

REVIEWS

Culture of silence: Midwives', obstetricians' and nurses' experiences with perinatal death

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ABSTRACT

Background: Health care personnel's experiences of grief and painful emotional involvements in situations facing perinatal death has attracted woefully little research and attention. In order to provide high standards of care for patients and their families, health care personnel needs to express their emotions in these situations in an adequate way.

Aim: The main aim was to explore how midwives, obstetricians and nurses experience perinatal death and what characterize these experiences.

Methods: This review study was designed through systematic examination methods to detect articles in English and Scandinavian language that describe midwives', obstetricians' and nurses' experiences with perinatal death and factors that characterize these experiences. Only ten articles met these inclusion criteria. A qualitative method was used to describe and comprehend the phenomena.

Results: The following categories emerged from the data: (1) emotional implications, (2) change in culture, (3) education and training, (4) hierarchical issues, (5) support and learning from others. Emotional implications when facing perinatal death were reported in all the ten articles.

Conclusions: This study revealed that withdrawal from the situation and denial were common reactions to perinatal death among health care personnel. These reactions may lead to a lower quality of care for the bereaved parents. Findings in this study indicate that the problem is related to culture and to accept this as a problem and challenge. Emotional reactions among health care personnel to perinatal death must be fully acknowledged and normalized.

Key Words: Perinatal death, Health care personnel, Emotions, Change in culture, Support

1. INTRODUCTION

Losing a child in stillbirth or hours after the birth is an extremely stressful event for the parents. Although grief is not a disease and most people adjust without professional help,^[1,2] bereavement after loss of a child is associated with increased risk of mortality and decrements in both physical and mental

health for the parents.^[3-6] Emotional implications and staff responses in situations when facing perinatal death have been inadequately addressed.^[7] Health care personnel responses have not been acknowledged in these situations leading to ignoring and suppression of reactions and symptoms. These reactions are not healthy and cannot help the health care per-

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sonnel to provide high quality care in these situations.^[1,2,7]

In 1966 Cullberg interviewed physicians and mothers that had experienced perinatal death and he concluded that when this happens it activates psychological defense mechanism both in the physicians and the parents, and how this influences on the physicians' ability to cope with the situation.^[8] The impact on working with death and dying for health care personnel have earlier been found as stressful.^[9,10] Earlier findings suggest that health care personnel exposed to multiple deaths are believed to be vulnerable for developing work-related psychological disorders.^[11] When emotional and psychological involvements have been recognized, such as in oncological and pediatric settings, it appears to allow health care personnel to find helpful ways to express their emotions.^[7,12] The need to develop and deliver empathic interactions for midwives and nurses may stand in conflict with their need to protect themselves emotionally and withdraw themselves from the situation.^[13] Midwives and nurses appear to experience significant and personal adverse effect because of caring for families experiencing loss. Understanding the potential impact of such work may help staff better to prepare and look after themselves, but also to provide higher quality care to the bereaved families.^[13]

Health care personnel's experiences of grief and painful emotional involvement facing perinatal death has attracted woefully little research or attention.^[7,13] Behavior such as "flung apart" and show only "aversion and silence" related to perinatal death were found.^[14] Furthermore, Bourne^[14] found that health care personnel avoided these situations and that problems related to these situations were not spoken about. Emotional responses in health care personnel facing perinatal death are surrounded by "a conspiracy of silence" and "denial within the profession".^[7,15,16] Such reactions to emotional responses are not just disturbing for the health care personnel who is subject to the rejection, but may also be challenging for quality of care when facing perinatal death.^[16] The health care personnel needs to express their emotions in an adequate way when facing perinatal death, in order to provide high standards of care to patients and their families. On this background, we explored the following research question:

- How do midwives, obstetricians and nurses experience perinatal death and what characterize these experiences?

2. METHODS

Literature examination

A literature examination was structured to detect studies that describe midwives', obstetricians' and nurses' experiences with perinatal death and the factors that characterize these

experiences. The inclusion conditions terms for the present study were a description of midwives', obstetricians' and nurses' experience with perinatal death and the factors that characterize these experiences. The examination was limited to English and Scandinavian language literature and comprised of articles published from January 1990 up to January 2016. Electronic examinations included internet-searching databases: PubMed, Medline, Ovid, Google Scholar, and Google and hand search. As reported in Table 1, the different search phrases were: pregnancy loss, perinatal death, doctor's and midwife's experience, stillbirth and staff support. The headings are described in Table 1.

Table 1. Databases and search terms

Databases	Search terms	hits
Google scholar	Pregnancy loss/ doctor's experience/stillbirth/midwives'/ perinatal death	7
Ovid/Medline	Stillbirth/midwives', doctors' experiences/staff support	166
PubMed	Staff support/perinatal death/stillbirth	101
Google	Perinatal death, doctors', midwives' experiences	1
Hand search		1

The examination was directed conferring to references from well-known researchers.^[17] The examination procedure lead to ten articles that encountered our inclusion conditions.

The articles that fulfilled the conditions for inclusion were methodically inspected by the way described in the following. The method used was a review of literature including content analysis,^[18-20] the objective were to contract the meaning into transcript that can be accessible and summarized, and to find the meanings implied in these summarized transcript. This method can add additional complexities to the consistency between how the midwives, obstetricians and nurses experience perinatal death on one hand, and the serious consequences of this on the other hand. Five methodological methods were used: categorization of meaning, condensation of meaning, structuring of meaning, interpretation of meaning and ad hoc methods for generating meaning.^[18,19,21] The articles who fulfilled the conditions were analyzed using the same method. The results have mostly been accessible as short or entire sentences as narratives.^[22]

3. RESULTS

The database examination generated 276 hits. Nearer examination disclosed that 147 of these were copies. We printed out the abstract of the outstanding articles, and in cases of uncertainty, the whole article was read through. Merely 10 of

these articles gave a description of midwives', obstetricians' and nurses' experiences with perinatal death and factors that characterize these experiences. The excluded cases did not encounter the inclusion conditions. Additionally, in some of the cases the excluded ones were theoretic articles missing both methods or/and outcomes.

3.1 A general description of the studies

A general description of the articles is reported in Table 2, including country of origin and year of publication, impact factor, and times cited, method applied in the study, informant group and number of respondents. The articles were not ranked according to any quality indicators, but are displayed according to the publication year. The impact factor is used as a proxy for the relative importance of a journal within its field and is a measure reflecting the average number of citations to recent articles published. The times cited indicate the numbers of times a published paper has been

cited. The impact factor in addition to the times cited may give an indication of the quality of the articles included. One study is presented in two articles, part one and two, and will in the following be treated as one.^[23,24]

Time prints for the 10 articles included were among 1990 and 2016. The articles origin from different countries, four from the USA,^[25-28] two from Nord Ireland,^[23,24,29] one from England,^[30] one from Australia and New Zealand,^[31] one from Spain^[32] and one from Norway.^[33] There were applied both quantitative and quantitative methods in the articles. The informant groups were midwives, doctors, obstetricians, nurses, nurses' assistants and parents. The amount of respondents in the articles ranging from five^[31] to 804.^[27] As shown in Table 2, the impact factor of the journals diverse from 0^[30,31,33] to the highest impact factor of 5,175.^[27] The numbers cited for the articles were from 70 as the highest times cited^[29] to zero.^[31-33]

Table 2. Included articles displayed according to the publication year with information of Impact factor, Times cited, Method, Informant groups and Number of respondents

Ref.	Impact factor of journal	Times cited	Method	Informant group	Number of respondents
Jones K, et al. ^[31]	0	0	Qualitative	Midwives	5
Farrow V, et al. ^[25]	1.367	8	Quantitative	Obstetricians	335
Montero SMP, et al. ^[32]	0.53	0	Qualitative	Nurses, midwives, nursing auxiliaries, obstetricians	19
Wallbank S. ^[30]	0	15	Quantitative experimental	Midwives and doctors	30
McCool W, et al. ^[26]	0.802	11	Qualitative	Midwives	32
Gold K, et al. ^[27]	5.175	45	Quantitative	Obstetricians	804
Nallen K. ^[23-24]	1.99	4	Qualitative	Midwives	18
McCreight B. ^[29]	2.901	70	Qualitative	Nurses	14
Andr�e B. ^[33]	0	0	Qualitative	Midwives	6
Gardner J. ^[28]	0.659	39	Quantitative	Midwives, Nurses and parents	170 (37 nurses and midwives in England 33 nurses and midwives in Japan 100 parents)

3.2 A quality assessment of the included articles

The range in sample size and methods of the included articles were puzzling. However, the articles in this study had also several other differences, including qualitative and quantitative method, different informant group and different number of respondents. A comprehensive quality assessment based on suggestions from an researcher with experience from designing review studies^[17] and assessing the quality of research^[34] were used. The included articles defined a suitable respondent collection, had an explanation of the methods, and a result debate.^[17] Three of the articles^[26,29,32] did not comprise a debate of potential biases, one of the

articles^[33] mentioned possible biases only briefly. One of the article had a brief description of the outcome assessment and a short discussions.^[32] The other included articles presented a suitable quality description^[34] as reported in Table 3.

Our results, reported in Table 4, are frequently obtainable as phrases, or as sentences.^[20] The narratives are reported in Table 4 as they are written in the articles in each of the included articles.^[22] We mined the narratives from the text in articles and the categories emerged from the data.^[20] The results are presented in the following categories: (1) emotional implications, (2) change in culture, (3) education and training, (4) hierarchical issues, (5) support and learning from others.

Table 3. Quality indicators of included studies

Authors	Appropriate subject selection	Description of methods of investigation	Control/ Discussion of biases	Outcome assessment/ Discussions	Summary of quality indicators
Jones K, et al. ^[31]	X	X	X	X	X
Farrow V, et al. ^[25]	X	X	X	X	X
Montero SMP, et al. ^[32]	X	X	O	(X)	((X))
Wallbank S. ^[30]	X	X	X	X	X
McCool W, et al. ^[26]	X	X	O	X	(X)
Gold K, et al. ^[27]	X	X	X	X	X
Nallen K. ^[23-24]	X	X	X	X	X
McCreight B. ^[29]	X	X	O	X	(X)
André B. ^[33]	X	X	(X)	X	(X)
Gardner J. ^[28]	X	(X)	X	X	(X)

^X acceptable presentation; ^(X) weak presentation; ^O no presentation; ^{((X))} very weak presentation

3.3 Emotional implications

Emotional implications were reported in all the ten articles. Only one article described the emotional implications as a positive resource.^[29] In their professional behavior, the nurses in this study were able to postulate their emotions as a resource in facing the bereaved parents. All the other nine articles described mostly negative emotional implications. The most intensive and most frequently reported emotions were stress and shock,^[26-28,30,31,33] but the articles also reported about personal loss and sadness among the health care personnel.^[25,26,31] Guilt and self-blame were reported in several of the articles.^[23-26,31-33] Withdrawal from the situation and depression were also reported emotions.^[25,26,30,32,33] Some reported denial and lack of meaning,^[31-33] anxiety and fear,^[26,32] and the difficulty in handling the bereaved parents emotions and shock while coping with their own feelings.^[23,24,28,33] Only two of the included articles described responses as departure from the profession^[26,27] and fear of legal actions against.^[25] Personal factors, such as bereavement in their own lives, were perceived as incongruent with effective bereavement care for the parents.^[23,24] Emotional difficulty transition from perinatal death and ordinary childbirth were also described.^[23,24,33]

3.4 Change in culture

Change in culture at units where perinatal death occurs and accepting emotional implications as an issue among health care personnel in these situations were reported in all the articles. Health care personnel's need to brace the silence related to emotional reactions to perinatal death and communicate about the emotions to normalize these reactions and to promote acknowledgments of the reactions.^[25,26,29-31] Fostering of a "no blame" culture are important and a management responsibility.^[23,24] The articles also reported that health care personnel felt unprepared in meeting these situations and that little is known about health care person-

nel's reactions and feelings.^[27,28,32,33] One article stated that the health care personnel focused on the physical care, and feared the taboo of emotional reactions when dealing with perinatal death.^[32] Another article reported that health care personnel feared negative consequences in the work culture when mentioned emotional implications related to perinatal death.^[30] The difficulty with transition should be acknowledged so that midwives could concentrate on providing care to bereaved, without being involved with other parents at the same time.^[23,24,33]

3.5 Education and training

Education and training related to perinatal death were an important issue in the articles. Two articles described an experience with implementation of a training program and described the positive benefits of that, which were related to an increased capability to reflect on their emotional implications and use them as a resource facing the bereaved parents and cope with their experiences in a better way.^[29,30] The other articles described a need for bereavement training related to; knowledge, communications, coping, reflection and reducing stigma associated with stress.^[23-28,31-33]

3.6 Hierarchical issues

One article pointed on the hierarchical issues associated to emotional implications for health care personnel related to perinatal death. They reported that the positivistic and scientific tradition in health care services can be an obstacle to acknowledging emotional implications due to the focus on product knowledge and not process knowledge through investigation of the process health care personnel go through in these situations.^[29] Another article had an inconsistency in reporting the findings, on one hand the multidisciplinary approach were highlighted as important and on the other hand the tasks were broken down by profession and not by experience, knowledge and personality.^[32]

Table 4. Findings in the included articles

Ref./ Quality indicator (QI)	Emotional implications	Change in culture	Education and training	Hierarchical issues	Support and learning from others
Jones K, et al. ^[31] QI X	Midwives experience a shock, an intense personal sense of loss, denial and self -blame	It is important that colleagues understand	The midwives must be encourages to acknowledge and accept the emotions and help to manage them effectively		There is a need for support for the midwife
Farrow V, et al. ^[25] QI X	The obstetricians' experiences personally grief, self-doubt, depression, self-blame and fear of legal action	While medical training may reinforce the concept that physicians should be emotionally detached, some obstetricians do form significant bonds with their patients	Important to draw attention to the fact that emotional reactions are quite common and normal-this can reduce stigma associated with distress		Colleagues can be a source of significant support, talking with colleagues as a coping method
Montero SMP, et al. ^[32] QI (X).	Health care personnel revealed unsuitable attitudes of distance and denial, but also anxiety, helplessness, guilt, failure and frustration	Focused on physical care, this is perceived as a taboo, and very little is known about obstetricians reactions to perinatal death	Specific training is needed, with focus on communication skills and relation techniques	It seems like an inconsistency related to focus on multidisciplinary approach and the statement from one of the respondent that special tasks are broken down by profession not by knowledge, experience or personality	Guiding would be good and reflection and encouragement to the caregivers can reduce anxiety and encourage more emphatic care
Wallbank S. ^[30] QI X.	Staff experiencing significant clinical level of stress and staff can be more likely to withdraw emotionally around parents experiences	Staff fear negative consequences when reporting emotional reactions in these settings. Health leadership programme to normalises the concept that staff working with care loads may need more support	Clinical supervision assisted them in improving their own capacity to reflect and cope with their workplace experiences		Staff spent time within the sessions discussing workplace experiences and the impact that these were having on their ability to think and make decisions
McCool W, et al. ^[26] QI (X).	The midwives experienced critical incident stress (CIS), fear, anxiety, guilt, shame, sadness, depression and departure from the profession	Midwives need to break the silence about their experiences with adverse outcomes in childbirth	Midwives are experiencing a range of CIS symptoms and have demonstrated a need for a set of skills to assist them in coping both professionally and personally – there is a need for appropriately tailored composite of coping skills for this subset of health care professionals		Midwives need support following unexpected adverse incidents that occur in practice
Gold K, et al. ^[27] QI X.	Stillbirth takes a significant emotional toll on obstetricians, caring for patients with fetal or infant death can be profoundly stressful. One out of ten considered giving up obstetric practice	Although medical training has increased, students, residents, and others often still report feeling unprepared for bereavement issues in patient care.	Improved bereavement training may help obstetricians care for grieving families but also cope with their own emotions after devastating event		Talking informally with colleagues or friends and family were the most common strategies used by physicians to personally cope with these situations
Nallen K. ^[23-24] QI X.	Midwives expressed how they frequently feel quilt about the death of a baby. Midwife feels time pressures about caring for perinatal death and other parents	The difficulty with transition should be acknowledged, and “no blame culture” should be fostered.	Knowledge about the grieving process in general and specific aimed at perinatal losses are needed		Support and advice from senior staff, practical experience and guidance would be invaluable
McCraith B. ^[29] QI (X).	Exposed to the intense emotions of parents, nurses must simultaneously manage their own emotions. The nurses in the study were able to postulate emotion as a resource, rather than a weakness, or deficit, in professional behaviour	The emotional needs of nurses need to be fully acknowledged through recognition of the importance of managed emotion in the construction of professional knowledge	The nurses interviewed, had received training and nurses with long qualified practice have gained knowledge through their professional reflections on their emotional labour	In the health care services, doctors, practice within a scientific and positivist ideological framework – the disciplinary approach has tended to regard product knowledge as being more value than the process knowledge nurses have	Justification for supporting the recognition of the importance of emotion in the development of nurse education polities and valuing aspects of nursing practice that may have been marginalized
André B. ^[33] QI (X).	The respondents found it difficult to face these situations and experience these situations as stressful, felling of guilt, lack of meaning	Little is known about how midwives and other health care personnel cope with experiences related to perinatal death	The midwives expressed a need for higher competence related to these situations		Talking with other midwives at the unit to adapt the emotions, while other expressed a need for a formal support group
Gardner J. ^[28] QI (X).	Perinatal death is a crisis for midwives and nurses-they have to cope with their own feelings while caring for bereaved parents	There has been little mention of the needs and feelings of perinatal nurses and midwives who care for them	Results emphasized common needs of caregivers for increased knowledge and communication skills		Need for personal support to confidently provide sensitive bereavement care and mentored the experience

X acceptable presentation; (X) weak presentation; (XX) very weak presentation

3.7 Support and learning from others

Support and learning from others was an important category in all the articles. In two of the articles where the researchers had implemented a support program they reported that when the staff spent more time discussing emotions and experi-

ences in sessions, this helped them to think more clearly and make decisions in emotionally difficult situations related to perinatal death.^[30] Justification of support and recognition of the importance of having and using emotions as a resource was important.^[29] Developing this philosophy in education

and practice were also stated as essential to develop the thinking and coping in these situations further.^[29] Other articles focused on the need for both formal and informal support: (1) from colleagues, family and friends, (2) in support groups, (3) in monitoring the experiences, and (4) as both personal and professional.^[23–28,31–33]

4. DISCUSSION

The included articles focused on imperative and typical factors in how midwives, obstetricians and nurses experience perinatal death. The overall characteristics of the included articles exposed a diversity of country of origin, year of publication, method, and sample. Also linked to the journals impact factor and the articles times cited, there were variances. Because of these variances, the debate of the results is rather extensive. The importance of this topic is shown by the fact that only two of the included articles^[29,30] described an intervention in the area, the other articles were descriptive. The lack of research in this area is worrisome due to the serious implications of not coping with emotions in these situations both for the health care personnel and for the bereaved parents.

4.1 How do midwives, obstetricians and nurses experience perinatal death and what characterize their experiences?

As reported in Table 4 health care personnel's coping with perinatal death is stressful and challenging. Several serious emotional implications were reported, while only one article reported that the emotions might be used as a resource.^[29] Earlier studies have shown that when emotional and psychological involvements have been recognized, such as in oncological and pediatrician settings, it appears to allow health care personnel to find helpful ways to express their emotions.^[7,12] The concept of emotional labor has emerged in opposition to the view that expression of emotion is a marginal or even dysfunctional aspect of the process of work.^[29] Nurses may have a longer tradition in focusing also on the process in the relationship with the patients, while physicians strive for a more positivistic and product oriented practice.^[35] Both nurses and physicians face more rationalization of their organizational context, as hospital systems struggles to become more cost-efficient.^[29] This may also contribute to further minimizing the emotional implications of their professional role. Expression of emotions is thought to be significantly embedded in the work of nursing care and as a dimension of nurses' professional orientation this may create a potential tension between structural demands for efficiency and expressions of emotions.^[36] In a study among medical students, it was stated that sometimes it may be desirable that physicians cry in clinical situations.^[37] How-

ever, it seems like there is a difference between nurses and midwives on one hand, and physicians and obstetricians on the other, in acknowledging emotion implications. While in nursing thinking and practice, this seems to be more natural, the physicians must also struggle against a stigma.^[25] Nevertheless, one of the more severe emotional implications reported in two of the articles in this study, departing from the profession, were reported from both midwives and obstetricians.^[26,27] Therefore, even if midwives can be more familiar with emotional implications, they also struggle with thoughts about leaving the profession. Change in the culture of silence related to the emotional challenges in these situations seem to be of vital importance. All the included articles in this study reported findings related to this category (see Table 4). To facilitate culture change in the "caring professions" introduction of educational programs and in professional programs have been suggested.^[38] Earlier findings suggest that hierarchical assumptions have been shown to be particularly irrelevant in this context, that it may be necessary for those who are less comfortable with explicit emotions to learn from those who are more comfortable.^[7] In our review study, we found no differences among the professions in their experiences of the emotional implications related to perinatal death. It seems like implications as stress, depression, guilt, shock, sadness, and sorrow are reported in articles with both midwives, obstetricians and nurses (see Table 4). One of the studies^[32] revealed inconsistencies about hierarchical issues. While multidisciplinary approaches were highlighted, it seems like the tasks were broken down by profession and not by knowledge, experience or personality. Processing and communication to parents were therefore randomly. The consequence of that affected the care quality given to the bereaved parents.^[32] Only three of the included articles^[28,30,32] consisted of more than one profession in their study, and hierarchical problems may therefore not have been highlighted. Fostering of a "no blame" culture was stated as a management responsibility.^[23,24] There is no doubt that cultural issue regarding perinatal death must be faced by management and in the collaboration teams. Findings in this review study show that there may be cultural differences in countries and hospitals regarding perinatal death. All the included studies reported several findings related to cultural issues that need to be solved. Particularly the fear of negative consequences in terms of emotional reactions (see Table 4) are very important issues to face in order to improve the situation of those who work with perinatal death.

4.2 What are the best intervention from the reviewed articles?

- A need to brace the silence related to emotional reactions to perinatal death through communication

about the emotions and to normalize these reactions.^[25, 26, 29–31]

- Management must foster a “no blame” culture.^[23, 24]
- No transition, midwives must concentrate on providing care to bereaved.^[23, 24, 33]
- Implementation of a training program: (1) to reflect on their emotional implications and use them as a resource;^[29, 30] and (2) training related to; knowledge, communications, coping, reflection and reducing stigma associated with stress^[23–28, 31–33]
- Implemented a support program: (1) discussing emotions and experiences in sessions;^[30] and (2) both formal and informal support, -from colleagues, family and friends -in support groups, - in monitoring the experiences and -as both personal and professional.^[23–28, 31–33]
- Use of multidisciplinary teams where the tasks were broken down by experience, knowledge and personality.^[32]
- Developing a philosophy of acceptance and recognition of the importance of having and using emotions as a resource in education and practice.^[29]

5. CONCLUSIONS

This study describes the experiences midwives, obstetricians and nurses have with perinatal death. These findings suggest that perinatal deaths has a serious impact on midwives’, obstetricians’ and nurses’ emotions, and that emotions such as anxiety, stress, shock, guilt and self-blame are common. The

lack of attention and acknowledgments of these reactions among health care personnel seems to be one of the greatest challenges and may lead to suppression of feelings that may have serious consequences, such as unresolved grief or low self-esteem. This study revealed that withdrawal from the situation and denial were common reactions to perinatal death among health care personnel. These reactions may lead to a lower quality of care for the bereaved parents. Departure from the profession was also found in this study to be a result of lack of attention and strain to stand in these situations. Two of the included articles^[29, 30] described a program for education, training and support as a mean for health care personnel to deal with their emotions in a more expedient manner. Therefore, even if there seems to be knowledge about how to deal with this problem, there may be difficulty using this knowledge to improve the situation for health care personnel. Findings in this study indicate that the main problem is related to culture and to accept this as a problem and challenge. Emotional reactions among health care personnel to perinatal death must be fully acknowledged and normalized. Health care personnel working with these issues needs support by both education in communication with bereaved parents and supervision to manage their emotions effectively.

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CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

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