EXPERIENCES AND PERCEPTIONS OF MIDWIVES AND DOCTORS WHEN CARING FOR MOTHERS WITH PREGNANCY LOSS IN A GAUTENG HOSPITAL

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ABSTRACT

The purpose of this study was to explore and describe the experience of midwives and doctors when caring for mothers with pregnancy loss. To realise this goal, the researcher followed a qualitative, exploratory, descriptive and contextual approach. A purposive sampling method was used to select the doctors and midwives, using set criteria. Data was collected by using focused, semi-structured, individual interviews, taped and transcribed verbatim. Open coding combined with conceptualisation were used to analyse data until saturation occurred. Seven doctors and nine midwives who were interviewed described their experiences and perceptions when working with mothers with pregnancy loss. It became clear that both midwives and doctors lack the know-how to support mothers with pregnancy loss, and that they are overwhelmed by problems like shortage of staff and overcrowding. It is recommended that further research be conducted in other public hospitals, i.e. on a larger scale, to see if the findings are the same. It is also recommended that a counselling programme be developed to help health professionals deal with problems in the ward situation, while they are still able to attend to the mothers. The institution should develop guidelines, policies and procedures to help health professionals to cope when a life can no longer be saved. A multidisciplinary approach and conferences that target causes of perinatal loss are also recommended.

OPSOMMING

Die doel van die studie was om die ondervindinge van vroedvroue en dokters te ondersoek terwyl hulle vir moeders sorg wat 'n miskraam gehad het. Om hierdie doelwit te bereik het die navorser 'n kwalitatiewe, verkennende, beskrywende en kontekstuele ontwerp gebruik. 'n Beskikbaarheidsteekproefmetode is gebruik om dokters en vroedvroue volgens vasgestelde kriteria te selekteer. Data is versamel deur gebruik te maak van gefokusde, semi-gestrukteerde, individuele onderhoude wat opgeneem en later getranskribeer is. Die data is ontleed deur oop kodering en konseptualisering te gebruik totdat versadigingspunt bereik is. Die sewe dokters en nege vroedvroue wat onderhoude toegestaan het, het hulle ondervindinge en persepsies beskryf tydens hulle werk met moeders wat miskrame gehad het. Dit was uit die resultate duidelik dat beide vroedvroue en dokters die kennis en ervaring ontbreek om moeders die nodige emosionele ondersteuning te gee. Probleme soos personeeltekorte en 'n oorvol saal is vir hulle oorweldigend. Daar word aanbeveel dat verdere navorsing op 'n groter skaal in publieke hospitale uitgevoer word, ten einde te bepaal of die bevindinge dieselfde resultate sal oplewer. Daar word ook aanbeveel dat 'n beradingsprogram ontwikkel word om gesondheidsprofessionele te help om probleme in die saal te hanteer terwyl die moeders nog versorg word. Die hospitale moet riglyne, beleide en prosedures ontwikkel sodat gesondheidsprofessionele gevalle kan hanteer waar hulle nie die baba se lewe kan red nie. Multidisiplinêre benaderings en konferensies moet gereël word om die oorsake van perinatale verlies te bespreek.

INTRODUCTION AND BACKGROUND

According to researchers (Kavanaugh & Wheeler, 2002:26; Kavanaugh & Moro, 2006:74), the death of a newborn is tragic and an unexpected outcome of a pregnancy. Instead of experiencing joy at the arrival of a new baby, bereaved parents are faced with unparalleled grief that is often misunderstood by their family or friends. Furthermore, little attention is given to newborn death in popular literature, and the news media focus further reinforces the attitude that death is avoidable (Kavanaugh & Wheeler, 2002:26). Yet, despite drastic reductions in newborn and infant mortality in the past 20 years, infant death is still a reality in neonatal intensive care units. Kavanaugh and Wheeler (2002:26) and Kavanaugh and Moro (2006:74) further articulate that mothers who had complications during pregnancy are unprepared for the infant's death and their own intense grief. Nurses who care for these parents must understand the range and intensity of reactions that are unique to this type of loss.

McCreight (2004:439) supports the contention that death through pregnancy loss is a tragedy which touches nursing staff as well as parents exposed to the intense emotions. The emotional needs of nurses have to be fully acknowledged by recognising the importance of managed emotion in the construction of professional knowledge.

Doctors and midwives, by the nature of their occupation, encounter emotional and stressful work situations. Studies have shown (Devlin, 1998; Foster, 1996) that midwives often suffer grief and fear when dealing with the loss of a baby, and may find themselves unable to cope with their emotional distress. Culsinier, Kuijpers and Hoogduin (1993:163) report that 40% of miscarrying women in their study were predominantly or totally dissatisfied with the care after miscarriage, and that dissatisfaction centred particularly on professional psychological support rather than care in a medical/technical sense. In a survey in Hong Kong involving 288 women who had a miscarriage, more than half of the patients regarded professional psychological support as being necessary, yet half of those patients were dissatisfied with the support they received (Lok & Neugebauer, 2007: 240).

As stated in Woods and Esposito (1987:18), the medical community is not consistent in attitude or skill when caring for patients with a pregnancy loss. Patients expect their physicians to be understanding and compassionate, especially when their worst fear has become a reality and the baby has died. Sadly, these expectations are all too often unfulfilled, leaving the patient angry and confused. Instead, according to Knapp and Peppers, *in* Woods and Esposito (1987:116), death becomes the enemy to be avoided and opposed at all costs. For students cultivating this attitude, death symbolises medical failure. It is not recognised (or accepted) as the end point of a natural physical process. Thus, in this life-oriented environment, the medical student may graduate without conceptualising life and death as part of an acceptable whole.

Laurent (1996:212) suggests that from the identified experiences of mothers with pregnancy loss, midwives and doctors who are caring for these mothers should improve their communication skills by providing information, time, choices and recognition of the loss. Parents need to be listened to in an open, supportive way by someone experienced and receptive, who is not afraid to acknowledge the loss.

According to Gardner (1999:121), perinatal death has been described as a life crisis for both parents and professionals. Communication between nurses and parents may be ineffective because of the reactions of each to the reality of death. Parents may withdraw from nurses as they experience initial feelings of shock. Nurses may hesitate to interact with parents because of feelings of inadequacy, helplessness, frustration, or lack of experience in caring for the bereaved.

PROBLEM STATEMENT

Although considerable research has investigated the needs and feelings of bereaved parents in perinatal settings, and the care practices that are helpful to them, there has been little mention of the needs and feelings of midwives and doctors who care for them. Despite the increased recognition of the distressing effects of miscarriage, training for dealing with women's emotional care is absent and depends largely on the compassion and understanding of individual health professionals (Condon, 1986:987). In addition, no research has been conducted on the needs of health professionals in situations related to caring for the bereaved. No research

has explored the feelings and needs of health professionals when caring for bereaved parents at the time of pregnancy loss or neonatal death. Gardner (1999:120) agrees that pregnancy loss is a very stressful time for all involved. Health care professionals are expected to interact with the bereaved in a supportive manner whether or not they feel adequately prepared or disposed to do so.

From the above problem statement the following questions arose:

- What are the needs and feelings of doctors and midwives in working with bereaved parents?
- What are the challenges that they face in working with bereaved parents?

PURPOSE OF THE RESEARCH

The overall purpose of this research was to investigate the experiences and feelings of midwives and doctors in dealing with mothers who have experienced pregnancy loss while in the maternity unit of a public hospital in Gauteng, South Africa. To achieve the purpose, the objective was to explore and describe how doctors and midwives experienced caring for mothers with pregnancy loss

CONCEPTUALISATION

Concepts used in this study are defined as follows:

Pregnancy loss: This is when a mother loses a foetus during pregnancy through a miscarriage, an ectopic pregnancy, or a stillbirth (Woods & Esposito, 1987:120).
Support: In this study, support is that function that prevents or reduces stress in a mother who experiences the loss of a baby during pregnancy. Supporting her makes her feel accepted and respected. She is reassured that she is cared for and is allowed to communicate freely and share her experiences and feelings. The support should be given initially by health workers, and later in co-operation with the family and other community members, for example the church.
Bereavement: This is the entire process precipitated by loss through death. In this research the bereaved mothers are those who have lost a pregnancy (Warland, 2000:10).
Doctor: He/she is a qualified practitioner of medicine, i.e. a physician (*The South African Pocket Oxford Dictionary,* 1989:220).
Midwife: A midwife is a person who has been regularly admitted to midwifery education by means of the prescribed course of studies in a midwifery educational programme that is recognised in the country in which it is located. In addition, he or she has successfully completed the prescribed course of studies in midwifery (Nolte, 1998:3).
Experience: This involves gaining knowledge by being personally involved in an event, a situation or circumstance (Burns & Grove, 2003:15).

RESEARCH DESIGN AND METHODS

In this research, a qualitative research design was used. This design is exploratory, descriptive and contextual in nature (Mouton, 1996:169; Mouton & Marais, 1990:45). The strategy of this research is contextual in nature (Mouton, 1996: 133; Mouton & Marais, 1990:52). The research aims to provide a description and exploration of different professional experiences within the context of the phenomenon's specific setting and to also examine/compare the phenomenon on a global level. The research focuses on how doctors and midwives experience caring for mothers who suffered loss of their newborn.

DATA COLLECTION

Data was gathered by means of focused, semi-structured individual interviews with doctors and midwives who met the set criteria. These interviews were taped and transcribed verbatim. They were carried out on prearranged dates and times, and held in the labour ward duty room. The interview took about 30-45 minutes, but depended on availability of the participants, that is when the participants were not busy in the ward. During the interview, communication skills were used to obtain the necessary information. Written consent was obtained from doctors and midwives before conducting the interviews.
The following questions were asked in order to assess the needs and feelings of doctors and midwives based on the Gardner tool (1999), which is a topic guide on perinatal death and how health care professionals feel and how they intervene:

- What are the issues that bother you when working with a family who is experiencing a pregnancy loss (i.e. abortion, stillbirth or

neonatal death)?

- What are the considerations that might inhibit you from discussing psychological concerns with bereaved parents?
- What are the ways that you applied to cope with your own feelings about a pregnancy loss?
- What are the needs of doctors and midwives in working with families encountering pregnancy loss?
- What are the interventions that you have found most helpful to bereaved parents?

The researcher contacted each participant to confirm an appointment at a central place and at an appropriate time. Explanations were given about sensitive ethical issues such as confidentiality of data, preserving the anonymity of the informants and using research for its intended purpose (Creswell, 1994:148). The ethical standards as set by the Democratic Organisation of South Africa (DENOSA) were adhered to before and during the interview (DENOSA, 1998:1-7).

The researcher created a context that was conducive to mutual trust between the researcher and the participant (Marshall & Rossman, 1995:67). Privacy was ensured during the interview. The participants were assured that their participation was entirely voluntarily and that they could withdraw from the research at any stage if they wished.

A pilot study was conducted with two midwives and one doctor to refine the questions (Burns & Grove, 2003:38). This was to determine whether the questions would be clear to the participants and whether the interview developed as planned. The question asked was: "Describe your experience in working with a bereaved parent". With this question, the researcher was unable to elicit all the information she was looking for, hence she used focused, semi-structured individual interviews to collect data. She used the topic guide developed by Gardner (1999). The responses of the participants used in the pilot study were added to the main sample.

POPULATION AND SAMPLING

Population

The population consisted of doctors and midwives who, at one time or another, cared for a mother with pregnancy loss who had been admitted to a maternity hospital in Gauteng. This research was confined to this specific academic hospital in Gauteng and is therefore not representative of the whole population.

A purposive sampling method was used to select the doctors and midwives, using a set criterion, which was that doctors and midwives had to have worked in the maternity unit for a period of 2 years and have cared for a mother with pregnancy loss at one time or another. Patton (*in* Denzin & Lincoln, 1994:229) suggests that the logic and power behind purposive sampling should be information-rich, that is, should focus on the inclusion of ample information that is easily accessible. In this research the adequacy of the sampling was attained when sufficient data had been collected so that saturation occurred and variation was both accounted for and understood (Denzin & Lincoln, 1994:230). Saturation means that themes and categories in the data become repetitive and redundant, such that no more new information can be gleaned by further data collection (Polit & Hungler, 1999:43). Nine midwives and seven doctors were sampled, after which saturation was achieved.

Inclusion criteria for participants (midwives and doctors)

- Relevant working experience of at least two years in the maternity unit; and
- Both males and females.

DATA ANALYSIS

Data analysis is a process of bringing order to the data, organising what is collected into concepts, categories and basic descriptive statements (Patton, 1987:144). "The intention of the analysis is to organise the data into a meaningful, individualised interpretation or framework that describes the phenomenon studied" (Burns & Grove, 1993:29). Tape recordings of the interviews were transcribed verbatim in the language in which the interviews were held. Transcripts were analysed by the researcher according to Tesch (unmodified) (*in* Creswell, 1994) and by an independent coder. The coder was requested to also analyse the data according to Tesch's method, independently of the researcher. The two analyses were then compared to ensure trustworthiness. The other evaluator was selected because she has obtained her DCur (Nursing), with a thesis in which a qualitative interview method was also used.

ETHICAL CLEARANCE

Ethical approval was obtained from the University Ethical Committee of the University of Johannesburg (RAU, 1999), and permission to undertake the study was obtained from the superintendent of the hospital concerned, the nursing service manager and the obstetrician (consultant), and written informed consent was obtained from both doctors and midwives.

Trustworthiness refers to the extent to which a research study is worth paying attention to, worth taking note of, and the extent to which others are convinced that the findings are to be trusted (Babbie & Mouton, 2001:276). The criteria established by Babbie and Mouton (2001:276-278), Lincoln and Guba (1985:290-300) and Leininger (1990:113) served as guidelines for the researcher.

To enhance credibility, the researcher applied data triangulation by interviewing key and general informants. The researcher, who is a health professional, has previous knowledge and clinical experience, and the literature that was consulted enabled her to satisfy the criterion of being knowledgeable about the phenomenon under investigation.

The researcher bracketed existing knowledge and preconceived ideas, and especially personal views about the existing problems in the clinical area. The researcher conducted the focused, semi-structured interviews until data saturation occurred, namely until the collected data was repeated and confirmation of previously collected data took place (Struebert & Carpenter, 1999:22-23).

To enhance conformability, the researcher established an audit trail by attaching the coding system to a research report. The researcher's interpretations were scrutinised by research supervisors who acted as independent coders. The categories identified by the researcher were contrasted with those identified by the supervisors. No major discrepancies were identified between these persons' analysis of the data. To enable the reader to judge transferability, the researcher provided a research report giving in-depth discussions of the data obtained, data analysis and interpretation of the research findings. The fact that the researcher complied with the criteria of data triangulation and establishment of an audit trail enhanced the dependability of this study.

RESULTS

Subthemes as indicated in Table 1 will be discussed below as excerpts from statements by both midwives and doctors. This discussion will include recommendations by the midwives and doctors.

UNIT CHARACTERISTICS

Increased workload and staff shortage leading to lack of time

Among other things, staff shortage was revealed through field observations and verbal statements made by midwives and doctors in relation to bustling units that cater for all women with obstetric conditions, including mothers with pregnancy loss. Because of the increased workload and shortage of staff, midwives and doctors are unable to spare time for these mothers.

The following excerpt confirms this: *"For me, I found that at times it's very stressful. We're very short-staffed and there are a lot of women in labour to look after and it is very hard to be working in that kind of situation".*

Gardner (1999:123, 124 & 127) suggests that increased staffing should be provided when pregnancy loss is expected or occurs unexpectedly. This would provide additional time and assistance needed for the support of parents as well as for the support of nurses and midwives. She further states that doctors and midwives lack the time to interact with bereaved families. In her study, participants were bothered by uncertainties in communicating with individual families. There was an inability to surmise what parents were feeling, and there was insufficient time to give needed attention to parents.

Demotivation in doing tasks

Midwives and doctors experience feelings of demotivation owing to the workload, the number of mothers being treated, as well as the challenges of providing care. The following excerpt will strengthen this

Table 1: Experiences of doctors (7) and midwives (9) caring for mothers with pregnancy loss (N = 16)

CENTRAL THEMES AND SUBTHEMES	Respondents (doctors) N	Respondents (midwives) N
1. Relevant issues and factors affecting rendering care		
1.1 Increased workload and staff shortage leading to lack of time	6	9
1.2 Demotivation in doing tasks	5	9
1.3 Social isolation from family and friends	6	8
1.4 Physical effects	6	9
2. Ways to cope with feelings		
2.1 Midwives and doctors experience difficulties in caring for mothers with pregnancy loss		
2.2 Rationalisation	6	8
2.3 Experience guilt feelings	4	9
2.4 Intellectualisation	6	7
2.5 Avoiding the mothers	6	7
2.6 Blaming each other	5	8
3. Intervention		
3.1 In-service training on counselling skills	6	9
3.2 Separate antenatal and postnatal wards	5	7
3.3 Multidisciplinary approach	6	8

discussion: *"I become irritable. Very irritable. When you become irritable and possibly slower, you get clumsy and make more mistakes".* McCreight (2004:445) reports that several nurses in her study stated that they could be required to deal with as many as five miscarriages in one day. It is apparent, therefore, that nursing staff and doctors may benefit from additional support in order to prevent "burnout".

Social isolation from family and friends

Some midwives become socially disconnected owing to the effects of their work environment. This is evident from the interviews: "*Every month is actually very heavy. You have no social life, you have nothing, and it is so frustrating*". No proof was found in the literature to support the social isolation of midwives and doctors.

Physical effects

It also appears that, because of the influences of the stressful environment in the maternity unit, midwives sometimes show physical effects. This is reflected in experiences such as the following:*"I get very tired, I*

get very emotional, and I start crying. Then how can I comfort another person?" Sweet (1995:41) states that the job-related stress in the labour ward is inherited. In a study to determine the stress associated with taking care of mothers in the labour ward settings, the following stress-related symptoms were reported: chronic fatigue, headaches, irritability and physical and emotional exhaustion.

According to McCreight (2004:441), in applying emotional input to the caring process, by tradition, nurses undertake the management of other's emotions as part of their routine work practices. Emotional labour is hard work and can be sorrowful and difficult. This is further confirmed by Kavanaugh and Wheeler (2002:34), who point out that midwives and doctors experience varying degrees of stress in their work. The major source of stress for those who work on a continual basis with the dying can be organisational, work related, interpersonal or intrapersonal.

The Canadian Health Services Research Foundation (2006), mention that teamwork might be an effective way of improving the quality of care as well as reducing staff shortages, stress and burnout among health care professionals. Teamwork can also reduce workloads, increase work satisfaction and retention, improve patient satisfaction and reduce patient morbidity.

Knowledge and skills required to care for mothers with pregnancy loss

Midwives and doctors experience difficulties and an absence of know-how in caring for mothers with pregnancy loss. They use the following defence mechanisms:

Rationalisation

To deal with mothers with pregnancy loss, the midwives rationalise their experiences. This was explained as follows: *"I feel bad. I do feel bad sometimes but at least I have done my job you see! I feel good that I have done my job, so if the baby dies it is because he couldn't be healed".*

According to McCreight (2004:441), the concept of emotional labour has emerged in opposition to the view that expression of emotion is a marginal or even dysfunctional aspect of the process of work. Nurses face increasing rationalisation of their organisational contexts, as the hospital system struggles to become more cost-efficient. This context can often serve to minimise further emotional aspects of their professional role.

In a study by Davies and Fallowfield (1994:284), senior nurses were interviewed about the satisfying areas of their work and aspects of their job that they felt should be changed. Many stated that they would like to see more emphasis placed on talking and listening to patients, thereby providing for adequate information and explanations.

Guilt feelings

Often, on the death of a baby or a neonate, midwives experience guilt feelings. This is evident from the following quotes: "*I feel suffering and I feel guilty. I feel guilty that maybe we could have done something more ... and things like that*". Bender and Swan-Parente (1992:8) suggest that, when a baby is lost, midwives feel their job has not gone according to plan. Because their job is to save lives, the cold hard facts can make them feel terrible and guilty. Sweet (1995:42) adds that, when a baby dies, midwives experience feelings of helplessness and intense sorrow. Brier (1999:153) states that, given the likelihood of guilt feelings and their destructiveness, there is a need to ask directly about feelings of culpability. There is also a need to try to provide protection from self-blame through provision of knowledge and using comments such as "there is no evidence whatsoever that anything you did or didn't do could have prevented the miscarriage".

Intellectualisation

To deal with mothers with pregnancy loss, midwives and doctors intellectualise their experiences: *"I feel sorry for them. I have got mixed feelings. I feel sorry for them and at the same time, I am very calm. It does not affect me. I don't feel angry with them or upset with them".* McCreight (2004:443) mentions emotional management of a particular kind, founded on an empirico-rational concept of care. By contrast, the findings from this study indicate that emotional involvement with parents by nursing staff, although emotionally draining, was more likely to be a positive feature of their work.

This is further supported by Brier (1999:153), who suggests that withdrawing might be more probable if the physician shares the patient's disappointment and feels guilty over the loss. Intellectualising rather than empa-

thising is a likely result of such feelings, with the physician at risk of referring to the foetus as a "blighted ovum" or making comments to the patient such as "things might have turned out differently if only you had come earlier, when you first noticed the bleeding".

Avoiding the mothers

The midwives and doctors interviewed mentioned that, because of their lack of counselling skills, when they work with these mothers, they do not know what to say. They end up ignoring them. The following excerpt confirms this: *"It is not lack of time or due to overcrowding. Sometimes it is just – I do not know what to call it – avoiding it".* Warland (2000:82) argues that health providers must be self-aware. If an individual's coping strategy is that they shield themselves from emotional pain by remaining professionally detached, this could cause significant stress to the parents. Gardner (1999:121) mentions that avoidance of bereaved parents by nurses and other health professionals often leaves the parents with feelings of extreme isolation and lack of acceptance.

Prince and Adams (1994:451) further suggest that some health professionals defend themselves against recurrent experiences of attachment and loss by instituting shifts and routines that militate against forming special relationships. Like the parents, they employ defence mechanisms ranging from detachment, denial and avoidance, to displacement, projection, splitting and manic reparation.

Blaming one another

Midwives blame doctors for not doing enough to give emotional support to mothers with pregnancy loss. They always leave these mothers with the doctors. On the other hand, doctors feel that their workload is more than anyone else's, and that they are responsible for physical care only. According to doctors, it is the midwife's duty to give emotional support.

The following excerpt confirms this: *"Afterwards, the patients will come for a post-natal check up, and I have observed that doctors don't usually give them moral support. Some do, but most of them seem to forget about the emotional aspect".*

McCreight (2004:442) explains that, because of the potentially high degree of emotional expression in the medical relationship, doctors and consultants often employ precautionary or self-protective strategies to limit investment of the self. For example, they do this by systematically limiting their involvement in the emotional aspects of their work. A further division of labour often occurs when "breaking the bad news" of pregnancy loss to parents. Although formally this is the province of the consultant, the view of the nurses interviewed was that it was normally left to the nursing staff to deal sensitively with parents' subsequent emotional distress.

RECOMMENDATIONS BY MIDWIVES AND DOCTORS

Both midwives and doctors came up with suggestions that may help to improve the care of mothers with pregnancy loss. They acknowledged their lack of counselling skills as the main stumbling block to giving the mothers the necessary support.

In-service training on counselling skills

Midwives and doctors suggested that counselling training might help them to care for these mothers in an appropriate way.

The following excerpt confirms this: "*It is so frustrating to take care of a mother with perinatal loss, because I usually don't know what to say. I think midwives and doctors need to be educated on how to counsel these mothers*". This is confirmed by Kavanaugh and Wheeler (2002), who report that nurses generally do not receive adequate preparation for coping with the stress of the workplace and of caring for the dying. Both doctors and midwives should be given adequate education about death and dying, or grief theory. Feelings associated with loss and coping strategies help health professionals to understand the need to develop adaptive coping mechanisms.

In the McCreight study (2004:442), the general view of the nurses was that their training had been focused on disciplinary knowledge, which was not always helpful in enabling them to cope with the emotional demands of their work.

One nurse said: *"The only education was psychology applied to nursing, and that was basically it. My first experience as a student was going to a patient who'd*

just delivered and I nearly disgraced myself and really you're going in and you don't know what to say". Educational programmes on pregnancy loss and support of families should be included in employee orientation programmes. Continuing education programmes centred on death and grief, including staff feelings about loss, should be offered routinely.

Lynch, Davis, Herbert, Richardson, Horey and Flenady (2002:58) emphasise that staff working with bereaved parents need to be provided with an opportunity to develop their knowledge and understanding of pregnancy loss, as well as to develop their skills in this area. Encouraging staff and supporting them is important.

Davies and Fallowfield (1994:336) assert that there is obviously a need to provide our doctors with a great deal more training in communication and counselling if things are to change for the better.

According to the Scottish audit of the management of early pregnancy loss (Scottish Programme for Clinical Effectiveness in Reproductive Health, 2003:22), education and training should be made available for all health care professionals involved in the management of couples experiencing early pregnancy loss. Emphasis should be placed on the emotional and psychological aspects of early pregnancy loss and on sound theoretical knowledge of loss and grief.

Lee and Slade (1996:240) say that, despite the increased recognition of the distressing effects of miscarriage, training for dealing with women's emotional care is absent and depends largely on the compassion and understanding of individual health professionals. Understanding the meaning of miscarriage is facilitated in medical staff primarily by contact with this process in their personal lives, and not through any aspect of their medical training. In the McCreight study (2004:444), most nurses stated that they felt the need for more training in the form of study days. Furthermore, the nursing staff related how most of their knowledge and learning with regard to dealing with miscarriage came from other, more experienced nurses.

Separate antenatal and postnatal wards

Doctors and midwives suggested that it may be better if mothers with pregnancy loss are seen separately rather than being mixed with other patients, because this could give staff the opportunity to concentrate on giving the mothers proper care. However, this should be done only in agreement with the parents.

The following excerpt confirms this: "*Maybe if the mothers with pregnancy loss are seen and placed in different wards, this would help, because you will know that you are faced with only these mothers. If they are mixed with other mothers then, because of the workload, there is no time to concentrate on giving them the right care*".

This is confirmed by the perinatal mortality audit guidelines of Australia and New Zealand (2003), which state that for some parents, it can be very distressing to return to or remain in the maternity ward. The sound of crying babies may add to their distress. It is important that clinicians do not impose their own preferences on parents. Woods and Esposito (1987:170) say that because of their unusual circumstances, the patient or couple should be removed from the mainstream of obstetric care and designated as unique, requiring specialist medical attention.

According to Lynch *et al.* (2002:58), other parents may find it more upsetting if they are moved to the surgical ward, and may interpret this as meaning that they are no longer considered to be parents. It is therefore important to ask parents if they prefer a room in the maternity section or in the surgical ward.

Multidisciplinary approach/teamwork

One of the recommendations of the midwives and doctors was to have interdisciplinary care of these mothers. In other words, obstetricians, midwives, psychologists and social workers should all be involved. Woods and Esposito (1987:228) explain that this group may include the participation of a social worker, nurse, chaplain, psychologist or doctor. A hospital-directed support group usually has these professionals as staff members, and can call on them for advice. Along with professionals, it is helpful to have trained parents to help in facilitating the group, because deaths occur at all levels in the pregnancy care system. There should be carefully prepared policies and procedures for the management of families who have experienced a perinatal death. The multidisciplinary aspect of these procedures should be stressed, and the responsibilities of

the physicians, nurses, social workers and consultants should be delineated clearly to ensure that the family receives the proper care, support and information. Such a programme of support and counselling has two major components:

- specific practical management in the period immediately following the foetal or neonatal death; and
- responsibility for ongoing bereavement follow-up.

Specific practical management in the immediate perinatal period should be directed towards two goals:

- learning as much as possible about the cause of death and implications for future pregnancies; and
- helping the parents create a memory of the dead foetus or stillborn.

The following excerpt confirms this: *"It will actually make the care of this woman appropriate, that is, both physical and emotional care will be given. That is what is lacking in our institution...".*

According to Gardner (1999:127), perinatal nurses and midwives should be included in the physician's discussions with bereaved parents and should participate in decision-making regarding their care. Multidisciplinary conferences targeting causes of perinatal death, effective interventions and continuity of support for bereaved parents should be scheduled regularly. Collaborative strategies should be addressed at the meetings for purposes of improving the quality of care to the bereaved, and providing support to the professionals.

RECOMMENDATIONS

Research

It is recommended that further research be conducted in other public hospitals, i.e. on a larger scale, to see if the findings are the same. Extensive research should be conducted regarding:

- pregnancy loss;
- the grieving process and the social support of families with pregnancy loss; and
- the needs and feelings of midwives and doctors.

This is affirmed by Gardner (1999:121), who says that no research had explored the feelings and needs of nurses and doctors when caring for the bereaved parents at the time of pregnancy loss or neonatal death.

Education

Because it was clear that both midwives and doctors lacked the know-how to support mothers with pregnancy loss, the grieving process and bereavement counselling should be included in their curriculum. By giving midwives and doctors this basic knowledge, and by rehearsing supportive communication techniques, they will be better prepared to support the bereaved.

This is supported by Gardner (1999:127), who states that schools of midwifery and medicine must include culturally sensitive care practices for bereaved parents by giving students this basic knowledge and rehearsing supportive communication techniques to prepare them.

Clinical practice

The following are recommended:

- Institutions should develop guidelines, policies and procedures to help health professionals to cope when a life can no longer be saved.
- There should be a hospital policy that includes providing support for staff members, because they are emotionally affected by working with bereaved families.
- There should be psychosocial rounds to improve networking and support among staff.
- There should be a multidisciplinary approach and conferences that target causes of perinatal loss. Effective interventions and continuity of support for bereaved parents should be scheduled regularly. Collaborative strategies should be addressed at these meetings for purposes of improving the quality of care to the bereaved, and providing support to the professionals. Case reviews could be used to provide both novices and experts with the opportunity to learn.
- Health care professionals skilled in caring for families who experience a loss should serve as mentors for their colleagues to ensure the availability of competent health care professionals.

CONCLUSION

The conclusions from the research are drawn with the following limitations in mind:

- The research findings were contextualised within one public hospital setting where the research field-

work was conducted. The results of the qualitative research are therefore not value-free.

- The researcher did not always gain the co-operation of the staff in the clinical area because they did not keep their appointments, claiming they were busy or forgot.
- When interviewed, the staff did not always find it easy to be frank. Their answers were sometimes short and to the point as if they were trying to hide something.

However, it can be concluded from the research that doctors and midwives are overwhelmed by problems like shortage of staff and overcrowding. However, these were not the main reasons for not giving enough attention to mothers with pregnancy loss. Doctors and midwives acknowledged their lack of knowledge and skills in giving emotional support, and expressed their willingness to undergo training. This need should therefore be addressed. This is supported by Gardner (1999:127), who states that common needs and feelings disclosed by participants were associated with their own grief, lack of experience with bereaved parents, lack of knowledge about the grieving process, bereavement care and lack of appropriate communication skills.

Therefore, it is recommended that further research be undertaken to enhance the bereavement care and counselling skills of health professionals. For this purpose, specialised courses should be designed and incorporated into the training curriculum of doctors, midwives and nurses.

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