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MEDICAL TERMINATION OF PREGNANCY: CASE REPORT

INTERRUPÇÃO MÉDICA DA GRAVIDEZ: RELATO DE CASO

INTERRUPCIÓN MÉDICA DEL EMBARAZO: INFORME DE UN CASO

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Abstract

Background: Termination of pregnancy can be voluntary or medical, depending on the reasons for it and the gestational age. While the voluntary option can only be carried out up to 10 weeks and 6 days, the medical option can be carried out up to 24 weeks in situations of fetal abnormalities or risk to the mother's life. **Goal:** To present a proposal for a nursing care plan centred on women undergoing medical termination of pregnancy. **Method:** A descriptive and observational approach, based on respect for ethical principles and confidentiality, of a case study of a 37-year-old woman who underwent a medical termination of pregnancy following a confirmed diagnosis of Trisomy 21. It was compiled through data collection, using the Roper-Logan-Tierney theoretical model, and bibliographical research. The case report was drawn up according to the CAse REport [CARE] guidelines, the care plan was based on the CIPE® taxonomy and the interventions according to the NIC classification. **Results:** Seven nursing diagnoses were identified, of which four were selected as the most relevant in this case: Anxiety, Pain, Grief and Risk of Hemorrhage. **Conclusion:** Termination of pregnancy requires an empathetic and humanized approach, especially in situations of fetal abnormalities. The obstetric nurse plays a fundamental role in managing care, acting to promote the physical and emotional well-being of the woman/couple, prioritising quality care and respecting ethical principles.

Keywords: Abortion, Therapeutic; Congenital Abnormalities; Nurse Midwives; Nursing Care.

Resumo

Enquadramento: A interrupção da gravidez pode ser voluntária ou médica dependendo dos motivos e da idade gestacional. Sendo que a opção voluntária só pode ser realizada até às 10 semanas e 6 dias, a opção médica pode ser efetuada até às 24 semanas nas situações de anomalias fetais ou risco de vida para a mãe. **Objetivo:** Apresentar uma proposta de plano de cuidados de enfermagem centrados na mulher submetida a uma interrupção médica da gravidez. **Método:** Abordagem descritiva e observacional, tendo por base o respeito pelos princípios éticos e da confidencialidade, de um caso prático de uma mulher de 37 anos sujeita a uma interrupção médica da gravidez, após o diagnóstico confirmado de Trissomia 21. Elaborado através de uma colheita de dados, onde foi utilizado o modelo teórico de Roper-Logan-Tierney e de uma pesquisa bibliográfica. O relato de caso foi elaborado segundo as diretrizes CAse REport [CARE], o plano de cuidados foi baseado na taxonomia CIPE® e as intervenções segundo a classificação NIC. **Resultados:** Foram identificados sete diagnósticos de enfermagem, dos quais foram selecionados quatro, considerados como mais relevantes neste caso: Ansiedade, Dor, Luto e Risco de Hemorragia. **Conclusão:** A interrupção da gravidez exige uma abordagem empática e humanizada, especialmente em situações de anomalias fetais. O enfermeiro obstetra desempenha um papel fundamental na gestão dos cuidados, atuando na promoção do bem-estar físico e emocional da mulher/casal, primando por um cuidado de qualidade e respeitando os princípios éticos.

Palavras-chave: Aborto Terapêutico; Anomalias Congénitas; Cuidados de Enfermagem; Enfermeiro Obstetra.

Resumen

Contexto: La interrupción del embarazo puede ser voluntaria o médica, dependiendo de los motivos y la edad gestacional. Mientras que la opción voluntaria solo puede realizarse hasta las 10 semanas y 6 días, la opción médica puede llevarse a cabo hasta las 24 semanas en casos de anomalías fetales o riesgo para la vida de la madre. **Objetivo:** Presentar una propuesta de plan de cuidados de enfermería centrado en la mujer sometida a una interrupción médica del embarazo. **Método:** Enfoque descriptivo y observacional, basado en el respeto a los principios éticos y la confidencialidad, de un estudio de caso de una mujer de 37 años que se sometió a una interrupción médica del embarazo tras un diagnóstico confirmado de trisomía 21. Se elaboró mediante la recogida de datos, utilizando el modelo teórico Roper-Logan-Tierney, y la investigación bibliográfica. El informe del caso se elaboró según las directrices CAse REport [CARE], el plan de cuidados se basó en la taxonomía CIPE® y las intervenciones según la clasificación NIC. **Resultados:** Se identificaron siete diagnósticos de enfermería, de los cuales se seleccionaron cuatro como prioritarios en este caso: Ansiedad, Dolor, Duelo y Riesgo de Hemorragia. **Conclusión:** La interrupción del embarazo requiere un enfoque empático y humanizado, especialmente en situaciones de anomalías fetales. El enfermero obstetra desempeña un papel clave en la gestión de los cuidados, promoviendo el bienestar físico y emocional de la mujer/pareja, garantizando una atención de calidad y respetando los principios éticos.

Descriptores: Aborto Terapéutico; Anomalías Congénitas; Cuidados de Enfermería; Enfermero Obstetra.

Introduction

Medical termination of pregnancy [MTP] is a practice used in specific situations, where the continuity of pregnancy may pose risks to the mother's health and where there is a diagnosis of fetal conditions that are incompatible with life or that result in serious anomalies. MTP entails a decision, often difficult and full of ethical and emotional dilemmas, being regulated by legislation that varies between countries.

Since 1984, in Portugal, abortion is no longer illegal when performed by a doctor. The interruption of pregnancy, according to Portuguese law – Article 142 of the Penal Code, law no. 16, of 17 April 2007, is within the legal limits when it is carried out by a doctor, in official establishments, with the consent of the pregnant woman and in the following:

- the only means of eliminating a risk of death or preventing serious and irreversible injury to the body or to the physical or mental health of the pregnant woman;
- prevent a significant risk of death or serious and lasting injury to the physical or mental health of the pregnant woman, provided that it is carried out within the *first 12 weeks and 6 days* of pregnancy;
- there are well-founded reasons to believe that the unborn child will suffer from a serious disease or incurable congenital malformation, and interruption is allowed *up to 24 weeks and 6 days* of pregnancy, except in cases of non-viable fetuses, in which interruption can be made at any time;
- pregnancy results from a crime against sexual freedom and self-determination, and interruption is allowed up to the *first 16 weeks and 6 days* of pregnancy;
- by choice of the woman, in the *first 10 weeks and 6 days* of pregnancy.

All interruptions of pregnancy are mandatory to be declared to the Direção-Geral da Saúde [DGS], through an already predefined registration template. In situations where the interruptions are due to congenital anomalies, they must also be reported in the *Registo Nacional de Anomalias Congénitas* [RENAC] (*Portaria* No. 741-A/2007 of 21 June – Article 8).

A congenital malformation is considered to be any structural anomaly that is present from birth, in which alterations in embryonic or fetal development are observed[1]. Congenital malformations can have various etiologies, with 5-10% originating from exogenous or environmental factors, which include infectious, physical or toxic agents, and about 20-30% correspond to endogenous factors such as genetic mutations or chromosomal abnormalities[2]. The development of prenatal diagnostic techniques has allowed the possibility of knowing the health of the fetus before birth[3], with the aneuploidies that appear with the highest incidence being those linked to somatic chromosomes 13 (Patau syndrome), 18 (Edwards syndrome), 21 (Down syndrome) and those linked to sex chromosomes[4]. The most frequent aneuploidy in Portugal is Down syndrome, with an incidence of 1 in every 800 births, it is a complex genetic condition that influences physical and cognitive development, characterized by specific traits that require differentiated care and an adaptation process by parents/family. Faced with the diagnosis of this syndrome, parents are faced with a mixture of emotions and challenges that can profoundly mark their experience of parenthood[5]. The early diagnosis of trisomy 21 gives parents more time to reflect on whether to continue the pregnancy and to choose the safest method should they decide to terminate it, though they are always faced with difficult and complex decision-making[6]. Although the prevalence of chromosomal diseases remains practically unchanged, the number of children born in these conditions has decreased, largely due to pregnancy interruptions, which have doubled in recent years, probably as a consequence of greater accessibility to prenatal diagnoses[7]. Prenatal screening includes ultrasound, biochemical screenings and Non-Invasive Prenatal Testing [NIPT] genetic testing. The combined screening of the first trimester allows the early detection of any anomaly and is performed between 9 weeks and 6 days and 13 weeks and 6 days[8]. The risk assessment combines maternal age, ultrasound markers – nuchal translucency [NT]

and the bones of the nose, and the biochemical markers, the beta fraction of the human chorionic gonadotrophin hormone Beta Human Chorionic Gonadotrophin [β-HCG] and the Pregnancy-Associated Plasma Protein A [PAPP-A]. Carrying out this screening allows a detection rate for trisomy 21 to be up to 95%, and for the detection of trisomies 18 and 13 it can reach 97% and 92%, respectively[7].

The non-invasive prenatal test includes the search for cell-free fetal Deoxyribonucleic Acid [DNA] in the maternal circulation, is performed through a collection of maternal blood and has a sensitivity of 99% for the detection of trisomy 21[9]. Although NIPT is seen as a good option for pregnant women at high risk for aneuploidies due to its high degree of sensitivity, it should be taken into account that it is not a diagnostic test so that an interruption of pregnancy should not be carried out without first performing an invasive confirmatory test. In situations in which the result is positive for any of the trisomies or malformations, it should always be confirmed by invasive tests, such as amniocentesis, chorionic villus sampling, or cordocentesis[7]. The main reasons for carrying out an invasive test are: the identification of a fetal alteration during an ultrasound, which is the most common reason, followed by a positive biochemical screening, advanced maternal age and, finally, the search for fetal DNA in maternal blood. The most common invasive tests are amniocentesis and chorionic villus sampling[10].

Amniocentesis is one of the most widely used invasive techniques, and consists of removing amniotic fluid from the uterine cavity through a needle. This procedure is performed transabdominally, by an experienced obstetrician and under ultrasound guidance. It is recommended to use it from 15 weeks of gestation until delivery, before this period there is a higher risk of miscarriage compared to chorionic villus sampling, which can be performed between 11 and 15 weeks[11]. It is essential to advise the couple about the indications, risks, benefits and limitations of the procedure. The final decision to terminate a pregnancy depends on factors such as religious and ethical beliefs, as well as the legislation in force in the respective country[11]. In Portugal, after confirmation of the diagnosis, parents are given the possibility to ask for a second opinion, and only then asked what the final decision is. Before any interruption of pregnancy, the whole case is analysed by a committee of doctors called the *Comissão Técnica de Certificação*, this exists in all establishments where interruptions of pregnancy are carried out. Each technical committee is composed of 3 to 5 doctors, which must include an obstetrician/ultrasounder, a neonatalogist and, whenever possible, a geneticist. After a positive decision for the interruption, the administration of therapy to the pregnant woman is initiated and hospitalization is proposed, as described in *Portaria* No. 741-A/2007 of 21 June – Article 20. MTP can be performed under therapy, with a mifepristone® tablet being first administered and after 12h/48h the administration of misoprostol® tablets begins. The schedule of administration and dose of misoprostol® varies according to gestational age and some particular situations. There is always the surgical option, but it requires specific resources and experienced professionals. The induction of fetal death (feticide) should be performed as an adjuvant in situations of MTP after 21 weeks, to prevent the fetus from being born alive[12].

In the context of the interruption of pregnancy, the Regulation of Specific Competences of the Specialist Nurse in Maternal Health and Obstetric Nursing (midwife), published in *Regulamento No. 391/2019*, assumes that several skills must be developed, namely "Promotes women's health during the prenatal period and in situations of abortion", "Diagnoses early and prevents complications in women's health during the prenatal period and in situations of abortion" and "Provides care to the woman and facilitates her adaptation, during the prenatal period and in a situation of abortion". According to these competencies, several interventions are identified, such as the development of projects to promote women's health, promoting an informed decision for the woman/couple about the interruption of pregnancy, providing guidance to the available resources, collaborating in the treatment and preventing complications after MTP, and also developing interventions to support the woman/couple in the mourning period and providing guidance on contraception[13].

The purpose of this case report is to develop knowledge about the process of medical interruption of pregnancy and the follow-up of a pregnant woman subjected to this procedure, with the objective of presenting a proposal for a nursing care plan centred on the woman submitted to a medical interruption of pregnancy.

Methodology

The main objectives of the case report are to describe the diagnostic and therapeutic process of one or more users in a given clinical context, in which there is sharing of experience with other health professionals in order to increase knowledge about a given theme[14]. The present case report has a descriptive and observational approach, elaborated based on the checklist of the CAse REport (CARE) guidelines in order to be able to respond to the main components of a case report, the collection of clinical information was carried out through a direct interview with the pregnant woman, physical examination, direct observation and consultation of the computerized clinical file. All the information collected followed the principles of the Code of Ethics – *Lei* No. 156/2015 of 16th September, which guarantees confidentiality of all information obtained, emphasizing professional secrecy and the anonymity of the person, who was informed about the study, having given their consent. In order to safeguard the privacy of the pregnant woman, her identity and the place of occurrence of the clinical situation were omitted.

The initial assessment of the pregnant woman was based on the theoretical framework of Activities of Daily Living by Roper, Logan & Tierney, which is based on the assumption that the way in which activities of daily living are performed by each person will contribute to their individuality, and the nurse, by having this knowledge, will be able individualize their care[15]. This case report concerns a 37-year-old pregnant patient, Caucasian, Portuguese nationality, with a university degree, entrepreneur, married, with a singleton pregnancy of 17 weeks and 6 days. The patient was admitted to the Pregnant Women's Inpatient Service by medical referral to undergo the pregnancy termination protocol due to congenital anomalies, following confirmation of trisomy 21 diagnosis by amniocentesis. Next, the assessment of the pregnant woman's activities of daily living is presented, according to the selected theoretical model (Table 1).

Table 1: Assessment of activities of daily living, according to Roper, Logan & Tierney.

Life Activity	Initial Patient Assessment
Maintaining a Safe Environment	Patient oriented to person, time, and place. Peripheral catheter placed in the left forearm and blood sample collected for analysis. Morse Fall Scale assessed: score = 15 (no fall risk). Patient remains in a single room with private bathroom.
Communication	Coherent speech, but very anxious due to the medical diagnosis and the procedure to be undergone. Anxiety assessed using the *SClínico* anxiety scale. Presents periods of emotional lability due to the pregnancy being highly desired and now needing to be terminated.
Respiration	Patient eupneic, approximately 18 respiratory cycles per minute. Peripheral oxygen saturation: 99%.
Feeding	Patient independent, on a general diet.
Elimination	Patient independent in self-care regarding use of toilet. No alterations in urinary elimination. Bowel elimination according to normal pattern.
Personal Hygiene and Clothing	Patient independent in self-care for hygiene and dressing. Appears well-groomed.
Body Temperature Control	Afebrile patient, tympanic temperature 36.7ºC.
Mobility	No gait alterations, ambulates within the room. Braden Scale assessed: score 22 (no risk for pressure ulcer development).
Work and Leisure	Patient is an entrepreneur. During hospitalisation, was always accompanied by her husband and used her mobile phone to communicate with the rest of the family.
Expression of Sexuality	Counselling was provided regarding available contraceptive methods and resumption of sexual activity after abortion.
Sleep	Sleep pattern altered due to anxiety experienced throughout the process of diagnosing the congenital anomaly.

After a careful analysis of the information collected, nursing diagnoses [ND] were formulated using the International Classification for Nursing Practice [ICNP][16], according to the most recent version 2019-2020, and the interventions were formulated according to the Nursing Interventions Classification [NIC][17]. The information is verified through a flow diagram, shown in Figure 1.

Figure 1: Case Report Flowchart.

Results

The existence of diagnoses and nursing issues are fundamental to guide clinical practice, so nursing interventions play a fundamental role in ensuring care focused on the needs of the woman/couple, who are going through a complex and delicate process such as the loss of a desired and planned baby.

Considering the interpretation and analysis of the data presented, seven nursing diagnoses were identified, of which four are highlighted: 1. Anxiety, 2. Pain, 3. Grief, and 4. Risk of hemorrhage, as resolving these may contribute to resolving the others. Table 2 shows the care plan developed for each of the four highlighted diagnoses, based on the ICNP[16] terminology and the NIC interventions[17].

Discussion

The termination of pregnancy following the diagnosis of a chromosomal anomaly is a complex clinical situation that involves ethical, emotional, and medical decisions. This case report aimed to deepen knowledge in light of recent literature, highlighting key aspects related to the role of the midwife and the importance of having a multidisciplinary team attuned to this issue. The confirmation of a chromosomal anomaly generally occurs through invasive procedures, such as amniocentesis or chorionic villus sampling, and following positive results from non-invasive screenings. All of these tests take time to yield results, and this waiting period corresponds to an increase in the anxiety experienced by the woman/couple and the family they are part of[18]. **Anxiety [10000477]** is a debilitating emotional state with the potential to affect quality of life, making it essential to have a multidisciplinary team that is sensitive to the emotions and concerns of the woman/couple from the very first appointment. Providing a safe and welcoming environment, where there is openness to express feelings and distress, along with a detailed explanation of the entire procedure and its possible physical and emotional consequences, is fundamental to reducing fear of the unknown and the sense of uncertainty, one of the main sources of anxiety. These interventions are promoted by the

Table 2: Nursing Care Plan.

ND1. Anxiety [10000477] "Negative emotion: feelings of threat; danger or distress".

Nursing Focus: Anxiety [10002429].
Nursing Judgment: Current.

Interventions by Midwife
Offer emotional support [5270];
Helping the woman/couple to express their feelings [5230];
Active listening [4920] to the concerns of the woman/couple and validating their feelings;
Teach relaxation techniques [6040], such as deep breathing;
Watch for verbal and nonverbal signs of anxiety [5820];
Provide comfort and safety throughout the process [6482];
To provide the woman/couple with the necessary information (and within our competences) about their situation [5602].

Expected Outcome: Anxiety, Reduced.
Result: Anxiety, Maintained.

Final Evaluation: The pregnant woman remained anxious about her clinical condition and the entire procedure to be carried out, as well as about communicating the loss to the extended family. She was given the possibility of staying in a private room and encouraged to have her husband present throughout the hospital stay. After the expulsion of the fetus, the anxiety persisted due to the fear of discussing the loss with the rest of the family, especially with her child.

ND2. Pain [10023130] "Impaired perception: increased uncomfortable body sensation, subjective reference to suffering, characteristic facial expression".

Nursing Focus: Labor Pain [10011088].
Nursing Court: Moderate.

Interventions by Midwife
Teaching and providing strategies for pain relief [5604];
Administer prescribed analgesic therapy [2210];
Managing environmental safety [6486];
Encourage women to adopt a comfortable position [0840];
Assess pain [1400].

Expected Outcome: Effective Pain Control.
Result Obtained: Effective Pain Control.

Final Evaluation: The patient reports moderate pain related to the contractions induced by the therapy administered, which have the function of expelling the fetus. It was found that there was no need to administer the prescribed analgesia in SOS.

ND3. Grief [10022345] "Emotion: Feelings of Pity Associated with Significant Loss or Death, Anticipatory or Real".

Nursing Focus: Grief [10008516].
Nursing Court: Current.

Interventions by Midwife
Offer emotional support [5270];
Encourage the sharing of feelings [5240];
Validate feelings of sadness, anger, and guilt [5300];
Provide information about the grieving process [5290];
Encourage extended family support seeking [7140];
Refer to psychological support, if requested [5440]:
Demonstrate empathy and willingness to be present [5290].

Expected Outcome: Effective Grieving Process.
Result Obtained: Effective Grieving Process.

Final Evaluation: The patient reports awareness about her reality, expressing feelings of sadness for the loss of a much-desired baby and guilt for having announced the pregnancy to the extended family. She received psychological support, after requesting it. She manifests some strategies for coping with grief.

ND4. Risk of Hemorrhage [10017268] Risk of "Blood loss: loss of a large amount of blood in a short period of time".

Nursing Focus: Hemorrhage [10000477].
Nursing Judgment: Risk.

Interventions by Midwife
Assessment of vital signs [6680];
Pinard Safety Globe Assessment [4026];
Teach how to recognize signs of bleeding and when to inform health professionals [4010];
Lochia surveillance – quantity, odor and color [4026];
Administration of necessary therapy [2314].

Expected Result: Absent Hemorrhage.
Result Obtained: Absent bleeding.

Final Evaluation: After expulsion of the fetus, vaginal blood loss persisted in expected amount and characteristics. Education was provided regarding warning signs and symptoms in the post-abortion period. During hospitalization, there were no complications, and the patient remained hemodynamically stable.

midwife. Psychological support plays a central role in controlling anxiety, the presence of trained professionals, such as psychologists, can provide emotional support, help process the decision constructively and help deal with feelings of guilt or fear, common in this context. In this case, a psychologist's support was requested by the patient, who was then present after the expulsion of the fetus.

Early diagnosis of trisomy 21 requires the provision of detailed and up-to-date information about the condition of the disease. Health professionals must ensure all the necessary support from the intrauterine diagnosis, assuming a role of reference throughout the process. However, it is imperative that the entire health team respects the autonomy of the parents, as well as their informed decision regarding the continuation or interruption of pregnancy[19]. As described in Portuguese legislation (Article 142 of the Penal Code – no. 1), interruption is allowed up to 24 weeks of pregnancy in cases of serious disease or congenital malformation of the fetus or non-viable fetuses. Data from Graf *et al*[20] show that, even within the legal context, many women face significant ethical and emotional dilemmas, reinforcing the need for support

From a clinical perspective, termination includes the possibility of being carried out through pharmacological or surgical methods. As mentioned by Bombas *et al*[12] the use of mifepristone® in combination with misoprostol® is more effective than the use of misoprostol® alone, as it contributes to a shorter average duration from the start of treatment to fetal expulsion. Although the therapy is described as safe, it is essential to monitor the woman throughout the entire process, minimising the risk of complications such as haemorrhage or infection, hence the recommendation for hospitalisation. The **Risk of Hemorrhage [10017268]** is considered one of the most common complications in a procedure of this kind, and may occur at different stages, from induction to the post-abortion period. The initial assessment of the woman, including clinical and obstetric history and existing risk factors, is essential for planning care appropriate to the medical termination process. Throughout the procedure, constant monitoring of the woman, including the assessment of vital signs and the characteristics of vaginal

blood loss, is crucial for the early detection of excessive haemorrhage. The use of uterotonic medication, such as oxytocin, should be administered as needed. It is important to highlight the education provided to the woman regarding expected blood loss during the first 9 to 12 days and the warning signs and symptoms that should prompt her to attend the emergency department[21].

Interruption due to fetal anomaly presents an additional specificity due to the parents' decision-making component, which often results in feelings of guilt, deep sadness and uncertainties about the decision made[22]. Thus, midwife plays a fundamental role in a more individualized and holistic care of the woman/couple. As reinforced by by Moreno *et al*[23] nursing interventions should include emotional support, health education, and the promotion of physical well-being. **Grief [10022345]** is a unique process for everyone, and the time required for its resolution may vary. The therapeutic relationship established by the midwife can help reduce the psychosocial impact of the process and promote a healthier recovery, as well as a more effective grieving process. Gestational grief is often marked by feelings of anger and guilt, and is emotionally challenging, particularly because it is an unexpected and unpredictable event, which makes it more difficult to accept the loss. The impact of the loss goes beyond the death of the child, also encompassing all the expectations the couple had for the future, representing the end of dreams and plans built around the experience of parenthood[24]. It is observed that when the loss occurs in the first trimester of pregnancy, it is common for couples not to receive social recognition for their grief. However, it has been shown that the emotional bond between the couple and the child is established from the beginning of the pregnancy and becomes stronger, especially after the first ultrasound scan[25].

In managing gestational grief, it is essential to demonstrate empathy, respect, and provide support throughout the care process. Communication plays a key role, and it is important to ensure a suitable physical environment that guarantees privacy and is isolated from areas where pregnant women or postpartum mothers with babies are present[26].

Pain [10023130], in addition to anxiety, risk of haemorrhage, and grief, is also identified as one of the main nursing diagnoses, specifically labour pain, as it is closely associated with the administration of misoprostol®, which induces uterine contractions leading to the expulsion of the fetus. The intensity of pain related to this procedure is highly variable, ranging from mild abdominal discomfort to severe pain similar to that experienced during full-term labour. Factors that can influence the pain include maternal age, gestational age (greater than 22 weeks is associated with increased pain), the duration from induction to expulsion, and the number of prostaglandin doses administered[12]. In this situation there was no need to administer analgesia, with the patient reporting mild pain. The expulsion occurred around 7pm, with treatment starting at 1pm, and only two doses of misoprostol® were given, one vaginal and one oral. The midwife plays an important role in providing the woman with pain relief strategies both pharmacological and non-pharmacological, such as breathing techniques, mobility and the use of the shower, and should always be alert to signs of pain[27].

Finally, it is important to highlight, in relation to this topic, the need for continuous training of healthcare professionals, enabling them to act effectively and empathetically in situations like this. The inclusion of evidence-based protocols and up-to-date guidelines is essential for the standardisation of care and the promotion of better outcomes for women and their families.

Final Considerations

The completion of this case report allowed a profound reflection on the complexity and multidimensionality of nursing care, highlighting the specific competencies of midwife, and demonstrating the importance of evidence-based clinical practice centred on individual needs.

Based on the Nursing Model centred on Activities of Daily Living, nursing diagnoses were established using the ICNP taxonomy, which is highly flexible and allows the construction of personalised diagnoses based on the needs of the woman/couple under study.

Among these diagnoses, Anxiety, Pain, Grief, and Risk of Haemorrhage were highlighted as priorities, representing the main challenges faced by the woman during hospitalisation.

Anxiety and Pain were addressed as immediate issues given their direct impact on the woman's physical and emotional wellbeing. Grief, associated with gestational loss, required a sensitive and humanised intervention, while Risk of Haemorrhage demanded specific clinical care to ensure the patient's safety. After implementing the appropriate interventions, a significant clinical improvement was observed, which also contributed to resolving other identified problems.

Writing this case report was fundamental to consolidating theoretical knowledge and understanding in practice the role of the midwife in the context of the Pathological Pregnant Woman's Inpatient Unit, particularly in situations involving the diagnosis of congenital anomalies and the need for pregnancy termination. It deepened the ethical principles guiding this practice, based on respect for the rights and choices of women and couples. Furthermore, the entire situation highlighted how essential communication is in the midwife practice, requiring adaptation to the needs of the women. Both verbal and non-verbal communication form the basis for establishing a relationship of trust and support, which is crucial in emotionally delicate situations such as this. The analysis of this case sensitised to the stigma associated with termination of pregnancy for medical reasons, encouraging the promotion of a safe environment marked by respect, empathy and absence of judgement.

Thus, it is concluded that the preparation of this case report and the experience gained reinforced the value of the midwife role as a professional capable of integrating technical-scientific knowledge, ethical competencies and emotional support, prioritising the quality of care provided. Regarding research, it highlights the need for studies on the impact of termination of pregnancy for medical reasons on maternal health, grief support strategies and improvement of interventions. Moreover, it encourages the development of evidence-based protocols, ensuring an ethical, effective and woman-centred approach, contributing to the evolution of clinical practice.

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