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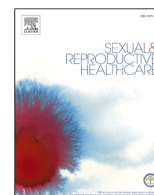

Review

Midwifery care for late termination of pregnancy: Integrative review

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ABSTRACT

Midwives provide reproductive healthcare to women, including during termination of pregnancy (TOP) after 12 weeks (late TOP). Their expertise, knowledge and woman-centred care approach sees them ideally placed for this role. However, the medical, social and emotional complexities of late TOP can cause midwives significant distress. An integrative review methodology was used to examine the research on midwifery care for late TOP and identify support strategies and interventions available to midwives in this role. Five databases and reference lists were searched for relevant studies published between 2000 and 2021. A total of 2545 records were identified and 24 research studies included. Synthesis of research findings resulted in three themes: *Positive aspects*, *negative aspects* and *carers need care.* Midwives reported a high level of job satisfaction when caring for women during late TOP. Learning new skills and overcoming challenges were positive aspects of their work. Yet, midwives felt unprepared to deal with challenging aspects of late TOP care such as the grief and the psychological burden of the role. Caring for the baby with dignity had both positive and negative aspects. Midwives relied predominantly on close colleagues for help and debriefing as they felt poorly supported by management, judged by co-workers and lacked appropriate support to reduce the emotional effects of late TOP care. Midwives need support, although current evidence has not identified the most appropriate and effective strategy to support them in this role.

Introduction

Termination of pregnancy (TOP) is a common, safe and effective reproductive healthcare intervention if carried out by a trained practitioner who uses a clinically recommended method appropriate to the gestation [1].

Midwives are an essential workforce for improving the quality of TOP care, increasing access for women[1] on a global scale and reducing the burden of maternal deaths from unsafe TOP procedures. Providing comprehensive TOP care is within the midwifery scope of practice [3] and both early medical TOP (<9 weeks) and manual vacuum aspiration are appropriate interventions for midwives to carry out, if they have received the necessary training [4].

The responsibilities for individual midwives in the context of TOP is regulated by legal frameworks, education, registration and health systems [5]. Midwifery is a separate profession in many parts of the world, although in some countries nurses perform duties of a midwife and the term nurse-midwife or labour and delivery nurse is used [3,6]. As all these health professionals provide reproductive health care for women within the domain and, what is considered, the scope of midwives, the term midwife has been used throughout this review for ease of writing and reading. All authors recognise and fully support the International Confederation of Midwives 2017 definition of a midwife [3].

Midwives also care for women undergoing TOP after 12 weeks (late TOP). Late TOP is used to describe TOP from either 12 weeks or 20 weeks onwards however, there is currently no firm definition [10–11]. Advances in prenatal screening and diagnosis have allowed early detection of fetal abnormalities, although treatment for many conditions remains limited [12]. Reasons for late TOP are most often genetic or chromosomal abnormalities, fetal abnormalities detected on ultrasound and maternal medical conditions where an ongoing pregnancy poses a threat to physical or mental health, or even life [13]. An unexpected diagnosis of fetal abnormalities or pregnancy complications can be a difficult time for women and families, and the decision to continue the pregnancy or terminate can be distressing [12]. Other reasons for late TOP are delaying factors, such as late detection of pregnancy,

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[1] The term 'woman' is used throughout this document. Individual parents and families may use different words and we respect their preferred terminology.

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indecisiveness or difficulties accessing an earlier termination, reproductive coercion or control, domestic violence and socio-economic disadvantage, which may cause poor maternal mental health and distress [14–15]. Late TOP can be complex for any reason and individual social issues and the stigma of TOP in general can add to the complexity of late TOP [16]. Care planning requires an individualised approach, careful consideration, sensitive discussion and multi-disciplinary teamwork. Midwives, medical practitioners, sonographers, social workers and other allied health workers come together to support women and families through this event. However, midwives are often the main care providers during the labour and birth part of late TOP.

After 20 weeks TOP is performed by inducing labour, generally with a combination of a single dose of Mifepristone followed by a Misoprostol regime given in regular intervals until delivery [1]. This approach might differ between countries and TOP guidelines. Below 22 weeks the antiprogesterone effect of Mifepristone and the uterine contractions during labour lead to fetal death just before or shortly after birth. Feticide, the process of injecting Potassium Chloride into the fetal heart in utero, induces fetal death and is recommended prior to labour induction for TOP after 21 + 6 weeks to avoid the distress of a live birth for parents and healthcare providers [10,13,17].

Maternal risks increase with gestational age and include postpartum haemorrhage, retained placenta and uterine rupture in women with a pre-existing uterine scar [18]. Midwives' expertise in optimising normality even in the face of multiple complications allows them to focus on the needs of women while negotiating the medical processes of late TOP. With their considerable training and knowledge they also manage medication, such as Misoprostol, fluids, analgesia, and recognise and seek obstetric assistance when complications develop [19–20]. Despite some risk, late TOP remains an essential component of reproductive health care and is a safe and necessary intervention which, in some cases, may be lifesaving.

Women undergoing late TOP for fetal abnormalities have described how the process of labour and birth was a traumatic experience which caused them emotional and physical pain [21]. Midwifery care has been described as fundamental to women's experience and the compassion, kindness, connectedness and understanding shown by midwives creates feelings of safety in women [21–23]. Keeping women who access TOP services safe and well supported requires a well-supported midwifery workforce in turn. Midwives themselves have described late TOP care as an emotional burden that is challenging and conflicting and is associated with ongoing grief, burnout and signs of secondary traumatic stress [26–28]. Currently it is unclear how well, and if at all, midwives are supported in this role to minimise the emotional impact. It is therefore important to get a better understanding of midwifery care for late TOP, to identify if midwives are appropriately supported in this role and to discover what might help them cope with the emotional impact of their work.

The aims of this review were:

- To ascertain what the published research currently reports about midwifery care for late TOP (>12 weeks).
- To identify supportive strategies for midwives working with late TOP to help them cope with emotional challenges.

Methods

To conduct this review the integrative review methodology as described by Whittemore and Knafl [25] was followed. This included the five-step approach to identify the problem, search for, evaluate the literature, analyse the data and synthesise and display the findings. The integrative review allows for the inclusion of experimental and non-experimental research to facilitate a better understanding of a phenomenon that can inform health care practice and research [25]. The rationale for using an integrative review methodology was the lack of research evidence on the topic and to allow the evaluation of a diverse range of research. This integrative review is not registered or associated with a pre-existing review protocol.

Search strategy and selection criteria

In October 2021 a literature search was carried out. The databases searched were CINAHL, APA PsycInfo, Medline Ovid, Scopus and Cochrane. Reference lists of included papers were also searched. The search strategy *(*Table 1*)* was developed with the assistance of an academic librarian and was focused on nurses, midwives and nurse-midwives, induced abortion and termination of pregnancy, and combined terms with psychosocial support strategies (counselling/debriefing/clinical supervision), effects of TOP (workplace stress/compassion fatigue/burn-out) and the concepts of grief and loss.

The population of interest were midwives and nurses working on gynaecological wards, in abortion clinics, women's assessment wards and labour and birthing rooms who provide care to women undergoing a termination of pregnancy from 12 weeks onwards. The sampling time frame was inclusive of years from 01/2000 to 10/2021 as advances in prenatal screening and diagnosis and practice in the context of late TOP have changed midwifery practice. There has been limited research into the role of midwives and midwives' experience with TOP over 12 weeks so far.

Considered for inclusion were original, peer reviewed research studies in English language with either quantitative, qualitative or mixed methodology and theses which described midwifery care during late TOP, midwives' experiences with late TOP and supportive strategies available to or accessed by midwives to deal with associated psychological effects. Publications primarily focusing on TOP in the first 12 weeks of pregnancy, perinatal loss or bereavement not inclusive of late TOP, opinions or practice, legal aspects of TOP, medical aspects of TOP (medication safety and efficacy, different methods of abortion, feticide), women's experiences with TOP, education of student midwives/nurses, reports not relevant to the research question and reports not written in English language or other grey literature were excluded from this review.

Table 1
Search strategy.

Search terms
Midwife/Midwifery
Nurse-Midwife/Nurse-Midwifery
Midwives/Nurse-Midwives
Abortion, induced
Termination of pregnancy/termination/medical termination
MH* support psychosocial
MH clinical supervision
MH counselling
Clinical supervision
Counselling or debriefing
Emotional support/psychosocial support/support strategies
Workplace stress or secondary stress or secondary trauma
MH compassion fatigue
MH stress, occupational
MH stress, psychological
MH burnout, professional
MH role stress
MH Grief
Grief and Loss
Bereavement
APA PsycInfo:
Emotional exhaustion
Distress
Compassion Fatigue
Posttraumatic Stress Disorder
Psychological Stress
Perceived Stress
Stress Management
Occupational Stress
Supportive Psychotherapy

* MH = minor and major concepts searched.

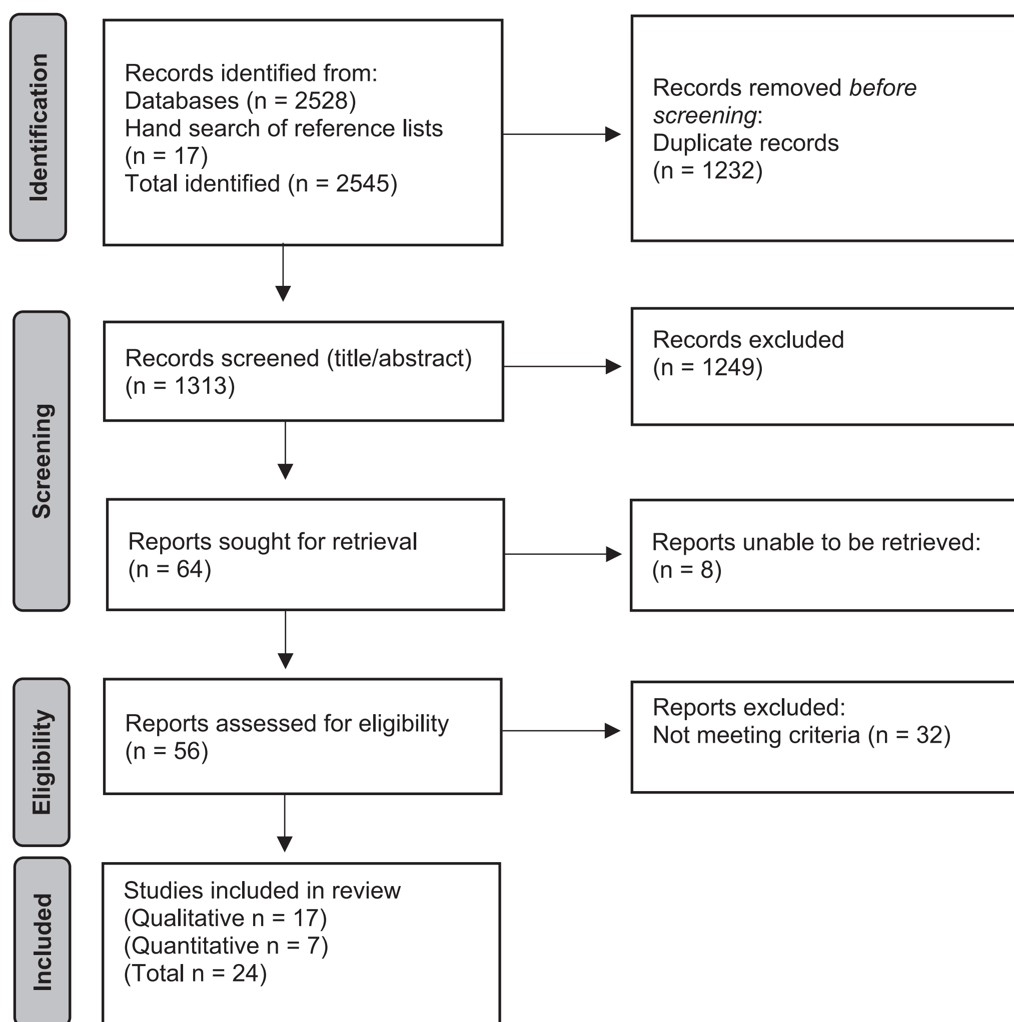

Fig. 1. PRISMA flow chart.

Results

There were 2528 records extracted from five peer-reviewed databases and exported to Endnote reference manager. An additional 17 records were identified through hand searching of reference lists of the included studies. The PRISMA flowchart *(*Fig. 1*)* was used throughout the screening process and to identify eligible records.

Following removal of duplicates and title and abstract screening (first and fourth author) we sought 64 reports for retrieval. Eight records could not be retrieved as they had been published in professional magazines or midwifery digests which had either ceased publication or were only accessible with professional memberships or individual subscription. Exclusion/inclusion criteria were applied to 56 full text reports by the first and fourth author. Disagreements were resolved through discussion with all authors. Consensus between the authors was reached and a total of 24 studies were included in the review. The included 24 studies stemmed from a broad range of countries and there were some differences between countries and their legal, social and health care context. Twelve studies focused only on midwives as participants, 8 studies included nurses/labour and delivery nurses, and 1 study included nurses as well as midwives. Three papers also included a small number of obstetricians, a small number of managers and one study included a small number of sonographers and allied health workers [29–30]. These papers were included as the vast majority of participants were midwives. One paper [30] was included following discussion between the authors as study's inclusion criteria were not clear enough to determine that staff had not cared for women experiencing loss in the context of late TOP and therefore the study was included in this review. Two theses were found where no manuscript had been published by the authors. These met inclusion criteria and were therefore included [31–32]. One additional thesis was found in the search where the author had also published a manuscript; the thesis was accessed for more information [33]. One thesis, which was retrieved following the search, was also accessed to provide further information to the author's published paper [34]. This thesis is not included in the search numbers. A summary of the studies has been provided in Table 2.

Evaluation of the data

Quality appraisal

The methodological quality of the included studies was evaluated with the Critical Appraisal Tools provided by the Joanna Briggs Institute (JBI) [35] *(*Table 2*)*. Studies with a qualitative methodology (n = 17) were appraised with the JBI critical appraisal checklist for qualitative research. The JBI checklist for analytical cross-sectional studies was used for the cross-sectional surveys (n = 7) included in this review. No study was excluded based on this appraisal due to the paucity of the published research.

Analysis

Data was extracted into an excel spreadsheet for detailed review (first author). Analysis of the data was focused on the aim of this review:

Table 2
Summary of included research papers.

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
Askey, 2001	United Kingdom	To explore the experiences of staff who have cared for women experiencing a TOP for fetal anomaly with a view to identify training and organizational needs and factors that will facilitate staff support.	23 participants: 5 obstetricians, 1 allied health worker,2 sonographers,4 gynaecology nurses,11 midwives	Caring evolved over time and was related to the emotional reaction of women and families to news of fetal abnormality. Process is described in a fluid model called 'the experience of the evolution of caring'. Three main stages are identified in the model through several categories such as support, boundaries and limitations, and detachment. Stage 1 getting experience (new to it, uncertainty about the right thing to do, no prior knowledge or experience). Stage 2 learning and development (aware of boundaries, developing empathy, acknowledge own limitations). Stage 3 experience and maturity (knowledgeable, getting it right, able to distance self from situation). "Doing the right thing" as core category. Negative experience can set mature midwife in stage 3 back to stage 1. Authors recommend formal support.	Grounded theory	8/10
Cignacco, 2002	Switzerland	To investigate how midwives view the TOP because of a pathological fetal condition and to clarify their ethical position.	13 midwives	Midwives face significant conflict between mother's right to choice and child's right to life which results in high levels of emotional distress in midwives and professional identity conflicts. Midwives suppress thoughts regarding the child and rationalise their support for women to allow them to continue with duties, however they lack the tools to make a proper informed ethical decision. Not being part of parents' decision to terminate is an aggravating factor. TOP care is a heavy emotional burden, causes feelings of anger, sadness, uneasiness, helplessness. Midwives are confused about the tasks they are expected to fulfill. Author recommends institutional support, clarification from professional bodies, training with emphasis on professional ethics.	Qualitative inductive	9/10
Huntington, 2002	New Zealand	To explore nurses' reality on the gynaecology ward.	8 gynaecology nurses	Late TOP is a complex procedure, demanding psychological and physical knowledge and clinical expertise. Nurses draw on these skills to appropriately support women. They have to stay emotionally connected to the woman throughout as emotional or physical distance can add to woman's trauma. Nurses have to experience TOP with the woman to make her right to choice a reality. Provision of service absorbed into nursing practice, unseen aspect of their work. TOP as unique female event that many women have fought to make freely available. Conscientious objection means increased strain on nurses who do provide TOP care. Impact on nurses must be recognised, support is essential to ensure	Feminist interpretive	3/10

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
				women receive good care and service is sustained. Author recommends continuity of care.		
Mayers, 2005	South Africa	To explore the lived experience of midwives who assist with TOP.	3 midwives	**Five themes.** *Obstacles experienced*: not prepared emotionally or skills wise. *Feelings evoked by the experience of assisting with TOP*: negative, anger, isolation, dependent on reason for TOP. *Conflicts encountered:* moral and religious conflict, live baby. *Coping mechanisms utilized* (emotional and physical distancing, self-justification, removing themselves from difficult situations, relying on colleagues. *Need for support*: sharing experiences with colleagues, partner support dependent on stigma, no managerial support, colleagues in room reduce loneliness and gives moral support. Authors recommend supportive structures.	Phenomenology	10/10
Chiappetta, 2005	Canada	To examine the experiences of genetic termination nurses and the strategies they develop to respond to this dirty work.	41 labour and delivery nurses	Study used sociological concept of 'dirty work'. Focus was on aspects of nurses' work which is viewed as unpleasant and undesirable. Lack of support from organisation led to problems. Nurses reported conflicts, challenges and frustrations but also job satisfaction. They described overcoming challenges by finding strategies and developing own models of care. If they were able to give high quality care the work turned from dirty to dignity and led to personal and professional satisfaction. Author recommends training, resources and support.	Grounded theory	9/10
Bishop, 2007	Canada	To explore the meaning of nurses' experiences of caring for women having pregnancy terminations for fetal anomalies using labour induction techniques by identifying, describing, exploring and explaining their experiences.	11 nurses	**Overarching theme**: Doing taboo work. **4 essential themes**. *Making choices:* taboo nature of the work made nurses choose as to how they wanted to be with women. *Being pulled in two directions:* nurses want to give the best care possible but they had to conceal themselves, the women and the work due to taboo/stigma of TOP. *Being given token bones:* lack of meaningful support and resources for nurses. *Riding an emotional roller coaster:* intense and polar opposite emotions of the work. Author recommends education, policies and guidelines, improved working conditions, emotional support.	Hermeneutic phenomenology (Thesis)	N/A*
Garel, 2007	France	To identify clinical, emotional and moral difficulties that French midwives encounter while performing TOP in labour ward and to determine factors related to such difficulties.	92 midwives	Midwives described late TOP role as difficult (65%). Issues reported: responsibility to support patients psychologically while experiencing emotional distress themselves; concerns fetus born alive (75%); moral conflicts for personal, cultural or religious reasons, mostly around indications for TOP (25%). Midwives agreed on clinical management of TOP. Midwives with professional experience, training, and those working in larger (referral) centres reported	Questionnaire survey	6/8

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
				fewer difficulties. Authors recommend institutional support and training and updates on psychological and ethical aspects of TOP.		
Lindstrom, 2007	Sweden	To describe Swedish midwives' clinical and emotional experiences and to search for influencing factors on midwives' views on working with TOP. A further aim was to study the midwives' perceptions of women's motives for having an abortion.	216 midwives	2/3 midwives had provided TOP care. Midwives working with TOP only few had thought about changing their job or had reservations/feelings of inadequacy caused by meeting women requesting TOP. Midwives currently working with TOP and previous experience had positive feelings about the procedure (50%). Midwives' perception of motives for TOP was consistent with motives provided by women themselves. Unease and inadequacy about late TOP reported by 50%. Midwives who had themselves had a TOP were less reserved about late TOP than those without personal experience. Religious belief no influence on midwives' views of TOP. TOP seen as part of midwives' duty and opting out should not be an option.	Questionnaire survey	6/8
Gallagher, 2010	United Kingdom	To explore the perceptions of nurses who work in abortion services.	9 nurses	**Two global themes**: 'Attitudes towards abortion' and 'Coping with'. **Six organisational themes**: Society, nurses, reasoning, role, clients, late gestation abortion. **Basic themes**: reactions, preconceptions, women undergoing abortion, abortion at all stages, not my decision, personal boundaries, internal dilemmas, team support, how clients do, how nurses help, difficult to understand. Study used Kim's theory of Human Living. 'Concept or nursing in abortion services' means respect of client choice, facilitation of choice through duty, focus is mainly on the client and the actions performed for her benefit. However, as gestation increased nurses struggled to understand desire for late TOP and to reconcile therapy with care. A fully formed fetus caused shift in care, rendered nurses distressed and led to considerations of the moral status of the fetus. No formal support was in place. Authors recommend organisational support and defined roles for nurses.	Thematic analysis	9/10
Mizuno, 2011	Japan	This study describes the clinical and emotional experiences of Japanese midwives working in a large urban general hospital maternity unit, that is nurses required to assist not only when a baby is born, but also with TOP.	11 nurse-midwives	**Two major themes**: *experiences of midwives' providing care in pregnancy termination and assisting in childbirth* (confusion about the care of the baby and aborted fetus, inability to cater to different mothers' needs, establishing emotional control) and *professional awareness and attitude as a midwife* (consistency with professional principles, suppression of feelings in relation to aborted fetus, previous and current professional identities).	Thematic analysis	9/10

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
				TOP important social and moral issue and midwives were isolated which caused professional confusion. Suppression of feelings the most common way to deal with emotions and uncertainties. Midwives were seen as the only profession which has to deal with the moral and ethical issues of live birth and TOP in the same space. Authors recommend improving working conditions and training on ethics.		
Christensen, 2013	Denmark	To explore Danish midwives' experiences with and attitudes toward late TOP. Another focus was on how midwives perceive their own role in late TOP and how their professional identity is influenced by working with late TOP in a time where prenatal screening is rapidly developing.	10 midwives	**Core category**: *To give the 'right' care*. **Categories**: *Personalisation of the fetus* and *justification of midwives' role in late TOP*. **Concepts**: *Acknowledgement of the grief of the woman/couple*; *Changing status of the aborted fetus*; *Changing procedures in late TOP*; *The ethical dilemma*; *Influence of other professions*.Midwifery practice of late TOP reflected care provided during normal birth and was influenced by the change in fetal status and increasing personalisation. Midwives supported women's rights and suppressed thoughts regarding fetal rights. A more mature fetus or a live birth caused dilemmas for midwives. Midwives were critical of counselling given to women by doctors. Authors recommend further research to investigate how to provide midwives with the best possible working conditions and how to optimise late TOP care.	Grounded theory and theoretical analysis	7/10
Mizuno, 2013	Japan	To explore the relationship between professional quality of life and emotion work and stress factors related to abortion care in Japanese obstetrics & gynaecology nurses and midwives.	255 nurse-midwives	High numbers of TOP performed positively related to midwives' burn-out and emotional dissonance. Negative feelings about late TOP lead to compassion fatigue in midwives. Caring for both live births and TOP lead to increased compassion fatigue, distress and confusion. Professional confusion about TOP care resulted in decreased job satisfaction. Stress factors "thinking that the aborted fetus deserved to live" and "difficulty in controlling emotions during abortion care" were positively associated with compassion fatigue (statistically significant) in midwives. Findings indicated that providing TOP care is a highly distressing experience for midwives. Authors recommend: increase awareness about importance of late TOP care, decrease professional confusion, clarify role, reduce distress in midwives and increase skills to deal with stress.	Cross-sectional survey	7/8
Wallbank, 2013	United Kingdom	To study staff responses to miscarriage, neonatal death and stillbirth using a well validated theoretical framework appropriate to reporting of distress. Assess the extent of professional distress as well as	184 participants: 104 midwives, 42 nurses, 38 obstetricians	Significant predictors of stress were negative appraisal of care given or own behaviour (self-criticism), negative experiences during care provision, low number of losses experienced (junior staff have discomfort about communication and interactions	Retrospective cross-sectional questionnaire survey	8/8

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
		theoretically suggested factors which might predict it.		with grieving families), maladaptive ways of coping, perception of support outside of work (perceived inadequacy of social support). Working environment, especially poor support from management, has significant correlation with negative coping strategies. Formal training was not found to be supportive. Authors recommend support and supervision to mitigate stress.		
Andersson, 2014	Sweden	To explore the experiences and perceptions of nurses and midwives caring for women undergoing second trimester TOP	21 participants: 4 midwives, 17 nurses	**Two main themes** *"The professional self"* with 6 subthemes, *"the personal self"* with 4 subthemes. Midwives needed empathy, knowledge and ability to reflect on ethical issues when providing late TOP care. Increased knowledge, skills and experience helped cope with more difficult situations, gave inner calm and maturity. Both themes clashed but the feeling of supporting women's rights bridged the difficulties midwives faced with TOP. Mentoring from experienced midwives and formal opportunities to reflect on ethical concerns fostered security in midwives' professional roles and personal lives. Study highlights emotions raised by caring for women through second trimester TOP. Authors recommend mentorship, more staff, debriefing, time for reflection, counselling, education and ethical discussions to help grow in the role.	Content analysis	10/10
Parker, 2014	Canada	What psychosocial supports and administrative and educational resources do nurses currently use? What supports and resources do nurses need to provide quality patient and family care on a Labour & Delivery unit where women undergo TOP?	10 labour and delivery nurses	**Three themes**: *Psychosocial support - interpersonal*; *psychosocial support - intrapersonal/internal coping skills*; *resource needs*.Support and guidance from experienced colleagues in managing the emotional aspect of late TOP care were highly valued. Concerns were raised about the effect of workload on patient care and the inability to provide one-on-one care. Midwives identified a need for knowledge and skill-building through access to evidence-based literature, ongoing education, and workshops. More information about genetic counselling and community resources available to women undergoing late TOP was also identified as a need. Authors recommend paying attention midwives' needs so late TOP care can be improved.	Inductive content analysis	8/10
Mauri, 2015	Italy	How do midwives experience the burden of care while assisting with TOP after 16 weeks' gestation?	17 midwives	**Four themes**: *influences, supports, empathy,* and *emotions.* Even if midwives expressed conscientious objection to TOP their experiences and memories were not affected. Midwives felt that it was important to share experiences with colleagues, discussing cases together and with the rest of the team. Midwives also suggested strategies to improve late TOP	Hermeneutic phenomenology	9/10

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
				care: to organise shifts in a way that care could be improved and personalised, continuous development, involving relatives in the care, and improving the rooms women are cared in during late TOP. Help from other professionals is fundamental to help them manage clinical and emotional complexities related to late TOP. Authors recommend senior and junior midwives on shift for learning, support and decreasing of workload. Ongoing professional development on aspects of practice and processing of grief are also recommended. For women the authors recommend a single room during late TOP.		
Yang, 2016	Taiwan	To explore the experience of nurses involved with induced abortion in delivery rooms in Taiwan.	22 nurse-midwives	**Main theme**: *Concealing emotions*. Subthemes: *Inability to refuse*; *Contradictory emotions*; *mental unease*; *respect of life*; *self-protection*. This study showed that the social-cultural beliefs nurses held greatly influenced their values and that their rights, when providing late TOP care, were neglected. Authors recommend support with relieving emotional distress and stress through professional education to help them overcome their fear of death in order to improve women's care. Small group and case discussions might assist with reflective thinking and ethical concerns.	Inductive content analysis	10/10
Burns, 2016	New Zealand	To gain a detailed understanding of nurses' perception of the impact of caring for women undergoing second trimester termination, specifically nurses in gynaecology inpatient setting. Objectives: 1) To explore nurses experiences of caring for women undergoing TOP, 2) To examine the emotional impact on nurses, 3) To assess the effectiveness of educational and other resource support for nurses.	6 nurses	Themes: *Staff experiences and attitudes, strategies for managing demands and challenges, and training and support.* Despite self-identifying as pro-choice nurse were still affected by stressors associated with TOP, especially at increasing gestational age. Support was shown to be arbitrary and when compared to other disciplines (palliative care or mental health) was found to be profoundly inadequate. TOP-specific education was random and poorly organised and happened mostly in the form of informal peer teaching. Author recommends the development of a framework to support nurses in their practice which is targeted to maintaining high-quality patient care. Author also recommends that training for nurses should be made a priority, should be evidence-based, focus on woman-centred care, and services should not rely on the willingness of experienced nurses to teach their young.	Case report(Thesis)	N/A*
Teffo, 2017	South Africa	3 aims: 1) to determine the proportion of designated TOP facilities in the public sector that actually provide TOP services; 2) to explore the factors that influence the provision of TOP services; 3) to explore the work experiences of TOP providers at designated	30 nurses and abortion providers (not further defined)	51 facilities (hospital or CHC) provide TOP services. Reasons for not providing TOP: human resource challenges, health system, lack of management support. Interviews showed **5 themes**: *Rewarding aspects of the job* (preventing complications, unwanted pregnancies, reduce	Interpretive phenomenological analysis	10/10

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
		facilities in 2 South African provinces (Gauteng and North-West).		client stress, duty to care, understanding people's problems), *negative relationships with colleagues* (no support, name calling and stigma, negative attitudes from colleagues, being undermined, no doctors for support, colleague refusal to TOP despite being trained), *unsupportive management* (TOP services not prioritised, no interest from management, no support, no appreciation, no debriefing or support services provided), *lack of enabling environment* (no equipment, no space, no medication, large workload, staff shortages), *emotional burden* (loneliness, emotional trauma/ traumatic experience, feeling demoralised). Authors recommend management support, making TOP services a priority, implementing employee wellness programs to reduce psychosocial concerns experienced by TOP providers.		
Teffo, 2018	South Africa	Paper explores the notions of compassion satisfaction, burnout and compassion fatigue among TOP service providers in two South African provinces.	103 nurses and abortion providers (not further defined)	High compassion satisfaction, especially when in management positions. Predictors of 1) *compassion satisfaction*: finding work stimulating, believing in making a difference, relationships with colleagues, lower years of TOP service (more years of TOP reduces compassion satisfaction); 2) *burnout*: only marginal predictor was belief in helping women make informed choices, burnout scores average across categories - surprise finding as in-depth interviews showed TOP as heavy burden, loneliness and courtesy stigma (from colleagues) which increased burnout; 3) *secondary traumatic stress* (STS) was average, believing in women's rights, finding work stimulating and working in Gauteng province were protective (greater availability of resources in this province), longer years in TOP services increased STS. Authors recommend employee assistance programs to reduce burnout and STS and increase CS.	Cross-sectional survey	8/8
Banasiewicz, 2020	Poland	To investigate the relationship between personality traits, styles of coping with stress and occupational burn-out among midwives participating and not participating in pregnancy termination procedures.	181 midwives	Midwives working with TOP most often used task-oriented coping style. Midwives who used emotion-oriented coping style were at higher risk of burnout. Neuroticism was a risk factor for burnout in both groups. Midwives with higher rate of neuroticism experienced more severe burnout. The authors recommend that organisations should assess midwives' personality resources during the recruitment process.	Cross-sectional survey	3/8
Zareba, 2020	Poland	To assess emotional complications in midwives participating in pregnancy termination.	181 midwives	Almost 50% of participants had never participated in TOP for fetal anomalies. Occupational burnout was measured through exhaustion and disengagement scales. Burnout was significantly higher	Cross-sectional survey	4/8

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Table 2 (*continued*)

Author, Year	Country	Aims	Participants	Results	Methodology	JBI appraisal
				in midwives who provided late TOP. Burnout contributors were moral conflicts and seeing the fetus, fear of live birth, and lack of psychological support. A correlation of burnout to numbers of TOP carried out was observed. Authors recommend that only midwives who find TOP acceptable should support women through the procedure. And psychological support and education should be provided.		
Armour, 2020	New Zealand	To gain a deeper understanding of the role of midwives in TOP care > 20 weeks, including the support they might need and the effects caring for women who are having a TOP may have on them.	8 midwives	**Three themes**: *A different kind of midwife; staying true to oneself; melting an iceberg.* Providing late TOP care is a specialised role within midwifery. Midwives become facilitators for the space where birth and death merge. They immerse themselves in women's emotional space and create meaningful connections with women to support their complex needs and provide a positive birth experience. Midwives are unprepared for the emotional effects of repeatedly caring for women undergoing TOP and their experiences are complex and intense. Due to a lack of appropriate support they can experience lasting grief. Authors conclude that midwives who provide late TOP care need to be supported and their work valued.	Hermeneutic phenomenology	10/10
Zwerling, 2021	USA	To qualitatively assess the attitudes of Labour & Delivery nurses. To evaluate moral objection vs general unease.	15 labour and delivery nurses	**Four themes**: *The emotionally intense work of perinatal loss; feelings of incompetence in bereavement care; the burden of the willing* and *ethical conflicts and judgement*. Midwives struggle emotionally, morally and logistically with bereavement care. Midwives who opt to provide TOP care feel a duty to care for all patients even when faced with increased logistics and the emotional burden. Discomfort with TOP care due to emotional impact, lack of skills and significant paperwork rather than moral reasons. Authors recommend that increasing staffing, making paperwork easier, improving bereavement training and providing emotional support to midwives may increase access to competent and compassionate abortion care.	Thematic analysis	9/10

* It is not standard practice to use a qualitative appraisal tool on a thesis.

to gain an understanding of midwifery care for women during late TOP, identify what support strategies midwives seek to help them deal with the associated emotional impact and what support strategies are available to midwives in the role. The data provided by obstetricians, sonographers and allied health professionals could not be separated from the results and thus has been included. In an iterative process the included studies were read by all authors, results were coded, concepts emerging from the data were captured and arranged (first author). These were then further arranged into themes by all authors and discussed to answer the research question. Any disagreements throughout the process were resolved through discussions between the authors.

Synthesis of findings

A narrative synthesis of the data was done to summarise and display the findings. Midwifery care during late TOP and supportive interventions available can be described through three themes: *Positive aspects* of TOP care (feeling rewarded, overcoming challenges, caring for the fetus), *Negative aspects* (unprepared to deal with TOP, dealing with the psychological burden, caring for the fetus, unsure and unsupported) and *Carers need care* (psychosocial interventions, supportive

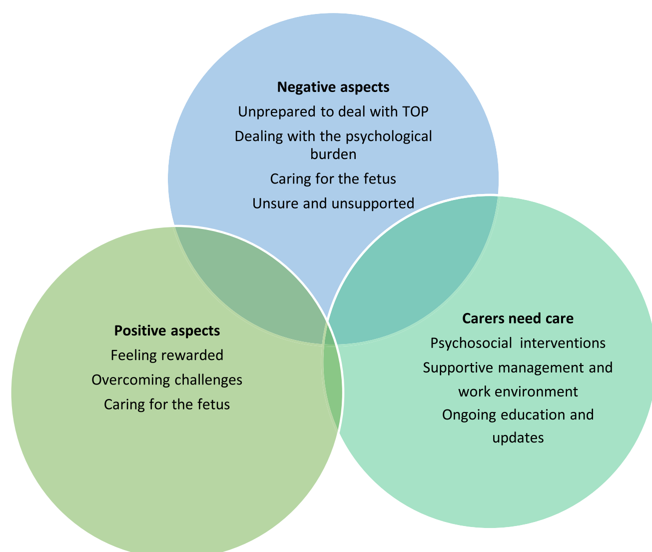

Fig. 2. Visualisation of thematic findings.

management and work environment, and ongoing education and updates). Fig. 2 presents a visual display of the findings. The left disc (darker green) shows the sub-themes of the positive aspects of late TOP care. Negative aspects are displayed in the top disc (blue) to demonstrate that there are more negative than positive aspects to late TOP, and these impact midwives in adverse ways. One of the sub-themes – caring for the fetus – was something midwives experienced as a positive part of their work, however it was also the most distressing aspect of late TOP care and this is represented in the overlap. The third disc (light green) on the lower right shows what the included research studies identified as necessary to support midwives. There is a slight overlap with the positive aspects disc as despite the positives midwives will always need additional support in this role.

Positive aspects of TOP care

The positive aspects described by several studies contributed to midwives' sense of job satisfaction and their motivation to provide midwifery care in the context of late TOP [28,36–39].

Feeling rewarded

Midwives believed providing labour and birth care was within their scope of practice and supporting women's reproductive rights was important to improve access and care overall [24,26–27,37–38,40]. Midwives felt more autonomous in this role as they were able to focus on being-with-woman and woman-centred care, which are at the core of their profession [24,41–42]. They connected with women emotionally to reduce trauma, relieve pain, create a soothing environment, and support their complex emotional and physical needs [24,26,28–29,37–39,42–45].

The joy of a job well done was essential for midwives to process their experiences, it reduced their stress and supported emotional wellbeing [30,39]. Positive feedback from women and their families was valued by midwives as it confirmed to themselves that the care given had been well received [28–29,32].

Overcoming challenges

As they had not received formal training or previously gained bereavement care skills midwives new to TOP care valued the support from more experienced colleagues [29]. Being shown how to take care of women undergoing TOP and informal mentoring was found to be important for gaining confidence, overcoming challenges and helping midwives cope [37,29–31]. By overcoming barriers, being resourceful and focusing on positive tasks TOP care became meaningful to midwives [37–38,41,43].

Caring for the fetus

Several studies described how midwives took pride in taking care of the deceased baby with dignity. Some midwives chanted, some held and talked tenderly to the baby, and others created a dignified space for attending to practical tasks, sourced clothes and blankets, showed parents how to bathe and dress their baby, engaged in memory making and facilitated the grieving process for women and their families. [28,38,41,43–45]. Although caring for the fetus was found to be positive, it was also the most distressing part of late TOP care for midwives. The overlap of positive and negative experiences regarding the care of the fetus has been shown in Fig. 2.

Negative aspects of TOP care

Midwifery care for women undergoing termination of pregnancy after 12 weeks was described as a unique and specialised role within midwifery which required a distinctive set of skills and thus was possibly not suited to every midwife [28,39,43]. Several aspects of TOP care were shown to be unique and highly distressing to midwives.

Unprepared to deal with TOP

Midwives felt ill-equipped for the unique aspects of TOP as they were directly and intimately involved in the process. Issues identified were a lack of clinical knowledge, training and skills, general bereavement care and counselling techniques, as well as difficulties in dealing with grief and being midwife and therapist at the same time [24,28–29,31,43,46–48]. Additionally, midwives were also caught unaware by the fact that they had to manage their emotions during work and that they would likely experience significant psychological effects [28,30,40–41,43–44,48–49]. Some midwives judged women for their decision to terminate their pregnancy although they did not necessarily understand what had informed their judgement [26–27,43–44,47]. Having chosen to support women's choice over the right of the fetus to life created professional and personal internal conflicts and contributed to distress and burnout [26–27,44,47].

Dealing with the psychological burden

Experience increased confidence and calmness and improved the midwives' ability to communicate easier with grieving parents [29,39,45–46]. However, the number of women midwives had cared for was directly linked to the midwives' experience of profound emotional distress, persistent grief, compassion fatigue and burnout [28,37,40–41,47–49].

Midwives also described a lack of choice and feeling trapped if conscientious objection was not an option [26,41,44]. Conscientious objection is defined as the refusal of a health care professional to provide lawful medical services or treatment, which are normally within their scope of practice, on personal or religious grounds [50]. In countries where the option of conscientious objection was provided for by law the number of midwives who were willing to provide TOP care was reduced. Midwives who did not conscientiously object were called on regularly to support women during TOP, which increased their emotional distress due to their willingness [24,28,31–32,40–41,43]. These midwives were also likely to experience the effects of the stigma associated with TOP and had to endure isolation, loneliness, judgement and bullying from colleagues and other medical personnel, the inability to talk to family and friends about their work and even fears for their safety in some counties [26,28,32,36,40–41,44,46,48].

Caring for the fetus

The most distressing aspect of TOP care for midwives was the care surrounding the fetus. While midwives were comfortable supporting women's right to choose a TOP before 20 weeks of pregnancy,

discomfort and doubts about the rights of the fetus mounted with increasing gestational age and reasons for TOP [38,42,44–45,48,52]. The possibility of signs of life at birth increases with advancing gestation and from 22 weeks onwards the fetus is potentially able to survive if born alive. This issue created a significant ethical and emotional burden as a lack of guidance from institutions on how to proceed in the event of signs of life meant midwives carried the duty of keeping the fetus comfortable until death had occurred [28,32,39,43,46,48].

After 12 weeks the fetus has fully formed and requires specific care. Handling the fetal remains presented another stress factor for midwives as the condition of the small body can deteriorate quickly and congenital abnormalities can be difficult to view. Midwives found it difficult to handle and touch the dead fetus, and conflicting emotions about their involvement in the death increased their emotional distress [24,26,31–32,37,44,47,49]. For some midwives having to place the fetal remains into Formalin or other solutions was highly confronting and stressful [41,47].

Unsure and unsupported

An unsupportive work environment, especially in the context of perinatal loss, was directly linked to negative coping strategies in midwives and was shown to contribute to distress and burnout [30,36]. While already confronted by various issues associated with late TOP care, midwives were faced with several additional challenges. Women's behaviour or thoughts around the process left midwives in doubt about the counselling the women had received to make a truly informed choice or about the information given by obstetricians regarding the induction process. Thus, they were left to counsel and prepare women for the procedure ahead as well as comfort them when realisation dawned that they had to go through a labour and give birth to their baby [27,38–39,41,43,45,48]. Conscientious objection expressed by peers, medical practitioners and allied health workers lead to significant pressure as midwives felt profoundly unsupported, even helpless, when medication needed to be prescribed, a clinical situation had to be discussed, or in the case of an emergency [31,37,40–41]. Other common issues midwives had to negotiate when caring for women undergoing late TOP were organisational shortcomings, a lack of equipment, poor managerial support, a lack of resource prioritisation towards TOP service provision, complicated paperwork and workforce deficits [26,30–31,37,43,39–41].

Carers need care

All studies identified an overwhelming need of support for midwives who care for women undergoing TOP as demonstrated in Fig. 2. Identified strategies which might be beneficial for midwives are summarised in Table 3.

Psychosocial interventions

Supportive interventions to reduce the psychological impact of TOP, like debriefing, counselling or clinical supervision, either in groups or individually, were generally not provided [24,28,30–32]. However, to overcome the lack of formal support and recognition, likeminded midwives formed groups to comfort each other. Working in teams, having collegial support and debriefing with each other helped to reduce the distress and loneliness experienced by midwives during TOP care [28–29,31,39,41–42,46,48]. All studies identified the need for appropriate emotional support in form of regular and ongoing debriefing, clinical supervision or counselling, and establishing of support networks to improve midwives' psychological wellbeing [24,28,31,38,43–44,46–48].

Supportive management and work environment

A lack of support from managers and the organisation overall was shown to be detrimental to midwives when dealing with loss and bereavement [30]. Midwives expressed how they wanted to feel supported and valued in this specialised role and were asking for a change in workplace culture and skill mix [24,26,29,31,39,41,43,46,48].

Midwives identified that increasing the workforce would give them the ability to care one-on-one for women and reduce their workload, which was seen as important for their own, as well the woman's experience [26,31,39,41,49]. Allocating junior staff to work together with experienced midwives was suggested to help them learn about the unique aspects of the role and gain confidence and skills before they were faced with the experience alone [29,38–39,41].

Other needs voiced by midwives were the prioritisation of resources towards TOP care, a single room for women to labour in away from the business of the unit, a dedicated room to prepare and store the fetus, access to equipment and medications and availability of educational material for women and their families [32,37,40–41].

Ongoing education and updates

Ongoing education was identified as important for midwives, with studies suggesting useful topics would include bereavement and grief, legal issues, updates on abortion care, pain relief, genetic anomalies and community support [26,32,37–38,44,46,48,53]. Opportunity to clarify and discuss ethical values could help midwives reduce some of the confusion their participation in pregnancy termination creates, especially in countries where conscientious objection is not part of the law [26–27,44,48].

Discussion

This integrative review aimed to examine the published research on midwifery care for women undergoing late TOP and identify support strategies available to midwives in this role. Caring for women during a late TOP is within midwives' scope of practice [3]. While the role can bring job satisfaction and moments of joy, the unique nature of late TOP means that challenges and distress are unavoidable. Midwives who provide any form of bereavement care are a vulnerable group of professionals [30,54], although late TOP care is even more challenging due to the social, emotional and medical complexities [23].

Connecting with and working in partnership with women are unique skills midwives hone over years [55]. Woman-centred care, the essence of midwifery, is vital for women's experiences and during the complex process of late TOP, keeping women safe and mitigating the trauma

Table 3
Summary of identified supportive interventions needed for midwives.

Psychosocial interventions	Supportive management and work environment	Ongoing education and updates
• Debriefing/counselling/clinical supervision • Support groups • Team/collegial support	• Manager support • Fully staffed workforce • One-on-one care • Guidelines and policies • Time out • Resources • Orientation to the role • Supportive unit culture and environment	• Values and ethics • Professional practice • Legal • Grief/bereavement • Counselling techniques

[21]. Yet, the closeness of the relationship with women can make midwives more vulnerable as professional boundaries are harder to maintain [56–57]. Emotional labour is described as a process where emotions are displayed or suppressed to create feelings of calm, compassion and safety in others [58]. In health professionals it is an essential skill that is expected and necessary yet invisible and undervalued and as such can be linked to compassion fatigue, exhaustion and staff attrition [26,58]. In the context of late TOP midwives practice a high level of emotional labour to manage their own emotions while creating safe spaces for the women in their care [26]. The lack of support for midwives in this role, which has been demonstrated in this review, shows how poorly valued their work is.

Health professionals working with death and dying generally have the practical knowledge and skills necessary to provide clinical care, although personal resources to deal with the emotional challenges and associated grief may not be so easy to achieve [54]. Emotional distress, unpreparedness for death, dying and grief and difficulties with supporting patients and families emotionally have been described by nurses across different specialties such as oncology, palliative care and intensive adult and paediatric care [59–62]. The nurses reported wanting time and space for processing their emotions, however staff and time constraints in the workplace and a lack of opportunity to talk about their experiences meant they did not get the respite they had asked for. This lack of respite has been attributed to secondary traumatic stress, burnout and lasting, even disenfranchised grief [54,59–62].

Midwives also experience grief with women who undergo late TOP, although the loneliness and isolation of the role, efforts to conceal their emotions and the inability to share their experiences may contribute to grief becoming disenfranchised. Termination of pregnancy is still stigmatised in society and grief experienced by midwives might not be seen as justified. Midwives are expected to cope, to always be professional, and crying in front of families and colleagues may be considered a sign of weakness by management and senior clinicians [61]. This stance devalues grief as a normal response to death and loss as part of midwives' experience of late TOP care.

Managing grief appropriately within the workforce is important to improve staff wellbeing and retention and decrease the effects of unprocessed or disenfranchised grief. Implementing support strategies on multiple levels, from regular and ongoing counselling or pastoral care, bereavement education, collegial support, time to allow processing, attendance at funerals, to a calming environment for regular breaks have been identified as some opportunities to help staff to grieve [60–62]. The research on the use of respite and restorative interventions for midwives experiencing grief is, however, still limited.

Limitations

The exclusion of non-English language studies might be considered as a limitation as some information might have been missed. Authors of this research report who had previously published a research paper included in this review did not participate in the appraisal of the paper. To reduce bias the other authors have provided an objective appraisal of the paper.

Conclusion

Midwives worldwide have reported that caring for women undergoing a late TOP has positive aspects which give them professional and personal satisfaction. The negative aspects, however, can lead to poor psychological outcomes and effective psychosocial support strategies to help midwives deal with the associated emotional consequences are lacking. The current evidence indicates that, no matter where they practise, midwives want and need to be supported. However, despite research recommending a variety of supportive strategies for midwives in this role there has been little progress. Midwives predominantly rely on each other for support, for debriefing and to process their experiences.

Recommendations for future research, practice and policy

Currently there is a gap in the international literature to demonstrate what education, structured support program or psychosocial intervention would be the most effective for midwives who care for women undergoing a late TOP. In the interim several recommendations aimed at hospital governance and midwifery practice might alleviate some of the needs identified by midwives. Globally, individual policy documents are insufficient to support midwifery practice.

Research:

- A global focus must be to strengthen TOP services so universal access to safe and comprehensive TOP care for women is achieved. The focus of each country should be to identify what midwives need to 1) provide high-quality, woman-centred care and 2) feel safe and supported when providing late TOP care. These needs must be individually addressed by governments drawing on experts in the field.
- An exploration of what is the most appropriate and effective psychosocial intervention for midwives who provide late TOP care. This should include evaluating short-term effectiveness, cost effectiveness, acceptability of psychosocial interventions and long-term outcomes. Researchers should be supported with funding from governments with a focus on universal psychosocial support rather than individual hospital-based interventions.
- A project exploring the outcomes of formal education during undergraduate studies on all aspects of late TOP. A program could be developed which involves utilising technological advances like augmented reality for improved learning. This could be an international multi-centre study.

Practice:

- Universal mentoring from senior clinicians with extensive experience in late TOP care for midwives in their first year of practice or midwives new to TOP services. The mentoring program should involve practical support, reflection, goal setting and should be for a minimum of 12 months.
- Management must be comfortable and supportive of TOP services and have good overall knowledge of legal frameworks, policies, practice guidelines, support services. Managers must also have the ability to debrief appropriately. TOP services within an organisation must be normalised to improve unit culture which in turn will improve care for women.
- Regular, ongoing education on all aspects of late TOP (legal, ethical, bureaucratic, practical).
- Recognised and established roles for midwives who provide late TOP care.
- Creating dedicated rooms for women undergoing late TOP with the input of the midwives who provide care.
- Recruitment drives to increase staffing levels.
- Providing midwives with spaces where they can decompress and process their experiences. If needed, offer time off. Open access to psychosocial support services.

Policy:

- Late TOP policy and practice recommendations developed together with midwives to ensure all aspects of care are addressed. Implementation through education.
- Clear policy guidance on live birth during late TOP and emergency debriefing for midwives experiencing distress following a live birth.

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