
DEATH IN THE MATERNITY HOSPITAL: HOW HEALTH PROFESSIONALS DEAL WITH THE LOSS¹

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ABSTRACT. The moment to break the news of a fetal death is a very delicate moment for the parents and relatives, as well as for healthcare professionals who, in addition to break the news to the family, must assist the mother throughout her recovery. The general objective of this work was to study how health professionals experienced and dealt with the situation of pregnancy loss, based on an investigation of cognitive aspects (perceptions and significance) and emotional aspects (feelings) related to the situation. The research was based on descriptive definitions of qualitative character and a sample of eight professionals who have provided direct assistance to patients in situations of pregnancy loss, specifically in Ultrasonography, Obstetric and Post-Surgical Care sectors of a public maternity hospital in the city of Rio de Janeiro. All participants were interviewed individually and the report taken was analyzed and processed according to L. Bardin's Content Analysis methodology. It was observed that pregnancy loss affected the professionals, given that they reported feelings of helplessness and frustration when confronted with the situation. For them, communicating the diagnosis of a fetal death was an extremely delicate moment in practical assistance that generally caused frustration and discomfort. Therefore, we conclude that providing attention to emotional and behavioral manifestations of health professionals can help them develop their subjective questions related to fetal death in their context of work.

Keywords: Maternity; death; health professionals.

MORTE NA MATERNIDADE: COMO PROFISSIONAIS DE SAÚDE LIDAM COM A PERDA

RESUMO. Comunicar a notícia de uma morte fetal é momento muito delicado, tanto para pais e familiares, quanto para o profissional de saúde, que, além de fornecer a notícia, precisa prestar assistência ao longo da internação. O objetivo geral desta pesquisa foi estudar como profissionais de saúde vivenciam e enfrentam a situação de perda gestacional decorrente da morte fetal, com base na investigação de aspectos cognitivos (percepções e significados) e emocionais (sentimentos) relacionados à situação. Com base em delineamento descritivo qualitativo e amostra de conveniência, participaram oito profissionais que prestavam assistência direta a pacientes em situação de perda gestacional, mais especificamente nos setores de ultrassonografia, centro obstétrico e enfermarias de uma maternidade pública de referência a gestantes de alto risco, localizada na cidade do Rio de Janeiro. Os participantes foram entrevistados individualmente e seus relatos verbais analisados e processados de acordo com a metodologia de análise de conteúdo de L. Bardin. Observou-se que os profissionais eram afetados pela situação de perda gestacional, já que relataram sentirem-se impotentes e frustrados diante da situação. Comunicar o diagnóstico de um óbito fetal foi indicado como um dos momentos mais delicados na prática assistencial, que, geralmente, causa frustração e desconforto. Logo, conclui-se que oferecer atenção às manifestações emocionais e comportamentais dos profissionais de saúde pode ajudá-los a elaborar suas questões subjetivas relacionadas à morte fetal no seu contexto de trabalho.

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Palavras-chave: maternidade; morte; profissionais de saúde.

MUERTE EN LA MATERNIDAD: ¿CÓMO LOS PROFESIONALES DE SALUD SE REFIEREN A LA PÉRDIDA?

RESUMEN. La comunicación de la noticia de una muerte fetal es muy delicada, tanto para los padres y familiares, como para el profesional de salud, que, además de hacer la comunicación, necesita prestar atención a lo largo de la hospitalización. El objetivo general de esta investigación fue estudiar cómo profesionales de salud viven y enfrentan la situación de la pérdida del embarazo debido a la muerte fetal, con base en la investigación de aspectos cognitivos (percepciones y significados) y emocionales (sentimientos) relacionados a la situación. Basándose en un diseño descriptivo cualitativo y muestra de conveniencia, participaron 08 profesionales que prestaban atención directa a las pacientes en situación de pérdida fetal, más específicamente en los sectores de Ecografía, Centro Obstétrico y Enfermerías de una maternidad pública que es referencia en casos de embarazos de alto riesgo, ubicada en la ciudad de Rio de Janeiro. Los participantes fueron entrevistados individualmente y su informe verbal ha sido analizado y procesado de acuerdo con la Metodología de Análisis de Contenido de L. Bardin. Se observó que los profesionales eran afectados por la situación de pérdida fetal, puesto que han reportado una sensación de impotencia y de frustración frente a la situación. Comunicar el diagnóstico de una muerte fetal fue indicado como uno de los momentos más delicados en la práctica de la atención, y en general causa frustración y malestar. Por lo tanto, se concluye que ofrecer atención a las manifestaciones emocionales y de comportamiento de los profesionales de salud puede ayudarlos en la elaboración de sus cuestiones subjetivas relacionadas con la muerte fetal en su contexto de trabajo.

Palabras-clave: Maternidad; muerte; profesionales de salud..

Death is a very complex phenomenon that often occurs throughout our lives; in spite of that, we are always trying to keep ourselves away from it (Pacheco, 2004). Although many people have to experience situations involving death more frequently, as health professionals do, there is a difficulty inherent to all human beings in dealing with death, since it represents the real in our psyche, something about which it is not possible to talk and that brings the impossibility of signification (Freire, 2005).

However, Pires (2010) argues that health professionals commonly have a “socially accepted commitment with life” (p.143), which causes many of them to present some trouble dealing with death. Thus, to face situations of death within their professional context, they lean on the use of technological support available, which means a practice of detachment and avoidance before death at all costs, with consequent experience of fears and anxieties that not always can be verbalized (Pires, 2010).

In the context of a hospital, as in a maternity hospital, it is common that people create representations with positive connotations in which birth is always acknowledged as an event marked by positive emotions, that is, the birth of beautiful and healthy babies with happy and tearfully parents. However, a maternity hospital can also be the stage for other gestation and birth experiences marked by not so positive situations, especially when pregnancy loss or fetal death occurs.

Fetal death is defined by the Ministry of Health (2009) as:

Death of the gestation's product before expulsion or complete extraction from the maternal body, regardless of the duration of the pregnancy. It is considered death the fact that, after separation, the fetus does not breathe nor gives any sign of life such as heartbeats, umbilical cord pulsation or effective voluntary muscle contractions. (Brasil, 2009, p. 24).

Concerning the distinction between fetal deaths and miscarriages, the Ministry of Health (2009) uses as markers the fetus' gestational age, weight at birth and height. Thus, according to such description, fetal deaths characterize deaths occurred from the 22nd complete week of gestation (or 154 days), or fetuses weighing 500g or more, or with height from 25 cm. Differently, miscarriages characterize the expulsion or extraction of a product of conception weighing less than 500g, and/or smaller than 25 cm, or with less than 22 weeks of gestation, with or without evidence of life (Brasil, 2009).

According to Fretts (2005), there are several factors associated with fetal death, including maternal diseases, fetal malformations, infections acquired during gestation and abnormalities in the placenta or in the fetus' development. To Nazaré, Fonseca, Pedrosa and Canavarro (2010), fetal deaths are associated more often with obstetric or delivery complications, in addition to maternal health problems, and, in a significant percentage of cases, with non-identified causes.

Studies reveal that health professionals encounter difficulties to approach and even to carry out the necessary care towards the patient with pregnancy loss (Montero et. al., 2011; Santos et. al., 2012). Commonly, some people mistake such attitudes for indifference and coldness; however, they may reflect the sensation of lack of preparation from the professional to deal with the loss along with the one suffering it.

Fetal death and grief among health professionals

Communicating the patient about a diagnosis of fetal death is a delicate moment, for it generates anxiety and insecurity in the professional in charge of bringing such bad news (Monteiro et. al., 2011). The way that this information will be transmitted depends above all on the personality of the professional in question, on his or her related life experiences, as well as on the way he or she finds to deal with these hard situations (Kain, 2012). It can be noticed that this moment is often underestimated by some professionals, when, on the contrary, a significant importance should be attributed to it, considering that the way a diagnosis of pregnancy loss is communicated can directly and indirectly affect the way the woman will react afterwards (Kübler-Ross, 2005).

The assistance to the birth of a baby who is already dead can also constitute a delicate and uncomfortable situation for many health professionals. At the moment of birth, it is a medicine and health professional's role to assist this lifeless baby wrapped in the silence his or her first cry did not fill in. In these cases, the turmoil after the birth of a baby is not aimed at the performance of first care measures towards the newborn, but at taking out this lifeless baby in front of the mother for a quick examination of his or her birth and, consequently, death conditions.

Believing it to be the best thing to do, right after birth some professionals act quickly to take the dead baby away from the mother's presence (and from their own), in order to eliminate the discomfort and suffering. Not rarely, they wonder at and oppose to the mother's desire to see and hold her dead child in her arms, an episode involved by silence, discomfort and disapproval from the professionals, followed by little information provided to the parents (Bowlby, 1989/2004).

Contrarily to what it might seem, such an attitude appears to reflect a concern and respect from the professionals towards the suffering that they imagine the woman is going through in that moment. However, it may also indicate an attempt to spare gestures and emotions before the pain for the death of a child (Freire, 2005). From this perspective, people around the grieving woman tend to eliminate (or minimize) any type of expression of suffering.

It is common to see health professionals near the woman who has suffered the loss trying to make her hold back her tears, convincing her that it was better that way or trying to make her contemplate the possibility of having another baby in order to make up for the emptiness the death of the fetus/baby has caused. With such attitudes, which are intended to help the grieving woman to overcome her loss, Freire (2005) argues that, in fact, the woman is pushed into holding in her suffering all alone.

In hospital wards, it can be noticed that the assistance provided to the patient is almost exclusively aimed at biological questions. In general, the professionals investigate quickly her complaints about the pains and discomforts in her body. It is clear that this type of assistance is important, but the quickness and detachment often adopted by the professionals may actually indicate the distress that this contact causes to them (Montero et. al., 2011; Santos et. al. 2012).

Research conducted with nurses who were assisting women with a diagnosis of fetal death in a reference maternity hospital in the state of Ceará, more specifically in the high-risk pregnancy assistance unit (Santos et. al. 2012), concluded that those professionals acknowledged the importance of offering an emotional support in a situation of loss. However, the nurses were also aware of their lack of preparation to deal with occurrences involving fetal death, which made them adopt strategies to dodge the discomfort with their own questions related to death, whether by assigning the assistance to

another professional considered more sensitive and more qualified to deal with such tough situations, or by focusing only on the biological aspects during the contact with the patient. Adopting this second attitude may lead many professionals to behave in a very detached way, denying, many times, the critical nature of the situation of pregnancy loss, especially when it comes to an early loss (Montero et al. 2011).

Thus, the way that each health professional deals with questions concerning death and pain for a loss hinges on different factors such as: their personal stories of losses, of experiences with death and of grief; values of the culture into which they are inserted, what influences their conception of death and the expression of their pain; besides their college education and in-service training (Kovács, 2010).

When a fetal death occurs, there is a grief that needs to be experienced and elaborated. Grief is comprehended as the entire psychic process provoked by the loss of an object, that is, a common reaction after the interruption of the relationship maintained with the object to which the subject directed a great affective investment (Freitas, 2000). Bowlby (1989) analyzes grief through the loss of a bond and interprets it functionally as a negative aspect of the bond and a response to separation.

Thus, grieving is a process of change of schemes that everybody experiences at some point in their lives when faced with a meaningful loss like death. Grieving is also about a subject starting a process of abandonment and learning, as certain schemes are abandoned and other ones are learned (Freitas, 2000).

Pires (2010) has a similar assumption when characterizing grieving as a cognitive process that leads an individual to confront the loss and its meaning, adapting himself or herself to a new reality. In this direction, the intention is to promote the psychic elaboration of the loss by making room for talking, through which he or she can report his or her distress, fears, frustrations and sadness.

In light of the above, this work aimed to study how health professionals experience and face the situation of pregnancy loss resulting from fetal death. In this way, it sought to investigate among this population the cognitive aspects (perceptions and meanings) and emotional aspects (feelings) related to their experience about the situation of pregnancy loss, in order to comprehend how these professionals feel when communicating the news of fetal death and when taking care of the woman in this hard moment of loss.

Method

The research followed a descriptive qualitative design and had a convenience sample, counting with the participation of eight health professionals, including physicians, nurses and nurse technicians. The participant professionals were providing direct assistance to patients in situation of pregnancy loss in the Ultrasonography sectors, Obstetric Center and Wards of a maternity hospital of reference in the assistance to high-risk pregnant women and newborns, located in the state of Rio de Janeiro. Aged between 26 and 39 years old (31 years old average), the professionals had on average 9 years and 4 months of professional training. Regarding the time of work at the institution, they had on average 5 years and 8 months. In addition, a great variation was observed in the answers about the religion professed, because some of them self-declared as Catholics (N=1), Christians (N=2), Kardecists (N=1) and Evangelicals (N=2), whereas two professionals claimed not to have a religion.

Thus, the participants were categorized as a team of young professionals but with a considerable average time of training (above 9 years on average) and period of experience at the institution (above five years).

The professionals were approached and invited to participate in an individual interview, when all objectives and procedures of the research were clarified and a free consent form was signed, with the approval by the Ethics Committee of the institution (CAEE No 10929612.0.0000.5275, of 22/02/2013). On a previously scheduled date and time and according to the participant's availability, the interviews were conducted, lasting an average of 20 minutes, being voice recorded and later transcribed.

To do so, an open-ended interview script was used, especially prepared for this research, called "Assistance to the Grieving Woman". The script contained a starting question from which the interview developed: How is it for you to have to assist a patient that has gone through pregnancy loss?

Moreover, at the beginning of every script there were additional items for the registration of general data for the characterization of the professionals, such as: role performed at the institution (profession), age, religion, time of training and time of professional experience at the institution.

The data of the interviews, that is, the speeches from the interviewees, were analyzed according to the Content Analysis methodology by Bardin (1977), resulting in the following categories: a) Communicating the baby's death, b) Dealing with a grieving patient, and c) The professional's feelings before the woman with pregnancy loss.

It is important to point out that all professionals received fictitious names in order to preserve their identities.

Results and Discussion

A great variety of answers was provided by the professionals to the starting question "How is it to you to have to assist a patient who has gone through pregnancy loss?" The verbal reports from the professionals will be descriptively presented according to the categories of analysis found and previously mentioned.

Communicating the death of a baby:

Bringing the news of a baby's death to his or her parents is always a delicate moment, faced by some professionals as a situation that leaves them uncomfortable and worried, due to the uncertainty about the best way to communicate the loss (Montero et. al., 2011), as the speech indicates:

...So you feel a little, like, apprehensive because you don't know how to talk, how to tell that and also how to calm down that little mother.... Sometimes, it might be, oh God, a fatality, it's not our fault, but it's always uncomfortable. I still have a little trouble dealing with this and trying to calm down the little mother and trying to comfort her..." (Nilma, physician, 29 years old).

To some physicians, the greater difficulty in assisting a woman with pregnancy loss seems to be communicating the fetus' death, more than the medical assistance afterwards. According to the speech below, such difficulty may be linked, among other things, to the malaise generated by the personification of the bad news in the physician:

I think that the worst thing is to give the news. Obviously, assisting the delivery is bad, but I think that the worst thing is you giving the news. You are the messenger of death, you know? The messenger of bad news, so... (Tito, physician, 39 years old).

In the general analysis of the reports from the eight professionals interviewed, it could be noticed that the physicians presented greater difficulty when compared to the nurse professionals to accept that the death was inevitable and that they could do nothing to revert the situation. In addition to the idea of the physician being the messenger of bad news, as described above, subjective questions related to the difficulty in dealing with death/loss pile up. Such a discomfort can also be related to the stalemate on which this professional stands, configured, as Pires (2010) states, by a conflict between the "commitment with life" (p.143) and the acceptance that the death has happened.

Thus, it becomes legitimate to the professional, who has the duty of saving one from death, to question himself or herself about the acceptance of death in face of the duty of preventing it from happening. Next, Jonas' speech approaches this question and exposes his difficulty in accepting death without thinking that there has been a personal and/professional fault:

Well... because... it's bad, that's it, it's the sensation of failure, and we, medicine professionals, have this "little symptom" of wanting to fix things, you know? So you're like: "damn", "should I have done something else?", this question doesn't go away, no matter if you have read the book and seen that it was like that, I did everything, she did exams every day and the baby died because she died and there was no way we could have prevented that death... I think it comes from the job, because I think

that it's not really a feeling of guilt, it's... that stubbornness thing, that thought: "I wish I could resolve that", I have this wish, I wish I could fix these things we're not able to fix yet. Maybe one day. (Jonas, physician, 31 years old).

It is common that people construct positive conceptions about the maternity hospital. There is a shared opinion that it is a place where life begins and that birth constitutes a happy moment, as previously discussed. It could be observed that the physicians in this research have similar conceptions as well and feel emotionally affected when a birth does not occur as expected, as the following reports exemplify:

One of the biggest advantages of obstetrics is that we deal with life, right? In general, there's a happy ending, everything goes fine. So, when a death happens and, especially when it happens more at the end of the gestation... The impact is bad on everyone. (Tito, physician, 39 years old).

It's hard to lose somebody, especially in our area, we may lose a baby, so what could be a happy moment... because I think that the normal, what we expect is to send the mother, the baby, the father away, with a small bag. So, if somebody happens to not leave with them there's something wrong. (Nilma, physician, 29 years).

During the hospitalization period, which may vary between 24 and 48 hours, health professionals need to deal with the grieving mother going through a process of pregnancy loss, more specifically with feelings derived from the death, as well as with their own feelings during assistance. Such assistance comprehends big challenges, considering that the woman finds herself emotionally weakened and still has direct contact with new mothers and their babies in the collective ward.

Dealing with the grieving patient

In the institution where the research was conducted, one of the first procedures about which the health team is concerned after receiving a patient with a diagnosis of pregnancy loss is to decide to which ward of the collective accommodation she will be sent after the performance of procedures in the obstetric center. The choice of the bed is very delicate, because there is a concern with not admitting a patient with pregnancy loss to the same ward where other women who have just given birth are staying, as this report seems to show: *"We try to put them in separate wards, you know, together with expectant mothers, avoiding to put them with little babies. (Nádia, nurse, 26 years old).*

It is possible to notice an attempt by the team to spare the patient this encounter with other babies and their mothers, right after her loss. However, this distance is not always possible, because sometimes the patient needs to be sent to a ward with new mothers and their babies due to the limited number of beds per ward. In these cases, when the grieving woman arrives at her bed, she and the entire team need to deal with this situation, as Elvira reports:

But that was a situation... I put myself in her shoes, you know? Whether I'd have the same attitude as hers or whether I'd manage to put up with that, you know? Just being there crying on the inside and seeing the happiness of the other mothers. (Elvira, nurse technician, 26 years old).

The way a woman manages to face a situation of loss is an important factor to consider, because this will define, among other things, the interaction between the professional and the patient. Put in other words, the way a woman manages to deal with her loss will interfere with the assistance provided to her:

That's why I say that everything depends on how the patient is reacting... if you stay with a patient that cries too much, you'll get involved. In front of her, you have to be professional, you have to be serious, you go and make the interview with her, and you do the anamnesis with her, but you end up getting involved. Oh! We say we get used to it, but... I haven't yet. (Nádia, nurse, 26 years old).

As seen in the literature (Montero et. al., 2011; Santos et. al. 2012), the professionals create strategies to handle the discomfort and anxiety generated in them because of the situation of death,

such as keeping some distance in order to reduce the distress and not to involve or mobilize themselves with the patient's pain, as the report illustrates:

We end up facing this day after day and I think that, somehow, we're a little cold, I think this is also a form of protection because it's hard to lose somebody, especially in our area, to lose a baby... (Nilma, physician, 29 years old).

Another strategy used by the professionals interviewed in order to avoid contact with the suffering of the grieving woman and their own is to act in sectors at the maternity hospital where necessarily there is no direct contact with this type of patient: *"At the ICU, I handle it a bit better, because I don't have to give news to anybody and I don't have much contact with the mother, but here [ward], because we work with them, it's very hard"*. (Luci, nurse, 26 years old).

This strategy adopted by the health professionals of drawing themselves distant from the patient's pain, aiming to protect themselves from the impact that that suffering may cause in them, can point to a feeling of lack of preparation they feel to deal with such situations of loss, which is corroborated by the literature (Santos et. al., 2012) and exemplified by the following report: *"Yeah, I think that even us, health professionals, as the medical part, we're not emotionally prepared to deal with that either."* (Nilma, physician, 29 years old).

It is interesting to mention that in most of the cases in which the health professionals claimed not to feel prepared to deal with a situation of pregnancy loss, they were all professionals with a shorter time of work at the institution, if compared with those who deemed themselves prepared. The literature points that one of the factors that can make it easier to health professionals to deal better with critical questions involving their assistance practice would be the time of professional experience, since the longer the time of experience the better the preparation to handle situations of death (Shimizu, 2007; Cavaleiro, Moreira Junior & Lopes, 2008). This data invites us to reflect about factors that influence the change of a health professional's conceptions and practices throughout the time of his or her experience.

Equally, our study also highlighted the expectations of a couple about a prematurely ended pregnancy as another factor that influences the perception of professionals about the situation and, consequently, their assistance practice. In the interviews, it could be observed that to the majority of the team (87.5%) pregnancy loss is a situation that mobilizes the professional that assists the woman, especially when the baby is eagerly awaited by the parents.

Some professionals state that they feel personally affected by the loss the woman has suffered; however, they still consider that their assistance practice does not suffer interference from it. This conception can relate to the idea of separation of that which is of emotional order from that which is of personal order, as the following speech seems to exemplify:

No, it doesn't affect me when I perform... my... my assistance, no, it doesn't, but I feel, like, moved by the patient's situation, you understand? ... It's important! You have to separate, otherwise you won't help the patient neither one way or the other. You can't be the person to be touched by that and won't do your job properly either, you understand? So, I think that it's important to separate, yeah, the professional from the emotional. In our area, that's essential, it really is." (Micaela, nurse, 34 years old).

Still about the difficulty to approach the grieving woman, personal availability and time were mentioned as factors that cause an impact on the greater or lesser approach and assistance towards the patient with pregnancy loss, as the report below shows:

Sometimes the patient is facing that anger and... we make it the psychologist's business real quick (laughs). Because it's something that takes your time. And nurses, sometimes, we lose ourselves in other things, you know? In the technical care: from administering a drug to checking vital signs, doing the bed, we end up putting aside that care for the other, as a whole, which would be like staying there listening. So sometimes we don't have this availability. And then there's those other things I told you about, those factors too: how I am feeling that day (...) you end up paying more attention to the technical care, which is about caring in another way. (Amélia, nurse technician, 38 years old).

This report is particularly interesting, because it indicates the organization of the work routine in the ward as a factor that prevents the professional's flexibility and mobility due to the great demand of patients for a reduced number of professionals. In addition, it demarcates the care routine in the ward, where the nursing team is often limited to physical care, the focus of their practice. From this perspective, the figure of the psychologist is appointed as a direct assistant to the patient in her emotional issues linked to her loss.

On the other hand, it presents an important question to be discussed: personal availability to make time for embracing and listening to the patient's suffering. Such report seems to indicate that, by caring about investigating the emotional aspects referring to the loss, the professional is doing something else for that woman, which configures an action that goes beyond his or her role of physical care. Amélia's speech seems to reflect as well the image that the other professionals construct of the psychologist, professional characterized as the one who often has the time to listen to the woman and give attention to the feelings generated by the loss of her child.

The psychologist has, indeed, differentiated ears turned to the singularity of the individual, seeking to welcome psychic demands and enable the elaboration of the emotional experience in order to ease the coping with the traumatic experience lived (Ribeiro, 2013). However, when showing himself or herself interested in knowing how the woman is dealing with her loss, the professional, whether a physician or a nurse, does not take the place of the psychologist, but acts towards cultivating and appreciating a humanized practice of welcomeness.

The professionals' feelings before the woman with pregnancy loss

It was observed that during the assistance to the grieving woman, the participant professionals assumed an attitude of putting themselves in the place of the woman who has suffered the loss, reflecting feelings of solidarity and empathy, as shown in the report below:

If that happened because the patient had a problem during the gestation I feel very (PAUSE)... sad for the patient, you know? Because I'm a mother and I know that losing a child at any age, even if gestational, is relevant. So I feel moved by that situation. (Micaela, nurse, 34 years old).

The lack of words to say to the patient was one of the reasons mentioned to justify the difficulty of approach to the grieving woman, especially to those more emotionally reactive. It is common that the health professional feels more unprepared and powerless, especially in situations in which the woman cries more and is more depressed:

But dealing with this situation is really hard.... You don't have much to say... Sometimes a feeling of powerlessness also overwhelms us, when you see that the mother is too sad, the mother is depressed, you feel powerless too.... (Elvira, nurse technician, 26 years old).

It is important to emphasize that feelings of powerlessness and frustration were mentioned by nursing and medicine professionals, with similar senses. This leads us to believe in a proximity between such discourses in spite of the difference of professional category. As described in the report above, the nurse technician talks about the powerlessness she feels when seeing the sadness and pain of the patient as she assists her in the ward, whereas she sees herself limited to help her to overcome that suffering. The physician, in turn, speaks of the frustration he feels when assisting the patient with a diagnosis of pregnancy loss, thinking/questioning about what else he could have done to prevent the death from happening, as exemplified in the report below:

I think that it's a huge sensation of frustration. Regardless of the fact that we know rationally that nothing else could have been done, that the death was inevitable.... No matter how much you say "no, we did everything right that had to be done", "everything right", "we couldn't make that surgery because there wasn't surgical possibility, "he/she died and would have died no matter what", but I have this sensation of frustration, that... I don't know (smiles). (Jonas, physician, 31 years old).

The approximation between the discourses of the nurse technician and of the physician seems perfectly possible to us, taking into consideration that both professional categories see themselves limited in the assistance to the patient in situation of pregnancy loss. However, physicians question themselves about their capacity to prevent the loss, whereas nurse technicians question themselves about their capacity to help the woman to overcome her loss.

Final Considerations

Based on the discussion held in the course of this work, it can be stated that health professionals are affected by the situation of fetal death or pregnancy loss, even if in a singular manner. Dealing with a grieving patient challenges their own convictions and beliefs and leads them to question their professional practice. Fetal death puts professionals before limitations of their professional activity, making them remember that there is a limit to their intervention, to their mission of saving lives.

Health professionals commonly use strategies to protect themselves psychically from the suffering experienced by their patients, such as showing little involvement and affection while assisting them; acting in sectors of the maternity hospital in which there is little or no contact with women that go through losses; and assigning to another health professional the assistance to grieving women, for acknowledging their personal limitation.

It is possible to observe that, to physicians, the confrontation with this limitation of their work is even more impacting, because it challenges the commitment with and the mission of saving lives discussed throughout the present study. In the interviews with the professionals of the nursing team, there is a greater concern about helping the woman to overcome a fetal death. However, many professionals claim that they do not feel prepared for that and request for such a situation the job of the psychology team.

The physicians, nurses and nurse technicians who participated in this research mentioned feelings of solidarity, empathy, powerlessness, frustration, sadness and limitation as being inherent to the assistance to the woman grieving for a pregnancy loss. In this way, making some room for the elaboration of the experience lived in the assistance to the patient in situation of pregnancy loss would need to be an institutional concern that involved the entire team, not only the professional specialized in mental health.

In conclusion, it is imperative that we stay more attentive to the complexity of the relationship between health team, patient and family in this moment of loss, in addition to being sensitive to manifestations of emotions and behaviors from health professionals in order to help them elaborate as well subjective questions that pregnancy loss reverberates in themselves. Interdisciplinary work can greatly contribute to a comprehensive assistance to the patient, besides helping health professionals themselves deal with their own worries before the assistance to women who go through pregnancy loss.

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