Attending the birth of newborns with disfiguring malformation: the nurse’s experience

Assistir ao nascimento de recém-nascidos com malformação desfigurante: a vivência do enfermeiro

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ABSTRACT

Objective: The aim of this study was to understand the nurse’s experience for attending babies with visible congenital disfigurement in the context of delivery room. Methods: The study consisted of qualitative survey and collective case study; for data analysis, the symbolic interactionism theoretical framework was used. The sample was composed by nurses working at the birth center of a public hospital in the southern district of the city of São Paulo. Data was obtained by a semi-structured interview, which was tape-recorded, transcribed and analyzed. Results: Based on data analysis, conceptual categories were identified and comprised two themes: sharing the newborn care with medical staff and assuming the responsibility of the mother-infant care. Conclusions: The results point out the difficulties faced by the nurses when delivering care to babies who have visible congenital disfigurement, due to their inappropriate training on the nurse-patient relationship and the difficulties to deal with their own emotions.

Keywords: Congenital abnormalities; Nurse-patient relations; Neonatal nursing; Infant, newborn

INTRODUCTION

Assuring the approximation and interaction between parents and newborns is an important role of the health team, in order to facilitate the mother’s adaptation to the baby as early as possible. This is currently practiced when delivery and birth are physiological and the child is born in good conditions with his/her vital functions intact and preserved.

In order to transform care practice, the Ministry of Health (MH) of Brazil established public policies shaped as programs and models to promote physiological delivery, using routine techniques that avoid unnecessary intervention and, at the same time, encourage beneficial practices for the mother-child dyad. Hence, the programs Iniciativa Hospital Amigo da Criança, Mãe-Canguru and Centro de Partos Normais were introduced in several public maternities in Brazil¹-³.

The study was carried out at Hospital do Campo Limpo, São Paulo (SP), Brazil.

Dissertation submitted to Escola de Enfermagem da Universidade de São Paulo (EEUSP) for the title of Master’s degree in Nursing.

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The authors declare that there are no conflicts of interest.

Received on: Jan 31, 2008 – Accepted on: Jun 1, 2008
In the daily practice, special situations occur when early approximation and interaction are not possible, due to emergency delivery and birth involving risks to the mother and/or child and when a child with physical malformation is born. In peculiar situations like these, the attending team considers inappropriate the early contact with the mother.

Working at an obstetric center and sharing experiences with the other delivery care team professionals it is possible to observe that at the birth of a child with any malformation, especially dysmorphic babies, the immediate care to the newborn, as well as the approach of the mother to inform of the anomaly is a difficult task.

One can observe that like the mother, professionals are impacted by the appearance of the newborn, and the professional's actions are impaired. On the other hand, the mother living this experience expects to see her child and establish the first contact after birth. In this situation, the professionals involved with the care, especially nurses, need to interact with the mother in order to prepare her and to offer support so that the initial contact with her child occurs.

Having these considerations in mind, the practices of nurses attending the mother and the newborn with physical malformation need an evaluation, in order to promote the approximation and bonding between them. Some questions emerged from these thoughts: How does the nurse feel when attending a mother and a newborn with disfiguring malformation, at the time of birth? Which are the Nursing practices in the immediate care to the newborn with disfiguring malformation? In an attempt to get answers to these questions, a literature review was performed and presented below.

Different from what common sense dictates, maternal bond is not a phenomenon that is triggered by an innate instinct or is biologically determined through genetic inheritance. Until the 18th century, historical facts suggest that a behavior of maternal indifference predominated, and it was common to give the task of feeding and delivering hygienic care to wet nurses.

The bond between mother and child develops during the prenatal period, birth and post partum period, and is strengthened when mother and child interact in the post partum period.

When mother and child remain together, right after birth, a series of sensory, hormone, physiological and behavioral events are initiated, many of which probably contribute to establishing the bond between both uniting them gradually and guaranteeing further development of the relationship.

The authors propose that there is a sensitive period, in the first minutes, hours or days of life in which the contact with the newborn may favor the later affective bond with the parents. Detailed observations showed that mothers who had the opportunity of keeping early and prolonged contact with their children demonstrate significantly more affectionate maternal behaviors.

Mother-child bond is a unique, specific and long-lasting relationship with profound effect on the physical, psychological and intellectual development of human beings. In order for a healthy bond to develop, it is necessary for the mother to be able to respond to the child needs and to give the means for the development of self confidence, in addition to contributing to her child perception of the world as a safe place, allowing a healthy growth and cooperative and attentive attitudes toward other people.

When the interaction mother-child is impaired, the mother may ignore the child, who will be at risk for abuse, neglect and failure in development.

An expecting couple usually hopes for a healthy newborn, and in the gestational period there are intense expectations, with thoughts and futures plans about this child.

During pregnancy, the woman has expectations and projects for receiving the child who will arrive, with feelings of fear about having a premature delivery or a child with malformation. Thus, when the expectations become true, the family suffers a blow, expressed as startle and fear that the child will not survive. Even when the child is born healthy, the parents feel the need to adjust the real child to that imagined or expected one. When a premature or malformed child is born, the parents have to endure a more intense degree of adaptation between what is real and what was expected. This experience of abrupt adaptation to a new reality is lived with feelings of intense frustration.

Any malformation may significantly change the child’s and relatives’ lifestyle. Although the defects are organic, they have an impact in the social life of the affected person and the family, because those who are different are prone to be socially stigmatized. Congenital defects are not only related to medical problems, they have a profound effect in the social and psychological well-being of those affected, especially when visible and uncorrectable.

Children with external malformation or with some type of disfigurement cause impact in their mothers and professionals, and the more visible the defect, the earlier the occurrence of worries and shame.

The impact of having generated a child with physical malformation is disturbing and becomes a burden for the parents. However, the bond may be facilitated by showing them the newborn as soon as possible.

The birth of a child with a major malformation usually generates guilty feelings in the parents, especially in the mother. Often, they react seeking for what might
Parents need medical information about their child condition during pregnancy and at birth, they expect open and honest communication with no half truths, with explanation on the concrete aspects of the outcome of the disorder, of the future events that may occur and of the positive and negative aspects regarding the child’s condition. They need time, in a private setting, where they may share their thoughts and feelings with the professionals. Many times they do not understand the meaning of pieces of information given by professionals. For some parents it is difficult to understand the explanation given, they regard them insufficient and standardized, as they wished to get more specific and individualized information. Different parents have different needs and they must be identified by the team, in order for the communication to be effective by answering individual questions.

The initial contact with the parents, telling them to observe the child’s appearance and acknowledge the extent of normality or abnormality is of paramount importance. The longer the time until presenting them the baby, the greater will be their feeling of anguish by the mental body and behavioral image of the child they construct, according to their fantasies, a factor negatively influencing the establishment of the parent-child bond.

In the initial period of interaction, when information about the child malformation is given, it is recommended that professionals hand conclusive and correct information. In case they are uncertain and need more detailed clinical investigation, the priority at the initial contact with the parent is to tranquilize them and avoid stressing negative information on the child status.

In 2003, a study by Speedweel et al. evaluated when and who should give the information to the parents about their children with disfiguring malformation. Most parents said that the information could have been given as soon as the diagnosis was established; they also reported the dissatisfaction in respect to the amount and synchronization of information received.

Tronchin studied parents of severely ill premature newborns. It is reported that if they were surprised by the unexpected arrival of the child, they would need to adapt to live with the appearance far from that idealized. The usual festive ritual at a child birth is impaired. Similar to the birth of a premature baby, the parents of a newborn with malformation are surprised with the birth of a child who does not meet their expectations.

The contact with reality and the expression of emotions should be encouraged because it is an important help for parents to elaborate pain and distress at their proper time and find a meaning for this experience.

Healthcare professionals attending the delivery and birth may represent facilitating or impairing elements in the process of establishing the mother-malformed child bond, depending on the institutional care model and on the practices adopted by the healthcare services.

For Urasaki, the current model which supports the action of the healthcare professionals does not meet the needs of people, because it is based on reason, most of the times, with no commitment to inclusion in a process of transformation towards a sensitive care.

Thus, the attitudes, statements and practices of physicians and nurses at the hospital affect the behavior of mothers and fathers in their relationship with the children.

There are no evidences suggesting benefits in restricting the early mother-child interaction after birth; on the contrary, the available evidence suggests that the effects of restrictive practices are not desirable for mothers and children who have internal resources for interacting at the initial moments. Hence, the single priority task of care givers is to warrant conditions for such natural skills to develop, not interfering in the process.

When the family perceives that there is an equilibrium between their feeling of vulnerability and the support given by professionals, self-confidence begins to develop, confidence in their knowledge and skills in helping and caring for the child with problems. The healthcare professionals are responsible for initiating a good interactive support, because the parents report that the most stressful situation after a long hospitalization of their child due to their health condition is the problem communicating with the professional team.

In the literature review, it was observed that there is scarce scientific production on the experience of Nursing professionals in the situation of attending the mother and the newborn with disfiguring malformation in the delivery room setting. Our initial questions remained unanswered.

Hence, the justification for performing the study is set on the need of obtaining data on the caring practices to the pair mother-newborn with disfiguring malformation, in the immediate post-partum period, from the nurse's perspective, obtaining subsidies to improve the quality of care.

Understanding the phenomenon allows identifying the practices implemented in the situation of the birth of a newborn with disfiguring malformation and the factors that interfere in the implementation of such practices.
Based on elements of reality experienced, it is possible to develop training and capacitating program on the care of birth of children with disfiguring malformation.

**OBJECTIVE**

To understand the nurses’ experience in attending mothers of children with disfiguring malformation in the delivery room setting.

**METHODS**

**Methodological approach**

This is a study with a qualitative methodological approach, a collective case study.

**Study participants**

Ten nurses with experience in the care of newborns with disfiguring malformation in the delivery room setting took part in the study after signing informed consent forms.

**Study setting**

This study was performed in a municipal public general hospital located in the southern region of the city of São Paulo, Brazil. Nurses with experience in the care of the pair mother-child with disfiguring malformation at the delivering room were interviewed.

**Data recording, interpretative analysis of the data and description of the phenomenon studied**

The subjects agreed to have their interviews tape recorded, thus assuring their identity would not be disclosed. Their initials and number according to the sequence of interviews, date and time of interviews identified the tapes.

At the end of each interview, observations were made at the field notes about verbal and non-verbal manifestations demonstrated by the participants during the interview, interruptions or any other interference in the free report of them. These pieces of information helped contextualizing the interviews and obtaining data, which favored a better understanding of the meanings given by the participants to the experience reported.

The tapes were fully transcribed. After that, a narrative-type report on each participant contribution was prepared.

Before each narrative, a brief description of the academic background and professional experience of the participants was made in order to contextualize the experiences in their professional career.

The qualitative analysis of the transcribed interviews follows the methods proposed by Burnard, in 1991, and by Byrne, in 2001. The transcribed material was thoroughly read and re-read, until understood. After this, the significant aspects of the nurses’ experience were identified and encoded.

The raw data were broken and each incident was considered in creating codes (encoding). The codes were grouped by similarities and differences, according to the meaning attributed by the study participants, leading to categories. The categories were compared among each other with the intent of identifying relations, differences and similarities, and were further compacted to compose the themes, which are the results of the study.

Data analysis was performed based on the theoretical reference of symbolic interactionism as described below.

**Symbolic interactionism: theoretical reference for data analysis**

According to Chenitz and Swanson(21), symbolic interactionism is a theory on human behavior, which seeks the meaning that occurrences and events have to the person, in its context. It allows understanding human experiences and it privileges the identification of meanings attributed by the subjects regarding their own experience, based on the symbols used.

**RESULTS**

The nurse experience in the care of the newborn with disfiguring malformation at the delivery room is a phenomenon composed of two themes: I – Sharing with the medical team and II – Taking the responsibility of caring the mother-newborn pair.

**Theme I: sharing the care to the newborn with the medical team**

Comprises the following categories: prepared and expecting to assist normal newborns; expecting the birth of a malformed child; being surprised with the birth of a child with malformation; shocked with the child’s aspect; having a supporting role in the immediate care; having difficulties in caring for the child; analyzing survival viability; expecting the child’s death and having to care for it. All these show the experience of the nurse, working with the obstetrician and neonatologist in the period that precedes birth, at delivery and when immediate care to the newborn begins, performing reanimation maneuvers in order to guarantee conditions for the child survival.
Theme II: taking the responsibility of caring for the mother-newborn pair
It encompasses the categories: having to care for the mother after the bad news; caring for the pair and realizing not to be prepared for caring for the birth of children with disfiguring congenital malformation. It shows the nurse experience after the neonatologist finishes the maneuvers of reanimation while the mother and the newborn remain under the Nursing team responsibility, until they are transferred from the delivery room to other units.

Having to care for the mother after the bad news
The physical and psychological care of the mother, right after the neonatologist gives the news of the birth of a child with malformation, becomes responsibility of nurses whom, from this moment on, takes charge of this mother, with no participation of the medical team. In order to do this, the nurse needs to have information on the beliefs and values attributed by the mother to the child’s birth and based on them, to establish his/her interventions.

…I don’t know which was this mother’s point of view, right…? I have no experience with this mother in order to know what is the value (meaning) that this child had for her… I think it was her first child… She was older… 35-40 years… then usually, this child must have had a very high value to her. (Faisão)

Realizing to be unprepared for the care of birth of children with disfiguring malformation
The nurse general expectation is to wait for the birth of a visually normal child, even in the case of a premature baby. When this expectation is frustrated, the nurse feels unprepared to deal with this situation. Not being ready to assist the birth of a malformed child encompasses the categories, as follows:

I have no academic training or experience
For nurses with little experience of working in obstetric centers or whose training did not include specialization course in gynecology-obstetrics and neonatology, their inability facing this situation becomes more explicit. Nurses reported that school does not prepare them to deal with this issue, and when it does, it only deals with the physical aspects of assistance.

…I did not prepare myself for this, I do not know if I am prepared and I do not know if I will ever be emotionally prepared …Then I do not now if someday, I will be prepared to deal with this matter… (Faisão)

Feeling impotent (limited)
Nurses feel impotent at the birth of a malformed child because it is a condition out of their routine practices, having to act according to the state and conditions of the newborns, which requires different actions, and at the same time, with limitations as to the interventions, depending on the type of the malformation. At the same time, to experience this situation places nurses in front
of their own limitations and shows that the existing resources do not allow correcting the malformation, to assure for survival and maintenance of quality of life of the newborn.

...This matter of substituting, would be... that the child was born perfect: really, would this be the issue of substituting, of course that this belong to God and not to us, human beings... I think that if I had the power at that time...conditions to uh... to fix the brain or perhaps at another time to construct this child’s brain, I would have done it... (Faisão)

Realizing how unprepared the team is to give the news
To tell the mother about the child malformation is an experience that shows how unprepared the professionals are to transmit this news. The nurses observed that other professionals of the team shared this difficulty.

... The obstetricians did not want to talk to the mother... We did not want to talk to the mother... nobody wanted to talk to the mother... (Colibri)
... the child was sent to the ICU, they did not even want to tell the mother. The physician talked superficially... (Andorinha)
... I think that no professional is prepared for telling the mother at that moment: - your baby has a malformation...” Ah! I think that for every professional, it is very hard, for me. That’s how it works, at that time... Then, it is...it is difficult; I think that for every professional, I think that is very difficult the time of... then, this is very difficult. I think that for all of us... to deal with this situation... (Canário)
... look, to watch the mother of a malformed child is very difficult (Faisão)
... for us it is difficult enough to be dealing with this, then it is a very difficult issue... (Beija-Flor)

Avoiding meeting with the mother
Attending the birth of a child with congenital malformation puts the nurse in the situation of needing to deal with the mother in order to continue delivery room assistance. In this situation, the nurse gets close to and interacts with the mother when no other professional anticipates what should be the approach. In the case another professional is involved, the nurse avoids interacting directly with her.

... if the neonatologist or other professional approaches the mother at the time to give her support, I close myself... (Bem-te-vi)
... I was with another nurse, right then I ran away from the relation with the mother... (Colibri)

Not knowing how to approach the newborn malformation with the mother
The birth of a malformed child disturbs other nurses who wonder how to talk about malformation with the mother and to deliver care depending on maternal answers.

... The first thing that you think, right? Which is how may I speak with the mother about this issue...? In reality, you end up with that feeling... you don't know if you have to comfort her...if you... let her... her ask...
At no time, I had the courage of asking her if she was crying for the child, for the death or for the malformation. (Faisão)
... only that, it was difficult for us to talk to the mother... is that, not even I did, it is difficult to start talking to the mother... I try but, it... is a bit hard, isn’t it? But at the time you have to be professional...
(Andorinha)
... well, with regard to the mother, also, I did not know (laugh) well what I was talking but I was saying... (João de Barro)
... because I didn’t have what to tell her... (Colibri)

Avoiding talking about the child malformation
For some nurses, the fear of not knowing how to deal with the mother’s reaction when telling her about the child malformation makes them avoid this subject. The interaction with the mother is concentrated in performing technical procedures and not, verbal communication.

Every time I went, in reality, I approached any other subject except for the malformation issue ... at no time I had the guts to talk to her like this – let’s talk about your child... (Faisão)
... I did not talk to the mother about the problem...
(Andorinha)
... But I didn’t get... (Canário)

Dealing with it in an impersonal way
Some nurses, when dealing with the mother, maintain some physical and affective distance, restricting themselves in the execution of technical procedures, and not being able to talk to the mother about the malformation.

... I tried, at the most, to pay attention to some ..., ok? To vital signs, to the pain. If she was well, if she was not... (Faisão)
... right at the time I was like this, strictly technical then... I was technical uh... the only thing that I was able to... vital sign... do you understand? It's not like this, is the... most I was able to do... then I was strictly technical, which was a defense mechanism then I was thinking for some time like this it was a protection
mechanism… than you realize at least I realized I am in the technical part, in the part that is a way to keep distance. (Colibri)

Not knowing how to deal with the maternal emotional reaction
To have to deal with emotional reactions of the mother facing the news of malformation and, in some situations, with the child’s death, is a challenge and an obstacle for nurses who perceives themselves unprepared for delivering care satisfactorily. In some situations the nurses observed their interventions were not effective.

… Yeah, when you see the mother crying, and you don’t know whether she’s crying due to the child’s physical defect… if it is due to the death or if because of some other reason like the delivery itself, no matter how well everything goes it is a matter of pain… it was very difficult, this issue with the mother… it is something very difficult for one to work along with the mother…But I was never able to approach her emotional issues and also because she could have said something like… I am very distressed because my child died. I don’t know… I haven’t the slightest…what to say to her, I wouldn’t have what to say to her at this time… (Faisão)

DISCUSSION
The results obtained broadened the understanding of practical experience of nurses attending the delivery of children with disfiguring congenital malformation. This experience occurs in a progressive way and is described by two themes: Sharing with the medical team the attention to the newborn and Taking responsibility of caring for the mother-newborn dyad.

In the first theme, the nurse shares with the medical team the care for the malformed newborn in the immediate period after birth, the mother remaining in second place, because of professional attention focusing on the child in order to assess vitality and depending on the magnitude of the malformation act to stabilize and improve it.

The second theme begins when the medical decision is not to interfere and wait for the child’s death or to transfer it to a neonatal unit when it is believed that there are chances for survival, or letting the child with the mother when the malformation is only disfiguring but does not affect its general health. At this moment, the neonatologists leave the room, because their work is done.

Then, the nurse has no choice but to interact with the mother. At this time the difficulties of the nurse to assist the mother of the newborn with disfiguring malformation becomes evident.

After the physical care is completed, for the newborn and the mother, the news about the malformation is told the mother by the neonatologist. Now, the medical team exits the scene because its role is finished and mother and child remain in the obstetrics center under the care of the Nursing team, which has the obligation of giving emotional support to the mother, in addition to taking care of the routines of the immediate post-partum period.

From this moment on the nurses perceives themselves as having to take care of the mother after the bad news. “Bad news” is defined as everything that can negatively change the outlook of the patient as severe disease, impending death or high level of limitations(22-23).

Fallowfield and Jenkins define bad news as any sort of information producing negative changes in the expectations of a person’s present or future(24). An example of bad news is to tell the mother that her child was stillborn or malformed.

Taanila et al. state that bad news should be reported with special care to the parents and that physicians and nurses must develop further skills to support the parents, helping them to adapt to the unexpected situation. In this study, the authors report an association between the way the information and counseling were transmitted to the parents by the medical team and the feelings of insecurity and helplessness of the parents(25).

They stated that several parents who received poor practical advice on how to deal with the problem were five times more insecure and helpless than the ones who were satisfied with the information and counseling received. At the patients’ discharge, most parents who received useful information and counseling were sure of their capacity to take care of the child. Initial information and counseling delivered to parents by physicians, nurses and other professionals has improved in the past ten years.

Parents expect more opportunity to talk and show their feelings hoping that the physicians will make them feel better(26).

Boyd stated that the nurses collaborate developing the family’s coping skills to face the problem, when the family needs are crucial(27). The nurse’s role at the time and after the bad news is to promote the parents’ interaction with the child as well as to support them in the care of a child with neurodegenerative disorder.

After the initial interview with parents, the attending nurse often gives them continuing support due to doubts and issues on how to face and handle the situation. It is also important that nurses and physicians be consistent in their approach. The adaptation process is slow and occurs through the interaction of physicians, Nursing team and family(25).
Maldonado and Canella stated that there are times in the healthcare professional-patient bond with a lot of sadness, anxiety and distress. Often, at these moments, the professional who does not know how to deal with the emotional reactions of the mother uses false support saying things like: “don’t feel so bad, you’re young and healthy soon you be able to have another child” or “it is a severe condition but you have to accept it, such is life”.

Although this type of communication has the apparent objective of relieving the parents’ distress, it is in reality a resource that serves especially to sooth one’s own anxiety, since it blocks free expression not allowing the parents to manifest their emotions, to be heard and understood.

**FINAL CONSIDERATIONS**

At the beginning of the study, the concern was centered in the nurse’s experiences of caring for the mother of a child with disfiguring congenital malformation and in trying to understand the meaning attributed by them to this experience in their professional lives. During data collection and analysis, it was realized that this experience is shared with the medical team when the focus is the immediate care of the newborn. After concluding the newborn care, however, the medical team leaves and the nurse becomes the main actor in the interaction with the mother and her malformed newborn.

As the study progressed the nurses’ experiences in such situation were understood, highlighting the following aspects:

- most of the times it is an anguishing experience, a reaction directly related to the severity of the malformation, often times unexpected in the delivery room, which is an environment suggesting celebration of life and joy and not of death and distress;
- nurses fear the emotional reactions of the mother because they do not know how to deal with them;
- the technicist professional attitude is a subterfuge to sooth the anguishes of the nurses for not knowing how to deal with this situation;
- nurses are not trained to deal with this situation;
- the need of specific academic training to promote communication and relation skills between nurses and patients when the diagnosis and prognosis are unfavorable;
- need of continuing education at the work place in order to fill the gap in academic training;
- the need to have support groups for professionals who in their daily activities face such stressful situations, in order to help them work through their anxieties.

This study and its methodological process present limitations. During data collection and analysis, in order to understand the symbolic world of these nurses, prejudices and biases incorporated during the authors’ professional career had to be stripped off to be able to understand nurses as separate and different people.

However, there was a reward when related to the category: “Realizing to be unprepared for caring for birth of children with disfiguring malformation”, as it showed that nurses have deficient training thus impairing or blocking their actions.

Nurses are aware that most of the times they would rather not be present in this situations but when they share care they refrain from relating to the mother. When required to care for the mother and relate to her, the focus of all this anguish, even if perceiving to be unprepared they seek for strategies to do it less painfully for both of them. Nurses reveal that anguish is a feeling also shared by the medical team.

In professional acts there is a tendency to follow activities according to pre-established routines, and this is not feasible when a child with congenital malformation is born. In this situation, in addition to appropriate techniques, emotional stability and verbal and non-verbal communication skills are required in order to meet the real needs of the mother-newborn dyad.

Silva affirmed that body language indicates either openness and availability or confrontation and rejection. In interpersonal communication it is necessary to have face-to-face interaction in an attempt to understand the other and making oneself understood. Communication is not done only by verbalization; messages have to be apprehended and properly interpreted.

In order to improve the quality of care given to mothers of a newborn with disfiguring congenital malformation it is necessary to think about professional training. Holistic care has been the focus of debate and raises issues about the syllabus of undergraduate and graduate schools which emphasize biological and pathological aspects of the human being, instead of subjects involving interpersonal relationships and skills which render the communication between health professionals and patients more effective.

As for teaching, it is necessary to stimulate students to value not only technical skills but to consider the patient beliefs and values and how these interfere in the health-disease process as well. Undergraduates should discuss curriculum reforms aimed at better preparing students for their professional life.
Gonçalves (30) states that the identification of gaps in professional training of nurses is fundamental for a broader proposal to change current teaching. It is stressed that the data from this paper point to the need of new studies in order to define which strategies are more efficacious in caring for the mother and the child with disfiguring malformation in the delivery room setting.

CONCLUSIONS
The results of the present study showed the difficulties faced by nurses in caring for birth of malformed babies due to insufficient professional training that does not prepare them to communicate with the patient and to deal with their own emotions.

REFERENCES