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Research Paper Healthcare

Midwives' Attitudes Towards Fetal/Neonatal Loss. Data From Clinical Centres in Silesia, Poland Midwives Towards Fetal/ Neonatal Death

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ABSTRACT

Although the medical education and professional experience prepare midwives for their day-to-day care of patients, cases of perinatal loss are always a challenge. The objective of the study was to analyze knowledge and experiences of midwives with respect to a fetal/neonatal death. Participants were 100 professionally active midwivesworking in obstetrics-gynaecology wards, pregnancy pathology wards and in childbirth rooms.

They filled the purpose-designed 63-item questionnaire contained mainly closed-ended questions related to the respondents' opinions and experience of having children, foetal/neonatal loss, preparation to provide support to women after foetal/neonatal loss, and expectations regarding training in loss management. We observed, that midwives make a great effort to care the patient after fetal/neonatal loss, bear the somatic and psychological costs of working and need more training and social support for themselves.

KEYWORDS : midwifery, foetal death, neonatal loss, psychological costs.

Introduction

Although the midwifery profession brings many joyful moments, sadly, there are also situations where the pregnancy or labour end in foetal or neonatal death: miscarriage, perinatal death, stillbirth or early neonatal death. The estimates and statistical data calculated on the basis of the number of births, suggest that miscarriages in Poland fall within 10% of all given births (Szymborski, 2012). The incidence of stillbirths in developed countries, including Poland, has been on decline in recent years. According to Polish statistics, the stillbirth rate in 2003-2010 decreased by 0.7 ‰, the infant mortality rate decreased by 1.1 ‰. Perinatal mortality rate (stillbirths and neonatal deaths) at the beginning of this century was close to 10‰, whilst in 2011 was 6.8 ‰ recorded. (The Polish MainStatistical Office, 2011).

Besides the purely medical aspect, the death of a foetus or a neonate also bears a psychosocial impact. The event may evoke extreme emotions, such as fear, horror, anger, or despair (Gausia et al., 2011). Naturally, these feelings are experienced first and foremost by the parents, but midwives rarely remain indifferent. Midwives may also become emotionally involved when witnessing or participating in medical procedures, such as termination of pregnancy, i.e. a medically directed miscarriage prior to independent viability, using pharmacological or surgical means (Mizuno et al., 2013; Puia et al., 2013). In Poland, as in other countries, the conditions for pregnancy termination are regulated by law (The Polish Journal of Laws, 1993). Although the medical education and professional experience prepare midwives for their day-to-day care of patients, cases of perinatal loss are always a challenge. Dealing with death arouses empathy and compassion, and may bring back memories in cases of personal traumas (miscarriage or loss of own child). This may result in a conflict between the midwife's own emotionsand the requirements ofthe professional role. Indeed, the midwife's profession requires emotional labour: the induction or suppression of feelings in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place (Halldorsdottir&Karlsdottir, 2011).

The emotional burden may also result from the organization of work. The principles and requirements of institutions and supervisors may be in conflict with the midwives' skills and values (e.g. the approach to childbirth - more medical or natural). This has an impact on both the emotional relationship with colleagues and the motivation for work (Hunter, 2010). As a result of the suppression of emotions and the state of permanent stress, midwives are vulnerable to a deterioration of their mental and physical well-being, the development of burnout and stress-related disorders (Halperin et al., 2011). However, in many situations midwives experience positive emotions associated with their profession. Job satisfaction is achieved more often in hospitals where the focus is on the woman ("with the woman"), and not on the institution (Hunter, 2004).

In a stressful situation, such as a patient death, the ability to cope is crucial. It is imperative to use strategies and experiences that minimize the psychological expenditure and facilitate a smooth return to a relative stability (Peterson et al., 2010). The selection of a particular strategy depends on individual preferences, the midwife's past experiences and the particular situation. The ability to cope with stress is associated with many factors, such as: temperament and personality traits, life experience, professional knowledge and skills, value system , the sense of influence and control over the situation, the availability of social support and coping skills (Bartram & Gardner, 2008). Objective aspects, such as the organization of the working environment and professional role requirements are also significant.

The acquisition of skills, such as effective communication, conflict resolution, assertiveness, relaxation techniques as well as self-awareness, may help in coping with stress. Effective stress management is a prerequisite for a midwife to remain mentally stable as well as to care effectively for the patient and her family (Knezevic et al., 2011; Folkman, 2011).

The aims of the study were to: demonstrate the perceptions and attitudes of midwives caring for women (during pregnancy, labour

or immediately postpartum) after a foetal/neonatal loss; determine whether midwives offered support to women after foetal/neonatal loss and if so, in what way; determine whether the midwives themselves required support.

Methods

Participants

The study was carried out between February and March 2014. The participants were employees of eight Silesian hospitals of different levels of referral. The participants were professionally active midwives working in obstetrics-gynaecology wards, pregnancy pathology wards and in childbirth rooms. Although 120 questionnaires were distributed, 20 were returned incomplete or were not returned at all. The final study encompassed 100 midwives. The participation in the study was voluntary. Full anonymity and the use of materials for research purposes only were guaranteed. There was an 83.3% return of the completed surveys. The tool was a diagnostic survey, specifically a questionnaire.

Measures

The purpose-designed 63-item questionnaire was developed based on the authors' knowledge and professional experience in the management of women after foetal/neonatal loss. The questionnaire contained mainly closed-ended questions related to the respondents' opinions and experience of having children, foetal/neonatal loss, preparation to provide support to women after foetal/neonatal loss, and expectations regarding training in loss management. Additionally, the participants were asked a number of demographic and work-related questions.

The questionnaire was distributed at the participants' work place and on completion was submitted to the researchers. The questions were answered personally by the respondents by ticking the selected answers or by entering the answers in the designated places.

Statistics

All responses were classified into three groups: Clinical practice, Costs and benefits, Coping skills. The collated data were analysed with the STATISTICA 19.1 statistical package. Descriptive statistics were used as measures of frequency.

The study protocol was approved by the Bioethics Committee of Medical University of Silesia (KNW/0022/KB/6/14) and all participants gave their informed written consent for participation in the study.

Findings

The vast majority of the respondents (95%) were aged between 25 and 55 years. The mean age was 37.5 ± 3.8 years. Most respondents were married (74%), lived in a city (93%), were mothers (77%) and had two children (44%). The participants worked in primary (38%), secondary (30.0%) or tertiary (32%) referral centres. The majority of respondents (69%), had over 15 years of professional experience and only 9% were beginners in the profession.

Clinical practice

All the participants had offered medical support to women after foetal/neonatal loss at least once in their practice. Some (9%) provided this kind of support on a regular basis, the majority (87%) did it willingly.

Working conditions

Most respondents were able to provide a separate room during the labour of a dead child (77%), limit the number of staff (89%), and arrange a separate room in the postpartum period (56%). The reasons for being unable to provide appropriate conditions were: poor hospital housing conditions, lack of single rooms and overcrowded labour wards. Only 24% of the respondents declared that they had sufficient time to ensure high-quality patient care, and as many as 90% of the respondents estimated that the number of midwives working in the ward was insufficient. In a situation of a foetal/neonatal loss, most respondents enable their patient to have contact with the child's father (97%), other family members (80%), a priest (68%), or a psychologist (56%). However, only a minority of the respondents (26%) declared the availability of support groups. The lack of psychological counselling was mainly due to the absence of psychologists in hospital settings. Most of the respondents ensured that patients after a perinatal loss were given analgesics (97%) and sedatives (99%). In most cases, it was the respondents that prepared the patient for self-care (93%), and informed her about the services of the district midwife (77%) but also about the necessary paperwork formalities (88%) and funeral procedures (87%).

Psychological context

The majority of respondents (89%) informed the patient about the possibility to spend some time with her dying baby; they facilitated a farewell contact for the mother (97%) and her family (93%) in a way requested by the patient (90%). The majority of respondents (82%) encouraged the patient to actively express her emotions after the loss, whilst 2% encouraged the patient to do the opposite. The vast majority of respondents (98%) informed the patient about the possibility of the child being baptized, and 71% of the respondents had personally baptized a child at least once. The majority of the respondents (68%) informed the patient about the significance of mementos, and 64% actually collected items such as a lock of hair, or an imprint of the foot or hand). Some respondents (12%) took additional measures to improve the quality of care for patients experiencing foetal/neonatal loss, including the provision of information about support groups, donating angel figurines, or maintaining contact after discharge. Only 7% of the midwives declared an on-going cooperation with support groups.

Costs and benefits

Although the respondents worked in centres of different levels of referral, they were affected by foetal/neonatal loss to a similar extent. Nonetheless, most of the respondents (56.3%) who reported adverse effects of managing patients after a foetal/neonatal loss were employed in primary referral centres.

Emotional and somatic consequences

Almost half of the respondents dealing with patients after foetal/neonatal loss experienced feelings of sadness (44%) and grief (48%). Other emotions were: indifference (3%), anger (2%), compassion, helplessness and powerlessness (3%).

The respondents evaluated contacts with their patients after foetal/neonatal loss as stressful. At the same time they experienced long-term implications, both mental and physical, such as depressed mood (37%), physical ailments (13%), changes in the system of values (7%) or self-esteem (1%).

Some of the respondents (36%) felt that their support given to women after foetal/neonatal loss was depreciated by other midwives, and the information given to the patient (e.g. regarding the possibility of burial of the foetus) was sometimes negated by the participating physician (17%). In some cases (22%), a patient who lost her baby reacted aggressively and vented her feelings on the midwife.

Emotional benefits

Despite the high psychological costs, the majority of respondents were satisfied with the level of support given to patients after foetal/neonatal loss (66%), and believed that patients were satisfied with the support they received (79%). A large percentage of the respondents (78%) received signs of gratitude from their patients after foetal/neonatal loss.

Coping skills

The respondents showed different coping strategies in front of stress related to caring for women after foetal/neonatal loss. The main strategies involved seeking an explanation of the event (41%), focusing on hobbies (24%), seeking support from colleagues (10%) and family (7%), trying to forget it (9%), emotional expression (5%), or releasing emotions in other ways, such as praying (4%).

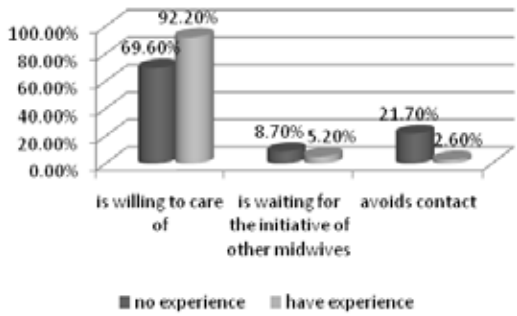
Impact of personal experience

Most respondents evaluated having a child as the purpose of their life (68%), followed by: a sense of relationship (49%), a biological need (14%) and a cultural norm (2%).

The majority of respondents (77%) had experienced the death of a loved one, including the death of their own child (15%). The study participants stated that a midwife who had experienced a loss would be more willing and able to provide patient support. By contrast,

avoidance was the prevailing attitude among midwives with no history of personal loss.

Figure 1. Midwives' own experiences of loss and their impact on patient care



Knowledge of law regulations

The majority of respondents (78%) stated that they were acquainted with the legal procedures regarding child loss. One-third (33%) of the respondents declared knowledge of the stages of grief, but only 66.7% were able to enumerate them correctly. Only 14% of the respondents knew the addresses of child loss counselling centres.

Acquiring new skills

The majority of the respondents (70%) during their apprenticeship had received no training related to the management of a woman after a perinatal loss. At the beginning of their professional career, 79% of the respondents did not possess any knowledge regarding psychological support. More than half of the respondents (55%) gained the necessary knowledge in the later stages of their education: bridge studies (52.7%), master's degree (32.7%) and specialty training (30.9%). The respondents also acquired knowledge on the subject at conferences (77%), from colleagues (72%), or the Internet (41%). The majority of the respondents (76%) still assessed their knowledge in the field of foetal/neonatal loss as inadequate and declared willingness to continue their education.

Looking for social support

More than half of the respondents (56%) themselves felt the need for support as a result of managing patients after foetal/neonatal loss. Of all the respondents expecting support, most (65.8%) were midwives working in tertiary referral centres. The vast majority of the respondents (89%) stated they needed further professional training. Only few of the surveyed midwives (27%) had easy access to professional literature concerning foetal/neonatal loss.

Discussion

The results of the study confirm that providing professional and effective care to patients after foetal/neonatal loss requires great efforts on the part of the midwives. In most cases, midwives offer medical support in the form of drugs (painkillers and sedatives), and facilitate contact with the patients' families. Midwives also provide information regarding the legal procedures and, if necessary, baptize the newborn. However, our study revealed gaps in the provision of adequate psychological care, such as preparing a separate room for childbirth, offering support services by an in-hospital psychologist, or sufficient time for contact with the patient.

Some of the respondents (36%) reported that physicians gave no support to midwives involved in the psychological care for patients after perinatal loss. This may be due to lack of empathy, defence mechanisms, or burnout. Indeed, numerous scientific reports confirm that the burden of the profession, ethical dilemmas, limited control over the situation, etc., all contribute to the development of the burnout syndrome among gynaecologists and obstetricians (Palmer-Morales et al., 2007; Farrow et al., 2011). One of the characteristics of burnout is depersonalization, which may explain the lack of empathy and the excessive distance in relations with patients.

Regardless of the cause, the lack of co-operation between the medical personnel in response to a patient's psychological needs after a loss hinders the correct execution of a crisis intervention: a form of psychological support, aimed at providing emotional support and a sense of security, as well as reducing anxiety. The intervention involves a confrontation with the patient's own emotions and developing coping strategies. A crisis intervention is an essential and effective form of psychological impact on a person who has suffered mental trauma (James. & Gilliland, 2013).

In our study, the midwives declared they collected mementos of the deceased newborns, such as an imprint of the foot or hand, or a lock of hair. As the majority of Poles are Catholic, baptizing a child is of particular importance, especially in situations when the baby's life is in danger. Baptism is important for parents, but also for the midwives. From a psychological point of view, all rituals and actions taken at that moment are particularly meaningful. They facilitate the acceptance of the baby's existence, give it an identity and enable the parents to identify with their role. This, in turn, may ease the grieving process. Many studies have shown that a disturbed or incomplete grieving process has long-term psychological and somatic consequences and makes the return to the so-called normal life very difficult (Worden, 2009;Kersting&Wagner, 2012).

For the majority of our respondents, having children was the primary goal in life. Not surprisingly then, midwives develop a high level of empathy towards patients after foetal/neonatal loss. Displaying feelings of empathy in medical professions is associated with a better quality of relationship with the patients and an improved effectiveness of treatment (Derksen et al., 2013). However, empathy can also trigger a release of negative emotions and painful memories resulting in excessive mental strain which can lead to the development of the so-called secondary traumatization. The condition is an adverse effect of assisting the person after a trauma (Gates&Gillespie,2008; Beck, 2011).

The respondents confirmed that in contacts with patients after foetal/neonatal loss, they mainly felt sorrow and sadness, although they also experienced a lowered mood and some somatic symptoms. This is a consequence of exposure to chronic stress.

The majority of our study participants suffered from work-related stress and showed poor stress management skills. Such skills are essential in minimizing the negative psychophysical consequences and facilitating a safe return to psychological balance (Roehrs et al., 2008; Chan et al., 2010). In our study, the midwives most frequently adopted a rational attitude, taking up a hobby as a method of stress relief. However, these are rather avoidance methods which impede confrontation with the real problem. Numerous studies have shown that a confrontation with a difficult situation and emotional expression are preferred as they help to raise awareness of the problem, release mental and physical stress, and increase the likelihood of gaining social support (Stanton&Low, 2012). The study participants strongly emphasized their need for support, both in emotional and informational aspects.

Many studies have shown that midwives dealingwith foetal/neonatal lossfeel that their knowledge on the subject is limited and they lack emotional support (Chan et al., 2008; Moon&Gordon, 2009). This is in consonance with our results: the majority of the respondents declared insufficient knowledge regarding the psychological care of patients following foetal/neonatal loss. This implies a need for professional in-depth theoretical and practical training and specialized courses.

In conclusion, midwives make great efforts to provide the best possible care for patients after perinatal loss. They bear the somatic and psychological costs of working with women after perinatal loss. More information on the psychological aspects of perinatal loss and more social support should be given to midwives.

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