Rural Rounds: Navigating Perinatal Loss as a Rural Health Professional

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Land Acknowledgement

I would like to acknowledge that I live and work on the traditional territory of the shíshálh (Sechelt) Nation and the Sḵwx̱wú7mesh (Squamish) Nation, and I recognize their ongoing stewardship of this land.

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PRESENTER DISCLOSURES

Name: Zoe Stratis, MPCC-P

Relationships with commercial interests:

- Honoraria/Speaking Fees: Received for delivering workshops on pregnancy and infant loss to hospital teams and healthcare organizations
- Founder: Wilder Way Counselling
- Other: Creator of the programs referenced at the close of this presentation, including the Burnout Recovery Protocol

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MITIGATION OF BIAS

- Recommendations are drawn from peer-reviewed literature and Canadian clinical guidelines where they exist, and from direct feedback from bereaved parents about their healthcare experiences.
- The evidence base for specific communication practices in perinatal bereavement care remains limited; recommendations reflect current best available evidence and practice wisdom.
- Financial relationships disclosed on the previous slide are unrelated to the content of this presentation.
- No pharmaceutical, medical device, or industry funding has influenced this content.
- All cited sources are listed on the References slide at the end of this presentation.

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LEARNING OBJECTIVES

- Identify specific phrases that support psychological safety versus phrases that unintentionally cause harm when responding to a family following perinatal loss.
- Differentiate the clinical “fixing” impulse from trauma-informed presence, and apply a presence-based response when supporting a bereaved family in an acute care setting.
- Describe strategies for maintaining professional boundaries and managing dual relationships when providing bereavement care to families you may know personally, as is common in small and rural communities.

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Case #1: A Rural Birth Emergency

A healthy, full-term pregnancy turns into a sudden emergency: a rapid drop in fetal heart rate leads to an emergency cesarean under general anesthesia, neonatal resuscitation, and an urgent airlift to a regional women's and children's hospital — followed by four days of life support and a family's hardest decision.

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Case #1 Discussion

- What would trauma-informed communication have looked like in the moments before and after an unplanned general anesthetic, when a partner and support person could not be moved from the room in time?
- How do rural-to-urban transfer logistics — an airlift versus an 8-hour ambulance transfer — shape a family's experience of an already traumatic separation?
- What language would you use to explain an unclear "hypoxic event" honestly, without overpromising answers the team doesn't have?
- How might your team structure a moment like an outdoor withdrawal-of-care ceremony to honour a family's wishes within a rural facility's constraints?

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Case #2: When Care Goes Wrong

In the days and months after their loss, the same family faces a preventable post-surgical infection, a medication error repeated seven times in a subsequent pregnancy, and a comment blaming their rural care for their baby's death — testing whether the health system can rebuild the trust it damaged.

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Case #2 Discussion

- What processes could have caught the widening infection sooner, and how should a trainee's uncertainty be supported rather than overridden by a parent's advocacy?
- How do you build a closed-loop safety culture around a known allergy, rather than one that blames a computer system or asks the patient to apologize for raising a safety concern?
- How should a clinician respond when a colleague's comment — such as blaming an outcome on the rural setting — undermines a family's trust in the system that cared for them?
- What would meaningful trust-repair look like for this family in a subsequent pregnancy?

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The Scope of Perinatal Loss in Canada

- 15–20% of known pregnancies end in miscarriage (SOGC)
- 5.1 stillbirths per 1,000 total births in Canada, 2017 (Statistics Canada)
- 3.1 neonatal deaths per 1,000 live births in Canada, 2017 (Statistics Canada)
- ~80% of bereaved parents report unmet support needs (Burden et al., 2016)
- This is not a rare event — every clinician in this room will encounter it, if they haven't already

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Understanding Types of Perinatal Loss

- Miscarriage — spontaneous pregnancy loss before 20 weeks gestation (~15–20% of known pregnancies)
- Stillbirth — death of a baby at or after 20 weeks gestation, before or during birth
- Neonatal death — death of a liveborn infant within the first 28 days (prematurity, anomaly, infection, birth asphyxia)
- SIDS/SUID — sudden unexplained infant death under one year, typically during sleep
- TFMR/abortion — termination for medical reasons, often complicated by stigma and moral injury
- Broader losses — fertility challenges, ectopic pregnancy, failed adoption, and loss through apprehension all constitute loss

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What Bereaved Parents Report About Their Care

- “No one said my baby's name.” — using the baby's name is one of the most frequently reported unmet needs
- “I wasn't told all my options.” — parents cannot advocate for what they don't know
- “They rushed me out of the room.” — discharge without adequate support is experienced as abandonment
- “They said things that hurt.” — phrases like “at least…” or “it wasn't meant to be” are consistently harmful in the literature
- “I felt completely alone with my grief.” — lack of follow-up after discharge is one of the most significant gaps reported

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Health Equity in Perinatal Care

- Black patients in Canada face a preterm birth rate of 8.9% vs. 5.9% for White patients, and describe feeling dismissed and rushed through obstetric care (McKinnon et al., 2016; Boakye et al., 2023)
- Indigenous families experience infant mortality more than twice the non-Indigenous rate — a gap that has persisted for decades (Statistics Canada; CBC, 2023)
- 2SLGBTQIA+ patients face added barriers: non-inclusive language, assumptions about family structure, and reduced access to affirming care (Logan, 2021)
- Canada collects less race-based health data than the U.S. or U.K., limiting visibility into these disparities

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Language That Helps vs. Language That Harms

- Say: “I'm so sorry for the loss of [baby's name].” — Avoid: “At least you're young — you can try again.”
- Say: “Would you like some time alone with your baby?” — Avoid: “Everything happens for a reason.”
- Say: “There are no right or wrong feelings here.” — Avoid: “At least you already have children.”
- Say: “What do you need from me right now?” — Avoid: “I know exactly how you feel.”
- Say: “Your grief makes complete sense.” — Avoid: “At least it happened early.”

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From Fixing to Presence

- Fixing: offering solutions or silver linings before listening → Presence: sitting with discomfort without needing to resolve it
- Fixing: rushing to discharge without adequate support → Presence: asking “What do you need from me right now?”
- Fixing: filling silence with reassurance → Presence: using intentional silence and open body language
- Fixing: minimizing (“It was early,” “At least you know you can get pregnant”) → Presence: acknowledging the loss fully (“Your baby died.”)
- Fixing: avoiding the topic or the room altogether → Presence: following the family's lead on what they need next

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Parental Empowerment & Shared Decision-Making

- Inform fully — pain management, memory-making, post-mortem decisions, autopsy, and disposition of remains, in writing, not just verbally
- Honour autonomy — parents have the right to be active participants in their child's care, even in tragic circumstances
- Offer pain management as choice — some birthing parents later regret heavy sedation; offer options that preserve alertness alongside comfort
- Preserve the parental role — facilitate skin-to-skin contact, holding, bathing, and dressing if desired; the role of parent does not end at death

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Understanding Grief: Clinical Frameworks

- The Kübler-Ross “5 stages” model was developed for the terminally ill, not bereaved parents — it is not a roadmap for perinatal grief
- Grief is not linear and has no timeline; parents may oscillate between acute grief and functional coping within the same day
- Better frameworks: Continuing Bonds Theory (Klass et al., 1996), the Dual Process Model (Stroebe & Schut, 1999), Meaning Reconstruction (Neimeyer, 2001)
- Worden's Four Tasks of Mourning are non-sequential: accept the reality of the loss, work through the pain, adjust to a world without the baby, find an enduring connection while moving forward
- Complicated grief is real — Prolonged Grief Disorder (ICD-11: 6B42) and PTSD require specialized referral; don't wait for families to self-identify

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Best Practices: Acute Care & Long-Term Follow-Up

- Acute: allow unlimited time with the baby where clinically safe; offer memory-making and document refusals as informed choice
- Acute: provide all information in writing; assign a consistent care provider; never transfer to postpartum ward without informed consent
- Long-term: bereavement follow-up call within 72 hours of discharge; acknowledge milestones (due dates, anniversaries, birthday)
- Long-term: screen for Prolonged Grief Disorder, PTSD, and perinatal depression; refer proactively (PAIL Network, grief counselling, community supports)
- Document loss history in the chart for all future providers

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Vicarious Grief, Compassion Fatigue & Burnout

- Warning signs: chronic emotional exhaustion or numbness, intrusive thoughts about patient loss, avoidance of related patients or clinical areas, decreased empathy or cynicism
- Assessment tools: Maslach Burnout Inventory (22-item gold standard) and the free ProQOL Scale (proqol.org)
- CBT and mindfulness-based stress reduction (MBSR) are both strongly evidence-based for burnout reduction in healthcare workers (West et al., 2016)
- Organizational supports — regular debriefs, clinical supervision, peer support, and psychologically safe workplaces — reduce risk

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Key Takeaways

- Perinatal loss is common — every clinician in this room will encounter it, if they haven't already
- Language shapes the clinical memory bereaved parents carry forward, for better and for worse
- Your role is not to fix grief — it is to be present with it
- Informed, empowered parents have better outcomes — offer all options, in writing, every time
- Bereaved families need follow-up — 72 hours post-discharge, and at every milestone
- Vicarious grief is real and it accumulates — you deserve support too
- “The most important thing a clinician can offer a bereaved parent is the experience of being fully seen.”

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In Loving Memory

Wilder George Stratis — November 24, 2019 – November 28, 2019

This work exists because of him.

Every clinician in this room has the power to shape the memory a bereaved family carries forward.

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Continuing This Work With Your Team

- Unit-specific sessions — customized for your clinical context: ED, OB, NICU, primary care, rural — language and scenarios tailored to your team
- Case consultation — debrief support after difficult losses; a structured space to process what happened and what comes next
- Train-the-trainer — so this content lives on within your team and organization, not dependent on one external trainer
- Self-paced online course — coming soon, for team members who missed the live session or want a refresher

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The Burnout Recovery Protocol

- A structured 6-week program for healthcare workers, paramedics, allied health, and caregivers
- 6 weeks of drip-released modules — a structured, evidence-informed curriculum
- Private peer community between sessions — no one does this alone
- Enrollment open now — or join the waitlist for live virtual cohorts at wilderway.net

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Q&A

POST YOUR QUESTIONS IN THE CHATBOX



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