Managing Ambiguity: Nurses Caring for the Mother of a Stillborn Baby

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MANAGING AMBIGUITY: NURSES CARING FOR THE MOTHER OF A STILLBORN BABY

by

Natasha J. Nurse, RN, MS, CNS

A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York
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This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

MANAGING AMBIGUITY: NURSES CARING FOR THE MOTHER OF A STILLBORN BABY

by

Natasha J. Nurse, RN, MS, CNS

Advisor: Barbara DiCicco-Bloom, Ph.D., RN

Purpose: The aim of this study was to describe and conceptualize the experiences and processes involved when labor and delivery nurses provide care to women experiencing a stillbirth.

Background: The care of a woman experiencing a stillbirth is an important topic that requires attention, however, there is a paucity of literature on the specifics of a nurse’s experience as she or he cares for a grieving mother. These experiences may shed light on gaps in care that may exist as well as gaps in the resources, education and support needed to appropriately prepare nurses for providing care to a mother at such a difficult and vulnerable time. Stillbirth is increasingly referred to in the literature as a traumatic death, unexpected and unplanned, resulting in post-traumatic stress responses. Understanding what the bedside nurse does, thinks, and feels during these moments of traumatic bereavement will contribute to a greater understanding of the nurse’s experience of providing care to a patient.

Method: This study used a grounded theory approach. Data were collected via in-depth interviews with 20 labor and delivery nurses. Each interview session was recorded, transcribed verbatim, and analyzed using the constant comparative method of analysis.
Results: Based on the inductive method of grounded theory and a thorough comparative analysis of the data, the theory Managing Ambiguity emerged as the basic social process of how nurses struggle to care for a mother whose baby was stillborn. This theoretical underpinning summed up the substance of what was occurring when nurses cared from a mother experiencing a stillbirth and was characterized in three different categories by labor and delivery nurses as Experiencing a spectrum of emotions, Managing the ambiguous patient, and Managing institutional ambiguity. These factors contributed to the overall ambiguity the nurse had to manage when providing care for the patient whose baby was stillborn and became the three main categories of the overall theory:

Conclusions: This theory of Managing Ambiguity provided a perspective on the experiences, behaviors, and social processes involved in caring for a woman delivering a stillborn baby. This theory also provided insights into how the interactions between the nurse and herself, the nurse and the patient, and the nurse and her environment impacted the process and the meaning of the event. The importance of this study is the resulting understanding of factors that impede and enhance the process of providing care to a mother whose baby was stillborn. Feelings of uncertainty, ambiguity, and discomfort must be addressed at the nursing education and nursing leadership levels.
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Chapter 1: Introduction

“When are you going to do something about the way the nursing staff acts toward a mother who has lost her baby?” (Yates, 1972, p. 1972), asks a mother quoted in an article published almost a half century ago, regarding the care she received three months prior, when her baby was stillborn (Yates, 1972). Far from uncommon, professional and bereaved parent authors have written thousands of articles and chapters on stillbirth since Yates (1972) first posed the question. Although issues related to death and dying are more openly acknowledged and addressed today, there are still gaps in care for the mother and family of a stillborn. Nurses who are eager to provide best practice care continue to consult research findings for help in answering the very question posed fifty years ago. To address how nurses act towards a mother who is having a stillbirth, we must first understand the experiences of labor and delivery nurses and the processes involved when they provide care to women who are enduring a loss.

Stillbirth is only one type of loss that is encompassed in the overall category of perinatal loss. While a stillbirth refers to the death of a fetus greater than 20 weeks gestation, a perinatal loss refers to all losses that may occur from the time of conception to the death of a newborn less than 28 days old (MacDorman, et. al, 2007). Of the literature that discusses a stillbirth, most view it in association with other types of perinatal losses; however, it is important to distinguish the unique loss of a stillbirth (Bourne & Lewis, 1991). Miscarriage, stillbirth, and neonatal death are unique losses; therefore, providing care to patients having them may involve different processes on the part of the nurse. Since these losses are almost always grouped together, it is difficult to ascertain what relevant nuances in care might be involved in caring for a woman experiencing a stillbirth.
In 2013, there were approximately 24,000 stillbirths in the United States (MacDorman & Gregory, 2015), which is equivalent to over 70 stillbirths a day and accounts for approximately 1 out of every 160 deliveries in the United States (ACOG, 2009). Since stillbirths occur late in pregnancy when the fetus is bigger and more developed, the fetus must be delivered through the same process as a live birth. The delivery, which usually occurs in a hospital setting with the help of a nurse and other skilled healthcare staff, is either vaginal or cesarean (Ladewig, Ball, Bindler, Cowen, & London, 2010). The nurse is the healthcare provider who has the most contact with a mother during this time (Overson, 2006). Thus, the care the nurse provides can greatly influence the mother’s perception of her loss and may crucially impact how she responds to it (Engler & Lasker, 2000; Murphy & Merrell, 2009; Rowa-Dewar, 2002). Therefore, it is important to understand how nurses experience and manage the care of a mother during a stillbirth.

This chapter provides an introduction to this research study that sought to generate a theory that would help to illuminate and explain the experiences and behaviors of labor and delivery nurses caring for women delivering a stillborn baby in a hospital setting.

**Aim of the Study**

The aim of this study was to describe and conceptualize the experiences and processes involved when labor and delivery nurses provide care to women experiencing a stillbirth. This research used a grounded theory approach through in-depth interviews with labor and delivery nurses. The findings from these interviews were analyzed in order to generate an applicable theory.

**Research Question**
The central research question in this study was: How do labor and delivery nurses manage the care of women experiencing a stillbirth?

Definitions

_Labor and delivery unit:_ A specialized department within a hospital facility that provides care for pregnant women before, during, and immediately after childbirth; most care that occurs in this area centers on the labor of a woman and delivery of an infant (Martin & McFerran, 2008).

_Labor and delivery nurse:_ A registered nurse working in the labor and delivery department of a hospital facility who provides direct patient care to women during labor and childbirth including the monitoring of the baby and mother, coaching mothers and assisting doctors (Johnson & Johnson, n.d.).

_S stillbirth:_ “The unintended intrauterine death of a fetus that occurs after the clinical estimate of the twentieth week of gestation” (New York State Department of Health (NYSDOH), n.d., para 6)

_Perinatal loss:_ “The unintended ending of a pregnancy at any time before or during birth, or death of a newborn in the first month after birth” (Limbo & Kobler, 2010, pg. 317).

Background

The care of a woman experiencing a stillbirth is an important topic that requires attention. Caring can be defined as “the mental, emotional, and physical effort involved in looking after, responding to, and supporting others” (Baines, Evans, & Neysmith, 1991, pg. 11). Caring is a defining characteristic of nursing and is central to the nurse’s role (Henderson, 2001). In order to understand the complexities involved in the care of a woman during a stillbirth, it is important to
first acknowledge that stillbirth is a death, understand the challenges that death presents in a hospital setting, and examine how these challenges have changed over time.

Since the first half of the 20th century, the culture of curative medicine has dominated Western societies (McGrath & Kearsley, 2011). This has caused a rapid shift in the thoughts and attitudes of individuals as well as health care providers who care for the sick and dying, making it more difficult to come to terms with the death of their patients (O’Gorman, 1998). Despite the high mortality in specialties such as oncology, intensive care units (ICU’s), and emergency departments, nurses still find it difficult to cope with dying patients, particularly when the death is unexpected and when they are required to work closely with bereaved family members (Dunn, Otten, & Stephens, 2005; Mak, Chiang, & Chui, 2013; King & Thomas, 2013; Peters, et al., 2013a). In the field of obstetrics, this is particularly true, as death is unexpected, and in the case of stillbirth, death is often sudden and unanticipated (Cacciatore, 2013; Foster, 1996). In these cases, working with bereaved family members is a certainty.

Despite this, there have been significant advances in the psychosocial management and care of women during stillbirth (Gold, Dalton, & Schwenk, 2007; Hughes, Turton, Hopper, & Evans, 2002; Ligeikis-Clayton, 1999; O’Leary & Warland, 2013). Some of these include: allowing mothers to see and hold their deceased infants, providing information about the baby’s death, supporting and validating of the mother’s grief; and encouraging parents to participate in burial practices (Caico, 2007; Defey, 1995; Gold, Dalton, & Schwenk, 2007; Hughes, et al., 2002; Ligeikis-Clayton, 1999; O’Leary & Warland, 2013). Despite advances in the emotional and psychosocial management of mothers experiencing this event, attention to the nurse and the experience of providing care during this time of crisis has been neglected (Wallbank & Robertson, 2008).
Sylvia Bruce (1962), a nurse who conducted one of the earliest studies on stillbirth and nursing care, described a breakdown in the nurse-patient relationship and found that nurses experienced both guilt and grief over the stillbirth. She then postulated that nurses found it hard to meet the needs of bereaved mothers because of the difficulties they faced in managing their own feelings (Bruce, 1962). By exploring how nurses meet the challenge of providing care to women during a stillbirth, we can begin to understand the meaning that the experience holds for them and how they respond to women at this time.

Justification for the Study

The process of providing care for women who are having a stillbirth delivery is an important topic and needs to be addressed. Stillbirth is a significant life-altering event that may have intense and enduring adverse psychological and emotional sequelae for mothers as well as care providers (Bruce, 1962; Cacciatore, 2013; Ligeikis-Clayton, 2000). Although much attention has been given to the experiences of mothers and families experiencing a stillbirth, this has not been reciprocated in terms of nursing. The few studies that have explored the nurse’s perspective have done so from the broader category of perinatal loss, encompassing miscarriage and neonatal death as well. However, the experience of stillbirth is unique, and the process of providing care to these women may be different from those involved in caring for a mother experiencing a miscarriage or neonatal death. Without exploring this process, potential nuances may remain unknown.

While research addressing the care provided to women experiencing stillbirth is very limited (Bruce, 1962; Ligeikis-Clayton, 2000), literature related to perinatal loss has suggested that although providing this type of intimate and meaningful care may be a potential source of satisfaction (Bolton, 2000) for the caregiver, it is most often described as a source of physical and
emotional distress (Limbo & Kobler, 2013; Papadatou, 2009; Puia, Lewis, & Beck, 2013; Wallabnk & Robertson, 2008). As early as the 5th century B.C., Hippocrates identified that the process of providing care for the sick may also impose suffering on the healer (Jones, 1923). The implications of emotional distress, poor staff retention, and lower job satisfaction and productivity among labor and delivery nurses have been associated with caring for families experiencing a perinatal loss (Wallbank & Robertson, 2008).

While researchers and parent advocates note that more can be done for families experiencing a perinatal loss (Cacciatore, 2013; Lang, Edwards, & Benzies, 2005; Limbo, Toce, & Peck, 2009 - 2016), support and attention to the nurses and healthcare workers who are often impacted by this care has been largely overlooked (Roehrs, Masterson, Alles, Witt, & Rutt, 2008; Bateman, Dixon, & Trozzi, 2012; Overson, 2006; Puia, Lewis, & Beck, 2013; Roehrs, Masterson & Gardner, 1999). As the healthcare professionals having the most contact with families affected by a perinatal loss, nurses have the potential to “diminish the negative impact of bereavement and promote the health and well-being of families after their baby has died” (Lang, Edwards, & Benzies, 2005, pg. 158). Increased support for the nurse can positively impact the care provided to the patient (Roehrs, et al., 2008). Therefore, in addition to the quality of care provided, the interaction between the mother and nurse has the potential to impact how the mother copes with the loss (Heazell, et al., 2013; Trulsson & Rådestad, 2004).

The knowledge, skills, and caring attributes that the nurse brings to the perinatal loss experience are critical and yet, poorly understood. There has been little research that explores the feelings, attitudes, and experiences of perinatal nurses toward perinatal bereavement care as a result of stillbirth (Bruce, 1962; Ligeikis-Clayton, 2000). As such, a substantive theory that can provide an understanding of this care will make a valuable contribution to the literature.
Method

The goals of the study were to examine the human behaviors related to care of women experiencing a stillbirth. It also sought to provide a perspective on the experiences, behaviors, and social processes involved when caring for women delivering a stillborn baby. Grounded theory was selected as an ideal methodology for this research because the goals of grounded theory are to provide a perspective on behavior (Glaser & Strauss, 1967) and to develop a theory that explains it within a given context (Sussman, 2012).

The focus of the research in grounded theory is on social processes (Corbin & Strauss, 2008). The theoretical underpinnings of grounded theory are deeply rooted in pragmatism and symbolic interactionism (Corbin & Strauss, 2008). Pragmatism is concerned with action and reaction, language, ethics, and practice (Jeon, 2004). Pragmatists maintain that human beings are constantly adapting to the changing world (Jeon, 2004). Symbolic interactionism is concerned with the meaning of an event and the knowledge that is created through action and interaction; more specifically, it is concerned with an individual’s behavior and how it has been shaped through social interaction in a particular context (Aldiabat, Khaldoun, & Le Navenec, 2011). Another premise involved in symbolic interactionism is the notion that a problematic situation prevents a person from acting automatically or out of habit. Such a situation requires reflective thinking (Mead, 1938) and reflective inquiry (Dewey, 1938) of how to resolve an uncertain situation. When a stillbirth occurs, it is often sudden and unexpected (Cacciatore, 2013; Foster, 1996). Therefore, a labor and delivery nurse cannot act out of habit and must consciously decide how to provide appropriate care. It is this process that the tenets and theoretical underpinnings of grounded theory are designed to uncover which makes it an ideal methodological approach for this study.
Data for the study were collected via in-depth interviews with labor and delivery nurses. Each interview session was recorded, transcribed verbatim, and analyzed using the constant comparative method of analysis. Grounded theory employs a method of comparative analysis, which is a strategic method used for generating theory (Glaser & Strauss, 1967). This method requires that the analysis of data be an iterative process whereby data analysis begins as soon as the first piece of data is available (Corbin & Strauss, 1990).

Participants in this study were obtained through the method of purposive sampling. Purposive sampling is a method of selecting a sample “based on the researcher’s experience or knowledge of the group to be sampled” (Lunenburg & Irby, 2008, pg. 175). Participants were recruited from a large urban medical center in Brooklyn, New York. Although stillbirths account for approximately 1 out of every 160 deliveries in the United States (ACOG, 2009), they are not a common occurrence in a single labor and delivery unit. Thus, a site was chosen that had the highest likelihood of yielding multiple nurses with a variety of experiences caring for mothers whose babies were stillborn. Brooklyn, NY has the highest occurrence of stillbirths in New York State (New York State Department of Health, 2013). The Medical Center chosen for this study had the highest number of newborn deliveries in New York State at the time of this study, which meant a greater chance that labor and delivery nurses in this hospital would experience caring for a woman as she delivered a stillborn baby.

During the data analysis process, the researcher explored the concepts that emerged during the interviews. Data collection and analysis occurred continuously using the constant comparison analysis method as described by Glaser and Strauss (1967). All concepts emerging from the data were analyzed to form categories, themes, and ultimately an overarching theory applicable to the research topic.
Implications for Nursing

The study may help to uncover the processes employed by labor and delivery nurses when providing care to women experiencing a stillbirth and how the interactions between the nurse and the mother give meaning to the event. The study produced a theory that provided an understanding of the behavior and actions of the labor and delivery nurse caring for a woman during stillbirth delivery. This provides an opportunity to address barriers to care and enhance bridges to care for the benefit of both the patient and the nurse.

Assumptions & Biases

The investigator has interacted with families who have experienced a miscarriage, stillbirth, or neonatal death while working as a Perinatal Bereavement Support group facilitator for over five years. The overwhelming majority of families who attended these sessions experienced a stillbirth delivery. During these sessions, many of these families discussed the distress they endured because of their loss, but also shared their dissatisfaction with the care they received while in the hospital. Some noted a lack of communication, feelings of neglect and insensitivity, and the poor way their baby was presented to them, if offered at all. These touching and sometimes disturbing stories often made me feel intense sadness and sympathy for the participants. Hearing these one-sided stories from patients led me to make assumptions about the care that patients receive in the hospital setting. Although this was only the patient’s perception of their care and many facts could not be verified in an authorized or ethical manner, they left me with the impression that there may be several areas for improvement in the care mothers received. The investigator was also a member of a Perinatal Bereavement Care Quality Improvement Committee. This Committee identified areas in need of improvement related to perinatal
bereavement care in a hospital setting. Some of the key areas identified led me to assume that nurses who cared for women experiencing a stillbirth were uncomfortable caring for women experiencing a stillbirth and were inadequately prepared for the experience.

These factors have led me to have pre-conceived ideas about the experiences of mothers whose babies are stillborn and the care they receive from nurses in the hospital setting. In order to minimize this bias during the research, the investigator kept an open mind, clear notes and memos, and ensured that all analysis came directly from the data obtained from participants. The investigator kept a journal where personal thoughts and feelings were captured throughout the research process. In addition, the investigator reviewed all data and analysis of data with the faculty advisor who served as an audit system, ensuring that findings were based on data obtained.

Summary

In summary, the study explored the experiences and processes that nurses underwent when providing care to women having a stillbirth and developed an explanatory theory of this process. Labor and delivery nurses are the primary healthcare providers involved in the care of women who are experiencing a stillbirth delivery. Their care in this time of crisis can provide women with essential support, thus facilitating women’s healing. Therefore, it was important to learn about this process of care. Developing a theory grounded in the recounted experiences of labor and delivery nurses and the care they provide to mothers of stillborn babies will allow for a deeper understanding of the nuances involved in their efforts, as well as the impact this care had on the nurse and the other factors affecting care.

Chapter 1 of this dissertation provided an overview of the research study. Chapter 2 provides an analysis of the literature pertaining to stillbirth, as well as the concepts and
phenomena that have contributed to the management of the care of women experiencing a
stillbirth. Chapter 3 describes grounded theory, which was the qualitative research methodology
selected for this study. Chapter 4 describes the study findings, including verbatim quotes from
participants. Chapter 5 presents a discussion of the study findings within the context of current
literature, and Chapter 6 provides a conclusion including implications of this study.
Chapter 2: Review of Literature

The aim of the study was to describe the processes and experiences involved when labor and delivery nurses provide care to women during a stillbirth and to develop a theory that provides an understanding of these processes. Although perinatal loss and bereavement care have been described in the literature, there have been limited research studies describing the process and the challenges of providing care to women experiencing stillbirth from the perspective of labor and delivery nurses (Bruce, 1962; Ligeikis-Clayton, 2000). Research studies that do investigate the experiences of perinatal nurses who provide bereavement care do so from the perspective of perinatal loss, which encompasses miscarriage, stillbirth, and neonatal loss (Roehrs, et al., 2008; Wallbank, & Robertson, 2013; Wood, 2005). However, stillbirth is a unique loss, so a deeper exploration of this experience, exclusively, is necessary.

This chapter presents a review of literature on the most pertinent topics related to nurses and stillbirth care. The first topic that will be presented is a brief overview of the history of death and dying in hospital settings. This section will provide the framework needed to understand how societal and healthcare related views of death have changed over time and some of the behaviors and practices related to perinatal bereavement care. Next, an exploration of studies describing the experiences of nurses caring for dying patients in various hospital units will be presented. This description will explore important facets of providing end-of-life care that will also be relevant to perinatal bereavement care. Lastly, an overview of literature related to stillbirth will be presented. This section will include a brief overview of the management of stillbirth in the past, models and theories related to stillbirth, and parents’ perspectives on stillbirth. This section will conclude with a synthesis of literature on the experiences of nurses working with parents experiencing a
stillbirth. Specifically, Chapter 2 is divided into three sections: 1) Death and dying in hospital settings, 2) Nurses and death, and 3) Stillbirth.

**Death and Dying in the Hospital Settings**

Major advancements in medical treatment and technology, as well as the resulting increase in life expectancy, have caused major shifts in societal perspectives on death and dying. Prior to the 1900s, the sick and dying were cared for at home, surrounded by loved ones; death was viewed as natural and expected (Aries, 1981). By the 20th century, however, hospitals were viewed as places where the sick went to be healed (Kaufman, 2006), and deaths that occurred in hospitals began to be viewed as failures (Kaufman, 2006; Papadatou, 2009; Pietroni, 1991; Chapple, 2010). Fear of death and avoidance behaviors among healthcare professionals toward the dying began to surface (Acring, 1971; Kübler-Ross, 1970). The focus of healthcare professionals was on health and wellness, with less preparation for and education about how to care for dying patients (O’Gorman, 1998; Price, 2011).

By the late half of the 20th century, new ways of thinking emerged that resulted in increased education about death and dying, holistic approaches to health, and palliative and hospice care. The work of Kübler-Ross (1970) shed light on the idea that dying could be a peaceful and transformative experience. Research studies and perspective articles in the area of hospice care and palliative care attempted to address the inadequacies and difficulties experienced by patients, relatives, and the providers caring for the terminally ill (O’Gorman, 1998; Pietroni, 1991; Rinpoche, 1992). This body of literature also acknowledged the profound effect of death on the bereaved and its associated symptoms such as anxiety, depression, and physical illness (O’Gorman, 1998; Parkes, 1986; Pietroni, 1991; Rinpoche, 1992).
Despite the advances made in end of life care through palliative and hospice services, we live in a society that struggles with the inevitability of death. Therefore, healthcare providers are often motivated to rescue patients from death and they will do everything possible in an attempt to delay it (Gawande, 2010; Kaufman, 2006; Papadatou, 2009; Chapple, 2010). In the field of obstetrics, acceptance of death is particularly difficult, as death is not expected, especially in the case of stillbirth, which often occurs suddenly and without warning (Cacciatore, 2013; Foster, 1996). Nurses are particularly impacted by the complexities of caring for dying patients and bereaved loved ones as they are the healthcare professionals who have the most contact with the patient.

**Nurses and Death**

Nurses may be exposed to dying patients at varying times in their careers. According to the American Nurses Association’s (2010) position statement on end-of-life care, nurses have an obligation to provide comfort and relief of suffering during these times. Although nurses may find these experiences to be rewarding, they are most often described as demanding and requiring skill (Dunn, et al., 2005; Mak, et al., 2013; Peters, et al., 2013b).

Various studies have identified certain characteristics that are common among nurses who demonstrate positive attitudes about caring for dying patients. These include older age, greater clinical experience, higher education, more experience caring for dying patients, and extensive continuing education related to death and dying (Dunn, et al., 2005; King & Thomas, 2013; Peters, et al., 2013a; Peters, et al., 2013b; Rooda, Clements & Jordan, 1999). While studies have shown that nurses demonstrate positive attitudes toward caring for dying patients (Dunn, et al., 2005; King & Thomas, 2013), other studies have identified barriers to nurses providing quality
care to patients (Irvin, 2000; Kirchhoff & Beckstrand, 2000; Peters, et al., 2013a). Some of these barriers included family barriers, such as families who were angry or unaccepting of a family member’s prognosis, lack of agreement with physicians, lack of workplace support, and emotional strains as the result of providing end-of-life care (Irvin, 2000; Kirchhoff & Beckstrand, 2000; Peters, et al., 2013a). Peters and colleagues (2013a) found that emergency room and palliative care nurses (n=56), were positive about their skills to care for patients who were dying, but were less able to cope with bereaved family members. Participants completed demographic questionnaires, participated in in-depth interviews, completed the Death Attitude Profile-Revised (DAP-R) scale and the Clinical Coping Skills Questionnaire-Peters (CCSQ-P).

The DAP-R uses a Likert scale (1-7) to respond to 32 statements that measure negative thoughts and feelings regarding death, attempts to avoid thoughts of death, the extent to which a person views death as an entry point to a happy afterlife, the extent to which a person views death as an opportunity to escape from a painful existence, and the extent to which a person views death in a neutral way (Dunn, et al., 2005). Reliability for the DAP-R scale was determined based on the test-retest alpha coefficients of each dimension of the scale on a 4-week interval. Alpha coefficients ranged from 0.65 to 0.97 on the test and from 0.61 to 0.95 on the retest. Face validity of the DAP-R was determined by asking 10 young, 10 middle-aged, and 10 elderly individuals to place the 32 statements into the 5 pre-determined conceptual categories. Agreement ranged from 70% to over 90%, exceeding the 70% criteria set by the developers and establishing face validity (Wong, Reker, & Gesser, 1994).

The Clinical Coping Skills Questionnaire-Peters (CCSQ-P), a 4-question tool developed by the primary researcher designed to measure nurses’ perceptions of their own personal coping skills. Each item on the CCSQ-P was rated from 1 (not coping at all) to 10 (coping extremely
well) and open-ended comments were also elicited. Validity and reliability of the CCSQ-P was not expounded upon in this study other than the authors’ assertion that “face validity of this section was examined by ED (emergency department) and PC (palliative care) nurse experts in the research team, and the whole survey was pilot-tested by both PC and ED nurses” (Peters, et al., 2013a, pg. 154).

Findings from this study demonstrated that nurses found it difficult to cope with the reactions of family members who were anxious and distressed due to the loss of a family member. Although this finding was mainly based upon responses from the CCSQ-P, that had questionable validity and reliability, they have been confirmed in other studies with oncology, palliative, surgical and critical care nurses (Dunn, et al., 2005; Dunne, Sullivan & Kernohan, 2005; Hatcliffe, Smith & Draw, 1996; Kirchhoff & Beckstrand, 2000; Finlay, 1999) where bereaved family members were often viewed as secondary patients and added to the stress experienced by nurses who were providing care. This finding is significant in the discussion about nurses and stillbirth where the nurse must care for the bereaved mother who is the primary patient. If nurses who specialize in areas where death is anticipated find it difficult to cope with bereaved family members, how much more might this be a factor for labor and delivery nurses whose primary patient is bereaved by the unexpected and sudden loss of a child?

An additional phenomenological study found that ICU nurses \( n=14 \) experienced a sense of satisfaction when they were well prepared for a death, in that goals were mutually met with the patient and family and a plan was set forth (King and Thomas, 2013). However, the nurses found the deaths that occurred unexpectedly were harder to cope with. In the case of stillbirth, death is almost always unexpected and resolutions such as mutually met goals are generally unattainable due to the lack of time available to come to terms with the full meaning of the outcome. If ICU
nurses who are trained in the care of critically ill patients admitted having difficulty with these conditions, how much more might these factors affect labor and delivery nurses who do not have training appropriate to such a loss?

Stillbirth

This section will provide a historical overview of how stillbirth was managed in the past, followed by a description of the experiences of parents who have had a stillbirth, and culminating with those of nurses caring for women experiencing a stillbirth.

**History of stillbirth management.** In the past, grief related to stillbirth was largely overlooked and denied (Capitulo, 2006; Clower 2003; Lovell, 1983; O’Leary & Warland, 2013; St. John, Cooke, & Goopy, 2006). In an early writing, one author indicated that after reviewing “hundreds of papers” on this subject, virtually no medical literature could be found on the emotional and psychological sequelae of the experience of a stillbirth, and the author referred to it as a “professional blind spot” (Bourne, 1968, pg. 111). It was thought that experiencing the loss of a baby was so traumatic that seeing the baby would only cause the mother additional, unnecessary grief (Defey, 1995; O’Leary & Warland, 2013; Lovell, 1983; Ligeikis-Clayton, 1999; Outerbridge, et al., 1983; Saylor, 1977). After a loss, mothers were often discharged from the hospital with “indecent haste” (Lovell, 1983, pg. 757) and advised to “go home and get pregnant again at once” (Defey, 1995, pg. 103). In recent years, however, significant efforts have been undertaken to fill this gap in the literature. Multiple research studies have highlighted the importance of allowing a mother to see and hold her baby, to hold burial services for stillborn babies, and to share information about the baby with parents, such as the gender and the circumstances surrounding the death (Cacciatore 2013; Cacciatore, Rådestad, & Froen, 2008;
Forrest, Standish & Baum 1982; Limbo, Wheeler & Gensch, 2015; O’Leary & Warland, 2013; Peters, et al., 2014; Rædestad et al. 2009). In one study (O’Leary & Warland, 2013), the authors performed a secondary thematic analysis of data obtained from two descriptive phenomenological studies with bereaved parents who had experienced a perinatal loss 50-70 years prior to the study (O’Leary & Warland, 2013). The authors highlighted the response of one mother who recounted the story of her stillbirth delivery that occurred in 1960. She was not allowed to be awake during the delivery, and she was never allowed to see or hold her baby, despite her requests. She was told to “forget it and get on with your life” (O’Leary & Warland, 2013, pg. 333). Although she described feeling regret over this, she stated, “That’s how it was then” (O’Leary & Warland, 2013, pg. 332). Another mother described being “put to sleep”, despite her wishes to remain awake and un-medicated during the delivery (O’Leary & Warland, 2013, pg. 332). When she awoke, she was told that her baby had died. She was not allowed to see or hold the baby nor to hold a funeral service (O’Leary & Warland, 2013).

Silence and avoidance among healthcare providers toward mothers were also common, and parents were forced to grieve in isolation (March of Dimes, 2002). In an attempt to address this avoidance among medical staff, one author wrote, “We seem unwilling to come to terms with the fact that it [stillbirth] is a tragedy that can seriously affect the mental health of a bereaved mother and her family” (Lewis, 1979, pg. 303). Another author attributed this “unconscious alienation” to discomfort with the topic, failure to address intense pain, and an inability to fall back on medical activities to correct the situation (Bourne, 1968, pg. 112). In one of the earliest papers on stillbirth and the reactions of healthcare providers, one author called for nurses to confront their feelings regarding stillbirth instead of avoiding them and stated, “How each nurse
handles her feelings determines the degree of support she can allow herself to give…” (Bruce, 1962, pg. 88).

When healthcare providers began to realize the traumatic effects of loss that was felt by parents, it became apparent that the prevailing psychosocial management was inadequate (Defey, 1995). Providers began to understand that parents required support and validation of their grief (Grubb, 1976; Kirkley-Best, & Kellner, 1982; Leon, 1992). Bowlby’s (1969) seminal work on the Attachment Theory as it related to the attachment between a child and caregiver as well as Peppers and Knapp’s (1980) extension of this theory to perinatal loss captured the essence and depth of the attachment between a mother and her baby by explaining that the baby had been a part of the mother since the earliest moments of pregnancy. Additional theories and models such as Leon’s (1992) Psychoanalytic Conceptualization of Perinatal Loss and Rubin’s Maternal Tasks in Pregnancy (1975) largely contributed to the understanding of perinatal loss and its effect on mothers by highlighting how the loss impacted the mother’s sense of herself and her ideas of her own capabilities.

It is now widely accepted that the mother-infant bond begins when conception occurs (Klaus & Kennell, 1982; Outerbridge, et al., 1983; Wood, 2005). This bond continues to grow and develop throughout the pregnancy and as the mother begins to feel the fetus move. Medical advances, such as ultrasounds, provide the opportunity for a visual bond between mother and infant, and this reinforces the existing attachment (Fletcher & Evans, 1983; Heidrich & Cranley, 1989). Even though the life of a stillborn may seem brief to others, the mother develops an emotional bond with the infant over a nine-month period and grieves the loss of that relationship (Saylor, 1977). It is not simply the loss of a child; it is the loss of an anticipated role as a parent and of hope for the future, which can have a significant impact on the mother’s self-esteem.
(Whyte, 1994). What makes this loss especially difficult to cope with is that nothing can be done to fill the void of the lost child. Although some women attempt to get pregnant again as soon as possible in order to mitigate their pain, they often discover that no one child can ever take the place of another child (Yates, 1972) that was lost.

As theories on perinatal loss began to proliferate, studies on parents’ experiences with stillbirth began to increase (Bourne, 1968; Cacciatore & Bushfield, 2007; Kelley & Trinidad, 2012; O’Leary & Warland, 2013; Rådestad, et al., 2009; Sålund, Sjögren & Wredling, 2004; Totten, 2013; Trulsson & Rådestad, 2004). Studies describing interventions that parents found to be helpful, as well as behaviors that they had difficulty with, were also described in various articles (Erlandsson, Warland, Cacciatore, & Rådestad, 2012; Kelley & Trinidad, 2012; Peters, et al., 2014; Peters, Lisy, Ritano, Jordan, & Aromataris, 2016). The following section will provide an exploration into the experiences of these families while also providing the background knowledge needed to understand the context and experience of stillbirth.

Parents’ experiences with health care providers as it relates to a stillbirth. The loss of a child has been described as the most devastating experience a family can have (Outerbridge, et al., 1983; Schoenberg, Carr, Peretz, & Kutscher, 1970) and leaves them feeling powerless and helpless (Saylor, 1977). The literature around perinatal loss is filled with stories of families who have had both positive and negative interactions with healthcare providers (Cacciatore, 2013; Gold, 2007; Lang & McLean, 2004; Lasker & Toedter, 1994; Leon, 1992; Sanchez, 2001).

In 2014, the Joanna Briggs Institute conducted a comprehensive systematic review of the literature describing the experiences and accounts of families who have had a stillbirth for the Stillbirth Foundation of Australia (Peters, et al., 2014). The goal of this review was to identify
effective, meaningful, and supportive psychosocial care interventions that healthcare providers could engage in to improve a family’s psychological well-being after a stillbirth. Studies included in this literature review ranged from quantitative studies including experimental and observational study designs, case control studies, and prospective and retrospective cohort studies to qualitative research studies including phenomenological, ethnographic, grounded theory, and qualitative descriptive studies. The authors performed a comprehensive search of published and grey literature between February and April 2014 across PubMed, CINAHL, EMBASE, PsycINFO, selected trial registries, and stillbirth-related websites with no restrictions on publication dates, followed by a manual search of the reference lists of included studies to expand the search (Peters, et al., 2014).

All of the studies in this review were assessed for methodological quality for inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute including the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information (JBI SUMARI), a premier software for the systematic review of literature, the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI QARI) for qualitative studies, and the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI MASTARI) for quantitative studies. Each study was appraised by two independent reviewers and disagreements were resolved by discussion between the two reviewers or when necessary, a discussion with a third reviewer. The initial search results yielded 10,177 records. After appraising for methodological rigor and removing duplicate records, only 30 studies (6 quantitative and 24 qualitative) were ultimately selected for inclusion in this systematic review. The published document includes a listing of all excluded studies including the explanations for exclusion.
Findings from this review revealed both positive and negative experiences of parents who experienced a stillbirth. Some positive experiences included receiving information about what to expect from the delivery and recovery (Dyson & While, 2008; Lee, 2012; Pullen, Golden, & Cacciatore, 2012; Sanchez, 2001; Säflund et al., 2004); having their feelings acknowledged (Dyson & While, 2008); experiencing sensitive and supportive care and compassion (Corbet-Owen & Kruger, 2001; Downe, Schmidt, Kingdon, & Heazell, 2013; Lee, 2012; Sanchez, 2001); making mutual decisions and collaborating with medical personnel (Corbet-Owen and Kruger, 2001; Downe, et al., 2013; Lee, 2012); having staff share their emotions and their own experiences (Dyson & While, 2008; Kelley & Trinidad, 2012); taking pictures of and holding the baby (Kelley & Trinidad, 2012); having staff express sympathy (Kelley & Trinidad, 2012).

Some of the negative experiences parents described included exposure to babies and other pregnant women, which mothers found distressing (Kelley & Trinidad, 2012; Lee, 2012); poor communication and avoidance behaviors by healthcare staff that contributed to feelings of isolation and frustration (Kelley & Trinidad, 2012; Pullen, et al., 2012); feeling as if the delivery was a medical event instead of the delivery of a baby (Lee, 2012); well-meaning but hurtful comments from clinicians who did not know what to say or do (Dyson & While, 2008; Kelley & Trinidad, 2012; Pullen et al., 2012; Säflund, et al., 2004); exclusion of a partner from involvement (Sanchez, 2001); lack of information about what to expect at delivery and the condition of the baby at birth (Downe, et al., 2013; Dyson & While, 2008); feeling pressured to make decisions when not ready (Downe, et al., 2013); lack of empathy and care that seemed cold and callous (Lee, 2012; O’Neill, 1999); and not knowing why the baby died (Pullen, et al., 2012).

The meta-synthesized findings from this comprehensive systematic review yielded 41 implications for practice that parents found to be key factors of care. They included: the need to
know what to expect at every stage of the stillbirth experience; effective communication, especially when delivering the prognosis of stillbirth; clear information and shared decision making about and leading up to the process of birth; providing guidance and support to help parents decide whether or not to see their stillborn baby and being prepared for the meeting; providing information and referrals for psychosocial support beyond the birth of their stillborn child; and providing culturally and spiritually appropriate care with the awareness that parental preferences may deviate from their cultural or spiritual norms (Peters, et al., 2014).

This comprehensive, systematic review encompassed the full scope of parental experiences with a stillbirth (Peters, et al., 2014). A review of additional studies since 2014 did not reveal any new findings apart from those reported in this study.

**Experiences of nurses caring for women experiencing a stillbirth.** Most research studies that examine the experience of nurses caring for women experiencing a stillbirth do so from the larger category of perinatal loss (Burgner, & Ruchala, 2006; Chan, Chan, & Day, 2004; Puia, et al., 2013; Wallbank, & Robertson, 2013). It can be difficult to extract data exclusive to stillbirth from these studies, as the experiences related to miscarriage and neonatal death are also grouped in these findings. During the review of literature, the investigator found only two studies that explored the experience of caring for a woman experiencing a stillbirth from the perspective of the labor and delivery nurse (Bruce, 1962; Ligeikis-Clayton, 2000).

Ligeikis-Clayton (2000) performed a descriptive, correlational study with 62 nurses to determine their perceptions of their own comfort levels and abilities when providing care, as well as the importance that they placed on implementing Resolve Through Sharing (RTS) protocols after the death of a stillborn infant. RTS is a not-for-profit national organization that provides grief
support materials and industry-leading comprehensive perinatal, neonatal, pediatric, and adult death bereavement training to healthcare professionals. These materials and trainings are designed to help healthcare workers provide high-quality family-centered care to patients and families experiencing loss through dying and death (Resolve Through Sharing, nd). This study also sought to determine the relationships between selected demographics (age, educational preparation, gender, religion, ethnicity, and experience and training in bereavement) and the nurses’ perceptions.

Participants in this study included nurses from units where parents experience fetal demise and perinatal mortality and also include nurses from the Post-Partum and High-Risk Unit, Newborn Nursery, Women’s Surgical Unit, Neonatal Intensive Care Unit (NICU) and Labor and Delivery Unit. While this study focused on nurses caring for mothers who had a stillbirth, there were participants included from areas where nurses do not care for mothers who have had a stillbirth, including the NICU and Newborn Nursery. It is unclear what their contribution to this study was and why they were included, although the author indicated that these units were selected because these were areas where nurses encountered fetal demise and were expected to implement the RTS protocol. This may suggest that the study focused more on perinatal loss than an exclusive focus on stillbirths.

The RTS program that was being evaluated was described as “a comprehensive program to assist families who have experienced the loss of a baby through miscarriage, ectopic pregnancy, fetal demise, stillbirth, and newborn death” (Ligeikis-Clayton, 2000, pg. 66), once again suggesting a perinatal focus rather than stillbirth. The RTS program also included the provision of an RTS Coordinator who served as a resource for nurses and assisted with continuing perinatal
loss education programs for the hospital as well as providing coordination for the Empty Arms Support Group for parents (Ligeikis-Clayton, 2000).

This study used a descriptive, correlational design to show relationships between demographics of age, educational preparation, gender, religion, ethnicity, experience and training in bereavement of the nurses and their comfort, ability, and perceived importance in implementing the RTS standards of care. It also used a researcher-designed survey instrument including seven research questions that addressed the variables of comfort, ability, and perceived importance of the RTS standards of care for nurses who implemented them which were scored using a Likert scale on a range of 1 through 5 as follows: (a) 1-not comfortable, not able, not important; (b) 2-somewhat comfortable, somewhat able, somewhat important; (c) 3- comfortable, able, important; (d) 4-moderately comfortable, moderately able, moderately important; and (e) 5-very comfortable, very able, very important. The reliability of the survey was evaluated using analyses of variance (ANOVA) measurements. The reliability of items relating to the nurses’ comfort in implementing RTS standards of care was 0.97 using analysis of variance (F= 14.26, P = .0000), which demonstrated a high degree of internal consistency among the items. The reliability of the items pertaining to the nurse’s ability to implement RTS standards of care for parents who had experienced the loss of a stillborn infant was 0.96 using analysis of variance (F=13.55, P=.0000) and also demonstrated a high degree of internal consistency among the items. The reliability of items related to nurses’ perception of the importance of implementing the RTS standards of care for parents who had experienced the loss of a stillborn infant was 0.93 using analysis of variance (F=24.28, P = .0000). This also demonstrated a high degree of internal consistency among the items.
The survey instrument was revised based on suggestions of key administrators at the hospital where this study occurred; however, the author did not describe the specific revisions that were made. The survey was pilot tested by 3 nurses from this hospital, although the author did not disclose what areas the nurses were from and simply stated that they “were able to answer all questions without problems” (Ligeikis-Clayton, 2000, pg. 70).

Content and face validity of the RTS protocols were grounded in the theories of Klaus and Kennell (1970), Kennell, Slyter, and Klaus (1982), Bowlby (1980), Davidson (1977), and Kauffman-Swanson (1986) who were regarded as experts in the discipline of thanatology. The protocol recommended that the nurse encourage parents of a stillborn infant to see, hold, bathe, take pictures of, and name their baby, to learn the baby’s gender, to have genetic studies and an autopsy done, and to make funeral arrangements for the baby. The protocol also suggested that the nurse record basic information about the baby such as its weight, length and name. Additionally, the protocol recommends that the nurse obtain footprints, handprints and photographs of the baby. Nurses are expected to save items such as a clip of hair for the parents, to initiate a grief care plan and grief discussion with the family, to refer the parents to a support group, and to retrieve the baby from the morgue if desired by the parents (Ligeikis-Clayton, 2000).

Findings from this study revealed that nurses were less comfortable when performing tasks that involved touching and handling the body of the deceased infant such as encouraging the parents of the stillborn infant to bathe their baby and retrieving the baby from the morgue, if necessary. In relation to abilities in implementing RTS standards of care, nurses were most capable when saving tangible items, taking photographs, and recording basic information of the infant and least capable when encouraging parents to bathe their babies and encouraging an autopsy of the infant. These findings suggested that nurses were able to provide “task-like”
interventions in which they were “doing for” the patient (Ligeikis-Clayton, 2000, pg. 109). In relation to nurses’ perceived importance of implementing RTS standards of care, this study found that nurses perceived certain RTS standards to be more important than others. For instance, completing the footprint record for the baby and encouraging parents to see and hold their deceased infants were deemed more important than encouraging parents to bathe their babies or encouraging an autopsy of the infant.

When considering all three aspects together, nurses had a higher rating of perceived importance of implementing RTS standards of care, but had lower ratings of their ability and comfort in carrying out these standards. Demographics that were identified as highly related to comfort and ability levels in carrying out RTS standards were age, years of experience as an obstetric/nursery nurse, education and expanded RTS training (an additional 3-day training). Findings from this study also suggested that nurses could benefit from educational offerings and debriefing sessions that focused on perinatal mortality.

Based on the study findings, the author concluded that nurses recognized the importance of parent contact with the infant in order to facilitate the grief process but avoided engaging them in more emotional discussions related to grief and also determined that nurses may be uncomfortable with the more intimate types of contact with the infant. Findings from this study are quite valuable, as it was one of the few research studies to address stillbirth from the perspective of the labor and delivery nurse. However, although this study provided information about behaviors of nurses, it did not reveal the thought processes behind these behaviors or insights into the reasons one action was taken over another apart from speculations by the author. Recommendations the author made for future research on this topic were a revised survey instrument, larger samples and other settings, as well as an investigation into the areas where nurses had difficulty implementing
protocols such as bathing the deceased baby, retrieving the baby from the morgue, autopsies, and initiation of grief discussions with parents (Ligeikis-Clayton, 2000).

The second research study that related to the perspective of the labor and delivery nurse was conducted by Bruce (1962) who sought to determine the needs of mothers who delivered a stillborn baby. Although this was the stated purpose, the author also identified that she had a general interest in learning about how nurses handled their own grief related to a stillbirth loss. Participants in this study included 25 nurses, 25 mothers and 5 obstetricians. The author was unable to obtain formal permission from the hospital to interview the mothers, and she stated that “no hospital would grant permission for such a study” (Bruce, 1962, pg. 88) and hospital spokesmen expressed that “such an interview would be too upsetting to the mothers and would only force them to focus their attention on the loss of the baby” (Bruce, 1962, pg. 88). Therefore, the author interviewed the mothers in their homes after they were discharged from the hospital. Given the time period, it is understood that stillbirth was a taboo topic that was not openly discussed. This brings into question the ethical standards of this study. It is important to consider that this study was conducted prior to the National Research Act of 1974, the Belmont Report, which outlined ethical principles related to human subjects, and the development of Institutional Review Boards, which seek to protect human subjects from physical or psychological harm. Although there was no specific mention of a consent form, the author did mention that “not one mother refused to participate” (Bruce, 1962, pg. 88).

A specific methodological procedure or conceptual framework was not identified for this study, however the author discusses the use of interviews, analysis of interview materials, and the extraction of correlating themes used to identify the processes used by mothers and nurses when faced with handling feelings of loss. Throughout the study, the author included verbatim quotes
from participants and often juxtaposed responses from nurses with responses from patients that correlated with each other in a table format as follows:

**Table 1: Nurse/Mother responses**

<table>
<thead>
<tr>
<th>Nurses Said</th>
<th>Mothers Said</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You can always say God has His reasons and we must have faith” (Bruce, 1962, pg. 89).</td>
<td>“I couldn’t care about what God thought. I only knew how I felt” (Bruce, 1962, pg. 89).</td>
</tr>
<tr>
<td>“Some mothers are always finding fault and demanding things. They take their guilt out on you, and you had nothing to do with the baby’s death” (Bruce, 1962, pg. 90).</td>
<td>I’d rather be alone than with someone who HAD to be there. I had to ask for everything and felt like a pest. Sometimes I’d ask for things I didn’t need because I was so lonely.” (Bruce, 1962, pg. 90).</td>
</tr>
<tr>
<td>“I don’t believe in letting them wallow in self pity. It only upsets them” (Bruce, 1962, pg. 90).</td>
<td>“I cried when I was alone at night. The nurses made me stop if they saw me” (Bruce, 1962, pg. 90).</td>
</tr>
<tr>
<td>“You should emphasize the future productive years, NOT what she lost. Tell her to think of the children at home” (Bruce, 1962, pg. 91).</td>
<td>“I didn’t care about what I could do. It was what I couldn’t do that hurt. I couldn’t think of the children at home” (Bruce, 1962, pg. 91).</td>
</tr>
<tr>
<td>“The mother with no children is hard to comfort as she has nothing” (Bruce, 1962, pg. 91).</td>
<td>“I think it’s easier for the nurses if you have children. It gives them something to talk about” (Bruce, 1962, pg. 91).</td>
</tr>
</tbody>
</table>

*Source: Bruce, 1962*
The author analyzed findings from this study and determined that mothers were in need of the support and comfort that nurses were most uncomfortable giving. She made a specific point to identify that these findings did not imply that nurses did not care, but that little effort and attention had been given toward helping the grieving nurse. She also stated that “until the nurse can handle her own response to grief, she cannot meet the mother’s great needs” (Bruce, 1962, pg. 88). The author ends by making a call for further research into areas of maternal and pediatric nursing to determine how grief affects the nurse and how nursing care, in turn, impacts those who receive it.

Although these two research studies occurred over 17 years and 55 years ago, respectively, their findings are still applicable today (Bruce, 1962; Ligeikis-Clayton, 2000). Despite the respective questionable factors related to scope and ethics, the implications of these studies, including the impact of care related to stillbirth on the nurse as well as the patient, warrant further research.

**Summary**

This chapter presented an overview of the relevant literature related to stillbirth including death and dying in the hospital setting, nurses’ experience with dying patients, a historical look at stillbirth, a review of parents’ experiences with stillbirth, and finally, nurses’ experiences with stillbirth. The following chapter will provide an overview of grounded theory, its philosophical underpinnings, and why it was selected as an ideal methodology for this study.
Chapter 3: Methodology

Chapter 1 of this study provided an introduction and background for the research topic of interest, which was to describe and conceptualize the process of caring for women delivering a stillborn baby from the perspective of the labor and delivery nurse. Chapter 2 provided a review of literature related to stillbirth. This chapter will present an overview of grounded theory, the chosen qualitative methodology for this study.

Developed in 1967 by two sociologists, Barney Glaser and Anselm Strauss, grounded theory is a method and technique for the exploration of a social phenomenon that offers a systematic and interpretive means of generating a theory (Glaser & Strauss, 1967). This approach to qualitative study was developed through their work with dying patients and was documented in their various published works including: “Awareness of Dying” (Glaser & Strauss, 1965), “Time for Dying” (Glaser & Strauss, 1968), and “The Discovery of Grounded Theory” (Glaser & Strauss, 1967).

The goals of grounded theory are to provide a perspective on human behavior (Glaser & Strauss, 1967), and to develop a theory that explains a social phenomenon within a given context (Sussman, 2012). Since the theory must emerge directly from the data, the researcher can be confident that it will fit the specific research problem that is being studied (Glaser & Strauss, 1967). It is imperative that a researcher utilize a methodology that can provide the most appropriate answers to the specific research question that is proposed (Jeon, 2004). Grounded theory is ideal for this study because it seeks to provide a perspective on behaviors and social processes associated with caring for women delivering a stillborn baby, as perceived by labor and delivery nurses. Grounded theory is also well suited for studies in non-traditional areas where
there is little to no existing research, such as the topic being researched for this project (Glaser & Strauss, 1967).

The focus of the research in grounded theory is on social processes (Corbin & Strauss, 2008). Its theoretical underpinnings are rooted in pragmatism and symbolic interactionism (Corbin & Strauss, 2008). Pragmatism is concerned with action and reaction, language, ethics, and practice (Jeon, 2004). Pragmatists maintain that human beings are constantly adapting to the changing world (Jeon, 2004). Symbolic interactionism is concerned with the meaning of an event and the knowledge that is created through action and interaction surrounding the event (Starks & Trinidad, 2007). According to Mead (1934) and Blumer (1969), the founders of symbolic interactionism, meaning is only made possible through social interaction with others. The only way to fully understand a social process is to grasp the meanings that are experienced by the participants within a particular context (Chenitz & Swanson, 1986; Schwandt, 1994). In other words, the manner in which a person reacts to another person, situation, or thing is based on the meaning that that person, situation, or thing has to them. To fully understand the processes involved for labor and delivery nurses in providing care to women experiencing a stillbirth by the labor and delivery nurses caring for them, it was important to first understand the meaning of the event for the nurses.

Another premise of symbolic interactionism and action/interaction is the notion that a problematic situation prevents a person from acting automatically or out of habit; it requires reflective thinking (Mead, 1934) and reflective inquiry (Dewey, 1938) about how to resolve an uncertain situation. The action that is selected may be based on several factors including one’s prior experience and the intended outcome. When a stillbirth occurs, it is often sudden and unexpected (Cacciatore, 2013; Foster, 1996). Therefore, a labor and delivery nurse cannot act out
of habit and must consciously decide how to provide appropriate care. This study sought to explore the process that individual nurses experienced and used when caring for a woman during a stillbirth, including the decisions made about providing care and the factors that affect and influence those decisions. Based on the tenets and theoretical underpinnings of grounded theory, it is an ideal methodological approach for this study.

**Research Plan**

Following Institutional Review Board (IRB) approval, data was collected via in-depth interviews with labor and delivery nurses. Interviews were recorded and supplemented with short notes taken during and after interviews to capture the non-verbal gestures, communications, and other nuances that occurred during interviews that could not be captured on a recorder. Each recorded session was transcribed verbatim. Both the transcriptions and the recorded interviews were used during the analysis.

This grounded theory study employed a method of comparative analysis, which is a strategic method used for generating theory (Glaser & Strauss, 1967). Comparative analysis requires that the analysis of data be an iterative process whereby data analysis begins as soon as the first piece of data is available (Corbin & Strauss, 1990). The interplay of data collection and data analysis is dynamic; neither occur in isolation, and both are ongoing (Glaser & Strauss, 1967).

**Sampling Plan**

Participants in this study were selected through purposive sampling, a method of selecting a sample “based on the researcher’s experience or knowledge of the group to be sampled” (Lunenburg & Irby, 2008, pg. 175). Concepts that emerged during interviews were explored in
prospective interviews with other participants. Participants were recruited from a large urban medical center in Brooklyn, New York that had the highest number of newborn deliveries in New York State. Therefore, there was a greater chance that labor and delivery nurses would have experienced caring for a woman delivering a stillborn baby. The total number of participants in this study was 20. Data collection and analysis occurred continuously using the constant comparison analysis method as described by Glaser and Strauss (1967). All concepts emerging from the data were analyzed to form themes, and ultimately an overarching theory applicable to the research topic was developed.

Following Institutional Board approval, recruitment flyers were posted in the labor and delivery unit and nursing staff lounge of the facility chosen for the study in order to generate interest and an initial interview sample for this study. Participants were asked to sign a consent form that contained the details of the study. Participants were also notified that they had the right to withdraw from the study at any time without any consequences.

**Inclusion and Exclusion Criteria**

Participants in this study were labor and delivery nurses that were either full time or part time staff nurses working in the labor and delivery unit. Nurses who were in orientation or nurses who had never been the primary nurse for a woman who had a stillborn baby were not invited to participate. Pregnant nurses were initially excluded from the study because it was thought that their experiences would be significantly different from non-pregnant nurses; however, an amendment to this was sought after it was discovered that the theme of the pregnant nurse was important to the study’s findings. A demographic tool was used to capture information regarding
the number of years of experience, age, and gender of each participant. This tool can be found in Appendix A.

**Interview Process**

Interviews were scheduled in advance and followed a semi-structured format organized around a set of pre-determined questions, with additional questions emerging throughout the course of the interviews (DiCicco-Bloom & Crabtree, 2006; Munhall, 2012). These semi-structured, in-depth interviews were guided by one central grand tour question: “Tell me about caring for women who are having a stillbirth” and was further refined to “Tell me about an experience you had caring for a mother who had a stillbirth.” Each interview occurred once and lasted approximately 45 to 75 minutes. The interviews were shaped by various factors and the investigator used a range of techniques throughout the interview process such as attentive listening, pausing, silence, appropriate facial expressions and non-verbal cues such as nodding to communicate understanding (Mishler, 1986). A list of probes was used during interviews, that served to provide more in-depth descriptions of salient aspects of the research topic (Charmaz & Belgrave, 2002; DiCicco-Bloom & Crabtree, 2006). The list of probes as well as a list of questions that guided the interviews can be found in the Semi-Structured Interview Plan in Appendix B.

**Data Analysis**

The investigator analyzed each recorded interview session, including verbatim transcripts, and interview notes using the iterative process of comparative analysis from the moment the first piece of data was collected. Concepts that were repeatedly and consistently present in interviews were identified and included in the data analysis process (Corbin & Strauss, 1990). These
concepts were grouped to form categories that were more abstract in nature. All concepts and categories emerging from the data were coded using a software program called AtlasTi. Data were further analyzed to form themes and ultimately, the analysis process resulted in an overarching theory to explain the experience of nurses who care for mothers who have had a stillborn baby. Grounded theory requires that concepts be grounded in the reality of the data, meaning that if a concept cannot stand up to the scrutiny of relevance through its repeated presence in the data, it must be discarded. This also provides a safeguard against researcher bias (Corbin & Strauss, 1990). Each piece of data was scrutinized for its relevance prior to being included in the development of categories and themes. The faculty advisor was also present and active throughout this analysis process and served as an auditor of the data analysis process. All data were secured on a password-protected computer, and all participant responses were coded with no identifying data associated with them.

**Trustworthiness of findings**

Trustworthiness was established by maintaining an inquiry audit trail which included a review of all memos, notes, and journals and engaged in additional reflections to ensure that themes and categories represented the authentic feelings of the participants (Lincoln & Guba, 1985). As themes and categories emerged, the investigator returned to interview recordings and transcripts to ensure that the interpretations came from the data. Additionally, the investigator kept a diary/journal during the data gathering process in order to maintain a separation of personal thoughts and ideas from those of the participants. During the data analysis process, the investigator returned to the diary at times to ensure that personal thoughts and words did not influence the interpretation of the data. The faculty advisor also served as an auditor for the data analysis process.
Summary

In summary, grounded theory is a method and technique for thinking about and studying a social phenomenon. Grounded theory offers a systematic and interpretive means of generating a theory through qualitative methods. Through the process of in-depth interviews with labor and delivery nurses, a theory describing the process that labor and delivery nurses go through when caring for women having a stillbirth emerged. The following chapter will present an analysis of the data gathered from this research.
Chapter 4: Findings

Introduction

The purpose of this chapter is to describe the results of a study on the process that labor and delivery nurses go through when caring for a woman whose baby is stillborn. Grounded theory, as described by Glaser & Strauss (1967), was used as the methodological basis of this study. This chapter will begin with a description of the participants who were interviewed and a description of the interview process. Findings from the study, including participant quotes, will also be presented in this chapter. Since all nurses in this study were female, participants will be referred to as she or her. The core variable, Managing Ambiguity, will be presented as well as the three main categories that emerged to form this overarching theory. These include Experiencing a Spectrum of Emotions, Managing the Ambiguous Patient, and Managing Institutional Ambiguity.

Demographic characteristics of participants

A total of 20 labor and delivery nurses participated in one-on-one interviews for this study (see Table below). All nurses were females. Four of those interviewed were between the ages of 20 and 29, 7 were between the ages of 30 and 39, 6 were between the ages of 40 and 49, and 3 were age 50 or older (see table 2 and figure 1). Seven participants had less than 5 years of experience in Labor and Delivery, 8 had 5-10 years of experience, 2 had 10-20 years of experience, and 3 had over 20 years of experience (see table 3 and figure 2). Three participants had Associate degrees, 10 had Bachelors degrees, and 7 had Masters degrees (see table 4 and figure 3). Of those interviewed, 8 had some type of training or had taken a course related to bereavement care, whereas 12 had not (see table 5 and figure 4).
Table 2: Age range of participants (years)

<table>
<thead>
<tr>
<th>Range</th>
<th>N</th>
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<tbody>
<tr>
<td>20-29</td>
<td>4</td>
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<tr>
<td>30-39</td>
<td>7</td>
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<tr>
<td>40-49</td>
<td>6</td>
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<tr>
<td>&gt;50</td>
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Figure 1: Age range of participants (years)

Table 3: Participants’ years of experience in Obstetrics

<table>
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<tr>
<th>Range</th>
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<tr>
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<td>7</td>
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<tr>
<td>5-10</td>
<td>8</td>
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<tr>
<td>10-20</td>
<td>2</td>
</tr>
<tr>
<td>&gt;20</td>
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</tbody>
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Figure 2: Participants’ years of experience in Obstetrics

Table 4: Participants’ level of education

<table>
<thead>
<tr>
<th>Degree</th>
<th>N</th>
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<tbody>
<tr>
<td>Associates</td>
<td>3</td>
</tr>
<tr>
<td>Bachelors</td>
<td>10</td>
</tr>
<tr>
<td>Masters</td>
<td>7</td>
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Figure 3: Participants’ level of education
Participant Recruitment and Study Setting

Participants were recruited from a large urban academic medical center in Brooklyn, New York. The labor and delivery Unit had approximately 85 nurses employed with 14-17 registered nurses working on each shift on any given day or night. Recruitment flyers for this study were posted in the labor and delivery unit and in the nursing staff lounge of the facility. Interested participants reached out to the investigator directly via email or by phone. Prospective participants made arrangements to be interviewed at a time and place of their choosing. Participants were asked to sign an informed consent form that included the details of the study. They were also notified that they could withdraw from the study at any time.

Description of interview process and changes that occurred

The investigator conducted in-depth, semi-structured interviews with 20 labor and delivery nurses between the months of January 2016 and January 2017. Initial interviews began with the investigator asking the participants to, “Tell me about caring for a mother who had a stillbirth.” It
became apparent after the first two interviews that this approach led to vague, general
descriptions. As a result, the opening question was changed to, “Tell me about an experience you
had caring for a mother who had a stillbirth.” This garnered more detailed and descriptive
responses, which led to more meaningful data and a deeper exploration of the topic.

After reviewing the first two interviews with the faculty advisor, the decision was made to
revise the interview style to include more follow-up questions such as, “Can you tell me more
about that?” in order to get the full account of an experience. The investigator interviewed two
more participants using the additional probes before meeting with the faculty advisor again to
determine if adequate probing was occurring. Both the investigator and the faculty advisor agreed
that the interview questions and probes were appropriate. Interviews lasted between 45 minutes
and 75 minutes and followed a semi-structured format. The interview questions were slightly
revised during subsequent interviews to fully explore emerging concepts and themes and to ensure
saturation.

In the initial IRB application, pregnant nurses were excluded from the study because it was
thought that their experiences would cause extraneous concepts to arise and interfere with
saturation of the main themes. However, based on initial interviews, the sub-theme of “the
pregnant nurse” began to emerge. Nurses described experiences they had when they were
pregnant and experiences they had with other nurses who were pregnant. Based on this, the
decision was made by the principal investigator and the faculty advisor to seek an amendment to
the IRB application in order to include pregnant nurses in the pool of participants. An IRB
amendment was sought and approved, however, there were no pregnant nurses who volunteered to
participate. Despite this, the experience of the pregnant nurse was integrated into the study.
through responses of the participating nurses who discussed the experiences and perceptions they had when providing care to a woman whose baby was stillborn while they were pregnant.

**Data Analysis**

Data analysis began after the first two interviews were completed. The principal investigator independently reviewed transcripts, interview notes, and audio recordings from the interviews in order to become more familiar with the data. The principal investigator used the software, *Atlas Ti* to complete this preliminary analysis of the data using *In vivo* coding, where the participants’ own words were used as code names for their respective pieces of data. Shortly after this, a meeting took place between the principal investigator and the faculty advisor to review the transcripts and interview notes. We began by reviewing interview transcripts for key words, phrases, and concepts. This data was listed on a large chalkboard and then coded and placed into various categories. Similar meetings occurred as additional interviews were conducted. Various codes and categories were developed, changed and rearranged based on data from the interviews. With each subsequent meeting, conceptual categories began to emerge from the data including various smaller sub-categories. It became apparent that the categories were held together by one overarching common theme and, as a whole, they began to describe the process experienced by labor and delivery nurses when managing the care of a mother whose baby was stillborn.

Additional interviews were conducted to confirm that there was no new data that could be identified to form new categories. After reviewing all transcripts, notes and recordings, it was apparent that the categories were indeed saturated. For example, in the category *Experiencing a Spectrum of Emotions*, nurses repeatedly expressed how difficult it was to provide care to a mother whose baby was stillborn. While each nurse had varying experiences, they all described their experiences as emotionally difficult.
After extensive reflection on the data, three broad categories emerged. These categories focused on: 1) the emotional experiences of the nurse, 2) interactions between the nurse and the patient, and 3) institutional factors that impacted care. For instance, in terms of the institution, various nurses spoke of specific policies that they grappled with when trying to provide compassionate care to patients. In terms of interactions with the patient, nurses described tasks they completed with patients and various ways they provided direct care. Much of the data from interviews fit into more than one category. Further time was spent developing the categories into firmer, clearer, and more specific areas, which made it easier to determine where a piece of data fit best.

After repetitive review and reflection on the data and the categories that emerged, it was apparent that nurses were continuously describing various situations marked by ambiguity and how they managed these circumstances. Ambiguity in the nursing profession is not a new concept and has been particularly prominent in situations where nurses feel uncertainty and discomfort. These circumstances typically include situations when patients and/or families are suffering, upset, or when there is conflict (Mitchell & Pilkington, 2000). As it relates to stillbirth, discomfort and uncertainty might arise due to the uneasiness that is felt in death and dying situations. Conflict may occur for various reasons such as if a mother’s grieving style is not congruent with the nurse’s idea of proper grieving or if a family member blames the nurse or other healthcare provider for the loss of the baby. These situations increase feelings of discomfort and may lead to feelings of ambiguity if the nurse is uncertain of how to proceed.

Although the Oxford Companion to Philosophy (Honderich, 1995) defines ambiguity as a condition having two or more distinct meanings, it can also refer to a situation marked by uncertainty, vagueness, obscurity, and indefiniteness (Mitchell & Pilkington, 2000). A more
conceptual definition of ambiguity was provided by Becker and Brownson (1964) who explored the role of ambiguity in decision making, building on the original work of Elsberg (1961) who classified ambiguity as a “subjective variable which determines the decision-maker’s confidence in his probability estimates” (Becker & Brownson, 1964, pg. 62).

When providing care to women experiencing a stillbirth, labor and delivery nurses faced ambiguous situations that were marked by uncertainty, vagueness, obscurity, and indefiniteness. After further development and analysis, the three main categories that emerged from the data were *Experiencing a Spectrum of Emotions, Managing the Ambiguous Patient, and Managing Institutional Ambiguity*. It became evident that the central process threaded throughout each category was *Managing Ambiguity*. This was determined to be the substantive theory and the core variable.

**Findings**

*Managing Ambiguity* emerged as the central process experienced by labor and delivery (L&D) nurses who cared for a mother whose baby was stillborn. Providing care to mothers who were experiencing a stillbirth created ambiguity for various reasons. In general, the labor and delivery unit was considered a happy and exciting place to work, and nurses found their work to be very rewarding. However, when a baby died, it left the nurse in a state of discomfort and uncertainty. The ambiguity of experiencing a tragedy such as a stillbirth in L&D created a dilemma because it was such a contrast to the usual outcome. In addition to the various emotions nurses experienced, there was the added discomfort of having to handle the body of the deceased infant, determining how to manage interactions with the mother and family, and handling additional aspects of care, often with little guidance from institutional protocols. This typically led to ambiguous situations for the nurse and left her to determine how to best handle each situation.
Life is full of ambiguity as individuals are continuously faced with feelings of uncertainty about how to make the best decisions in a particular situation. Ambiguity is always present when difficult choices must be made (Mitchell & Pilkington, 2000). Similarly, nursing is fraught with ambiguity, as nurses are faced with instances where they may not be sure of what to do, say, or how to act in difficult situations (Mitchell & Pilkington, 2000). The ambiguity involved in caring for a mother whose baby was stillborn is different than other ambiguous situations because it involves the loss of a baby. Losing a child has been considered the greatest of all losses (Umphrey & Cacciatore, 2011), and caring for a mother whose pregnancy has ended in death is considered the most difficult practice situation for nurses (Roehrs, et al., 2008). It raises uncomfortable feelings that accompany death, but is compounded by the fact that the loss is of a baby. Additionally, nurses must continue to function in a professional manner and complete necessary tasks and responsibilities that they are obligated to perform in line with their job description. They are faced not only with caring for the deceased baby, but also caring for the mother and family. Providing care to the mother and family includes attending to their physical and emotional needs. As such, it is not surprising that this experience is wrought with ambiguity. The findings of this study will describe how labor and delivery nurses managed this ambiguity.

There were three distinct categories that surfaced and led to the conceptual development of the overall theme of Managing Ambiguity. They included Experiencing a Spectrum of Emotions, Managing the Ambiguous Patient and Managing Institutional Ambiguity. Each category included conceptual sub-categories (see figure 5). Inherent in each category was the nuance of attempting to manage an aspect of ambiguity despite the underlying themes of discomfort, confusion, indefiniteness, vagueness, and uncertainty that were evident in each situation.
Ambiguity presented itself in multiple ways through the data, particularly in the areas of personal emotions, interactions with patients, and institutional factors. Nurses described feelings of discomfort and uncertainty when caring for mothers experiencing a stillbirth. They expressed the need for support, guidance, and an environment that was more conducive to their needs and the needs of their patients. Nurses were dissatisfied with feeling that they had to manage their patients and their feelings without support. Some nurses described getting to a point where they just went through the motions of providing care. Nurses attributed this to a prolonged lack of support and attention. Despite this, many nurses described going above and beyond the call of duty due to a connection they felt with a patient or a personal experience they had that made them more in tune with the needs of their patients. Unfortunately, some nurses described an inability to manage or cope with the enormity of their feelings when caring for mothers experiencing a stillbirth. The
following section will provide a description of each category and their respective sub-categories, including verbatim responses from the participants.

**Experiencing a Spectrum of Emotions**

The category of *Experiencing a spectrum of emotions* described the various emotions that nurses experienced when caring for a mother whose baby was stillborn. Nurses interpreted the care of a mother having a stillbirth in a variety of ways that were disparate and unguided by any support or protocol that would have, in some cases, helped them focus their energies in a constructive manner. When faced with the prospect of caring for a mother experiencing a stillbirth, nurses never knew what their own reactions would be, but almost all knew that it would be “emotionally draining.”

Nurses experienced a spectrum of emotions ranging from sadness to feelings of reward. Although every nurse did not experience every emotion listed, most experienced several of them during the course of caring for a single mother whose baby was stillborn. These responses of emotion were captured under the main sub-themes of this category and were conceptualized as *Acknowledging the emotional difficulty, Suffering while acting professional, Becoming inured,* and *Feeling rewarded.* It is important to note that these categories were not mutually exclusive. For instance, a nurse who described feeling sad when providing care to a mother experiencing a stillbirth may have also described feeling rewarded as a result of the care.

**Acknowledging the emotional difficulty.** Nurses classified caring for the mother of a stillborn baby as emotionally difficult for multiple reasons. The most common reason was personal feelings of sadness. This was usually due to the enormity of the feelings nurses experienced at either knowing a baby had died or seeing a deceased baby. They also expressed empathy for the mother and family. Nurses described these experiences as “emotionally draining.”
Some nurses even described the experience as being so emotionally difficult that they felt incapable of caring for a mother having a stillbirth, also known as an intrauterine fetal demise (IUFD). One nurse said:

Even now to this day, I still can’t deal with or I can’t take care of a patient that I know has a stillbirth, or IUFD or potential for IUFD. I just can’t, and a lot of nurses can’t because it’s difficult.

Some nurses found it particularly difficult when the mother or father took the news very hard. Watching another person as they grieved for their baby was emotionally taxing. Even though nurses expected to see a significant response from the parents when they learned that their baby had died, at times, their reaction made it especially painful for the nurse. One nurse stated:

There was one patient I actually cried with once… And I think the father started crying. That’s what it was. The father broke down crying, and then, I lost it. I think there was another nurse with me, and we just all ended up just boo-hooing in there.

Nurses found tasks related to bereavement care emotionally challenging as well. These included tasks such as wrapping the baby in preparation for the morgue or giving the baby to the mother to hold. Some nurses described getting “choked up” while performing these tasks, but most noted that it was the condition of the baby that really provoked an emotional response. Nurses never knew what to expect at the delivery of a deceased baby or what the condition of the baby would be. Sometimes the baby was disfigured from congenital anomalies or had begun to decompose after being dead for an extended period of time. One nurse described the delivery of an infant with multiple congenital anomalies including hydrocephalus, a condition where there is a build-up of cerebrospinal fluid in the cavities deep within the brain (Perry, Hockenberry, Lowdermilk, & Wilson, 2014). She said:
The delivery itself was quite upsetting from my perspective because of these anomalies. You had a baby being born that… really… had gross abnormalities. And they had to actually do some extra manipulation of the fetus to be able to deliver [it] because of the hydrocephaly, so everything was just mis-shapened… it was so horrifying to look at. Another nurse described an experience where the baby had been dead for several days and began decomposing:

I had a bad reaction the first time I saw one… because the baby was very macerated. Like she had been demised for a couple of days and the skin was all coming off, and I remember thinking, “Oh my god. This baby doesn’t even look like a baby.” Because the head was crushed, and it was just, I was like – yeah…

However, some nurses found it difficult even when there were no deformities, but rather when the baby was bigger or full term. One nurse said:

That one… was tough just because, like her eye lashes were so long, like this child should have just like taken a breath. It's so disconcerting when it's a full term stillborn… it's much harder to like disconnect and just be very clinical about it. Because even if you have a mom or a family that’s sort of disconnected, when you yourself are seeing a full, like a 37 weeker, or a 40 weeker, it's hard. It just doesn’t feel… they should be warm… they feel like they should be warm.

Nurses also described distressing symptoms they experienced such as losing sleep. One nurse mentioned symptoms she experienced after a troubling experience of a baby that died during labor, saying, “I couldn’t sleep…for days after that.” Other nurses described feeling anxious when they knew they had to care for a mother experiencing a stillbirth. They tried to avoid being assigned to the mother and even had physical reactions when given the assignment. One nurse
said, “My heart dropped into my throat, I couldn’t breathe, I had palpitations.” That nurse described going to a co-worker and saying, “If this lady delivers, I’m gonna need help. I’m gonna need somebody to come in with me because I’m already freaking out. I’m having palpitations!”

Many nurses also admitted that the experience of caring for a patient having a stillbirth often stayed with them and resurfaced, even years later. One such nurse stated, “These things come home with you. Think about it. I’m here 25 years. I can still remember things that happened with demises over all these years. They never go away. You remember them…”.

This section described the emotional difficulties that nurses experienced when providing care to a mother whose baby was stillborn. The ambiguity of caring for a mother having a stillbirth coupled with the emotions experienced by nurses ranging from sadness to anxiety, further added to the uncertainty and overall discomfort inherent in providing care. Through these descriptions, Acknowledging the emotional difficulty emerged as a sub-theme under the category, Experiencing a spectrum of emotions, and a part of the process involved when providing care to a mother experiencing a stillbirth.

**Suffering while acting professionally.** Another state of emotions that nurses described was the need to act professionally. Acting professionally meant remaining composed and exhibiting a professional demeanor despite the contradictory range of emotions that nurses were feeling. Nurses felt that acting professional was an expectation of them because providing nursing care was their job and profession. As such, personal feelings were to be kept at bay. Additionally, it was generally thought that having an outward emotional reaction would take the focus away from the patient. One nurse explained:
Well, our role here is to be an advocate for the patient, to take care of our patients, right? So even if I’m emotional about it, I try and show them empathy… as much as possible, but I don’t want to take over what’s going on with them or impose my feelings on them.

In order to maintain an appearance of professionalism, nurses described clearing their head, and putting on a “front” or “fake façade.” When describing the difficulty she had trying to maintain her composure when wrapping a dead baby, one nurse said:

I was trying to kind of clear… my mind. Because remember I still have to go back, I still have this patient to take care of, and once that patient delivers… another patient needs to come in. And I still need to go on with my shift, and I still need to act like I’m okay.

When speaking about other nurses who seemed to be “immune to it,” one nurse said, “Just because you put on a front does not mean you’re not suffering internally or dealing with your own things internally.” Yet another nurse described, “I had to kind of put on a fake façade… this smile and persona that I’m okay and I’m not.”

Crying or having an emotional reaction in front of the patient was generally frowned upon. Even if the nurse wanted to cry or felt the need to cry, she usually held back these urges when in front of a patient. One nurse stated, “We do get emotional… we do feel for the mother and the baby and the… family—but not in front of them.” Another nurse said, “I really just try to be an emotional support, like a rock.”

Despite the desire to avoid having an emotional reaction in front of the patient, many nurses admitted to having cried with or in front of a patient while still trying to maintain professionalism. One nurse said, “I teared up in the room, and that was appropriate. Like everybody was tearing up, and it was just a very serious thing.” Another nurse said:
You do get emotional. I readily admit I’ve cried on a couple of occasions. If you get emotionally attached to your patients…And then especially that one I told you about that sent me the pictures the next day. I was crying with her because I spent two days with her and then she finally had the baby… Yeah, you try to be strong for the patient and their family, but sometimes, you just lose it.

There were two sides to the issue of acting professional as described in this section. On the one side, nurses expressed their feelings in a modest way while with the patient. On the other side, some nurses put on a “façade” and “stayed strong” by not showing their own grief. The ambiguity of determining what professional behavior was appropriate in a situation where there were no clear rules of conduct added to the already ambiguous state of caring for a mother having a stillbirth. In each instance, the respective nurse felt that her response maintained professionalism.

In the cases where the nurses cried or “teared up” in front of the patients, no one described an adverse response on the part of the patient at seeing this reaction from the nurse. In fact, in a comprehensive systematic review of families who had experienced stillbirth, researchers identified that “parents appreciate when healthcare professionals show emotion, empathy, and human reactions to their tragic experiences” (Peters, et al., 2014, pg. 6). Some nurses felt they could maintain professionalism while expressing their emotions, albeit contained, while others did not. Each case, however, included an innate sense of suffering on the part of the nurse while trying to balance her personal feelings and her professional duties. The data showed that this was a salient process that occurred when providing care to a mother experiencing a stillbirth.

**Becoming inured.** Some nurses described a sense of being inured to the experience of providing care to a mother. They described “going through the motions” of providing care and did not particularly seem fazed by the emotional aspects of the loss. Some nurses attributed this to
MANAGING AMBIGUITY

becoming so “routined” that they were no longer emotionally affected by it. One nurse explained, “I think before I used to be more like, you know, affected by it. But I think now that I’ve had so many – It’s wrong – But I feel like now,.. it’s just another thing. I just keep moving.” Another nurse admitted:

You kind of become – I don’t want to say complacent? Like it’s just – not that it doesn’t faze you, but like the whole process is just the process, to me. How I feel, by the end of it, is more – it’s more dependent on how the patient is taking it.”

Another nurse said, “In the cases of still births… It’s just like we’re just routinely giving care, and this a part of it. This is what we have to do. We go through the motions, and everybody’s on their way.”

Other nurses described becoming inured as a necessary protective coping method required in the field of labor and delivery. When discussing how she handled the dichotomy of experiencing the happiness of birth alongside the sadness of death one labor and delivery said:

I think you become a little bit inured to both, you know. It's like I see this joyous miracle of birth every day, and it's like uh, great, the baby's out, so now maybe I'll make it to my break or whatever. You know? Like… you can't feel the highs and the lows. Like you just couldn't. I don't think you could cope if you do.

Some nurses seemed to use this process as a way to avoid dealing with the enormity of their true emotions. They felt they could just “deal with it” by moving on. One nurse said, “Maybe it sounds very harsh, but I don’t know… If you move on and you have another patient… you forget… it’s not [as] fresh… You just move on”. One nurse more explicitly admitted:

You become so routined that you start to get cold and callous… And you don’t wanna get there. You don’t wanna not care about what you’re doing. But it happens when you’re not
tending to your own emotional needs, and you start to just put walls up. So that… you know, you guard your own emotions, you put up your own walls and, you know, you start to pull yourself away from what it is that’s actually happening.

The preceding section described the experience of becoming inured to caring for mothers having a stillbirth. The ambiguity of working in the midst of an emotionally charged environment and not allowing themselves to be emotionally affected proved challenging for many nurses. Many reconciled this by “going through the motions,” or becoming hardened to the experience, denying the reality that they were being impacted by the experience. Through these descriptions, *Becoming inured* emerged as part of the process of providing care to a mother experiencing a stillbirth.

**Feeling appreciated/rewarded.** Many nurses described that despite their struggles to obtain support and the fears and discomfort of working with the mother of a stillborn baby, they were able to experience a deep sense of reward and appreciation as they provided care during such a difficult time. This was especially true when the patient was expressively appreciative of the care. One nurse discussed a patient who was very grateful for the care she received:

What was unique also is that the patient regard—like, set aside the fact that she had to deliver, we had to induce her into labor to deliver a baby that had died—But if you set that aside, she was one of the most grateful, appreciative, thankful, like just verbally expressing her gratitude for our help, for our attention, for us giving her pain medication. She was really super like, just thank you so much. When like my heart was breaking for her… That’s a very unique one, but… within a week maybe, I came into work, and I had a thank you gift from the mom. That she actually bought me chocolates and had a really nice thank you that I kept, of course. I kept it because you don’t get very many of those in nursing,
you know. Just thank you for your time, your patience… Just showing she was so grateful.

Like, even a mom delivering like a normal delivery, we don’t get a thank you. And this is a mom who had a baby that died. Who someone else would be so wrapped up in her own misery, but nope she gave me a thank you gift… It made me feel great, you know.

Several other nurses described mothers who sent them thank you notes after they had provided care to them, but receiving material rewards and “thank yous” were not the only reasons why nurses felt appreciated. Some expressed a feeling of knowing that they had done everything they could to help the patient, and that in itself was rewarding:

[It’s a] feeling inside that I did everything, what I could for the – for the patient’s wellbeing, for her to not be in pain, to feel good even with the sad situation. It’s just a feeling inside [for]… what I’ve done for this patient.

This category demonstrated that the juxtaposition of tragedy in a place that is typically joyful, such as labor and delivery, could still result in a rewarding experience for the nurse. Thus, the confusion and ambiguity of a stillbirth as an unexpected and out-of-place event sometimes presented the nurse with opportunities to intervene and to experience deeply felt rewards. Through these descriptions, Feeling rewarded emerged as a part of the spectrum of emotions nurses experienced as they managed the care of a mother whose baby was stillborn.

**Summary of Experiencing a Spectrum of Emotions.** This section described a range of emotions that nurses experienced when providing care to mothers experiencing a stillbirth. They included Acknowledging the emotional difficulty, Suffering while acting professional, Becoming Inured, and Feeling rewarded. These categories were not mutually exclusive, and nurses described experiencing a variety of them when caring for the mother of a stillborn baby. In this category, nurses described the difficulty they experienced when confronted with the complexity of
providing genuine and compassionate care despite their own range of emotions. The ambiguity of caring for a mother experiencing a stillbirth was further complicated by the various emotions that nurses had to manage and endure in the midst of providing care. Some of these emotions were positive, but most were negative. All were marked by the ambiguous undercurrent of navigating the care of a mother whose baby had died. As such, Experiencing a spectrum of emotions and its sub-categories as described above emerged as a part of the process of caring for a mother whose baby was stillborn.

Managing the ambiguous patient

The category of Managing the ambiguous patient described how nurses coped with the ambiguity of caring for a patient that was different from the typical patient in labor and delivery. Being in a position where the nurse had to not only interact with a grieving patient but also handle a deceased infant was uncomfortable. Either one of these facets would be difficult, but the coupling of them added another layer of complexity. Due to these challenges, the nurse responded to the patient in a variety of ways. Some nurses responded in a negative way, as evidenced by unconstructive behaviors such as avoidance and stigmatizing of the patient whereas others responded in a more positive way and found ways to provide meaningful and compassionate care through unconventional methods. These measures comforted the patient and served as a literal and figurative protective barrier.

When assigned to a patient who had a stillbirth, most nurses managed it in a variety of four ways. These four ways emerged as the main sub-categories under Managing the ambiguous patient and were conceptualized as Avoiding the patient, Stigmatizing the patient, Learning to provide care, and Protecting the patient. Once again, it is important to note that these categories were not mutually exclusive. Nurses fell into multiple categories at various times. For instance, a
nurse who described stigmatizing a patient may have also described protecting the same patient. Each category, however, described a distinct way that nurses managed the ambiguity of providing care to a mother who was different from the typical labor and delivery patient.

**Avoiding the patient.** *Avoiding the patient* was one of the themes that emerged under the category of *Managing the ambiguous patient.* Research has indicated that discomfort with ambiguity diminishes the opportunity for meaningful dialogue between nurses and patients (Stilos, Moura, & Flint, 2007). In no other area was this more apparent than the sub-category of *Avoiding the patient.* This sub-category described various avoidance behaviors nurses exhibited when providing care to the mother of a stillborn baby. There seemed to be a general desire among the participants to give the mother space to grieve, and therefore they did not enter the room of a mother who had a stillbirth as often as a mother who had a live birth. After further probing, however, discomfort with death emerged as the main reason for avoiding the mother of a stillborn baby. Nurses admitted that they struggled with finding the right words to say to a grieving mother and felt awkward carrying out nursing care tasks. One nurse explained, “I just kept thinking, I hope she doesn’t deliver on my shift. Not because… I didn’t want to take care of her, but I didn’t know what to say”. Watching a mother go through the grief of losing a baby was very uncomfortable for nurses. The ambiguity of not knowing what to say and or do led to a barrier in the nurse-patient relationship and consequent avoidance behaviors.

Even when they knew what to say, some nurses avoided mothers because they were uncomfortable providing care that was related to bereavement such as asking if the mother wanted to hold the baby or if she wanted pictures of the baby. Although the nurse knew that these difficult questions were necessary, there was uncertainty about how the mother would respond and how to best communicate with her. One nurse stated:
I did have a checklist to kind of figure out what I needed to get done, and what the previous nurse had gotten done. The previous nurse also felt very reluctant and we knew what we had to do, but no one wants to ask those certain questions. No one wants to ask about burial. No one wants to ask, once the baby’s delivered, do you want to hold the baby? You’re afraid. You don’t know what’s the right thing to say. You don’t want to come off as offensive.

Another situation where nurses felt uncomfortable was if mothers were unemotional. Nursing is a profession that focuses on a patient’s response to a condition or disease. Similarly, nurses in labor and delivery who cared for a mother having a stillbirth often followed the patient’s lead in order to determine how to best help her. Nurses expected mothers to be emotional and distraught at the discovery of the death of their baby, and they felt confused when a patient had no reaction or seemed to be unaffected. Mothers who did not give an indication as to how they were feeling left the nurse to interpret her behavior. The absence of clear signals about how a mother felt often compounded the nurse’s discomfort and led her to engage in avoidance behaviors. One nurse recounted:

I had one in particular… She did not seem pleased or not pleased. She had no emotions, a very flat affect. It was very hard as a nurse to respond to someone like that because you don’t know how to respond. You don't know how to treat her. And with mothers like that, you automatically think, “You know what? Let me just give her space because… it seems like you're bothering them by just asking questions. You’re like: okay, I'm gonna leave you to sleep.”

In addition to the discomfort of not knowing what to do or say, another reason given for avoiding patients who were having a stillbirth was due to pregnancy. Being pregnant and caring
for a mother who had just lost her own baby was particularly distressing and led to various
avoidance behaviors among nurses. Some labor and delivery nurses described how they avoided
assigning a pregnant nurse to a patient who was delivering a stillborn. One nurse explained, “It’s
kind of something on L&D that… you don’t take care of demises. You don’t even interact with
them while you’re pregnant.” Various reasons were given for this practice. Some nurses believed
superstitions that if they cared for a mother having a stillbirth their own baby would be stillborn.
Other nurses suggested that it would be too distressing for the patient to have a pregnant nurse
care for her. One nurse said, “I don't think she should have to go through having a nurse who has a
baby inside of her if she just lost hers.” When describing a patient’s reaction to seeing her
“pregnant belly”, one nurse said:

The patients don’t feel too comfortable with a pregnant nurse… I had one woman who was
38 weeks, and she was a week more than me. I was 37 at that time… and she already had
delivered… [When] she looked at me… she was amazed that I was pregnant. She bust out
crying when she saw me very big.

Other nurses suggested that not assigning pregnant nurses to women who had a stillbirth
was for the benefit of the nurse. For example, one nurse who was caring for a patient who had a
stillbirth while she was pregnant recounted that the surgeons she was working with that day told
her, “You know, you’re pregnant. This is not something you should be watching. You should be
enjoying your pregnancy and not living in someone else’s grief.” Overall, nurses seemed to
believe this was for the benefit of both parties:

I [was] not only advocating for the patient, but advocating for myself. It’s like, I don't want
to go through this, and I especially don’t want her to go through looking at me with a big
belly in front of her.
Another nurse said:

With all pregnant nurses, we try very hard not to have them take care of the patients with fetal demises. And… the reasons for that – I mean here is somebody clearly walking around with their baby kicking and moving inside of them, and here you're lying and losing yours. And… of course, the nurse is being supportive, [but] at the same time in the back of her mind thinking this could be me. But at the same time, I don't think the patient is seeing the nurse as a pregnant nurse, she's seeing her as somebody who's pregnant with a live baby still moving, kicking in them. So, we try to be sensitive not just to a coworker but also to the patient.

Although the participants suggested that this was the predominant attitude of the labor and delivery unit, some nurses indicated that this sentiment was not reciprocated by everyone. One nurse said, “I remember when I was pregnant. I had a 16-week demise, and my partner was like, ‘It’s your patient, go ahead.” Another nurse described being met with resistance when she tried to change her assignment because she was pregnant. She said, “They turned it into, ‘You’re pregnant, but you're still a nurse… That’s the assignment you got.”

This section described various reasons nurses provided for avoiding the patient having a stillbirth, including discomfort and pregnancy. The uncertainty of not knowing what to say or do added to the ambiguity already present and led to avoidance behaviors. Similarly, nurses who were pregnant also felt uncomfortable caring for a mother who had a stillbirth and avoided these patients and/or requested not to be assigned to them if possible. Of the 20 nurses interviewed, all but one agreed that when possible, pregnant nurses should avoid caring for the mother of a stillborn. However, there were no clear guidelines or official policies to support this practice.
Through these descriptions, *Avoiding the patient* emerged as one way that nurses managed the care of an ambiguous patient.

**Stigmatizing the patient.** Another process that emerged under the category of *Managing the ambiguous patient* was *Stigmatizing the patient.* To stigmatize means to devalue or disqualify from full social acceptance (Goffman, 1963). As nurses described, during interviews, ways in which patients having a stillbirth were labeled and differentiated, stigmatization of the patient was identified. For instance, nurses made subtle statements that signified distinctions between patients having a stillbirth versus patients having a live birth. These statements suggested that patients having a stillbirth were not in “real labor,” and the babies were not “real babies.” One nurse made a reference to her patients who gave birth to live babies as her “real patients”. She stated, “Sometimes I tell my real patients- that, you know, take home babies…” The implications of this are manifold. When nurses themselves did not classify a stillbirth as a real delivery, the baby as a real baby, or the mother as a real patient, it added to the ambiguity of providing care by impugning the validity of the loss, which affected the care given and the attitude of the nurse toward the patient.

This section described ways in which nurses stigmatized patients experiencing a stillbirth. Stigmatization was demonstrated through methods of labeling and differentiating between patients having a live birth and patients having a stillbirth. This labeling did not always have a negative undertone but rather identified a significant difference between these patients and other patients. Through these descriptions, *Stigmatizing the patient* emerged as one way that nurses managed the care of an ambiguous patient.

**Learning to provide care.** Another theme that emerged under the category of *Managing the ambiguous patient* was learning to provide care. This theme was specific to the category of
managing the ambiguous patient because there were many times when providing care to a patient experiencing a stillbirth was different from providing care to a patient delivering a live baby. Nurses indicated that their formal education and training was focused on how to provide nursing care to patients such as administering medications, assisting with deliveries, and managing the patients’ medical needs. However, there was little training that focused on the patients’ emotional needs or bereavement care.

Most nurses attributed their knowledge of how to care for a mother having a stillbirth to experience. One nurse stated:

Through the years I’ve learned many things. How to deal with the stress… how to express myself… This [does] not come from [a] book. You have to experience the situation yourself and see… how you can deal with the situation.

Many nurses agreed that it was necessary to “work through the process multiple times” in order to know what to do, and most sought the assistance of co-workers:

Most people don’t get it on orientation and… We still have people today, I mean, they’ve been here for a good amount of time, but you don’t get fetal demises often so you have to go to people – like, what do you have to do? What’s next? Who do I send this to? Who do I call?

Another nurse concurred with this sentiment by stating: “You don’t get this on orientation. You know? This is something you learn as you go along, and I relied on the older nurses to give me guidance at that point.”

New nurses received 4 months of orientation before they were able to work independently. Their orientation included classroom instruction, as well as a preceptorship with an experienced nurse. Bereavement care was briefly presented during orientation, but there was no guarantee that
orientees would experience caring for a mother with a stillbirth during orientation. If a nurse did not have this experience, they would typically reach out to a charge nurse, senior nurse, or nurse manager to assist them if they were assigned to a mother experiencing a stillbirth.

One nurse who often helped newer nurses care for women with a stillbirth discussed the difficulty she had explaining the process of providing care. She said,

Every case is so different. There isn’t a step one, do this. Step two, do that… I’ve never done two that were exactly the same… And I can’t tell you how many I’ve done. Umm because again, the age or the gestation of the baby, what the mom’s preference is, what the dynamics in the house is, depending with the father. What their religion and their background, and their culture [is]. Every single thing you have to take into consideration can be an extra step more or step less in what you have to do.

Similarly, one nurse admitted, “We try to care… for every patient the same. But not every patient is the same.”

Although most nurses indicated hands-on experience was the best way to learn how to provide care, some nurses admitted that there was a need for additional formal education in regards to perinatal bereavement care. One nurse said, “That could actually be helpful to have some kind of more formalized training for the emotional part rather than the – the medical part… because your training is all about like how to deal with women in labor”. Some nurses thought additional training could help them know the right things to say to patients and avoid saying the wrong things. One nurse who was frustrated at hearing the offensive cliché’s that nurses often said to patients stated:

I would not mind having more formalized training on bereavement stuff because whenever I hear somebody say one of those of those things… to a patient that just drives me crazy,
it's like how – how can you think that's an appropriate thing to say?... things like… ‘Oh, well, this is part of God's plan’. Like wow, so God must really hate me, you know… because this sucks or like maybe you don't even believe in God.

Some nurses who had received additional training specific to bereavement care found it to be monumentally helpful when providing care to patients who had a stillbirth. One nurse who had formerly received hospice training at another institution said:

The training was really helpful… [There was] a lot about just like the importance of listening and just being present and um also thinking about death, just like to be more comfortable with death… Just to like check in a lot and ask them… about the person who has died… because a lot of people get like really uncomfortable to talk about it. And then just to realize how little we think about that and how little we talk about death and acknowledge grieving.

After going to an educational program that focused on perinatal bereavement care one nurse stated:

Honestly going to the conference really changed the way I have approached my patients since then. Sometimes at the end of the conference they’ll say, “Will you change your practice because of what you learned here today?” And in that case for sure, because I had always just assumed, so naively and so ignorantly that like this was a separate event and this happened, and now they're gonna go back and just live their life. Whereas for some people in fact, no, this is like – there's a baby… that maybe they’ve held and bathed and – like, dressed, and named and taken pictures with… I was sort of horrified that it was so astounding to me, but it really was. Like, wow, I have really not been very open to a different way of looking at it… and I don't know… if that’s a reflection of the providers,
or my nurse coworkers, or my perceived impressions of what the patient is feeling, I don’t know why, but the conference really changed how I talk about the baby, like calling it a baby, asking if it has a name, encouraging do you want to hold her or him, or how about your husband? Wrapping the baby in such a way that if there is skin that sloughed off, I can just hide it and just put on a hat and she can still hold the baby.

Some nurses felt they were able to provide more sensitive care because of a personal experience with loss, such as losing a close relative, having a friend or loved one who experienced a perinatal loss, or even losing a child themselves. One nurse said:

I had, like, – a loss myself… but it was, like, a first-trimester loss. But a loss is a loss. So, as such, I think that probably is part of what makes me a little bit more sensitive to it.

Another nurse who had a family member who experienced a perinatal loss stated:

I have a cousin who’s about six years older than me. And 12 years ago, she had conjoined twins so they had one stomach, one liver, and they shared some intestines. So, um, she was told to terminate as soon as they found out, but she refused to terminate and she delivered at eight months via C-section. The babies survived the NICU [Neonatal Intensive Care Unit] for three days… They discharged her that same day that the babies died. And what they told her was, “At least you got to hold your babies.” It was no, “I’m sorry for your loss.” I was there for that, and I just feel that things… could have been handled better. So, whenever I have a stillbirth, I remember my cousin.

This section described the most common ways nurses learned to provide care to mothers having a stillbirth. These included learning from hands-on experience, seeking the assistance of co-workers, participating in specialized trainings or going through a personal experience of loss.
Through these descriptions, *Learning to provide care* emerged as one way that nurses managed the care of an ambiguous patient.

**Protecting the patient.** *Protecting the Patient* emerged as another theme under the category of *Managing the ambiguous patient*. Nurses engaged in activities to provide emotional protection and support to patients experiencing a stillbirth that were not typical when caring for mothers having a live birth. Nurses described taking steps to ensure that patients received the support and care they needed during such a difficult time.

Nurses found that there were behaviors and occurrences that compounded the mother’s grief while she was in the hospital. One such behavior was when a mother blamed herself for the loss. Nurses believed that self-blame could lead to negative consequences. One nurse stated:

> Them having guilt is going to make the whole process much worse on their part. They won’t cope well. I mean, it’s hard enough to cope with the whole situation to begin with, but then on that, having the guilt on top of it.

As a way to protect the mother from self-blame, the nurse would encourage her not to blame herself. “You don’t want to make them feel blamed... that’s very important. I always say, “Mommy, it’s not your fault”. That is a big, big thing.” Another nurse told of a situation where a mother blamed herself for the loss of her baby because she did not come in to the hospital sooner.

So, we had a patient who was obviously an orthodox woman who hadn’t felt the baby move since Friday night, but because it was Shabbos, she didn’t go to the hospital. Finally, about 2:00 p.m. on Saturday, it started bothering her. So, she actually walked here by herself just to be put on the monitor. I got a doctor to do a sonogram [and]… we… confirmed that there was a fetal demise. She was early 30s, maybe 31, 32 weeks… She stayed with me in triage for like an hour, hour and a half. She felt that, “Maybe if I came in
last night when I first didn’t feel the baby move, maybe the baby would be alive,” all that kind of stuff…

Sometimes the blame came from other family members who insinuated that the loss was the mother’s fault, or at times directly accused the mother of doing something to cause the baby’s death. One nurse described a patient whose husband blamed her for a fetal demise because he felt that she “cleaned their home too much.” This made her feel worse. As a way to protect the mother, sometimes a nurse would find a way to diffuse the situation or separate the family member from the mother. One nurse gave examples of what she would say, such as:

“Oh, you can check on your other kids at home. She’s here now, when she’s gonna deliver then we’ll call you back.” Or, “She’s really hungry, and I think she has this craving. Can you go get it?” So at least separate them for a little bit… I told her, “Sometimes people say things out of anger. They don’t always mean them. But just know that nothing that’s happened is your fault. And we’re here for you, you have supportive nurses, and we’ll be here with you every step of the way.” I always tell the patient it’s not their fault. Things happen, and we don’t always know why they happen.

Another approach was to try to make the experience meaningful for the mother. Nurses felt that by making the experience meaningful, the mother would have a positive grief experience, which would help her cope with the loss. Nurses accomplished this in a variety of ways including allowing the parents to hold the baby, taking pictures of the baby, and providing the parents with a memory box that contained memorabilia such as pictures of the baby, clothing, a locket of hair, and a journal book. The participants stated that they always provided the mother with these options and acknowledged their importance. One nurse stated:
We go over everything with them; ask them what they’re going to want once the baby is born. Do you want to hold the baby? Do you want pictures of the baby? No matter what, we always take pictures. All of these things are really important.

Another way that nurses protected the patient was by spending time with her. By spending time with the patient, nurses felt that she would not be so alone and isolated in her grief. In this way, the nurse cared for and provided emotional support to her. Although the participants had a busy workload, those that were able to spend time with their patients described a bond that occurred and that patients were appreciative of the attention. One nurse even described sitting in her patient’s room to write notes and eat lunch just so she would not feel alone. She recounted:

Instead of sitting at the nurse’s station – I don’t always do it, but there’s been times that I sit in my patient’s room and chart in the patient’s room. That’s not something I have to do – but just to let the patient know that they’re not alone. [One] patient felt comfortable with me because we were talking for two days pretty much. And then she said, ‘I don’t wanna be alone. You’re the only one that understands me…’ So what am I gonna say? I can’t leave… But I – I just grabbed my paperwork; I brought it to her room. She went to sleep, but she physically wanted me right next to her... So I had to put the side rail down and sit so where she felt my arm … And once she fell asleep I was like, ‘Okay, I can leave.’ Like how you would treat a little kid…. She woke right up… And she said, “I told you not to leave’ … So that bond, even though we didn’t say much, but just me being there I know I was a big help to her.

Additional ways nurses protected patients were by maintaining their dignity. There were certain situations that caused additional grief and embarrassment to the mother experiencing a
stillbirth, such as reminders of the delivery in her room including dirty bed sheets or disarray after the delivery. Nurses described trying to shield mothers from these experiences. One nurse said:

You have to make sure that the cleanliness and the room is presentable so there’s nothing to embarrass the mother. She doesn’t need anything extra to feel… conscious about after going through these things or worried about what people will see.

Another nurse explained:

I don’t leave them in bloody gowns… I change their pads more often than I would do another patient because everything makes them more sensitive. Not that I don’t provide care to the living ones, but – because the baby is already dead, and they don’t need a reminder that, ‘Oh, that’s my dead baby’s blood. I delivered my baby, and the room is still dirty.’ Or, ‘I still have my baby’s blood’ … I don’t wanna make them forget that they had a baby because that will always be their child, but you should give the patient dignity.

One nurse recounted an incident when a mother, thinking she had to use the bathroom, ended up delivering her stillborn baby in the toilet. She described the effort it took to protect the patient from embarrassment and shame and still make the moment meaningful. She stated:

She delivered in the toilet, but the cord was hanging – because the placenta was still inside of her, but the baby was in the toilet so the baby was like – like a pendulum in the toilet– so it was very traumatic… I was already in the room, on my hands and knees, in between this woman’s vagina and she’s on the toilet. So, I’m trying to hold the baby and give the baby as much dignity as I can and give her dignity… Then about five to six residents came in, plus all the doctors. And then the patient was embarrassed so I told them, you know, ‘I just need two people.’ So, I cut the cord as best as I could and, um, I rinsed the baby real quick so that she can hold it and I wrapped it up in … the baby blanket … So I explained
to her what was going on, and she was happy that she got the chance to hold her baby. And I didn’t throw the baby in a bucket or do things that other nurses do. I always refer to her baby by its name, even though we couldn’t really determine the sex… because it was still early, but I told her, you know, what do you think it is? Are we gonna have a name? So, we named the baby. She – she held the baby for about an hour. The husband fell asleep with the baby in his arms. We discussed, um, the importance of a support group and I went over the bereavement packet.

This section described the steps nurses took to ensure that patients received the support and care they needed during such a difficult time. These included ensuring the mother did not blame herself, making the experience meaningful for the patient, spending additional time with her, and maintaining her dignity surrounding the circumstances of the stillbirth. Through these descriptions, protecting the patient emerged as one way that nurses managed the care of an ambiguous patient.

Summary of Managing the Ambiguous Patient. This section described the four main ways that nurses responded to and interacted with a patient that was different from the typical laboring mother. They included Avoiding the patient, Stigmatizing the patient, Learning to provide care, and Protecting the patient. These categories were not mutually exclusive, and nurses described using a variety of these methods to manage the challenges involved in caring for a mother whose baby was stillborn. In this category, nurses described how the ambiguous nature of providing care to a woman having a stillbirth resulted in feelings of uncertainty and discomfort when interacting with the patient directly. Based on how the nurse interpreted the situation and the mother’s response, she managed the mother’s care in a constructive way by learning how to care for and protect the patient or in an unconstructive manner by avoiding and stigmatizing the patient.
or a combination of both. As such, *Managing the ambiguous patient* and its sub-categories as described above, emerged as a part of the process of caring for a mother whose baby was stillborn.

**Managing institutional ambiguity**

*Managing Institutional Ambiguity* described how the nurse managed the institutional barriers she encountered when providing care to a mother whose baby was stillborn. This theme described the difficulty nurses faced when challenged with a dilemma due to institutional policies or circumstances. The absence of effective protocols, education, and support often left the nurse feeling unsure of how to provide effective care for her patients. There were also several instances in which nurses had to fill the role of other staff and members of the healthcare team. This made them unsure and less confident in their actions. Nurses found ways to manage these ambiguities and thereby attend to the needs of their patients. This section will present the methods that nurses used to manage the institutional ambiguities with which they were faced. The main sub-categories of *Managing institutional ambiguity* were conceptualized as *Managing barriers to care,* *Managing alone,* *Fighting institutional policies,* and *Getting or not getting support.*

**Managing barriers to care.* Nurses identified several institutional obstacles that were barriers to their ability to adequately care for the patient. The two biggest obstacles participants identified were language barriers and workload. Nurses agreed that caring for a patient who did not speak the same language added to the complexity of providing care. Although translation services were available, they were sometimes too inefficient and impractical for the nurse to use effectively. They also identified language barriers as an impediment to forming a bond with the patient and to providing emotional support. One nurse stated:

> We have a lot of patients who only speak Chinese, [and] you try, but… I'm certainly not gonna talk to her about her like fears about her family, you know, the reactions of her
peers or whatever when… you can't speak the same language. I mean you can get a
translator phone for like important things like, you know, ‘Do you wanna hold the baby?’
But I can't have a translator phone for the entire time, you know. And also, to even have
any of those conversations through a translator is difficult, so that was – that's another
barrier to like bonding with a patient. I felt sad about that lady. I remember thinking about
that afterward just like… if I could speak Chinese, she would've… probably had a better or
at least better supported experience…

Another nurse recounted an experience she had with a mother who spoke a language that was
particularly difficult for which to find a translator and the difficulty that it caused in facilitating
effective care:

The one last week was a 35-weeker. She didn’t speak English, so I mean, it’s hard to
communicate even though you have the phones. It’s just difficult because you literally
have to use the phone for everything when sometimes you were just trying to comfort
them. So, it’s especially difficult when they don’t communicate with you in your
language… It’s time-consuming. I mean, I’m willing to spend as much time as possible,
but… it’s frustrating… that there’s a language barrier. She spoke… Uzbek. That was the
problem. Yes. Uzbek apparently is a very hard language on the language line. So, each
time I called I’m on hold for like a half hour.

It was difficult to determine the right course of action to take when there was a language barrier.
For instance, nurses felt it would be inappropriate to leave the mother during the actual delivery of
the baby or immediately after to get a translator or language line phone to explain what was
happening. One nurse said:
The baby’s face itself was very purple, very bruised. There was a cord around the neck… So, you could look at the baby and see that the baby was probably passed away, maybe a couple days ago based on how the skin was. But then how do you now prepare the mother to explain to her how this baby looks when she doesn’t speak English but I’m not gonna go run out right now and get the translator phone in the middle of me like, trying to wrap your baby to now wait for a translator to explain to you, this is what your baby’s gonna look like…– it’s wrong and inappropriate.

When addressing barriers such as this, nurses attempted to explain everything that they could while a translator was available. When they were without this service or when they felt it would be inappropriate to obtain this assistance, they described using facial expressions and non-verbal communications, such as smiling, to express feelings of empathy and compassion. When appropriate, they also discussed using presence and touch to express what words could not. One nurse stated:

She didn’t speak much English, but caring always goes a long way; smiling when you’re taking care of a patient. Even if they don’t understand everything, trying… if the patient’s pointing at you about something don’t just say, “Well, I don’t speak your language” … But you try your best to understand the patient… touch is always important [and] smiling.

Although there was more they wanted to do, many stated that they believed these non-verbal measures made a big difference to the patients.

Another barrier to providing effective and compassionate care was the nurse’s workload. This often affected the amount time the nurse had to spend with a mother. The labor and delivery unit was very busy, and time with the patient was thereby limited. Nurses typically had one to two
other patients that they had to care for and additional paperwork that had to be completed when there was a stillbirth. This left the nurse with little time to spend attending to the emotional needs of the patient. One nurse said, “You try to be like supportive, but a lot of times … we're so busy.” Another nurse stated, “If you have other patients that have a lot of other things going on and you're just like in and out of that one patient's room like very briefly, it's hard to bond with somebody if you have like such a short period of time.”

Another nurse spoke of the lack of one-to-one nursing care where a nurse would be dedicated to just one patient for a period of time. She said:

> In the nursing capacity who is supposed to be the advocate, you don't have even the time really to sit and hold her hand because they're like, waiting for you to come back to do what you gotta do. You know, I mean, there's no one-to-one. There's no such thing. So, you will be taking care of her and some other – maybe two other patients … I mean, there's certain things … she needs that you can't really address.

When addressing the barrier of workload, some nurses found innovative ways to spend time with the patient such as writing notes in the patient’s room or volunteering to care for her on the following day if they were returning to work. In order to spend more time with her patient, one nurse described giving over all her other patients to a fellow nurse until her patient was transferred to another unit. Despite these maneuvers, most nurses struggled to balance the time with the patient and the time that was necessary to attend to their other responsibilities.

This section described how nurses managed the institutional ambiguity involved in providing care to a mother whose baby was stillborn by managing institutional barriers to effective care. These barriers included language barriers and workload. Nurses found ways to manage these barriers by using novel methods such as nonverbal communication and different
methods to get around their workload constraints. Through these descriptions, *Managing barriers to care* emerged as one way that nurses were able to manage the ambiguity involved when providing care to a mother experiencing a stillbirth.

**Managing alone.** *Managing alone* was one of the ways nurses managed institutional ambiguity when providing care to the mother of a stillborn baby. Nurses felt that some of the support and team work they typically could expect when caring for the average patient on Labor and Delivery was not reciprocated when caring for a patient with a stillbirth. Thus, they were left to manage the patient’s care alone. This resulted in feelings of abandonment by the health care team and the institution.

Nurses identified that physicians frequently avoided patients experiencing a stillbirth due to their discomfort. Nurses expressed the challenges they faced when requesting that a physician check on their patient or attend the delivery of a stillborn baby. One nurse discussed an incident when she reached out to a physician who was hesitant to offer assistance. She said:

“'She looks really uncomfortable, someone needs to come and examine her, I think she’s gonna deliver.' [He replied], ‘Did you call the private provider?’ … ‘I did but no one answered.’ … ‘Well try again to call them to see if they’ll come.’ … As opposed to if it was a 39 weeker viable baby, that provider would say, ‘I’m coming right now, then we’ll call the private doctor.’ And I think that does happen often. And I guess you know everyone’s human. You know it’s difficult to deal with death, especially death of an unborn… baby.

Another nurse discussed how she felt abandoned by physicians who immediately left the room after confirming with the mother that there was no heartbeat. She recounted a scenario that typically occurred when a mother having a stillbirth first came into the labor and delivery unit:
There was a 34-weeker and she came in… contracting… and I was a triage nurse and you put the monitor on and you can’t find a heartbeat. So, you know sometimes, you think maybe it’s just you. You call somebody else. They can’t find it either. They do a sono on her. Then they come in, and they told her, ‘There’s no heartbeat.’ And the doctor’s all just walk out after that. And then you’re left with the person who’s now crying, and the world is falling, and it’s just you now. They just announce it and leave. And then you’re there. You’re the person to comfort them.

Another instance where nurses described feeling abandoned by physicians was in relation to pain management. Although nurses could administer regular pain medications, they could not administer epidurals. It was common for the nurse to contact physicians or anesthesiologists to administer an epidural, but they had little control over how long it took for the provider to attend to the patient. One nurse stated:

Sometimes there are like institutional things going on that are out of your power like that the epidural takes an hour to get there or whatever. That can create kind of a barrier between you and the patient because you’re the person who has to keep saying, ‘I’m sorry they’re not here yet,’ or ‘I’m gonna call them again,’ whatever. And you’re trying your best, but they’re still not getting the thing that they really need, you know.

Nurses took their patients’ pain experiences very seriously. One nurse said, “I really feel like it’s unfair to have to go through labor, to push a baby out, and number one, be in pain, and number two, not have a baby to show for it.” Participants explained that they did all they could to manage this problem to the best of their ability, even when this meant calling the doctor repeatedly until they showed up, because they felt this was at least one area where they could offer some comfort. One nurse said:
I teach them that they can get it [pain medication] at any time they want. It is important for [the] patient because [they have] this traumatic thing that… they’ve learned that the baby died and now they’re expecting pain during labor… it wouldn’t be right… So at least we can relieve the physical discomfort by giving them pain medications.

In addition to the physician, the patient representative was another member of the interdisciplinary team that played a big role when there was a still birth. One nurse said, “She’s the person that everyone else seems to… go to.” Nurses found the patient representative to be an invaluable resource. “You call her, and then she comes. I do actually find that helpful in terms of going over some of the like burial options and that kinda stuff that I don’t know a lot of details about,” said one nurse. When the patient representative was off or not around, nurses were often left alone to answer questions they did not feel prepared to address. They felt frustrated and powerless to assist patients in the way that they needed.

They ask you about cost and things like that and as nurses, I mean, we’re not given any of this information. Usually [the patient representative] or someone else would help them with that. And then, I mean, it’s frustrating when you wanna help someone and then the thing you can tell them is oh, I don’t have the information. This person is the person you have to speak to. Oh, but this person is not here until Monday, and today is Friday. It’s just a standstill. And it’s frustrating for them, it’s frustrating for us.

Nurses expressed feelings of frustration toward the institution for not having a reliable alternative or adequate support in times of need. Although there was an individual assigned to this role when the regular patient representative was not present, nurses did not find this substitute to be helpful. The “covering” patient representative often did not have any more information than the
nurse herself and would refer the mother back to the patient representative who was off duty. One nurse recounted:

You call the patient rep and all they do is bring up a paper with [the other patient representative’s] number. I’m like, I could’ve done that. The patient wants something else that I can’t handle…I’m thinking your name is on the paper saying that if this person is not here, you’re supposed to handle it. And you’re just referring back to the person that’s not here.

This was very frustrating for nurses and many seemed angry and even bitter that they were left to manage the patient so ineffectively. In order to meet their needs, nurses made it a point to follow-up with the regular patient representative once she was back. Other nurses answered the patients’ questions as best they could, and over time, many became more familiar with common questions and answers.

This section described how nurses managed institutional ambiguity when providing care to mothers experiencing a stillbirth by managing alone. Nurses described feelings of abandonment by members of the healthcare team, namely the physician and the patient representative, but also the institution as a whole. They described instances where a lack of institutional and interdisciplinary support created a barrier in the nurse-patient relationship and described methods they established to manage these complexities. Through these descriptions, Managing alone emerged as one way that nurses were able to manage the ambiguity involved when providing care to a mother experiencing a stillbirth.

**Fighting institutional policies and procedures.** Nurses described fighting institutional policies and procedures as a method of managing institutional ambiguity when providing care to a mother whose baby was stillborn. Nurses found certain institutional policies and procedures
difficult to adhere to when providing care because they impeded the nurse’s ability to provide effective care and had the potential to cause emotional harm to the patient. One such policy that nurses described was making sure the baby was sent to the morgue by the end of their shift. One nurse said:

One thing that I find really difficult is there is a pressure to like get the baby to the morgue, especially …[if] it was the end of the shift… I remember in my training they were always like, ‘The baby has to go to the morgue by the time you leave the shift.’ I was like, ‘What if they baby's born like five minutes before the shift is over?’, you know.

Nurses did not find this to be practical at times and struggled with the ambiguity of determining their best alternate recourse. One way that nurses managed this dilemma was by disregarding the policy when they felt it was inappropriate. One nurse recounted a situation where she was caring for a mother who was holding her stillborn baby and felt pressured to send the baby to the morgue based on hospital policies. She stated:

It was like two hours [after the mother had been holding the baby], but… she wasn't ready. She wasn't ready and whatever. That's ridiculous like that you're gonna, ‘Okay, well, my shift is over, so now you have to say goodbye to your baby FOREVER,’ you know… And I have said like, ‘No, I'm not doing that.’ There are certain things that I'm just not going to do… I mean we are under so much pressure to turn over rooms and patients all the time….

In addition to this, finding an appropriate space for a mother, particularly during the post-partum period, was another obstacle nurses had to face. After the delivery of a stillborn baby, the mother might be given the option of going home after several hours if bleeding was under control. This usually depended on the mother’s condition, and the gestational age and size of the baby. If the baby was smaller (closer to 20 weeks gestation) and there were no complications, she would
be allowed to stay in a private room in the labor and delivery unit for a few hours after delivery and then be discharged home. This was not typically offered if the baby was bigger, however, there were times when mothers who had bigger babies were given the option of being discharged early. Some nurses did not agree with this practice because they felt the mother required postpartum care and was entitled to receive it. When discussing a patient who was to be discharged home shortly after her stillborn delivery, one nurse said:

She didn’t want to leave the hospital at the same time, so we got social work to get her a room. Because a lot of times they just leave after. They just leave in a couple, two hours after giving birth. Because they don’t have to stay in the hospital like post-partum. And I never really understood why they don’t get post-partum care where they’re still delivering a big baby. That’s a big thing to me, especially when they went through the entire delivery course as delivering a real [live] baby. Sometimes we even have to C-section them because we can't get the baby out. And a lot of times, the normal deliveries, they still don’t get their two days here. They just get two hours or three hours and then they say that they can go home. This mother I advocated for her in order for her to get a room. So she got to stay.

If a mother was delivering a baby that was closer to term (larger), or if there were complications, the mother would be transferred either to the post-partum unit or to an antepartum unit. The post-partum unit was where most mothers were transferred after they delivered a baby (live or stillborn) for a recovery period of 2-4 days. This was also where the newborn nursery was located and all well babies were kept. Nurses did not believe this was an appropriate place for a mother who had just lost her baby because crying babies could be heard throughout the floor. One nurse stated:
We try to be sympathetic in that way, where we’re like, okay, well, you don’t want her to recover somewhere where her next-door neighbor has a screaming baby [but] sometimes, that happens, and you’re like, okay. What were you thinking? Why would you do that, and they weren’t thinking.

If a mother experiencing a stillbirth was sent to this unit, nurses attempted to ensure that she was kept in a private room and farther away from the newborn nursery so she was not exposed to the sound of crying babies. However, this hospital offered only a limited number of private rooms, so this was not always possible.

Many nurses would advocate for mothers to be sent to an ante-partum unit that housed pregnant women who required close monitoring. However, on this floor, the sounds of fetal heart beats coming from maternal monitors could be heard just as loudly as the crying babies on the post-partum unit. This was still not an ideal location for the mother of a stillborn baby, but many nurses felt it was better than the post-partum unit. As an alternative, one nurse suggested mothers be placed on a Medical-Surgical floor where there were no pregnant women or babies crying. Here they could be visited throughout the day by a post-partum nurse and doctor as needed. She stated this was a practice that was successful at other facilities. However, this was not something that was in her power to enforce or carry out.

Finding space for a mother was even a concern within the Labor and Delivery Department at times. One nurse discussed a situation where a patient whose baby was stillborn had to be placed in the Post-Anesthesia Care Unit (PACU) because she needed close monitoring. This area is a large room with space for five pregnant or post-operative patients who were separated by cloth curtains.
My partner and I, we fought not to put her there because in PACU, we’re having the C-Sections in and out, and then we had two inductions. The heart rate [monitor is] high because we’re trying to do something else. You have babies coming in… and we’re like, ‘Guys, this is not the right place to put a person.’ But they’re like, ‘No, she needs to be specially monitored’… [so] they still put her there… they rolled her in… and then they put her right next to a lady who is now on the phone talking to her other kids, ‘Aren’t you excited about the new baby’, and we’re looking at her face… and we could see that she’s uncomfortable. So, we try to move things around and move her to the other corner of the room… and then she ends up delivering there the next morning because she was maybe like, 20 weeks or so… Not only was she in the area all night with other people who have babies, but now she’s delivered, and it’s such an impersonal space. You’re in a space with three other people now, and we’re just behind a curtain and we’re scooping your baby and your placenta into a bucket.

Even when their ideal goal could not be met, nurses still did what they could to make the best of a difficult and complicated situation in order to meet the patients’ needs, even if it meant going against hospital policies.

This section described how nurses managed the institutional ambiguity involved when providing care to mothers experiencing a stillbirth by fighting institutional policies and procedures. These included the policy of ensuring the baby was sent to the morgue by the end of their shift and the procedure of finding an appropriate place for the mother before, during, and after delivery. Through these descriptions, fighting institutional policies and procedures emerged as one way that nurses were able to manage the institutional ambiguity involved when providing care to a mother experiencing a stillbirth.
Getting support or not getting support. Getting support or not getting support emerged as a theme under the category of Managing institutional ambiguity because many nurses identified that there was no formal support system offered by the institution that provided an outlet for the intense emotions and reactions they were having. Many nurses were able to manage this by seeking out support on their own, however, some nurses encountered barriers to seeking or receiving needed support. Those who were able to get support described accomplishing this through a variety of ways. Most nurses stated that they were able to get support from peer co-workers. One nurse explained:

They’re the best people, because they know- they’ve been through it, they’ve had similar experiences. So sometimes when you talk to them about it, it helps. It really helps you cope because you have to cope as well as the patient has to cope with it.

One nurse described an occasion when she broke down crying to another co-worker and expressed how nice it was to have that support. She said:

It was nice to share that moment with her, the other nurse, because she was about to start taking care of this patient, and you know, some days like it really gets to you.

Although nurses often sought support after a loss, they did not always find it. They acknowledged that there was no place where they could go for respite in their institution after a difficult experience. One nurse stated: “Emotional support… you will not find… there’s not really a place where you could say, ‘I need to go down and I, you know, need to decompress.’ Most nurses stated that there was generally no formal support available or that they were unaware of any support that was available. Some nurses admitted to requesting more support services. One nurse described a program that she thought might be beneficial for nurses and described why she believed it was so important for nurses to get support after a loss:
Some hospitals have in place a second victim [program]. Because you have the victim itself, who would be the patient…. But we’re the second victim, in that we suffer a loss as well, especially when these things are unexpected. And after a time, these things will start to take a toll on you, and you don’t have a place to release… I feel that… when you suffer a loss, even though it may not be your loss, it starts to chip away at you.

In addition to not having a formal place or system for support, there were times when nurses found it difficult to seek support from their peers due to their workload. For instance, getting support from co-workers was particularly difficult to do immediately after the loss if it was in the middle of a shift because of other responsibilities, such as caring for other patients.

Speaking to this point, one nurse said:

What I took from this is that, here there is no kind of support for you, you know, other than your colleagues. And yes, you know, I can come to you and say, ‘Oh my God… I’m so sorry you dealt with that, do you wanna talk about it?’ But right after that or during that time, a patient’s ringing a call bell cause she feels like pushing. Or you need to watch the tracing on a live baby because you don’t want them to end up, you know, a demise. So, it’s kind of like you don’t even have a chance to get yourself together. You just kind of have to talk for maybe two minutes and snap out of it. Because of other patients depending on you.

Similarly, when asked if she talks to her co-workers about her feelings during the day, another nurse said:

No, no talking because there is no time for talking [chuckles] in… this unit. She… delivers. You get her well. Like, recover her… you prepare the baby for morgue or for, um, pathology. And, uh, you have to move on… because there may be a sicker patient waiting outside… who really needs that room, too.
When talking was not possible, some nurses described strategies that they implemented to offer support to co-workers. One nurse expressed:

You need a break in between… We all know how that’s difficult. That’s the first thing we always say after we know somebody went through the bereavement part and everything is done, we’re like, ‘Go on a break. You need to go on a break. Go take a nap, go do something to clear your head.’ And we have to. It’s hard… I’ve never gone straight back to another patient. I won’t. I think it’s too much. No.

In addition to getting support from co-workers, some nurses stated that they turned to close friends and sometimes family members for support. One nurse said, “If I have like a really hard IUFD… [or] like a really hard experience at work, there are certain friends that I would talk to just at home.”

Conversely, some nurses did not seek support at all. They felt that this was not something they could share with others. One nurse said, “You can’t share that with anyone, and you don’t wanna go home and tell your family members about that because that’s depressing”. Other nurses felt it was best to just “put it out of their mind”. One nurse said:

I feel like I try to leave it here… Once I leave here, I try to put it out my mind. I try not to dwell on it too much or like when I go home I like, ‘Oh, yeah I just had a fetal demise.’ Like it’s not something I try to talk about. I try to just let it out and just go… Whenever I leave this place, I swipe my card and I just leave. I try not to take any of that home because that will really just mess you up.

Even when support was formally offered at the institution for especially difficult situations, some nurses admitted to not taking advantage of this support that was offered. One nurse explained:
Like the baby that died in labor, um, they brought… a bereavement counselor just at shift change… But it’s hard to stay or it’s hard to get relief or there’s times that… you just wanna go home. That’s all you wanna do.

This section described how nurses struggled when faced with a lack of resources and time to process the experience of caring for a mother with a stillbirth. This often included seeking support from co-workers, which was not a consistent source of solace, as well as from family or friends. At times nurses also described barriers to seeking support or a lack of support within the institution. Through these descriptions, Getting support or not getting support emerged as one way nurses managed emotional ambiguity.

**Summary of Managing Institutional Ambiguity.** This section described the different ways that nurses managed the institutional ambiguity of providing care to mothers experiencing a stillbirth. This category focused on the institutional dynamics that negatively impacted the nurse and the care she provided to a patient experiencing a stillbirth. Vague procedures and ineffective protocols, coupled with a lack of institutional support left nurses feeling hesitant and uncertain in their actions. Nurses found ways to manage these ambiguities but felt unsatisfied, and at times, disappointed about the various institutional obstacles they felt they had to overcome.

**Summary of Chapter**

Chapter 4 presented findings from the study on how nurses provided care for a woman whose baby was stillborn, including verbatim participant quotes. The core variable described in this study was Managing Ambiguity and included three main categories: Experiencing a spectrum of emotions, Managing the ambiguous patient, and Managing institutional ambiguity. Each category included additional sub-categories that cohesively revealed the process that labor and
delivery nurses went through when providing care to women experiencing a stillbirth. The following chapter will present a discussion of these findings.
Chapter 5: Discussion

The grounded theory study presented in this paper explored the processes by which labor and delivery nurses provided care to mothers experiencing a stillbirth. The core variable that emerged from this study was Managing Ambiguity. The present chapter will provide an overview of this theory in the context of the study’s key findings. The discussion will include an exploration of the overarching theory, as well as the key categories and sub-categories that emerged from this study, through the framework of existing relevant research studies and the literature in order to provide a deeper understanding of how this salient theory is applicable to nursing practice, particularly the process of providing care to the mother of a stillborn baby. This chapter will also present a brief review of the grounded theory methodology, including a discussion on the relevance of symbolic interactionism and pragmatism.

Discussion of Findings

The present study sought to provide a perspective on the experiences, behaviors, and the social processes involved in overcoming the challenges of caring for women delivering a stillborn baby. Based on the inductive method of grounded theory and a thorough comparative analysis of the data, the theory Managing Ambiguity emerged as the basic social process of how nurses struggle to care for a mother whose baby was stillborn. This theoretical underpinning summed up the substance of what was occurring when nurses cared from a mother experiencing a stillbirth and was characterized in three different categories by labor and delivery nurses as Experiencing a spectrum of emotions, Managing the ambiguous patient, and Managing institutional ambiguity. The factors described in these categories contributed to the overall ambiguity the nurse had to manage when providing care for the patient whose baby was stillborn and became the three main categories of the overall theory:
1. *Experiencing a Spectrum of Emotions* described the various emotions that nurses experienced when caring for a mother whose baby was stillborn.

2. *Managing the Ambiguous Patient* described how nurses managed the ambiguity of interacting with and caring for a grieving patient. Nurses also discussed the intricacies of care that were distinct when compared to the typical patient in labor and delivery.

3. *Managing Institutional Ambiguity* described how the nurse managed the institutional barriers she encountered when providing care to a mother whose baby was stillborn.

![Diagram](image)

*Figure 6: The process of caring for a mother whose baby was stillborn*

Each category illustrated the ambiguities involved in the care of women experiencing a stillbirth and how nurses managed these challenges. Some facets were positive in nature, but most were negative and ranged from managing their own feelings to interacting with the patient and struggling with institutional obscurities. The results suggested that the absence of effective
protocols, education, and support often left the nurse feeling unsure of how to provide effective care for her patients. This was further complicated by the manner in which the nurse interpreted each obstacle and the complexity of stillbirth, which seemed to impact how the nurse was able to manage the care of the patient.

Although the theory of Managing Ambiguity is original as it applies to nurses caring for women experiencing a stillbirth, there are several existing research studies, theories, and concepts that can shed light on the core components of this substantive theory. There are several existing research studies and theories that can be influential in providing additional perspectives and a deeper understanding of the current study’s findings. Some of the relevant theories include the theory of ambiguous loss (Boss, 1999), Kanter’s theory of structural empowerment (Kanter, 1977), the theory of emotional labor (Hochschild, 1983), Patricia Benner’s novice to expert theory (Benner, 1984) and Kristen Swanson’s theory of caring (Swanson, 1991). In addition, there are also existing concepts that may assist in providing the appropriate context and foundational support needed to understand the theory, such as the concepts of stigma (Goffman, 1963), and death anxiety. Findings from various research studies will also be used to help provide a fuller understanding of the theory Managing Ambiguity. Some of these theories, concepts, and studies provide insight into one component of the overall theory while others overlap into multiple categories.

The following section will provide a brief overview of the overarching theory of Managing Ambiguity and an understanding of the study findings in the context of existing literature, theories, and concepts. It will be followed by a discussion of each category and sub-category of the overarching theory.

Managing ambiguity
Managing Ambiguity emerged as the central process experienced by labor and delivery nurses who cared for a mother whose baby was stillborn. The Oxford Companion to Philosophy (Honderich, 1995) defines ambiguity as a condition having two or more distinct meanings. However, in most nursing literature, the term refers to a situation marked by uncertainty, vagueness, obscurity, and indefiniteness (Mitchell & Pilkington, 2000; Stilos, et al., 2007). More conceptually, ambiguity is a condition that falls between the two extremes of risk and complete ignorance and occurs when a person does not know enough about a situation to rule out a number of possibilities (Elsberg, 1961). For the purpose of this paper, ambiguity will refer to a condition in which one does not know what to say or do due to a lack of clear answers or direction.

Providing care to mothers who were experiencing or had experienced a stillbirth created an ambiguous situation for nurses because of the emotional challenges related to the care of a dead baby and the intricacies of caring for a bereaved mother. Furthermore, the lack of clear and effective institutional protocols to guide the nurse during this period of uncertainty left the nurse alone to make decisions she felt were in the best interest of the patient, such as overlooking policies she felt were harmful to the patient. Other times, nurses had to make decisions that were in their best interests, such as building up a wall of protection and not allowing themselves to be emotionally affected by the loss. Additional underlying conflicts related to the inability of healthcare professionals, and western societies as a whole, to confront death and dying situations also contributed to the overall obscurities of this event. Multiple factors such as the nurse’s personal feelings, her interactions with the mother, and various institutional factors influenced the way in which nurses managed these ambiguities.

The term Managing Ambiguity has never been used in relation to caring for a mother experiencing a stillbirth; however, ambiguity as a concept has been applied to human experiences
in a wide and varied range of disciplines. For instance, the terms “Dealing with Ambiguity” and “Managing Ambiguity” have been discussed in relation to several professions such as business and education in reference to volatile working conditions and the institution of new policies and practices (Gleeson & Shain, 2007; O’Driscoll, 2008). It has also been applied to circumstances and conditions in health care and nursing (Mitchell & Pilkington, 2000; Stilos, et al., 2007).

Ambiguity in nursing care. Ambiguity is not a new concept in the field of nursing. Various articles have documented the discomfort that nurses experience when confronted with uncertainties in their daily practice (Mitchell & Pilkington, 2000; Stilos, et al., 2007). This discomfort usually stems from caring for patients and families during times of suffering, distress, or conflict and not knowing what to say or do in order to be therapeutic (Mitchell & Pilkington, 2000). In general, nurses seem to be intensely uncomfortable with the ambiguity inherent in nursing practice during times of struggle. Some authors (Mitchell & Pilkington, 2000; Stilos, et al., 2007) have described ambiguity as being a necessary part of nursing and have called for more research into in this area in order to help nurses embrace the ambiguity of being with patients who are suffering.

Ambiguity is expected in nursing practice due to the complexities associated with balancing knowledge, skill, and efficiency with being open to an unknown person, attentive to their uniqueness as individuals, and reflective about intentions, which is required in order to provide high quality nursing care (Mitchell & Pilkington, 2000). Ambiguity is even more probable when caring for patients for whom the norms and rules that apply to most nursing care challenges do not comfortably apply. Care situations involving death and grieving loved ones are typically accompanied by more intense feelings of discomfort due to inexperience, the awkwardness of not knowing what to say or do, and little guidance from leaders (Stilos, et al., 2007). This was a
finding that was also highlighted in the present study under the category of Managing the Ambiguous Patient where nurses described the intense discomfort they felt at not knowing what to say or do to comfort the mother having a stillborn baby.

Studies have demonstrated that nurses in other areas such as oncology and the emergency department experienced anxiety when faced with the prospect of a dying patient and were uncertain of how to cope with the procedures that surrounded death (Lange, Thom, & Kline 2008; Payne, Dean, & Kalus, 1998; Peters, et al., 2013). Similarly, nurses in the present study were uncertain of how to cope with the intricacies involved in caring for a mother having a stillbirth and often had to manage with little preparation or support. For instance, many nurses struggled with the emotional aspects of providing care as noted under the sub-category of Acknowledging the Emotional Difficulty and often did not have a supportive outlet for these feelings, as described under the sub-category Getting or not getting support. Under the category Managing the Ambiguous Patient, nurses grappled with trying to provide care to a grieving patient despite having little education or experiential preparation as described under the sub-category Learning to Provide Care. In the category Managing Institutional Ambiguity, nurses wrestled with institutional policies that seemed contradictory to the care they wished to provide and expressed feelings of being abandoned by other members of the healthcare team.

At times, the care provided by nurses seemed inconsistent with their own intentions, as seen in the seemingly incongruous sub-categories Protecting the Patient and Stigmatizing the Patient. Despite this, many nurses described practices that fit into both categories when providing care to a single or multiple patients. Although this may appear to be counterintuitive, there are various relevant theories, concepts, and existing research studies that can help to provide a deeper understanding of these seeming inconsistencies within the greater context of the overall theory,
Managing Ambiguity (Meliones, 2000; Papadatou, 2009). As the core variable of this study, these theories, concepts, and research studies are also pertinent to each of the categories and sub-categories described in this study and may provide helpful information in understanding the decisions that nurses chose when managing the care of a woman whose baby was stillborn. Those that will shed the most light on the core variable include the theory of ambiguous loss and a discussion of death and dying in hospital settings.

The theory of ambiguous loss. Stillbirth has been referred to as an ambiguous loss (Cacciatore, DeFrain, & Jones, 2008). Pauline Boss, a researcher who developed the theory of ambiguous loss (1999), identified it as one in which there is no finality or resolution. Stillbirth has often been considered an invisible death and is rarely legitimized as a real loss (Cacciatore, DeFrain, & Jones, 2008). The basic tenets of the theory of ambiguous loss (Boss, 1999) indicate that people who experience and live with an ambiguous loss find it hard to understand their situation, difficult to cope, and almost impossible to move ahead with their lives without professional counseling, love, and support. Examples include stillbirth, a person who has a parent or loved one suffering from Alzheimer’s disease, individuals waiting to learn the fate of a spouse or family member who has disappeared in a disastrous event such as 9/11 or Hurricane Katrina, or the loved ones of kidnap victims (Boss, 2012; Dupuis, 2002). A description of how each of these losses relate to an ambiguous loss is presented below.

Stillbirth has been described as an ambiguous loss because it is a loss that is not socially recognized. There is juxtaposition between the grief of the bereaved parents and society’s minimization of the loss, which often disenfranchises parents from traditional grieving processes (Lang, Edwards, & Benzies, 2005). Similarly, a person who is caring for a loved one who has dementia experiences a loss in which that person’s body is present, but the mind is absent (Boss,
2012; Dupuis, 2002). For caregivers, this can generate feelings of grief and ambivalence. However, since the loss is not a physical one, it is not recognized as a loss by society (Boss, 2012). Individuals who have loved ones who were the victims of disastrous events or kidnapping must cope with not knowing if their loved one is alive and must find a way to live with this (Boss, 2012).

Although the term ambiguous loss as it relates to stillbirth has largely referred to the parents and loved ones who experience the loss of a stillborn baby, it could also be extended to encompass the experience of the health care provider who is involved in caring for the patient under these circumstances. In her observation and opinion article, Defey (1995) observed that perinatal loss exposed staff to parents’ distress symptoms, as well as their own feelings of distress, impotence, frustration, and guilt. Much of the ambiguity described in that study stemmed from the dilemma of medical staff who were trained to cure and alleviate physical pain and support bereaved parents but who lacked the means and resources to recognize their own grief. This often resulted in avoidance behaviors and what Defey (1995) referred to as a “conspiracy of silence”. This present study has corroborated many of the findings of Defey’s (1995) work such as avoidance behaviors and an inability of healthcare providers to deal with the enormity of their own emotional responses.

In her text on professionals who care for the dying and bereaved, author Danai Papadatou (2009) emphasized that despite advances in medical and nursing practice, suffering among healthcare professionals is largely ignored and neglected due to the widespread belief that the suffering of patients is not supposed to be experienced by experts. In addition to this, healthcare providers themselves prefer to suppress their feelings and keep them private, which, generally prevents them from acknowledging their anxiety, anger, sadness, guilt, fear, disgust, and grief
(Bolton, 2000; Kerasidou & Horn, 2016; Meier, Back & Morrison, 200; Papadatou, 2009). As a result, healthcare providers may choose to avoid those situations that trigger these feelings. Evidence of this was apparent in this study that revealed behaviors of avoidance among nurses, the need to act professional when in the presence of patients, and instances in which nurses stigmatized patients. This present study revealed that many of the difficulties nurses encountered stemmed from the ambiguity that they experienced due to their inability to confront death.

This section provided an overview of the theory of ambiguous loss within the context of the theory of Managing Ambiguity. It highlighted the idea that stillbirth can represent an ambiguous loss to healthcare providers as well as parents, and it can leave them with feelings of anxiety, anger, sadness, guilt, fear, disgust, and grief (Kelley & Trinidad, 2012; Papadatou, 2009; Puia, et al., 2013; Roehrs, et al., 2008). The following section will provide an overview of death and dying in hospital settings to provide a context from which to understand the reactions of staff to a stillbirth.

**Death and dying in the hospital setting.** As described in Chapter 2, there was a rapid shift in society’s thoughts and attitudes around caring for the sick and dying during the 20th century due to the rise of curative medicine. There was a new focus on health and wellness, with less preparation for death and dying situations and less education about how to therapeutically handle them (O’Gorman, 1998). The result was a medical model that was primarily concerned with the assessment and treatment of the sick, their diseases, and the mental health conditions of patients with the overriding goal of finding a solution to a riddle rather than caring for a whole person (Nuland, 1994; Papadatou, 2009). As a result, death and bereavement were no longer considered natural processes, but rather dysfunctional conditions to be controlled by science. This attempt to control and avoid death was even more significant in the area of perinatal loss where
mothers were not allowed to see, touch, or even ask questions about their babies. In some cases, mothers were even sedated during the birth so as to avoid the chance of even a glimpse of the infant (O’Leary & Warland, 2013; Ligeikis-Clayton, 1999; Outerbridge, et al., 1983; Saylor, 1977).

Death within a hospital setting has often been viewed as a failure, with healthcare providers feeling a sense of helplessness and despair over their inadequacies (Kaufman, 2006; Papadatou, 2009; Pietroni, 1991; Chapple, 2010). To overcome these feelings, providers often subject dying patients to futile treatments and therapies that compromise their quality of life (Gawande, 2010; Papadatou, 2009). When these efforts fail, patients are sometimes abandoned by their providers who can no longer maintain the illusion of control over death and suffering (Back, Bauer-Wu, Rushton, & Halifax, 2009; Carline, et al., 2003; Lo & Snyder, 1999; Papadatou, 2009). This phenomenon was clearly demonstrated in this present study where nurses described physicians who delivered the news that the baby had died to the parents and then quickly left the room. In his article “Letting Go: What should medicine do when it can’t save your life?” Dr. Atul Gawande (2010) highlights the fact that those practicing modern medicine would prefer to engage a terminal patient in aggressive treatments rather than accept the imminent death of a patient and work to improve his/her last days. In his most recent book, Dr. Gawande (2015) argues that the goals of medicine may at times run counter to the goals of the human spirit. In the end, physicians who are committed to extending a patient’s life may insist on carrying out procedures that may instead extend suffering (Gawande, 2015). This presents a conflict in the area of stillbirth where the baby is already deceased and there are no tasks or procedures that can be offered to a grieving mother that will restore her baby’s life.
One of the reasons healthcare professionals are so determined to find a cure is because their educational preparation has emphasized dysfunction, pathology, and disorder (Papadatou, 2009). This preparation was designed to develop experts in identifying what is wrong with people or what must be fixed or changed (Papadatou, 2009). This explains why, when this cannot be achieved, providers consider themselves failures; because they are unable to accomplish what they set out to achieve. This suggests that the care of dying patients may present ethical challenges for healthcare professionals, contradicting the medical mandate that is strongly focused on restoring patients to health (Meliones, 2000). An additional consideration is society’s view of death. Avoidance of death and death situations are precipitated in our society and are most likely ingrained in health professionals long before they enter an institution of education. For instance, in the area of perinatal loss, it was historically considered socially unacceptable for a mother to discuss her deceased infant. If a loss occurred, it was to be kept quiet and never spoken of (O’Leary & Warland, 2013; Ligeikis-Clayton, 1999; Outerbridge, et al., 1983; Saylor, 1977), as if the loss would become invisible as long as the subject was never broached. In the rare instances that it was discussed in social settings, it often led to feelings of intense discomfort and anxiety for all parties involved.

The concept of death anxiety has been studied extensively from the 1980s to the present day. Death anxiety refers to the apprehension exhibited by individuals that is generated by death awareness (Abdel-Khalek, 2005; Lehto & Stein, 2009). This has specifically referred to the fear of dying, whereas, the concept of a “fear of death” refers to a more concrete belief that death is frightening (Momeyer, 1988; Moorhead, Moorhead, Johnson, Maas, & Swanson, 2008). For the purposes of this study, these terms will be used synonymously. Death anxiety is considered a universal human phenomenon that is heightened by imagery such as viewing a corpse (Lehto &
Stein, 2009). Western societies have been accused of taking actions to limit the awareness of death, such as concealing the sick and elderly from view (Schumaker, Barraclough, & Vagg, 1988). This was even more salient relative to perinatal loss where discussions of miscarriage, stillbirth, and neonatal death are emphatically avoided and mothers were prevented from seeing their dead babies (O’Leary & Warland, 2013; Ligeikis-Clayton, 1999; Outerbridge, et al., 1983; Saylor, 1977). Such actions can increase feelings of death anxiety and are usually accompanied by death denial, which is also common in American societies. Death anxiety is avoided through an elaborate system that offers few reminders of disability, aging, illness, and death (Martz & Livneh, 2003). Similarly, in the area of stillbirth, mothers were often advised not to have burial services and to “go home and get pregnant again at once” to avoid any public revelation or discussions of the deceased infant (Defey, 1995, pg. 103).

The concept of death anxiety has also been studied extensively in relation to the nursing profession (Black, 2007; Dunn, 2005; Lange, et al., 2008; Rooda, et al., 1999). These studies have revealed that the nurses who are affected by death anxiety are uncomfortable communicating with patients and families and may use avoidance behaviors to cope with their fear of death (Deffner, 2005; Matsui & Braun, 2010). Communication education, death and dying training, as well as improved standards in end of-life care in institutional settings were found to be important in fostering more positive attitudes toward death and caring for dying patients (Deffner 2005; Matsui & Braun 2010).

The previous section provided an overview of death and dying in hospital settings and provided a context from which to understand the reactions of staff to a stillbirth. It highlighted the fact that death denial is instilled in American society, as well as in its health care institutions.
Consequently, fear of death and death avoidance are common occurrences. The following section will provide a summary of this discussion on Managing Ambiguity.

**Summary of Managing Ambiguity.** Managing Ambiguity refers to the way a nurse manages a variety of ambiguous conditions to which she is exposed when caring for a patient experiencing a stillbirth. This theory provides a framework by which the process of caring for a mother whose baby was stillborn can be understood. The theory of ambiguous loss and a discussion of death and dying in hospital settings were presented in the previous section to provide the background information needed for a fuller understanding of this overall theory and the categories it encompasses.

There were three distinct categories that emerged from the study findings that led to the conceptual development of this overall theme of Managing Ambiguity. They included *Experiencing a Spectrum of Emotions, Managing the Ambiguous Patient,* and *Managing Institutional Ambiguity.* These categories were not mutually exclusive and often times were in direct contradiction to each other. The following section will provide a discussion of each category and their respective sub-categories in the context of the overall theme and the existing literature, theories, and concepts.

**Experiencing a Spectrum of Emotions.**

The category of *Experiencing a spectrum of emotions* focused on how the nurse emotionally responded to providing care for a mother experiencing a stillbirth. Studies of nurses’ experiences of grief following a patient death have revealed that when providing care, nurses found themselves in conflicting roles (Gerow, et al., 2010). On the one hand, the nurse must provide support to the patient, and on the other hand, they are often affected by the grieving of someone for whom they have provided intimate care (Gerow, et al., 2010).
When assigned to a mother experiencing a stillbirth, most nurses experienced a wide range of emotions. A single nurse could experience feelings of sadness, feeling overwhelmed, and in contrast, feelings of reward. These emotions were categorized into four main sub-categories and are presented as **Acknowledging the emotional difficulty, Suffering while acting professionally, Becoming Inured, and Feeling rewarded.** The following section will present an overview of these sub-categories in the context of the overall theme and the relevant theories and concepts.

**Acknowledging the emotional difficulty.** Nursing has been identified as “emotional work” because the nurses’ own emotions may become involved when they experience feelings towards their patient (Erickson & Grove, 2007). When providing End-of-life care, which typically involves skills in dealing with both the patient and a grieving family, the nurse may experience even more emotional turbulence. In addition to this, caring for a mother experiencing the death of a baby has been classified as one of the most difficult and traumatic practice situations for nurses (Beck & Gable 2012; Puia, et al., 2013; Roehrs, et al., 2008). The juxtaposition of having feelings of sadness while in an environment that is typically joyous and surrounded by new life makes for arduous working conditions. Various studies have emphasized the importance of nurses acknowledging their own personal grief when working with a patient who has experienced a perinatal loss (Jonas-Simpson, McMahon, Watson, & Andrews, 2010; McCreight, 2005; Roehrs, et al., 2008; Wallbank & Robertson, 2008).

In this present study, the ambiguity of providing care to women experiencing a stillbirth yielded various emotional difficulties among nurses. Many expressed their personal feelings of sadness, empathy for the patient, panic when given the assignment, and fearfulness during interview sessions. It was difficult to consider the loss of a human life even before it had started and very difficult to care for a grieving mother who had just lost her child. Similar findings were
described in a study investigating the grief experiences of pediatric intensive care nurses where nurses described feelings of sadness and sorrow at the death of a child and empathy for their families (Rashotte, Fothergill-Bourbonnais, & Chamberlain, 1997). Other studies of obstetric nurses who were present for a perinatal loss conveyed the depth of their emotions, describing feeling despondent, mentally drained and overwhelmed, and profoundly sad (Ben-ezra, Palgi, Walker, Many, & Hamam-Raz, 2014; Puia, et al., 2013).

Although it can be very difficult, the emotional work of nurses is especially important in forming a therapeutic relationship with a patient, but also carries the risk of stress and burnout (McQueen, 2004). Research on trauma workers who were regularly exposed to individuals who had suffered a death, experienced abuse, or other disasters suggested that professionals were prone to experiencing vicarious traumatization and compassion fatigue (Abendroth & Flannery, 2006; Dominquez-Gomez & Rutledge, 2009; Todaro-Franceschi, 2012; Maytum et al., 2004; Perry, Toffner, Merrick, & Dalton, 2011; Quinal, et al., 2009; Townsend & Campbell, 2009; Von Rueden, et al., 2010; Young et al., 2011). Compassion fatigue includes symptoms of profound physical and mental fatigue that may result in negative effects on personal relationships and the consideration of leaving the nursing profession (Perry, Toffner, et al., 2011). Vicarious traumatization can be defined as a transformation that occurs on the part of the helper as a result of the empathetic engagement with a patient’s traumatic experience (Papadatou, 2009; Pearlmen & Saakvitne, 1995). These findings were supported by a mixed method study of secondary traumatic stress in labor and delivery nurses and found that moderate secondary traumatic stress was experienced by 35% of the sample studied (n=464) (Beck & Gable, 2012). Secondary traumatic stress was operationalized by Bride, Robinson, Yegidis, & Figley (2004) as symptoms
resulting from indirect exposure to traumatic events by means of a professional helping relationship with a person who directly experienced a traumatic event.

This section provided a discussion of literature related to the sub-category *Acknowledging the emotional difficulty*. The following section will present a discussion of the sub-category *Suffering while acting professionally* in the context of the overall theme and existing relevant literature, theories, and concepts.

**Suffering while acting professionally.** *Suffering while acting professionally* was one way that nurses described the experience of *Managing Ambiguity* when caring for a mother whose baby was stillborn. Acting professionally was described as an outward appearance of remaining composed and exhibiting a professional demeanor despite the wide and varied emotions nurses were feeling. This has also been referred to as the façade of a false professionalism (Kaplan, 2000; King & Thomas, 2006; Papadatou, 2009). An expression of grief on the part of the healthcare provider has historically been considered unprofessional (Zambrano & Barton, 2011). Many providers were taught to avoid emotional reactions during their trainings (Jonas-Simpson, et al., 2013; Zambrano & Barton, 2011) and as a result, they do not consciously acknowledge them. Consequently, healthcare providers may experience burnout, vicarious traumatization, and may avoid people, places, or things that trigger thoughts of these events (Papadatou, 2009).

Despite their façade, healthcare providers are affected by death encounters. However, they seldom acknowledge it or process it therapeutically (Gerow, et al., 2010; Keene, Hutton, Hall & Ruston, 2010; Papadatou, 2009; Papadatou, Bellali, Papazoglou, & Petraki, 2002; Spencer, 1994). Attesting to this point, one participant in this present study remarked that, “These things come home with you. Think about it. I’m here 25 years. I can still remember things that happened with demises over all these years. They never go away. You remember them.” Similarly, another study
found that obstetric nurses continued to feel sorrow for the bereaved families and their infants up to 10 and 15 years after a perinatal loss; they described being changed forever by their experiences (Puia, et al., 2013).

_Suffering while acting professionally_ was also a theme in a study conducted by Kaunonen, et al. (2000) who developed an open-ended format questionnaire for nurses (n=102) who had encountered the death of a fetus or infant on a labor and delivery unit at a university hospital in Finland. One of the findings was the anxiety nurses felt about “unveiling” their feelings for fear that they would lose their professional integrity in the eyes of the patient’s family (Kaunonen, et al., 2000, pg. 49). In that study, one nurse stated, “How is one able to maintain one’s professional integrity and support the grieving person at the same time?” (Kaunonen, et al., 2000, pg. 49). Multiple studies in the field of perinatal nursing have corroborated these results by identifying that staff find it difficult to maintain professionalism while managing their own personal emotions and attitudes (Beck & Gable, 2012; Gold, 2007; Puia, et al., 2013; Wallbank & Robertson, 2013).

The act of suppressing one’s true feelings and countenance to bring about a desired state of mind in one’s client is known as _emotional labor_ (Hochschild, 1983). Emotional labor can have positive or negative effects depending on varying factors. There are two main forms of emotional labor: surface acting and deep acting. _Surface acting_ refers to displaying false organizationally desired emotions whereas _deep acting_ requires the modifying of inner feelings to match expressions (Hochschild 1983). Surface acting is associated with the more negative effects of emotional labor such as psychological distress, emotional dissonance, higher levels of emotional exhaustion, and lower levels of job satisfaction (Brotheridge & Grandey, 2002; Grandey, Fisk, & Steiner, 2005; Hochschild 1983).
In this present study, nurses’ descriptions of holding back their feelings seemed to more closely mirror surface acting, with responses that suggested that they experienced some of the negative effects of emotional labor such as emotional dissonance and anxiety when caring for a patient having a stillbirth. A study on perinatal grief and emotional labor among nurses found that there was a need for more recognition of the importance of the nurses’ emotions (McCreight, 2005). It found that this was an aspect of nursing practice that has been marginalized and indicated that the emotional needs of nurses needed to be fully acknowledged (McCreight, 2005).

This section provided a discussion of the sub-category *Suffering while acting professionally* in the context of the overall theme and relevant literature, theories, and concepts including the concept of emotional labor. The following section will present a discussion of the sub-category *Becoming Inured* in the context of the overall theme and existing relevant theories and concepts.

**Becoming inured.** Some nurses described a sense of becoming inured as a coping mechanism and a way of protecting themselves emotionally. Others described becoming so “routined” they were no longer emotionally affected by the occurrence of a stillbirth. While all nurses expressed a desire to ensure that the patient received the support that they required, they also felt the need to protect themselves emotionally. Some admitted that the best way to do this was to pull themselves away from what was actually happening, guard their emotions, and build up walls. This conflict has been documented by studies showing that the mother’s need to have empathetic interactions that may conflict with the nurse’s need to protect herself emotionally (Saylor, 1977; Wallbank & Robertson, 2013).

Research has suggested that providers may focus on clinical tasks rather than allowing themselves to feel vulnerable to the loss and suffering of patients because tasks are a distraction.
that offer a sense of direction, control, and achievement (Papadatou, 2009; Speck, 2006).
Although this may be an effective way to get through an emergency situation, when it becomes constant action, it can get in the way of connecting with patients and viewing them as human beings instead of an object to be fixed. In Managing Ambiguity, nurses described staying busy at work and allowing the intensity of their feelings to dissipate with the passage of time. One nurse stated “If you move on and you have another patient,… you forget … You just move on.” An unmistakable parallel can be made here between the avoidance strategies used by nurses and the behaviors many mothers were encouraged to do in the past which was to move on, and things would be better.

Research suggests that there’s a high price to pay for becoming immune to human pain and suffering (Branch & Klinkenberg, 2015; Showalter, 2010; Wenzel, Shaha, Klimmek & Krumm, 2011). Consequences of not allowing oneself to acknowledge grief include feelings of depression, stress, and avoidance of relationships with dying and bereaved people in order to protect oneself (Branch & Klinkenberg, 2015; Showalter, 2010; Wenzel, et al., 2011). Becoming inured to an experience typically occurs as a result of not receiving appropriate support or not having a therapeutic outlet for processing feelings of grief (Gerow, et al., 2010; Papadatou, 2009). This sentiment was reflected in the words of one participant in this present study who stated, “You don’t wanna not care about what you’re doing, but it happens when you’re not tending to your own emotional needs and you start to just put walls up”.

This section provided a discussion of the sub-category Becoming inured in the context of the overall theme and the relevant literature, theories, and concepts. The following section will present a discussion of the sub-category Feeling rewarded in the context of the overall theme and existing relevant literature, theories, and concepts.
**Feeling rewarded.** Somewhat contrastingly to the previous findings, *Managing Ambiguity*, also found that nurses were able to manage the emotional ambiguity of providing care to a mother experiencing a stillbirth when they felt a deep sense of inner reward and appreciation from the experience. This was usually the result of feelings of appreciation from a mother or feeling that the nurse was able to effectively meet the mother’s needs. Similarly, studies have also shown that although caring for a mother experiencing a stillbirth can be an emotional strain, it can also be very rewarding (Bolton, 2000).

As caregivers, nurses experience reinforcement and reward when their efforts are appreciated by their patients and their families (McGrath & Kearsley, 2011; Pines, 1993). The positive feelings derived from helping others in a professional capacity have been referred to as compassion satisfaction (Stamm, 2010). Compassion satisfaction protects against professional burnout (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Pines, 1993; Stamm, 2010) and buffers the negative consequences associated with traumatic events (Wu, Singh-Carlson, Odell, & Reynolds, 2015). Compassion satisfaction has been associated with low nursing turnover rates, fewer mistakes, improved patient health outcomes, and maintenance of a positive work environment (Aycock & Boyle, 2009; Burtson & Stichler, 2010; Hooper, et al., 2010; Sabo, 2011; Neville & Cole, 2013).

This section provided a discussion of the sub-category *Feeling Rewardeded* in the context of the overall theme and existing relevant theories and concepts. The following section will present a discussion of the category *Managing the Ambiguous Patient* in the context of the overall theme and existing relevant studies, theories, and concepts.

**Managing the Ambiguous Patient**
The category of *Managing the Ambiguous Patient* described how nurses managed the challenges of interacting with and caring for a patient that was different from the typical patient in labor and delivery. When deciding to pursue a career as an obstetrics nurse, individuals rarely considered situations of death and dying. Labor and delivery is considered a positive and happy place where babies are born into the world and families come together in joy to welcome the new addition. When this does not occur, both families and providers suffer a range of psychological and emotional responses (Wallbank & Robertson, 2008). No one wants to think of a baby dying or confront the difficulties and emotions that may arise. When faced with this type of assignment, most nurses in this study managed it in a variety of four ways. These four ways emerged as the main sub-categories under *Managing the ambiguous patient* and were conceptualized as *Avoiding the patient*, *Stigmatizing the patient*, *Learning to provide care*, and *Protecting the patient*. The following section will present a discussion of the category *Avoiding the Patient* in the context of the overall theme and existing relevant literature, theories, and concepts.

**Avoiding the patient.** Multiple studies have found that some nurses may use avoidance behaviors to cope with their aversion to death and dying. (Black 2007; Braun, Gordon, Uziely, 2010; Dominquez-Gomez & Rutledge, 2009). Communication behaviors among nurses caring for dying or bereaved patients are closely related to their personal attitudes and experiences with death (Black 2007; Braun, Gordon, & Uziely, 2010). Avoidance behaviors related to perinatal loss is not a new concept. Several studies have found that nurses feel the need to distance themselves from bereaved parents for various reasons. Among these are the inability to deal with the enormity of the parental feelings of loss, feeling uneasy over not knowing what to say, and/or the challenge of providing care to a mother who is having a perinatal loss and a mother who is having a live
birth at the same time (Caico, 2007; Defey, 1995; Paterson & Zderad, 1988; Roehrs, et al., 2008; Säflund, K., Sjögren, & Wredling, 2004).

In Managing Ambiguity, there seemed to be a general desire among participating nurses to give the mother “space to grieve.” Avoidance behaviors were most commonly described as a result of feelings of discomfort. One reason nurses gave for discomfort was being pregnant. There seemed to be an urgent need to keep pregnant nurses away from mothers who were experiencing a stillbirth. One reason given for this was an imagined fear that the nurse’s own baby would die if she cared for a stillborn baby. This was influenced by personal feelings and beliefs about death related to different cultural backgrounds. One nurse stated in her culture, there is a belief that if you touch a dead baby while you were pregnant or looked at anything ugly it would “reciprocate on you.”

After performing an extensive literature review on death anxiety among nurses, Peters et al. (2013b) suggested that if a nurse had strong beliefs and attitudes toward dying, she may develop negative attitudes toward caring for a dying patient and engage in protective coping mechanisms by distancing herself from the patient. The term death anxiety has been used to describe the negative emotional reactions provoked by the anticipation of a state in which the self does not exist (Nia, Lehto, Ebadi, & Peyrovi, 2016; Peters, et al., 2013b; Tomer, 1996). Based on this definition, death anxiety was evident in this present study as described by the avoidance behaviors exhibited among participant nurses.

**Stigmatizing the patient.** Goffman (1963), a sociologist that conducted extensive research on stigma, argued that stigmatization is the process of applying a label that devalues a person because they are perceived as different from an identified standard norm. As a result, the victim of stigmatization is disqualified from full social acceptance and “reduced in our minds from a whole
and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). Goffman suggested that within medical institutions stigma played a role in determining the attitude of providers and staff toward patients. He used the example that alcoholics and drug-addicts were stigmatized as having a weak character or disposition. Examples of literature that have been written about stigmatized patients include individuals who are members of the LGBT community (Canestraro, 2015), individuals with HIV (Sohler, et al., 2009), the mentally ill (Kisely & Chisolm, 2009) and the homeless (Salize, Werner & Jacke, 2013). Research shows that these individuals have systematically faced stigma, a lack of cultural competence, and insensitivity to their unique needs (Canestraro, 2015).

Participants in Managing Ambiguity described ways in which patients having a stillbirth were labeled and differentiated by nurses through subtle statements that signified distinctions between patients having a stillbirth versus patients having a live birth. These statements suggested that patients having a stillbirth were not in “real labor,” and the babies were not “real babies.” This behavior is also observed outside healthcare institutions. Parents have reported their frustrations when family or friends discount the life of their stillborn baby (Cacciatore, DeFrain, & Jones, 2008). They have expressed their desire to convey to others that their stillborn baby was real and remains a real member of their family (Cacciatore, DeFrain, & Jones, 2008). These sentiments relate back to the earlier discussion on the theory of ambiguous loss and the idea that the loss of a stillborn baby is not socially accepted because the loss may be invisible to most of the world (Boss, 1999; Cacciatore, DeFrain, & Jones, 2008; Kelley & Trinidad, 2012).

As alluded to in the previous discussions of death and dying in a hospital settings and the historical look at how stillbirth was managed in hospital settings, there is an attempt to minimize the events of death and dying in order to avoid the discomfort and pain that accompanies these
discussions. As a result, parents are left feeling isolated, abandoned, and unsupported with their loss (Brierley-Jones, Crawley, Lomax & Ayers, 2015; Bruce, 1962; Cacciatore, & Bushfield, 2007; Fahey-McCarthy, 2003; O’Leary & Warland 2013). Studies showed that health care professionals made cliché statements that minimized and attempted to normalize their loss such as, “You are young—you can have another” (Kelley & Trinidad, 2012, pg. 8), “It will be fine next time.” (Brierley-Jones, et al., 2015, pg. 151), and “God has His reasons and we must have faith.” (Bruce, 1962, pg. 89). Statements such as these are dismissive and fail to recognize or respect the loss (Kelley & Trinidad, 2012). The consequences of stigmatization are that the experience for the patient is often negative.

Learning to provide care. Although they all received conventional education such as learning about grief and how to care for a deceased infant in a classroom setting during orientation, the participants felt that the real learning took place when they were actually in the position of caring for the patient. Most of the participants expressed the process as “something you learn as you go along” and they described their learning as one that occurred through experience. Patricia Benner’s novice to expert theory (1984) also proposed that practical knowledge learned from professional experience may influence how nurses care for patients. Multiple studies have supported these findings and have shown that increased experience caring for dying patients leads to more positive attitudes toward death and providing end-of-life care (Dunn, et al., 2005; Lange, et al., 2008; Rooda et al., 1999). Similarly, Chan, Lou, & Arthur (2010) found that labor and delivery nurses who had previous experience in handling grieving parents had a more positive and sympathetic attitude than junior nurses and ones with little or no experience. These findings suggest that classroom or textbook knowledge may not be sufficient in learning how to provide care to mothers experiencing a stillbirth.
Although most participants in this present study did not identify a lack of education as a key factor in their ability to provide care to women experiencing a stillbirth, they were open to the provision of additional education. Most studies related to perinatal loss have supported the need for specialized education and training in the area of perinatal bereavement care (Chan, Day, & Chan, 2005; Chan, Lou, & Arthur, 2010; Chan, Lou, Cao, et al., 2009; Gold, 2007). In addition to bereavement training and education, one qualitative master’s thesis study that investigated the effects of perinatal loss on the labor and delivery nurse (n=5) suggested that hands-on training may be the best way to learn how to provide care. Additional studies have recommended that nurses caring for dying patients be educated about communicating with patients and families regarding death (Defner, 2005, Dunn, 2005; Ho et al. 2012; Matsui & Braun 2010). Education that focuses on death and dying has also been found to have a positive effect on reducing death anxiety (Dunn, 2005; Iranmanesh, Dargahi, & Abbaszadeh, 2008).

**Protecting the patient.** Nurses in this study engaged in activities to provide emotional protection to the patient and described taking steps to ensure that patients received the support and care they needed during such a difficult time. These interventions were different from those used when they cared for mothers who had a live birth. They included ensuring the mother did not blame herself, making the experience meaningful for the patient, spending additional time with her, and maintaining her dignity when it came to circumstances surrounding the stillbirth.

Many of the findings in this sub-category related very closely to the concept of caring. Various nurse theorists have described caring as central to nursing’s role and indeed as being the defining characteristic of nursing (Benner & Wrubel, 1989; Watson 1990; Swanson 1993). Kristen Swanson’s theory of caring (1991) was of particular interest in this study because it specifically addresses nursing care of families experiencing a miscarriage. Swanson defines caring as “a
nurturing way of relating to a valued other toward whom one has a personal sense of commitment and responsibility” (Swanson, 1991, pg. 162).

Swanson’s theory of caring provides strategies that the nurse can use to help the family through the healing process after a perinatal loss. In her middle-range theory, she identified 5 categories or caring processes involved in providing care including knowing, being with, doing for, enabling, and maintaining belief (Swanson, 1991). Some additional facets of this theory included centering on the one cared-for, being there, comforting, protecting, preserving dignity, supporting/allowing, and going the distance (Swanson, 1991). These characteristics were mirrored in the findings of this present study where nurses sought to support mothers experiencing a stillbirth, maintain their dignity, and be there to comfort them.

One area in which Swanson’s caring processes were exemplified in this present study was in the area of self-blame. Themes of self-blame, guilt, and shame have been described in multiple qualitative studies of bereaved parents (DeFrain, et al., 1990; Hsu, Tseng, Banks, & Kuo, 2003; Frost & Condon, 2006; Cacciatore, 2009) and have been noted to compound feelings of grief resulting in somatic problems, anxiety, and depression (Cacciatore, Froen, & Killian, 2012; Garstang, Griffiths, & Sidebotham, 2016; Hazzard, Weston, & Gutterres, 1992).

Although parents have a strong need to know the cause of death, this is not always possible because a significant portion of stillbirths remain unexplained despite thorough evaluations (ACOG, 2009; Garstang, et al., 2016). In this present study, when a reason for the loss could not be determined, mothers tended to blame themselves for reasons such as not coming to the hospital sooner or for not recognizing that something was wrong earlier. Recommendations from the Stillbirth Foundation of Australia suggested that healthcare providers had a responsibility to address issues of self-blame when they surfaced during the mother’s hospital stay (Peters, et al.,
Nurses in this study described strategies they used to prevent the mother from engaging in self-blame such as countering blame that came from family members and reassuring the mother that it was not her fault. These actions closely align with Swanson’s caring process of “enabling”, which includes actions that inform and support the mother experiencing a loss, as well as providing alternative thinking (Swanson, 1991). They also have features of the caring process of “maintaining belief” in which the nurse attempts to maintain a hope-filled attitude and offers realistic optimism (Swanson, 1991).

Nurses also advocated for the emotional and psychological health of patients by making the experience meaningful for them. This was accomplished by allowing the mother to bond with and grieve for her baby such as providing time to hold the baby, take pictures with the baby and name the baby. Nurses also found that mothers experiencing a loss were very sensitive and noted that keeping the environment clean and removing reminders of the delivery such as bloody gowns and dirty pads made a big difference. Additional interventions such as spending extra time with the patient and finding a way to connect with her were beneficial. Efforts such as fulfilling the mother’s requests or talking to her seemed to impact her in a significant way. Additionally, handling the baby with care such as carefully cleaning and wrapping the baby were among some of the interventions nurses engaged in to give the patient a sense of dignity and to protect her emotional and psychological health. These actions very closely align with Swanson’s caring processes of “being with” and “doing for” where the nurse engages in activities to comfort and support the patient as well as preserving her dignity (Swanson, 1991).

The findings in this sub-category were supported by another study of obstetric nurses who cared for mothers who had a perinatal loss (Puia, et al., 2013). Similar to findings from this present study, nurses described the need to protect the patient and be present with her (Puia, et al.,
2013). Key themes from that study such as, “Giving of self: Going above and beyond” and “Providing the best possible care: Putting your heart into it” described efforts that nurses engaged in to provide excellent care to the patient as a way of making the situation more bearable.

Multiple organizations, authors, and professionals have recommended that healthcare providers implement various interventions, such as those described above, which aimed to improve the psychological well-being of individuals experiencing a stillbirth (Peters, et al., 2014; Rajan, 1992; Hutti, 1984; Hutti, 2005; Bartellas & Aerde, 2003). These can include allowing the mother to hold the baby, keeping the baby in the room with the mother, and dressing and taking pictures of the baby and the family (ACOG, 2009; Alexander, 2001; Lemmer, Boyd, & Forrest, 1991; Limbo, Wheeler, & Gensch, 1989; Garstang, et al., 2014). Other interventions such as consistently keeping the family updated, and providing individualized, genuine, and personal care are also paramount (Peters, et al., 2014). This present study found several examples where nurses used many of these recommended interventions as strategies to advocate for, protect, and make meaning for the patient.

**Managing Institutional Ambiguity**

*Managing Institutional Ambiguity* described how the nurse managed the institutional barriers she encountered when providing care to a mother whose baby was stillborn. This theme focused on the institutional dynamics that impacted the nurse and the care she provided to the patient. The work environment in which nurses provide care to patients has been closely linked to the quality and safety of patient care (Institute of Medicine, 2004). Understanding the complexities of the work environment and engaging in strategies to improve its effects are needed in order to provide safe, high quality care.
When faced with an institutional-based predicament, most nurses managed it in one of four ways. These four ways emerged as the main sub-categories of *Managing institutional ambiguity* and were conceptualized as *Managing barriers to care, Managing alone, Fighting institutional policies*, and *Getting or not getting support*.

**Managing barriers to care.** Nurses in this study identified several institutional obstacles that created barriers to adequately caring for their patients. These included language barriers and workload difficulties. These barriers had the potential to hinder the basic foundations of communication that was essential to the provision of safe and quality care (Schyve, 2007). They also served as barriers to the development of the nurse-patient relationship, which has a critical effect on nursing care (Kleiman, 2009).

Language barriers threatened the nurse-patient relationship by creating an impediment to effective communication. Nurses in this present study found it difficult to provide emotionally sensitive care to patients who spoke a different language, despite the use of a translator. A language barrier was also identified as a significant source of frustration in a study of obstetric nurses who were present for a perinatal loss, and it prevented the nurses from providing compassionate care (Puia, et al., 2013). A systematic review of literature on families who had experienced a stillbirth found that communication was a key factor that impacted their experience of care and psychological well-being after a stillbirth (Peters, et al., 2014). Recommendations from that study included the use of clear and understandable language with explanations from health care professionals in a warm, sensitive, genuine, and reassuring manner (Peters, et al., 2014). A language barrier can be an impediment to instituting these recommendations.

An additional barrier identified in *Managing Ambiguity* was the small amount of time nurses had to spend with the patient. Nurses emphasized that they did not have enough time to
provide the sensitive care they wanted to give because of their workload. Nurses wanted to be able to sit down and spend time with their patients, discuss their fears and concerns, and help them cope or simply be present with them in silence. Their heavy workload of 2-3 patients and the business of the labor and delivery unit prevented them from engaging in these activities. Similar findings were highlighted in a study among oncology nurses who cited workload and lack of time to spend with the patient as a source of stress that contributed to compassion fatigue (Perry, 2011). Bowlby (1988), a well-known psychologist, identified that in order for caregivers to create a safe environment for those for whom they cared, they needed adequate time and a relaxed atmosphere. Spending more time with the patient also had a positive effect on caregivers. Studies show that nurses who reported spending more time with the patient had more positive attitudes towards the care of dying patients (Dunn, 2005; Iranmanesh, et al., 2008). However, this can be difficult in a rushed environment where there are constant interruptions and intrusions (Papadatou, 2009). This was particularly true for areas such as critical care, intensive care, and emergency rooms which tend to be in high demand, with limited time for caring (Leung, Peter, Rodin, & Fitch, 2012).

High workloads are related to occupational stress and often leads to loss of productivity, high rates of absenteeism, high turnovers, and poor physical, mental, and emotional health among nurses (Golbasi, Kelleci, & Dogan, 2008; Greenglass, Burke, & Fiksenbaum, 2001; Hackett & Bycio, 1996; Hayes & Bonner, 2010; Schaefer & Moos, 1993; Tyler & Cushway, 1995).

**Managing alone.** Nurses described instances when they felt left alone to manage the care of patients. Most of these instances were in relation to physicians who ignored their requests for assistance. However, nurses also felt left alone to manage the care of patients when the patient representative was not present. The patient representative typically assisted the patient and family with any questions, complaints or concerns they had. In the case of stillbirth, the patient
representative also provided the mother with information regarding burial options and support services. Nurses found her to be an invaluable resource and expressed great dismay when she was not present. These situations left the nurse to fill a role for which she felt unprepared and ill-equipped.

Mutual collaborations and a deep understanding of team dynamics are required when providing services to dying and bereaved people (Kobler, 2014; Papadatou, 2009; Perry, Toffner, et al., 2011). A lack of team cohesiveness within the workplace contributes to burnout and compassion fatigue among nurses (Wu, et al., 2016), whereas a culture of teamwork has been linked to considerable benefits such as higher staff retention, better patient relationships, effective interdisciplinary communication, and improved patient outcomes (Brunetto et al., 2013; Wu, et al., 2016). Participants in this study expressed feelings of frustration and helplessness due to breakdowns in team dynamics and when left to fill the shoes of other team members.

**Fighting institutional policies.** Nurses described fighting institutional policies and procedures as a way to manage the institutional ambiguity involved in providing care to a mother whose baby was stillborn. Nurses found some institutional policies and procedures difficult to adhere to when providing care because they impeded effective care and, at times, caused emotional harm to the patient. One such concern was having mothers placed in rooms and floors where newborn babies or mothers delivering live babies were kept. Nurses felt it was cruel to subject a mother to the sights and sounds of live babies. This was often a challenge because the physical environment of the hospital maternity unit is rarely prepared to support parents who have lost a baby before or during birth (Kelley & Trinidad, 2012). One of the recommendations put forth by the Stillbirth Foundation of Australia was to place mothers having a stillborn baby in a designated private area that was separate from newborn babies (Peters, et al., 2014).
Another policy that nurses in Managing Ambiguity fought was the policy of ensuring that the infant was sent to the morgue before the end of their shift. Nurses tried to advocate for mothers to hold and spend as much time with their stillborn baby as they needed even when it meant going against this policy. Allowing a mother to see and hold her baby has been identified as one of the interventions that parents found to be helpful when experiencing a perinatal loss (Cacciatore, 2013; Harper & Wisian, 1994; Heazell, et al., 2013; Lang, Edwards, & Benzies, 2005; Peters, et al., 2014). Nurses in this study also found this to be important and they intervened in ways to provide this support.

Occasions when institutional policies were not in alignment with the care that the nurse determined was best for the patient added to the ambiguity of the situation and left the nurse to try to determine the best course of action. Mitchell and Pilkington (2000) suggested nurses’ feelings are when they feel a disconnect between what they are taught and what they encounter in professional practice. Studies among providers caring for oncology patients noted that not being able to provide the care they were taught and desired to give was associated with worsened compassion fatigue (Perry, Toffner, et al., 2011).

As the health care provider who has the most contact with the patient, nurses shoulder much of the responsibility of managing patient care in the face of, and despite, shortcomings that may exist within the organization. Studies have shown that when organizations support the care processes that enable teamwork, nurses are more satisfied with their jobs, and patients receive higher-quality care (McGillis-Hall & Doran, 2007; Schmalenbberg & Kramer, 2007). The effectiveness of healthcare providers is dependent on leadership, a shared understanding of goals and individual roles, effective and frequent communication, having shared governance, and being
empowered by the organization (Golanowski, Beaudry & Kurz, 2007; Laschinger, Sabiston & Kutscher, 1997; West, 2003; West & Sacramento, 2004).

Kanter’s (1977) theory of structural empowerment suggests that factors such as perceived access to power and opportunity and the structure of the work environment are significant determinants of an employee’s behaviors and attitudes. Kanter’s theory has been used in multiple nursing studies to evaluate relationships between work environment and factors such as organizational commitment, involvement in work environments, perceived autonomy, job satisfaction, work effectiveness, burnout, and intent to stay (Laschinger, Finegan, Shamian, & Wilk, 2001; Nedd, 2006; Sabiston, & Laschinger, 1995; Sarmiento, Laschinger & Iwasiw, 2004). These studies have supported Kanter’s propositions and the need for enhanced involvement from nurses in professional and organizational decision making.

In this present study, nurses found it difficult to mobilize and access the resources, information, and support they needed in order to do their jobs successfully. As research in this field has found, individuals who lack access to opportunity, information, support, and resources consider themselves powerless and may foster feelings of job dissatisfaction (Kanter, 1977; Laschinger, Finegan, et al., 2001; Laschinger, Sabiston, & Kutscher, 1997; Laschinger, Wong, et al., 1999; Nedd, 2006). Nurses experience feelings of frustration and failure when they are held accountable without the appropriate power to make decisions (Laschinger, Sabiston, & Kutscher, 1997; Miller, 1995). One study found that administrative efforts were needed to strengthen nursing in areas where nurses cared for dying patients (Miyashita, et al., 2007).

Getting or not getting support. Similar to other studies in this field, the need for support emerged as a key finding under the category of Managing Institutional Ambiguity. There is a vulnerability that comes with caring for another person (Gerow, et al., 2010). This is even more
true when providing End-of-life care and more profoundly true when the loss is that of a newborn (Jonas-Simpson, et al., 2010; McCreight, 2005; Roehrs, et al., 2008; Wallbank & Robertson, 2008; Roehrs et al., 2008). The loss of a newborn is an exceptionally difficult and emotionally stressful event for both the parents and the healthcare provider (Beck & Gable, 2012; Puia, et al., 2013). In order to manage these feelings, participants in this present study discussed taking comfort in the emotional support of others. However, some participants did not receive support. This was either due to an inability to obtain support when needed or denying the need for support.

There was an apparent lack of formalized support in the work setting, but nurses identified talking to co-workers as the main way that they coped. They suggested that talking to individuals who knew what they were experiencing was therapeutic. Multiple studies have found that nurses caring for a patient experiencing a perinatal loss preferred to speak with a co-worker who would understand what she was going through (Burgner & Ruchala, 2006; Beck & Gable, 2012; Puia, Lewis, & Beck, 2013; Wallbank & Robertson, 2013; Wood, 2015).

Although talking was the main form of coping that nurses described in this present study, workload often prevented them from seeking out someone to talk to, so they often coped by staying busy at work. With the passage of time, the intensity of their feelings would dissipate. Similarly, some nurses suggested that their way of coping was to avoid thinking about the experience once they left the job. Some nurses did not identify any specific coping methods other than to simply “let it go” and admitted that even if support services were available they might not take advantage of them. This suggests that nurses may not place as much importance on self-care as might be necessary. In a dissertation study of labor and delivery nurses' experience of fetal demise, Wood (2005) also found that nurses felt they were not prepared to care for themselves following a fetal death. The author recommended better training on caregiver grief and self-care
be made available to nurses providing perinatal bereavement care (Wood, 2005). Additionally, a more formalized method of support may be needed to provide nurses with an outlet for their emotions. One such example might be providing support in a formalized setting within the institution and making it an expectation for nurses to participate. This would reinforce that the institution also viewed self-care as important and was willing to provide a supportive resource.

Multiple studies have shown that perinatal nurses experience significant levels of distress as a result of the care they provide and may need someone to share their feelings with in order to facilitate healing (Beck & Gable, 2012; Puia, Lewis, & Beck, 2013; Wallbank & Robertson, 2013). These studies also showed that there was a need for perinatal nurses to recognize the effects that their work can have on them and to take preventative actions to address any symptoms that might manifest themselves (Beck & Gable, 2012; Puia, Lewis, & Beck, 2013; Wallbank & Robertson, 2013). A lack of support has also been linked to poor coping, expressions of secondary traumatic stress, compassion fatigue, and burnout among oncology and trauma nurses (Perry, Toffner, Merrick, & Dalton, 2011; Von Rueden, et al., 2010).

**The problem of ambiguity.** The problem of ambiguity is that it holds significant consequences as it relates to the nurse and the nurse-patient relationship. The discomfort nurses feel when providing End-of-life care diminishes the opportunity for meaningful dialogue between nurses and patients (Mitchell & Pilkington, 2000; Stilos, et al., 2007). The nurse’s lack of certainty also affects her confidence and enhances her doubts and fears (Stilos, et al., 2007). These challenges can be best understood through the lens of symbolic interactionism and pragmatism. As stated previously, the theoretical underpinnings of grounded theory are deeply rooted in pragmatism and symbolic interactionism (Corbin & Strauss, 2008). Pragmatists maintain that “human beings go through a continual process of adaptation in the constantly changing social
Symbolic interactionism is concerned with the meaning of an event and the knowledge that is created through action and interaction. These factors were significant in considering how the nurse interacted with a patient experiencing a stillbirth.

The essence of pragmatism and symbolic interactionism was clearly evident throughout this study. Interactions that nurses had with patients strongly influenced their responses and how they understood their patients and the situations. In order to manage the ambiguity involved in providing care, the nurse had to first determine the meaning of the event both for herself and the patient. This interpretation held consequences in terms of the nurses’ actions and interactions with the patient. For example, if a mother was unemotional or unresponsive, the nurse responded by limiting her interactions with the mother, believing from the mother’s response that she wanted to be left alone.

The nurse’s beliefs and ideas about death may have significant consequences on the nurse-patient relationship as well. When viewed in a negative manner, these ideas often led to fewer interactions with the patient, avoidance behaviors, and greater anxiety for the nurse. This was exemplified in the behaviors of keeping pregnant nurses away from mothers having a stillbirth. However, when nurses viewed their experience as an opportunity, they were able to focus on the meaning that the event had for the patient and provide more effective and appropriate care. Some of the examples nurses gave exemplifying this included spending time with the patient, altering the patient’s environment to make them more comfortable, and maintaining the patient’s dignity. These instances seemed to be followed by feelings of reward and satisfaction described by nurses who felt they did everything they could for the patient. Overall, positive interpretations resulted in a better ability to manage ambiguous circumstances while negative interpretations enhanced the ambiguity. As such, learning to recognize and acknowledge the discomfort associated with
knowing what to do or say, or when there are no clear answers or direction is a professional skill that all nurses should embrace (Stilos, et al., 2007).

The nurse’s ability to manage the ambiguity involved in providing care may have also impacted how the nurse cared for herself; however, these findings were inconclusive. Those nurses who felt more inured to the event did not seem to perceive the importance of self-care and getting support. However, even those who did see this as important skill admitted that formal support was not something they actively sought out. The degree to which ambiguity impacted self-care, therefore, was undetermined in this study.

Summary

This chapter presented an overview and discussion of the overarching theory that emerged from this study on the process of providing care to the mother of a stillborn baby. This discussion included an exploration of the overarching theory, Managing Ambiguity, through the framework of existing relevant research studies in order to provide a deeper understanding of how this salient theory is applicable to nursing practice. This chapter also included a description of the key categories and sub-categories that emerged from this study, as well as theories and scholarly writings associated with these themes. An assessment of the study’s recommendations for future studies, correlations between the study findings and literature on perinatal loss, limitations, and implications for nursing practice will be presented in the following chapter.
Chapter 6: Conclusion

Chapter 6 will present a discussion of areas that were not explored by this study, the implications for nursing practice that were obtained from this study, and an assessment of the study’s limitations including recommendations for future studies.

Further research

The present study sought to explore the processes by which labor and delivery nurses provided care to mothers experiencing a stillbirth. Findings from this study revealed the basic social process of Managing Ambiguity. The theory provides a perspective on the experiences, behaviors, and the social processes involved in overcoming the challenges of caring for women delivering a stillborn baby. It is important to identify barriers that can make it difficult for nurses to provide this care and to develop interventions that may prevent or eliminate distress among nurses. Additional strategies to enhance the understanding of nurses' experiences might include the development of a tool to measure attitudes toward providing care to a mother having a stillbirth. Current tools, such as the Frommelt Attitudes Toward Care of the Dying (FATCOD) (Frommelt, 1991) and the Death Attitude Profile–Revised (DAP-R) (Wong, et al., 1994), might be adapted to focus on the care of a mother experiencing a stillbirth and might be used with multiple healthcare professionals and staff. The FATCOD Scale is a 30-item scale designed to measure participants’ attitudes toward providing care to dying patients, and the DAP-R a 32-item multidimensional scale that measures participants’ attitudes toward death using a seven-point scale (1 = strongly disagree to 7 = strongly agree).

Once a fuller understanding of the nurse’s experience has been explored, additional studies might examine the effectiveness of interventions aimed at supporting the nurse through the process of caring for a mother having a stillbirth. One possible intervention might include pairing
up an inexperienced nurse with a supervisor or senior nurse and comparing their experience to nurses who did not receive this support. Such a study might reveal important information about how to best support inexperienced nurses through the process of caring for a mother having a stillbirth. Another possible intervention might include the institution of a hospital requirement that nurses receive bereavement education related to caring for mothers experiencing a stillbirth on a regular, mandatory basis. This educational program might evaluate the nurses understanding before and after the education. Additional interventions might focus on implementing a support program to provide psychosocial assistance to nurses who provide care to mothers who have had a stillbirth. Focus groups or questionnaires may be used to evaluate the effectiveness of this intervention. Lastly, other studies might focus on institution-specific concerns such as the development of a committee focused on the care of mothers experiencing a stillbirth. This committee would review policies, practices, and algorithms being used in this care. A review of staff and patient satisfaction before and after these interventions would demonstrate the effectiveness of such a program.

**Correlations between findings and literature on perinatal loss**

Stillbirth is a unique loss, and investigations into the experiences of nurses caring for women experiencing a stillbirth are needed to address the needs of both patients and nurses. Although there are many factors of care that differ when caring for mothers experiencing miscarriage, stillbirth, or neonatal death, this present research study has uncovered several similarities that have been identified in the literature on perinatal loss. For nurses caring for women experiencing a perinatal loss, maintaining professionalism while managing their own personal emotions and attitudes have been identified as a challenging feat (Puia, Lewis, & Beck, 2013; Wallbank & Robertson, 2013). Additionally, several research studies have supported the
need for specialized education and training in the area of perinatal bereavement care (Caico, 2007; Chan & Arthur, 2010; Gold, 2007). In addition to bereavement education, studies and reviews in the area of perinatal care also highlighted the need for additional support for nurses caring for women experiencing a perinatal loss (Beck & Gable, 2012; Bride et al., 2004; Cacciatore, 2013; Wallbank & Robertson, 2008; Wood, 2005; Workman, 2001). These studies suggested that nurses who cared for women having a miscarriage, stillbirth, or neonatal loss experienced significant levels of distress and needed someone to share their feelings with in order to facilitate healing (Wallbank & Robertson (2013). These salient areas of the need for emotional and educational support were also pervasive throughout this present study.

Implications for Nursing

Findings from this study have significant implications for nursing practice. These include implications in the areas of nursing education, nursing administration and leadership, as well as implications for all nurses.

Implications for nursing education. All nurses in this study pointed out that experience was a key factor in learning how to care for patients experiencing a stillbirth. With this knowledge, there may be an opportunity to implement unconventional methods of education in this area, such as simulated scenarios using computerized mannequins or standardized patients where actors are trained to take on the characteristics of real patients and act out medical scenarios. This should be preceded by an educational session and followed by a debriefing period to discuss each scenario and the nurse’s actions. It is crucial that the educational segment also encompass the emotional, psychosocial, and psychological aspects of stillbirth, as it is important to remember that parents have lost a baby and not simply experienced a medical event (Peters, et
al., 2014). Pairing up with a nurse experienced in such care may provide support, guidance, and experiential learning to nurses who have not provided it themselves.

Implications for nursing leadership and administration. An additional need revealed in this study was that of enhanced nursing involvement in decision making and policy development. Kanter’s (1977) theory of structural empowerment suggested that this involvement would contribute to the overall morale of the staff and work environment. Nurses in this study voiced many concerns that they felt should have been addressed for the benefit of the patient as well as the nurses involved in her care. These included: concerns about the appropriate place to put a mother before and after the delivery of a stillborn infant, policies related to transferring a baby to the morgue prior to the end of a shift, difficulties encountered when a patient representative was not available to share needed information with a patient, concerns about pregnant nurses caring for mothers experiencing a stillbirth, and the lack of time and support nurses needed during and after caring for a mother experiencing a stillbirth. Giving nurses a forum in which to bring up their concerns and contribute to the decision making and policy development process may lead to better outcomes for all involved.

Support for nurses was also an area of need identified in this study. Many nurses admitted to feeling inured by the experience of caring for patients having a stillbirth and admitted that they were aware that these feelings could result in care that was distant and cold. One nurse also described feeling anxious and losing sleep after a difficult experience when a baby died during the delivery. It is important that nurses receive the appropriate support required when caring for patients in emotionally-charged situations in order to prevent these negative consequences. Ideal support for hospital staff after a perinatal loss has been identified as debriefing within the first 72 hours, including reflection on and discussion of emotions, sharing stories with peers, and allowing
time to regroup and make sense of the situation (Roehrs, et al., 2008; Bateman, et al., 2012; Overson, 2006; Perry, Toffner, et al., 2011; Puia, et al., 2013; Gardner, 1999; Yoder, 2010). Teaching nurses to reflect on their experiences and providing a forum for them to share these feelings can be monumental in assisting nurses to reconcile feelings of ambiguity and help them recognize how they respond in ambiguous situations. Reflecting on practice is a conscious and skilled activity that requires the capacity to assess one’s own actions and consider the intent and effectiveness of them (Driscoll & Teh, 2001).

Research on stillbirth has shown that parents may be extremely sensitive to health professional’s communication styles and behaviors and appreciate when healthcare professionals show emotion, empathy, and human reactions to their tragic experience (Peters, et al., 2014). Therefore, it is important to identify the nurses who are more personally affected by stillbirth or the circumstances surrounding the care of mothers having a stillborn baby, to help them address areas of concern and provide the support they require. One such nurse in this study was crying out for help because she was so anxious about having to care for a patient delivering a stillborn baby with congenital anomalies. She said, “If this lady delivers, I’m gonna need help… because I’m already freaking out. I’m having palpitations!” Nurses in such a state of anxiety can not be expected to provide the level of compassionate and empathetic care parents are in need of. While knowledge and experience provide nurses with some of the information needed to provide bereavement care, coping strategies and defense mechanisms that can help nurses deal with the anxieties that come with caring for dying patients and their families are also needed (Stoller, 1980; Dunn, et al., 2005). An understanding of the grieving and coping processes by nursing faculty, administrators, and leaders is needed in order to provide better learning opportunities and more supportive practice environments for professional nurses (Gerow, et al., 2009).
Implications for nurses. This study has also revealed the need for nurses to develop increased comfort in ambiguous situations. The awkwardness of not knowing what to say or do and/or being faced with a situation the nurse has never encountered before will be ever-present in nursing because each patient and situation is unique. Nurses must come to terms with the idea that certain questions and issues cannot always be resolved (Stilos, et al., 2007). In death and dying situations, it is particularly important for nurses to realize that their role is to bear witness to the grief and not try to fix or change it (Stilos, et al., 2007). Nurses must build the capacity to be present in situations where emotional intensity is high and become armed with the knowledge, skills, and abilities to face the ambiguity that inevitably exists in such difficult situations (Stilos, et al., 2007). When patients, families, and nurses are able to honor complexity and ambiguity, they will be more open to exploring possibilities of the nurse-patient relationship and practicing the art of nursing (Hartrick, 1997; Stilos, et al., 2007). This will enhance their ability to provide care that encompasses the five caring processes identified by Kristen Swanson in her middle range theory of caring, which includes knowing, being with, doing for, enabling, and maintaining belief (Swanson, 1991).

Limitations

Participation in this study was completely voluntary. Therefore, many nurses who volunteered to be interviewed may have been relatively comfortable discussing this sensitive subject. Many nurses who were uncomfortable providing care to mothers of stillborn babies or discussing this subject may not have come forward to be interviewed. As such, there may be additional underlying areas of this subject that were not uncovered.

Further research on this topic should include an exploration of the experiences of labor and delivery nurses who identify as being uncomfortable caring for mothers delivering a stillborn
baby, and other ancillary staff, such as physicians, patient representatives, and translation service workers who participate in the care of patients experiencing a stillbirth. Exploring the experiences of these additional stake holders may confirm the assumptions made by participants in this study or identify other social processes not uncovered in this study.

**Conclusion**

The overall process of *Managing ambiguity* unfolded in three ways - *Experiencing a spectrum of emotions*, *Managing the ambiguous patient*, and *Managing institutional ambiguity*. The degree to which each component was present seemed to contribute to the amount of ambiguity the nurse would have to navigate or manage when caring for a patient experiencing a stillbirth. Additionally, some nurses were better able to manage the ambiguity that was present than others. When there were fewer personal, interactional, and/or institutional dilemmas or barriers, the nurse seemed to be able to focus more on the meaning that the event had for the patient and meeting the patient’s needs. Ambiguity was evident in either instance, but the degrees of ambiguity varied depending on the nurse, the patient, and the way the nurse interpreted the event.

This theory of *Managing Ambiguity* provided a perspective on the experiences, behaviors, and social processes involved in caring for a woman delivering a stillborn baby. This theory also provided insights into how the interactions between the nurse and herself, the nurse and the patient, and the nurse and her environment impacted the process and the meaning of the event.

The importance of this study is the resulting understanding of factors that impede or enhance the process of providing care to a mother whose baby was stillborn. Feelings of uncertainty, ambiguity, and discomfort must be addressed at the nursing education and nursing leadership levels. This will require a shift in practice from an illness and disease paradigm to more
holistic care models (Stilos, et al., 2007). Providing the necessary support and education nurses need to provide care to vulnerable patients, such as those experiencing a stillbirth, is fundamental to the principles of a patient-centered model of care. Although nurses may not always be aware of appropriate things to say, their presence may provide an opportunity to give support and engage in discussions about the meaning of the event for the patient (Stilos, et al., 2007). This cannot occur if nurses are not provided with the knowledge and support they need to care not only for patients but also themselves.
Appendix A

Demographic Data Form

Please answer each question with ONE answer.

1. Experience caring for a woman having a stillbirth (20 weeks gestation or greater)
   Yes ☐  No ☐

   If you answered no to this question, you are not eligible to participate in this study. Thank you for your time.

2. Age (years)
   20–29 ☐  30–39 ☐  40–49 ☐
   50–59 ☐  > 60 ☐

3. Experience in Obstetrics
   <5 years ☐  5–10 years ☐  10–20 years ☐  > 20 years ☐

4. Education level
   Diploma ☐  Associate ☐  Bachelors ☐
   Masters ☐  Doctorate ☐

5. Taken training/courses related to bereavement care
   Yes ☐  No ☐
Appendix B

Semi-Structured Interview Plan

Initial Grand Tour Question:

“Tell me about an experience you had caring for a mother who had a stillbirth.”

Changed after first 2 interviews to:

“Tell me about an experience you had caring for a mother who had a stillbirth.”

Probes:

**Body language:**

- Leaning in
- Keep arms unfolded
- Not responding when the participant pauses in order to allow them to continue speaking

**Verbal prompts:**

- “Uh huh”
- "Tell me more."
- "Can you give me an example of that?”
- "You have described XXXX several times. Can you tell me about a time when this did not happen?"
Appendix C

MANAGING AMBIGUITY

EXPERIENCING A SPECTRUM OF EMOTIONS
- Acknowledging the emotional difficulty
- Suffering while acting professional
- Becoming injured
- Feeling rewarded

MANAGING THE AMBIGUOUS PATIENT
- Avoiding the patient
- Stigmatizing the Patient
- Learning to provide care
- Protecting the Patient

MANAGING INSTITUTIONAL AMBIGUITY
- Managing barriers to care
- Managing Alone
- Fighting institutional policies and procedures
- Getting or not getting support

The process of caring for a mother whose baby was stillborn.
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