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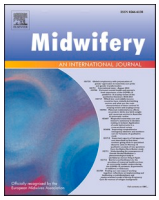

Witnessing a loss and the lived experiences of physicians, nurses, and midwives providing care in perinatal loss in Turkey: A phenomenological study

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ABSTRACT

Background: Perinatal loss is a globally prevalent experience, yet little is known about the lived experiences of physicians, nurses, and midwives involved in perinatal loss care.
Objective: This study aims to explore the lived experiences of physicians, nurses, and midwives in Turkey who witness and provide care in cases of perinatal loss.
Methods: The study was designed using an interpretative phenomenological approach, one of the qualitative research methods. A purposive sampling method, a type of non-probability sampling, was employed. The sample consisted of 15 participants, including 5 physicians, 5 nurses, and 5 midwives who had witnessed perinatal loss. Data were collected through individual, face-to-face, in-depth interviews using a semi-structured interview form between February and August 2024. Interviews were audio-recorded and subsequently transcribed verbatim. Content analysis was conducted using an inductive and data-driven approach.
Results: The experiences of the participants were summarized under five themes. The theme "Impact on Personal Life" encompassed emotional intensity, discomfort due to loss, internalizing the sense of loss, and questioning life. The theme "Impact on Professional Life" reflected desensitization to loss, questioning their desire to continue the profession due to negative emotions, avoiding caregiving to escape negative feelings, and exercising greater caution. The feeling of helplessness during caregiving, forming emotional bonds with the baby, dealing with unexpected situations, first experiences, and the occurrence of loss were summarized under the theme "Professional Challenges." Respect for loss, focusing on psychosocial and medical treatment, and effective communication and education were categorized under the theme "Support in the Patient Journey." Attitudes and behaviors developed by healthcare professionals to cope with negative emotions were grouped under the theme "Process Management."
Conclusions: As this study was conducted in Turkey, its findings are specific to the socio-cultural and clinical context of Turkish perinatal care, and they may not be applicable to other healthcare systems. Participants indicated that clinical intervention is a brief process and that they could not provide support to families in the post-clinical phase. They also stated that men are often overlooked during this period, that they experience emotional challenges while providing care during the loss process, and that they feel inadequate in providing bereavement counseling, education, and care. In this context, it is recommended to support personnel working in this field with training on managing the loss and bereavement process and to establish institutional policies for process management.

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Introduction

Perinatal loss is defined as stillbirth, neonatal death, or spontaneous miscarriage occurring between the 20th week of pregnancy and the 28th day postpartum. It is one of the most painful and devastating experiences for parents (Zhuang et al., 2023). Globally, approximately 7000 stillbirths and 6700 neonatal deaths occur daily, making this an increasingly critical public health issue (World Health, 2022). The impact of perinatal loss is profound, encompassing not only direct and indirect economic costs but also often invisible emotional, psychological, and social effects (Heazell et al., 2016; Herbert et al., 2022; Hunter et al., 2017). Between 25 % and 75 % of parents experiencing perinatal loss are reported to suffer from conditions such as depression, anxiety, prolonged grief, suicidal tendencies, substance abuse, eating and sleeping disorders, obesity, and hypertension (Berry et al., 2022; Hutti et al., 2017). Therefore, adequate clinical care, behaviors, and communication skills demonstrated by healthcare professionals during the loss process can help reduce the impact of the loss on parents (Ellis et al., 2016; Almansa-Sáez et al., 2024).

For healthcare professionals, loss is a stressful, complex, and emotionally challenging experience (Farrales et al., 2020; Gandino et al., 2019). Parents often struggle to cope with their negative emotions, and healthcare professionals frequently feel unprepared to support them (Salgado et al., 2021). In a study by Shorey et al. (2017), healthcare professionals reported feeling that they lacked the necessary resources and training to address perinatal loss and grief. A systematic review examining the experiences of healthcare professionals and parents following loss revealed that healthcare professionals often coped by distancing themselves from parents and focusing on clinical duties, a strategy that increased stress levels among parents (Ellis et al., 2016). Continuous exposure to negative experiences and stress can cause healthcare professionals to suppress and ignore their emotions. As a result, they may experience physical symptoms such as headaches, fatigue, and general physical exhaustion, as well as emotional symptoms including sadness, guilt, and frustration (Gandino et al., 2019; Zhang et al., 2018).

Perinatal loss in Turkey is perceived as a culturally sensitive issue and is often surrounded by silence. Grief-related rituals vary across cultural contexts and are not applied in a consistent or standardized manner at the societal level (Yenal et al., 2023). Within the Turkish cultural context, such losses are typically interpreted through spiritual or faith-based frameworks. Many individuals perceive them as "part of destiny," beyond human control. Fatalistic expressions such as *"God's will"* often serve to minimize the loss, which may contribute to suppressed grief, feelings of loneliness, and guilt, especially among mothers. Fathers are frequently overlooked emotionally during this process, with societal expectations urging them to "remain strong" and suppress their grief. Currently, there is no national guideline in Turkey to support healthcare professionals or bereaved families dealing with perinatal loss. In contrast, countries such as the United States, Canada, and the United Kingdom have comprehensive and structured national bereavement care guidelines (Gandino et al., 2019). While some hospitals in Turkey have developed local practices, these efforts have not yet been standardized at the national level (Yenal et al., 2023). As a result, healthcare professionals often feel unprepared and unsupported when encountering perinatal loss, which can increase their emotional burden and negatively impact the quality of care they provide (Gandino et al., 2019; Qian et al., 2023).

A review of studies on this topic reveals that Mills et al. (2023) reported healthcare professionals were deeply affected on a personal level by infant deaths, and as they internalized these experiences, their ability to provide care was negatively impacted. Additionally, they experienced stress due to deficiencies in communication and informational skills. In a study by Sheehy and Baird (2022) exploring the grief and trauma experiences of novice midwives following a loss, it was noted that limited exposure to loss during their student years contributed to feelings of unpreparedness, complexity in care, and anxiety. Some participants indicated that when supported by colleagues, they felt capable of providing necessary care as new midwives and even viewed perinatal loss as a rewarding aspect of their profession (Sheehy and Baird, 2022). Other studies have examined nurses' experiences with loss (Griffin et al., 2021; Martins et al., 2023) and the perspectives of nurses and midwives on perinatal loss and grief (Karaca et al., 2020). However, no research to date has simultaneously evaluated the lived experiences of nurses, midwives, and physicians on this subject. Understanding the experiences of nurses, midwives, and physicians, who maintain the closest proximity to the woman during the loss process, may help identify needs and inform the development of training programs. Therefore, this study was conducted to explore the lived experiences of nurses, midwives, and physicians in Turkey who witness and provide care during perinatal loss.

Materials and methods

Study design, setting, and participants

The researchers employed a qualitative descriptive design to address the research objectives and examine the data from a comprehensive and holistic perspective (Cesario et al., 2002). Qualitative description is particularly suitable for understanding participants' experiences regarding a healthcare phenomenon, such as lived experiences in perinatal loss, by using their own words and narratives to identify common themes (Willis et al., 2016). An Interpretative phenomenological analysis design, a qualitative research method, facilitates the detailed exploration of personal experiences (Akgün et al., 2022). This design draws upon the theoretical framework of phenomenology, aiming to deeply explore how individuals make sense of their personal and social worlds from their own perspectives and narratives. It fundamentally seeks to capture the quality and texture of individual experience and involves a 'double hermeneutic' process where both the researcher and participant interpret meaning (Smith and Osborn, 2003; Smith et al., 2009; Gill, 2015). In this study, an interpretative phenomenological design was employed to deeply explore participants' experiences while remaining close to the surface meanings of words and events (Sandelowski, 2000, p. 334; Akgün et al., 2022). Additionally, qualitative description provides a focused understanding of participants' experiences and clarifies the contextual factors shaping those experiences. To enable the discovery of new and unexpected insights, data collection was conducted through semi-structured interviews, a preferred data collection method in qualitative descriptive research (Neergaard et al., 2009).

The study was conducted with five midwives, five nurses, and five physicians actively working in Turkey, who witnessed the loss of a baby in the second or third trimester, during labor, or the death of a newborn within the first 28 days postpartum, and who provided treatment and care during these events. Participants were selected using a non-probability purposive sampling method. Since this study was conducted in Turkey, it is important to consider the influence of cultural and religious norms on participants' experiences. In Turkish society, perinatal death is often interpreted through spiritual or fatalistic beliefs, and open expressions of grief may be socially constrained. These contextual factors may have shaped how participants internalized and conveyed their experiences of perinatal loss. Therefore, the findings of this study should be interpreted within this specific sociocultural framework, as the lack of national guidelines on perinatal bereavement care in Turkey may influence both the provision of care and the emotional experiences of healthcare professionals.

Data collection

Data were collected between February and August 2024 through individual face-to-face in-depth interviews. A semi-structured interview form was utilized (Fig. 1). After the interview form was prepared by the

1. Could you describe the process of witnessing a perinatal loss?
2. How did you feel when the event occurred?
3. How did witnessing a perinatal loss affect your personal life?
4. What was your approach to the patient during the perinatal loss process?
5. How does talking about perinatal loss now make you feel?

Fig. 1. Sample Interview Questions.

researchers, a pilot study was conducted, and the questions were subsequently reviewed and refined. Sample questions posed during the interviews included the following:

Each interview session lasted approximately 20–30 min. Appointments were scheduled by phone with volunteer participants who met the eligibility criteria. The interviews were conducted in formal or informal settings chosen by the participants. With the participants' consent, all interviews were audio-recorded. To ensure data reliability, note-taking was also employed by two researchers. The researchers systematically recorded their thoughts, observations, and emotional reactions during the research process by keeping field notes. Writing reflective diaries contributed to the in-depth analysis of reflectivity and enhanced self-awareness throughout the research process (Demirkasımoğlu and Bezen, 2024, p. 782). Emotions and non-verbal communication were included in the analysis. To enhance credibility, frequent participant quotations were incorporated. All researchers possessed the necessary knowledge and training in qualitative research models and qualitative interview techniques (Fig. 1).

Analysis

The qualitative responses obtained from the semi-structured interviews were transcribed immediately after each session using the Otter tool. To ensure high reliability during data collection, transcripts were cross-checked against digital recordings by two researchers throughout the process. Initially, the transcripts were read to familiarize the researchers with the data. Subsequently, the data were coded, key quotes and ideas were highlighted, and these were grouped under relevant themes (Fig. 2). During this stage, both the transcripts and field notes were utilized, and the data analysis followed the qualitative content analysis process described by Elo and Kyngäs (2008). In the content analysis method of Elo and Kyngäs (2008), written, verbal, or visual communication messages are examined in qualitative research. Data are systematically analyzed using either inductive or deductive approaches. In this study, an inductive approach was utilized to organize the qualitative data. The process begins with selecting the unit of analysis and deeply reading the data to make sense of the whole. Subsequently, data are organized through steps such as open coding, categorization, and abstraction, leading to the formation of concepts or categories that describe the phenomenon. The inductive approach derives categories and concepts directly from the data, while the deductive approach involves developing analysis matrices based on an existing theory or model for coding the data. Finally, the analysis process concludes with transparent reporting of the analysis process to enhance the

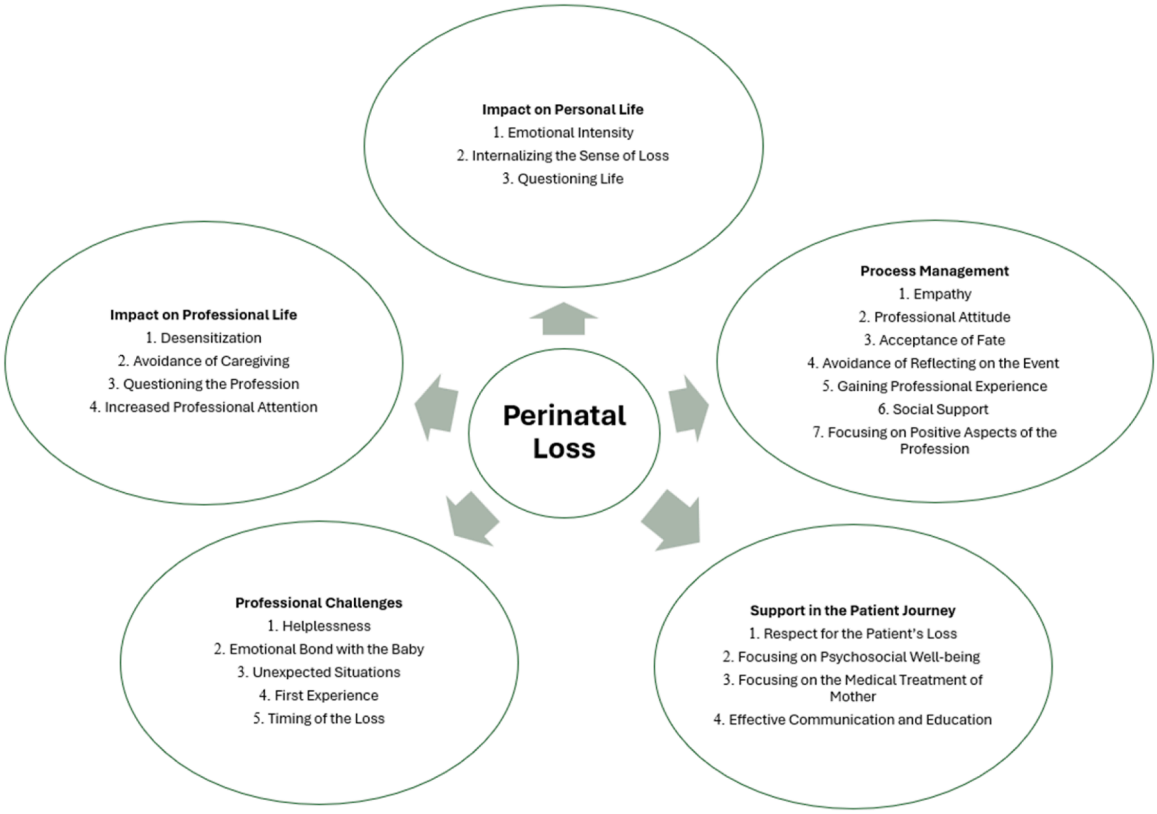

Fig. 2. Classification of themes and codes.

trustworthiness of the findings.

In the final step, the generated codes and themes were reviewed collaboratively by all authors, and cross-validation was conducted to minimize the potential impact of bias. To ensure internal consistency, inter-coder agreement was calculated, and it was found to exceed 90 % (Miles and Huberman, 1994). Additionally, the themes were contextually developed based on the researchers' reflections (Braun and Clarke, 2019). Following the analysis, three separate peer reviews (expert opinions) were obtained for the themes and codes. The themes and the codes contributing to their development were translated into English, with supporting quotes, by expert researchers fluent in both English and Turkish. Strict adherence was maintained to the Consolidated Criteria for Reporting Qualitative Research (COREQ) throughout the study.

Ethical approval

Ethical approval for the study was obtained from the ethics committee of an accredited university (Application ID: 17,412, Decision: 2024/641). Before data collection, informed verbal and written consent was obtained from the participants. Participants were assured of confidentiality, and their consent was secured for audio recordings and note-taking. Throughout the study, the principles of the Declaration of Helsinki were followed (World Medical Association, 2013). Participants were informed that participation was voluntary and that they had the right to withdraw at any time without providing an explanation. During data analysis, participants' privacy and confidentiality were maintained.

Rigor

To ensure the validity and reliability of the study, the principles of trustworthiness outlined by Guba (1981) and Lincoln and Guba (1986) were applied. These include the criteria of credibility, transferability, dependability, and confirmability to enhance the quality of the research. The research team strengthened scientific trustworthiness through the use of reflective diaries, field notes, peer debriefing, peer review, inter-rater reliability (consistency of coding), re-coding, and maintaining an audit trail (Arslan, 2022).

Results

The average age of the participants was 33.07 years. Of the participants, 12 were women, and 3 were men, with professional experience ranging from 1 to 30 years. The number of perinatal losses witnessed by the participants ranged from 1 to 80. Participants were identified using abbreviations denoting their profession, participant number, gender, and age (e.g., *N1, F, 29*). The data were presented under five themes and 27 codes, as determined through content analysis (Fig. 2, Table 1).

Theme 1. impact on personal life

It was determined that the experience of perinatal loss had significantly varied impacts on the personal lives of healthcare professionals (Table 1).

Code 1. Emotional Intensity

Three participant statements associated with the code are presented below:

"The challenging process in which the life of a baby eagerly awaited to come into the world ends naturally evokes pain and complex emotions." (N1, F, 29)

"I felt sadness, but at the same time, there was also fear. … Then a couple of tears fell from my eyes." (N4, F, 30)

"… After learning about the baby's death or that it was stillborn, my mood was very low for the rest of the day. I couldn't eat…" (N3, F, 32)

Table 1
Themes and codes related to the lived experiences of physicians, nurses, and midwives during the perinatal loss process.

Theme	Code	Participant statements
Impact on Personal Life	Emotional Intensity (n:12)	The emotions experienced were described as complex, predominantly emphasizing negative feelings such as sadness.
	Internalizing the Sense of Loss (n:6)	Negative emotions stemming from the loss were internalized, leading healthcare professionals to question the possibility of facing such a loss personally.
	Questioning Life (n:2)	Following the loss, healthcare professionals reflected on their lives in both positive and negative ways.
Impact on Professional Life	Desensitization (n:5)	Some participants noted that negative emotions and thoughts diminished as they gained experience, resulting in increased desensitization.
	Avoidance of Caregiving (n:3)	Some participants avoided providing care to patients experiencing perinatal loss.
	Questioning the Profession (n:2)	Some participants considered leaving their profession after experiencing a loss.
	Increased Professional Attention (n:1)	Following a loss, some participants reported feeling a greater responsibility to provide careful care.
Professional Challenges	Helplessness (n:3)	Participants felt helpless when clinical interventions failed to change the outcome for patients experiencing loss.
	Emotional Bond with the Baby (n:1)	Spending more time with the baby increased the likelihood of healthcare professionals forming emotional bonds.
	Unexpected Situations (n:2)	Some participants felt they were caught unprepared during loss experiences.
	First Experience (n:6)	Participants experiencing perinatal loss for the first time reported more intense negative emotions and greater difficulty coping.
	Timing of the Loss (n:5)	Losses occurring after live births or in later gestational weeks were associated with more profound sadness compared to early losses.
Support in the Patient Journey	Respect for the Patient's Loss (n:5)	Participants respected the mother's decisions regarding herself and her baby during and after the loss.
	Focusing on Psychosocial Well-being (n:10)	Many participants focused on supporting the mother's psychosocial state during the loss and discharge process.
	Focusing on the Medical Treatment of Mother (n:7)	Many participants prioritized addressing the mother's medical condition during the loss.
	Effective Communication and Education (n:6)	Some participants emphasized maintaining effective communication with the mother and family during the loss process.
Process Management	Empathy (n:13)	Almost all participants demonstrated empathy with the mother/family during the loss process.
	Professional Attitude (n:13)	Nearly all participants aimed to focus on their professional roles and maintain professionalism during the loss process.

(*continued on next page*)

Table 1 (*continued*)

Theme	Code	Participant statements
	Acceptance of Fate (n:11)	Most participants coped with negative emotions by perceiving the loss as fate.
	Avoidance of Reflecting on the Event (n:2)	Some participants coped by avoiding thoughts about the event.
	Gaining Professional Experience (n:10)	Most participants reported that experience reduced negative emotions related to loss and facilitated professional behavior.
	Social Support (n:5)	Some participants relied on support from their social circles to cope with negative emotions and thoughts related to the loss.
	Focusing on Positive Aspects of the Profession (n:3)	Some participants managed negative emotions by focusing on the rewarding aspects of their profession, such as successful and healthy deliveries.

Code 2. Internalizing the Sense of Loss

Two participant statements associated with the code are as follows:

"You know, we too might think about having children, and I felt fear, wondering if something like this could happen in our own pregnancies." (N4, F, 30)

"I entered such an emotional state that I felt as if, if I got pregnant, I wouldn't have a normal pregnancy." (M5, F, 29)

Code 3. Questioning Life

One participant statement associated with the code is provided below:

"On the days when you witness a loss, you don't really enjoy the food you eat or the events around you. Sometimes, you even question life." (M1, F, 46)

Theme 2. impact on professional life

It was determined that the experience of perinatal loss had various impacts on the professional lives of healthcare professionals (Table 1).

Code 1. Desensitization

Two participant statements associated with this code are provided below:

"… After a certain point, it starts to feel routine. You begin to act like a robot. You know the steps you need to take…" (M5, F, 45)

Male participants expressed that this desensitization might be related to their gender ($n = 2$).

"… There is some sadness, but ultimately, there is the nature of being male, and at the end of the day, I'm a surgeon now. When I look back, I see just a little sadness but also a sense of moving forward. I stay composed…" (P3, M, 32)

Code 2. Avoidance of Caregiving

Two participant statements associated with this code are as follows:

"You want to escape from that situation, from that environment, you know…" (M5, F, 45)

"For example, I used to tell my colleagues, 'Let me assist with three normal deliveries, and you handle the delivery of the woman experiencing the loss.' I thought the less I saw, the less it would affect me because being exposed to such a situation for a long time is overwhelming." (M1, F, 46)

Code 3. Questioning the Profession

Two participant statements associated with this code are provided below:

"…To be honest, I wondered if I could continue doing this profession…" (M4, F, 29)

"In the early years of my career, since I was young, I couldn't cry at the hospital, but I would go home and feel very upset, crying a lot. I would say, 'I can't do this job.' I even considered resigning." (N3, F, 32)

Code 4. Increased Professional Attention

The participant statement associated with this code is provided below:

"Not more detailed, but more careful. For instance, when the fetal heart rate starts to drop, I ask myself, 'Is this baby's heart rate actually dropping, or is it because the probe shifted?' I act a bit more cautiously because of this." (M5, F, 45)

Theme 3. professional challenges

It was determined that healthcare professionals faced challenges in fulfilling their professional roles during experiences of perinatal loss (Table 1).

Code 1. Helplessness

The participant statement associated with this code is as follows:

"… What stays with me is not so much the sadness but the helplessness of not being able to do anything." (N5, F, 45)

Code 2. Emotional Bond with the Baby

One participant statement regarding this code is provided below:

"… It's only with patients we've followed for a long time in the ward. For example, a diaphragmatic hernia case—we followed that patient for 12–13 days. With those patients, you develop a bit of a bond. That's why, it can take a few days to overcome the sadness." (P5, M, 32)

Code 3. Unexpected Situations

Two participant statements associated with this code are provided below:

"In this process, it falls to us to deliver this news… It's very difficult. Normally, parents are waiting for a miracle, joyfully anticipating their baby. The mother has bonded with the baby for nine months, and the family is expecting to bring a sibling home to their children. And then, it's an entirely different situation." (P1, M, 27)

"Pregnant women mostly arrive happily… but afterwards, after that incident… I will inevitably encounter such patients, such families. How can I provide care? What can I say to them…" (M5, F, 29)

Code 4. First Experience

One participant statement regarding this code is as follows:

"When I experienced it for the first time, there were times when I went home and cried… during my initial experiences. But later on, yes, I would feel sad and think about it constantly, but honestly, I didn't go home and cry my eyes out… Because when I see something for the first time, it seems to affect me more… Firsts are always harder for me." (M4, F, 29)

Code 5. Timing of the Loss

Two participants made the following statements:

"You know that a baby who died in the womb will be delivered stillborn, so you don't feel as sad, but losing a live baby—this was much worse." (M2, F, 29)

"…A full-term patient… if it's 8 or 10 weeks, you don't feel as sad, but with a full-term baby, you feel deeply saddened." (M3, F, 48)

Theme 4. support in the patient journey

It was determined that during the experience of perinatal loss, healthcare professionals developed certain attitudes and behaviors to support the mother and family (Table 1).

Code 1. Respect for the Patient's Loss

The participant statement associated with this code is provided below:

"No one wanted to see their child; they would say they wanted to remember them in a good way. We always respected their wishes." (M1, F, 46)

Code 2. Focusing on Psychosocial Well-being

Two participant statements associated with this code are provided below:

"I try to console them. I talk to them, saying, 'Look, you're healthy, you're young'… I make eye contact, and I adjust my conversation based on their facial expressions. If they seem satisfied with what I'm saying, I continue talking." (M2, F, 29)

"I think the real problem begins after this period. Once the woman gets over the initial shock and goes home, we are not there to support her during this process. I believe she needs more support during that time." (N3, F, 32)

Code 3. Focusing on the Medical Treatment of Mother

Two participant statements associated with this code are provided below:

"I administered an injection to prevent milk production, and since bleeding was excessive, I paid particular attention to monitoring bleeding in these situations." (M1, F, 46)

"In such cases, there is a higher risk of complications like bleeding, so I focus on monitoring and preventing complications." (P1, M, 27)

Code 4. Effective Communication and Education

Two participants made the following statements concerning this code:

"…I carefully choose every word I use with an individual experiencing profound grief because unnecessary reassurances or meaningless consolations can make the patient feel like you don't understand them." (N1, F, 29)

"…We explain the procedures, telling them these are the stages that will occur, and offer education, such as explaining that we can send the sample to pathology to investigate the cause if they wish." (M4, F, 29)

Theme 5. process management

It was determined that during the experience of perinatal loss, healthcare professionals developed specific attitudes and behaviors to cope with the negative emotions they encountered (Table 1).

Code 1. Empathy

Three participant statements associated with this code are as follows:

"I immediately put myself in their place. I put myself in the mother's position. I feel as if I'm the mother. Naturally, that makes me feel sad." (P2, F, 32)

"…A person empathizes with the pain the mother and family are experiencing, and of course, you feel sad…" (M1, F, 46)

One participant also noted that fathers are often overlooked during this process:

"Actually, I feel very sorry for the father too. Usually, we focus on the mother, but for some reason, there's a societal perception that fathers must be strong. Yet, he's also losing his baby. Another point we neglect is that we only see them for a day or two after the loss." (M2, F, 29)

Code 2. Professional Attitude

One participant made the following statement associated with this code:

"It's upsetting to see a woman go through these emotional states. It's impossible not to feel sad. But you have to maintain a professional perspective…" (M5, F, 29)

Code 3. Acceptance of Fate

The participant statements associated with this code are as follows:

"When such an event occurs, I think of it as something beyond our control; not every birth is destined to result in a live baby." (M1, F, 46)

"You say it's God's will. I am affected and saddened in the moment, but I don't let it significantly impact my life." (M2, F, 29)

Code 4. Avoidance of Reflecting on the Event

One participant made the following statement regarding this code:

"I have a tendency to escape. I try to distance myself from the thought, to avoid thinking about it. I think that's how I manage to cope." (N4, F, 30)

Code 5. Gaining Professional Experience

Two participant statements associated with this code are provided below:

"If I were answering this in the early years of my professional life, I would say I felt bad, but with experience, I can now speak more calmly." (N1, F, 29)

"When I first started working, I honestly didn't know how to approach these women or what to say to them, but over time, I learned through my experiences…" (M2, F, 29)

Code 6. Social Support

The participant statement associated with this code is as follows:

"… For example, I would tell my mother, 'Mom, this happened, that happened,' because she knew how upset I was. She would comfort me by saying, 'We all will die someday. Don't wear yourself out. You'll keep seeing these things.'" (M3, F, 48)

Code 7. Focusing on Positive Aspects of the Profession

One participant made the following statement concerning this code:

"…These (perinatal losses) happen, but they are in the minority. Most of the time, the mother and baby are healthy. I try to reassure myself with this thought, and honestly, that's how I cope…" (P4, F, 30)

Discussion

The aim of this study was to explore the lived experiences of nurses, midwives, and physicians in Turkey who witnessed perinatal loss and were involved in the treatment and care process. The findings revealed that nurses, midwives and physicians internalized the sense of loss and reflected on their own lives. They also reported feeling intense sadness while providing care during the loss process and noted that the experience affected them not only professionally but also psychologically. A systematic review on the potential consequences of witnessing traumatic births stated that such experiences can lead to negative emotional and psychological outcomes for healthcare professionals (Aydın and Aktaş, 2021). In the study by Karaca et al. (2020), 71.2 % of the participants reported that they did not feel well when faced with perinatal grief (71.2 %). Consistent with the literature, these findings demonstrate that distress during perinatal loss is not experienced solely by parents;

healthcare professionals also face emotional challenges in response to such losses.

The study revealed that witnessing the loss process affected participants' professional lives. One such effect was depersonalization. Other studies in the literature also indicate that healthcare professionals experience negative emotions when they encounter perinatal losses, and these emotions can lead to emotional atrophy over time (Qian et al., 2023; Kendall-Tackett and Beck, 2022). Regarding depersonalization, male healthcare professionals in this study reported managing the process more easily and stated that the loss had no significant effect on their professional lives. Similar to these findings, other studies have observed that men tend to exhibit higher levels of self-efficacy and self-confidence than women when coping with the difficult emotions associated with death and in maintaining their well-being (Baqeas and Rayan, 2018; Dijxhoorn et al., 2021). These differences may be attributed to cultural patterns that shape distinct emotional coping mechanisms between men and women.

In the study, other effects of perinatal loss on participants' professional lives included questioning their career choice and avoiding caregiving. In a study conducted with nurses, it was observed that they did not feel prepared to cope with loss or the possibility of facing death and often questioned their choice of profession (Galvin et al., 2020). Mills et al. (2023) also reported that some healthcare professionals expressed a desire to change their profession. Additionally, other studies have indicated that healthcare professionals sometimes avoided providing care because they experienced negative emotions such as frustration and guilt during the loss process (Puia et al., 2013; Wallbank and Robertson, 2013). Consistent with the literature, our findings show that emotional exhaustion experienced during the loss process can lead to avoidance of caregiving and eventual disengagement from the profession. These results highlight the importance of providing healthcare professionals with appropriate support and training programs. In addition, midwives, nurses and physicians in this study stated that, as a reflection of their experiences with perinatal loss, they felt a heightened responsibility to provide more careful and attentive care to patients following such events.

In the study, participants reported that the professional difficulties they encountered during the perinatal loss process were caused by factors such as feelings of helplessness, emotional bonding with the baby, experiencing a first loss, the timing of the loss, and its unexpected nature. In line with the literature, participants noted that the intensity of the emotions they experienced increased with the amount of time spent with the baby (Fernández-Alcántara et al., 2020; Laing et al., 2020; Qian et al., 2022). Those who experienced perinatal loss for the first time reported more intense emotions and greater difficulty coping. According to participant statements, perinatal loss is often as unexpected for health professionals as it is for parents, which creates particular challenges when delivering bad news. It was also emphasized that the emotional burden intensified with increased time spent with the baby. Martins et al. (2023) reported that nurses' coping mechanisms improved with greater experience of pregnancy loss, and that both the timing of the loss and gestational age influenced the emotional impact, with loss experiences becoming more intense as the gestational week progressed. However, other studies have argued that the gestational week does not necessarily affect the intensity of grief (Rolim et al., 2001; Martins et al., 2023). These differences may be attributed to participants' personal characteristics, sources of social support, stress-coping abilities, and levels of emotional intelligence.

Participants stated that they took care to respect the patient's decisions in the care process, sought to meet both physical and psychosocial needs, and provided support to the patient and family through effective communication and education. They also reported involving the mother and family in the decision-making process, including asking about their wishes regarding whether or not to see the baby. Laing et al. (2020), and Fernández-Alcántara et al. (2020) emphasized the importance of involving parents in decision-making by offering options such as participating in religious ceremonies, requesting an autopsy, and preserving memories of the deceased baby, such as photographs. Black et al. (2022) found that allowing parents to see their deceased babies was associated with an increased risk of Posttraumatic Stress Disorder (PTSD). In contrast, Nurse-Clarke et al. (2019) highlighted the importance of parents acknowledging the existence and lifelessness of their baby, suggesting this may facilitate acceptance. These different findings suggest that the positive or negative effects of involving parents in decision-making may depend on individual differences, cultural values, and emotional resilience. Therefore, healthcare professionals should adopt a sensitive and informative approach, taking into account the unique needs and preferences of each family.

In the study, participants emphasized that another critical aspect of supporting the patient and family during the perinatal loss process was the education provided to the family. In the study by Martins et al. (2023), participants noted that nurses' communication skills are crucial during pregnancy loss and that information should be conveyed using appropriate and understandable language, even when patients appear ready to receive information. The study also highlighted the importance of providing timely information about individual procedures in the care process and avoiding delays in confirming the loss (Martins et al., 2023). Similarly, in a study exploring the lived experiences of nurses caring for women with early pregnancy loss, nurses stated that their most important role in care involved providing information and explanations (Griffin et al., 2021). These findings suggest that establishing effective communication with families experiencing perinatal loss and providing appropriate education are critical to enhancing the quality of care delivered by healthcare professionals. In line with the literature, our results emphasize the importance of healthcare professionals' communication skills and family education during the perinatal loss process. Therefore, improving the training of healthcare professionals in this area may enable more effective support for families navigating this challenging experience.

The study found that midwives, physicians, and nurses believed they provided empathic care in managing the loss process. However, they also emphasized that fathers are often overlooked during this process. In the study by Martins et al. (2023), healthcare professionals noted that male partners had an ambivalent role as grievers and carers during perinatal loss. These findings suggest that hospital practices often remain female-oriented and support the need to include men as active participants in the process. Participants in this study also reported sharing their experiences and emotions related to loss with their social networks and receiving support. Abeni et al. (2014) noted that expressing feelings or experiences to others is a commonly used coping mechanism to alleviate stress during the provision of loss care. These findings indicate that social support can serve as a protective factor, enhancing both job satisfaction and psychological resilience. In addition, the study showed that as midwives, nurses, and physicians gained professional experience, they learned to maintain professional behavior and manage the loss process by focusing more on the positive aspects of their profession.

One of the key themes that emerged from this study was "Acceptance of Fate." Healthcare professionals often interpreted perinatal losses through fatalistic expressions such as "God's will," reflecting a culturally embedded belief system. This approach appears to serve as a psychological defense mechanism, helping professionals emotionally distance themselves from the traumatic impact of such experiences. A recent study conducted in Turkey found that religious coping strategies during the perinatal loss process enhanced psychological resilience and reduced the intensity of grief (Altuner and Çankaya, 2025). The limited openness around perinatal loss in Turkish society, combined with a predominantly internalized and individualized grieving process, seems to facilitate the continuation of this fatalistic perspective. Furthermore, the absence of a nationally structured bereavement care guideline results in care practices that are often shaped by individual beliefs and personal experiences. In contrast, countries such as Canada provide culturally sensitive

bereavement services, including grief photography, which supports families in making meaning of their loss. Vivekananda et al. (2024) found that such services were widely accepted by bereaved parents and provided significant emotional support during the grieving process. Photographs were reported to help transform painful memories into meaningful ones, fostering emotional connection and aiding in the recognition and expression of grief. In the United States, structured bereavement programs within hospitals offer families memory boxes and widespread access to psychosocial support services (Gold et al., 2024). Similarly, in the United Kingdom, national guidelines developed by the Stillbirth and Neonatal Death Society (SANDS) standardize practices such as involving parents in decision-making, addressing religious and cultural needs, and creating opportunities for farewell and memory-making rituals (SANDS, 2020). These international examples highlight the importance of multidimensional support systems that address not only the needs of healthcare professionals but also the emotional and cultural needs of grieving families. In this context, it is essential to develop nationally standardized bereavement care guidelines in Turkey that are grounded in a multidisciplinary and culturally informed framework.

Conclusion and recommendations

The study revealed that perinatal loss experiences affected both the personal and professional lives of healthcare professionals, who employed various coping mechanisms to manage the negative impacts. Many participants expressed a need for support during this process. Since the majority of participants in this study were female, future research should include more comprehensive studies that examine the perspectives of male healthcare professionals and conduct comparative analyses of the views of both male and female professionals. Most participants reported deficiencies in training, bereavement counseling, and care provided during the perinatal loss process. In this context, regularly scheduled in-service training programs could enhance healthcare professionals' knowledge and coping skills in managing loss. Furthermore, institutional support is critical for fostering emotional resilience. Institutions could organize regular training sessions and experience-sharing meetings to increase healthcare professionals' self-efficacy and their ability to cope effectively with the loss process. However, it was also observed that while the needs of mothers are predominantly addressed during the loss process, fathers are often excluded from psychological and medical support services and frequently overlooked. Therefore, it is recommended that future practices adopt a holistic approach to care that includes fathers as well. This study was conducted in Turkey, where perinatal loss is a culturally sensitive and often underdiscussed issue. The absence of nationally structured bereavement care guidelines in Turkey and the frequent interpretation of perinatal loss through spiritual or fate-based approaches may be decisive factors in the emotional processes and coping mechanisms experienced by healthcare professionals. Therefore, the findings should be interpreted in a sociocultural context and should not be directly generalised to other countries with more structured perinatal bereavement protocols.

Limitations

This study was conducted with the participation of 15 health professionals. Although this sample size provides a valuable starting point for revealing different perspectives on perinatal loss, further research involving larger and more diverse groups of participants would enhance the diversity and generalizability of the findings. The data obtained in this study are based on participants' personal experiences and recollections, which may introduce subjectivity and limit objectivity. Additionally, although various methods were employed to minimize researcher bias during the analysis process, the influence of the interpreter cannot be completely eliminated in qualitative research.

Another limitation of this study is the marked variation in participants' levels of experience, as they had provided care in between 1 and 80 cases of perinatal loss. This variation may have influenced the depth and content of the narratives, as well as the ways in which participants described and reflected on their emotional experiences. In this study, participants who experienced perinatal loss for the first time reported more intense emotional reactions and greater difficulty coping. This finding suggests that healthcare professionals' emotional responses and coping strategies are closely related to the number of cases they have encountered and their overall professional experience. Therefore, future research should take into account participants' levels of experience with perinatal loss and examine in greater detail how this variable may impact the study findings.

Ethical Statement

Ethical approval for the study was obtained from the ethics committee of an accredited university (Application ID: 17412, Decision: 2024/641). Before data collection, informed verbal and written consent was obtained from the participants. Participants were assured of confidentiality, and their consent was obtained regarding audio recordings and note-taking. Throughout the study, the principles of the Declaration of Helsinki were followed (World Medical Association, 2013). Participants were informed that the study was based on voluntary participation and that they had the right to withdraw at any time without providing an explanation. During data analysis, the privacy and confidentiality of the participants were maintained.

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CRediT authorship contribution statement

Gül Büşra Altunay Davran: Data curation, Formal analysis, Investigation, Methodology, Software, Writing – original draft, Writing – review & editing. **Merve Yazar:** Data curation, Formal analysis, Investigation, Methodology, Software, Writing – original draft, Writing – review & editing. **Emel Ege:** Investigation, Methodology, Software, Writing – original draft, Writing – review & editing, Project administration, Supervision. **Şerife Didem Kaya:** Investigation, Methodology, Software, Writing – original draft, Writing – review & editing, Project administration, Supervision.

Perinatal loss represents a stressful, complex, and emotionally challenging experience for health professionals. A review of the literature reveals studies that have explored nurses' experiences with loss, as well as the perspectives of nurses and midwives regarding perinatal loss and grief. However, no study to date has examined the lived experiences of nurses, midwives, and physicians collectively within this context. Understanding the experiences of these professionals, who maintain the closest proximity to the woman during the loss process, may help identify needs and inform the development of relevant training programs. Accordingly, this study aims to explore the experiences of nurses, midwives, and physicians in Turkey who witness and provide care during instances of perinatal loss.

Participants indicated that clinical intervention is a brief process and that they were unable to provide support to families in the post-clinical phase. They also reported that men are often overlooked during this period, that they experience emotional challenges while providing care during the loss process, and that they feel inadequate in offering bereavement counseling, education, and care. In this context, it is recommended that personnel working in this field receive training on managing the loss and bereavement process and that institutional policies be established for process management.

Declaration of competing interest

There is no conflict of interest between the authors.

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