

**A HEAVY HEART AND A POCKET FULL OF GRIEF:
AN INTERPRETIVE INQUIRY OF MIDWIVES' FIRST
EXPERIENCES OF STILLBIRTH AS A COMMUNITY
BASED MIDWIFE.**

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**This thesis is submitted to Auckland University of Technology in
partial fulfilment of the degree of Master of Health Science
(Midwifery)**

2012

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualifications of any degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed:.....

ACKNOWLEDGEMENTS

I thank the midwives who bravely shared their stories with me, even though, for some, it was the first time they had talked about their experiences since it happened. They allowed me to hear their words without hesitation or self-consciousness. Through their courage, I have been able to bear witness to their accounts of what it is to be a midwife involved with a still born baby.

Much love and gratitude goes to my friends and family who listened to my often self-indulgent and frantic attempts at trying to decipher my own realisations. At times, just their quiet presence enabled me to hear my own echo and thereby clarify my thoughts.

My supervisors, Liz Smythe and Judith McAra-Couper, have always been quietly walking beside me, even though at times I doubted my journey. Their support brought me a renewed understanding of believing in the process. Although the concept of faith is simple, the action is often challenging.

The financial support of the New Zealand College of Midwives post graduate grants was greatly appreciated.

Finally, I would like to acknowledge all the women and families who have lived through the devastating experience of having a 'still' baby and all the midwives who have supported them through these sad times. I hope that through pondering the lived experiences of the midwives as well as the families involved in these tragic situations, more light can glow in the shadows and the sacredness of birth can radiate through the darkness of grief.

ABSTRACT

This study has developed from recognition of the potential impact on midwives caring, for the first time, for women experiencing stillbirth. The main aim of the research is to identify and interpret this impact, if any, on the midwife. It also seeks to reach an understanding of the world of the midwife in relation to fetal loss. Current research focuses mainly on the experiences of the families who have gone through stillbirth. The specific experience of the midwife involved in this care is relatively absent in current research.

It could be suggested that when caring for a woman who is going through a stillbirth, the midwife must navigate her own personal and professional journey. This journey was the focus of this qualitative study, using Heideggerian hermeneutic phenomenology. This philosophical approach seeks to reveal the lived experience of the midwife and explore the phenomenon of stillbirth from her viewpoint.

Five community based midwives were interviewed and asked to talk about their story of the first time they cared for a woman who had experienced a stillbirth. Data from these interviews was analysed using van Manen's framework. The findings of this thesis suggest that midwives also experience a sense of loss. These experiences are described in the following themes: Shockwave; denial + invisibility = self- protection; blameworthiness; touched by death; empathetic loss; and broken.

This research strives to recognise that the death of a baby is a significant event for the midwife providing this care. A deeper understanding of the lifeworld of the midwife provides other midwives with the nod of knowingness about the hidden experience of caring for women who have had a stillbirth. The beneficiaries of this study will be midwifery students, new graduate midwives and, in fact, the wider midwifery community.

Recommendations for organisational acknowledgement and support for community-based midwives, education for both under graduate and post graduate midwives and further research are made based on the findings of this study.

Chapter One

ORIENTATION TO THE STUDY

Introduction

This study explores the meaning of the experience of midwives caring for women and their families who have had a stillbirth. It explores the first time a midwife provides this care as a community based midwife (self-employed). It offers an interpretation of the narratives of five midwives who, at different stages of their midwifery careers found themselves in this clinical scenario. The methodology of hermeneutic phenomenology was chosen to help me explore the lived experiences of the midwives, from their own personal vantage points. My quest was to find meaning within their narratives and to shine a light on the interpretations of their experiences.

What is a stillbirth?

The legal definition of a stillborn child is a dead foetus that - (a) weighed 400 grams or more when it issued from its mother; or (b) issued from its mother after the 20th week of pregnancy (*Births, Deaths and Marriages, and Relationships Registration Act 1995*)

What are the stillbirth statistics in New Zealand?

Stillbirth accounts for approximately 0.5% of births in New Zealand (PMMRC, 2012). The birth rate in New Zealand for 2010 was 65,124 babies and there were 341 stillbirths (www.statisphere.govt.nz). As a comparison, in 2007 the birth rate in New Zealand was 65,603 and there were 368 stillbirths. Despite marked advances in obstetric and midwifery care, stillbirth rates have remained relatively stable in past decades (Nallen, 2006).

What are the causes of stillbirths in New Zealand?

The most recent report of the Perinatal and Maternal Mortality Review Committee (PMMRC, 2012) states that the main reason for a baby to be stillborn is under the classification of unexplained antepartum death (21.1%). The second most common cause is maternal antepartum haemorrhage (13.5%). Spontaneous preterm birth accounts for 12% of babies born still and fetal growth restriction is the known cause of

11.4% of stillbirths. 10.3% of babies are stillborn because of congenital abnormalities and the remaining numbers are because of various other causes. Stacey, Thompson, Mitchell, Ekeroma, Zuccollo & McCowan (2010) also state that others suggest that advanced maternal age, high pre-pregnancy body mass index (BMI), smoking, fewer than four ante natal visits, maternal ethnicity (Pacifica) and low socio-economic status all may be associated with stillbirth.

What is the notion of community based midwifery?

A registered midwife in New Zealand has a multitude of options for practising in New Zealand but the two main areas of practice are either as an employed core midwife in a District Health Board (DHB) or as a community based, self-employed midwife, also known as a Lead Maternity Carer (LMC). Both of these paradigms of practice are based on the framework of the partnership model of care but the main difference between a community based midwife and an employed core midwife is the time frame of care and the continuity of carer. The hospital based midwife usually works an eight or twelve hour shift and potentially provides midwifery care for more than one woman at a time. The hospital based midwife usually works in a specific area of the maternity unit. For example, the ante natal ward, labour and birth suite or the postnatal ward but has the ability to provide care over the whole scope of a woman's childbearing year. The midwife is able to provide continuity of care albeit care provided by different midwifery practitioners, it is still midwifery care. The community based midwife is on-call 24 hours a day and has a known list of women she provides on-going care for. This care encapsulates the complete childbirth experience; from conception through to six weeks postnatal. The women and the midwife are known to each other and because of this relationship the midwife is able to provide continuity of carer over a longer period of time. Firkin (2004) suggests that this is "the care that many women seek and that case-loading (community-based) midwives offer" (p. 7). For this research, because of the potential for a longer partnership timeframe, the stories of community based midwives were the focus.

Community-based midwifery has also been known by many different names:

- Self-employed midwifery

- Case-loading midwifery
- Independent midwifery

The partnership model of midwifery practice.

Guilliland and Pairman (1995) define the term partnership as “a relationship of sharing between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding” (p. 7). Although this concept is generally accepted as a basic principle of midwifery in New Zealand, the ideology that supports it can be understood and practised in different ways. This, in itself, highlights the individual relationship that is unique to each midwife and each woman. As Benn (1999) suggests, this partnership is on-going and evolutionary. The continuity of carer is also an essential concept described in this text and is seen as giving time for the woman and the midwife to form a professional friendship upon which to base the childbirth experience. Because of the on-going nature of this relationship there is the opportunity for the woman to build a trusting bond with a midwife who will “share this intimate time in the woman’s life” (p. 40).

Research Question

The question that is asked in this research is: ‘What is the lived experience of midwives the first time they care for a woman having a stillbirth?’ The reconstructions of their experiences highlighted their insights into their personal lived experiences that showed both uniqueness and commonality between all of the midwives interviewed. By hearing their stories, I sought to find meaning in the words they used to describe the first time they were required to care for a woman who had a still baby.

Methodology

This study was guided by the methodology of Hermeneutic Phenomenology. This is a philosophical paradigm that strives to see “things themselves” (Willis, 2001, p. 1). The phenomenon of stillbirth in a midwifery context could relate to Heidegger’s thought that “the notion itself is deeply veiled” (1996, p. 23). That is to suggest that the phenomenon is hidden and veiled. This suggestion is supported by the literature review provided in this thesis. Therefore the use of this research methodology is

appropriate to help unveil and find meaning in the midwives' lived experience of stillbirth. By hearing their own interpretation of their experiences and using the framework of Heideggarian hermeneutic phenomenology, this research will endeavour to find a way of representing the lived experience in as raw and unelaborated way as possible.

The Impetus for my Study

The role of caring for women who have birthed a still baby is a role I am familiar with from my years of community based midwifery practice. These women and their birthing stories have stayed with me. I have pondered the impact that these experiences have had on my own midwifery practice and the practice of my colleagues. The uniqueness of each story has joined together to build on a cumulative bigger picture of midwifery care of women who have felt the loss of a baby. The tragedy of each and every baby that has been lost never lessens and nor should it. For each woman that I have cared for, there is usually a particular memory that reminds me just of her and her story of loss. It may have been a conversation we had at the time or perhaps an unspoken connection we both felt or even just a memory of what else was going on in the world around that time. Regardless of what the memory is, the overwhelming thoughts are based on the shared experience.

A story from my practice

The first stillbirth I was involved with as a registered midwife was with a woman that I had met when I was a third year midwifery student. Each time she got pregnant she phoned me and we simply reconnected again. She was pregnant with her fourth baby and she was prepared to travel from a nearby city to have me as her midwife again. The pregnancy progressed well until she was around 26 weeks pregnant. She reported to me that her baby wasn't moving as much as usual and she felt vaguely unwell. I met her in the local maternity unit and began my assessment. She didn't speak to me during the check-up but she kept her eyes on me the whole time. I attempted to find the baby's heart beat with my Doppler but was unable to. Still no words were spoken. I kept trying for another ten minutes or so and then turned off my Doppler.

She said to me quietly, to begin with, “Don’t say it....don’t you dare say it.....” then louder and louder until she was screaming ...”Don’t tell me...don’t say it....don’t you dare.....don’t.”

By this time she was inconsolably sobbing and clutching her partner. I sat with her for a while then stood, said how sorry I was and then quietly left the room. When I shut the door behind me all I could do was stand in the corner of the hall and breathe. I stood so close to the wall I could feel my breath reflect back on me. I just breathed and breathed as if every breath required my utmost attention. They were long and slow and methodical breaths. I wondered if I was to stop concentrating on my breathing that I would actually stop breathing. My eyes welled up with tears and one single, solitary tear tipped over and ran down my face. I had to fight the need to cry out loud. I must have stood there for several minutes, I’m not sure. Time was immeasurable and of no consequence. I was overwhelmed with the physical, emotional and spiritual response of my body and I needed to stop and “catch my breath”.

Thinking back to this experience, it feels as if it could have happened yesterday but in fact it was quite a few years ago. The heart-pounding feeling of realising that this woman was finding out that her baby had died is easily accessible to me and at times is just under the surface of my memory. At times, I struggle to put words of emotion to those memories. No words can encompass the true sensation of being a witness to another’s grief and loss. Nothing I had ever experienced before prepared me for having the resilience, the words to say or the appropriate personal response I needed that day.

I had, in the past, experienced obstetric situations that caused an adrenaline-like response and I had coped with these as expected and as I had been educated to do. So why was this different? Why was my response more personal, more heart-wrenching, and more heart-breaking? It was not my baby that was lost. I could go home that evening to my own family and feel as if my world was safe. Why had I responded as if I too had lost something I felt so attached to? I started to doubt my own innate response guide. I felt guilty for allowing myself the self-indulgence of this emotive response. I knew this woman’s life would never be the same again. I knew this experience would transform her. Did this experience have the ability to transform me? I knew that I would continue to be a midwife, I would carry on caring for women and

there would be times when the baby would be lost. But why did this experience, above all other midwifery experiences, impact on me so greatly that I remember it so vividly? We, as health professionals are expected to sympathise with women who have suffered a loss and provide them with holistic, woman-centred care. We are not meant to wear our hearts on our sleeves and allow ourselves to personalise their experience as our own experience. We are aware of the need for professional distance between the midwife and the woman that ensures that the focus remains with the woman, who is central to our care.

Something happened to my midwifery sensibilities that day. It brought to the surface some emotions that I was not expecting and I was not sure how to deal with. Looking back at this time, I began to understand and accept that I too felt a sense of loss. Not for the loss of the baby but something else less tangible. The concept of loss of purpose seems to be the most succinct way of describing these feelings and I believe they represent, for me, a sense of unfulfilled expectations of myself and of my partnership with the woman. The relationship I had with the woman was based on a shared goal, on shared hopes and most importantly, a shared vision of what the near future held. Perhaps I was feeling grief for the loss of possibility or a loss of meaning to our relationship. Along with these notions of loss, I acknowledge my own feelings of sadness and a definite feeling of melancholy. Could it have been a sense of the loss of *self*? Perhaps it was my response to entering into someone else's moment of agony and to be overwhelmed by their suffering, chaos and heartbreak. How can anyone witness this tragedy and *not* be affected? No one deserves to suffer one of the greatest losses there is, that of losing a baby.

A colleague's story

An experience of a midwifery colleague raised further questions around the midwife's experience of caring for a woman who has lost a baby. She reflected on the overwhelming impact she felt when caring for a woman whose baby had unexpectedly died. She remembers feeling numb, initially, then angry at the staff who were also involved in this woman's care. She found being with the woman almost impossible and on several occasions avoided caring episodes with her. She found her normal ability to 'keep calm and carry on' was lacking and she wished someone would make it all go away. Overriding all of these feelings was a sense of guilt that would not shift.

So, if she found her own responses difficult to understand, just as I had, then how many other midwives have felt this way too? Why are our experiences not often acknowledged as being times of sorrow and loss? Why are we reluctant to allow ourselves a time of accepted grieving? Are we, as midwives, experiencing disenfranchised grief and if so what can we as a profession do about this phenomenon? So many issues surrounding the midwife's experience of stillbirth are hidden and almost unmentionable. Why is that so, in a profession that has its cornerstone built on caring, understanding and supporting a woman's journey through childbirth? Why is the midwife's journey through childbirth not understood with the same amount of wisdom? If we are committed to working in partnership with women then why do we not acknowledge the time, thought, heart, spirit and love that midwives invest in these relationships? Is it this investment that predisposes the midwife to being vulnerable when the expected outcome of the relationship does not come to fruition?

My Pre-assumptions

The questions that are raised from my own practice experience and the experience of my colleague, led me to search for understanding from the available literature. There was a bulk of research on other health professionals' experience around the loss of a patient but minimal insight into the lived experience of midwives working with women who had lost a baby to stillbirth. The questions remained unanswered and this helped me shape my research question and methodology.

My own experiences were certainly pivotal to why I chose to search for other midwives' meaning of their experiences. I came to this research with my own understanding of this phenomenon and while I heard their stories I also heard my own memories of caring for women who had lost their babies. For me, the phenomenon of stillbirth is about suddenness. Not just from the concept of lived time but also from a viewpoint of unexpectedness. Until the baby's death is declared, the outcome of the woman's pregnancy is generally assumed and in fact, anticipated by all involved. When this assumption does not come to fruition, the midwife's anticipation of how events will turn out, changes. There is often no time to sit back, reflect and plan. Instead, as in my experience, a sense of trepidation, fear and uncertainty prevails. I have experienced the deeper, more personal effect that stillbirth can have on midwives who

provide this care and wanted to know if this experience was shared by others. My interpretation of the midwives' stories was focused on their own narrative of their experiences but nestled in the background was my own *truth* that was the embodiment of my own knowing. This constructed knowledge was informed by my own midwifery life and my own personal way of looking at the world. The conversations I had been party to, the sights I had seen and the reflections I had pondered, all of these had formed my assumptions on both life and death. Even more importantly, the often unspoken yet clearly 'heard' realities of being *the* midwife involved in this midwifery care were pivotal to my own understanding of what it is *to be*.

Liz Collins, a midwife, writes of attending a stillbirth and acknowledges her own realization that she, too, was impacted by what she experienced.

*Four women
waiting together
as women have always waited
outside of time
Four heartbeats
where five might
have been
Your mother
wailed gasped
sharp rhythmic breaths
But you were silent
Empty seconds
Incomprehensible minutes
Sluggishly pass.
Sobered
We try to prepare
Each other, try to prepare
Your mother
But your birth
Is unknowable. So we simply
Wait.
Limp, grey baby, born
into my pale, wavering hands.
Still
you fell from your mother's glorious body
onto the white sheets below. Blood red
umbilical cord, wound around
shocking in its vibrant colour*

*Your absence, Amaya, was unbearable.
Do you know
What your mother did next?
She lifted
You to her breast
Smiling
And with a deep joy
She called you by your name
She admired your silky red hair
Creamy skin
Dark lips
Proud, she exclaimed out loud
how beautiful
you were
And I sobbed
My voice rang
Strangely in my ears
And tears blurred my vision
How foolish of me to think
that I could be present
but remain untouched*

(Liz Collins, 2011)

Summary

In this chapter of introduction I have illustrated the background to this research. I have described my own pre-assumptions that sit within my own practice experience and the practice story of a colleague. These serve to uncover my own interpretational bias and remind the reader of my background for this research. I have provided some statistical and clinical background to this study and described the midwifery context by which this research is informed. I have stated the research methodology chosen for this research and also the research question that pertains to this research.

Overview of the Thesis

Chapter Two contains the literature review in which I explore health care journals, research articles and texts as well as midwifery texts to provide a wider concept of 'end-of-life' care that may pertain to stillbirth. There was minimal research on the lived experience of the community based midwife, specifically related to stillbirth.

Chapter Three contains the methodology chosen for this study. This chapter also seeks to explain the philosophical approach and the use of the works of Heidegger and van Manen to inform this research. The issues of ethical approval and interviewing are also discussed.

Also included are some brief introductions to the participants of this research.

I have chosen to include some of my original poetry in this chapter to offer the reader some further clarification on where this research 'sits' in the phenomenological framework.

Chapter Four offers the beginnings of the analysis of the data collected from the five interviews conducted. The title is "Data- beginning of the analysis" and includes verbatim dialogue from the midwives. I believed it was important to keep each story 'whole' within this chapter, thereby showing more clearly, the impact on each midwife.

Chapter Five offers interpretation of the emergent themes of this research. It attempts to draw my findings together to make sense of what was spoken. The first theme is called 'Pocket Full of Grief' and has three sub-themes:

- Shockwave
- Denial + Invisibility = self-protection
- Blameworthiness

The second theme is entitled 'A Heavy Heart' and this also has three sub-themes:

- Touched by Death
- Empathetic Loss
- Broken.

Chapter Six discusses the implications of this research and the findings offered. It looks at implications for practice, for education and also for further research. It also describes the limitations of this study. Finally, this chapter provides my final thoughts and The Midwife's Lament of Sorrow.

Chapter Two

LITERATURE REVIEW

Introduction

In exploring the literature, it became apparent that there were gaps relating to the lived experiences of midwives, caring for the first time, for women who had a stillbirth.

In writing this literature review, research findings and articles from midwifery journals, educational texts and other various sources were used. Ebscohost search engine was used in the wider search, finding national and international sources.

This study draws upon material from a predominately midwifery orientation although some literature comes from writings on bereavement care and the health professionals that provide 'end-of-life' care. This was necessary to gain an understanding of how other health disciplines educate, prepare and support their own bereavement carers. It also offered insight into the lived-experience of other health colleagues that find themselves acknowledging the 'silent sorrow' of bereavement care. The nature of this review, given the limited amount of specifically relevant research, is to take the insights that have emerged from others and use them in thinking about this study. In other words, the review takes a discursive nature, linking the ideas from the literature with thinking about how such insights may relate to this research.

The phenomenon of stillbirth

The phenomenon of stillbirth is something most parents do *not* want to understand. The incongruity between what they expected to happen and what actually occurred could be thought to be absurdly cruel. How is it conceivable that a woman can give birth to a baby that is in fact not alive? It is possible to imagine that their experience of birthing a dead baby will combine severe emotional, spiritual and physiological distress.

It could be suggested that improved access to antenatal care and frequent midwifery/obstetric visits during the final weeks of pregnancy still has not altered the

rate of stillbirth. The 2010 Report of the Perinatal and Maternal Morbidity Review Committee (PMMRC, 2012) concludes that the main risk factors for these stillbirths were unexplained, therefore potentially, unpreventable.

The PMMRC (2012) states that the current rate of stillbirths in New Zealand is 0.5% of the births recorded. It is 10 times more likely to occur than Sudden Infant Death Syndrome (SIDS) (Cacciatore, 2007). Mitchell (2004) suggests that with developments in antenatal screening, it may be believed that if a problem develops, obstetric intervention can solve it. If not then pregnancy loss can be seen as a failure from the parents', obstetric and midwifery viewpoints.

From this increased obstetric knowledge comes the added complexity that midwives are now required to factor into the care they provide and the skills they possess (Nallen, 2006). Lifestyle and health issues are increasingly requiring midwives to be more analytical, more thoughtful, more responsive, more understanding and more able to offer women appropriate sympathetic, sensitive, realistic advice and skilled care. Although it is acknowledged that midwifery care sits in an ever changing context of healthcare, there is an ever increasing demand on the midwife's professional expertise (Hendricks, Mooney & Berry, 1996). To illustrate this point, the recent review of maternity care in Counties Manukau (2012) states that the women of childbearing age in this District Health Board are more likely to be Pacific (32%) and more often living in the most deprived areas (47% in quintile 5, the highest deprivation quintile). This population of women are more likely to smoke compared to the general female population and they are more likely to have a BMI above the normal range (65%). The rate of preterm births is higher than the national average (7.6% for Maori women) and that rate of maternal infection that contributes to fetal loss is greater than the rest of the country. All of these issues have known contributing links to increased risk of stillbirth and therefore add to the complexity of care required from midwives.

The intensity of potential grief responses of the woman and her family and the often complex clinical issues, calls for the midwife to have extraordinary skills in order to provide appropriate care (Nallen, 2006). Along with these suppositions, midwives are also expected to cope on a personal level with the numbers of women experiencing a stillbirth.

Since the early 1990s there has been a wealth of research that has focused on stillbirth and bereavement. So profound is the grief response by those experiencing this loss that it has captured the attention of many clinicians and researchers. Consequently, women's experiences of the death of a baby in a pregnancy are well documented, with emphasis on the overwhelming emotional impact that follows such a loss (Edmunds & Scudder 2009; Rowland & Goodnight 2009; Caelli, Downie & Letendre, 2002; Wallerstedtet et al, 2003). Much of the research highlights the grief responses of the woman and her partner/whanau/family and the midwifery role in supporting them through this emotional adjustment.

Even though the birthing environment is often in an institutional context, with pre-determined time frames and hospital routines, it is the people- the midwives, doctors and others that matter most to the woman and her supporters. The preconceived notion that midwives 'know what to do' can cultivate a degree of reliance and trust in the midwife that can have more influence on the experience than normal midwifery care. Lovell (2001) believes bereaved parents turn to midwives for advice and emotional support following the death of their baby. The midwives in this study are therefore likely to be at the interface between the often impersonal culture of the hospital and the woman's deeply personal encounter with grief and loss. This place is where the woman and the hospital meet and it is here that the midwife sits.

Midwifery practice

Midwives strive to be compassionate and caring as they know their care can be transformative to the parents' experience (Kohner & Henley, 1991). Mitchell (2004) shows in her research into student midwives' practice preparation, the care provided around the time of a baby's death could have an important impact on the parent's ability to cope. So, considering the commitment of the midwife to support the parents through their journey of loss and the parents trusting that the midwife will care for them, sits the tension of the potential impact on the caring midwife.

Despite the abundance of practice knowledge and wisdom in regards to the care and support of grieving mothers/parents, it appears that there is a scarcity of researched midwifery practice in regards to the care and support of the midwife providing the

care in this clinical situation (Cartwright & Read 2005; Wallbank & Robertson, 2008). However, it has been suggested by health professionals working in bereavement care, that without the ability to manage the emotional responses to the death of a patient (child), the practitioner may experience physical, emotional, cognitive, behavioural or spiritual distress (Keene, Hutton, Hall & Rushton, 2010). This has been suggested in relation to nurses caring for children with life-threatening conditions rather than midwives caring for women/families who are experiencing a stillbirth. The difference between these two clinical bereavement scenarios is the nurse would probably have established a relationship with the child whereas the midwife has a more abstract relationship with the unborn baby. It could be said that the relationship between nurse and the child is based on the inevitability of death whereas the relationship between midwife and the unborn child is based on anticipation and expectations of a normal outcome. One is based on predictability and the other is based on unpredictability. Does this suggested difference in the relationship play a part in the practitioner's response? Does the predictability of death allow time to accept the outcome?

For many midwives, the dilemma may be who cares for *them* during these most challenging and arduous times. Indeed, for many midwives' in this situation, it may be more a question of how do they identify *their own needs* and even if they are entitled to have any neediness at all. Keene, Hutton, Hall and Rushton (2010) consider that the opportunity for health care professionals (midwives) to process personal and professional responses to death is important yet they suggest these opportunities are lacking, in reality. Kohner and Henley (1991, p. 241) suggest that those who care for and support bereaved parents "may find it difficult to manage their personal reactions at the same time as performing a professional role" and those involved should receive appropriate training. They go on to propose that few midwives working with bereaved parents have extensive experience with this level of care and therefore are unlikely to feel confident.

Mitchell (2004) suggests in her research on preparing student midwives to care for bereaved parents, that preparation is needed to enable midwives to fulfil this role. Cartwright and Read (2005) reiterate this in their evaluation of workshops focused on training practitioners in perinatal loss. They suggest that practitioners (midwives) need the knowledge and skills to deliver appropriate holistic care within this sensitive area

of practice. The New Zealand College of Midwives states in the tenth standard of midwifery practice that a midwife “participates in on-going midwifery education” (2008, p. 24). These practice philosophies are to be commended but could it be questioned that theoretical knowledge alone, without the development of actual clinical skills, be enough to sustain a midwife’s practice when caring for bereaved parents for the first time?

Nallen (2006) in her study exploring midwives’ views regarding provision of bereavement support, also talks of the lack of a comprehensive body of evidence regarding midwives’ needs in relation to the provision of this intense midwifery care. Her descriptive qualitative research findings were collected from focus group discussions with hospital based midwives working in the Republic of Ireland. Her findings suggested that one of the key issues midwives had about caring for bereaved families was professional experience. The midwives felt that with experience they were better able to cope with the challenges of providing appropriate care but also felt that it was difficult to build up these skills because bereavement care was not an everyday occurrence. Clinical experience was generally viewed as advantageous in terms of confidence and coping ability. These findings were based on hospital-based midwives rather than self-employed midwives, whereas the current study looks at the self-employed midwife’s practice. If experience is seen as pivotal to the midwife’s ability to manage the impact of this clinical situation, then where can that experience be found and what is the impact on the midwife who does not yet have this experience? A paper on bereavement debriefing sessions and their usefulness written by the Bereavement Team at Johns Hopkins Children’s Centre in Baltimore concluded that learning to manage grief responses is a crucial yet underemphasized skill for health care professionals (Keene, Hutton, Hall & Rushton, 2010). The midwife experiencing stillbirth care for the first time may well not have *learnt* to manage her grief responses and may therefore be at risk of bearing the impact of this care.

The lived experience of the midwife providing bereavement care.

For many midwives, death remains a mystery and their own personal responses to grief remain silent. Could this be because they don’t know what to do with their grief? Romesberg (2004) in her article on understanding grief suggests that “we don’t want

to face death because we are afraid of grief” (p. 1). Research findings on a study done on student midwives’ anxieties and fears about caring for bereaved families, indicated that one of their main concerns was about their own ability to cope with the situation and the feelings that emerge in themselves (Mitchell, 2004). Perhaps it is the reality of needing to understand their own fears surrounding death and confront their own meaning of death. It may force midwives to be more defensive in the care they provide so as to not highlight their own anxieties around the inevitability of death. For some, these thoughts may cause discomfort and be frightening. It may be suggested that for some, the focus is displaced onto the clinical care rather than the humanistic model of care that focuses on the person. By diverting the focus away from the face of suffering, the midwife is not reminded of her own limits and failings and perhaps her own mortality. It is acknowledged that caring for bereaved parents after the death of a baby can be emotionally challenging for midwives so understanding the potential impact of such work may help the individual midwife better comprehend the experience. By using her own personal and social frameworks, she may be able to place her own fears and emotions into a context that offers clarity.

Grief responses

One of those personal/social frameworks may be how the midwife herself experiences grief. Although the midwife has not ‘lost’ she has stood by and watched a woman/family as they suffer a significant loss. Understanding how that loss may feel is seen as central to the relationship between the woman/family and the midwife. This understanding could be seen as part of the definition of empathy as offered by La Monica (1981) “feeling with and in the client’s world” (p. 390). Ewing and Carter (2004) acknowledge, in their discussion paper on supporting staff caring for grieving families, that the personality trait of caring can, in turn, increase the nurses’ (midwife’s) vulnerability to the stressors inherent in serving others. Sabo (2006) suggests that when compassion is evident, an awareness of other’s suffering and the desire to act to relieve that suffering is seen.

Not every woman/family responds in the same way to the death of their baby but many authors have spoken of some of the shared responses to loss. The question that this research strives to investigate is whether the midwife caring for the bereaved

family also shares some of these grief responses. Although it is freely acknowledged that the loss is not the midwives' loss, a vicarious grief response may appear to be related to and may signify the empathetic engagement of the midwife with the woman and her family.

The grief cycle

The nature of the cycle of grief is just that, it is a succession of emotions that can go around and around. The stages are merely a suggested path and may be much less organised and predictable. For some it is a linear journey and for others it follows a more muddled path, going backwards and forwards like a roller coaster of grief.

Kubler-Ross (1969) suggests that often there is an initial sense of denial. Parents can seem numb and find it hard to accept what has happened. Denial is seen as a temporary defence that is often used as a buffer that allows the woman and her family to collect themselves. In essence, they are 'buying' some emotional time to come to terms with the reality of their loss. As if in respite, it is not uncommon for women to day-dream about happier, brighter ideas and plans. Perhaps this form of denial lets them escape from the raw pain that they know is just under the surface and is seemingly inescapable. This phase is said to be a self-defence mechanism that distracts the woman from the unbearable loss she is feeling, even for just a short time (Kubler-Ross, 1969). This stage of grief permits the woman to face the death of her baby while still maintaining hope for the future in an ebb and flow approach.

Bowlby and Parkes (as cited in Stolberg, 2011, p. 8) talk of a time of disorganisation that may involve a host of worries and fears. Parents may feel anxious, helpless and/or insecure. Kohner and Henley (1991) talk firstly of extreme shock and an overwhelming emotion of sadness. Facing the reality that there is no escaping the hurt and the grief death becomes real to them and the realisation that there is nothing they can do about it.

For the midwife, when she first realises that she is now involved in caring for a woman who has lost her baby, her initial response may also be one of denial. She may doubt the inevitable outcome. The midwife may respond with shock, great sadness and anger towards others. Morrison (2007) in her study on vicarious trauma and the health

worker, talks of trauma reactions such as avoidant reactions. In this situation, the midwife could be seen as being less responsive and avoidant in her mannerisms, even for the briefest of times. She may, at best, try and keep encounters brief and at worst, be tempted to avoid contact with her, especially in the very initial stages of care and/or diagnosis. Again, this could be seen as a rejection of the reality of the situation. Perhaps this is an initial response that numbs the impact of such shocking news. If the midwife separates herself from the woman then she too is 'buying time' to deal with her own raw emotions that need to be dealt with *before* she can provide professional midwifery care for this woman. It could be argued that this de-personalisation is part of an avoidant reaction that many health professionals default to, even temporarily, to enable some processing of their own grief responses (Morrison, 2007). Fenwick, Jennings, Downie, Butt and Okanaga (2007) in their research on aspects of care for midwives when providing perinatal loss care, found that midwives described being emotionally overwhelmed. Midwives reportedly found it emotionally draining to deal with their own shock and found it hard to accept the loss. They suggested that an aspect of that distress was from the midwife witnessing the 'trauma' experienced by the woman whose baby had died.

Kubler-Ross (1969) looks at the next potential stage in the grief response: anger. She suggests that when denial can no longer be sustained, it is often replaced with anger, rage, envy, and resentment. Many parents feel anger towards themselves, towards their caregivers, towards God or fate. The question 'why me?' is often asked. This is a time of an apparent lack of justification and of unfair heartbreak. Perhaps they see others who 'do not deserve to be pregnant' because of lifestyle choices, the number of children they have or the supposed inability of those parents to 'take decent care' of the children they already have. It seems inevitable for the woman and her family to find grievances. What they are going through is not meant to happen, it is unfair and their world has been turned upside down. The natural response to feeling wronged is anger. It could be that the woman and her family are unconsciously fearful of being forgotten and left alone, therefore are forced to cope by themselves. Could it be that the fear of being alone is greater than the fear of being seen as demanding and unreasonable? Along with these feelings of underserved tragedy may come the response of tears, guilt and shame. The parents may also experience the sentiment of

having done something bad to cause such misfortune or that they deserved this loss because of what they did or didn't do.

Compared to the stage of denial, this stage of anger may be considered difficult for the midwife to handle. Kubler-Ross(1969) states that the bereaved person's anger is often displaced and can be aimed at anyone and anything, almost in a random manner. The midwife abandoned them, the doctor was disrespectful and the allied staff didn't know what they were doing. The midwife, herself may have similar feelings of anger and shame. Why didn't the woman ring her sooner with her concerns? Why did this happen to her? Why didn't her colleagues support her more during this time? What will people think of her midwifery practice? She may see the woman and family's anger as solely directed at her. She may be desperate to justify her actions and have someone else validate her decisions and actions. The midwife may feel anger or resentment towards the woman for causing such chaos, for having such an impact on her life.

The third stage of a grief response is bargaining (Kubler-Ross, 1969). This stage involves searching for a way out, for the possibility of an agreement which may postpone the inevitable. For the woman, it may involve making a pact of promising to be a better parent, to never think bad thoughts again or to not grumble about the discomforts of pregnancy ever again. Perhaps she is hoping against hope that these promises may produce a miracle or that she will be granted a dispensation. Alternatively, she may beg to feel the baby move just one more time or to have one more day of innocence, a day without having to acknowledge her loss. These pleas are often kept secret and perhaps these private conversations are meant to be heard only by those who can manifest these longed for miracles.

The midwife who goes through the bargaining stage may promise to be a better midwife. She may promise to be more compassionate and understanding when frustrated, less ill-tempered and more tolerant when tired and a more cautious and clinically adept practitioner. Do these silent promises neutralise a quiet guilt by promising anything and everything that may have contributed to the situation, whether assumed or proven? The hope is that someone or something will just make this heavy feeling go away.

Depression is the fourth stage, according to Kubler-Ross' grief cycle (1969). The woman may have exhausted, for the time being, all hope of avoiding the raw truth of her loss. There is a deep realization of what has really happened and it confronts her with nowhere to hide. It is somewhat predictable that the woman may become silent, refuse visitors and spend much of her time crying with an even deeper and renewed sense of grief. *'I'm too sad to do anything'*. Kubler-Ross (1969) suggests this distancing from those around her may allow the woman to disconnect herself from the baby she has lost. It may enable her to detach herself from affection that is buffering the aching feeling she may *need* to acknowledge to let the baby go.

It could also be about the overwhelming awareness that the loss of her baby is only one of the losses that she may be about to endure. The loss or perceived loss of her dreams, her relationships, her own self-image and her future could all be seen to be in jeopardy. A preparatory sense of depression can occur *because* of these impending losses and can add to the initial reactive depressive response associated with the loss of her baby.

The midwife perhaps does not have the same source of depression but this similar response may be triggered by a sense of dread of the possible consequences of the stillbirth and the on-going relationship complexities that the midwife may well have to cope with. The midwife may feel self-doubt about her own midwifery wisdom. The feeling of having failed not only the woman but also themselves may bring about feelings of helplessness and guilt. Perhaps she will never be able to practice with confidence again. There may be a sense of sadness for the woman's loss which could be associated with the concept of compassion fatigue. Sabo (2006) talks of this being a natural response of caring for clients (women) who are in pain, suffering or traumatized. A pilot study conducted in the United Kingdom found that working in obstetrics and dealing with loss has been shown to increase the levels of stress and that one of the symptoms of this is depression (Wallbank, 2010). Likewise, Morrison (2007) suggests that healthcare workers who care for clients (women) who have been traumatised can express a "heavy feeling that gets inside you" (p. 2). For some, they may use the word 'depressed' to describe this feeling.

The final stage in the grief cycle that Kubler-Ross (1969) talks of is that of acceptance. This is a time of peace and understanding of what happened. The acceptance may even be in the acknowledgement of *not* understanding what happened but accepting that it, in fact, did happen and nothing will change that. For many women, a sense of finally finding a way forward is achieved. This sad event is not forgotten but has become part of their personal history. Also, a sense of gratitude can be felt for those who were there for her during her time of need with thankfulness for memories made and perhaps even an appreciation for 'making it through' the dark days of loss. This stage may include the inclination for the woman to want to relive or share her experiences. From a time of silent sadness where there is often little need for words, the woman may well feel empowered by talking of her loss and how it was for her. To verbalise what happened can be seen as a way of gaining acknowledgement from others of the loss suffered and may consolidate her experience into how she now sees herself.

For the midwife to go through this stage, it is suggested that by sharing her experiences she puts the event into context. By telling her story and perhaps hearing other midwives' stories she can express a commonality of understanding, an experience that others have lived through. Peace and acceptance can come through knowing that others have also experienced caring for a woman who has lost her baby. This could be described as a mutually expressed sadness that could promote compassionate equality. As Blum suggests (as cited in Sabo, 2006), when compassion is experienced between individuals there is an inherent regard and respect for each other. Sabo (2006) talks of the need for individuals to understand and be understood. By reflecting on the experience, alone and with others, the midwife may be able to conceptualise the event into something more meaningful to her. By doing this she will be able to look forward in her practice rather than occupy herself with what has happened. For some midwives, caring for a woman who has suffered a stillbirth could be seen as the "perfect storm". This is a phrase put forward by Shara Yurkiewicz, a medical student (2011, para. 4), in her blog on spirituality and the health professional. When putting the coexistence of birth, death, witnessing suffering without supposed purpose and a lack of control to 'make things better' into the mix, there is the potential for the health professional (midwife) to hit an emotional wall. For the

midwife who finds herself in this position, the quest may be for her to find refuge in that storm, to turn to others who may have empathy with her experience or to find someone who understands. For that midwife to reach out for support there needs to be people around her who *can* support her.

This research will document what happened when the midwife reached out and if, indeed she *did* reach out for support. It will hear her story about who was there to support her and what it meant to her to know that support.

The potential impact on the midwife

Midwives traditionally embrace the notion of midwifery representing a happy, healthy unimpaired outcome for mother and baby. Gould (2000) states that midwives usually follow a paradigm that sees childbirth as normal and is predominantly involved with new life. For some midwives, either by choice, clinical responsibility or by chance, they are involved in situations that do not reflect this model.

Both Mitchell (2004) and Moffitt (2006) write about modern society being adverse to sorrow and grief. Mitchell (2004, p. 79) suggests we live in a “death denying society” and therefore we are somewhat distanced from death. This could indicate that midwives, along with other health professionals, have minimal experience of death. Consequently, it could be suggested that death and its impact has been smothered or, as Moffitt (2006) suggests, death has been silenced.

Thomas (2001) suggests that a midwife who is required to support parents whose baby has died has one of the most challenging roles that a midwife will ever undertake. Magill-Cuerden (2006) talks of the psychological and emotional support offered by midwives, encouraging women to articulate their feelings by using appropriate listening skills. She suggests these are often hidden characteristics of midwifery (2006). If this is true, do these ‘hidden’ skills extend to supporting fellow midwives, enabling them to share their own personal feelings surrounding their clinical experience of fetal loss? Perhaps these skills are kept solely for the woman and her family as this level of support is seen as not needed, self-indulgent or of a low priority for most midwives. Magill-Cuerden (2006) again, believes that lack of time and being overstretched at work may see this support of midwives to be at an inadequate standard. It could be possible that some midwives are unsure of what is needed or how to support another

midwife in this situation. Again, their own feelings of discomfort around stillbirth may overshadow their ability to reach out to a colleague and offer the supposed 'correct' support. It is acknowledged that each midwife will have their own personal philosophy and particular way of seeing the world so, in this context, the support offered to each individual midwife needs to be as unique as she is. This suggests that the concept of offering and providing collegial support, is complex and multifaceted. This research strives to investigate this and will sit with the reality of being a midwife caring for a woman who has lost her baby.

There seems to be realisation in existing midwifery literature that few individuals can indeed cope with the death of a baby without carrying a heavy and often long-lasting psychological burden (Doka & Davidson, 2001). This may be even more so if the midwife feels unprepared or unskilled in coping with such a tragic pregnancy outcome.

The inexperienced midwife

So, what of the midwife who is inexperienced in stillbirth care. In a midwife's first few years of practice, she is often found searching for a safe path through the challenges that face her. Experience is seen as the magic potion to any dilemma and is often perceived as lacking to a less experienced midwife. When caring for a woman who is going through a stillbirth, the midwife must navigate her own personal journey. In reality, this notion could relate to any midwife, irrelevant of her practice experience. The first time caring for a bereaved family could be, in essence, similar to being a recent graduate. Uncertainty, anxiety and the strong desire to 'do no harm' may well be paramount to the practitioner. Acknowledging best practice in bereavement care is usually only theoretical until a midwife comes face to face with the clinical situation of stillbirth. Caring for a bereaved family must surely be an even harder task for the midwife when she is experiencing this clinical situation for the first time. For many midwives, they may feel inexperienced in this complex level of midwifery care, irrelevant of how many years midwifery experience they have had.

An article reflecting on the impact of inexperience in not only dealing with the woman's grief but the practitioner's own grief was written by Morgan (2009). Morgan

states that many nurses (midwives) reported having inadequate knowledge, expertise and skills to recognize and handle their own personal reactions in the face of death let alone the parent's responses to loss (2009). Mitchell (2004) concludes that from an inexperienced midwife's point of view, the challenges faced in coping are not well discussed in current literature and further research is indicated.

Sabo (2006) in her research on compassion fatigue and the possible impact on nurses and other health professionals (midwives) who provide "caring work" (p. 136) states that more research should be undertaken to explore such factors as years of experience and the relationship between this and possible impact on the practitioner providing this care.

There is a corresponding relationship between lack of experience and proficiency in caring for women who have had a stillbirth and the recognized difficulty in coping with these cases (Walpole, 2002). In a review of three workshops on training recently qualified practitioners in working with perinatal loss and bereavement, it was stated that little had been written specifically regarding the health professional's role in this context (Cartwright & Read, 2005). What was determined during these workshops was health professionals felt that they needed to acknowledge the pain associated with this area of care and time given to deal with their own related fears and anxieties (Cartwright & Read, 2005). If the significance of the loss for the midwife is not appreciated by her own family, friends and the wider society but is instead surrounded by a conspiracy of silence then the midwife is at risk of feelings of isolation and abandonment. One of the challenges for the self-employed midwife is being able to acknowledge her own limits and possible inner conflicts regarding the care provided to the bereaved family. Ideally she would feel supported enough to face these difficult practice situations. She needs to be able to make meaning out of the experience and to start to effectively deal with the task of grieving, whatever that concept is for her.

Research done in Scandinavia suggests that we should consider the midwife's psychological skills, emotional maturity and experience with stillbirths when analysing how a midwife cares for a woman having a stillborn baby (Radestad & Christofferen, 2008). The dilemma remains that the midwife's skills (or lack of skill) in this area have

long-term impact on the woman's birthing experience. This could be seen as implying that the 'inexperienced' midwife is at risk of harming the woman, physiologically, emotionally and psychologically. Again, the midwife's clinical encounter with stillbirth is seen only through the eyes of the woman and still there is no reflection on the stress that 'getting it right' has on the inexperienced midwife.

Donovan (2008) concluded in her research into confidence levels in newly qualified midwives that confidence is a complex concept and is seen as different to competence. She reflects on the idea that clinical competence is based on performing a particular task that has been practiced, whereas confidence is seen as a more generic construct that is based more on self-assurance than skill. This notion could translate into any midwife's practice that does not include the experience of caring for a woman who has had a stillbirth. She may feel competent in caring for a woman who has lost but not feel confident providing care. That is to suggest, the midwife is able to provide clinically appropriate midwifery care to the woman but may flounder providing 'situation sensitive' care. This thesis will ponder the real life experiences of midwives who have provided this care to women and what impact this experience had on them.

Summary of literature review

It is acknowledged in numerous literary sources, that the birth of a still baby is a tragic and devastating experience for families. Stillbirths are often unexpected and with no known cause. Just the phrase instils fear and anxiety into many parent's minds. In the current consumer-driven, high-tech maternity landscape, the idea of birthing a stillborn baby is perhaps not considered. Along with developments in antenatal screening, it may be believed that if a problem develops, obstetric intervention can solve it. If not then pregnancy loss can be seen as a failure both from the parents and obstetric viewpoints.

Literature supports the view of stillbirth or fetal loss being one of the most shocking losses and there is much written on the impact this loss has on women and their partners/families. This literature review illustrates that although there is ample evidence that informs practice for bereavement care, there is a shortage of literature that enlightens the midwifery profession on the impact of providing this bereavement

care for the first time in a midwife's practice. Due to this complex clinical environment, healthcare professionals could benefit from reflective practice on the lived experience of providing bereavement care.

Key words: bereavement, stillbirth, midwife, inexperienced

Chapter Three

METHODOLOGY

Introduction

The philosophical framework that has informed my approach to this research will be discussed in this chapter. There will be discussion on the notions of Heidegger (1962) and van Manen (1990) as the theoretical philosophical basis for the interpretation of the data collected. Issues concerning the selection of participants, the interviewing process and the collection of data will also be discussed.

Philosophical Underpinnings

Heideggerian phenomenology, a qualitative research approach, is positioned within the theoretical perspective of interpretivism and concerns itself with understanding meaning (van Manen, 1990). It is this philosophical underpinning that this research is informed by. Heidegger [1899-1976] was a German philosopher who was concerned with understanding *Being*. Although Heidegger stated that the concept of 'being' is undefinable, he suggested a focus on everyday existence of people is necessary in order to explore the nature or meaning of a phenomenon (Heidegger, 1962). As a methodology it allows for an exploration and then interpretation of the human world as it presents itself. Using this philosophical approach, I will seek to get an understanding of what it is to be a midwife caring, for the first time, for a woman who has had a stillbirth. By hearing her lived experience I will attempt to interpret the meaning placed on the experience by the midwife herself. I will see the significance of her 'lived-world'; the events, the thoughts, the memories, the emotion, the bodily awareness, the embodied action, the flow of time, the self and others.

The nature of this research was likely to be sensitive as I was hearing the personal thoughts and experiences of the interviewees. Cowles (1988) defines a sensitive subject as one having the potential to cause physical, emotional or psychological distress to participants. As Elam and Fenton (2003) suggest, qualitative research, using in-depth semi-structured interviewing is best suited to topics with this level of

sensitivity. Because of this, the narrative approach was more suited to exploring those experiences.

Van Manen (1990) talks of that which makes a thing what it is. Therefore, it could be suggested that hearing the story of a midwife having lived-through caring for a woman who has had a stillbirth, highlights something of the essence of the experience before others attach meaning to it. The narrative allows us to hear the experience as close to the primordial experience as a researcher can position herself. The researcher can sit with the experience before she analyses it. The narratives that the midwives shared were recollections of their experiences, told in a free-flowing manner.

Willis (2001) suggests that phenomenological research strives to uncover and attend to the lifeworld which is the only reality people really possess. The lifeworld is the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it (van Manen, 1990). As van Manen also states, "Phenomenology aims at gaining a deeper understanding of the nature of meaning of our everyday experience" (1990, p. 9). When asking midwives about their experience of caring for a woman who has had a stillbirth, the lived experience of the midwife will be heard as their perception of the phenomenon, their awareness of what it felt like to be *them* during this time and in the months following.

The research focus links to the chosen philosophy and methodology that allows for an unearthing and revealing of deeper levels of understanding of being-in-the-world. The methodology involves bringing the researcher's insight to hearing what the study participants' experience of 'being-in-the-world' is all about. This requires interpreting the meaning from participants' interview narratives, and the stories crafted from them, in order to capture something of the essence of the experience (van Manen, 1990).

In this vein, Heidegger talks of hermeneutics, the art of interpretation in context (Heidegger, 1962). In the hermeneutic tradition, listeners and speakers are participating in a cooperative process of determining meanings. This research method is based on the premise that an interpreter (interviewer) does not recreate a meaning

originally created by an author (participant) but that the interpreter joins the author in the creation of meaning (Murphy, 1989).

The interpretative stance that this phenomenological study takes is based on the work of Heidegger (1962) who informs the interpretative tradition of phenomenology. He believed that it is impossible to rid the mind of preconceptions and approach something in a completely blank or neutral way. He believed instead, that we may use our own life experiences to decipher what others describe.

The method involves staying close to the person's story "because it is the nearest you can get to the thing itself" (p. 17) and this requires repeated readings of the transcripts.

Writing and rewriting the stories occurs until the researcher considers that their interpretation captures the meaning of the experience (Grant & Giddings, 2002). Having said this, Willis (2001) suggests that things are not simply things but instead they become things in the act of perception and naming. By naming or calling the experience 'something' the interpretation is again formed by all manner of influences like culture, social context and even the memory of the experience. Willis (2001) suggests that phenomenology is not concerned with generating abstractions, concepts, hypotheses or theories, or with identifying causes. Instead, it slows the researcher down and holds her gaze on the phenomenon itself. It is anticipated that the findings will illuminate or explain this human experience and its meaning. This research study strives to use phenomenology to understand what it feels like to be a midwife caring for a bereaved woman and what meaning midwives attach to this life event in the months following.

The method of interpretation used to identify shared themes and patterns was as follows.

I first read the interviews to gain a sense of the text, followed by line-by-line analysis of the text to illuminate shared beliefs and common practices. Emerging themes and patterns were refined through a circular process of analysis where a greater understanding of the data resulted from the overlapping process of analysis and reflection on the findings. A final return to the data ensured that the interpretations

were supported by the information in the data. This gave clarification and trustworthiness to the interpretation.

Willis (2001) states that a person who is involved in phenomenological reflection is trying to engage with the lived experience and is in fact a “processed experience” (p. 6). This would imply that the transcribed data is written and re written, read and reread, thought about and thought about some more until “it resonates with our sense of lived life”(van Manen, 1990, p. 27). As van Manen states “a good phenomenological description is collected by lived experience and recollects lived experience- is validated by lived experience and it validates lived experience” (p. 27).

To ensure rigour in this study the researcher will use Guba & Lincoln’s (1989) points of trustworthiness; reflexivity, credibility, transferability and dependability. The ontological stance this research proposal will assume is one of a constructionist view. Constructionist ontology views the interpretation of the world as being internally constructed or of our own knowing and understanding. We individually and collectively create meaning from our experiences in a world where we can never know what is real. As van Manen (1990) suggests “Ontological inquiry is concerned with what it means to *be*” (p. 183).

Phenomenological research and midwifery seem to be perfectly suited but the numbers of studies done in midwifery research using this methodology are small compared to that in other health professions. Midwifery is historically seen as a woman’s profession that involves “wise women” (Gelis, 1991, p. 105). It could be asked: where did they get their wisdom from? Perhaps one source was the telling of stories and learning from other’s experiences. Phenomenology could be said to support this knowing by acknowledging the learned understanding of phenomena as seen by women and midwives alike. As phenomenology attempts to understand aspects of a phenomenon as related to those who are likely to experience that phenomenon, then stillbirth and midwifery is a likely pairing.

To uncover the meaning of stillbirth and the midwife, I have written this poem to inspire my own research journey of discovery about what is ‘around the corner’. I believe it exemplifies the notion of always searching and always being mindful of what is unsaid so as to see ‘things themselves’. It is my attempt to highlight the meaning I give to hermeneutic phenomenology:

*Sometimes I need to know what is around the corner
Light or dark, me or you, life or death.
To see the past by looking forward
In trusting the steps that I will take
Believing the direction shown to me
Going towards my faith
Seeking the truth of my heart*

*Sometimes I need to see what is around me
The secret shadows of people's minds
The thoughts falling from open cracks
They hit the ground without a sound
We trip over them without knowing
Dissolving into slips of the tongue*

*Sometimes I need to see what is happening
Clarity is the gift of reason
Nonsense becomes reality and
mystery becomes the truth
The stillness of the mind reflects the vision within*

RESEARCH DESIGN

Introduction

The design of this research is based on van Manen's (1990) and Heidegger's (1962) work on interpretation of the lived experience and it "sets out to make sense of a certain aspect of human existence" (van Manen, 1990, p. 31). In this instance, the aspect of stillbirth in relation to the midwife.

Ethical approval

The Auckland University of Technology Ethics Committee granted ethical approval in August 2011 (see Appendix A). I heeded my obligation to protect the participants in my study throughout the process.

Data analysis

Banonis (1989) suggests that researchers who use the methodology of phenomenology seek to ensure that data analysis enables the meaning of the experience to be understood while saving the individuality of each participant's experience. The

interpretation of the transcribed data was based on van Manen's (1990) phenomenological interpretation methods:

- Turning to a phenomenon which seriously interests us and commits us to the world.

As suggested in the narrative on my own midwifery practice experience of caring for a woman whose baby was stillborn, I have come to understand that this experience had a great impact on me, as a midwife. The care of women who have suffered a loss, has become an important and pivotal part of my clinical practice and these experiences have defined who I am as a midwife. When I have reflected on my own midwifery practice experiences of caring for women who have lost their babies, I have been aware of a sense of 'being whole', in a place of harmony. This practice reflection places me firmly in *my* world of midwifery but I do understand that not every midwife feels this way. In fact, it seems that my strong sense of self is not the usual response to caring for bereaved women. My commitment to this specialist area of midwifery is deeply connected to my impetus to do this research. The research topic of stillbirth and the midwife seemed to be an obvious choice because of these clinical experiences.

- Investigating experience as we live it rather than as we conceptualize it.

To have the lived experience of caring for a woman who has had a stillbirth has given me a sense of the reality of this clinical situation. Rather than working only with a concept of stillbirth, I am able to investigate the reality of this phenomenon. The task of interpreting the narratives of the five midwives' stories, also gives me the framework to bring to life *their* reality of this situation. The concept of stillbirth was apparent in the very beginning but their lived experiences came to the fore and guided this research. By investigating this phenomenon I am attempting to make sense of a certain aspect of human existence.

- Reflecting on the essential themes which characterize the phenomenon.

Reflection required me to have thoughtful deliberation of the phenomenon (Tickle, 1994) and by doing so I was able to reflect on the emergent themes that developed in this study. The two main themes are: a pocket full of grief (shockwaves, denial +

invisibility = self protection and blameworthiness) and a heavy heart (touched by death, empathetic loss and broken). The process of developing the themes that emerged from the data was not as straight forward as I anticipated. The themes changed and grew, almost without conscious input from me. The themes at the beginning of my reflection are certainly not the final themes. I believe my pre-assumptions coloured my view of these themes to begin with. I thought I knew what the themes *would be* rather than allowed them to develop into what they *needed to be*.

- Describing the phenomenon through the art of writing and rewriting thereby considering the meaning of these emergent themes.

Reading, re-reading, writing, re-writing. This process seemed to be never ending. The more I considered the data the more I heard and the more I understood. This process was, at times both painful and exhilarating. Painful because the stories were so truthful and *real*. Each midwife's story reverberated in my memory of my own clinical experiences. The tangible pain and anguish that some of the midwives shared, touched me deeply. Not only because they spoke with such vulnerability but also because they trusted me enough to put their hearts on their sleeves and share their deepest and most painful memories of the experience. For some, it was the first time they had spoken about it with anyone, other than those directly connected with the experience. Exhilarating because they were describing their personal responses that midwives desperately needed to hear. Their stories affirmed what I believe many other midwives have felt but had not voiced, ever.

- Maintaining a strong relation to the phenomenon which then becomes a description of the phenomenon.

Remembering to bring the phenomenon of stillbirth back into focus was a constant battle. There were times of frustration when I struggled to *hear* what was being said and decipher the hidden meanings. Yet there were many moments of illumination when the meanings appeared like opening a book. Sitting with the phenomenon from my own personal framework was a default position or a position of knowing. This was not the purpose of this research though and I was frequently challenged to trust the process and not sit back and just accept my own interpretations. As van Manen

suggests, the aim is to see the phenomenon as a more “direct contact with the experience as lived” (1990, p. 78). This is about the lived experiences of the midwives interviewed rather than just my own lived experiences. By trusting the process I was able to practice thoughtfulness and in the fullness of thinking I could establish a renewed contact with my original experience (van Manen, 1990). This meant I could combine my own knowing of the phenomenon with the narratives and support the themes as they developed.

- Balancing the research context by considering parts and whole.

By facilitating an intimacy with the data through repeated reading and re-reading I was able to not only focus on specific parts but also reflect again and again on how these parts constituted the whole. By sitting with the “whatness” or “what is it?” (van Manen, 1990, p. 33) of the phenomenon, I was able to reveal the meaning found in the words. I frequently heard myself asking ‘what is it they are truly saying?’. Sometimes I felt that the wholeness of the themes were a figment of my imagination and elusive but finally after stepping up and stepping back from the data I gained clarity of the wholeness of the phenomenon.

To assist with my interpretation of the data collected I utilised Smythe & Spence’s guide for “dwelling with a transcript” (1999, p. 3). That is, writing, drawing and grouping stories together looking for themes. It is suggested to use questions as prompts to delve deeper and deeper into meaning behind or below the data.

Questions such as:

- What is the “thing itself” that I am searching for?
 - How could it be covered over or be in disguise?
 - What lies behind what is said?
 - How do they reveal new understanding to me?
 - How do they take away the concealment of taken for granted understandings?
- (Smythe & Spence, 1999)

Sampling Strategy

The sample size for this research project was five midwives. The inclusion sample was made up of registered midwives who, for the first time in their community based midwifery practice, cared for a woman who experienced a stillbirth. This sample of midwives were able to speak English and had no communication difficulties that would have made participating in an interview difficult for them. Midwives who were currently under a practice review were excluded to protect them from further outside focus on their practice.

Purposive sampling was used to select interviewees that had experienced caring for a woman having a stillbirth, therefore having an understanding of the phenomenon. This strategy was suggested by Streubert and Carpenter (1999) as a method of obtaining invaluable and rich experiential data.

In order to identify suitable participants I first used purposive sampling via professional networks where midwives were asked if they knew of anyone who could be sent an invitation. As it turned out, the participants found out about my study informally through chance meetings, in various circumstances. When the midwives voiced interest in being involved in my study, I gave them appropriate information about the study and asked if I could contact them at a later date to discuss any questions they may have and gain further consent to be participants. All agreed with this plan and when approached again, all the midwives agreed to be interviewed. Dates and locations were discussed.

Data collection

The data for this study was collected through face-to-face interviews with the participant midwives. The meetings were in the form of semi-structured interviews. When using this methodology interviews are individual and use a style that allows the researcher and participant to engage in a conversation (van Manen, 1990) where the researcher asks the participant to tell a story about an experience. The location for these interviews was chosen by the participants. For some of the interviews, the midwife's home was chosen and for others, they chose their place of work, in a quiet

room. These interviews were audio taped and a note book was used to jot down any data that the recorder may not pick-up. Most of the interviews lasted about one hour.

Once the interviews had taken place, I transcribed the interviews from the audio tapes. By transcribing the interviews myself, it allowed me to have a close involvement and recognition of the detail of the narrative.

The experiences encapsulate a time frame of practice that spanned from almost two years qualified through to twenty five years plus of practice experience. The clinical experience of stillbirth happened as recently as six months before the interview and as long ago as eight years ago.

To facilitate the reconstructions of their personal narratives, the participants were asked to tell their story of the first time they cared for a woman who had had a stillborn baby. Each interview started with a similar question "Can you set the scene for your experience?" This question helped each midwife start her journey and provided some details to help clarify the background to her experience. This question was designed to help her not only remember the clinical experience but to also recall the thoughts and feelings associated with the event. Each story was a distinct representation of their own lived experience and was unique to each midwife. Following the initial question, the questions that followed were in direct response to the midwife's story. This enabled the midwife to stay as close to her own story or her own lived experience as possible.

Each midwife started their story from *their* beginning point. They were encouraged to set the scene and to settle themselves into the way they wanted to represent their story.

After the five interviews and transcribing the narratives, I believed that I had collected enough data to be able to proceed with my analysis and interpretation. This methodology often only uses small numbers of participants as each midwife's experience was 'data rich'. Because of the in-depth nature of each interview sample sizes do not need to be large (Robinson, 2000). The emphasis lies in listening to other midwives' experiences and hearing accounts of their own interpretation of the events. Phenomenology does not seek to generalise the phenomenon but instead derive

meaning from participants' stories that remain authentic to the phenomenon (Willis, 2001).

Study Participants

All of the five midwives lived and practiced in the central and upper North Island. To provide a context to the data collected, I will provide a basic overview of each midwife, using the assumed name used in the discussion:

<u>Pseudonym</u>	<u>years of practice</u>	<u>rural/urban</u>	<u>team/solo</u>
Mary	almost 3 years	urban	team
Jill	25 years plus	rural	one other
Fay	20 years plus	urban	team
Lou	almost 2 years	rural	team
Vicky	over 10 years	rural	team

Protection of participants and clients

In order to keep the participants feeling as safe as possible while telling their sensitive stories, I asked each midwife to select the location of the interview. I offered guidance as to the need for privacy and personal comfort but other than that, they chose the location of the interviews.

By using assumed names, I have provided anonymity for all the participants. Although a geographical practice location has been mentioned, I believe the size of this area is great enough to allow further anonymity. If another midwife was mentioned in the transcript, I have also allocated a pseudonym to them to avoid identification.

As I transcribed all the interviews, there was no second party or other typist used. This further protected any identification of the participants. All transcripts, either audio or written are securely kept in a private, secure location.

In the discussion of the data, all identifying terms, locations and people have been either changed or removed from the writing. None of these details detracted from the midwives' stories so I felt it important to remove them from the data.

Trustworthiness

The ultimate test of this study's worth is that the findings ring true to the people who read it. The findings should reflect the reality of the experience. Even if they haven't experienced the phenomenon of stillbirth themselves, by reading this research they will gain a sense of possibility from what they read. The trustworthiness of phenomenological research is critical to not only the reader but also those who are impacted by the research. There are many critics who are reluctant to accept trustworthiness as a dependable form of rigour in qualitative research (Shenton, 2003). Many favour more empirical criteria for evaluation but it is said that this is unacceptable in an interpretive paradigm (Koch & Harrington, 1998). In this research, rigour can be shown in a more reflexive way which allows the reader to decide for themselves if the results are credible or not.

Reflexivity

To be a reflexive researcher, I acknowledge that I am part and parcel of the setting, context and culture of what I am trying to understand and analyse. My own pre-assumptions and previous lived experiences give a framework for this research with a generalised context of midwifery practice. My professional position in relation to the phenomenon of stillbirth has been discussed in previous chapters and I have described my own practice experiences. Although the midwifery context or clinical considerations remained the same for each midwife interviewed, the content was guided by the midwives and how I found meaning in the interpretation of their experiences.

Earlier in this research process, I was interviewed by both of my supervisors, in a way that enabled me to reflect on my own pre-assumptions and unpack the meaning of my experiences. I believe this was vital to show me where I was in my own journey. What was uncovered were untold truths that I had not yet heard and through the process of reflective practice, I was able to gain a deeper and more meaningful understanding of the phenomenon. For me, to be encouraged to talk about my own experiences was cathartic and the experience gave me a clear slate to work from. For me to know the

phenomenon is to start to understand it. From this starting point I could acknowledge my own pre-assumptions and begin to engage with the stories of others, not to compare but to share the commonalities that developed. I was aware that to compare stories was not the purpose of this research.

As van Manen (1990) suggests “to write means to write myself, in a deep collective sense” (p. 132). So, while I wrote I heard the voices of all midwives as well as the midwife whose interview I was contemplating. The collective voice of midwifery guided me when I asked myself ‘What are her words trying to say?’ ‘How could it be covered over or be in disguise?’ ‘What lies behind what is said?’ Comments made by both academic and clinical colleagues and women who had lost a baby came to mind when sitting with the data before me. Conversations with my supervisors triggered further analysis and reflection. Ideas and thoughts that came to me from reading many different journals and texts informed my developing concept of meaning. All the while remembering that my interpretation is just one way of describing the phenomenon of stillbirth. There is always the possibility of other interpretations which may be richer or deeper (van Manen, 1990).

Credibility

In a phenomenological study, there is an fundamental notion that there are potentially multiple meanings or truths related to a phenomenon. In this study, truth value or credibility was obtained from the discovery of experiences as they were lived and perceived by the midwives interviewed rather than from my own experiences. To show credibility I acknowledged that there were multiple realities and I endeavoured to represent those realities revealed by the midwives as appropriately as possible. To further demonstrate credibility, I contacted the participants and asked if I could return the transcripts and my interpretations to them. I asked them to spend some time reading through the transcripts and to comment on them. By giving each midwife the opportunity to change or expand anything in the transcript, I was acknowledging that my interpretation of what was said may well be different to theirs. Any alterations were implemented and although the majority of changes were relatively minor, the incorporation of these is seen as a measure of credibility (Streubert and Carpenter, 1999).

Both of my supervisors read and provided constructive comment on my writing throughout the process of interpretation. The deeper I got into my interpretive work the more focused their comments became and the more I felt affirmed. Comparing my beginning analysis to where I have ended up, I believe the process of reading, re-reading and writing, re-writing has led me to a place of 'being-with' the data. I found that I could use more of my senses to be with the data: I could see meaning, feel meaning, know meaning and touch meaning. My new found understanding of the phenomenon came from a place that was not visible to me prior to this study. From time to time I shared pockets of ponderings with my midwifery colleagues and I received what van Manen (1997) describes as the 'phenomenological nod'. That is when others show recognition or a felt understanding of what is being said or described. This reaction supported my measure of credibility in my study. Sandelowski (1986) suggested that a phenomenological study is credible when it presents such accurate interpretations of human experience that people who also share that experience would immediately recognize it. I hope that those who care for women who have had a stillbirth can recognise their own experiences in those described by the participants and can feel a commonality of experience.

Transferability

The question that may be asked to determine transferability is 'could these findings be applied to a wider population?' Although the findings are specific to a relatively small number of individuals the overall results may be relevant to others caring for bereaved families. The contextual factors around midwifery care do make these findings very specific to midwifery but if the lived experience of 'the carer' is the highlight then some of the thematic data may well be applicable to other caring professions. Lincoln and Guba (1985) suggest that if practitioners believe their situations to be similar to that described in the study, they may relate the findings to their own positions. I have endeavoured to provide a sufficiently rich description of the phenomenon to allow the reader to gain an understanding of it, thereby enabling them to compare these interpretations and themes with those that they have seen emerge in their own situations.

Dependability

As Talbot (1995) states, to ensure the dependability of a study, another researcher would need to travel the same path, resulting in similar findings. For this to happen I need to provide an 'audit trail' (Lincoln & Guba, 1985). This provides precise steps taken in the research process. I have provided this detail in earlier sections of this chapter. If similar findings were found using the same context, with the same methods and with the same participants then the study could be deemed dependable. It could, however be argued that by the very nature of interpretation within phenomenological research, the subtleties or nuances that are heard or *not* heard may alter the findings and may be difficult to repeat.

Conclusion

This chapter includes discussion on my philosophical approach and how it directed my research question and methods used to carry out the research. I have discussed gaining ethical approval, recruiting participants and how I interviewed them. The purpose of this writing is to draw the reader closer to the midwives' lived experiences and to offer my interpretations of their stories. For this to be useful to the reader the trustworthiness of the findings need to be addressed and confirmed. For these findings to be incorporated into a midwife's practice the data needs to be authentic and the discussion around these narratives has to stay true to the experience.

The following chapter begins the analysis of the data collected from the five midwives interviewed. It contains verbatim narrative excerpts from the participants and my interpretation of their stories of caring for a woman who has lost her baby to stillbirth.

Chapter Four

DATA- BEGINNING THE ANALYSIS

Introduction

This chapter presents the narratives from the interviews of five midwives who shared their first experiences of caring for a woman who had a stillborn child. The reconstructions of their experiences highlighted their insights into their personal lived experiences that showed both uniqueness and commonality between all of the midwives interviewed.

The structure of this chapter presents the beginnings of my interpretations of the stories told. These stories include the anticipated reality of, one day needing to care for a woman who has lost her baby and the feelings of readiness, or not for this eventuality. The realism of their first experience is captured in this chapter also and finally, the significance or the aftermath of their experience is considered in each of the narratives.

Mary

Background

Mary is a community based midwife who works in partnership with other midwives. She has been qualified for almost three years and lives and works in the upper North Island. Her midwifery experience has been as a community based midwife, since qualifying. A midwifery colleague introduced me to Mary although I had met her several times earlier on in her career. I met Mary at her home and discussed the research and the interview process. She willingly agreed to participate. She then shared her experience of a stillbirth that happened at an unplanned home birth.

Experience

Mary was called to attend a woman in labour with her fourth child. The woman had experienced a normal pregnancy and she was to birth at the local maternity unit. Both Mary and the woman were anticipating a normal vaginal birth. Mary was meant to have the weekend off as it was her birthday, but instead she chose to remain on call

for this woman. The possibility of a relatively prompt, normal birth with a woman who had birthed before is often reason enough to stay on call.

I was going to have the weekend off because it was my birthday but anyway I got a call from her early Saturday morning. She said she had broken her waters. She had no pains except maybe some period cramps and she was feeling well. She was on the toilet and her waters had just gone. They were nice and clear. The baby moving and she said the baby had been moving in the night but she hadn't felt movements now. So her waters had just gone. I said that's fine and she should tuck herself back into bed and see how things go. I said to let me know when she needed me.

The experience of a woman having a stillborn baby often starts like any other birthing experience. Mary was conscious of all the safety issues as with any woman heading towards birthing her baby. The baby had been moving. It wasn't moving right now but that is not unusual. There was nothing specific that alerted Mary to any problems. She acknowledged the key indicators of normality and with this reassuring conversation, both the woman and the midwife went back to bed. The anticipation of 'something is about to happen' is understated but both Mary and the woman are expecting the same thing. The unknowness is when it will happen. The distressed or even perhaps already dead baby has not yet announced what was to come.

The woman had a history of quick births so they were planning to head to the hospital quite quickly once she was in labour. Within a short time of being called and even before Mary could leave home, she was informed by the woman's husband that she was birthing on the toilet at home, unexpectedly.

I felt fine but I was a little bit worried. It was an unplanned homebirth but I wasn't concerned about the baby at all. Just a little stressed because of the unexpectedness of it.

An unplanned home birth indicates a sudden change of plans. For Mary, her sense of unease could have come not from the speed of the birth, which she was already anticipating, but the abrupt change of location of the birth. Along with this comes a change of vision of how the birth will be, of what changes Mary will need to make to her usual practice of birthing in hospital. While the woman's home may be a representation of her own comfort zone, it is not necessarily the midwife's place of comfort. Yet there was more than discomfort in what she was hearing from the phone call:

At that stage the baby had been born and the mother was hysterical. She was screaming and yelling. I was trying to get someone to listen to me. I wanted to find out what was happening with the baby. Finally I got the partner to talk to me and he said the baby wasn't doing anything so I told him to rub the baby and see what was happening. He said that nothing was happening. He said the baby was not making any noise and the baby was white and floppy.

When Mary got the call to say the woman had progressed very quickly and had already birthed her baby, she was naturally concerned. To hear yelling and screaming on the other end of the phone would have raised her anxiety even further. Then she heard the heart-stopping news “the baby wasn’t doing anything”. Mary gave advice about how to stimulate the baby to breathe, but then she heard that the baby was white and floppy. It is a slowly unfolding set of information that builds the picture of what was happening; the baby was in serious trouble.

At the worst of times, Mary wasn’t even there. Mary was desperate for someone to tell her what was happening, for someone to listen to her in the hope that her absence would not hinder the outcome. But the possibility of trying to resuscitate the baby had already gone. Mary describes how she felt:

I was a mess actually. I didn't have my jersey, I didn't take her notes. I didn't take anything. If the homebirth kit wasn't in my car I would have left them at home. I just took off. I had my phone and my key but I didn't have my diary, my notes. Actually I had nothing. I couldn't remember anything. I was not safe getting over there and I didn't even have my shoes on. I didn't even take my shoes. I was a mess, an absolute mess.

Mary could only phone for an ambulance and drive to the home herself. She rang her second midwife, Sally and asked her to attend also. This call for help was possibly in response to what Mary thought was about to unfold rather than to help with the unalterable reality of what had already happened.

On her way to the house, Mary tried ringing the couple again and again but the phone was engaged. The helplessness of the stillbirth situation was perhaps reinforced all the more. It was too late to save this baby. Yet, the sense of urgency totally pervaded. Mary didn’t even take the time to put her shoes on. She was beyond thinking what she needed to take; she just needed to get to the woman and that baby as quickly as possible. Mary’s panic reveals itself in her remembering the trip as a chaotic blur, her mind racing and heart pounding. Her focus at that time was on just getting there. The myriad of possible outcomes that would greet her arrival was overwhelming for her.

This feeling of trepidation symbolizes Mary's journey into the unknown experience of stillbirth.

When I got there, I asked the partner if everything was OK and he just said no. So I dropped my bag right there and ran inside. There were three ambulance people working on the baby who still hadn't shown any signs of life. Sally arrived soon after me. They decided to ring three more ambulance people so within ten minutes of me getting to the house there were eight people working on the baby. I found it hard to function. I didn't know how I knew to cut the cord. Actually if the ambulance crew weren't there first I think it would have been really hard. I was physically shaking. I couldn't find the cord scissors and I knew exactly where they were but I couldn't find them. It was hard to function. My mind felt like mush and it felt like I just stood there like a stunned mullet. They said that there was no heart rate, there was just nothing. So they wrapped the baby up and gave him to the parents.

When Mary finally arrived at the house, the first person she saw was the woman's partner. When she found out that things were not OK, the alarm Mary felt would have jolted her into action as she dropped her bag and ran inside. The ambulance crew were trying to resuscitate the baby. For Mary, attending an unexpected homebirth and arriving to see a baby that was lifeless, she could not relate what she was seeing to anything she had ever experienced before. Her own practice wisdom abandoned her and she found herself unable to function. She remembers standing in the room feeling like a 'stunned mullet', physically shaking with shock. Even though eight experts were present, the terrible situation was a reality. There was nothing that could be done.

As if in her own place of denial, Mary's actions highlighted how difficult it was for her to accept what had happened. The sense of hope, the chance that the baby might be resuscitated, the possibility that all was not lost, was gone. The disbelief that this had actually happened left Mary with a feeling of nothingness, as if in a void. She realises that there is nowhere to escape to, nowhere to hide. So when her own responses of anxiety and angst do surface, they get hidden under her professional guise.

Mary describes that the police were called quite quickly by the ambulance crew because of the unexpected nature of the baby's death. The realisation of what had just happened began to sink in. The police arrived and started to interview those at the house. Mary felt her stress levels rise again with their arrival. Suddenly the home had turned into a perceived 'crime scene'.

It all became very traumatic when the police turned up. The parents thought that we thought that they'd done something wrong. They believed that was why the police were involved. They thought we were suspicious of the parents. Why would the police be involved when a baby had just died? The father was very angry that the police were there. They had just lost a baby and there were all these ambulance crew. There were two midwives and he had not met either of us. We were in his house and his wife had just lost a baby. All his family were turning up and then the police turned up. The mother was in shock. She wasn't saying anything. She was just sitting there with her baby and he was really defensive. He was yelling and screaming.

Again, the unknowness of what others were thinking and planning was apparent for Mary. The individual participants in this situation became visible to Mary as she regained some sense of process. She could empathise with the partner who was responding to the trauma of his own grief and loss but was conscious of his defensive manner. Mary was also aware of the woman withdrawing from the situation, as if in a protective bubble.

The police took the partner outside to talk and he finally calmed down. They explained to him that they were not suspicious at all but there was a process that had to be followed. Their role was to ascertain what had happened and if in fact the Coroner needed to be involved. One of the police officers interviewed Mary, Sally and the paramedics and talked with the partner. Mary, for a moment in time became a part of a crowd, a collective identity that separated her from her role as the woman's midwife. This allowed Mary a reprieve from being the midwifery focal point. It enabled her compassionate focus to be on the distressed family, to step outside her own personal trauma; the compassion and understanding that she hoped would be reciprocated later on.

I didn't know what a baby that has died recently would look like. I didn't understand. I thought that babies who come that quickly usually come out screaming. It was such a shock. It was just so unexpected. Just the last thing I expected to happen. I didn't know what to do. It was all very new to me. I didn't know what was allowed. Even if I was able to bath the baby. I had no idea.

Once the police and ambulance crew left Mary and Sally stayed with the parents. Quietness descended on the home and Mary was back in the parent's focus. Again, Mary felt hesitant about what to do. The limitations of her own midwifery experience would have been apparent to her and therefore her insecurities surfaced again.

By mid-morning they both left the parents to be with their baby. Mary visited again that afternoon to finish some more of the paperwork and attend while the Funeral Director collected the baby to be embalmed.

They had rung a Funeral Director and the baby was going off to be embalmed that afternoon. He came within hours really. With all the paperwork that needed to be done. That was all a nightmare as well. Before a baby can be cremated it has to be seen by a doctor. We couldn't get hold of their doctor because it was the weekend. They said that the only way they could do that was for them to take their baby in the car and go into A & E to have a doctor to see that the baby was dead. I didn't know what to do and it didn't sound right to me. It was all drama, drama, drama. I was sort of just flapping around really. I said why don't they just wait until Monday and sort it then. Then there was a change of staff and they said that the midwife could sign the form. The midwife was there and saw that the baby showed no sign of life. So the paperwork slowly got sorted.

Mary had a sense of being in the middle of a nightmare. The whirlwind of happenings forced Mary into a place of uncertainty that made her see everything as a drama that she could not rectify, only muddle through as best she could. She found that her own self-expectations were difficult to meet, let alone her perception of what the parent's expectations of her were. Amazingly, she still had the insight to try and slow the pace down though, to gain some perspective.

Mary ended up at Sally's place later that afternoon. The day it happened was Mary's birthday and she had been receiving texts and phone calls from friends and family all day. Her mother had rung and asked what time she was going to be around for her birthday dinner with the family. Her sense of dread at her family's response is illustrated by her staying away from her planned birthday celebrations.

I couldn't cope with that. So every year on my birthday I am going to remember. I didn't go home until about 5pm that evening. I hung-out at the hospital. I just hung-out wherever. I hung-out at Sally's. I had a bath at her place. She said 'You need to go home...can I ring your husband and tell him what happened?' But I didn't want to talk to him. The hardest thing was just telling him so I said, 'No, no I will tell him'. So I went home and told him. He knows now. I told him. I had to. He was fine. It's just telling people. I didn't want anyone else to know. If I could have kept it to myself and have no one else know, I would have.

As a form of self-protection she ran away as she couldn't cope with having to explain what had just happened. She could hardly make sense of it herself. Mary called on her inner strength to deal with this experience alone or perhaps this was more about

having to put words to something she had not yet accepted herself. By telling her husband she would make the experience real. By keeping the details to herself and not letting anyone else know she could maintain the facade of everything being alright, almost as if it had never happened. Perhaps she was buying some emotional time to come to terms with the reality of the loss. The only person she could reveal her distress to was Sally. Mary saw Sally's home as a safe place, a place where explanations were not necessary. The symbolism of 'having a bath' could be seen as Mary needing to wash the events of the day away, to rid herself of the burden she felt she was carrying. The connection between a baby dying and Mary celebrating a birthday was one of pure irony that Mary wanted to keep hidden.

Afterwards

Mary continued to care for the woman postnatally. Mary initially thought the relationship with the woman and her family would be strained. Her experience, however, did not prove this to be true.

She was fine with me and didn't blame me. She actually had a shrine and it had his ashes and a photo. She had a photo album with photos of the baby but the last photo was of me weighing the baby. Oh dear, that hurt. Well it didn't but I felt so guilty. I didn't know why I felt guilty. She didn't show any blame but I assumed that they needed to be angry at someone and the midwife is a good place to start with that.

Mary expected the family to blame her for what happened, not because of what she did or didn't do but rather as a vent for their anger. She was unsure of why she felt guilty when logically she knew that the outcome was out of her control. Out of a sense of professional responsibility she was prepared, although with some trepidation, to take the brunt of their distress.

The heart-rending fact that the family cherished a photo of Mary weighing their baby, as part of the normal celebratory rituals associated with the birth of a baby, brought Mary's emotions back to the surface. All the family had left were these memories, the potential of the baby gone but the longed-for 'normalness' of weighing their baby was captured in a photograph.

I thought she would have lots of questions like I did. But she didn't. They just accepted that some little babies don't make it and they didn't need to know anything else. It was quite bizarre really. It took me quite a while to accept that. If it was me I don't know what I would have done. I was thinking about myself really. She was fine. Going to visit her made me feel better. When I wasn't seeing her it was quite horrid but when I had been to see her I felt so much better. I talked to hundreds of people and every time I felt really bad and it was only after I had seen her that I felt better. I think it was because she was so accepting that these things happen but to me it doesn't just happen so I couldn't really accept that. I wanted to ask her questions but I knew she didn't want to answer them so I didn't.

As the visits with the woman became more comfortable, Mary found solace being with her. Without the threat of being blamed, Mary was able to sit with her own vulnerability in front of the woman, knowing that she was in a place of acceptance. It seemed to Mary that the woman had all the answers and Mary had all the questions. This could be seen as an example of the paradox in the relationship between the woman and the midwife.

Mary turned towards her own needs in an attempt to gain some understanding of what the experience meant to her. She personalised the experience by reflecting on how she viewed the world as a young midwife whose journey towards motherhood was still ahead of her. The tension Mary felt between her current role as a midwife and her future role as a mother was evident. Mary found herself needing to make deeply personal adjustments in her world-view of how she thought things should be.

I went into the hospital and everyone knew what had happened. I remember "Samantha" looking at me and looking like all she wanted to do was give me a cuddle. I said 'You can't look at me like that because I am going to burst into tears'. I didn't want that at all. Everyone would look at you and be thinking 'I am so sorry'. Sometimes sympathy is really hard. People would show it in their eyes. I would just sit there and bawl. It was re-opening everything. Everyone has an opinion and everyone wants to know what happened so for the next few weeks I kept a very low profile. People talk don't they?

Although dealing with the woman was somewhat therapeutic, Mary found dealing with her colleagues more of a challenge. She tried to avoid talking about her experience, hoping that people would soon forget about it. Her emotions were tender and close to the surface like a newly healed wound. Mary conceptualised the meaning of sympathy as an agonizing reminder of her association to a situation involving grief and loss. Again, the risk of being blamed or judged was apparent to Mary. She chose to

keep a low profile, waiting for the intensity of the situation to settle down. She may have felt her own grief response to the stillbirth was open to misinterpretation and that her vulnerabilities would become visible to others.

Her colleagues rallied around her and relieved her of the pressure of work. This was seen as a kind-hearted gesture to Mary but she felt that this made her feel even worse.

My work got taken off me and that was the last thing I wanted. I just had to keep busy, almost like a distraction. I felt like I wanted or needed to get back to work. Well, maybe not a birth but something.

Although they were well meaning, Mary actually craved the comfort that can be found in normality. She found the loss of direction in her day-to-day routine made her feel uncomfortable and ill at ease. Distraction and a sense of being 'too busy to think' was what Mary believed she needed and wanted. Mary did continue doing some work and described an incident that made her realise that she was still exposed to the fall-out from the stillbirth. She recalls her response to a woman she visited who complained that her newborn baby was waking every two hours or so.

I wasn't in a good head space. I thought 'Gee, if that is the worst thing that you have to deal with then...' I felt really bad thinking that and knew I shouldn't be at work.

Mary remembers getting frustrated with the woman and thinking that perhaps she should not be back at work so soon. This was a reminder to Mary that she was not 'in a good head space'. Again, this brings to light Mary's silent thoughts that illustrate the complexly intertwined experiences she was having. This was a time of integrating new experiences into her world-view.

Mary explained that she had another client who was a good friend of the woman who lost her baby. She was due to have her baby just six weeks later and Mary describes her anxiety around being her midwife:

I felt that I had to be the perfect midwife for her. I felt like I was defending myself again. I could not do one thing wrong so everything needed to go to plan. She needed to have a great outcome. Anything I did I had to do it perfectly. I felt that I was proving myself to her. If I did anything slightly wrong then it might have added weight to any doubt anyone might have had about me. Even the words I used had to be perfect. I couldn't say anything that would scare her.

Just the thought of doing something wrong or being perceived as being less than perfect compelled Mary to strive for midwifery perfection. The fear of being found out or someone realising that she really was to blame for the death of the baby was confronting for Mary. She felt extremely nervous of what may happen at this birth. The quest for approval was one way that Mary could put her own self-doubts to rest. By affirming her proficiency she would be able to bury her guilt deeply out of sight. Her aim was to prove to this woman, to her colleagues, to herself and to the 'universe' that she was a competent and blameless midwife.

When it first happened I wanted to talk to those who knew. Everyone had an opinion and that really helped me but now I don't want to have a bar of it. I wanted to stop talking about it. Sally went to the funeral with me. Those midwives will talk about it if I bring it up but they don't mention it. It's not forgotten but just not brought up.

Mary chose not to discuss the stillbirth with anyone other than her husband and her immediate midwifery colleagues. At first she needed to talk to those colleagues close to her to find the answers to her questions and to hear their uncensored, blameless voices. But after a while, she wanted to escape, to flee from remembering the feelings the experience evoked in her. As she mentions, she didn't want to forget what happened but she needed desperately to shake off the negative thoughts that invaded her consciousness.

Mary found it difficult to explain the situation and what actually happened to her husband. She certainly wasn't prepared to try and explain it to her family.

They don't understand and I'd have to explain it all to them. They'd have so many questions and they don't get it. My husband said 'But why did it happen?' But I didn't know! It's bad enough that my husband or anyone else knows. They were the same questions that I had and I didn't have the answers either. I was just guessing. It's hard for him. We haven't had children and all of this would scare him. I can't talk to him about that stuff. He has questions and he's worried. I almost felt like I needed to defend myself because... Well, he never implied blame but I still needed to explain why it wasn't my fault. Talking to my colleagues was different. I wasn't defensive at all because they understood the issues. I could never tell my parents because they would think that the job was too stressful for me.

The risk of misinterpretation was high for those who didn't understand. It didn't help that she was still confused by the experience and felt that she didn't even have answers to her own questions let alone anyone else's. She was acutely aware that she

could have become defensive when trying to explain the intricacies of the situation. In a sense, trying to protect the experience from being over-analysed. Sometimes it seemed easier to hide the details about what happened. The risk of delving too deeply into what was packed away may have been too great. It could have seemed like Mary had to justify her actions to her husband. He was just trying to gain an understanding of the circumstances. In fact, Mary may have had a sense of protection towards her husband. The cold hard facts of birthing were not something Mary felt would benefit their future together. It appears that Mary was shielding her husband, her family and even perhaps herself from the stressors involved with being a midwife by keeping this experience 'under wraps'. It could also be suggested that Mary's hesitation to discuss the event is indicative of her trying to protect her own truth or interpretation of what happened. She may have been at risk of misreading her own memories and going back to a place of self-doubt.

I asked Mary if she preferred not to discuss this with her husband and family because they didn't have that midwifery knowledge...that everything surrounding birth was a mystery to them.

Yeah, they never understand even if it is all normal. They don't understand the responsibility that we have. If a mother or baby dies then it is because something or someone must have done something wrong. Babies don't die. What did you do to cause this? You are defensive because it is not acceptable. When there isn't any answers, that is definitely the hardest part. It's telling someone who isn't a midwife. I could have easily not told him. I had enough support elsewhere I wouldn't have needed to. I had to go home and yeah, if I could have stayed out another night I would have. It's because when you get home after 12 hours of having to deal with this and then having to explain that I've had a baby die. If you could tell him a week later then it might not have been so hard but you can't do that. No...it wasn't very nice.

For Mary, staying away from having to explain herself shows that perhaps she felt the need to defend herself from potential judgement, judgement made through ignorance rather than blame. There is an assumption that she would be found 'guilty by association'. She believed that if she was given time to digest the experience, then it wouldn't have been so hard to tell her husband. This may have been in an effort to get rid of the sharp edges of her emotions, to fine tune her truth. The weight of responsibility is clearly evident in Mary's narrative. She had an obligation to fulfil her role as a midwife but the complexities of doing this are highlighted in Mary's dialogue.

The personal impact of this experience on Mary was hard-hitting. She describes what she felt like after the stillbirth:

My appetite was okay but sleeping was impossible. I had some sleeping tablets but I was still on call so you can't take them. I would just tire myself out and wouldn't go to bed until I physically couldn't keep my eyes open anymore. Sometimes I would go to bed at a normal time but then I would wake up and the thoughts would start again and so I would get up. I would think about the little things like 'what did she say to me.....what else should I have checked?' I kept myself busy. I changed my sleeping patterns so I would still be up at 2 or 3 in the morning and I would sleep until late. I chucked the clothes out that I wore. I knew that I would never wear them to another birth. It might be bad luck. I even remembered the song that was playing on the car radio and now I hate that song. I have changed my cell phone ring tone because that was the ring tone that woke me in the middle of the night. I had to sleep with the phone out of the room when I was off call. I would wake up and think that the phone was ringing. I was scared that I would forget the phone calls. I would think 'did someone ring or not?' It drove me batty. This being on-call is a nightmare really.

Again, her midwifery responsibilities were at the fore front of Mary's thoughts, even when she was trying to cope with her own feelings. She couldn't self-medicate because she still needed to be on call for her midwifery clients. The feelings of guilt weighed heavily on her shoulders although logically, she knew she was blameless. Superstition became the key that kept unpleasant thoughts from her mind. The familiarity of comforting rituals like 'going to bed' abandoned her, the events replaying in her mind like a roll of film going around and around. Change became her protective behaviour. She even changed the phone ring tone that woke her in the middle of the night. The combination of exhaustion from changed sleep patterns, self-doubt and self-recrimination, the unending demands she put on herself and her role placed on her, drove her 'batty'.

When Mary was asked if she had cried about the stillbirth she hesitated for a minute before replying.

Not by myself but with other midwives I did. With Sally I cried a lot. I was a mess. I would go to the kitchen to get a drink and instead I would just cry. The dog ran away and I sat on the grass & cried. I went nutty and I didn't think to eat. I didn't sleep. My husband had to put food in front of me. He asked me if I wanted to go out to dinner and I thought, 'I can't go out to dinner...what if someone saw me....I've just had a dead baby...how could you go out.' I just didn't know what to do. I cried when I was triggered.

Mary saw her crying as dysfunctional behaviour rather than a release or coping strategy. She described herself as 'a mess'. She remembers her husband, desperate to nurture her, suggested going out for dinner. Mary's response was very personal as if *she* had lost the baby. Her reply reminds him that 'she had just had a dead baby'. This confirms the unspoken feelings Mary had about her own personal sense of loss, the veiled grief that she felt, that as yet remained unspoken. Her crying, instead of signifying that she was a mess, highlighted the sadness and pain she was feeling.

Six months after the stillbirth, Mary still thinks of the woman, her baby and the unexpected experience of caring for a woman who has had a stillbirth.

It definitely gets easier. I think it has changed my practice. If a woman rings me in the middle of the night I freak out and I think 'what do I do?' I want to take them into the hospital but I can't do that every time. It goes through your mind though. I don't know if it goes through your mind forever. I don't know.

She is feeling more at-ease with the experience but acknowledges that it has made her slightly distrustful of her own midwifery practice. She sees the hospital birthing environment as safe territory when she is unsure of herself. Whether she sees this as sharing the load of responsibility or that's where any rescue is located, it is unclear. For Mary, she is unsure if this sense of mistrust in herself will last forever or will lessen over time.

But how do you know that it won't happen again. I know it was a freak situation. I know it was random but it happened and it could happen again. I am still cautious. I know it happens but why did it happen to me so early on in my career? Was it randomness? Is it bad luck or is it bad management? Was this always on the cards?

Mary reflected on the experience and although she understood that midwives have to deal with stillbirth, she did wonder about the possibility of it happening again. Caution is still part of her mind-set as is the concept of bad luck and randomness. She still has self-doubt but that could also be considered normal and even beneficial. Midwifery has a way of humbling many. It could be suggested that her lack of experience did not cause the stillbirth but impacted on her own resilience in this clinical situation.

Mary's final thoughts were positive. She reflects on the memories of feeling supported through the experience of caring, for the first time, for a woman who had a stillbirth.

I feel so close to Sally. She was there with me and she saw what I saw. I didn't need to go any further for my support. She is a midwife and she understood.

Jill

Background

Jill has been a midwife for many years and considers herself a rural midwife whose practice is based in the Waikato area. She works with another midwife who lives in the same area as Jill. Their practice supports women birthing at home, in the local primary unit or at the base hospital. When I contacted Jill to ask her about being part of this research she was very keen to be involved. The interview took place in the local midwifery clinic rooms in a small rural town.

Experience

Jill was attending a twenty nine year old woman planning to birth her first baby at a rural primary unit. She was a low risk woman and both she and her partner wanted to birth in a small birthing unit rather than a large impersonal hospital. Jill had her midwifery partner (Molly) at the birth as well, which was their normal practice.

The scene was set. We were heading towards a nice normal birth. She wanted a normal delivery and that's what we were planning for.

They were all anticipating a normal, straight forward labour and birth. A comforting sense of predictability was present. The only variable was that the woman had not experienced birth before and was, in a way, an unknown quantity.

Jill had discussed all the different scenarios with the woman and her partner. This also included the possibility of transferring into the base hospital if the need arose. The woman went into labour in the evening, one day past her due date. Jill was relieved that the timing of her going into spontaneous labour was a reassuring sign. The woman's birth plan stated that she wanted to remain active and use hot towels. She wanted to stay at home as long as possible and get support from her mother and partner.

The labour and birth progressed normally. Both mother and baby were stable throughout the labour.

Jill would have felt reassured that labour was progressing and both mother and baby were coping well. There were no thoughts or indications that anything untoward was going to happen. She went into the birthing unit in established labour, later that evening. The rituals around this woman getting into established labour were, again a familiar and comforting process for both woman and midwife. Labouring under her 'own steam' at home was the expected behaviour of a woman who was at ease with birthing, even though it was her first birthing experience.

She got to fully dilated and we had not more than 2 hours of pushing. That wasn't too bad. That's what we considered normal.

Again, Jill reflected on what constituted normal to her. All was as it should have been. The assumption was that this birth was going according to plan. Labour progressed further and the baby's head was born. Jill could feel a very tight cord around the baby's neck. The baby's body was born and behind it came copious amounts of thick fresh meconium, the baby was white and floppy. The baby had declared the environment that it had emerged from. Up until that point, this had been hidden from everyone. The suddenness of this reality would have caught both Jill and Molly off guard.

I knew before we even started CPR. As soon as I untangled the baby I was taking the baby over to the table, I remember thinking, 'I've never seen a baby look like this before'. I've seen babies that need resuscitating but not babies like this. The baby was so pale and so floppy. Just like a rag doll. My heart just went 'thump' down to the floor. I looked up when I was doing CPR and she knew that the baby hadn't cried after the birth. She knew that so I took the baby over to the resuscitation table and she kept looking at me. I could feel her looking at me.

Seeing a baby that was limp and lifeless; 'just like a rag doll', made Jill's heart drop to the floor. She already had a sense that the baby was not going to survive but wasn't prepared to deny the baby the potential of living. As Jill started to resuscitate the baby, she could sense the mother's knowing. She could feel the woman's eyes staring at her even though she had her back to her. The woman was aware that her baby's life was in peril, she didn't need to be told. For Jill, the woman's sense of knowing would have been bitter sweet. She wouldn't need to break the news to her but the longer she stayed focused on helping the baby, the longer she could avoid acknowledging the truth of what had just happened.

They continued CPR and soon the ambulance staff arrived. Despite desperate measures to save the baby's life, there was still no response. Jill handed over to the paramedics and resuscitation was continued by the ambulance crew. The sense of helplessness would have been almost palpable in the room. For Jill, the arrival of the ambulance crew signalled a renewed possibility that the baby may survive. She may not have been able to resuscitate the baby but maybe someone else could.

So it wasn't nice. A big flat white baby and then in the end she said 'no, give me my baby...you know as well as I do Jill that baby is dead.' It was written all over her face that she knew that the baby was dead. So I just gave her the baby and she cuddled it.

The woman, in her wisdom, called a halt to the resuscitation attempt. She declared what everyone else was thinking but not saying. By saying it, she made it real. In the end, all Jill could do was hand the woman her baby.

When I went out of the room the partner was there and he said 'the baby's dead isn't she?'

The partner had left the room to ring his mother so when Jill saw him she was confronted with the dreadful task of confirming the baby's death. The moment of reality for both Jill and the partner, there alone in the hallway must have been excruciating for both of them. The raw grief of the partner would have been brutal to witness.

One of the ambulance crew rang the police and the Coroner. They also informed the rest of the staff. Now, there were more people than ever involved with this tragedy. Only a short time before, there had only been the two midwives, the woman and her partner. Now it seemed that everyone was going to know what had happened.

Talking to the Coroner was a big thing. Actually that all happened within a few hours. It all had to happen quite quickly.

As it often happens, a sense of hurriedness pervaded the scene and time seemed to speed up. Things happened in a blur and actions were missed. Jill's thoughts would have been infused with a sense of disbelief and uncertainty.

I remember ringing 'Sonia' (another local midwife) and asking if I could get a SANDS pack. I had to tell her about it. I don't know why. We didn't even have a little gown or a little basket or anything. Everyone was just expecting a normal live, healthy baby. So, do you dress the baby in their clothes or do you wash the

baby. What do you do? I had no idea. The actual step by step stuff. We realised that we had to photograph the baby. It had a mark around its neck. The cord was long and flat, over its shoulder as I untangled it.

Jill felt overwhelmed with what needed to be done. The birthing unit did not have any stillbirth protocols or any of the necessary supplies. Jill didn't know where to start so she rang another local midwife for advice. Although Molly was still at the birthing unit, Jill felt compelled to tell someone else what had happened. Perhaps a normal response to help diffuse the building tension Jill was feeling. In this instance, it seemed that Jill wanted her experience to be visible, as if looking to others to acknowledge her dilemma and to commiserate with her. It could be seen as an attempt to gain absolution from the sudden heaviness of self-blame. Jill repeats that she was anticipating a normal, live baby. Not a dead baby. That was not in the vision she had for this birth. Jill, who was forced to stay in the moment become distracted by her own apparent lack of practice wisdom. She struggled to know what to do. The truth was starting to sink in and along with this came the uncertainty of what was needed. In the confusion of what to do next, Jill remembered that she needed to take some photographs of the baby. It was then that Jill recognised the tell-tale signs of the reason for the baby's demise. The umbilical cord had been so tight around the baby's neck it had left an actual mark on the baby's skin. Jill also remembered that as she untangled the cord she noticed it was long and flat, what was hidden was now visible for all to see. The baby had strangled itself on its own cord. This was an unpreventable accident that no one could have anticipated.

The partner was quite distressed but the woman was OK. She was holding it together but she was sobbing to herself. But the partner was loud. He was quite distressed and he was loud. That upset me but I could cope with it. I gave him a big cuddle and then her mum arrived. She couldn't understand what went wrong either. The woman was sobbing loudly by this time. I then got her off the bed to put on some clean clothes. I think we went into "do" mode. You don't think about it you just do it don't you?

The couple's families started to arrive to offer support. The intense response of the partner was distressing for Jill but as an experienced midwife she found the resilience to cope with his out pouring of grief. Initially, the woman was encapsulated in her own grief but when her family arrived she broke down and threw herself into the heartache she was feeling. For Jill and Molly, their 'port in a storm' was to remain clinically

focused. Jill described this as her 'do' mode. This was a way of distracting herself from what was going on around her; unconcealed grief. Jill mentioned that the woman's mother arrived and was disbelieving of what had happened. By Jill keeping busy she would have possibly diverted those predictable questions from being asked. The notion of busyness itself was a way of deflecting what was to come. The potential for blame, recrimination and questions that were too painful to think about was to be averted at all costs. Jill was vying for time- time to make some sense of what had happened.

I felt that I must have missed something and that I should have been able to make that baby come alive. I don't know why, it's just I have live bobbies not dead ones. Why did it happen...did I do something wrong...how did it happen...yeah...what did I overlook...what didn't I see happening...yeah...all those sorts of things. Could I have done anything differently? It was quite raw. Yeah, raw emotions really. We were all sort of in a daze and to be quite honest I don't remember what happened after that. I think you blame yourself for something like this. More than you think you do.

When the police had left along with the ambulance crew and Jill had spoken to the Coroner, she spent some time in the office with Molly. The manager had brought some food and she remembers sitting crying and wondering what went wrong. The self-doubt was overwhelming for Jill. Crying allowed her to let go of some of her own responses of shock and disbelief. She remembers being in a daze – feeling stunned. She mentions the 'rawness' of her emotions and having the heart-breaking thought that at least she couldn't hurt anyone, anymore. Her belief was that she alone was accountable for what had happened. She reproached herself for maybe missing some signal that the baby had tried to give her. She had a feeling that she might have overlooked some clue that the baby was in danger. She condemned her own practice, even after years of being a midwife and even though there was nothing which indicated any wrong-doing. The impact of these thoughts were so great that Jill has deleted these details from her memory and stated that she couldn't remember what happened after that.

I asked about Jill's midwifery partner, Molly, and how it felt to have her supporting her during this time.

Oh, just the fact that she was there was great. Just her being there was very important. The fact that she kept hovering around in the background doing all the bits and pieces that needed to be done. I was in a daze and I had no idea

what to do. She had actually been through it, a while ago, yes, but she knew. She kept me going.

Having the assistance of a trusted colleague who expressed unfaltering support is what helped Jill get through the newness of her experience. Molly had been through this before so could offer Jill a strong brace for her to lean on. Molly's quiet presence gave Jill a comforting reassurance that she was not alone. The calmness of her being in the background allowed Jill to catch a moment in time to still her frantic thoughts and gain some composure.

Afterwards

The woman and her family left the birthing unit soon after lunch and headed home. Jill went up to see them at home later that afternoon. As Jill was approaching their house she felt unsure about what reception she might get. She describes her thoughts as she drives up to their house:

Quite frightening, well, not frightening but scary because there wasn't a baby. Yeah. What am I going to enter into? I wondered if they had got to the stage of thinking 'you're at fault Jill or you should have done something different Jill '. Would it come back to haunt me? But it wasn't like that. That feeling didn't hit me until the day of the funeral.

The acuity of the event was still with the family but being back in their home could have taken away some of the sharpness of the morning's events. Perhaps there was some sense of distance from the clinical memories. The smells, the sounds, the unfamiliarity of the hospital setting could be put behind them now. For Jill, the unfamiliarity would have been from being *away* from the comfort zone of the birthing unit. Entering the woman's home made Jill feel like she may have been an unwelcome visitor- a memento of the day's heartbreak. Jill was in their territory now and she was the outsider. She was unsure and scared of the response that she may receive. Jill wondered if, in the solitude of their home, the family had started to attribute blame for what had happened. The visit turned out to be a time of shared grief with the family, not recrimination or blame. During the visit, Jill asked the family if she and Molly were able to attend the funeral.

I wanted to go to the funeral but it was a big decision. Will I or won't I...shall I or shan't I? But the little bit of Maori in me says you must go. It was really distressing going but I felt I had to go. There were lots of people crying. I didn't tell my husband or my family. Some things you just don't tell your family, till

afterwards. My husband said 'what's the matter with you?' as soon as I walked in the door, 'cause you look a wreck'.

She felt that the woman and she had a partnership and she wanted to honour that relationship by showing her respect at the funeral. The courage Jill showed by attending the funeral was a reflection of how seriously she took her responsibilities as a midwife. Her own cultural frameworks guided her behaviour and she did what she felt was the right thing to do. She selflessly put the woman and the family's needs above her own need to protect herself from criticism and possible condemnation. It would have been impossible to predict how her being at the funeral would have been viewed. Jill found the public out-pouring of grief difficult to witness but was steadfast in her determination to be present. Both Jill and Molly attended but Jill did not mention any of this to her family until afterwards. Her husband could see that she had been through something stressful and commented that she looked 'a wreck'. The hidden experience of having a stillbirth was seen as a professional boundary that should not be crossed. Perhaps Jill believed that there was no benefit in her family knowing about the loss. This could be seen as Jill protecting herself from unwanted comments, questions and perhaps judgements. If the family didn't know then Jill wouldn't need to explain.

Soon after the funeral, the couple decided to go to the Pacific Islands to get away from it all. While they were gone, Jill was asked to attend a family de-briefing meeting to discuss the incident. She was certainly apprehensive about the meeting so she asked Molly to come as her support person.

Yeah, I was frightened I suppose because I didn't know how or what they were going to say. But actually it was really quite lovely because they just wanted to know what happened and how it happened and if anything could have been done differently. I had to re-live it all again and I had to go back to where it was quite sore and hurtful but at the same time it was quite healing in a way. I'm pleased that the family know now that I did try my very best. But that is what you do anyway. But even now when you meet them in the street you think 'oh, dear, there's the family'. Your heart takes a skip. It's not a frightened skip, it's just a skip. You do sort of stop and think 'Oh, what are they going to say today?'

The debriefing meeting was both painful and cathartic for Jill. She remembers feeling as if she had to re-live the stillbirth again and was aware of the hurtful memories resurfacing. She was relieved that the family left the meeting with a deeper understanding of what happened at the birth. There was a feeling of

acknowledgement that Jill had done her very best. Jill reflected with a sense of irony that midwives *always* do their very best, anyway. It seemed to Jill, that the family just wanted answers rather than to lay blame. Although Jill believed that the family did not think badly of her, she still felt anxious every time she saw them. She described this as her heart 'skipping a beat'. She may have wondered if one day the reality of their loss would make them turn against her. She was always expecting them to suddenly blame her for the death. She waited for the day that their empathy would be lost and they would change their minds about her blamelessness.

Jill remembers an incident soon after the stillbirth that involved her caring for a client of another midwife who was on holiday. The young woman asked Jill if the rumours were true.

I do have the tag 'baby-killer' in town you know. Yeah, in a little town you just have to bite the bullet sometimes and go with the flow and think 'OK that's how you feel about me.' If the woman who lost the baby had said that I was a baby killer and that she never wanted to see me again and never wanted to speak to me again, I think I would have given up. That's the hurtful thing. You know people in the community can be so horrible.

The loss of a baby due to a stillbirth was hard enough but Jill felt to be accused of being a 'baby-killer' was cruel and heartless. Nevertheless, Jill continued working even though she knew what people in the town were saying about her. The main barometer for Jill was how the woman who lost the baby felt about her. Jill believed that if *she* had blamed her for the loss then she felt almost sure that she would not have been able to carry on practising as a midwife. The weight of the woman's blame would have made Jill give up. The relationship with the woman had a personal significance to Jill and meant more to her than anything else. Jill found the condemnation by some of the people in the community, extremely hurtful. The ignorance of her accusers was almost too much for Jill to bear.

Jill started to reflect on her role as a self-employed midwife in a small rural town where everyone knows her.

How long have I been a midwife? Forever! Your whole life and you just throw it all away. The thing that upset me more than anything was the fact that this can affect you more than anything. You have these preconceived ideas about how

you're going to cope and you can cope because you have coped forever. You know, carry on, carry on, carry on. My Mum said to me 'You can't be strong for everybody all the time. You are a person.' I said 'Yes, Mum, I know that but sometimes you have to be more than just a person. We try our best and you just keep on keeping on. I thought I had gotten away with it after all these years. But it could have happened to any baby along the way. It is to be expected and you don't know which baby is going to die and which one isn't and I think that's the frightening thing about the whole deal.

Jill had a sense of resilience from having been a midwife in this community for so long yet felt that this experience had shaken her to the core. She was used to coping with the responsibilities that came with being a rural midwife and because of this had clarity around her own coping abilities. She described her own perception of what her role entailed and believed that this involved her total commitment to her profession, her clients and her community. She saw her role as giving a life time of dependability and of always being available to her clients. Jill implied that just being a woman who happened to be a midwife was never enough. She called this as being 'more than just a person'. This could infer that being a midwife has almost a 'super-human' concept attached to it. That could mean being resilient to pressure, being quick to recover from attack and impervious to self-doubt and uncertainty. This is not what Jill experienced after the stillbirth yet her perception of what was expected of her as a midwife seemed to imply this. Jill thought that after all her years of practising as a midwife she had gotten away with having to deal with a stillbirth. The impression of what it is to deal with a stillbirth must have been so distressing for Jill she thought she had been lucky to escape this clinical scenario. Now that Jill had actually experienced caring for a woman who has had a stillbirth, she reflected that in fact any baby is at risk of dying. She now believes that this event may well be random and that concept frightens her.

I asked Jill to think back to what happened and what impact it had on her practice:

It is on-going. You have heart palpitations about it with every baby and if I am concerned then there is no arguing. They are off to the base hospital now! Yeah, it has impacted on my practice because I am very selective about who I take on now and I am practising defensively. I can't understand why anyone would have their babies at home any more. That's the scary thing. Actually I've got a home birth coming up in a couple of months and I'm thinking 'ummmmm'. I'll be fine, I will be fine. I'll be OK but it is just actually am I going to be OK? Is the heart going to start pounding so much that you can't hear yourself think? Are you going to say 'Help...let's go to the hospital'? Yeah, probably. I have found this year I have not had as many clients and I think that is because of the rumours but also

because I've said no I am not available. It has actually been quite nice because I have had that time to think about things. That's what happens isn't it?

Because of this experience, Jill has been quite happy to have a smaller caseload. She rationalized this by suggesting that she has been more selective about the clients she has accepted but is also aware that the rumours also played a part in this decline in bookings. Jill consoled herself with the idea that this was quite pleasant and it had given her time to reflect. It could be said that this pause in her practice has also given Jill time to come to terms with the stillbirth experience. By escaping the persistent risk of having to deal with another stillbirth, Jill has made the fear and anxiety she is feeling, less visible. She acknowledges that she is much more defensive in her midwifery practice now and it seems that this defensiveness is also evident in her own self-belief. If this happened once, it may well happen again. As a self-protective behaviour, she defends this practice as an issue of safety rather than her inability to trust her own practice wisdom, a wisdom that has informed her practice for many years. Caution in her risk assessment is paramount and she now sees birthing in a hospital as the most prudent option. She declares that she feels scared of supporting any woman to birth at home, because of her mistrust in normal. She stated that she is, in fact supporting a woman birthing at home in the near future but seemed to have strong reservations about the sanity of such a plan. She was still feeling unsure of herself and her ability to cope with the possibility of it going wrong. The fear is such that she wonders if her heart will pound so hard that she won't be able hear herself think.

Jill then started thinking about the impact on her own personal life. She reports a sense of needing to escape:

I drank more coffee. I stopped going to my walking group and I put on pounds and pounds, kilos and kilos and kilos. I think I've got passed that initial thing. Yeah, I don't know, I didn't want to go out. I annoyed my husband because I didn't want to go out to tea. I didn't want people to ask 'Hi, Jill, are you busy?' 'No I'm not busy.' 'Why aren't you busy?' I'm not busy because I don't want to take on anyone else, if I'm honest.

Jill goes from explaining her reduced workload as her being more selective to declaring that she is, in fact not wanting to take on new clients because of her apprehension that

history may repeat itself. Her anxiety of having another baby die was something Jill was not able to keep at bay. It made logical sense to reduce her numbers to have a break but the reality of why she declined bookings was harder to admit to. Even that she felt she had to justify her lack of busyness is testament to Jill's own self-perception of being able to cope because 'You have coped forever'. The on-going impact of this experience was hard for Jill to be candid about; the realisation that although she is a very experienced midwife, she is still able to feel vulnerable and scared.

When Jill went to the first birth after the stillbirth she was terrified and shares her story:

I was petrified. Ummm, yes. Molly & I still ring each other. Sometimes I feel like a student again. Sometimes I think, 'oh, goodness...what's going on, what the heck has happened...am I feeling that or aren't I?...am I hearing that or aren't I'? You know you mistrust yourself. I have misplaced my skills. I have lost them under the bed! I don't know where they are Kay! They've retired! Ummm...no I haven't lost the skills but I feel that I don't have them .I don't trust what I am seeing or feeling or hearing. I'm forever thinking is baby OK or isn't it? Is this baby stuck or isn't it? Is this baby going to be OK or not? It happens every now and again. Most of the time it's fine and I think that I'm going to get away with this. It's all going nicely and all of a sudden the heart starts pounding again. Sometimes I just have to walk out and go for a 5 minute break. Go and have a coffee, yeah. You need that collegial support.

Jill felt that her confidence in doing what she had done for years had deserted her. She felt that she had misplaced her knowing through experience, the skills that she had developed over many years. The stillbirth experience had left her scared to trust herself and stripped her of her own intuitive wisdom. She found herself second-guessing what she was seeing, feeling and hearing. It appears that she is, at times, reliving her own experience of initially feeling confident then suddenly feeling totally overwhelmed with doubt, so much so that she has physical symptoms of stress including heart palpitations. To work through these feelings of distress she finds herself needing to flee from the present and have a break.

Working in such a small town, Jill's main support remains Molly.

We cover each other a lot and we have had a fair few coffees and chat about it. We have come to the same conclusion that we would not have done anything differently. Sometimes it feels as if we are running scared but then we're not. It's quite weird. My faith in the process is coming back, slowly coming back. But the thoughts will never go away and it's weird. I don't think it would be any different

if you were fifty years in this job or two minutes in this job. It would still feel the same. If you have the compassion and the same attitude, it is such a privilege to be at such lovely births.

The shared experience between Molly and Jill reinforces their partnership as does their agreement of what happened at the stillbirth. The joint ownership of the memories confirms a mutual experience and for Jill, a sense of not being alone. Jill felt comforted and supported by Molly's acceptance of them being in this together. Jill reflected on the longevity of the memories of the stillbirth which may imply that the memories may fade but they will never be totally forgotten. For Jill, the impact of this experience was not based on her years of being a midwife and the skills she had acquired, rather just that fact that she experienced it at all. The feelings she had would have been similar, irrelevant of her years of experience. Stillbirth was seen as something a midwife just lived through rather than prepared for or gained familiarity with. Jill reported that over time she was feeling more trusting in the process and is regaining some of her midwifery knowing.

Fay

Background

Fay has also been qualified for many years and considers herself an experienced midwife. Her experience of caring for a woman who has suffered a stillbirth was as an urban community based midwife. She worked with several other midwives. Fay stated that this was her first experience, as a community based midwife, caring for a woman and offering her continuity of care, from the beginning to the end. Fay had experienced, as a student midwife, caring for women who had lost their babies but she felt that her care was cushioned by the supervising midwives she worked with. She described her care of them as '*piecemeal*' or defined by the timeframe of the shifts she worked. The one thing that did concern Fay was the anticipation of actually telling a woman that her baby had died. Fay and I met at her home and that is where the interview took place.

Experience

Fay introduces her client as a woman having her first baby who was now about thirty one weeks pregnant. Fay sets the scene:

She had an uneventful pregnancy up until she went for an anatomy scan. She was told that she had quite large uterine fibroids. They were completely asymptomatic and she didn't even know they were there. It was recommended that she be referred to an obstetrician because they were very big and potentially at risk of obstructing labour.

Fay completed her routine referral process as was appropriate. The woman was seen by the Obstetrician and was given the advice of just wait and see, with the understanding that they may cause problems later on in the pregnancy or during the labour. Having uterine fibroids diagnosed on an ultrasound scan would not have worried Fay unduly, at this stage.

I remember being able to palpate one. It was almost as big as the baby's head and that made for interesting palpations but they didn't cause her any trouble at all.

Being able to palpate the fibroids would have been more of a curiosity for Fay and the woman, especially when she was not particularly bothered by them.

Fay had been away on holiday and was just due to return to work the next day when she was told by the midwife covering her practice, that her client was being induced for an intrauterine fetal demise.

Her client with the uterine fibroids had been admitted into Delivery Suite. When she heard she remembers thinking:

Oh, I almost didn't want to know. I was still on holiday and it was the Sunday. I wasn't supposed to pick up my pager until the Monday. But I went in. I remember she was an amazing woman and she called a spade a spade. She was very black and white. She was quite a talkative woman. He was a security guard. The strong silent type.

The struggle Fay felt between doing the right thing and remaining distant from the news would have made her decision whether to attend or not, difficult. Being still on holiday would have given her a very justifiable reason to not attend the woman. If she hadn't found out, she would have not been in this dilemma. Fay made the decision and attended the woman in hospital. It appears that Fay felt an affinity with the woman describing her as amazing which may have determined her responsiveness. The decision to attend the woman may have been because of the personal opinion Fay had of the woman or because of Fay's feelings of professional responsibility; it is unclear

what motivated Fay. In this circumstance, a woman who is 'black and white, calls a spade a spade' may be seen as being less vulnerable to the overwhelming emotions that accompany the loss of a baby than a woman who is less resilient to what Fay knew lay ahead. Caring for a woman who is more pragmatic about life and death may have seemed to Fay to be less arduous and less likely to have confronting emotional needs. There may have been a sense of personal safety for Fay around caring for this woman.

Fay talks about her preparedness for walking into the room to see the woman:

I had to get my head around it, prepare myself and go in. I hadn't yet had to diagnose. Hadn't had to be the one, you know to say 'Gosh, I'm so sorry but your baby has died'. I had escaped that and I guess I felt a little bit relieved that it hadn't been me that put the Doppler on and had to say it.

She felt almost insulated from the event and the prior notification gave her a chance to prepare herself before attending the woman in the hospital. She could steel herself for whatever emotional response the woman had to this dreadful news. Fay was relieved that she had not been the one to tell the woman that her baby had died. The time of revealing the truth had passed. There was a sense of escape as if Fay had avoided being the bearer of bad news. This sense of clinical escapism may have served as a protective barrier as if to separate Fay from being directly involved in the outcome. There was nothing Fay could do to change the facts - the baby had already died and the woman already knew it. Fay found out the woman had rung the relieving midwife reporting that she hadn't had any fetal movements all day. The midwife and the woman met at the hospital and the fetal heart was not able to be heard. The woman had a scan to confirm fetal demise. By the time Fay got into the hospital the woman was just waiting for labour to establish. The devastating news had already been delivered.

So we talked and hugged and cried and laughed. What rotten luck, how awful, how sad. We made plans and I stayed for a couple of hours and went home again as nothing much was happening.

Fay could offer the woman physical and emotional support yet remain at a distance as if viewing proceedings from a vantage point. Fay wasn't directly connected to the loss, yet. Her words of sympathy were soothing and comforting to the woman but Fay remained neutral, objective. The words of sympathy did not convey the personal

relationship Fay had with the woman. They had not had a shared experience of stillbirth. The reality was yet to unfold.

The core midwives looked after her overnight and they rang Fay at about 5am in the morning to say that she was getting into established labour. Fay reported that she was having quite an odd labour and was experiencing more pain than was expected. After getting adequate pain relief, her membranes ruptured and she then went on to birth. The baby was a compound breech presentation.

Gosh, I'm doing a breech extraction and he is teaching me skills for other babies. You know? He didn't have a post mortem because they didn't want that and I guess I regret that. I suppose I could have talked more about that and maybe I could have called it an operation to find out what caused his death rather than calling it a post mortem. Perhaps I should have encouraged that but I didn't. Everything about it was as positive as it could have been. I couldn't have wished for, in a macabre sort of a way, a better first experience of stillbirth. For the woman, she had a straight forward birth. It wasn't long and heinous or horrible.

Fay talked about feeling a sense of relief that the birth was over and the birth, although incredibly sad, was as good as a birth could be. She describes a sense of satisfaction that she had provided good midwifery care. Fay did everything in her power to avoid a distressing and traumatic experience for the woman. This could be seen as Fay trying to counteract the stressful effect of ending up with a still baby rather than a live baby, as anticipated. This was not just because the woman deserved it but because this level of midwifery care would be seen as Fay providing benevolent care. A shared positive birthing experience may have alleviated some of the potential for added trauma for both the woman and Fay. In a sense, a long and distressing birth may have been seen as adding insult to injury. The least Fay could do was to make the birth as positive as possible. The philosophical thought that the baby was teaching her skills for other babies may have given her a feeling of enlightenment, of feeling that there was a bigger purpose to the loss of this baby. There seemed to be a sense of regret from Fay that the parents declined to have a post mortem. It could be suggested that the parents made their decision irrelevant of how Fay worded it. The onus was not on Fay but yet she had a sense of wrong-doing or regret, that what she had done was flawed. If a post mortem had found a reason for the baby's death, the pain of the loss may have been eased and again, Fay may have felt that her actions further comforted the parents. By not encouraging this examination, Fay may have felt that

she would be held accountable for the parent's on-going grief. Ironically, the parents may well have made the same decision, irrelevant of what words Fay used.

He looked perfect, he wasn't deformed in any way, he didn't smell, his skin wasn't falling off him, he was easy and pleasurable to be with.

The potential for this innocent baby to be a source of visual distress confronted Fay. Babies are meant to be perfect in every way. Perfection in death is what Fay saw in this baby. If the baby had been anything less than perfect, Fay could have considered it her role to soften the blow, to cover-up the unpleasant reality. If Fay saw him as being easy and pleasurable to be with then the actuality that he was dead was not the focal point, his perfection was. For a moment in time, the scene was unspoiled.

Afterwards

The woman went home after all the official procedures had been completed. Fay continued to provide post natal care for her until she was six weeks post birth. Fay described what it was like, for her to visit the woman after the stillbirth:

The hardest part was the post natal care when you didn't know what else to say when the physical questions were answered and the initial emotional stuff was over. I didn't go to the tangi as it was out of town. When that was over and I had looked at the photos of the baby endlessly and we had talked about it endlessly I felt that we were re-hashing the same stuff and repeating the same platitudes. I felt I was saying the same things again and again. She still wanted me to come but I felt that I had said all that I could say but it wasn't about me. That was the least of it. I would go and I would be there, with her. I would spend time with her. I wouldn't squeeze her in. Not just a quick 20 minutes, oh, I didn't mind going but I thought what else can I say and I wanted to be useful but what could I give to this woman? Yeah, I felt a bit useless. I had to steel myself to go not because it was hard for me but I felt I was not being useful to the woman.

Fay had a clear vision of what her midwifery role involved. She attended to the physical aspects of the woman's post natal care but the emotional aspects were more of a challenge. It seemed that Fay felt compelled to hear the woman's story, to look at the photos and share the memories of the event time and time again. It was not that Fay did not want to share this time with the woman, quite the opposite. Fay's main concern was that she wanted to be useful to the woman. Fay felt useless and was keen to provide some benefit to the woman by visiting her. Ironically, Fay spending time

with the woman, listening, remembering, being with her in her grief, showed the poignancy of the situation. Fay's understanding of her true role seemed to be obscured by her need to be useful. Fay was a witness to her experience, the commonality of having lived through the experience, together. The understoodness of what happened. Fay's presence signified the link between the past (what had happened) and the future (what was still possible).

The woman had an uneventful post natal period and conceived again about a year later. Fay was asked to be her midwife for the second time.

Being asked to be the woman's midwife again may have seemed incongruous but both the woman and Fay were comfortable with this arrangement. For Fay, this situation was somewhat reassuring as this implied that the woman did not feel any misgivings with Fay's care during her stillbirth experience. For the woman, Fay was the midwife who had a 'thereness' for her. She knew her story and there were no explanations needed between them. Both women had been thrown together through the experience of stillbirth.

This mutual understanding was illustrated by Fay's recollection of a distressed phone call from the woman during her next pregnancy. The woman had been alerted to her baby's lack of movements and called Fay to come and check the baby.

I remember one morning she rang me about 6am saying that she hadn't felt the baby move. I went around there and heard the baby's heartbeat straight away. But she was like a possum caught in the headlights. Her pupils were really dilated and she was holding the quilt that her stillborn baby had been wrapped in and she was clutching it and was talking to the dead baby. She very much believed that he was a spirit that was very strong in her life. It took her a long time to settle down and be able to go to work.

Fay was able to calm the woman quickly by hearing the baby's heartbeat but the woman had been struck by the possibility of losing another baby. She was re-remembering how it felt to be told that her baby had died and was understandably anxious. With her presence, Fay was able to reassure the woman that her baby was alright. Their history together offered the woman the chance to be with her fears

without the need for justification- to be in her own moment of angst. To witness a woman in such a state of terror would have been chilling for Fay. For the woman, the baby's blanket symbolised the spiritual protection offered her by the deceased baby. The blanket provided protection from the harmful effects of losing a baby to stillbirth. To understand another's spiritual reality is challenging, especially around what may be perceived as real or fantasy. The woman's soul was searching for meaning and comfort and she called upon her dead baby to provide that. Irrelevant of Fay's own personal beliefs, she supported the woman in her time of spiritual distress. Fay was able to respect the woman's connectedness to her own spiritual self. All Fay could do was be with her offering her comfort while she settled herself down.

Acknowledging the woman's own experience of seeing the stillborn baby as a spiritual figure in her life was one way that Fay showed acceptance of the woman's on-going grief. Fay expressed that although she believed that the woman would have gained comfort having this belief, she could not relate to this spiritual concept. The realness of the baby for the mother was understood by Fay but it was a concept that she struggled with.

Fay felt relatively comfortable with her first experience of caring for a woman who had a stillbirth. She stated that if a midwife had to have an experience of stillbirth then it was a good one to have. She believes that her time as a core midwife helped find that comfortable clinical place for herself.

I don't think she knew that she was the first woman that I had cared for from beginning to end. I don't know if we ever discussed that.

She acknowledged that every stillbirth experience must be different and she admitted that she didn't know what to do in this particular situation but she stated that she adapted her practice as she went along. Fay believed that the woman gave her cues to guide her practice. Fay had her own embodied way of knowing about midwifery care but acknowledged the woman's own knowing about what she needed 'in-the-moment' and Fay listened.

I can remember a woman having a termination for fetal abnormalities. I must have been working a night shift. I came on and the midwife I took over from was really lovely. We had a good talk about how it would be for me and how the baby would look. Another midwife came in as the baby was being born and it was very supportive. It was very sad. There is an honour of doing that care well. There is something very satisfying about caring for women who are having a stillborn baby. My role is to make a horrible experience as good as it possibly can be. I can't think of a better word than honourable. I'd like to think I am honouring the woman. It's not about the profession; I think it's about the woman.

Fay talks about having wonderful collegial support during her past experiences of bereavement care. There is a gentleness about Fay's recollections that talk of feeling very supported and how she remembers the midwife she took over from as being 'really lovely'. These memories were testimonies of the experienced guidance Fay had with her earlier times of caring for bereaved women.

Fay described what she called the 'honour' of caring for women suffering fetal loss. For Fay, the caring ethic was seen as an authentic model of midwifery care that holistically supported the woman through her lived experience of stillbirth. From these impossibly stressful clinical situations, Fay had a sense of satisfaction and was able to lessen the impact on herself by minimizing what the experience was like for the woman. She was buffering both the woman and herself from the trauma of stillbirth by providing the best midwifery care that she could.

I think it's vital to provide excellent midwifery care for all women but for women who have lost their baby, it seems that everything you say and do takes on a more crystalline effect. It is so fragile and anything that might be said that at another time and another woman when she is having a healthy baby might go over her head. But everything is for evermore etched into her brain, almost seared into her brain and those women need, not better midwifery care but I almost want to say that. They need the best possible care and midwives who are not frightened of it. That they aren't going to gloss over it and be afraid to be real about it maybe.

Yeah, I think even though I am quite emotional and I am touched by death very easily and it hurts, it's not my grief. Well, it is my grief because I am sad for the people but I'm not sad for me. It's not my place to be sad for me. I'm sad for the woman, I'm sad that anyone has to have a dead baby but where there is life there is death.

Fay reflected on the acuteness of women's memories around experiencing a stillbirth. Their senses are heightened and sensitivities at an extreme level. To this end, Fay highlighted what she thought was an important issue around bereavement care: bravery. She talked about the midwife not being frightened about death and the loss of a baby. This could be seen as emotional openness to the pragmatism of life and more importantly, death. Fay talked about being real about death and not glossing over the reality. She implied that the core of midwifery care is understanding and interpreting what the woman is experiencing. The rawness of the experience for both the woman and the midwife is undeniable yet the loss belongs with the woman. Fay acknowledged that she is easily touched by death and knows the pain of loss. Her notion of 'where there is life, there is death' spoke of the cultural context that she places death in, its inevitability. She commented about who the grief belonged to when a baby dies and the professional boundary that limits the emotional response that is appropriate for her to show. She did not feel grief for the loss of the baby but grief for others having to experience loss. Her sense of sadness was for the woman and her family not sadness for herself, more of a sympathetic sadness.

I couldn't influence if that baby was alive or dead. I felt that I had nothing to beat myself up about. I didn't feel like I needed to go home and unpack it all and wail and gnash my teeth. It was over and done with. The fact that I had nothing to reproach myself for made a difference to how I coped with it.

Fay felt that this was less traumatic for her as a midwife than some of her other experiences even though this was her first stillbirth as a community based midwife. She perhaps had a sense of this being unforeseeable and out of the control of the woman, herself or anyone else. Fay's own personal interpretation of the death of this baby was perhaps one of providence. Because she felt the death was inescapable, her own liability was not in question. She felt blameless and therefore did not feel the need to agonise over it. She believed that this positively influenced how she handled the situation.

But babies die. That sounds awful doesn't it? I don't recall thinking about the meaning of life or the whole spiritual aspect when this woman birthed. I think I would have if I had gone to a church service or a Tangi. I think then it would have been much more in my face. Thinking about spirituality....I only saw him in the guise of an alive baby. He never went into a box so he was either in a cot, a Moses basket, a car seat or in someone's arms. I never saw him in a coffin or a

box. I never saw him at a funeral with a spray of flowers. I have only seen him as a 'live baby'. It was quite an easy & natural progression because he was always regarded as a real baby. He was handled like he was a live baby. Maybe he didn't have any of those accompaniments of death with him and maybe if I had, that would have bought it home. The finality of a coffin going into a grave or the macerated skin. You know, the wailing of the woman throwing herself on top of him. So for that family they did everything around perceiving that baby as being real and alive for all intents and purposes.

Fay was apologetic for her frankness about the death of the baby. She may have had a sense of detachment from the reality of the baby's death because she did not attend the Tangi or witness any rituals around death that stir the usual emotional responses. For Fay, the essence of this baby was one of normality. The meaning of death was not apparent because he was treated as an alive baby. The finality of this baby's life was hidden.

For Fay, grief is seen as a response to great emotional pain but she believed that she was not grieving in this circumstance as she had not lost anything. Her emotion of sadness was more from sympathy rather than empathy. She reflected that although the loss of a baby must be excruciatingly painful, she herself had never had that experience so she felt relatively unaffected by the experience. She believed her own cultural context supported her 'matter-of-fact' approach to loss.

I guess they did things that I accepted as being "fitting". I suppose my experience or expectations on how people handle death was similar to what they did and that meant I could internalise it, I could cope with it. There was a sense of ease about it. If they had said 'Don't want to hold him, he's too ugly....take him away' then I would have been much more upset but because there was humour, there was warmth, because there was genuine caring. It was what I expected. It was what my culture told me 'that that is how you behave around death'. You are upset and it is OK to cry but it wasn't about them throwing themselves onto the funeral pyre.

The family responded to grief the same way Fay would have; a way that was almost comfortable for her, from a cultural framework. Their emotional sameness was, in itself confirming for Fay. Her experience was validated by others and her responses to other's grief had a knownness to it. There was a dead baby and nobody wants that but there was a sense of closure; a very comfortable experience.

Lou

Background

Lou has been working as a community based midwife since graduating. She is most comfortable working as a primary care midwife but decided to venture out of her comfort zone to challenge her practice. She had heard from other midwives about their experiences volunteering and decided that the time was right for her to broaden her own clinical experience. She reflected on her days doing clinical placements as a student. She remembers thinking about having to deal with stillbirth as a qualified midwife and was quite aware of this possible scenario.

Her stillbirth experience happened while working as a volunteer midwife at a Maternity Hospital in the Pacific Islands. On her return, I asked her if she would like to be a participant in this research, after I heard of the experiences she had while away volunteering. We met at the local birthing unit for the interview, with Lou's agreement. Her stillbirth experience had happened only a month or two before the interview.

Lou reported that the hospital she had been working at had about 10-15 births every day. When she was there it was surprisingly quiet.

Experience

Lou started by giving an overview of her experiences, so far, on the small Pacific Island she was staying on. She reported that the majority of the island's women live at a very low socio-economic level. They live in shanties with dirt floors. There are a lot of children in one house, in fact lots of families in one house. The women generally stay home and very few of them work. They stay and look after their babies and support the rest of their family. Ante natal care is minimal and there isn't an expectation of receiving post natal care either. Consequently, there is a lot of mortality whether it is maternal or fetal or neonatal mortality.

Lou remembered, with some fondness, the birthing culture on the Island:

These women push so beautifully. They give it everything they've got and this head almost shoots out. The most babies we had in a day was 10 babies and 5 of them were born in a 25 minute period so it's just crazy, there are babies everywhere, popping out all over the place.

Lou's description of the birthing environment was one of relative chaos with the unpredictability of birth evident. Women birthed seemingly independent of medical intervention. The woman Lou was caring for on that day was having her second baby. She had not met this woman before- she arrived at the hospital in labour. Lou wasn't surprised when the woman told her:

Her first baby had to be resuscitated. He had thick meconium and was really sick as well but now he was absolutely fine. You know most of the babies I had, I guess 80-90% of those babies had thick meconium -I don't know why. I don't know if it is because of the lack of ante natal care. I don't know, yeah a lot. You were constantly thinking 'Oh, my God, this baby cannot breathe this in'.

This news would have alerted Lou to the past birthing experiences of this woman and the possibility of this situation happening again. Knowing that women often birthed quite rapidly, Lou would have been anticipating what was to come. She had attended many births during her time there and had frequently seen meconium liquor. It seemed to be relatively common. In fact, into her second week of working on the island she had become almost accepting of thick meconium being present at the birth. The meconium was just an outward sign of the baby's in utero environment, not its ability to cope with it. Therefore, Lou would instinctively have had a watchful eye on what was happening making sure that she was ready for this baby to announce its arrival. She was also mindful that help and supplies were not always easily found. The baby was born after quite a short but normal labour.

The baby was born and with it came a tidal wave of thick, green, horrible, horrible meconium. Coming out this baby's nose, out its ears and out its mouth. The skin was green and there was meconium everywhere. It was just horrible. The baby had a glazed look on its face. Every midwife's worst nightmare.

Even with Lou's frequent experiences of meconium being present at a birth, this scenario was extreme. She describes a 'tidal wave of meconium' and reports that the meconium was everywhere- coming out of the baby's mouth, nose and out its ears. For Lou, this horrible sight would have indicated just what the baby's environment had been like. The chain of events that may be about to happen would have been rushing through Lou's mind. Seeing the baby with a glazed look on its face is confronting evidence that all was not well with this baby. The reality of what this meant was clear

to Lou and her response was to see this scenario as a nightmare- a situation that she knew would put fear and dread into a midwife's mind.

Yeah, so quickly rubbing baby down, suctioning it on the bed, yeah. The baby is not responsive and time went really, really quickly. So I felt like, oh God, you know. So I was now in charge and all the other midwives had left.

Lou seemed to be in a vacuum of time, watching the baby's unresponsive body. The other midwives left the room while Lou was there deciding what she should do. Her training told her to rescue this baby but nothing she did seemed to help. The weight of being in charge of the situation was sitting heavily on her shoulders. The sense of time rushing by would have added to Lou's sense of urgency to do something to save this baby.

I was having this huge battle in my head about why it was happening and given that I have been practising for two years. I have had experience with certain things but this was the first time that I had had a baby that was so, so sick and I kept on telling myself that this baby is so sick and there is nothing else I can do. Yeah, in my head I was having this emotional battle. It was the torment of letting this baby go.

The battle playing out in Lou's mind was not one of uncertainty of what to do clinically but a deeper emotional dilemma of whether to let this baby go or not. She knew the baby was seriously unwell and there was nothing she could do to save it. But she still was unable to resign herself to the fact that she could do nothing to salvage this baby's life. That moment in time when this sort of decision needs to be made seemed to be beyond Lou's known ability. For her to deal with the intensity of this situation was more challenging than anything else Lou had ever experienced.

The registrar had come and put in a line and there was nothing more that she could do and she had left again. She already knew that baby wasn't going to make it and she had just left it in my hands. I was so angry about that. That she had done that.

Lou's anger was highlighting her aloneness in this situation. Not only had all the midwives left but also the doctor. There was no one there to support Lou, to make the decision for her. Everyone had realised the situation was hopeless but Lou was blinded to this reality by her hesitation to make the decision to cease the resuscitation

attempts. She desperately wanted someone else to acknowledge hope for this baby and when they didn't she became angry. Without hope there would be no chance for this baby. Hope might have saved this baby and hope may have protected Lou. She wanted someone else to 'allow' her to stop, to give her permission. She was drawn beyond herself to find her own path through this dilemma.

I kept on telling her to talk to her baby. Talk to her baby, tell him that you want him to stay, that you want him to be here. it's OK to be naughty for a little while but now it's time to start behaving. I remember her saying 'Come on Lexi, come on Lexi, Lexi, Lexi, come on Mummy wants to feed you, Mummy wants to feed you. You wake up now so Mummy can feed you'.

Lou's attempts to get the baby to 'behave' were an opportunity to draw the mother to the same conclusion as Lou. That the baby was not going to survive. Suggesting that the baby was just being 'a little naughty' was a veil of desperate hope that Lou held onto. By appealing to the baby's better nature 'to behave' might prove that all was not lost. To hear the mother pleading for the baby to wake up must have been excruciating for Lou to witness. A mother calling to her baby is such an instinctive response but yet, this too, did not work. It seemed to Lou that not even a mother's love could not save this baby.

I told the staff that this baby was so sick, he was not going to make it, what did they want me to do? I said 'I need you to help me because I have not done this before. You need to tell me what to do.' They said, 'Lou, you know what to do'. That was heart wrenching because I knew, deep down I knew that baby wasn't destined for these islands but baby was destined for elsewhere.

Finally, Lou asked the other midwives what she should do and their reply was not what she wanted to hear. All she wanted was some help but instead they provided her with the honest truth. So again she was left alone. She needed some experienced guidance but she was left to rely on her own self-knowledge, to find her own practice wisdom. In the absence of certainty, Lou resorted to her spiritual knowing for some level of comfort. This was the beginning of her acceptance of this baby's destiny. Lou was gaining some clarity around how she should proceed.

So I thought 'Right...' So I went back into the parents, I didn't say anything to them but I think they already knew. I took baby's IV line out. We dressed him and we wrapped him up in a blanket and I gave him to his Mum and she was holding

him. She was sobbing and I think she was really happy to be holding her baby. So, for me, if I was in that position I would want to hold my baby. So as I passed him to his Mum I gave him a kiss on his head and I gave her a hug and a kiss on the cheek. The father was standing there with his arm around his wife. So it was really quick, he opened up his eyes. It was the first time that he had opened up his eyes and he looked at his Mum and took a big breath and then closed his eyes and that was it. That was it. It was like he was just waiting for his Mum's cuddle.

Lou found her own inner strength to stop her futile work trying to save the baby and handed him to his mother to cuddle. The decision finally felt the right thing to do and Lou believed that the family were just waiting for this to happen as well. The simplicity of what Lou did seemed incongruous with the torment she was experiencing just moments before. Once the decision was made, the clearness of the action needed became apparent. There were no more arduous decisions to be made. Instead, she just needed to be with the woman, her husband and her baby. Lou saw the baby as having control over his time of death. Her description of how he had waited for his mother to cuddle him before he died shows a concept of the baby being in command of his own destiny. That the baby had the power to control his own demise would have been spiritually consoling for Lou and would have enabled her to quietly recognize her own spiritual centre. In fact, this could be seen as Lou *not* having any responsibility over when the baby chose to die.

When I went home I sat in my little room with my lap top and wrote an email to my partner. I had to tell him what happened. I probably typed for 45 minutes. I just kept on typing, telling him what happened and when I went back to read it there were all the signs of grief. There was the denial, there was the anger, the questions. Why did it happen to me...why did this happen to this baby...did I do something wrong... what had I done wrong to lose this baby? There is nothing that can be done now so there is no point questioning it but at the time I wondered if I didn't inflate properly. Did I not suction properly? Did I not suction deep enough? The question that got me was who was I to decide whether that baby was to stay or to go. I don't even know what made me make the decision to wrap that baby and put him in his mother's arms. I don't know what made me decide to take the oxygen off and let him go...um...I don't know...I don't know...but at the time I had no midwifery support. They'd all left. They'd left the room.

Afterwards

The outpouring of emotions for Lou was her way of debriefing about what had just happened. Lou was trying to make sense of her experience by writing and writing, without stopping. She was experiencing such profound emotion that all she could do

was write the events down. To get them onto paper meant that they could escape her 'being'- she could gain some distance from the enormity of what she was feeling. She didn't debrief with the other midwives as she may have felt a sense of abandonment- they had left her to deal with this catastrophe alone. So, instead she wrote an email to her partner, back in New Zealand. Ironically, Lou never actually sent that email to her partner- once she had finished writing it she felt she didn't need to send it. As she ran through what happened, she realised that she was experiencing some of the signs of a grief response. This was Lou finding something to secure her thoughts to. She knew about how people grieve so found shelter in her response. Being alone at this time may have been confusing and alienating so finding something she considered normal could have been confirming for her. Her self-doubt was a reflection of her supposed inexperience in this particular situation, although she managed to find her way through this doubt and became an advocate for the family. Again, Lou pondered the irrationality of her making a 'God-like' decision to stop resuscitating the baby. She couldn't understand how she made that decision and the realisation that she even did caused her some emotional turmoil.

I was expecting it but I wasn't expecting what actually happened. I've never had anything happen like this in the two years that I have been practising. I went expecting it to happen but when it did. 'Oh, God...what was I thinking?' It really knocked me. It really knocked me.

For Lou, when she did find herself in this situation her response was one of shock rather than unpreparedness. She had gone to the Pacific Islands fully aware that the mortality rates were higher than those in New Zealand and that there was a high probability of something like this happening while she was working there. The revelation that babies do die came as a reality shock. She certainly knew on an intellectual level that women lost babies but the reality was still an abstract concept to her. She couldn't have prepared herself for what she had experienced. The actuality felt like a physical blow and she saw her world unravelling. But, the next day she got up, ready to go back to work.

I didn't sleep well and the next day I went up to the hospital and I said to myself 'I knew this would happen'. You know I thought that I just need to dust myself off, pick myself up and get back on the horse and just carry on. I got up there and it was really busy and the first woman I cared for was having her second baby. She

told me that her first baby had meconium and needed resuscitating and it sounded just like a mirror image of what had happened the day before. I thought to myself that I was going to be OK and it was going to be just fine and when she SROM'd she had thick meconium and I just thought 'I can't do this'. I just couldn't do it so I handed over and I left. I felt really uneasy about handing over but I just couldn't cope with it so I just went home and for the next two or three days I didn't actually go back to the hospital. I actually got on the internet and looked at flights home. I wanted to change my flights and come home because I had had enough. I thought 'I am done, I've had enough.'

Just the physical effort of going back to the hospital the next day would have been monumental for Lou especially after having an unsettled sleep. She filled her mind with thoughts of needing to be strong and to just carry on. She stated that she knew this would happen so there is almost a sense of 'I told you so'. The analogy of having just 'fallen off her horse' seemed to imply that the experience was of no consequence and could be easily forgotten about. Lou saw herself as a health professional who knew what she was getting herself into and almost didn't allow herself to be vulnerable or be impacted, in anyway by this experience. The truth of what had happened and the impact it had, turned out to be quite different to what Lou thought. It was almost too hard to truly see what had happened. Perhaps it was easier to turn her back on it and think about what experiences were still to come. Unfortunately, this was not going to be easy to do. The maternity unit was busy and Lou could not escape the realness of her environment. To be present meant to be ready to work. The suddenness of being thrown back into a repeat of what had happened the day before was too much for Lou. Her instant response was to run and hide. No amount of reasoning or self-talk was going to get her through this. Lou's action of running away was a shield for her to shelter behind. Perhaps armour to protect her until she was ready to face the world again. Lou planned her escape by planning to fly home to get away from what still hurt her.

She didn't end up leaving. She phoned her partner back in New Zealand and he encouraged her to stay, to learn from the experience and grow from it:

That whole experience broke me as a midwife. It really, really upset me. So those three days were really important to me to re-build myself after I had been broken. I felt a little bit better but those three days I did a lot of thinking. There was a lot of transition within me. There was a lot of re-growth and development. If I had come back 10 days early I would have come back with a pocket full of

grief, a heavy heart and a lack of enthusiasm for my job that I really, really loved up until that day. I don't think I would have been well enough to continue practising, to be honest I was thinking that I probably wouldn't even go back to work when I got back. Because this baby that I had lost, I was blaming myself really.

Lou describes a deeply personal and transformative time of self-reflection. She portrays a sense of 'being broken' by the experience and the need to re-build herself. The impact of her experience was so great that she felt she needed to heal from her own personal pain. She did not imply the pain was directly from the loss of the baby but the loss of herself. Her identity of self had been shattered and she was unsure of who she was, who she had become. During her time of re-inventing herself, she felt that she had grown and developed as a midwife. Perhaps she saw the experience as a 'rite of passage' from novice to being more worldly wise. As this time passed, she began to realise the decision to stay on the island had been a good one. She recognised that returning home too soon would have left her still feeling hurt from the experience. The richness of the experience would have been shadowed by her need to break away from the painful memories of what had happened. Lou believed that if she had returned home she wouldn't have been capable of returning to work. This reiterates the immense impact this experience had on her. Poignantly, all of her thoughts were resolutely set on self-blame. Through all her self-analysis and her self-reflection, she still believed that she was at fault, she was culpable.

I finally decided to go back to the hospital. I had a primigravida and when she SROM'd she had clear liquor and it was so nice to see clear liquor and this baby came out and cried on the perineum and it was pink the second it was born with Apgars of 10, 10 & 10. It was just amazing. I burst into tears as soon as this baby was born because I was just so relieved. The baby was screaming and the baby was well, the mother was well and I was well...yeah...I was well and that was the main thing.

After three days of trying to regain what she felt she had lost, Lou returned to work. Her response to this normal birth was one of personal emotional release. Her truth was reaffirmed -there was still a possibility that babies can be born alive and well. The relief for Lou was palpable - an emotional release that led to tears. The risk of returning to the hospital and then something bad happening had passed. For Lou to find normal birth so overwhelmingly amazing was an indication of how her own birthing wisdom had been shattered. It would seem as if her worldview of birthing had

been turned upside down and then finally found some semblance of normal. Her birthing radar had been re-set. Lou discovered that she, *herself* had survived the birth, that *she* was well. This could be seen not just in a physical concept of survival but one that sits with a spiritual and emotional view of survival as well. For Lou, this sense of her making it was seen as even more important than the baby or the mother being well. Not because of a disregard for the mother or the baby but because perhaps the risk of Lou truly not making it through was a possibility for her. Her own perception of her being in danger was real to her.

Lou couldn't help but contemplate the personal connection to this outcome:

For part of that period I was thinking of that baby as if it was my own. I was thinking 'I can't lose it, I can't'. What if that was my baby? What if that happened to me? What if that was my baby on the table and the midwife couldn't let baby stay or couldn't keep baby around. It's that argument that goes on in your head. In reality it last about 10 seconds but in your head it goes on forever.

As Lou continued to intellectualise the loss, she couldn't help but reflect on her own situation as a woman who, in the future would like to have children. To personalise the experience was an attempt to gain some understanding about what it may feel like to lose a baby. This empathetic loss response may be seen as making the emotional wound bigger but for Lou, it enabled her to see the loss from another's point of view. It is difficult enough to witness another person's grief but to try to 'walk a mile in their shoes' takes courage and resilience. It also implies the personal connection that Lou had with the woman by seeing herself as *that* mother and *that* woman rather than a midwife only. For Lou to assimilate the experience, she almost could imitate the woman's story and make it, potentially, her own. For that moment, the loss belonged to her, the unknowingness of losing a baby became known. What once was mysterious became familiar. Lou's acknowledgement that these thoughts only last such a short time but feel like forever could, perhaps indicate the self-realisation of what it is like to actually lose a baby. The loss lasts 'forever'.

Lou describes her preparedness to return to midwifery practice:

If I don't think about it, yes, I feel confident enough to practice midwifery again and to support women in labour. But I think or I don't know if I am completely re-

built enough that if it was to happen again in the very near future how I would cope with that. If it was to happen again, the wound is not completely healed and that would open the wound up again. I think I would need a little bit longer. I wouldn't say that the wound is raw and nasty but it is like a heavy 'yuk' in your tummy. It's in your chest. It's not a weight but it's heavy.

To not 'think about it' suggests that Lou chose to keep her thoughts or memories of her experience buried. If they were hidden away then she felt confident enough to function normally. She stated that she was unsure if she had recovered or rebuilt herself enough to feel that she could cope with a stillbirth, if this were to happen again. The rawness of the wound caused by her first stillbirth experience was still very real to her, to the extent that she felt that the wound would be opened up again if she were to be placed in this situation again. She was vulnerable to attack, still. There is a sense of irony that Lou used the analogy of having a 'wound'. This would imply that she had sustained an injury; she had been damaged and needed to heal. She described the sensation as heaviness in her chest. A heaviness that is not a weight may represent a feeling of profoundness. From a cultural context, it may be seen as an unanswered search for sympathy and a lack of acknowledgement of what the 'sufferer' has been through. Irrelevant of all of these suggestions, Lou seemed to be carrying the experience close to her core.

When asked to describe or summarise her experience on the island, Lou was unable to put it into words:

I don't know. No, I can't. A lot of what happened on the island, I can't describe. The experience, for me is so hard to describe because the experience was so different from what I expected or what I have already experienced. There were so many things that I learnt. There were so many things that were different to New Zealand. It's hard to explain and I guess everyone deals with these experiences differently but unless you have experienced something like this, you won't know. No amount of explanations or talking about it with other midwives or your family. No one will understand what it feels like unless they have experienced it. You can use as many descriptive words as you like but you will still not be able to describe what it is like unless you experience it yourself. Even then, if you and I were at the same birth and the baby dies you would feel completely different to me because we both have different life experiences and different backgrounds. If I hadn't spoken about it and said how I felt and kept it inside then I would have been the only one who knew about it. I would be the only one to know what it felt like to lose that baby. I would be the only one who knew what it felt like to feel that baby slip away beneath your very hands.

Lou's deeply insightful views highlight the complex emotions she had around the experience of stillbirth. To be unable to describe how it was for her indicates the lived experience was beyond her current reality. She had not come up with any words that fitted her experience. Her expectations of what her time on the island would be like were completely irrelevant to her own pre-understandings. Lou believed that to understand what happened, one had to experience it; to live it first-hand. No words or explanations would have done the experience justice. Perhaps, this was the first time she had experienced herself-in-action rather than hearing about it from others or theorising about what it may be like. She exposed an experience that she knew existed but had never had as her reality. Lou's story also highlighted the loneliness she felt during this time. She alluded to the private world of her experience that others did not share, even though they may have been present. Other midwives may have also experienced stillbirth but Lou reiterated that *her* experience was private to her. She reflected that she was the only one who felt what it was like to lose *that* baby. The exclusivity of her experience was tightly held onto as if to confirm or endorse her experience. The authenticity of her lived experience cannot be judged or critiqued by anyone else because, by her reckoning, she was the only one who lived her experience. Her reality was personal to her.

The following is her own description of the midwife she believes she is now:

The one before was excited and naive and the one coming back was a different midwife, I think. I would practice the same way as when I left but I have a different understanding of life and death. Now that I have experienced the death part, I have a different understanding of it. A more accepting view of unexpected outcomes, I guess. I hope that the midwife that got off that plane will be able to cope with that situation a little better than the one that got on the plane.

Lou describes the 'different midwife' she has become since arriving home. Her own personal understanding of death was changed and redefined by what she experienced on the island. She sees herself as being somewhat wiser and perhaps braver from the lessons learnt. She seems to have found a more comfortable place to be when unexpected outcomes occur. A feeling of being at ease is expressed and there is a sense of acceptance of the inevitability and also the finality of death. Her own performance expectations have increased and she trusts that learned coping skills will support her with any similar situations she may face. It could be suggested that she has

lost her novice practitioner exuberance but found a practice wisdom that belies her relatively few years of practising.

Her final words reiterate the lived meaning she places on her role as a midwife:

Midwives deal with life and unfortunately we have to deal with death. Death is final. There is nothing you can do once that baby has gone. You can blame all you want, you can point the finger but at the end of the day that baby has gone and there is nothing you can do about it. I knew coming into this career as a midwife, I knew that something like this would happen sooner or later.

There is an intentionality in her words that talks of her place in the world. She is a midwife and she understands what 'it is' to be a midwife that deals with life and death. There is no detracting from Lou's lived truth. Although she acknowledges that we often blame ourselves for what has happened, this, in her eyes is pointless. Her acceptance is that some babies are born still and nothing will change that.

Vicky

Background

Vicky works as a community based midwife in the Waikato region. She works with several other midwives and has been qualified for well over ten years. I met Vicky during an ante natal visit I was doing in the area. She agreed to be interviewed, without hesitation and we arranged a time to suit. I interviewed her at the local birthing unit.

Vicki's story was from some years ago. The memories associated with this event seemed to be as strong and easy to recall as any of the interviews. Time had not faded Vicky's memories or her emotions around the stillbirth.

Experience

Vicki was supporting a woman having her sixth baby at a rural birthing unit. The woman was a fit and healthy woman who had no risk factors and a normal obstetric history.

She had been in to see me in the morning. She was 38 weeks pregnant. She had a beautiful happy baby. There were no concerns at all.

Vicky had a sense of comfortable familiarity around this birth. It could be suggested that a woman having her sixth baby is the expert around her own birthing. The midwife sits in a place of trust and respect for the woman and could see herself as more of a birthing companion rather than a trained obstetric attendant. Vicky had seen the woman, earlier in the day and both were reassured that all was well. The woman was full term and neither the woman nor Vicky had any concerns about what was ahead of them.

The woman started labouring and contacted Vicky with this news. They met at the local birthing centre and, as per usual, Vicky did a full assessment of the woman, including completing a CTG (Cardiotocograph) monitoring.

It was in the days when every woman had a CTG as soon as they walked in the door in labour, it was standard procedure. I just had this horrible flat trace so I left it on for 20 minutes and I said to her that I really don't like this trace so I'm not going to take you off but you can get up and walk around.

Vicky did the monitoring, not because the woman was high risk but rather because it was accepted as best practice. To have a reassuring trace was the anticipated result of such an assessment. The woman and the midwife could then get on with the task at hand, knowing that the baby was, so far, coping with the labour. Vicki, however, was not happy with her assessment of the woman during the early stages of her labour. When Vicky discovered a 'flat trace' the anticipated reassurance was not forth-coming. She describes the trace as horrible which suggests that the baby was indicating that there was something amiss with its world. She rang the nearest secondary maternity unit to discuss her findings. The staff were not desperately concerned enough to suggest an urgent transfer to a secondary maternity unit but they were alerted enough to suggest continuing the monitoring of the baby. Once again, Vicky was guided by best practice and her own practice wisdom. The baby was describing its environment and was advising those who were watching. Some time passed and Vicky was still not reassured with the monitoring:

So I rung back again and said, look I really just want to come because she is starting to establish in labour and this trace is not getting any better.

The trace didn't improve so after much discussion with the base hospital, she decided to transfer the woman to the secondary care unit. The timing of transfer is often fraught with complex and intertwined issues. It would seem to some that this decision is based on need only when in fact there are many, often conflicting factors that make this process difficult and often complicated. She was concerned that the situation was not improving and felt the best idea was to head into a secondary unit for further assessment.

So I said I am going to come. So I took the trace off, the parents were aware of what was going on obviously and by the time we got to Waikato that baby had died. We get over there and we try to get a fetal heart but we couldn't find a fetal heart and the woman said 'this little baby has died hasn't it?' I never thought the baby would die. I knew I wanted to get the baby out but didn't think that little baby would die. You could have knocked me down with a feather.

Once the decision was made to transfer things moved quickly. To get to that decision point would have validated Vicky's clinical thoughts. A sense of direction and resolve would have been felt by Vicky. Any other factors were rationalised and this led to action. The ambulance was called, the woman was settled in the back of it and they quickly left. Arriving at the base hospital would have given both the woman and Vicky a sense of 'getting there' - to a safe place. Assistance was on hand and all would be well. Any uncertainty about the baby's well-being would soon be alleviated. To try and find the baby's heart beat on arrival and not be able to would have given Vicky the unwanted confirmation of her worst fears. When she realised that the baby had probably died while they were in the ambulance, during the transfer process she was overwhelmed with emotion. For the woman herself, to acknowledge what everyone else was finding unbelievable was staggering. In the nightmare of this discovery, the woman had the courage to come to her own conclusion that her baby had, in fact, already died. She put into words what everyone else was hoping to avoid: the horrible truth that it was too late to save this baby. For Vicky, this was not what she expected to happen, at all. She states that she was very aware that the baby was probably going to require further assistance during and possibly after the birth but she never anticipated the baby dying. She had transferred many women needing further

assistance but had never had this outcome before. Her response was one of disbelief. She felt as if she could have been knocked down by just a feather. This wasn't meant to happen. They had arrived at the safe place only to discover that it was too late.

Vicki's preparedness for this experience was affected by her anticipation that the woman was going to have a normal birth of a normal baby. She had already done it five other times and this was going to be just the same albeit at a base hospital rather than at the primary birthing unit they both were hoping for.

What you are feeling inside is just... I was just absolutely mortified. I was sobbing and I went into the tea room and let rip .I just felt dreadful and I was a sobbing mess. All I know was that I was a distraught mess. It was shock, horror, just 'Oh, my God!'

The worst thing is trying to hold it together. You're trying to hold back all of these...it was about them, not about me. It was a horrible experience.

Nothing could have prepared Vicky for what actually happened. She describes feeling shocked and felt she had to leave the room to save the woman seeing her own distress. She had tried to keep her emotions under wraps but couldn't. Out of sheer desperation to not add to the woman's pain, she needed to get away to let her pent up emotions out. She was acutely aware that she personally had not suffered a loss but her anguish was from a mixture of many different factors relating to what was happening around her. For Vicky the sorrow she was feeling was not just about her client losing her baby but also about the circumstances around the loss. They had made it to the security of the base hospital but yet even that could not rescue them. The fractious conversations with the base hospital around the timing of the transfer and the complexities around this would have added to Vicky's feeling of being overwhelmed. Her distress was a normal response to an unexpected outcome and the associated complicated nature of her role as a rural midwife. Vicky quickly returned to the room to support the woman and her partner, but everyone else had gone.

Everyone left me in the room by myself. I rung the bell for someone to give me a hand but no one came and people were looking at me like, you know. I just felt dreadful, you know. But they all just went away. Of course soon after the doctor ruptured her membranes she started pushing and we had this wee baby. I didn't even get any gloves on. You can't get your head around the fact and then being left to catch this little baby. So perfect and so beautiful and you're just waiting for something. Come on! You wait and there is just nothing. That wishing that that

baby would breathe. I didn't know what to do. You have a care plan for a live baby not a dead baby. What do you do?

Vicky found herself alone in the room with the woman and her partner. The doctor had performed an artificial rupture of her membranes, and then she left the room. The woman's labour progressed extremely quickly and the baby was born. The outcome was now visible for everyone to see. The reality was confronting for all in the room; this was not a mistake, the baby had truly died. Vicky remembers seeing the baby and thinking that it was so perfect and she waited for it to show signs of life. This was the one chance for the truth to be challenged. She waited and waited for something to happen but there was nothing to show that this baby might actually be alright. Vicky had called for assistance but her calls for help were left unanswered. The feeling of abandonment would have been hidden from the woman but seen as an unkind blow to Vicky. To help birth a baby is one thing but to help birth a still baby is an arduous task and one she found herself doing by herself. A midwife bears witness to a baby being born and when supported by other midwives her story is validated. To feel neglected by others, she would have been denied this sense of 'togetherness' with her colleagues. The sense of being supported would have been missing. Vicky had a sense of being condemned by others. She believed she was being judged for something but was not sure what. This sense is often difficult to put words to: it is more of an impression or a perception that there is a lot *not* being said. She couldn't comprehend what was actually happening because it all occurred so quickly. This would have felt surreal to Vicky not just because she had never experienced anything like this before but because her understanding of how birth should be was being tested. Vicky was so unsure about what she should be doing. Again, not from a clinical point of view but from an outlook of seeing so many unknown variables. The clinical setting was not her usual place of work, her colleagues were unfamiliar to her, the birth outcome was unique and this situation was not meant to happen. In her head she had a vision of how this woman would birth and nothing she witnessed was in that vision.

It was six o'clock in the morning by now. I bathed that baby, dressed that baby and measured it and did everything. It's funny what goes through your mind. Do they still want skin-to-skin? Some people are freaked out by death. I didn't know what to do so I can remember asking 'Do you want to cuddle your baby?' Which they did. Esme had arrived by now and I felt a huge sense of relief. She sat with the couple for a while because I didn't feel that I could leave. What do you do?

Do you leave them to their own devices to look at their baby or do they want someone around? I didn't know what to do so I just waited.

By this stage Vicky's back-up midwife, Esme had arrived to offer some support. Vicky would have been exhausted by now and the support would have been gratefully accepted. The uncertainty about what the family may have wanted was unsettling for Vicky. Just by doing what she *knew* to do would have been confirming for her. Her midwifery knowing about performing those comforting and even normalising rituals around birth may have given her a sense of clinical direction and purpose. She acknowledged that some people are 'freaked out' by death and this thought would have made her perhaps hesitate when initiating normal bonding opportunities. Although she states that she didn't know what to do she still acted as if she did. When she was unsure of what to do, she waited and let the moment unfold.

So I got back here at 5 o'clock or so. You could imagine with no sleep. I had gone through by ambulance so I had to get a ride back. So I was just an absolute crying tired mess. You just don't expect it and I waited until they were discharged. They didn't want a post-mortem so they carried their baby out in a little box. You don't expect to see that. You know, what do you say to these people?

By the time Vicky got back to the rural birthing unit, she had been involved with the care of this woman for almost 32 hours. She had stayed at the base hospital with the family until they had been discharged home. She had support from her midwifery colleague for a time but still, she had been the main carer for this woman and her baby. This was partially through choice and partially through the need to be present with this family as they came to terms with their loss. By staying with the family until they left the hospital, Vicky may have seen her role as one of protector, protecting the family from what she perceived as a threat, the lack of attention and support from the staff. If she had felt unsupported then perhaps the family would feel the same way if she left them. It could also be said that Vicky chose to stay with them as a way of her personally trying to process what had happened. By remaining in 'the moment', Vicky may have been able to at least start to intellectualise the grief she felt and saw. By leaving, her thoughts may have been disrupted and overtaken by day-to-day concerns that could have distanced her from what she had just experienced. Almost, in a way, her staying enabled her to immerse herself in what was happening in an attempt to find a path through it. She may well have felt a sense of being united with the couple

by staying with them during their lived experience of stillbirth. In turn she would have gone from mere onlooker to an actual participant.

Even the need to get a ride back from the base hospital would have been almost too much to think about. Her memory of them walking out with their baby in 'a little box' highlighted the bleak reality for all of them. She desperately wanted to find the right words to say but she was still stunned by what had happened. She struggled to know what to say as they left. Perhaps there were no right words to say. The profound emotions as they all left the place where it had happened would have almost been impossible to verbalise.

Vicky talked about going out to the woman's home to see her:

That was the worst thing was seeing her again. You dread it because what do you say? God, those visits were hard but silence was OK. I saw her again about 3 months ago. I still feel sick. It was that guilt- Oh my God. When I remember her I always feel guilt. Why didn't I just go? Why didn't I just follow my gut instinct and just go sooner? I don't know that it would have changed the outcome. I don't know but why didn't I? I kept thinking in my own mind and didn't think that I had done anything wrong but I still had that gut feeling that I should have just gone so now I just go. So that was a huge learning curve for me. I'm coming whether they want me or not.

Afterwards

The post natal visits were hard for Vicky. Again she felt unsure about what was the right thing to do or say. She acknowledged that sitting with the woman in silence felt like an OK option. Vicky's midwifery skills extended to her being able to be with the woman without having to fill the silences with meaningless words. In fact, it may have given each of them an opportunity to be alone with their own thoughts and memories of what had happened yet at the same time support each other by being together. The shared memories made for a knowingness, an appreciation of what it had been like. Vicky's feelings of guilt were brought to the surface every time she saw the woman, even after some time had passed since the stillbirth. The timing of the transfer plays on her mind as she remembered that she wanted to transfer sooner but this didn't happen. She consoles herself that the outcome may well have been the same whether

she transferred sooner or not. For Vicky, the main issue is more about her trusting her own midwifery wisdom. She talks about her gut-instinct and that she should have listened to it. Midwives are often said to have a tacit way of knowing; an unspoken feeling that often guides practice. In this instance, she was distracted by others and let her own implicit judgement get waylaid. This reflection on practice has given Vicky a strong sense of clarity around what she will do in the future. Her determination to act on her innate knowing is a force to be reckoned with now. She stated that she will transfer whether they 'like it or not'.

She wouldn't have a clue how I feel. I am sure she wouldn't have a clue. Absolutely. But it doesn't alter the fact that I feel it. I think their grief is priority. They've lost. I couldn't even imagine losing a baby. That's your baby you know? It is a loss to us as well but it's worlds apart. But nobody really takes care of you when something like that happens.

Vicky reflected that the woman would have never guessed what impact this stillbirth experience had on her. This was not with bitterness but more a reflection on the professional role that Vicky believes the midwife has in these situations. The midwife shares the experience and often the sense of sadness with the parents. Although the loss belongs to the parents some of the sadness and the guilt around the loss often finds a home with the midwife. Vicky suggests that she couldn't imagine what it must be like to lose a baby, but walking along side the parents, the midwife's compassion for their loss can be very deeply felt. Vicky also remarked on the loneliness of being *that* midwife. She shared a feeling of being uncared for and left to find her own path through this devastating event. Vicky implied that she felt a wound or some form of hurt that required nurturing, but also felt that nobody noticed the damage. Vicky shares a memory of a moment that highlights this:

When I arrived back the midwife on duty, instead of giving me a hug said 'Gee, I've had a hell of a day. God it's been busy'. So I just went home. I was back on call the next day. There was no time to get your head around it. One of the receptionists was lovely. She dropped in and gave me some flowers. It wasn't my day off so I had to just get on with it.

This memory reiterates Vicky's sense of aloneness. So much so that instead of sharing her experience with her colleague she 'just went home'. This was Vicky's way of making her pain become less visible to others. Home represented a sanctuary where

Vicky could attend to her own wounds. To ask for understanding or a shoulder to lean on would have meant having her response to the stillbirth ignored or worse, judged. To be back on call the next day would have forced Vicky to keep her experience hidden. Yesterday was in the past now and she had other priorities to attend to. She needed to get on with the job at hand and 'just get on with it'. Even if this was *not* how Vicky felt, there seemed to be no option for her to do anything else. Having some time to reflect and debrief about the experience was not going to happen. Having the receptionist show Vicky some support by bringing her flowers shows, even more than ever, that she was alone in this experience. The token of support would have been heart-felt and very gratefully received but the receptionist was perhaps not the person Vicky needed a response from. To get support from fellow midwives who, potentially have a mutual understanding of what the lived experience of stillbirth is like, would have meant everything to Vicky. To have the terrible events of the past few days personally acknowledged by your close colleagues could be seen as 'supporting the supporter'. They weren't directly involved but Vicky was and that deserves recognition.

Vicki had a rather cynical view of what she believed other midwives thought, albeit tongue-in-cheek:

If we don't talk about it then it won't happen to me. I think in this day and age women or society believe that Mums and babies should not die. With all the technology that we have mothers and babies should not die. Nobody actually wants to know. I don't think I talked to anybody other than my own family. It's a subject that brings up too many emotions maybe.

Could this be the reason Vicky felt alone in her experience of stillbirth? Perhaps she felt that other midwives *can't* speak about stillbirth rather than *won't* speak about it. Vicky understands that the expectations society puts on childbirth outcomes may well resonate with other midwives as well. Vicky speaks of the discomfort around death that many people have, including midwives. Whether she thinks this is denial or sheer terror from a midwife's point of view is almost irrelevant. Vicky suggests that the subject of death may well be too uncomfortable, too confronting for most midwives to deal with. Vicky's isolation was still apparent when she suggests that nobody wants to know. She was left to cope with her own grief and to find her own way of moving on.

Vicky planned to see the woman one last time and she was relieved that Esme was able to join her. She describes the last visit she made to the bereaved woman and the feeling that she was not going to be alone for the visit:

Oh, perfect because I wasn't left on my own again. We were still stuck in that place of silence, the silences were OK. We had learnt to deal with that by then but it was a relief. It is so nice to have some else there. Esme and I talked about it probably when we drove out there together. That's probably the only time we talked about it really.

It wasn't until the very last visit to the woman that Vicky felt supported again. Esme, the midwife that supported Vicky at the hospital after the stillbirth, visited with her and Vicky was comforted by her presence. The three of them shared a common experience. It wasn't until they were driving out to see the woman that Vicky and Esme actually talked about their experience. This was the one and only time it was discussed. For both Vicky and Esme, the experience was covered up, not spoken of. Perhaps it was easier to not mention it so as to not stir uncomfortable emotions for both of them, ever hopeful that it will somehow disappear. If their other colleagues didn't talk about it then it would seem that it was destined to be forever unmentionable.

When Vicky was asked what this experience meant her response was one of anger and confusion:

I was angry. Why would this happen to this perfect, healthy beautiful little boy. Yeah, there are no answers to any of that stuff. Nobody can give you an answer. Why do bad things happen to good people? I don't know...I just don't know. Nothing good could come out of it. How could anything good come from that at all? How can losing a baby ever be good? I still see her from time to time and every time my heart misses a beat. There is not a day goes by that I don't think about it. It is always going to be there. It is not something that ever leaves you. It's not as raw but it never leaves you. You both want the same outcome, the same invested interest in the outcome.

It appears that her anger is universal rather than personal. But she may well be angry at the world, at God, at herself, at the baby. She asked herself the deeply philosophical question that often follows a loss. Why do bad things happen to good people? It is unclear who the good people are but it could well have been both the parents and her. She is unable to make sense of losing a baby to stillbirth. The futile nature of the loss of

a baby stops Vicky from being able to get anything positive out of the experience. For her, the memories seem to have stayed current, as if the loss happened very recently. Could this imply that Vicky remains in the moment, unable to move past the hideous memories to gain some insight into why these things happen? In the absence of certainty, Vicky sits with her own, deeply personal thoughts about the pointless nature of stillbirth. Vicky's response to seeing the woman could suggest that she is indeed still feeling the impact of the experience. This response is a natural reaction to having those painful memories brought back to the surface. To think about the stillbirth every day reminds Vicky of what the family went through and not surprisingly, what she went through. She talks of the partnership she had with the parents and the same invested interest they had in the outcome. The parents believe they will have a healthy live baby at the end of the day and the midwife believes the same.

When Vicky was asked if this experience changed her at all her response was brutally honest:

Changed my practice, changed my faith a little bit. I lost a little bit of respect for human nature really. I lost a bit of trust maybe. I think it changes you. I think I practice defensively. I lost a little bit of faith in humanity I think.

From this statement it appears that the family were not the only ones to experience loss. Not the loss of a much loved baby but the loss of what constitutes goodness and righteousness. For Vicky, she experienced a loss of dependability in her colleagues. She also seemed to have lost faith that people will always do what is right. There is a sense of her having lost her optimism that all will be well and this has led her to practice in a more defensive manner.

Vicky recalls the very next birth she attended after the stillbirth:

Dear God...do I remember!? I remember because it was the next day at 10.30. It was like 'I don't think I can go'. I did anyway and the woman had a history of big babies. So this baby got stuck and ended up with a third degree tear. So that was the next birth! I guess the longer that you leave it the harder it would be to go back. As hard as it was coming back it was probably the best thing to do. Yet, the hardest thing to do, when your heart is beating so hard. You're thinking 'Oh, my God'. You are saying everything is going to be fine. The harder your heart is beating the calmer you appear. I think the expectations we put on ourselves is almost impossible to attain. Why do we do it?

Vicky expresses her anxiety of having to return to work so soon after the stillbirth and attend her next birth. She remembers thinking that she couldn't go but understood that she had no choice and went anyway. It is difficult to comprehend how that truly must have felt for Vicky although she remembers her heart beating so hard. Her self-talk sustained her through the birth. Ironically she reported that the harder her heart was beating the calmer she appeared. This is how she was seen by others but it is unlikely she felt that same calming reassurance. A cruel twist of fate meant that the next birth was again, an example of extreme midwifery experience, yet she coped because she had to. She stated that going back to work so soon was probably one of the hardest things she has had to do yet she also could see it as the best thing to do. She believed that to put off going back to work could have made returning very difficult.

Again, she asked an almost unanswerable question: why do we do it? She commented on a midwife's own personal self-expectations and the difficulty in ever attaining these goals. It could be suggested that these expectations are linked to our own perceptions of what a midwife is in the eyes of others. Perhaps to be a midwife means to strive to meet these expectations whether they are achievable or not. The persona of a midwife could be said to be greater than the reality.

The woman went on to have another baby and asked Vicky to be her midwife again:

It was good. There was some healing that took place. I thought that if they came back to me then I guess that meant that they felt that I didn't do anything wrong.

It took the woman's belief in Vicky and her ability as a midwife to enable some healing to take place. Vicky was glad to be asked and even happier to accept this role in their family, again. The faith the family had in Vicky confirmed, for her, their belief that she had done nothing wrong to cause the loss of their last baby. Vicky would have felt vindicated at least and defended from others who may have doubted her. To be asked to step back into stride with a family that has walked the path of loss must, surely have been an absolute blessing for Vicky.

Conclusion

The intensity of each midwife's story of caring for a woman who has had a stillbirth reflects the deeply personal journey travelled. The midwife is entrenched in the woman's experience and this, in turn brings the midwife into the experience loop that encircles them both. Although each midwife attempts to unravel their experience from their own personal perspective, there are commonalities that are apparent. The sense of loss is highlighted and also shared between both the midwife and the woman. The midwife is seen to be searching for meaning, searching for solace and searching for validation of both herself and her midwifery practice. The midwife's practice is always to be found within her lifeworld and this could be seen as describing the midwife's "being-in-the-world". The meaning found is what informs her 'being'.

Chapter five provides further interpretation and the emergent themes that developed from the narratives.

Chapter Five

EMERGENT THEMES

Introduction

The purpose of this study was to listen to the experiences of midwives who, for the first time cared for a woman who had a stillbirth. My hope was to firstly 'hear' their stories and secondly to take notice of what was said. This chapter represents discussion of the key themes that emerged from the stories told by the five midwives interviewed.

The experience of caring for a woman who has had a stillborn baby could be seen as a double tragedy. When a baby is born still, the woman and her family and the midwife caring for her enter a time and place of struggle and pain. The woman and her family are expecting a healthy live baby: a baby that has been in their dreams, and its arrival, anticipated. For the midwife, she too is expecting a healthy live baby but she is also aware of the twists and turns pregnancy and birth can take, often without reason or warning.

While sitting with the text of the interviews I was aware of the possibility of there being multiple interpretations of what was said. I was also very aware that beneath what was said were other layers of meaning. This could be said to be the whole point of interpretation of text. I was looking for exactly that, looking beyond the story itself to also take heed of what was not explicitly said, what was hidden, yet glimpsed. My interpretations are constructed by how I heard what was said. I identified phrases that related to the phenomenon and delved into those phrases to find meaning. I am also mindful of the risk van Manen (1990) mentions that to see the experience as text only, would be to risk seeing only part of what happened. The symbolic nature of the phenomenon may well be lost in translation. The complexities of the midwives' experiences deserve more than a cursory glance.

Overview of Findings

Two main themes appeared out of the text. They represent how the midwives made sense of the experience and gave meaning to their narrative. They described what was 'out there' as an event and brought it back closer to themselves as their personal experience. As Davis suggested, the meaning is not in the object but is "located in the individual's inner life" (as cited in Willis, 2001, p. 3).

The first theme is based on each midwife's immediate response to the death of the baby; that is a response of intense grief. The reactions described by all the midwives correlates with grief responses that are described in the literature. These responses seemed to overwhelm them and often took them by surprise. They tried desperately to keep their responses hidden but this seemed to be too difficult.

The second theme relates to an even more personal path the midwives travelled. This theme talks of the midwives' own feelings of sadness about the loss and their personal concept of death. This theme is more reflective and covers a longer period of time post-stillbirth. The feeling of empathy is highlighted with this theme and shows perhaps a more spiritual concept. This contemplative reaction seemed to be more emotionally and spiritually confronting. This was a time of introspective conceptualisation of the 'meaning of things.' Beyond the initial response to the loss, the midwives sat with a feeling of sorrow that, for some felt like a 'heavy heart'.

Pocket Full of Grief

Shockwave

It has been suggested that health professionals working in bereavement care, may well have emotional responses to the death of a patient (child) and the practitioner may experience physical, emotional, cognitive, behavioural and/or spiritual distress (Keene, Hutton, Hall & Rushton, 2010). This research has shown evidence of the midwives experiencing personal grief and so, reiterates this idea. The stories of physical and emotional distress felt by the midwives interviewed in this research were very evident.

As soon as the realisation of the baby's demise entered each midwife's consciousness the impact was like a shockwave. Jill remembers her heart dropping, with a thump

down to the floor. Vicky's response was one of shock and horror, so much so that she had to leave the room to 'let rip' with her emotions.

I was sobbing so I went into the tea room and let rip. I just felt dreadful. I was a sobbing mess. All I know was that I was a distraught mess. It was shock, horror, just 'Oh, my God!'

Vicky

Lou felt physically knocked by her experience and she talked about feeling angry about being left on her own to figure out what to do. Mary felt herself physically shaking and that left her feeling that she was unable to function.

My mind was just mush... I just stood there like a stunned mullet.

Mary

In the days that followed Mary's emotions were always close to the surface. If anyone looked at her with a sympathetic gaze, she would say to them:

You can't look at me like that because I am going to burst into tears. I would just sit there and bawl.

Mary

It is of interest that Keene, Hutton, Hall and Rushton's (2010) writing acknowledges the responses as being holistic in nature. Not just a physical sense of distress but also behavioural and spiritual distress. McHugh (2003) suggests that midwives often do not recognise the sense of the spiritual within their work environment and the role that this plays in their life experiences. Pembroke and Pembroke (2008) suggest the term spirituality is defined as "the quest for meaning, purpose and edifying values" (p. 322). This notion is not necessarily related to a religious construct but more of a concept through which the spirit-being comes to know itself as it is. The findings of this research add substance to this suggestion; midwives may feel spiritual dissonance when caring for women who have had a stillborn baby. The midwives may not put their feelings into a concept of spirituality but certainly describe a sense of *not all being well in their world*, of uncomfortable feelings of confusion or personal disharmony. These feelings may not be immediately apparent but for some, this spiritual context sits with them sometime over the event.

What had happened hit them like a shockwave, a jolt that left them feeling overwhelmed by the event. The suddenness of their own realisation that, in fact the baby was not alive but still. The concept of the midwife feeling shocked is supported by research done by van der Putten (2008) in a qualitative study of newly qualified midwives. They reported experiencing a reality shock when they found themselves in a situation for which they thought they were prepared but suddenly found that they were not.

Heidegger (1962) talks of thrownness or a sense of being projected into the unforeseen. In this study each midwife was thrown as she realised the reality of the situation; the baby was stillborn or was going to be stillborn. Heidegger proclaimed that our Being-in-the-world is a thrownness and therefore we are thrown with “neither prior knowledge nor individual option into a world that was there before and will remain there after we are gone” (Steiner as cited in Hornsby,nd). The ‘thereness’ which is all encompassing, is already ‘there’ even if the midwife did not acknowledge or attend to the existence or possibility of this thrownness. The possibility of the baby being stillborn was unnoticed or unthought-of although all of the midwives knew it was possible. The midwives’ being with others (Heidegger, 1962) in their own thrownness suggests the understanding of the presentness of others, to care for others. As Heidegger also states, we (the midwives) are, at any given moment of our lives “where we have been thrown” (Heidegger, as cited in Fox, 1997, p.1). This ‘thrown into the world’ is one of the notions of *Da-sein* or ‘Being-in-the-world’. As suggested by Yurkiewicz, a medical student who shared her personal reflections on grief and the health professional, (2011, para. 4) there is the potential for the health professional (midwife) to hit an “emotional wall”. Reflecting on what the theorists describe as a normal grief response, many of the immediate responses by the midwives can be seen in these theories. The feelings of shock, denial, anger and guilt were all evident. These reactions are all considered predictable by theorists such as Bowlby (1981), Kubler-Ross (1969) and Worden (2003).

Fenwick, Jennings, Downie, Butt and Okanaga (2007), in their research on aspects of care for midwives when providing perinatal loss care, found that midwives described

being emotionally overwhelmed. Midwives reportedly found it emotionally draining to deal with their own shock as well as witnessing the trauma experienced by the woman whose baby had died. The concept of the midwife feeling a shockwave revisits this concept of the midwife feeling overwhelmed, emotionally. As Kubler-Ross (1969) suggests in her writings on grief, the grief response can be initiated by perceived personal trauma and not just death and dying. Perhaps the phrase empathetic grief could be suggested and the findings of this research would support this notion. In this paradigm, this notion could be defined as the ability to sense the woman's private world and to communicate this understanding so as to validate the world as perceived by the woman (Sabo, 2006).

Midwives are perceived as caring practitioners, a taken for granted aspect of their professional persona (John & Parsons, 2006). It is therefore anticipated that they too are affected by the death of a baby. Ewing and Carter (2004) from Vanderbilt Neonatal Intensive Care Unit in Nashville acknowledge, in their discussion paper on supporting staff caring for grieving families, that the personality trait of caring can, in turn, increase the nurses' (midwife's) vulnerability to the stressors inherent in serving others. The care the midwife provides to the bereaved family is complex and is associated with the personal relationship the midwife has with them. This sense of attachment that is felt is real and the grief felt is also real.

Denial + invisibility = Self -protection

For the midwives in this study, the experience of stillbirth found them searching for a place of self-protection. Some used denial and others used invisibility. It seems that in our physical presence we can both reveal something and we can hide something at the same time, often not consciously but as a way of 'being' (van Manen, 1990)

...but now I don't want to have a bar of it. I just don't want to talk about it anymore.

Mary

Mary had talked and talked about what happened and then wanted to forget it had ever happened. Mary's perception of time passing changed depending on her own needs to dwell in the event. She saw time as her saviour when she wanted to talk

through the events but then it turned into the enemy when she wanted to turn away from the events. In essence she was experiencing lived time (van Manen, 1990), a subjective concept of how time passes. Her impression of time passing impacted on how she coped with the stillbirth. Time had given her space to talk about the stillbirth, to deliberate with her colleagues as a way of finding solace and comfort. As time passed her need for the events to be hushed in her mind saw her wishing for time to speed up. She needed to escape the reality as she believed this to be easier than constantly confronting what had actually happened. To help hide from the pain of now she decided to keep a low profile for a few weeks so as to vanish out of people's thoughts. Mary's anticipation was of relief 'in-the-future' and although the future was unknown, its appeal for Mary was the possibility of the lessening of the emotional pain she was experiencing in the present.

Jill remembers being in a sort of a daze, just functioning rather than spending time thinking about the dead baby. Fay remained detached to the reality by being thankful that she was not the one to tell the woman of her loss. These strategies were used as a way of protecting themselves from whatever they dreaded.

Morrison (2007), in her study on vicarious trauma and the health worker, talks of trauma reactions such as avoidant reactions. If the practitioner is able to avoid the issue for long enough then it may well become invisible. To continue to talk about it and think about it was more than likely going to keep the wound (the memory of the event) raw and painful. Some of the midwives reported feeling numb and found it hard to accept what had happened. Vicky's escape to a place of perceived safety and a place that was not connected to the horrible events was evident in her statement:

So I just went home...

Vicky

Vicky's home was seen as a space of refuge, a space that was hers and somewhere she felt protected. In her 'lived space' (van Manen, 1990) she felt she could be herself and not the midwife. The concept of space is not necessarily made of bricks and mortar but more of a place of 'being'. Van Manen described the concept of home as somewhere "where we can *be* what we *are*" (1990, p. 102). In Vicky's situation, she could be Vicky and not the woman's midwife.

Kubler-Ross (1969) suggests that in a grief response there is often an initial sense of denial. This is seen as a temporary defence that is often used as a buffer that allows people to collect themselves and their thoughts. The midwives' stories certainly ratified this. They were buying some emotional time to come to terms with the reality of the situation. Keene, Hutton, Hall and Rushton (2010), in their paper on bereavement debriefing sessions for health care professionals, suggest that the opportunity for health care workers (midwives) to process personal and professional responses to death is important yet they suggest these opportunities are lacking, in reality. The stories, in fact, highlighted the desire for these midwives to find some space to acknowledge their own fears and anxieties surrounding the stillbirth, both from a clinical perspective and from a personal place of vulnerability. This phenomenon is said to be a self-defence mechanism that distracts from the reality even for just a short time. Bowlby and Parkes (as cited in Stolberg, 2011, p. 8) talk of a time of disorganisation that may involve a host of worries and fears. Feelings of anxiety, helplessness and/or insecurity are common. Fay tried to avoid the news that one of her clients had been diagnosed as having an intrauterine fetal demise and needed inducing:

Oh, I almost didn't want to know.

Fay

Mary found herself totally overwhelmed by the news that the baby was dead and declared that she didn't know what to do. Lou even tried to cajole the baby back to life by appealing to his better nature:

I kept on telling her to talk to her baby. Tell him that you want him to stay, that you want him to be here. It's OK to be naughty for a little while but now it's time to start behaving.

Lou

Vicky didn't have much time to come to terms with the death of the baby. She found herself very quickly involved with catching the baby:

You can't get your head around the fact and then been left to catch this little one

Vicky

The findings of this study illustrated the common thread of each midwife trying to escape, even for a short period of time, the realness of the death. In an effort to protect themselves from their own responses, they used a variety of unconscious/conscious actions to draw themselves away from the situation. Whether it was in the form of rejecting the notion that the baby had died, avoiding their connection with the event or running away, they all described self-protective behaviours. Hunter (2001) talked of this idea of invisibility in her paper on the 'emotional labour' of midwifery and suggested that this concept of midwives needing to hide was largely unacknowledged. These research findings suggest that midwives distanced themselves from the potentially distressing and deeply challenging emotions that may be evoked by caring for the woman who has lost her baby. This generally happened post-birth so this may imply that the midwives involved in this research were able to or felt they had to hide their feelings until they could 'hatch an escape plan'. In essence, they remained professionally focused on the woman until they felt safe enough or far enough away from the woman to let their feelings out.

Returning to Heidegger's (1962) notion of 'thrownness', for the midwife to make sense of where she has been thrown, Heidegger says that she must take over her thrownness, to find a way back to her thrownness and *be it*, rather than run from it, evade it or cover it over. As Heidegger states, 'this means to let *it* come to us in its own way' (1962, as cited by Fox, 1997). By metaphorically turning around to face the reality that there is no escaping the truth; truth becomes the truth. It is then that death becomes real to them and the realisation that there is nothing they can do about it. They are involved in this tragedy, whether they want to be or not.

Blameworthiness

As with any adverse outcome involving birthing, the midwife involved is potentially going to hold the mantle of blame. The self-doubt and questioning is often prolonged and distressing.

Why did it happen? What did I do wrong? How did it happen? Yeah .What did I overlook? What didn't I see happening? Yeah, all those sorts of things. What could I have done differently? It was quite raw.

Jill

Jill's mistrust of her own actions when reflecting on the events felt raw and painful. The questions she asked herself were almost unanswerable. They illustrate the immense pressure midwives put on themselves to have all the answers and do nothing wrong. The role of the midwife is complex and although, theoretically constructed by the woman, the midwife sees herself through the eyes of those around her. Heidegger talks of uncovering the 'who' or the midwife's sense of self and suggests that this sense, this description of 'self' is constructed from the outside rather than from within 'oneself' (1962). The midwife interprets herself from how the world sees her. That is how a midwife is or isn't in the everydayness of being a midwife. Dasein or 'being-in-the-world' (Heidegger, 1962) is already present and the midwife is not the cause of the situation rather she finds herself being-in-the-world regardless of what she did or didn't do. The midwife is 'thrown' into the world already before her and the possibilities of who she is, becomes apparent. The midwife did not choose to be in this situation but through her 'thrownness', she can choose how to be with how she was thrown. As Fox (1997) interprets Heidegger's notion of 'thrownness'; the midwife may be completely innocent in her thrownness but is absolutely responsible for how she relates to that 'thrownness'. When the midwives' 'thrownness' is disclosed to her she responds with a bodily felt sense. One of the senses highlighted from these research findings suggest the sense of 'blameworthiness'.

If the philosophical underpinnings of her relationship with the woman are based on partnership then, together they share the knowledge. The midwife brings her own "midwifery intuition, scientific knowledge and experience" and the woman brings "her intuition, intrinsic wisdom, self-knowledge and experience" (Guilliland & Pairman, 1995, p. 45). If the baby is born still, then perhaps the assumption may be made that the midwife did not live up to the shared expectations. Both the midwife and the woman may ponder these possibilities; if the she (midwife) had *checked* more frequently, if she had *known* more, if she had *seen* more, this tragedy may not have happened. These are natural questions that such events lead us to ask of ourselves. If all is well with the woman and the baby, then the midwife is doing her job. It seems ironic that when the baby is stillborn the midwife defaults to self-blame. The term "the wholeness of things" (Fowler, 2008, p. 53) could be interpreted as things being free of mistake or impairment. Everything is just right and as it should be. The never

ending quest for this state of equality and equilibrium undoubtedly motivates the midwife to do the best by the woman, the baby and by herself. When things do not show themselves as being the epitome of perfect, the midwife is potentially going to feel responsible.

A Heavy Heart

Touched by death

Most people are touched by seeing others in emotional pain and these midwives were no different. For midwives who normally work with wellness and life, to care for a woman whose baby is born still can bring on a feeling of melancholy.

It is like a heavy 'yuk' in your tummy. It's in your chest. It's not a weight but it's heavy

Lou.

Lou's response to the realisation that the baby was not going to survive touched her on a deeply spiritual level:

Deep down I knew that baby wasn't destined for these islands, baby was destined for elsewhere. That whole experience broke me as a midwife. I would be the only one who knew what it felt like to feel that baby slip away beneath my very hands.

Lou.

For Lou, this feeling was deeply personal and shared by no one else.

The impression of being touched by death is defined by each individual midwife's cultural conceptualisation of death. For some, death was an inevitability that we will all face. For Fay, she approached death as a sad reality of life yet a reality that is part of the midwife's job:

It is sad that anyone has to have a dead baby but where there is life there is death and death hurts.

Fay

The professional role of the midwife was clearly articulated by each interviewee and this initially supported their response. It could be said that as soon as each midwife

had acknowledged her professional role she then could put words to the layers below this outward persona. They could then acknowledge their own personal journey of coming to terms with the death of a baby. These findings would suggest that for each midwife, the construction of their own meaning of death was vital for them to integrate the experience into their own social construct. This is seen as the midwife organising and developing their own personal story concerning the stillbirth, as if to pay homage to the events by telling the tale. There is evidence of this process being incredibly challenging for some of the midwives in this study. The notion of personal sorrow or sadness was discussed by all the midwives.

I think I am quite emotional and I am touched by death very easily.

Fay

Hunter (2001) suggested in her paper on the emotional work in midwifery, that the profession is an “emotional minefield” (p. 441). This concept certainly supports the battle these midwives experienced, albeit a very personal one, when trying to find meaning in the death of these babies.

Why do bad things happen to good people? I don't know, I just don't know.

Vicky

For Vicky, the cruel twist of fate of losing a baby to stillbirth was hard to accept. She could not see that anything positive could ever come from losing a baby. For her, the social context of death was seen almost as a punitive result. This was illustrated by her comment about bad things happening to good people. This comment may well have been based on her own concept of the finality of death and the witnessed trauma of the bereaved parents. It could be suggested that Vicky saw the death of an innocent baby as wrong on many levels and this experience challenged her belief system of ‘good versus bad’.

It could be surmised from the findings of this research that midwives who care, for the first time, for a woman who has had a stillbirth, may well find themselves having to take the time to reinvent their own personally held assumptions about the meaning of life/death. It may well be the first time that they have been confronted with what was, until now, a theory of what could happen. The ontological experience impacts them

unexpectedly and to significant depth. Perhaps nothing could have prepared them; one has to live-through to 'know' (Heidegger, 1962).

There seems to be some sense of paradox with each midwife's narrative. They all described a 'lived body' (van Manen, 1990) perspective that seemed to reflect an extremely personal emotional response even though their physical experience was quite separate from this. They were not the ones birthing the still baby yet they had a sensation of loss that could have been interpreted as their loss. Being with the women as they birthed, the midwives perhaps concealed their own lived experiences of loss and these events reignited the fear, the vulnerability and the feelings of deep sadness that the experience of loss brought with it. The *space* in which they found themselves affected the way they felt. Van Manen (1990) talks of this as being the 'lived space' or the space that we experience *being-in*.

To be touched by death one needs to understand death or at least have a personal interpretation of the concept of death. Interpretation always occurs in the context of the world as we are in it. It occurs in the way that midwives are with a woman and how they can 'be' with her, what Heidegger called '*Dasein*' (1962). By '*being*' with the woman, the midwife shares 'lived time' with her and 'breaths the same air' as the woman. It could be questioned if the concept of death has only a biological significance or is it more about being the 'end of something'? It could be suggested that death is commonly interpreted as being 'lifeless' (Heidegger, 1996) and this is why these midwives were so 'touched by death'. Their normal professional experience is of 'life' and the expectation of birth is life. Heidegger explains understanding as "...the existential being of the own most potentiality of being of Da-sein in such a way that this being discloses in itself what its very being is about" (Heidegger, 1996, p. 135).

Empathetic loss

For all the midwives, one of the more personal and private experiences was of a sense empathetic loss. The loss of the baby was felt by each midwife as if they had suffered a similar loss or at least had the potential to lose a baby. Vicky had a sense of disbelief:

I couldn't even imagine losing a baby. That's your baby you know?

Jill

If empathy is the ability of one to identify with another person's pain then these midwives certainly exemplified this skill, whether they consciously thought it as a skill or not. This experience of reality transcended doing 'what was right'; it had become much more personal than that. When they personally identified with the pain of each woman and her family who had endured such a terrible loss, they brought their grief, fear and despair into their own awareness and experience. Lou literally put herself in the woman's shoes, imagining that the desperately ill baby was hers. This compelled her to keep resuscitating the baby that lay in front of her.

What if that was my baby? What if that happened to me? What if that was my baby on the table and the midwife couldn't let baby stay or couldn't keep baby around?

Lou

For each midwife, the concept of losing a baby was seen from their own world view: what would it mean to them to lose a baby and how would their own personal and unique lifestyle be impacted by such a loss? Their feelings were real and authentic, as if they had actually lost a baby to stillbirth. Mary felt that it was inappropriate to continue normal day-to-day activities because:

I've just had a dead baby.

Mary

The theme of empathetic loss may indicate that each midwife in this research enters into the lived agony of the woman who has lost her baby. The relationship formed between woman and midwife includes a sense of empathy by the very nature of that relationship. This was not seen as undermining the woman's grief, rather more as a reflection of the empathetic response to what the woman had experienced. Their shared lived experiences seem to have overlapped even if the midwife's grief was

anticipatory and the woman's grief was actual. These findings could suggest that the midwife felt a sense of loss in her core-self, a place of essence, where personal meaning and understanding sits. The midwife was part of the woman's reality and felt her emotions. It could be interpreted as this empathy being a double-edged sword for the midwife; on the one hand, this empathy illustrates 'being-with' the woman; on the other hand, the act of 'being' leaves the midwife vulnerable to this very act. Heidegger's Dasein, 'a human being in the world', operates out of a sense of 'concern' for the world around us. It talks of our "humanness which is capable of wondering about its own existence" (Heidegger as cited in van Manen, 1990, p. 176). In order to 'understand' the grief of another the midwife uses her imagination to wonder about the woman's lived experience. By 'being-in-the-world' as a midwife caring for the bereaved woman, the midwife can dig deeply into the meaning of the phenomenon- *the loss of a baby*. By being more than just "a sensitive observer" (van Manen, 1990, p. 29) the midwife sees the experience and rather than just visually constructing meaning, the midwife's sight is all encompassing. Meaning is found for the midwife by being with the woman's grief in a place of empathy, where a caring presence is evident. This existential engagement (giving meaning & value) can be acknowledged when the midwife takes on the grief and 'feels' it herself. The awareness of grief is concealed until it is revealed by those who are touched by it. As Heidegger suggests "Death does not reveal itself as a loss, but as a loss experienced by those remaining behind" (1996, p. 222) therefore the feeling of loss is felt by those who are left by the 'not-there' baby.

Broken

To define what was actually 'broken' may well be difficult to determine but from the narratives, it could be suggested that what was broken was the midwife's purpose or 'midwifery heart'. It could also be interpreted that the sense of 'being broken' could have been a sense of been 'broken open'.

Ball (2005) suggests that the heart represents the centre of the being and represents 'feeling' wisdom rather than 'intellectual' wisdom. It is also representative of compassion and understanding. So, it could be anticipated that for a midwife who is caring for a woman who has had a stillborn baby, her lived experience of this could be felt in her heart.

That whole experience broke me as a midwife. It really, really upset me. So those days were really important to me to re-build myself after I had been broken and I did a lot of thinking. There was a lot of transition within me. There was a lot of re-growth and development. I don't think I would have been well enough to continue practising to be honest. I was thinking that I probably wouldn't even go back to work when I got back. Because this baby that I had lost, I was blaming myself really.

Lou

The narratives had a common thread of 'otherworldliness'; that the experience was bigger than just the woman and the midwife. The experience of meaning was characterized by a sense of connectedness, of being embedded within a larger whole. Caring for a woman who has had a stillbirth transports the midwife to a place that talks of the sacredness of birth and death. It perhaps opens up a dimension of possibilities that may offer solace to the midwife that she was not merely a 'hostage of fortune'.

I have a different understanding of life and death now

Lou

The silent sorrow that the midwife feels is heart breaking for many. Acutely aware that many believe they have no right to be grieving; the pain of loss is felt in a place of solitude. The midwife herself often devalues the loss as not belonging to her and therefore keeps those feelings of grief hidden.

It is a loss to us as well but it is worlds apart. But nobody really takes care of you when something like that happens.

Vicky

It was frequently acknowledged by the midwives, themselves that the loss was not theirs yet they responded, with what resembled a grief response.

It's not my grief, well it is my grief because I am sad for the people but I'm not sad for me. It's not my place to be sad for me. I'm sad for the woman. I'm sad that anyone has to have a dead baby but where there is life there is death.

Fay

Romesberg (2004), in her discussion on understanding grief, validates these findings by acknowledging the personal journey with grief that each midwife (nurse) takes whether it is publically or professionally declared. Her writing suggests that health professionals (midwives) often struggle to accept the death and share in the grief, loss and fear experienced by families. It is also suggested by Romesberg that the midwife's

grief is often downplayed because of the clinical setting. Papadatou (2000) reported that the grief experienced by health professionals (midwives) “is an ongoing fluctuation between experiencing and avoiding grief reaction” (p. 64). The findings of this research are therefore validated by both Romesberg and Papadatou’s writing on this issue.

For the midwife to feel broken implies that their personal investment in the relationship with the woman and baby was such that she was at risk of feeling this way.

You both want the same outcome-the same invested interest in the outcome.

Vicky

Ironically the innate philosophy of midwifery is to *be* connected, to *be* invested in the journey and to *be* the woman’s “professional companion” (NZCOM,2008, p. 5). As Flint (1989) suggests, the relationship between the woman and midwife is “a close and intimate one...midwives and women are intertwined” (p. 14). For the midwife to work in partnership with the woman is paramount to the midwife. The midwife’s involvement in the relationship may well lead her to have emotional liability and not a lot of space to acknowledge the spiritual dimension of that relationship.

The thing that upset me more than anything was the fact that this can affect you more than anything. You have these preconceived ideas about how you’re going to cope and you can cope because you have coped forever. You know, carry on, carry on, carry on. But sometimes you have to be more than just a person...

Jill

The midwife’s interpretation of her thoughts, in this instance, suggests that she could be seen as being in a place of personal /professional crisis. The shakiness of the midwives’ experienced world is mirrored by the shakiness of the midwife’s inner hidden world. It could be suggested that the midwives felt a loss of purpose and that is where the common reaction of grief originated. Their lived meaning of being a midwife has been challenged. Suddenly their ‘knowingness’ about their role has been altered. Could it be that their anchorage was lost? As Yang, Staps & Hijmans (2010) suggest, in their writing on existential crisis;

That it is evident that in human existence there are many things and events that cannot be understood or controlled in an active and rational way. They cannot be interpreted within an existing system of meaning and they escape the control of familiar coping strategies. (p. 57).

Their perceptions of what was happening became a disorganised tangle of inner-conflict. Their clarity of purpose was gone and what they believed to be predictable 'midwifery work' was heading down an unfamiliar and daunting path. The midwife's lifeworld or way-of-being in the world had changed. Heidegger (1962) said that to know something is a touchable kind of Being-in-the-world which implies that with this knowledge of loss and grief, each midwife was there with each woman and could share their grief also.

*I didn't know what to do. You have a care plan for a live baby not a dead baby.
What do you do?*

Vicky

For most midwives, their role is intimately entwined with the philosophy of partnership with the pregnant woman. Together they will work towards the ultimate goal of healthy mother-healthy baby. This rationale is based on the concept of mutual respect, individual and shared responsibilities (NZCOM,2008, p. 15) and the woman being central to all care. The commonly accepted meaning of the word midwife is "with woman" (NZCOM,2008, p. 5) and therefore midwives are joined in a relationship with the women that has multi-layered dimensions. To be "with woman", the midwife connects with her in a holistic way which may include being emotionally, spiritually, physically and culturally attuned. As Ina May Gaskin suggests in her seminal text, *Spiritual Midwifery* (1990) each birth is a spiritual experience that is concerned with the sacrament of birth. She goes on to suggest that women need midwives to "nurture them through the very impressionable and vulnerable period of pregnancy, labour and birth, and the time following birth" (p. 14). When this path deviates from the common purpose of both woman and midwife, the midwife may be disconnected from the original intention of her relationship with the woman. If the intent of the midwife is to nurture them (mother *and* baby) through this time and she is unable to do this because the baby has died then the intentionality of being a midwife has been impacted. The relationship that remains is now defined by a different set of parameters. As van Manen (1990) suggests, "Intentionality is only retrospectively

available to consciousness” (p. 182) and this could highlight the reflective nature of the midwives ‘brokenness’. In essence, the midwives’ grief was announced through their ‘brokenness’.

I have live bobbies not dead ones.

Jill

These findings could suggest that the concept of being broken is one that could also mean crushed or damaged. The prospect of recovery is however, apparent. This could imply that the midwives were able to regain some of their midwifery faith, not instantly or particularly easily but there is a sense of possibility. The final comments from the midwives had a sense of healing and revival. Lou talked of her return from her time in the Pacific and sums up her sense of being re-invented albeit with some scars;

The midwife before was excited and naive and the one coming back was a different midwife. I have a different understanding of life and death. Now that I have experienced the death part, I have a different understanding of it. I wouldn't say that the wound is raw and nasty but it is like a heavy 'yuk' in your tummy. It's in your chest. It's not a weight but it's heavy.

Lou

Conclusion

Through the themes of this research a deeper understanding was gained of the lived experience of community based midwives who cared, for the first time, for a woman who has had a stillbirth.

Midwives are aware that the care they provide to bereaved women and their families is pivotal in how they cope with the loss of their baby. The midwifery action of caring for a woman and supporting her through the experience is fundamental to the midwifery model of care. The woman and her baby are central to all that the midwife does. The midwife’s consciousness has an active part in her practice, whether this knowing is intuitive or is evidence-based. Irrelevant of how the midwife knows, her actions are *with* and *for* the woman and her baby.

This concept of being with the woman is not just a physical locality but a journey travelled together. The findings of this research suggest that the journey through the loss of a baby is navigated personally and privately by each midwife. Each step of the way, the midwife steers her way between providing situation sensitive care to the woman and her family and coping with her own intense and overwhelming feelings that are often hidden and not spoken of. There is no map to follow on this journey but rather a sense of finding your way. Hearing these five midwives' stories it is suggested that they came out of this experience with an altered concept of themselves as midwives. Some were weary and scarred and others were quietly reflective about the meaning of it all. It is also suggested that these five midwives experienced something that changed them and their midwifery practice, forever. Individually each midwife gained practice wisdom that cannot be taught or scripted. They were taken to uncharted territory and deciphered the experience in their own unique way.

As midwife, Lori Wrangle, discusses in her Birth Change blog "Midwifery has brought me to my knees, made me go to depths I wouldn't have chosen to go to and broken down my soul many, many times, but through it all, it has remained a constant, powerful force that reminds me of what it means to serve humanity and contain the empathy of the world in your heart" (September 26th, 2010). This commanding statement seems to speak to the lived experience of the midwives interviewed in this study and the empowerment of the midwife by some of the women.

Chapter Six

IMPLICATIONS

Introduction

It is clear from the findings that midwives experience significant impact, not only professionally but also personally, from these experiences. Through hearing the midwives stories of disenfranchised grief, self-doubt and perceived blameworthiness, the wider midwifery community can gain a deeper appreciation for the lived experiences of their colleagues providing this type of care. Their reflective thoughts finally seemed to give them a sense of knowing what it is for them to be a midwife. The midwives who have had this experience have perhaps finally felt heard and can put words to their often hidden feelings. What once was unspoken and unheard can now be given a voice that all midwives will hear.

Implications for Practice

Midwives' experiences of caring for women who have had a stillbirth seem to be unspoken yet much thought about encounters. There seems to be a silence around the impact these situations had on the midwives involved. The first time each midwife faced the reality of actually losing a baby they 'closed-up, shut-up and locked-up'. That is to suggest that they all went into a mode of survival, both professionally and more worryingly, personally.

It seems incongruent that although midwives work so closely with life and birth everyday they do not seem to recognize the closeness of death. It could be suggested that where there is life there is also death. The actual real-life implications for the community based midwife when caring for a woman who has lost her baby seems to have been underestimated at best and ignored at worst. It is the accepted culture of midwifery to underplay the lived experience of the midwife while prioritizing the lived experience of the woman and rightly so. It is true that the childbirth story is the woman's story to tell and the midwife's role is to 'turn the pages', that is not debated. What may be contemplated is the midwife's version of the scenario. If the midwife bears witness to the woman's journey then when does her version get heard? When

does her experience matter? Perhaps it never does but if the findings of this research reflect the authenticity of the midwife's experience then it could be suggested that the midwife's story also needs to be heard.

Midwives are expected to holistically connect with women in a personal and intimate manner, as shown in the partnership model of care. It is stated by Flint (1986) that "women and midwives are intertwined- whatever affects women affects midwives and vice-versa" (p. 14), yet this study suggests that the impact of this partnership is seldom acknowledged, especially in the case of stillbirth. The professional persona of the midwife is frequently described as "the accompanying, experienced, knowledgeable and supportive presence" (Guilliland & Pairman, 1995, p. 46) where the midwife provides woman-centred care that captures the needs of the woman. Being-with-others and having concern for others is a caring paradigm that implies that when the midwife cares for a woman she commits to the lived-experience of that woman. When the experience does not fulfil either the woman's or the midwife's expectations then both are impacted. Because of the midwife's emotional investment in caring for the woman, the loss of a baby is often an emotional deal-breaker.

Self-employed or community based midwifery is now very much part of the New Zealand Maternity Services psyche and midwives are very conversant with this model of care. There has been some reflection on *how* the midwife manoeuvres her path through the unexpected outcomes that can occur and how she manages these situations as the Lead Maternity Carer. The New Zealand College of Midwives has produced a booklet for midwives who are involved in a case that results in an unexpected outcome (NZCOM, nd). This resource could be immensely helpful to midwives with information of the legal and professional issues surrounding this clinical situation. The booklet covers the concrete and task orientated concerns that the midwife may need to attend to. It also encourages the midwife to seek support from family, friends and colleagues. This booklet is a step in the right direction but this research implies that perhaps the midwife can't or doesn't feel able to share the true impact of her experiences with those closest to her.

If the impact described by all five of the midwives in this research is a shared experience of other community based midwives, then it could be suggested that these

findings highlight the urgent need for a framework of support for midwives when caring for bereaved women and their families. This support does not have an obvious appearance at this stage but it is suggested that time and thought be dedicated to developing a supportive process that acknowledges the needs of midwives who work with bereaved families.

The themes developed from this study also suggest that future analysis and reflection be used to assess the effects of stress and other psychosocial factors on the health and well-being of the individual midwife and this needs to be grounded in an historical understanding of midwifery experience. It is hoped that just by hearing other midwives' stories and experiences of caring, for the first time, for a woman who has lost a baby, that other midwives personally and professionally acknowledge the concept of loss and the midwife. Bereavement debriefing sessions, both one-on-one and in groups, could be seen as pivotal in providing the midwife an opportunity to reflect and process her experiences in a safe, nurturing and holistic manner. But it is suggested that the builders or designers of such a framework ask the midwives themselves what they want before assuming a 'one size fits all' approach to this bereavement support.

Additionally, this study demonstrated the impact that both professional and personal paradigms of caring have in defining and perpetuating our beliefs and feelings of the role of the community based midwife in New Zealand society today. Support from midwifery leaders is essential for the profession, as a whole, to accept that disenfranchised grief is real and affects midwives not only as community based midwives but across all midwifery workforces regardless of work locations, space and time. The establishment of professional bereavement programmes for midwives (bereavement teams) is suggested to enable provision of innovative and comprehensive support for midwives who care for bereaved families. From this research, it is proposed that two of the key intentions of the bereavement team are to enable the midwife to find meaning in her experience and to acknowledge this as potentially being a high-impact experience in her midwifery career. The midwife is therefore supported to find appropriate coping strategies and is able to redefine her experience in a more positive light.

Cowan and Wainwright (2001) capture the essence of these proposed bereavement teams when they state:

If the bereaved midwives' needs are met, she will learn from experience, adapt her assumptions about midwifery, integrate the experience and move on- hopefully to enjoyable, confident, optimal midwifery practice with a more sophisticated appreciation of the complexities of childbirth (p. 316).

Implications for Education

This research may be used to broaden our understanding of how midwives experience stillbirth and may lead to changes in our educational approach to stillbirth. Midwifery educational programmes, at both undergraduate and post graduate levels, are encouraged to facilitate authentic debate around the practice reality of caring for a woman who has lost her baby. Open, realistic and accurate discussion on the lived experience of the midwife who provides bereavement care may be seen as a genuine attempt to highlight an aspect of midwifery care that commonly evokes fear and vulnerability in students. As part of the proposed story-telling the learners will be able to consider their own feelings around death and explore their own cultural concept of bereavement. By acknowledging these issues in a safe and nurturing environment, the students may well begin to reflect on how *they* feel they may cope in this situation. Through dialogue the students are able to integrate new and shared understandings into their own lived stories; from the past or in the future.

Offering clinical information that reflects best practice and in turn supports the midwife's practice could be seen as crucial for the learner's sense of clinical preparedness. It is not, however, suggested that the educational objective be the institutionalisation of bereavement care. Instead it is suggested that the curriculum include a narrative approach to gaining insight and knowledge around providing bereavement care. This facilitates care that is situation sensitive and acknowledges individual differences in grieving families rather than midwifery care based on protocols.

Developing strategies to help the student midwife build both resilience and self-nurturing practices could also be seen as a vital component of midwifery curricula. This

may well enhance the student's degree of professional agency needed to navigate their own way through this experience. Similarly, discussion around the professional support available to midwives through the New Zealand College of Midwives, is an important educational topic that informs students of the on-going role of this professional body.

Midwifery educators should be encouraged to include information on possible divergent grief responses and the concept of empathetic loss in the midwife caring for bereaved parents. By focusing on these variable responses the student midwife can see how their own grief response may unfold and allow them to acknowledge the possible professional and personal impacts of this care scenario.

The following quote seems to reflect the challenges faced by midwifery educators and midwifery students alike, when thinking about gaining *knowledge* about stillbirths:

There can be no knowledge without emotion. We may be aware of a truth, yet until we have felt its force, it is not ours. To the cognition of the brain must be added the experience of the soul. Arnold Bennett (1867-1931)

Implications for Further Research

This study has given rise to many further questions. The many studies on stillbirth that have already been done explore and interpret the experience of stillbirth for the woman and her family but this research, on the lived experience of the community based midwife, sits mainly by itself. The experiences of hospital based midwives are still to be explored, as is the experience of midwives who have been involved with several stillbirths. What of the lived experience of others involved with stillbirth, namely the obstetric medical staff; do they have the same or similar experiences? If the concept of bereavement teams is adopted nationwide, then the experiences of all health professionals involved in providing this specialist care should be sought.

Although the midwife-woman partnership model of care is the cornerstone of midwifery care in New Zealand (Guilliland & Pairman, 1995) there has only been one study done in New Zealand that looks specifically at that distinctive relationship (Pairman, 2000). The connection between the impact on the community based

midwife when caring for a woman who has had a stillbirth and the impact on that midwife-woman partnership has not been explored and it is suggested that this issue requires further research. This is even more pertinent as the midwifery paradigm in New Zealand is unique to this country.

What of the experiences of midwives who have cared for bereaved women more than once? Do multiple experiences of caring for women who have lost a baby to stillbirth increase or decrease the personal and professional impact on the community based midwife? What changes for the midwife when she becomes experienced in bereavement care? These questions are a natural progression from the findings of this study, especially when experience seems to be the elusive ingredient required by novice midwives.

For community based midwives to continue to provide woman-centred, holistic and partnership based care to New Zealand women, we need to fully understand the lived experiences of those midwives. To not hear the stories of those midwives who provide that care to women who have suffered a stillbirth and to not acknowledge their experiences would be to let their voices go quiet. It would imply that we do not want to hear them and we do not appreciate the impact these experiences have had on each individual midwife.

Limitations of the Study

This research was conducted in a defined geographical area of New Zealand and therefore did not include the experiences of midwives in other areas of New Zealand. The hermeneutic process refers to the way people interpret and make sense of experiences, usually by naming them according to their pre-existing values and ways of seeing the world (Willis, 2001). So do midwives in other areas of New Zealand see their world differently to the way the participants in this study do? The stories in this research were authentic to this particular group of midwives, yet I suggest the findings will resonate with the wider midwifery community.

Because of time limits and acceptable thesis size at Masters' level there are some areas of this research that have not been developed to their full potential. Although this in itself is motivation to continue contemplating further research, it is considered that this study has been conducted in a holistic manner, giving due attention to the main themes identified and being mindful of the methodology and the method. Although the number of midwives interviewed in this study was relatively small at five, it would seem appropriate in the context of a phenomenological methodology. The findings and discussions developed from the interviews suggest a wealth of rich descriptive data was obtained.

Final thoughts

When a baby is born still the silence is deafening. Instead of hearing the crying baby all that is heard is the sound of grief. The declaration of death adds nothing to the silence in the room. For the midwife the silence is a travesty of all that she knows and trusts about birth.

A midwife who cares for a woman who has lost her baby finds herself in a place of interconnectedness. It is a place where the boundaries that usually guide her are somewhat blurred. She is involved intimately with the loss yet the loss is not hers to openly grieve over. Her public sorrow is for the woman's loss but her private sadness is for herself. The complexities surrounding this situation can find the midwife drawn beyond herself to a place that challenges her sense of self in a profound way. Her experience can be mysterious and exquisite and touching and tragic and scary and sacred, all at the same time. The situation can be overwhelming in its humanness.

This research tells the story of five midwives, each directly involved with a woman and her family during their time of loss. Each story is unique and describes the profound emotions felt by each midwife. For most, these emotions were only able to be visible for the briefest of moments. Their true sorrow was hidden and only acknowledged in their own private world of self-reflection. They found themselves experiencing the loss of a baby from a place on the outside looking in, as if in the shadows.

Perhaps the most challenging commentary of these research findings is the notion of the midwives experiencing disenfranchised grief or grief that isn't seen as belonging to

them. Each midwife's testimony of the experience of caring for a woman who has had a stillbirth confirms that although the loss was not theirs, the midwife's own sense of loss was intense and deeply personal. The phenomenon of grief was real to each midwife and ultimately concluded in them having a sense of being transformed by the loss. They described a sensation of having been taken apart and then put back together again.

Just by acknowledging the possible impact of caring for a woman who is bereaved, the midwives' lived experiences can be accepted as being authentic and real. This research illustrates that midwives can also experience a sense of loss; a loss of purpose, a loss of voice, a loss of guiding boundaries. As a way of validating their experiences, providing them a chance to share their stories may facilitate a sense of healing and closure for the midwives involved in this bereavement care.

The following poem is my interpretation of the stories shared with me of the lived experience of these midwives having cared for a woman that has lost her baby:

The midwife's lament of loss

The birth feels real to me: It's what I know to be true
The death feels real to me: I held it in my hands today
The grief feels real to me: heavy in my heart like a stone
The tears feel real to me: they dry without leaving a trace
The loss feels real to me: but I leave with everything I came with
The anger feels real to me: the blame has nowhere to go
The guilt feels real to me: I wait for my time of judgement
The sadness feels real to me: a beginning as well as an end
The darkness feels real to me: I open my eyes to see the light
The end feels real to me: How can it be so final?
The memory feels real to me: But I have others to remember
The sorrow feels real to me: It washes over me like a wave
The wound feels real to me: I don't have time for it to heal
The fear feels real to me: but beauty unfolds before us
The time feels real to me: I'm watching it happen right now
The pain feels real to me: But I'm not the one with the scar
The relief feels real to me: It's over, for me anyway
The faith feels real to me: trembling on a rock of devotion
The hope feels real to me: My trust is in divine purpose.

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APPENDIX

Letter TO Midwives



29th April 2011

Calling all Midwives.....

I am planning to do some research into the personal experiences of midwives' first experience of caring for a woman having a stillbirth. I am interested in hearing what it was like for you to be the midwife in this situation.

This research is in the form of interviews between the midwife and myself and will probably take about 1-1 ½ hours. The interview can be held at a place that is convenient to you. The interview will be audiotaped.

The information gathered will be held in total confidentiality.

The outcome of this research will hopefully help determine how, as a midwifery educator, I can better understand the realities, for a midwife caring for a woman who has had a stillbirth and integrate this knowledge into the education and pre-registration support of midwifery students.

The invitation to participate in this research is extended to midwives who, in their first few years of practice after registration, experienced this situation and are happy to share their story with me.

Please feel free to contact me directly for more information, as required.

Kindest regards,

Kay Jones,

Midwifery tutor

Email: Kay.jones@wintec.ac.nz

Cell: 021 887 520

Office: (07) 834 8800 ext 8939

Consent form

Project title: The first time a midwife cares for a woman having a stillbirth - a descriptive interpretive inquiry.

Project Supervisor: Dr Liz Smythe

Researcher: Kay Jones

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 5th June 2011.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's

signature:

.....

Participant's

name:

Participant's Contact Details (if appropriate):

.....

Date:

NB : the participant should keep a copy of this form



MEMORANDUM

TO Kay Jones

FROM Kevin Baker

SUBJECT Psychological support for research participants

DATE 5th October 2011

Dear Kay

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

“The first time a Midwife cares for a woman having a stillbirth - a descriptive interpretive inquiry.”

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing
- Participants outside Auckland may benefit from using Lifeline telephone counselling service 0800 543 354 to talk confidentially.

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing

Participant Information Sheet



A. Date Information Sheet Produced:

05/05/2011

B. Project Title

The first time a midwife cares for a woman having a stillbirth- an descriptive interpretive inquiry.

C. An Invitation

Thank you for considering becoming a participant in this research on “the impact on a midwife after caring, for the first time, a woman who has experienced a stillbirth”.

My name is Kay Jones and I am a midwifery tutor. I am currently doing my Masters’ Thesis (MSc-Midwifery) research into the personal experiences of midwives who cared for a woman having a stillbirth. I am interested in hearing what it was like for *you* to be the midwife in this situation.

As a practising midwife myself, I am very sensitive to the realities of caring for bereaved mothers and their partners/families. It is always an intensely challenging experience both personally and professionally. It is hoped that the midwives that participate in this research will have a sense of “being heard” and their stories given life. Perhaps their stories will help support other midwives who have been through this sad experience themselves.

In my own self-employed midwifery practice, I have cared for women who have lost a baby to stillbirth and appreciate the feelings surrounding this. Over the thirteen years of my practice I have gained some sense of acceptance that although it is not our grief, I do believe that there is a vicarious over flow of feelings that the midwife experiences.

Before you agree to be part of this research there are some issues that you need to be aware of and consent to. The aim of this form is to gain informed and voluntary consent from the participant. You may terminate your involvement in the research at any time prior to the completion of data collection without any adverse consequences.

D. What is the purpose of this research?

The outcome of this research will hopefully help determine how, as a midwifery educator, I can better understand the realities, for a midwife caring for a woman who has had a stillbirth and integrate this knowledge into the education and pre-registration support of midwifery students. My findings will be published in the New Zealand College of Midwives Journal and will be presented at International Stillbirth/Midwifery conferences. This research is also my thesis for my Masters in Health Science.

E. How was I identified and why am I being invited to participate in this research?

The research sample is made up of New Zealand trained, registered midwives. For the first time in your career, you have cared for a woman who experienced a stillbirth. Because you have experienced caring for a woman having a stillbirth you will have an understanding of the phenomenon. In order to identify suitable participants, an invitational flyer has been distributed to two geographical areas, Bay of Plenty

and Waikato. This included all midwifery practices in these areas, all DHB obstetric units and all birth centers. If you feel that you would like to participate in this research please contact me directly. I will then answer any questions you may have.

It is anticipated that you will be able to speak English and have no communication difficulties that would make participating in an interview difficult.

I believe that midwives who are considered vulnerable should exclude themselves from participating in this research. That includes midwives who are off work because of burn-out or “compassion fatigue”. This also includes midwives who have left midwifery, because of the experience of caring for a woman having a stillbirth. Midwives who are currently under a practice review are also excluded to protect them from further outside focus on their practice.

F. What will happen in this research?

The data for this study will be collected through face-to-face interviews with you and will probably take about 1-1 ½ hours. The location for these interviews will be of the your choosing and ideally it will be quiet and undisturbed. These interviews will be audio taped and a note book will be used to jot down any data that the recorder may not pick-up.

A second shorter interview, maximum of an hour, or telephone conversation may take place in order to gain additional stories of your experiences or to gain greater detail or explanation of something you have already talked about.

G. What are the discomforts and risks?

It is the absolute intention of this study project that no midwife be harmed from participating in this research. I clearly understand that the topic of research is a sensitive and very personal experience for you. Every attempt will be made to maintain your personal safety, during this process. Included are some of the possible questions that may be asked at the interview:

- “Can you tell me how your experience of looking after a woman that had a stillbirth came about?”
- How did you feel?
- At what stage did you realize that the baby had died?
- How did it feel when you became aware of the baby’s death?
- Who was it that told the woman about her baby’s death?
- What was it like to tell her or be present when she was told?
- What place do you think the baby held in this woman’s life?
- Did you always assume that you would, someday, have this happen in your midwifery practice?
- How did you think you would handle this situation when it happened?
- Was the experience different or similar to what you expected it to be like?
- What happened after you left the woman after she had birthed?
- How was it to see her again?
- What sense did you make of what happened?

H. How will these discomforts and risks be alleviated?

If you feel that you have suffered any psychological damage before, during or after the research, I will halt the interview and counseling service information will be offered.

- You are able to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- Please let the receptionist know that they are a research participant
- Please provide your contact details to confirm this
- You are able to find out more information about our counsellors and the option of online counselling on our website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing
- If you live outside Auckland may benefit from using Lifeline telephone counselling service 0800 543 354 to talk confidentially.

To ensure that your story is a true reflection of your story, you will be sent a copy of your transcript for your perusal. You will have an opportunity to review and amend the transcripts of the interviews.

I. What are the benefits?

It is anticipated that this will ultimately highlight a midwife's perceived preparedness for practice. The beneficiaries of this study will be midwifery students, new graduate midwives and in fact, the wider midwifery community. Your lived experience may well draw attention to the difficulties that many midwives face when dealing with fetal loss.

J. How will my privacy be protected?

Confidentiality will be maintained by using only pseudonyms or made up names of both you and your clients. All notes, audiotapes, transcripts of interviews and any other information gathered at any time or any experience will be kept in a secure way.

K. What are the costs of participating in this research?

It is anticipated that each interview will take 1-1 ½ hours to complete. There may be a need to briefly contact you again to clarify any details. It is anticipated that any follow-up contact will be no longer than ½-1 hour in duration.

L. What opportunity do I have to consider this invitation?

It is anticipated that I will have my selection of midwives within a month of sending out the invitational flyers.

M. How do I agree to participate in this research?

If you agree to participate then I will send you a consent form for you to read. If you have any queries then my contact details will be on the consent form.

N. Will I receive feedback on the results of this research?

Yes, you will receive feedback on the results once the data has been analysed.

O. What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Liz Smythe, liz.smythe@aut.ac.nz (09) 921-9999 ext 7196

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Dr Rosemary Godbold, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902.

P. Whom do I contact for further information about this research?

Researcher Contact Details: Kay Jones

Email: kay.jones@wintec.ac.nz

Project Supervisor Contact Details:

Dr. Liz Smythe, liz.smythe@aut.ac.nz,

Approved by the Auckland University of Technology Ethics Committee on *Aug 2011* AUTEC Reference number
ST9600362

1st August 2011

Kay Jones
69B Casey Avenue
Woodstock
Hamilton 3214



Private Bag 92008
Auckland 1020, NZ

T: +64 9 921 9999
www.aut.ac.nz

Dear Kay

ST9600362 MHSc thesis topic and supervisors

Thank you for submitting your MHSc thesis *Research Proposal PGI* application. Your proposal has been reviewed and approved by the Faculty of Health and Environmental Sciences Postgraduate and Research Committee 29th July 2011 meeting. Details are:

Your topic:	The first time a midwife cares for a woman having a stillbirth- a descriptive interpretive inquiry.
Primary supervisor:	Liz Smythe
Secondary supervisor:	N/A
Start date:	08/08/2011
Expected completion date:	12/07/2013
Enrolment:	Part time

You will see processes for your progress within the thesis paper are laid out in the *Postgraduate Handbook*. If you do not have a copy of this booklet please contact the Executive Administrator on (09) 921 9999 extension 7020. The AUT website for forms and handbooks is:
<http://www.aut.ac.nz/study-at-aut/current-students/postgraduate-support>

Please contact your supervisors to complete your *Postgraduate Supervisors Agreement* and development of your ethics proposal, if you have not already done so.

Please feel free to contact me with any questions or clarification you may require.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M. Jones'.

Associate Professor Marion Jones
Associate Dean Postgraduate
Postgraduate and Research Office
Faculty of Health and Environmental Sciences



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Liz Smythe
From: **Dr Rosemary Godbold** Executive Secretary, AUTEC
Date: 20 October 2011
Subject: Ethics Application Number 11/243 **The first time a midwife cares for a woman having a stillbirth - a descriptive interpretive inquiry.**

Dear Liz

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 12 September 2011 and that on 13 October 2011, I approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 31 October 2011. Your ethics application is approved for a period of three years until 13 October 2014.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 October 2014;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 13 October 2014 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this..

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902.

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Kay Jones kay.jones@wintec.ac.nz