, the world still has hope" (W8).

For one midwife, the experience of working with women who suffered a loss was emotionally taxing. The fact that she had no way to hand this group of women over to other midwives led her to take a temporary break from work:

— "[…] this is very taxing mentally and there was a time in my work when I had to take a break for a year and a half because I was no longer able to work, this was really difficult for me… This shouldn't be organised so that you are the only one who handles 'difficult' deliveries, […] because this will just lead to burnout… I had to take a break, I couldn't take it any more" (W9).

One midwife emphasised the traumatic nature of the experience of taking care of a woman who was giving birth to a baby affected by a life-limiting foetal condition:

— "But for me, this is always a traumatic experience. I don't think it's just me either. After all, if we don't have to attend such a birth, we prefer to deliver a healthy baby, right? This is because it ultimately taxes us emotionally, it lingers in the mind for a while. So I feel that, for me, this is definitely a negative experience" (W3).

Confronting one's own emotions

Accepting the reality related to saying goodbye to a baby in the delivery room in a way forces midwives to confront their own emotions.

— "[…] until the baby was born, it was still possible to hold back these emotions, but once the baby was born, it was impossible to not cry. This was simply stronger. So I always had to have tissues prepared somewhere in my pocket" (W10).

Almost all midwives had difficulties reconciling the ambivalent feelings that they experienced when attending such births. Simultaneously reconciling the difficult emotions which stem from empathetic care, while at the same time dissociating themselves from these emotions, was emotionally a very difficult experience for them:

— "[…] we, as midwives, are in such a very difficult situation mentally. Because on one hand, to perform our work well, that is, to carry out these medical procedures, to not forget about anything (prepare for the procedure, prepare the tools, documentation), […] we really have to distance ourselves from emotions. But on the other hand, to provide proper support for this woman, and to show empathy, we have to confront those feelings of ours. It is a kind of balancing act on the rim of these feelings. And it is very difficult, difficult emotionally" (W9).

The repeated experiences of midwives in accompanying parents in "welcoming" and "saying goodbye to" their babies led to the subject of death appearing in all interviews. Two midwives stated that death is an inevitable consequence of life, that for them it was not a subject that was distant or frightening, but was rather an issue that was "tamed", so to speak.

— "[…] I then have this feeling that I am participating in the fullness of life, meaning also in death, which is a part of that life. On the other hand, well, attending the kind of birth that ends in joy is, ultimately, only a part. While complete fullness comprises both" (W4).

Impact on the scope of interaction with others

Empathising with the woman

The nature of the work carried out by midwives involves empathetic care focused on the needs of the woman. Accompanying women in an event as difficult as giving birth to a baby with fatal defects entails empathising with, and often also sharing in, the emotions of the parents:

— "[…] the emotions of these parents are also transferred onto us in such situations. On one hand, being frustrated with everything, asking why such situations even happen…, makes one want to cry… And on the other hand, these parents need support, they have to be given this sense that we are professionals and that they can look to us for help, that we suggest the path they should take, what they can do, how to act to make this difficult situation at least a little bit easier on themselves" (W6).

When answering the question about emotions which accompany such deliveries, the midwives most frequently mentioned: compassion, empathising with the woman, fear, anxiety, and sense of responsibility. The midwives felt solidarity with the women and did all they could to spare them from the greater suffering which they could potentially cause:

— "For me, the knowledge that it is through my actions (delivering a baby) that they will experience a great tragedy in their lives is very difficult. And it is very important to me to do everything I can so that they don't have to so that they wouldn't think that I have done something, that I have »added« even more worries to this suffering… I'm very afraid that I will do something that will later linger in their memory, that I will simply add to their sadness. For me, this is a great burden, a really great burden" (W7).

Despite an objectively short duration of a delivery, the empathetic care for the woman who is expecting the death of her baby may create a strong bond between the woman and the midwife:

— "[…] such deliveries sit kind of deeper in us, midwives… I, at least, have a sense of »being a mother« to these women during delivery. I want them to feel that they are being cared for. And then, this gets transferred onto me in a way, as I think about this later" (W5).

One element of empathetic care in the delivery room is to identify and satisfy the needs of the parturient woman. All participating midwives wanted to support the woman to meet her needs. They knew that they could not fulfil her greatest need — to give birth to a healthy baby — and so they delivered the baby with even more empathy to meet those needs that could be met given the situation, to protect the woman from even greater suffering, to not »add« to this suffering:

— "If we are unable to fulfil this greatest desire, we have to meet all the other small needs. Or do so-

mething to help her get through it in the best way possible. And then you have to define what this »best way« means for this particular woman" (W4).

— "Every time there are these thoughts to do this well, to not add to their suffering…" (W7).

The empathy-focused model of the work carried out by a midwife caused the experience of delivery to take on the nature of mutual interaction. The midwives expressed admiration and respect for the mothers and fathers who decided to give birth to a baby affected by a life-limiting foetal condition. They were impressed by the incredible love that the mother showed her child, celebrating her short-lived motherhood:

— "[…] these parents were completely, with tears in their eyes, aware that this is the only time of their parenthood when they will have contact with their living baby. And they decided to use this time to say goodbye to this baby" (W4).

— "[…] I admired them for awaiting the day of birth with this awareness. This has always amazed me… As has the calmness and the courage to welcome this baby. After all, the mother and father did not fully know what this baby would look like, and the defects were varied. So I take my hat off to them" (W10).

Community with other midwives

Mutual understanding and sharing similar, difficult experiences led to the formation of deep relationships, a kind of community with other midwives. The respondents pointed out the importance of these relationships:

"I think that I definitely need to be able to talk to someone about this (delivery). It's liberating… I must admit that it's important for that someone to be a woman, even better if it's another midwife, someone who »wears the same shoes«. And I think that we are giving each other this kind of informal support. And this happens completely spontaneously, it's great that we can just tell it to someone" (W4).

All midwives stressed the therapeutic aspect of the relationship with another midwife. Talking to another midwife, being able to "talk it out", to discuss a difficult event, and their emotions were the most frequently mentioned form of coping with difficult emotions. Midwives spontaneously formed support groups within their community. Solidarity with other midwives and mutual support manifested themselves in ordinary kindness, and readiness to listen or to hug.

— "I think that it's simple, listen, huddling in the on-call room. That she understands me, that today you are the one to handle this difficult delivery" (W9).

The main source of knowledge and support for the midwives when they had to deliver a sick or stillborn baby for the first time came from their colleagues sharing their knowledge and experience with them. The midwives also declared that they themselves try to support their less experienced colleagues and share their knowledge and experience with them.

Discussion

The present study indicates that taking care of a woman who is giving birth to a baby affected by a life-limiting foetal condition is an extraordinary experience for midwives. Although participants stressed that it is a very difficult experience emotionally, they also emphasised that it has a positive impact on their personal and professional development. This is confirmed by research carried out by authors which describe the experience of transformation of worldview, professional satisfaction and personal and professional development of medical carers who were taking care of their patients [23]. Current research indicates that taking care of parents during birth in the event of prenatal death is also a very difficult experience which implies considerable stress for all involved [14]. Midwives who accompany women in labour after a lethal foetal diagnosis for the baby may be exhausted by empathising, which is a kind of emotional stress associated with general fatigue and tension. Stress concerns the group of medical carers who, in their everyday work, have contact with emotions related to trauma, disease and death [24, 25]. Symptoms may also include general exhaustion, loss of compassion and empathy as well as reduced vitality and life energy [26].

Caring for this vulnerable group of women is associated with a lot of stress and tension for midwives. Only talking to one another and working together to share responsibilities gave midwives emotional support. Lack of cooperation between midwives, or delegating the care of women giving birth to babies affected by a life-limiting foetal condition to a single midwife, lead to the feeling of overburden. As stressed by one of the participants in our study, being informally designated as an only midwife to care for this group of women, resulted in a high level of stress and a need for a temporary break from work. All participants of this study integrated with other midwives who have had similar experiences related to taking care of women. The sense of community with other midwives who have had similar experiences made it possible to feel "good" in a professional community which understood the difficult emotions related to taking care of a family welcoming and saying goodbye to a baby in the delivery room. Research indicates that a relationship of similarity (relationship modality)

develops best in spontaneously liminal situations, especially between persons of equal status [27, 28]. "Communitas" with other midwives was for all participants of this study the primary form of emotional support. Research confirms that the development of the so-called "social capital", understood as a benefit stemming from being part of a social group, affects the health and well-being of an individual [29].

In modern midwifery, care focused on the needs of parturient women is becoming particularly important. The model of work carried out by a midwife based on the concept of reciprocity, with "giving and taking" present on both sides (midwife–parturient woman), can be emotionally satisfying also for the midwife [30]. Midwives participating in this study stressed the relational nature of care. Empathising with the pain and suffering experienced by a woman due to the loss of her baby was at the same time a testament to humanism and respect for every human being, including a newborn child. The midwives felt enriched by the experience of the mothers celebrating their short-lived motherhood.

All midwives experienced emotions related to saying goodbye to the baby in the delivery room. The subject of death often remains taboo, although in recent years there has been more and more information on how to understand a good death and what are its elements [31, 32]. A definition of a "good death" was proposed by the Institute of Medicine, Committee on Care at the End of Life, which stated that it is the kind of death that is free of fear and suffering for patients and their families as well as for persons taking care of them [33]. According to research, the process of joint anticipation and mutual accompaniment between medical staff and parents in the event of childbirth helps parents accept a good death for their baby [34].

Limitations of the study

One of the limitations of the conducted study is the manner of selection of the studied group. The study involved only those midwives who were willing to share their experiences. It is difficult to determine the experiences of midwives who refused to take part in the study. In addition, the midwives worked in different hospitals, at various referral levels, which means that varying standards of care for this group of parturients may have directly affected the comfort of work for the midwives.

Conclusions

Midwives value the close relationship with the parturient, although it is a difficult experience for them. For this reason, midwives need to be prepared through education to effectively deal with the problems which appear in their everyday practice. Psychological support for midwives who take care of a woman with a lethal foetal diagnosis for her baby is insufficient. Midwives should be given solid knowledge on this issue. An opportunity to participate in training courses would enable them to develop their skills related to handling difficult situations, coping with stress, and above all the ability to talk to women and their partners in such difficult situations.

Article information and declarations

Declaration of conflict of interest

The authors declare that there is no conflict of interest.

Funding

This study is supported by the Department of Midwifery at Center of Postgraduate Medical Education Research Program for year 2022.

References

1. Rice H, Warland J. Bearing witness: midwives experiences of witnessing traumatic birth. Midwifery. 2013; 29(9): 1056–1063, doi: 10.1016/j.midw.2012.12.003, indexed in Pubmed: 23415352.
2. Rozporządzenie Ministra Zdrowia z dnia 16 sierpnia 2018 r. w sprawie standardu organizacyjnego opieki okołoporodowej [Internet] 2018. https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20180001756 (23.06.2020).
3. Wool C, Kain VJ, Mendes J, et al. Quality predictors of parental satisfaction after birth of infants with life-limiting conditions. Acta Paediatr. 2018; 107(2): 276–282, doi: 10.1111/apa.13980, indexed in Pubmed: 28695618.
4. Côté-Arsenault D, Denney-Koelsch E, Elliott G. 'Creating a safe space': how perinatal palliative care coordinators navigate care and support for families. Int J Palliat Nurs. 2021; 27(8): 386–400, doi: 10.12968/ijpn.2021.27.8.386, indexed in Pubmed: 34672781.
5. Wool C. Systematic review of the literature: parental outcomes after diagnosis of fetal anomaly. Adv Neonatal Care. 2011; 11(3): 182–192, doi: 10.1097/ANC.0b013e31821bd92d, indexed in Pubmed: 21730912.
6. Côté-Arsenault D, Denney-Koelsch E. "My baby is a person": parents' experiences with life-threatening fetal diagnosis. J Palliat Med. 2011; 14(12): 1302–1308, doi: 10.1089/jpm.2011.0165, indexed in Pubmed: 22077542.
7. Blakeley C, Smith DM, Johnstone ED, et al. Parental decision-making following a prenatal diagnosis that is lethal, life-limiting, or has long term implications for the future child and family: a meta-synthesis of qualitative literature. BMC Med Ethics. 2019; 20(1): 56, doi: 10.1186/s12910-019-0393-7, indexed in Pubmed: 31395047.
8. Tataj-Puzyna U, Węgrzynowska M, Ryś M, et al. "This pregnancy makes sense": Experiences of women who have decided to continue pregnancy after lethal fetal diagnosis. Death Stud. 2023; 47(2): 149–158, doi: 10.1080/07481187.2022.2038310, indexed in Pubmed: 35201971.

9. Côté-Arsenault D, Denney-Koelsch E. "Have no regrets": Parents' experiences and developmental tasks in pregnancy with a lethal fetal diagnosis. Soc Sci Med. 2016; 154: 100–109, doi: 10.1016/j.socscimed.2016.02.033, indexed in Pubmed: 26954999.
10. Côté-Arsenault D, Denney-Koelsch E. "Love is a choice": couple responses to continuing pregnancy with a lethal fetal diagnosis. Illness, Crisis & Loss. 2017; 26(1): 5–22, doi: 10.1177/1054137317740798.
11. Carolan M, Hodnett E. 'With woman' philosophy: examining the evidence, answering the questions. Nurs Inq. 2007; 14(2): 140–152, doi: 10.1111/j.1440-1800.2007.00360.x, indexed in Pubmed: 17518826.
12. Halperin O, Goldblatt H, Noble A, et al. Stressful childbirth situations: a qualitative study of midwives. J Midwifery Womens Health. 2011; 56(4): 388–394, doi: 10.1111/j.1542-2011.2011.00030.x, indexed in Pubmed: 21733111.
13. McNamara K, Meaney S, O'Connell O, et al. Healthcare professionals' response to intrapartum death: a cross-sectional study. Arch Gynecol Obstet. 2017; 295(4): 845–852, doi: 10.1007/s00404-017-4309-9, indexed in Pubmed: 28210863.
14. Puia DM, Lewis L, Beck CT. Experiences of obstetric nurses who are present for a perinatal loss. J Obstet Gynecol Neonatal Nurs. 2013; 42(3): 321–331, doi: 10.1111/1552-6909.12040, indexed in Pubmed: 23682697.
15. Ellis A, Chebsey C, Storey C, et al. Systematic review to understand and improve care after stillbirth: a review of parents' and healthcare professionals' experiences. BMC Pregnancy Childbirth. 2016; 16: 16, doi: 10.1186/s12884-016-0806-2, indexed in Pubmed: 26810220.
16. Kelley MC, Trinidad SB. Silent loss and the clinical encounter: Parents' and physicians' experiences of stillbirth-a qualitative analysis. BMC Pregnancy Childbirth. 2012; 12: 137, doi: 10.1186/1471-2393-12-137, indexed in Pubmed: 23181615.
17. Gandino G, Bernaudo A, Di Fini G, et al. Healthcare professionals' experiences of perinatal loss: A systematic review. J Health Psychol. 2019; 24(1): 65–78, doi: 10.1177/1359105317705981, indexed in Pubmed: 28810447.
18. Benza S, Liamputtong P. Pregnancy, childbirth and motherhood: a meta-synthesis of the lived experiences of immigrant women. Midwifery. 2014; 30(6): 575–584, doi: 10.1016/j.midw.2014.03.005, indexed in Pubmed: 24690130.
19. McCool W, Guidera M, Stenson M, et al. The pain that binds us: midwives' experiences of loss and adverse outcomes around the world. Health Care Women Int. 2009; 30(11): 1003–1013, doi: 10.1080/07399330903134455, indexed in Pubmed: 19809903.
20. Shorey S, André B, Lopez V. The experiences and needs of healthcare professionals facing perinatal death: A scoping review. Int J Nurs Stud. 2017; 68: 25–39, doi: 10.1016/j.ijnurstu.2016.12.007, indexed in Pubmed: 28063339.
21. McIntosh MJ, Morse JM. Situating and constructing diversity in semi-structured interviews. Glob Qual Nurs Res. 2015; 2: 2333393615597674, doi: 10.1177/2333393615597674, indexed in Pubmed: 28462313.
22. O'Brien BC, Harris IB, Beckman TJ, et al. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014; 89(9): 1245–1251, doi: 10.1097/ACM.0000000000000388, indexed in Pubmed: 24979285.
23. Newell JM, Nelson-Gardell D, MacNeil G. Clinician responses to client traumas: a chronological review of constructs and terminology. Trauma Violence Abuse. 2016; 17(3): 306–313, doi: 10.1177/1524838015584365, indexed in Pubmed: 25951839.
24. Austin W, Goble E, Leier B, et al. Compassion fatigue: the experience of nurses. Ethics and Social Welfare. 2009; 3(2): 195–214, doi: 10.1080/17496530902951988.
25. Meadors P, Lamson A, Swanson M, et al. Secondary traumatization in pediatric healthcare providers: compassion fatigue, burnout, and secondary traumatic stress. Omega (Westport). 2009; 60(2): 103–128, doi: 10.2190/om.60.2.a, indexed in Pubmed: 20222232.
26. Thomas RB, Wilson JP. Issues and controversies in the understanding and diagnosis of compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder. Int J Emerg Ment Health. 2004; 6(2): 81–92, indexed in Pubmed: 15298079.
27. Côté-Arsenault D, Brody D, Dombeck MT. Pregnancy as a rite of passage: liminality, rituals & communitas. J Prenat Perinat Psychol Health. 2009; 24(2): 69–87.
28. Turner MJ, Reynolds CME, McMahon LE, et al. Caesarean section rates in women in the Republic of Ireland who chose to attend their obstetrician privately: a retrospective observational study. BMC Pregnancy Childbirth. 2020; 20(1): 548, doi: 10.1186/s12884-020-03199-x, indexed in Pubmed: 32957947.
29. Gagnon AJ, Sandall J. Individual or group antenatal education for childbirth or parenthood, or both. Cochrane Database Syst Rev. 2007; 2007(3): CD002869, doi: 10.1002/14651858.CD002869.pub2, indexed in Pubmed: 17636711.
30. Hunter B. The importance of reciprocity in relationships between community-based midwives and mothers. Midwifery. 2006; 22(4): 308–322, doi: 10.1016/j.midw.2005.11.002, indexed in Pubmed: 16616398.
31. Kristjanson LJ, McPhee I, Pickstock S, et al. Palliative care nurses' perceptions of good and bad deaths and care expectations: a qualitative analysis. Int J Palliat Nurs. 2001; 7(3): 129–139, doi: 10.12968/ijpn.2001.7.3.8911, indexed in Pubmed: 12192329.
32. DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: a balance of relationship and rigour. Fam Med Community Health. 2019; 7(2): e000057, doi: 10.1136/fmch-2018-000057, indexed in Pubmed: 32148704.
33. Approaching Death: Improving Care at the End of Life [Internet]. Washington, D.C.: National Academies Press; 1997. https://nap.nationalacademies.org/catalog/5801 (21.02.2023).
34. Moore BS, Carter BS, Beaven B, et al. Anticipation, accompaniment, and a good death in perinatal care. Yale J Biol Med. 2019; 92(4): 741–745, indexed in Pubmed: 31866789.