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Evaluating a perinatal bereavement care programme in Catalonia (Spain): Healthcare professionals' perceptions of facilitators and persistent barriers

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ABSTRACT

Background: Perinatal bereavement is a traumatic event, and healthcare has an impact on the grieving process and mental health of the woman and their families. The lack of training amongst healthcare professionals is recognised as a barrier to providing high-quality care in cases of perinatal loss.

Objective: To explore healthcare professionals' perceptions of facilitators and barriers following the implementation of a continuing professional development programme and specific guidelines for the care of perinatal bereavement.

Methods: An exploratory qualitative design was used, employing focus groups and semi-structured interviews involving all professional groups within the obstetric team of a medium-sized hospital in Catalonia, Spain. All eligible professionals were invited to participate; 32 met the inclusion criteria and agreed to participate. Data were analyzed thematically. The COREQ guidelines were followed.

Results: Two overarching categories and 10 subcategories were identified. Facilitators included: 1) having established care guidelines, 2) having received training on how to implement them, 3) working as a team, 4) support and leadership from the organisation, and 5) the changes they observe in the support provided to the women they care for. Persisting barriers included: 1) The hospital structure, 2) The emotional toll of caregiving, 3) A lack of social recognition of perinatal loss, 4) Personal resistance to change, and 5) Persistent shortcomings in the training provided.

Conclusions: Multidisciplinary continuing professional development empowers professionals and strengthens teamwork. Institutional support and guidance are essential. Persistent challenges include caring for those who care by recognising the emotional toll on healthcare professionals, improving hospital infrastructure, and emphasising continuous professional development to overcome resistance to change.

Keywords: perinatal loss; qualitative research; perinatal bereavement; health personnel; perinatal death; attitudes of health personnel

INTRODUCTION

The WHO defines a prenatal death (1) as one occurring at 22 completed weeks of gestation and over and up to 28 completed days of life. However, an increasing number of authors and associations (2–5) advocate for defining perinatal loss as that which occurs at any time during pregnancy, childbirth, and up to 28 days of life, without allowing gestational age to determine either the acknowledgement of grief or the care provided

Psychological distress following a pregnancy loss is common among women (6,7), and it is not always duly addressed by healthcare professionals, nor is it widely recognised by the people around the mother (8,9). Caring for those experiencing perinatal grief requires skills that go beyond clinical knowledge, including communication skills, the ability to provide emotional support, and the tools for managing these highly emotionally charged situations. Health professionals on obstetric teams typically do not acquire the skills needed to provide emotional support to women in these situations during their formal training (10–12).

This lack of emotional support is even more pronounced in situations involving early and recurrent losses (13,14). Healthcare professionals' lack of sensitivity to the situation, along with the fact that the women had not had previous children (15,16), are described as the main risk factors for developing symptoms of anxiety, depression, and post-traumatic stress following perinatal loss (17).

To improve care for perinatal grief, specific training programs and clinical practice guidelines have been developed to standardise care, promote best practices, and foster more responsive care for families' needs (10,11,18–24). In Spain, perinatal bereavement care has been revised and improved in recent years, as clinical care guidelines have been developed in accordance with the available scientific evidence in the various autonomous communities (25–28). In Catalonia, one of Spain's autonomous communities, Sant Joan de Déu Hospital in Sant Boi, where this study was conducted, has played a pioneering role in advancing perinatal bereavement care.

However, despite growing interest in improving care for perinatal bereavement through training programmes and clinical guidelines, evidence on their evaluation after implementation in clinical practice remains limited. The available studies focus on the experiences of families or on specific interventions, while those that analyse, in

conjunction, the perceptions of the various professionals involved regarding strengths and challenges are less common (15, 18, 22, 24).

Consequently, the aim of this study is to assess healthcare professionals' perceptions of the facilitators and persistent barriers following the implementation of a continuing professional development programme and specific guidelines for the care of bereaved individuals after perinatal loss in a tertiary hospital.

METHODOLOGY

STUDY DESIGN AND SETTING

An exploratory qualitative study was conducted to identify facilitators and persistent barriers in the care provided by healthcare professionals to women who had experienced pregnancy loss. This approach was considered appropriate for exploring and understanding the perceptions and experiences of healthcare professionals regarding the implementation of a perinatal bereavement care programme in routine clinical practice. Focus groups and semi-structured individual interviews were used to gather information (29).

STUDY SETTING

The study was carried out at the SJD Hospital, a mid-size hospital in Sant Boi, within the Barcelona Metropolitan Area (Catalonia, Spain), which serves a population of over 300,000 people. In 2025, 1,151 births were attended, out of the more than 53,000 births recorded in Catalonia, as well as 322 pregnancy losses, of which 97.5 per cent occurred before 20 weeks' gestation, with the remaining 2.5 per cent occurring between 20 weeks and the onset of labour.

As part of an institutional strategy to improve care for perinatal bereavement, a multidisciplinary training programme and a specific practice guideline for professionals involved in its care were developed and implemented. At the time of the study, the obstetric team consisted of 18 obstetricians, 25 midwives, 16 nurses and 23 nursing assistants. Drawing on the collaboration of the multi-professional team and the women who had experienced perinatal loss and had been treated at the centre, a care guide was drawn up containing a specific care pathway for perinatal bereavement based on international standards (30–32), and designed to address situations of loss at any stage of pregnancy, during childbirth and up to 28 days after birth (see Table 1).

Table 1. *Contents of the perinatal care pathway developed at SJD Hospital, Sant Boi.*

Moments	***Diagnosis***	***Treatment***	***Farewell***	***Administrative management***	***Follow-up***
Content	How to break bad news	Hospital admission Emergency department treatment	Creating memories	Administrative procedures Civil registry	Specialist obstetrics consultation
	Planning your admission Checklist of administrative procedures	Pain management	Welcome and farewell	Post-mortem procedures	Specialist psychology consultation
	Palliative care planning	Respect for cultural diversity	Psychological/ spiritual support	Funeral arrangements	Care during subsequent pregnancies

To facilitate the practical implementation of the proposed care pathway, the centre provided material resources such as a camera, fingerprint cards and keepsake boxes. It was subsequently recognised that members of the obstetric team needed specific training in perinatal bereavement care. The training programme was designed based on the best practices described in the literature (15-24) (see Table 2). Three face-to-face editions of this training course were held in 2018, 2021 and 2023, each lasting 12 hours. Attendance at the courses was voluntary, and the courses took place outside working hours.

Table 2*. Syllabus of the perinatal bereavement support courses run at the study centre*

Course content on perinatal bereavement care	**Teaching method**
Overview of maternal mental health	Theoretical session
Distinctive characteristics of perinatal bereavement	Theoretical session
Breaking bad news	Role Playing
Hospital care following pregnancy loss	Role Playing

Training in memory-making practices	Theoretical session
Legal and administrative procedures	Theoretical session
Healthcare professionals' self-care	Theoretical session

SAMPLING AND DATA COLLECTION STRATEGY

An invitation to take part in the study was sent via the centre's corporate email to midwives, nurses, nursing assistants and obstetricians on the team who spent most of their working day in the maternity ward and who had been on a permanent contract for at least one year. Of the 46 professionals working within the obstetric team, 32 met the inclusion criteria and were invited to participate. All individuals who received the invitation agreed to participate. During data analysis, no substantially new themes emerged from the later interviews and focus groups, indicating that sufficient thematic depth had been achieved.

DATA COLLECTION

A total of three focus groups were held (in two of these the participants were midwives, whilst the third consisted of nurses and nursing assistants); the groups took place in one of the hospital's meeting rooms and were led by the study's third author, a midwife, doctor and sociologist with extensive experience in qualitative research. A non-participating midwife acted as an assistant to the focus group moderator, documenting significant non-verbal expressions. The three focus groups lasted an average of 60 minutes. Given the difficulty of bringing all the obstetricians together at the same time in a focus group, it was decided to interview them individually. Semi-structured interviews were conducted with six obstetricians in a private hospital office by the study's first author, a midwife and pre-doctoral researcher. The interviews lasted 40 minutes on average.

The same interview script (see Figure 1) was used in both the focus groups and the interviews. The guidelines were drawn up based on the scientific literature (33–36). Open-ended questions were used to start the conversation, allowing it to flow naturally. To minimize the influence of researcher's preconceptions on the development of the focus groups and interviews and during the analysis, the three researchers made an exercise of bracketing.

Focus groups and individual interviews were conducted in Catalan and Spanish according to participants' preferences. Audio recordings were transcribed verbatim in their original language prior to analysis.

Figure 1. Interview script

- *Have you undertaken any specific training in perinatal bereavement support?*
- *If so, which one? The training offered by the hospital? Postgraduate training? Undergraduate training?*
- *Do you consider the training provided by the hospital to have been adequate and sufficient? Did you find it helpful?*
- *What impact do you think the training you have received has had on the care you provide for perinatal loss?*
- *What difficulties (physical, structural or other) do you encounter when providing care for perinatal loss?*
- *Do you apply it in the same way whether the woman has already been diagnosed or whether the diagnosis is made during that appointment?*
- *What professional aspects do you consider important for providing high-quality care in cases of perinatal loss?*
- *[1]As a medical team, what role do you think you play in the process? Is that the role you believe you should play?*
- *What has made it difficult for you to put good practices into action when caring for these women?*
- *How do you cope when the wife/partner/companion does not accept or understand the purpose of your care?*
- *When you have doubts about how to care for these women, who or where do you turn to for support?*
- *If a case arises and you don't feel prepared to deal with it, how do you handle the situation?*
- *Are you familiar with the hospital's guidelines on perinatal bereavement support?*
- *Have you read it from cover to cover? Do you know it inside out?*
- *What do you think of the guide? Have you implemented the guidelines for managing cases of pregnancy loss? In cases where you have not been able to apply it, what were the reasons?*
- *Do you apply it in the same way regardless of the gestational age at which the loss occurred?*
- *Does a woman's background or origin influence the way you apply the guidelines?*
- *Is it difficult to follow the guide? What difficulties have you encountered in applying it?*
- *What aspects of a woman and a relationship influence you most when applying the guide?*
- *Do you think there has been a change in the care model since the introduction of the guide and the training courses?*
- *What has had the greatest influence on the change in the care model?*
- *What do you think could be improved in the guide, the training or the overall care process?*
- *Is there anything else you'd like to mention that hasn't been covered?*

Interview script used in focus groups and semi-structured interviews.

[1] This question was asked only during the interviews with medical staff

DATA QUALITY ASSURANCE

The study was designed, conducted, and reported in accordance with the COREQ guidelines (37) (Consolidated Criteria for Reporting Qualitative Research), to ensure transparency and thoroughness in qualitative research. The focus groups and interviews were audio-recorded and transcribed verbatim. The transcripts were emailed to the participants for review. Each participant was assigned a code to ensure confidentiality and anonymity.

DATA ANALYSIS

An inductive thematic analysis was conducted following Braun and Clarke's reflexive thematic analysis framework (38): reading, familiarising oneself with the data, generating codes, constructing themes, reviewing themes, defining and naming themes, and finally drafting the final analysis report. The first and third authors were involved in the initial definition of the categories. The final categorisation of the results obtained was agreed upon by all the authors.

ETHICAL CONSIDERATIONS

This study forms part of the first author's doctoral thesis, which is being supervised by the other two authors. It has been approved by the Research Ethics Committee of the Sant Joan de Deu Research Foundation, (Ref: PIC56-2022) (Spain), and subsequently obtained approval from the Bioethics Commission of the University of Barcelona (Spain). Clinical trial number is not applicable.

Written information about the study was provided to the participants, and they all signed an informed consent form before the interview/focus groups took place. The transcripts were stored on the University of Barcelona's OneDrive, and access was restricted to the study's researchers.

RESULTS

The sociodemographic characteristics and professional categories of the participants are presented in Table 3.

Table 3. Sociodemographic characteristics of participants.

N	*Code*	*Professional role*	*Age M(SD)*	*Women*	*Years of experience (range)*
16	M	Midwives	38 (8,4)	15	1-21
2	N	Nurses	33,5 (5)	2	8-14
8	H	Nursing assistants	46,5 (13,3)	8	1-30
6	D	Obstetricians	48 (8,9)	5	5-32

Analysis of focus groups and interviews data identified facilitators and persistent barriers perceived by healthcare professionals in providing high-quality care for pregnancy loss following the introduction of the care pathway and continuing professional development.

Perceived facilitators in perinatal bereavement care

Following the analysis, five subcategories relating to facilitators were identified (see Table 4).

Table 4. Facilitators identified by the professionals during focus groups and interviews.

Subcategory (symbolic-evaluative name)	*Description / Aspect analysed*
The training empowered us	The training raises awareness and sensitivity regarding the role of healthcare professionals in the face of perinatal loss and equips them with the skills to provide care.
The guide sets out the course to follow. (Shared compass)	The guide provides a common framework to guide practice and offer reassurance.
Care through collaboration: The importance of teamwork.	Teamwork and support among colleagues help us cope with these situations.

Institutional support and proactive leadership	The institution's support legitimises and ensures the continuity of change.
Signs of change	Observable changes in attitudes, communication and practices following the training programme. Gratitude from the service users.

"The training empowered us"

All participants acknowledged that the training had positively impacted the care they provided to those who were grieving and reported improvements in their practice following the ongoing training. In this regard, it is worth highlighting the comment made by this midwife:

> *M1: At first, I didn't want to provide support to a woman who had suffered a loss because I didn't know how to be there for her, and I think the training we were given gave us the confidence, right? To say, "Well, yes, I'm qualified and I can do this, can't I?*

However, obstetricians and midwives who did not attend the continuing professional development session stated that they were aware of their lack of skills in dealing with bereavement situations and found it difficult to provide emotional support to these women, which made them feel insecure in their practice:

> *D6: I would need to learn how to do a number of things that I'm currently lacking.*

The training provided has been greatly appreciated by nurses and nursing assistants, as it has enabled them to gain a better understanding of the grieving process, its different phases and stages, and also to understand the emotional support required by each family, whilst taking into account their specific circumstances and individual needs:

> *N2: Thanks to our training… The fact that we have embedded a respectful approach to supporting that family means we focus very much on their needs.*

The need for personalised care is another factor that the participants identified; the training has helped them to understand that every woman's experience is unique and should be treated as such. In this regard, they say they have learnt how to handle refusals from families and to accept it when a woman does not wish to keep mementoes or perform

rituals. Although such practices are recommended within the established framework, they recognise that they must respect the individual's decision and allow sufficient time for reflection and decision-making; as a team, they are willing to address and facilitate such memories when required.

> *H3: When they tell us they don't want any of the things we've offered them… It comes as a shock at the time, doesn't it? … But I think I've given them the information, and when they realise they need it, they'll know where to turn. So no, we're not closing the door on them*

Some nurses and nursing assistants said that the training had empowered them; they even feel capable of identifying shortcomings in the care process and modifying any interventions they consider incorrect. As this nurse explains, she now feels that she is able to disagree with some decisions made by colleagues who do not recognise the need to offer psychological support upon discharge:

> *N2: They say to you…no, an appointment with a perinatal psychologist, why? If this girl has told me that she is OK?" No, no, no. Whether she's fine or not in your opinion, she still needs to be offered an appointment*;

One aspect highlighted by the participating professionals is how their perspective on first-trimester losses has changed. They have realised that the focus should be on what the pregnancy means to the woman or couple, rather than on the number of weeks of gestation. They are now prioritising women's needs without considering the fact that early miscarriage is a common and frequent occurrence.

> *M3: Before, it used to always be, well — I mean, it's very common and normal in the first trimester, but now I see it in a completely different way. A first-trimester miscarriage is viewed very differently.*

The participants also acknowledge that the training has helped them to respect cultural diversity, regardless of geographical or cultural background, as this nursing assistant mentioned.

> *H1: There are cultural differences, yes, but differences between people. We have learned to be open to the possibility of changing and broadening our perspective as to how we should treat each person individually.*

However, they recognise that there may be linguistic or cultural difficulties in caring for these families, but they have developed the skills to use non-verbal communication as a tool in such cases. We can therefore highlight the comments made by these two midwives:

> M9: *But there's one thing that never fails, and that is body language and facial expressions – can glances also convey meaning? Yes, they can.*
>
> *M1: And silences also communicate, yes.*

"The guide sets out the course to follow"

The existence of a specific care guide with its own protocol was viewed very positively by all participants; as this nursing assistant notes, the document provides guidance on how to proceed:

> *H1: I think the guide makes us aware of the importance of the moment; besides guiding you on what you can do and what you should do, it will make you aware of the importance.*

Some participants compare the current care model with their previous professional practice, when they had few resources; this midwife states that the established system provides them with the support they need to manage the process for the families.

> *M12: When I started my professional placement, all we had was a sheet listing the phrases you could say and those you could not. I remember reading them through before going in, and they were the only thing we had on hand.*

Other participants emphasise that the programme lays the foundations for teamwork, in which each professional forms part of an overarching process. In this regard, we can highlight the comment made by this midwife:

> *M8: Ultimately, it's like a tool that will help all of us, health professionals, to work in the same way.*

They describe the scheme as helping to ensure continuity of care, even when it is not possible for the same carer to continue providing it. As this obstetrician explains:

> *D5: It ensures that everyone acts in the same way and that it is not an individual matter, so that no one in the service can do a bit as they please and that all patients can be treated in the same way.*

All participants view the inclusion of a checklist of tasks in the care guide positively; they find it very useful during their time in hospital, particularly for administrative tasks, which, although necessary, are tedious and complicated, as this midwife explains:

> *M13: Any cases we'd dealt with in the past had been a complete stumbling block for me. Now I find it easier to follow the steps set out in the checklist to fill everything in and get everything done.*

The checklist helps them follow the established procedures and gives them the confidence to make decisions together with the family.

> *D4: Having the checklist document makes it easier to know where to look for guidance. From a logistical point of view, it also helps to have some pre-configured options, especially in this case where there is so much to cover and where so many options are available.*

In cases of advanced loss, which are relatively uncommon, the checklist helps staff remember the procedures involved:

> *M7: Above all, it's really useful when it comes to the paperwork – it's a great way to keep things fresh in my mind, because, for me, all this business of filling in forms tends to slip my mind, so I need to keep refreshing my memory.*

Care through collaboration. The importance of teamwork

The fact that the programme brings together the work of the entire care team and that training is delivered in a multidisciplinary manner has reinforced the importance of working together and strengthened the team:

> *M7: Besides, when one of us can't help, someone else steps in – I mean, listen, I need help, don't I? And we've got each other's backs.*

In this regard, nurses, nursing assistants and midwives emphasised that the support of their colleagues enables them to provide the care each family needs; together, they have learnt to listen more to one another and share the burden of providing emotional support to a grieving woman. They have even learnt that they need to agree among themselves, as a team, on who is best suited to take on the care of that family.

M6: There's always communication within the team to decide who is going to be with that family; in other words, it's not just a case of 'it's your turn and that's that' – we're in it together with our colleague.

The implementation of the circuit makes it easier for teams to clearly define each member's role. In this regard, obstetricians state that they now have a clearer understanding of the roles of other professional groups in providing emotional support to women, which means they feel less burdened by the responsibility for their care.

D2: I feel more comfortable explaining the process to her. In some cases, they have the option of having more continuity with the midwife than with the gynaecologist because of the workload distribution. It has to be a team effort, doesn't it? But each in their own way.

Institutional support and proactive leadership

Professionals acknowledge the institution's commitment to improving care. At the study centre, admissions of this type take place in the maternity unit, in single rooms. The same unit provides care for women with a range of pregnancy-related problems, as well as those who have given birth to a healthy baby and women who have experienced a perinatal loss. The professionals who were interviewed unanimously agree that having a private room in such cases helps to ensure the woman's privacy while she is going through this difficult situation:

D6: The privacy of the room. I think that's almost more important – the fact that they're in a room on their own with their family, going through the grieving process.

In accordance with the centre's recommendations, a vinyl butterfly is placed on the room's door as a symbol of perinatal loss, so the whole team is aware of the situation before entering.

M12: "All the staff ... in the maternity ward – even the cleaner knows – which is why they wear an identification badge; they're all very considerate"

Among the specific materials provided by the institution, it is seen as a positive feature to have a specially designed card on which to present a printout of the ultrasound scan as a keepsake in cases of early miscarriage, and also to be able to create prints of hands and feet or of the placenta where possible. Taking photographs during or after the birth is

also considered appropriate, as is offering the family symbolic items such as fabric letters spelling out their child's name or unofficial death certificates; all these resources have proved to be helpful tools when supporting these couples:

> *M12: It is possible to take photos if they don't want to see the baby at that moment. But they want us or their partner to take the photos so that they can look at them later.*

Furthermore, the provision of specialised equipment such as the CuddleCot®, a cot that maintains a cool, stable temperature, thereby slowing down the physical changes that occur in the body after death, allows families to have as much time as they need to get to know their child and say goodbye. For the professionals who were interviewed, this is yet another tool to help these families cope with their grief, as this nursing assistant explains:

> *H2: The feeling that she wanted to have her baby with her – she had him there in the cot for hours; she didn't always hold him in her arms, but rather he was in the cot – the very fact of having her baby there. And yes, yes, the girl felt somewhat comforted; every now and then she'd pick him up; time wasn't the important thing; she just had him there close by.*

Sometimes, there is uncertainty about how to proceed in certain administrative processes or in unforeseen situations, such as on public holidays or at weekends. In such cases, the training has helped them identify key staff members, such as the supervisor or other team members, whom they can contact for help (if needed) to manage the situation and provide the care the family requires.

> *M15: But today's a bank holiday – does this apply today, or not? Right, but these are very specific cases where we usually end up phoning up and asking, 'Right, what should I do here?'*

Signs of change

The participating midwives see changes in the care they provide, in the expressions of gratitude they receive from women some time later, or even when they care for them during subsequent pregnancies and births. The mothers' accounts have helped them understand the extent to which they influence the acute phase of grief. This is what these two midwives said:

M9: Even amongst those women who are initially in a state of shock and have doubts – who are barely aware of how we work when it comes to grief – afterwards there is always gratitude; everything we do with them has a very, very positive impact.

M7: Even when we see them again during a new pregnancy, the subject comes up once more, and the gratitude of these women is very clear.

The expressions of gratitude, the resources and the training they have received to provide high-quality care have reinforced their commitment to this change. They understand the impact this has on how women go through the grieving process, as these midwives acknowledge:

M9: I think we help make the grieving process much healthier. We support people through it.

M8: We don't look the other way. We stand by them and respect them.

Persistent barriers in the care of perinatal bereavement

Regarding the barriers perceived by professionals following the implementation of the guidance and the continuing professional development they have received, the analysis has identified five subcategories (see Table 5).

Table 5. Barriers identified by professionals in the focus groups and interviews

Subcategory (symbolic-evaluative name)	**Description / Aspect analysed**
The burden of the system	Institutional constraints: a lack of time, resources or suitable spaces for emotional support
The emotional cost of caregiving	Burnout, emotional involvement and feelings of guilt. The need for self-care opportunities.
The invisible loss	The symbolic and social invisibility of perinatal bereavement, which influences professional care.
Individual resistance	Individual difficulties in sustaining change. Lack of coordination or consensus between different roles and departments.

Shortcomings in the training	Areas not covered, or not covered using the correct methodology, in the training provided

The burden of the hospital system: *"Surrounded by living babies…"*

In the hospital under study, the delivery rooms are private, as are the rooms in the maternity ward. Even so, participants point out that hospital facilities are not sufficiently adapted to situations involving miscarriage or stillbirth. They find it difficult to respect a woman's grieving process when there are still communal areas, such as waiting rooms in doctors' surgeries or A&E departments, where families with living babies are present.

Furthermore, as this midwife explains, you can sometimes hear the cry of a newborn baby when a woman is giving birth to a live baby in an adjoining delivery room:

> *M6: And physically, women give birth in the delivery room. I mean, in that space, you're surrounded by living babies, so you often hear babies crying.*

The ward where these women are admitted is a matter of debate. At the centre under study, admission takes place in the maternity ward, and although they are accommodated in single rooms, the cries of other babies can be heard in the corridor, or when answering the intercom to respond to a call from a patient in another room. As this nursing assistant explains, this is a challenge recognised by the team:

> *H5: Sometimes I get really scared when I'm in a room where there's been a stillbirth, and I'm worried about answering the doorbell in case I can hear the cry of (a living baby) in another room.*

Some of the participants in the study acknowledge that it is not possible to provide facilities exclusively for these mothers to separate them from those who have given birth to live babies during their hospital stay, given the small number of advanced perinatal losses requiring hospitalisation. Concerns were also raised about admitting these women to other hospital wards, as this could be perceived as undermining recognition of their motherhood, despite efforts to prevent this. This was expressed by one of the nursing assistants:

> *H1: In other places, they would feel even more excluded. I mean, they're even denying me my chance to be in a maternity ward.*

Professionals almost unanimously emphasise that the structure gives them the opportunity to avoid stigmatising the situation and to frame the event as simply another stage in the journey of motherhood. They believe that not 'hiding' these women raises awareness of perinatal loss. In this regard, we can highlight the comment made by this obstetrician:

> *D1: They cannot be completely cut off from everything that constitutes reality; nor should they be stigmatised. And they should not be ignored. Well, it's an undesirable situation, but one that they've had to live through.*

One difficulty identified by the participants was a lack of time; it was mainly the obstetricians who highlighted that the pressure of clinical work means they do not have enough time when diagnosing a pregnancy loss:

> *D3: They are women who need a consultation slot because it's not just an examination and that's it; they need to talk, and sometimes you don't have that time, but what you want is for them to leave your surgery, because you have a long list of patients.*

The emotional cost of caregiving

The emotional strain placed on healthcare professionals when supporting families experiencing perinatal bereavement was evident in both the focus groups and the individual interviews. Having to care for families with healthy babies and families with stillborn babies in the same department and at the same time places a huge strain on them.

> *D6: The fact that pain and joy can coexist at the same time – because although I can be empathetic, I also protect myself.*

Most professionals emphasise the intensity of the situation and acknowledge the emotional toll of supporting these families through their grief, as this midwife explains:

> *M12: … I kept it to myself, but there came a point when I had to share it. In this case, I shared it with my supervisor and explained how I was feeling, because I was so angry – I just couldn't carry on as normal – and, well, it went really well. I think it's important that we professionals look out for one another and that we have the space to express how we feel at such times.*

On the other hand, this emotional burden is rarely acknowledged, even though it can be very intense during the later stages of pregnancy. This aspect becomes more evident in the interviews with obstetricians, as explained in this case:

> *D3: With all due respect, and without wishing to trivialise a first-trimester miscarriage – because it's a terrible blow… – but for me, the key difference is that a late-term miscarriage is like a nuclear bomb, whereas a first-trimester miscarriage is like a firecracker: sure, it might blow your fingers off, but that's it. But the other is a nuclear bomb that's going to stay with you for the rest of your life. And for me, it's not the same, it's not the same, it's not the same.*

When the loss occurs early on, and particularly amongst obstetricians, they find it more difficult to acknowledge their grief:

> *D4: So I learnt that right from the start… well, I mean, at the end of the day, this sort of thing happens – it happens quite often.*

In cases of late-term loss, the administrative burden is greater, and much of it falls on obstetricians, who identify these tasks as barriers to focusing on the emotional management of the situation, and emphasise the administrative and legal pressures involved in such situations:

> *D3: The colleague who's dealing with that really tough situation… Bureaucratically speaking, a piece of paper will be left, yes, but he's gone to great lengths for that woman. As for that little piece of paper, well, never mind – they can sort it out the next day.*

Both obstetricians and midwives identified a sense of responsibility when faced with a diagnosis of late foetal death in a woman who had previously been treated by the team; there is always the question of whether it could have been prevented, leading to doubts about their professional conduct and even feelings of guilt; they recognise that these feelings act as a barrier, and obstetricians are the most likely to acknowledge that this triggers a self-protection mechanism, sometimes leading them to try to avoid emotional involvement with the families.

> *D2: that personal commitment to self-reflection and self-examination, to constantly reviewing what I have done, what I haven't done, what I could have done, and what I have failed to do. So, the way you experience it is also different.*

Among midwives, especially following late-stage loss or intrapartum death, peer support is seen as invaluable in helping them cope with these difficult circumstances; obstetricians, by contrast, tend to adopt a more individualistic professional approach and rely less on their team colleagues, making it more difficult for them to cope with these situations:

> *D6: I don't share this with my colleagues; I've worked it through myself. Being on my own in difficult situations has led me to develop my own coping mechanisms.*

Faced with this emotional distress arising from late-stage pregnancy losses, obstetricians and some midwives are calling for support from the institution; they say they feel like secondary victims and are showing signs of vulnerability. They are calling for a space in which to share and manage their emotions.

> *M12: And it helps you carry on; I think it's absolutely essential to have a space for professionals.*

> *D3: No, nobody's helped you; that's something you have to deal with yourself. The concept of 'secondary victims' is all very well, but I haven't come across it anywhere I've worked – not a single place. Not one, not at all. I believe that someone who diagnoses something like this or deals with a situation like this is a secondary victim… And they're more alone than anyone else; nobody helps them.*

The invisible loss

Participants have stated that the lack of social recognition of grief following a pregnancy loss is often evident among family members, particularly in cases of early losses. They have discovered that the care model does not always align with the beliefs of the woman's family and social circle; participants state that, at times, family and close friends do not seem to understand the woman's experience, nor do they know how to help her.

> *M12: But the fact is that the family doesn't really know how to tackle these issues.*

With regard to the differences between partners facing this situation, the view emerged that the difference in how the mother and her partner experience pregnancy is due, in part, to the fact that the mother 'feels' the baby, which makes the pregnancy more tangible and real for her. Conversely, for their partner or those around them, particularly in the early

stages, the pregnancy may not be so obvious, leading to a reduced sense of loss. In this regard, it is worth noting how one of the nurses puts it:

> *N2: Perhaps the partner was not denying it, but he did need more time to process all that information. For the partner. Does he exist? He does exist, but they don't notice it, they don't feel it, and it isn't that obvious.*

These differing experiences of grief within a couple present a barrier for professionals, creating an additional challenge, as one of the nursing assistants acknowledges:

> H2: *I find it harder to cope with, personally right? because I have the feeling that I'm not helping them enough.*

Individual resistance

There is a clear reluctance, particularly amongst obstetricians, to recognise the benefits of the proposed interventions in cases of early pregnancy loss; indeed, they even consider that creating memories or carrying out farewell rituals may be counterproductive. In cases of early bereavement, some even go so far as to claim that the professionals themselves may contribute to the development of pathological grief:

> *D3: It's a case of poorly managed grief, where we've turned a first-trimester miscarriage into some sort of epic saga, complete with a keepsake box and all that. I think it's a case of poorly managed grief, because, yes, obviously there's grief – there must be sadness – but the thing is…*

Despite this reluctance to acknowledge early pregnancy loss, most obstetricians recognise a broader social shift in the meaning attached to pregnancy and pregnancy loss, including the growing importance attributed to pregnancy from its earliest stages. As one obstetrician explained, her professional perspective sometimes differs from that of the women she cares for:

> *D6: I've found it hard to understand why we need to pathologise a whole range of things, but anyway, I can see the point. It's taken me a while, but I can see your point … for you, it's something that's absolutely part of your day-to-day life, but it isn't part of the day-to-day life of that woman you are caring for.*

One of the situations identified as a persistent challenge is the discrepancy between professional practices, the individualised nature of care and the potential contradiction

between professional messages and practices; all of which make it difficult to provide high-quality care:

> *D2: It may be that we work differently, and I tell her one thing, but the person below tells her something else. We've seen that – the adage about never saying, 'No, you're far too young,' and the woman doesn't see that we're both heading in the same direction.*

Shortcomings in the training

Participants have identified areas not covered in the training they received, such as the various options that can be offered regarding breastfeeding to women who have suffered a late-term miscarriage. There is still a lack of training and knowledge regarding the processes involved in managing milk let-down. This was mentioned by one of the nurses:

> *N2: Talking about breastfeeding is difficult too. Breastfeeding after a miscarriage is also difficult, because first of all, you must explain to them that, depending on the week, they'll experience milk let-down, and that really affects them. What's more, I don't think there's much awareness amongst professionals about taking that step. It's just another step – even after the guidelines were in place, it was still just a case of how we do the tablets, end of story.*

One aspect highlighted, primarily by obstetricians, is their lack of training in delivering bad news – a major barrier they point out, given that they are responsible for informing the pregnant woman of a foetal death in current clinical practice.

> *D6: Difficulties – the fact that whenever you have to break bad news to a patient, well, nobody – certainly not us, at least not when I was training as a doctor – was ever trained to deliver bad news.*

DISCUSSION

Various authors (39–42) have identified inadequate professional training as a major barrier to high-quality bereavement care. In our study, the professionals acknowledged that the training they had received, together with the existence of the hospital's own support network, are factors that make it easier to care for a bereaved family. A lack of training among midwives (22, 39) can lead to negative emotions and avoidance behaviours when caring for these families. In our study, midwives, nurses, and nursing assistants described this situation prior to the training and reported substantial changes

afterwards. Nursing assistants stated that they now feel confident providing emotional support, whereas previously they had lacked the confidence to do so. However, obstetricians find it difficult to recognise grief in cases of early pregnancy loss, as they regard such losses as common and part of routine clinical care, although they state that their perceptions may not be in line with the feelings of the women they care for.

Other authors describe various formats of continuing professional development (22,24,39,43); in our case, the face-to-face, interprofessional programme was not equally well received by all professional groups, being well received by midwives, nurses and nursing assistants, but attracting lower participation among obstetricians. No studies have been found relating to continuing professional development offered exclusively to obstetricians.

Studies of perinatal bereavement care commonly exclude losses occurring before 20 weeks' gestation (44). The high prevalence of early pregnancy loss may influence healthcare staff's attitude towards women's grief, leading them to fail to acknowledge the women's own experiences, as demonstrated in the studies by Stoodley et al. (45) and Crockett et al. (46). In our case, the training has helped to understand the concept of the grieving process and the individual experience of grief, rather than focusing solely on the number of weeks of gestation.

Our study found that a dedicated care pathway facilitates care. In the review by Lee et al. (47), professionals call for clear guidelines where none exist; our professionals welcome a model to follow in order to ensure consistency in the care provided to families.

At our centre, peer support was identified as an important facilitating factor, particularly amongst midwives. This contrasts with other studies (48–50) which highlight the lack of a peer support structure as a barrier, even where a set of guidelines exists. These studies do not analyse the perspective from the point of view of different professional groups, as is the case here.

Institutional support in the procurement of materials, organisational resources and coordination assistance was viewed positively by the professionals interviewed. In other studies (40,50), healthcare professionals call for this support from the healthcare organisation.

The physical space in which the grieving process takes place has been little studied in the scientific literature. Little research has been carried out into the effect that a suitable space might have on the care provided to bereaved families (51), and the characteristics that such a space should possess have not been clearly defined (52). Respect for the family's privacy throughout the process has been recognised as important by the professionals at our practice, in contrast to the failure to acknowledge this need for privacy, which other authors identify as a significant obstacle to providing high-quality care (2,40,49). Hospital infrastructure can act as a barrier to care (47,51); in our country, maternity wards generally do not have specific areas for admission and individualised care in cases of foetal death; and these women must share certain spaces with other mothers of living babies. The professionals at our study recognised this difficulty, but they also argue that perinatal loss should not be stigmatised by excluding it from maternity wards, given the opportunity that a shared space can offer to reveal another side of motherhood, one that is hidden and rendered invisible by society.

A lack of time when supporting bereaved families is a barrier identified in the literature (10,22,36,53), which is consistent with our obstetricians in our study. In previous studies (40,50), it is midwives who report not having the time to provide high-quality care to women experiencing a pregnancy loss; in our study, it is the obstetricians who most frequently report this lack of time.

The emotional strain involved in providing bereavement support, as acknowledged by our participants, as well as the need for organisational opportunities for self-care – a point particularly emphasised by obstetricians – is consistent with similar studies (40,41,47,49,50).

LIMITATIONS

The study was conducted within a single regional public health system in [blinded for review], which may have introduced cultural bias in participants' expressions, terminology, and health practices. In this regard, the use of qualitative methodology does not allow the results to be generalised to other contexts.

The time elapsed since implementation of the care pathway and training programme varied across participants. One limitation is that the passage of time may influence, to varying degrees, professionals' confidence when dealing with perinatal loss and implementing interventions.

Most participating obstetricians had not attended the specific training programme. The reasons for non-attendance were not explored in depth and may represent an additional limitation.

CONCLUSIONS

Continuing professional development has proved essential insofar as it enables professionals to understand the individual experience of perinatal loss and acquire the skills required to respond to it.

Interdisciplinary continuing professional development enables better integration of obstetric teams by empowering professionals, such as nursing assistants, who are generally excluded from both training and further study.

Having specific care guidelines in place is essential for providing high-quality care, both in cases of early-stage loss and in more advanced cases.

Defining the physical characteristics required for care settings for women and couples experiencing perinatal bereavement is essential to providing high-quality care.

Developing strategies to support healthcare professionals and provide opportunities for self-care should be a priority for healthcare organisations.

Ethics approval and consent to participate: This study forms part of the first author's doctoral thesis, which is being supervised by the other two authors. It has been approved by the Research Ethics Committee of the Sant Joan de Deu Research Foundation, (Ref: PIC56-2022) (Spain), and subsequently obtained approval from the Bioethics Commission of the University of Barcelona (Spain). 'Clinical trial number is not applicable. Written information about the study was provided to the participants, and they all signed an informed consent form before the interviews/focus groups took place.

Consent for publication: All authors have made substantial contributions to the study, approved the final manuscript, and agreed to its submission**.**

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