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RESEARCH

Women's Length of Stay in a Danish Specialized Unit for Perinatally Bereaved Parents

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ABSTRACT

Objective: To describe the clinical characteristics of women admitted to a specialized unit for bereaved parents and to identify the characteristics of women who stayed more than 2 days.

Design: A population-based descriptive study.

Setting: A midwifery-led specialized unit for bereaved parents at Aarhus University Hospital, Denmark.

Participants: Women with miscarriage (>14 weeks), missed abortion (>14 weeks), termination of pregnancy (>14 weeks), stillbirth, or death of their neonate during the first 48 hours after birth.

Methods: We collected information from the electronic health care records for women admitted to the unit from January 2012 through December 2018, including parity, type of loss, gestational age, mode and duration of birth, pain relief, and duration of stay.

Results: From January 1, 2012. to December 31, 2018, 579 women were admitted to the unit. Hospitalization varied from 1 day to 1 week. More women with a loss after 22 gestational weeks stayed for more than 2 days. In multivariate analyses, the hazard ratio (HR) of staying longer than 2 days was 1.3 times greater for primiparous women than for multiparous women (HR = 1.3, 95% confidence interval [1.0, 1.7]) and 2.4 times greater for women with near-term loss compared to women with perinatal loss before gestational week 22 (HR = 2.4, 95% confidence interval [1.7, 3.6]).

Conclusion: Providing unlimited stay at a specialized unit for perinatal loss resulted in variation in length of stay. Primiparous women and women who lost neonates or fetuses closer to term gestation were more likely to stay in the unit for up to 8 days. This may indicate a need for individual support not available in standard care.

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In Denmark, approximately 2,000 fetuses or neonates, or 3%, die annually in the second or third trimester of pregnancy, during birth, or shortly after Abortankenævnet (2017); (Lidegaard, 2018). Parents who experience these deaths are often young and inexperienced concerning death and bereavement and may rely on staff for adequate and sensitive support and guidance (Kingdon et al., 2015). The attitude of health care professionals may have long-lasting effects on how parents remember and comprehend the experience (Crawley et al., 2013; Erlandsson et al., 2011; Gold, 2007; Lisy et al., 2016; Ravaldi et al., 2018), and clear information combined with compassion and sensitivity have been requested by parents (Boyle et al., 2020; Cacciatore & Bushfield, 2007; Farrales et al., 2020; Peters et al., 2016). Some research findings suggest that care for parents who experience perinatal death should be provided by specifically trained health care professionals experienced in bereavement and grief (Bakhbakhi et al., 2017; Boyle et al., 2020; Ellis et al., 2016; Kenner et al., 2015; Siassakos et al., 2018). However, as the death of a fetus or neonate in late pregnancy or during or shortly after childbirth is an infrequent event in high-income countries, obstetric health care professionals may experience stillbirth only a few times during their careers (de Jonge et al., 2013).

Caring for bereaved families is a complex task (Burden et al., 2016; Krosch & Shakespeare-Finch, 2017). Complex tasks are typically organized in highly specialized units with trained staff to ensure adequate professional knowledge and

Numerous challenges have been reported about the care offered to couples after pregnancy loss or perinatal death.

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patient safety, physically and mentally (VIVE, 2018). However, the care offered to bereaved parents varies from hospital to hospital, even within a small country such as Denmark, with approximately 5.4 million inhabitants. Bereaved parents are often admitted to the gynecology, labor, or maternity ward. They are in close proximity to pregnant women or live newborns and are often discharged within 12 hours after birth. In Denmark, participation in bereavement support groups is offered at some hospitals.

Aarhus University Hospital in Denmark has offered participation in bereavement support groups since 1987 for couples who experience perinatal death. To further improve the quality of care, a specific unit with specially trained midwives who provide bereaved parents with extensive support during their loss was established in August 2011 at the hospital. The unit is the only one of its kind in Denmark. At Aarhus University Hospital, all couples (the mother and her partner) who experience pregnancy loss after 14 weeks gestation, intrauterine death, intrapartum death, or death of a newborn within the first 48 hours after birth are admitted to the unit for care. Patient groups are defined in Table 1. All couples are routinely admitted to the unit except for parents of newborns in the NICU who are offered a transfer from the NICU to the unit if their newborns die. However, the latter was not done consistently during the study period because of staff replacement in the NICU. All couples can stay in the perinatal bereavement unit for as long as they need after the loss, and they decide themselves when they go home.

In addition to women with spontaneous pregnancy loss after 14 weeks gestation, the patient group also includes women with preterm premature rupture of membranes (PPROM) without contractions before 22 weeks gestation and poor prognosis for the child's development who choose to have labor augmented and women who undergo termination of pregnancy because of fetal anomaly (TOPFA). Permission for TOPFA is granted if the child is expected to experience severe physical or mental conditions and is considered not viable outside the uterus when termination is performed, usually before 23 weeks gestation (Ministry of Health, 2014). In case of TOPFA, when permission to terminate the pregnancy is granted, the midwife provides information about the procedure. Induction of labor is initiated medically, and the following day, the woman is admitted for continued labor augmentation. Feticide before TOPFA is not performed at Aarhus University Hospital and accordingly, the midwife informs the couple that their child may show vital signs after birth.

At Aarhus University Hospital, intrauterine death is often diagnosed at the obstetric emergency ward after women experience lack of fetal movement. If contractions are not established, the couple can be admitted directly to the unit for perinatal loss immediately, or they can come back the next morning. In both cases, induction of labor will usually begin the following day. All procedures are performed at the unit by the unit

Table 1: Definitions of Types of Loss

Type of Loss	Definition
Loss	
Miscarriage	Spontaneous birth of a dead fetus before 22 gestational weeks
Missed abortion	Fetal death without contractions before 22 gestational weeks
PPROM	Preterm primary rupture of membranes before 37 gestational weeks
TOPFA	Termination of pregnancy because of fetal anomaly
Intrauterine death	Intrauterine fetal death after gestational week 22 before the onset of labor
Intrapartum death	Intrauterine fetal death after gestational week 22 after the onset of labor
Procedure	
Feticide	Fetal intracardiac injection of potassium chloride before termination of pregnancy to end heartbeat before 23 gestational weeks

Figure 1. The Unit for Perinatal Loss at Aarhus University Hospital.

midwives, who provide information before induction and care for the woman and her partner during the induction of labor, augmentation of labor, birth before 22 weeks gestation, and the postpartum period. Women who give birth after 22 weeks gestation will do so at an ordinary birth suite assisted by the unit's midwife and return to the perinatal loss unit 1 to 2 hours later.

Denmark has a tax-financed, free-of-charge health care system, and comprehensive midwifery and obstetric care is available to all women. Thus, admission to the unit for perinatal loss is also free of charge. The labor and birth ward at Aarhus University Hospital is highly specialized, with approximately 5,000 annual births. The unit for perinatal loss is situated close to the labor ward with a separate entrance in a shielded area. The unit consists of two patient rooms, a restroom with shower, a small living room area between the patient rooms, and an easily accessible open office space facing the two patient rooms (see Figure 1). The unit was designed especially for bereaved parents, and the staff were involved in the interior design. The goal was a homelike atmosphere with curtains, plants, television, pictures from nature, and windows facing a garden. Both patient rooms have double beds; the mother and her partner are admitted together, and they can stay as long as they need after birth. Visiting hours are open. The parents decide how much and when they want to be with their deceased child, and there is a small room with a refrigerator where the deceased child may be placed if the parents prefer.

The organization of the unit allows continuity of care and combines medical care and emotional support. The unit is run by seven midwives who are qualified by continuing education within the field of loss and grief and regularly receive counseling and guidance by a psychologist. Staff salary allocated to the unit amounts to 1.7 fulltime equivalent midwives. The midwives offer participation in support groups for bereaved couples and prenatal visits during a subsequent pregnancy. The unit is midwifery led and characterized by a great degree of staff self-management, and there is close collaboration with the department of fetal medicine, the labor ward, and the NICU. The hospital chaplain is available for support and conversations. A unit midwife is available from 7 a.m. to 8 p.m. at the unit and manages most aspects of the care during hospitalization (if assistance is needed during the night, a labor ward midwife attends to the couple). Being with the bereaved parents in a compassionate way, talking about practical as

Table 2: Characteristics of Women Admitted to the Unit for Perinatal Loss at Aarhus University Hospital, 2012 to 2018 ($N = 579$)

Characteristics	*n* (%)
Type of loss	
Miscarriage (<22 weeks)	37 (6)
Missed abortion (<22 weeks)	69 (12)
PPROM (<22 weeks)	48 (8)
TOPFA	221 (38)
Intrauterine death (>22 weeks)	104 (19)
Intrapartum death	10 (2)
Death within 48 hours	57 (9)
Maternal conditions, for example, cancer	5 (1)
Missing	28 (5)
Any medical condition	
Some medical condition	101 (17)
No medical condition	418 (72)
Missing	60 (11)
Pain relief[a]	
Epidural analgesic	151 (20)
Intravenous fentanyl pumps	161 (28)
Morphine	91 (16)
Mode of birth	
Vaginal	514 (89)
Cesarean	35 (6)
Missing	30 (5)
Mode of placenta delivery	
Spontaneously	331 (57)
Curettage	69 (12)
Manual placental removal	81 (14)
Missing	98 (17)
Autopsy	
Yes	248 (43)
No	258 (44)
Missing	73 (13)
Sex of child	
Female	179 (31)
Male	266 (46)
Not identifiable because of low gestational age	133 (23)
Missing	1

Note. PPROM = preterm primary rupture of membranes before 22 weeks gestation; TOPFA = termination of pregnancy because of fetal anomaly.
[a]Overlapping categories.

well as emotional and existential issues, or just being together with the parents in silence or tears is central. Midwives' responsibilities also include postpartum care; documentation; creating mementos with the parents such as footprints, handprints, and pictures; autopsy arrangements; setting up a blessing of the child; and assisting with funeral preparations.

The midwife discusses matters of grief; individual and gender differences; and how to involve other children, friends, and relatives with the parents. If the parents wish to take the child home, a cooling cot is offered. After discharge, the midwife contacts the woman to offer a health status follow-up and invite the couple to participate in a bereavement support group. When there are no couples at the unit, the midwives work at the labor ward, which optimizes use of staff resources. The purpose of the study was to describe the clinical characteristics of women admitted to a specialized unit for bereaved parents and to identify the characteristics of women who stayed for more than 2 days.

Methods

Design

We conducted a population-based, descriptive study using data collected for administrative purposes. The study was approved by the Danish Data Protection Agency in Central Denmark (Legal Office Region Midt, 2019).

Sample

The sample included all women at Aarhus University Hospital who experienced spontaneous pregnancy loss after 14 weeks gestation, TOPFA, intrauterine death, or intrapartum death between January 1, 2012, and December 31, 2018.

Women who experienced the death of a newborn in the NICU within the first 48 hours after birth and desired a stay in the unit were also included.

Data Collection and Measures

Since January 2012, information on nearly all women and their deceased children admitted to the unit has been collected in the unit's database by the midwives. Data were collected for administrative purposes and based on electronic health care records. In Denmark, all pregnant women have online health care records that contain information from antenatal visits with the midwife, the obstetrician, and the ultrasonography clinic. The first author (D.H.) compared the database information with other administrative records and added missing data when available. Data collected included each woman's parity, any medical conditions, type of loss, sex of the child, duration of stay, mode of birth (cesarean or vaginal), duration of labor, pain relief during labor, gestational age (GA) based on early ultrasonographic assessment, mode of placenta delivery (spontaneous, manual removal, or curettage), and whether an autopsy of the child was performed. The partner was admitted as spouse, and no data related to the partner were available.

We dichotomized parity as primiparous or multiparous. We categorized GA into four groups: 14 weeks 0 days to 21 weeks 6 days, 22 weeks 0 days to 31 weeks 6 days, 32 weeks 0 days to 36 weeks 6 days, and greater than 37 weeks. We categorized type of loss into five groups: miscarriage, missed abortion and PPROM at less than 22 weeks, TOPFA, intrauterine death, intrapartum death, and death of a newborn within 48 hours. We dichotomized duration of stay as 1 to 2 days and 3 to 8 days for subanalyses. Danish Data Protection Central Denmark granted us a license to use the data contained in the unit's database.

Statistical Analyses

We entered data in SurveyXact by Ramboll and analyzed it using Stata, version 15.0. We present descriptive information as absolute numbers and frequencies. To characterize women who needed longer stays at the unit, we describe the numbers and percentages of women staying 1 to 2 or 3 to 8 days according to parity, sex of the child, medical conditions, mode of birth, and type of loss. We used Cox regression analyses calculating hazard ratios (HRs) with 95% confidence intervals (CIs); hence, the outcome variable was length of stay, and "time to event" was the time from birth to discharge. Using Cox regression, we analyzed the association between length of stay in days and parity, sex of the child, medical conditions, mode of birth, and type of loss in uni- and multivariate analyses. Furthermore, we analyzed the association between GA in the four categories and length of stay in days in crude analyses and adjusting for parity, sex of the child, medical conditions, mode of birth, and type of loss. Statistical significance was defined as a two-sided p value of less than .05.

Results

From January 1, 2012, to December 31, 2018, 579 women were admitted to the Unit for Perinatal Loss; the mean was 83 women per year, ranging from 68 in 2013 to 96 in 2018. Nearly all women were admitted together with their partners and a few with their mother or a friend; very few ($n < 5$) were admitted alone. The term *child* is used to cover any outcome of pregnancy throughout the remainder of the article, although legally in Denmark a child is defined as a live-born neonate at any GA or a stillborn fetus after 22 gestational weeks. Parents cared for on the unit generally refer to the fetus or newborn who died as their child.

Characteristics of women admitted to the unit are shown in Table 2. Most women gave birth vaginally (see Table 2), and only one cesarean was performed at the woman's request after intrauterine death. Epidural analgesia or intravenous fentanyl pumps were the most common choice for pain relief during birth (see Table 2). Fentanyl was mostly used by women giving birth at lower GAs (<22 weeks). A substantial number of the women ($n = 101$, 17%) had medical conditions such as cardiovascular disease, kidney disease, diabetes mellitus, or metabolic disease, and 18 women (3%) had mental illness disorders. Women who underwent TOPFA constituted the largest patient group (see Table 2). Feticide before TOPFA was not performed during the study period. Table 3 shows the GA and state of the child at birth after TOPFA. In TOPFA, 28 (13%) children had vital signs after birth (see Table 3). The percentage increased by GA and between gestational weeks 19 and 23; 26 (23%) children showed signs of life at birth, in most cases for less than 20 minutes. During the study period, 10 (2%) children died intrapartum, 9 because of placental abruption between gestational weeks 23 and 40 and 1 because of rupture of the uterus in gestational week 25. Fifty-seven women were admitted from the NICU with a newborn who died shortly after birth; 20 of these gave birth before 25 gestational weeks.

Primiparous women stayed longer than multiparous women, and the greater the gestational age at birth, the longer the stay, which emphasizes the need for individualized care.

Length of stay after birth varied from 1 day to 1 week depending on characteristics such as parity, type of loss, and GA at birth. Length of stay was longer among primiparous women than multiparous women (see Table 4). According to type of loss, most women who experienced miscarriage, missed abortion, TOPFA, and PPROM stayed for 1 to 2 days, whereas women who experienced intrapartum death, intrauterine death, or death of a newborn stayed between 3 and 8 days. We found no difference in length of stay according to sex of the child.

Length of stay by GA is shown in Figure 2. The greater the GA, the longer the stay after birth. Adjusting for parity, sex of the child, mode of birth, and medical condition and using a GA of less than 22 weeks as the reference, the hazard of staying longer increased by GA group (see Table 5).

A total of 104 (18%) women experienced intrauterine death, and they often stayed at the unit for several days after birth. Subanalyses within this group showed that length of stay increased with greater GA at birth. Using the group of women with an intrauterine death between GA 22 weeks 0 days to 31 weeks 6 days as the reference, the hazard of staying longer was 1.7 times greater for women with intrauterine death at GA 32 weeks 0 days to 36 weeks 6 days (HR = 1.7, 95% CI [1.0, 2.9]) and 2.4 times greater for women with an intrauterine death at GA week 37+ (HR = 2.4, 95% CI [1.4, 4.2]), adjusted for parity. Women with a newborn who died shortly after birth often stayed in the unit for several days (see Table 4). In a multivariate analysis, we found that the significant characteristics of women with increased length of stay at the unit were primiparity compared to multiparity (HR = 1.3, 95% CI [1.0, 1.7]) and near-term loss compared to perinatal loss before gestational week 22 (HR = 2.4, 95% CI [1.7, 3.6]).

Discussion

During the first 7 years of the Unit for Perinatal Loss's existence, 579 women were admitted, and extensive experience has been gathered by the staff, with a low turnover rate. Women were admitted with a loss at gestational week 14 or later due to miscarriage, missed abortion, PPROM, TOPFA, intrauterine death, intrapartum death, or death of a newborn within 48 hours after birth. Parents decided the length of their stay after birth, which resulted in substantial variation; some parents went home on the day of birth, and others stayed at the unit for up to 1 week after birth. The greater the GA at birth, the longer the stay, which suggests that women who experience perinatal loss near term need more professional support or more time with the deceased child. Also, primiparous mothers tended to stay longer than multiparous, possibly because parents with other children at home wanted to go home earlier to be with them. For some women, the length of hospitalization may have been influenced by their own medical conditions, such as whether intravenous antibiotics were required.

In TOPFA, one out of seven children showed vital signs when they were born. Limited research exists on parents' experiences with feticide during TOPFA, but a study from Great Britain of TOPFA at 22 to 28 weeks gestation highlighted the importance of an individual approach. Some parents found signs of life as a welcoming opportunity to say goodbye to their child before death, and others considered feticide a way to reduce their child's suffering (Graham et al., 2009).

Table 3: Vital Signs According to Gestational Age at Birth in Termination of Pregnancy Because of Fetal Anomaly

Gestational Week	Vital Signs, *n* (%)	No Vital Signs, *n* (%)
14	0 (0)	41 (100)
15	0 (0)	36 (100)
16	1 (5)	21 (95)
17	1 (17)	5 (83)
18	0 (0)	8 (100)
19	3 (16)	16 (84)
20	7 (19)	30 (81)
21	12 (37)	20 (63)
22	4 (24)	13 (76)
Total	28	190

Note. Data were missing for one case of termination of pregnancy because of fetal anomaly.

Researchers from other countries reported substantial obstacles to high-quality care for bereaved parents, including lack of education and knowledge among staff, staff burnout (Agwu et al., 2018; Siassakos et al., 2018), insufficient support in creating a relationship with the child (seeing, holding, making mementos), inadequate communication between staff and parents, lack of time for support and care during birth, lack of continuity in care, neglect of the partner, variations in the care offered, and parents not being involved in decision making (Nuzum et al., 2018; Siassakos et al., 2018). The Unit for Perinatal Loss seems to solve many of these problems. Staff members have specialized training in the support of bereaved parents, there is continuity of care, and staff members do not seem to experience burnout, because staff turnover has been very low.

Parents rated the sensitivity and kindness of staff, acknowledgement of the child as an irreplaceable individual, provision of mementos, ritualization, and spending adequate time with their deceased child as important (Aiyelaagbe et al., 2017; Bond et al., 2018; Farrales et al., 2020; Nuzum et al., 2018; Peters, 2014). Parents specifically asked for guidance from staff in creating memories and being with their deceased child, and they stressed the importance of privacy and adequate time spent with their child and caregivers (Bond et al., 2018; Farrales et al., 2020; Peters, 2014). Obviously, time and timing are of the utmost importance. At the Unit for Perinatal Loss, the extended stay enabled parents and their families to spend time with the deceased child, create mementos, and generate narratives while being guided by their midwives. Not all parents may want to see and hold their deceased

Table 4: Length of Stay Dichotomized by 1 to 2 and 3 to 8 Days at the Unit for Perinatal Loss at Aarhus University Hospital, 2012 to 2018

	Length of Stay, *n* (%)			
Characteristics	1–2 Days	3–8 Days	Crude HR[a] [95% CI]	Adjusted HR[b] [95% CI]
Parity				
Primiparous	159 (66)	82 (34)	1.3 [1.3, 1.5]	1.3 [1.0, 1.7]
Multiparous	191 (78)	54 (22)	Reference	Reference
Sex of child				
Female	93 (64)	53 (36)	1.1 [0.9, 1.3]	1.1 [0.9, 1.3]
Male	156 (66)	81 (34)	Reference	Reference
Medical conditions				
None	284 (74)	101 (26)	Reference	Reference
Any	52 (62)	32 (38)	1.2 [0.9, 1.5]	1.1 [0.8, 1.5]
Mode of birth				
Vaginal	337 (75)	113 (25)	Reference	Reference
Cesarean	5 (19)	21 (81)	2.2 [1.5, 3.3]	1.6 [0.9, 2.6]
Type of loss				
Miscarriage, missed abortion, PPROM at GA of <22 weeks 0 days	109 (79)	29 (21)	Reference	Reference
TOPFA	181 (91)	18 (9)	0.9 [0.7, 1.1]	0.8 [0.6, 1.1]
Intrapartum death at GA of >22 weeks 0 days	2 (29)	5 (71)	2.1 [1.0, 4.5]	1.4 [0.6, 3.3]
Intrauterine death at GA of >22 weeks 0 days	36 (37)	61 (63)	1.9 [1.4, 2.4]	1.7 [1.2, 2.3]
Neonatal death within 48 hours	13 (36)	23 (64)	2.3 [1.5, 3.2]	1.8 [1.1, 2.8]

Note. GA = gestational age; HR = hazard ratio; PPROM = preterm primary rupture of membranes.
[a]Cox regression analysis. [b]Cox regression analysis with all variables mutually adjusted.

Research on the long-term emotional health of bereaved parents after admission to a specialized perinatal loss unit is required to make recommendations for clinical practice.

child or benefit from this. Helping parents find their own individual paths in the midst of crisis requires staff with well-developed skills and knowledge (Kingdon et al., 2015). Especially in cases of TOPFA, some women prefer to think of the experience as a lost pregnancy and not a child (Lafarge et al., 2014). Most women with TOPFA went home within 2 days after birth.

There is limited evidence on how hospitalization in a specialized unit with skilled midwives affects parents in the long term. Thus, parents who are admitted to the unit and those from all regular labor wards in Denmark are now invited to participate in a national study (Hvidtjørn et al., 2018). When a sufficient number of parents is enrolled, studies comparing outcomes between parents admitted to the Unit for Perinatal Loss and regular wards will be performed to assess emotional well-being, satisfaction with the care provided, and the occurrence of prolonged grief disorder (Hvidtjørn et al., 2018).

In studies from Ireland (Agwu et al., 2018), Spain (Steen, 2019), Italy (Ravaldi et al., 2018), and the United States (Roehrs et al., 2008; Steen, 2019), midwives and nurses reported that lack of education and professional counseling support impedes the quality of care and challenges the staff on a personal level when caring for parents experiencing perinatal loss. Other challenges mentioned by health care professionals were the organization of care, including staff shortages, caring for more than one woman at a time, and inadequate competency to manage the extensive paperwork (Agwu et al., 2018; Roehrs et al., 2008). The organization of the Unit for Perinatal Loss seems to address these matters. However, there is a lack of knowledge on how the midwives in the unit experience the intense work of dealing consistently with perinatal death and caring for grieving parents. These issues require further investigation.

Limitations

Our study was based on data from the database at the Unit for Perinatal Loss at Aarhus University Hospital. Since 2012, all admissions to the unit have been documented, and completeness of information is expected because documentation is provided by the dedicated midwives at the unit. However, missing values for some variables impeded the quality of some of the results presented, for example, whether autopsy was performed or not. Also, the survey held no information about partners' admissions, and this information is based solely on the midwives' observations. Furthermore, there was no post-discharge follow-up of parents to understand their satisfaction with the care they received at the unit or their ongoing needs for grief counseling.

Conclusion

A substantial variation in length of stay was seen for women admitted to the Unit for Perinatal Loss

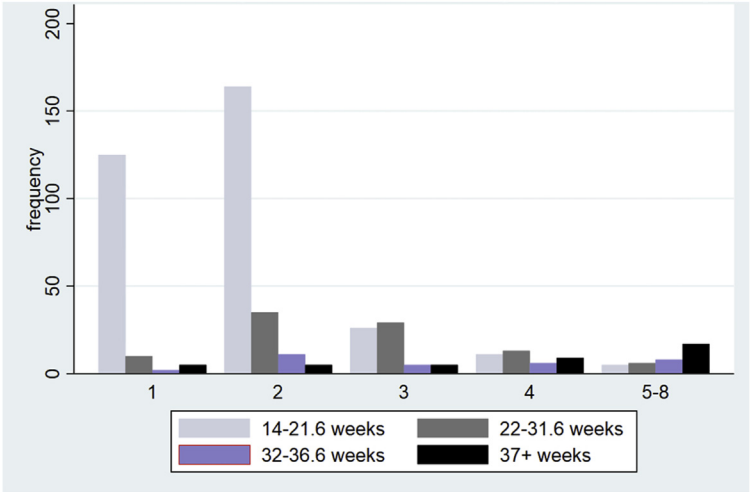

Figure 2. Number of days in the unit according to gestational age at birth.

Table 5: Length of Stay at the Unit for Perinatal Loss at Aarhus University Hospital, 2012 to 2018, According to Gestational Age

Gestational Age in Categories	Crude HR[a] [95% CI]	Adjusted HR[b] [95% CI]
14 weeks 0 days to 21 weeks 6 days	Reference	Reference
22 weeks 0 days to 31 weeks 6 days	1.7 [1.4, 2.2]	1.5 [1.2, 2.0]
32 weeks 0 days to 36 weeks 6 days	2.2 [1.6, 3.2]	2.1 ([1.4, 3.2]
37 weeks+	2.5 [1.8, 3.6]	2.4 [1.7, 3.6]

Note. Unadjusted and adjusted HRs for longer stays after birth. CI = confidence interval; HR = hazard ratio.
[a]Cox regression analysis. [b]Cox regression analysis adjusted for parity, sex of the child, mode of birth, and medical condition.

at Aarhus University Hospital, where parents themselves decide the length of stay after birth. Primiparous women stayed longed than multiparous women, and the greater the GA at birth, the longer the stay, which emphasizes the need for individualized care. Authors of the sparse literature on caring for parents who experience the death of their child during pregnancy, birth, or shortly thereafter report that organizing care on a separate unit with specialized staff may address the complexity of the medical, psychological, and sociologic challenges present when caring for bereaved families. However, research on the long-term emotional health of bereaved parents after admission to a specialized perinatal loss unit is required to make further recommendations for clinical practice.

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CONFLICT OF INTEREST

The authors report no conflicts of interest or relevant financial relationships.

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