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Health professionals' roles and practices in supporting women experiencing miscarriage:
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Abstract

Background: Miscarriage can result in significant psychological morbidity. Research suggests health professionals play a role in shaping women's experience of miscarriage.

Aims: This study explored the views and practices of Australian health professionals in caring for women experiencing miscarriage.

Materials and Methods: Twelve health professionals from disciplines including medicine, midwifery and sonography were purposively sampled. Semi-structured interviews were recorded, transcribed, and subjected to thematic analysis.

Results: Participants acknowledged miscarriage is often a distressing event associated with feelings of grief and failure. They believed women who conceived through in vitro fertilisation, had experienced multiple miscarriages, or had a pre-existing mental illness were likely to experience more distress than others. Despite limited training, participants generally felt competent in their ability to provide emotional support. They viewed their role largely as guilt-mitigation, which they achieved by stressing the frequency of miscarriage and emphasising that women were not at fault. Follow-up practices varied, and where they did occur, focused on physical recovery.

Generally, participants relied on women to express the need for further support. Participants reported that time and resource issues, compassion fatigue and a need for self-protection restricted their ability to provide better support care.

Conclusions: There are discrepancies between the emotional support health professionals think women want and are able to provide, and the support women would like. This exploratory study suggests the need for further investigation into provision of improved health professional support for women.

Introduction

Miscarriage, the spontaneous termination of a pregnancy before 20 weeks gestation, is one of the most common complications of pregnancy, occurring in approximately 20% of all pregnancies.¹ The frequency and limited physical morbidity of miscarriage often leads health professionals to treat it as a minor medical complication, overlooking the burden of psychological distress frequently experienced by women. Feelings of grief, guilt, isolation, sadness and anger are common,^{2,3} and in some women, the psychological distress can be significant enough to fulfill criteria for

diagnosis of psychiatric illnesses such as anxiety, depression and post-traumatic stress disorder.^{4, 5}

Increasing evidence shows health professionals play a role in shaping women's experience of miscarriage and the associated psychological impact, with numerous studies showing women commonly feel dissatisfied with their miscarriage care, citing inadequate sensitivity, compassion, information and follow-up care.⁶⁻⁹

There is limited research into the perspectives and practices of health professionals caring for women experiencing miscarriage, particularly in Australia where only two quantitative studies have been undertaken.^{10, 11} The aim of this study was to explore the views and practices of Australian health professionals in caring for women experiencing miscarriage.

Methods

Ethics approval

Ethics approval for this study was granted by the University of Melbourne Human Ethics Advisory Group on October 11th, 2016 (ID 1647195.1)

Participants

To be eligible to participate, health professionals had to be involved in the care of women experiencing miscarriage over the last 12 months. Health professionals were purposively sampled to cover a range of ages, gender, and professions, including obstetricians and gynaecologists (O&Gs), midwives, GPs, emergency physicians, and obstetric sonographers.

Recruitment

Participants were recruited between February and April 2017, through a number of networks, including through the Victorian Primary Care Practice-Based Research Network, a practice based research network at the Department of General Practice (University of Melbourne), existing networks known to the researchers (acquaintances and work colleagues), and snowball sampling methods. Eligible

participants were sent a plain language statement and consent form prior to the interview.

Participation

Interviews were conducted in person or by telephone. Participants were asked a series of structured demographic questions before being asked a number of semi-structured questions exploring their views and practices in caring for women experiencing miscarriage and their views on the barriers to providing optimal miscarriage support.

Data management and analysis

Interviews were audiotaped, transcribed verbatim and de-identified. Two additional questions were added to the interview schedule after the third interview was completed and new themes were identified. Data were analysed using a general inductive approach, in which each transcript was read multiple times and coded to identify the key themes arising from the data. A coding framework was developed in which the coded segments of text were tabled under the key themes and subthemes and the excerpts re-read and compared for meaning, similarities and differences. The three researchers met regularly throughout the data collection period to discuss emerging themes. A subset of interview manuscripts was read and coded independently by each researcher to compare coding and thematic analysis, with no major differences in interpretation evident. At the completion of the recruitment period, 12 interviews were complete and data saturation had been met among GPs, O&Gs and midwives however not among emergency physicians or obstetric sonographers (see limitations).

Results

Seven interviews were conducted face-to-face and five by telephone. Interviews took between 26 and 62 minutes. Table 1 outlines the demographic and practice characteristics of the participants.

Psychological impact of miscarriage

Most participants felt that women could have a broad range of reactions to their miscarriage and reported that grief, despair, or frustration was common.

Almost all participants felt women in certain situations were more likely to experience higher levels of miscarriage-related distress, such as women who conceived through in vitro fertilisation (IVF), who had experienced multiple miscarriages, with no other children, or who had a pre-existing mental illness.

- The level of distress can be much worse if *it's an IVF pregnancy, where there's a lot of emotional and financial and time and energy gone into it and then there's a miscarriage follows ... that's pretty dreadful* (Eva, GP)

I'd say if they've had children before they're far less distressed, so if it's their first pregnancy, if they've had multiple miscarriages in a row they're far more likely to be distressed. Certainly if they've got any mental health issues, especially anxiety and depression. (Hannah, O&G)

Training, competency and emotional care of women experiencing miscarriage

Participants reported that due to the low medical complexity of miscarriage management, miscarriages are primarily managed in the public hospital setting by junior doctors. While education is provided around the physical management of miscarriage, little to no training is provided around emotional support to women.

It was certainly absolutely and completely no training in the emotional side, or I don't remember that even if there was. I don't think it was even thought about that much. (Eva, GP)

In this absence of training, participants were left to learn about providing emotional care through experience.

I think I probably have learned a bit by trial and error. (Fiona, O&G resident)

Despite the lack of training, participants generally felt competent in their ability to provide emotional support. Most of the participants described accomplishing this by explaining to women that the miscarriage was not the woman's fault.

I make a point of saying to them that “Please understand that there’s nothing that you could have done to prevent this from happening” (Ingrid, sonographer)

Many of the participants also reported counselling women on the statistical frequency of miscarriage. For some, this was again to show that miscarriage was not a “blame attributable condition” (Adam, O&G), while for others this was to reduce feelings of isolation.

Trying to normalise, and in a way sort of frame it as though “you’re not the only one in the world who’s had a miscarriage, and so you’ll probably find there’s a lot more people.” (Leon, GP)

There was no relationship between the frequency with which health professionals cared for women experiencing miscarriage and their self-perceived competence or their practices.

Follow-up care

Overall, participants working in public hospitals reported that follow-up was not routinely provided as they perceived it to be outside their role or there were insufficient resources to allow them to do so. Some participants would instead encourage women to follow-up with their GP.

There's no system capacity to see all women who have a miscarriage...The service that's provided is really to make the diagnosis, discuss management and arrange for follow-up but not direct follow-up. (Ben, O&G registrar)

For participants working in private practice, O&Gs generally arranged a follow-up appointment at six weeks post-miscarriage, while GPs either encouraged an appointment within a week or provided follow-up phone calls instead. For most of these participants, follow-up was primarily viewed as an opportunity to review the woman’s physical recovery.

I ask them how their bleeding is, how their pain is, whether they've had a normal period yet. I ask them how they're feeling. I ask them whether they're thinking about [conceiving again]... I don't spend a huge amount of time on

the psychological aspects of it... *unless* they bring something up. (Adam, O&G)

Only two participants asked women direct questions about their mood or behaviour to assess their emotional state.

Getting a bit of a feel for whether 'I haven't left home for a week, I've been sitting in the corner crying' versus 'No, no I've been out talking to people and since then I've found a few other people who've had miscarriage as well and we've chatted about it.' (Leon, GP)

None of the participants used mental health screening tools to assess a woman's mental state at follow-up. Only a few were familiar with, and none routinely referred women to external miscarriage support organisations. In general, participants relied on women to communicate any need for further support.

I think normally they're able to give it to you, they're giving you a pretty good history, an idea of where they're at. (Chloe, GP)

Perceived barriers to better care

When discussing barriers to providing ideal care, participants tended to focus on external barriers, especially time pressures, language barriers, and limited availability of resources.

To be compassionate and to be clear it would take a minimum half an hour...

Time is just always a battle in general practice. (Chloe, GP)

The availability of ultrasound is a massive sticking point (Fiona, O&G resident)

Only a small number of participants were introspective about the personal characteristics or behaviours that may prevent health professionals from providing ideal care, but of those who did, two different phenomena emerged: compassion fatigue and self-protection.

Participants who frequently cared for women experiencing miscarriage flagged the risk of becoming indifferent to the personal significance of miscarriage because of frequent exposure

Sometimes you get fed up with seeing the same thing all the time and it's hard for you to maintain your vigor... you have to remind yourself that it's completely new for that person, even though you've seen it a hundred times.

■ (Fiona, O&G resident)

Other participants felt that some health professionals may chose not to provide comprehensive emotional support as a form of self-protection.

If you're seeing ten women with miscarriages in an afternoon, and for every woman you have to counsel them about the loss in detail, about the psychological impact of the miscarriage. Then you go home feeling like you've had ten miscarriages and that can be very difficult as a doctor. (Adam, O&G)

Discussion

This study sought to understand the practices and views of Australian health professionals involved in miscarriage care. While participants recognised that miscarriage often resulted in feelings of grief, frustration and guilt, they felt women in certain circumstance were more likely to experience higher levels of distress. Participants reported having received limited training about supporting women through miscarriage. Despite this, they felt competent in their ability to provide emotional support. They acknowledged that the emotional support provided by health professionals could be lacking, and felt this was largely due to time and resource restraints, as well as compassion fatigue and need for self-protection.

Practice and Perception Mismatch

Several studies have explored the care that women experiencing miscarriage want from their health professionals, including an acknowledgment of their bereavement, more comprehensive information, and adequate follow-up.^{8, 9, 12} It's clear from the literature that a gap exists between the nature of the care women want and the care they receive.⁸ There appears to be two components to this gap: the discrepancy

between health professionals' actual practice and their perception of ideal practice – a “practice mismatch”, and the discrepancy between health professionals' and women's perception of ideal practice - a “perception mismatch” (see Figure 1).

The “practice mismatch” represents health professionals not being able to perform their work as well as they would like. This study, as well as previous research demonstrates that health professionals feel a lack of time prevents them from providing optimal miscarriage care.^{3, 9, 10, 13, 14} Health professional compassion fatigue has also been identified as a barrier to ideal care in previous research.^{3, 15}

The “perception mismatch” is related to a difference in views between women and health professionals about the type of care women want. Evans et al (2002) asked health professionals and women to rank the changes that would most improve care for women experiencing miscarriage, and found that each group had very different perceptions of how care could be improved.¹⁰ The perception mismatch is evident in several aspects of miscarriage care and includes different views about the role of the health professional in providing support, different beliefs of how miscarriage can impact on a woman and different understandings of what information is important to impart.

This study and previous research identified that health professionals generally focus on the physical needs of women following miscarriage,^{3, 13, 16} even though women consistently rate recognition by health professionals of the significance of their loss as the most important attribute of quality care following miscarriage.^{6, 8, 9, 11, 17}

In this study, while most health professionals acknowledged miscarriage is often a distressing event, they felt there were particular circumstances (such as recurrent miscarriages) that would make women more likely to experience higher levels of distress. However there is no strong evidence to support the supposition that the degree of psychological distress experienced by women following miscarriage can be correlated with any particular aspect of her circumstances.^{10, 18}

It appears likely a “perception mismatch” also exists around the information health professionals believe is important to impart to women, and the information women want. Research has shown that women would like more information about the aetiology of their loss, and what physical and emotional symptoms they may expect

as this can help prevent feelings of guilt and reassure them that their grief is normal.^{9-12, 17} The health professionals in this study felt it was important to tell women about the high prevalence of miscarriage in order to reassure them it was not their fault, however women in previous studies have repeatedly reported that focus on the statistical frequency of miscarriage devalues the significance of their loss.⁹

Finally, women's dissatisfaction with the provision of follow-up likely illustrates both a practice and perception mismatch. Past research has consistently shown women believe post-miscarriage follow-up and support to be a high priority, and ideally in the days to weeks after diagnosis.^{4, 9, 12, 19} Furthermore, a positive effect on resolution of grief has been found with a formal follow-up program consisting of visits to a nurse at one, five, and 11 weeks post-miscarriage.²⁰ In this study, many health professionals felt they could not offer follow-up due to time and resource constraints. Furthermore, where health professionals were able to provide follow-up, they generally focused on the physical management, rather than emotional wellbeing of their patients.

Strengths and limitations

The major strength of this study is that it is the first Australian qualitative study to examine health professionals' views and practices in caring for women experiencing miscarriage. The main limitation of this study was that as a six-month medical student project, recruitment time was limited. While data saturation was met among some clinical groups, further interviews are required with sonographers and emergency department professionals to gain a deeper understanding of their views and practices and to provide inter-group comparisons. Given the frequency with which women present to emergency departments, it is imperative that future research aims to better understand the views and practices of emergency department professionals in caring for women experiencing miscarriage. Further research is also required to better understand the differences in views and practices that may exist between rural and metropolitan based health professionals.

Future Implications

In order to address the gap between the care women want and the care they receive, the discrepancies in both "practice mismatch" and "perception mismatch" need to be addressed.

Several of the barriers causing the “practice mismatch”, such as time-pressure and resource limitations exist across most fields of healthcare, and may therefore be difficult to change. However, further research is needed to explore if changes to workplace rosters, or staff support programs could reduce compassion fatigue and increase health professionals’ emotional resilience.

The “perception mismatch” is simply a difference in understanding and could likely be addressed with improved education, awareness and training. DiMarco et al (2002) reported that health professionals’ perceptions of the emotional needs of women experiencing miscarriage were significantly increased after attending a bereavement program.²¹ Furthermore, a positive association between health professional confidence and the provision emotional support has been reported,¹⁵ suggesting that education and training could directly improve care. Further research is required to explore acceptable and feasible modes of support training in the Australian context.

Finally, increased awareness and utilisation of miscarriage support services may augment the care that health professionals are currently able to provide. Further research is needed to explore the feasibility and benefit of formal follow-up or referral programs in order to overcome this gap in care.

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Table 1: Demographic and practice characteristics of participants

Characteristic	<i>n</i>	(%)
Gender		
Women	8	(67)
Men	4	(33)
Occupation		
General practitioner	4	(33)
Obstetrician gynaecologist	4	(33)
Midwife*	3	(25)
Sonographer	1	(8)
Practice Location		
Urban	10	(83)
Rural	2	(17)
Age (years)		
30 – 39	6	(50)
40 – 49	2	(17)
50 – 59	3	(25)
60 – 69	1	(8)
Miscarriages managed in the last 12 months		
Less than 5	2	(17)
5 – 49	3	(25)
50 – 99	2	(17)
100+	5	(42)

* While this study was specifically targeting midwives, all three participants were dual-trained nurse midwives.

“Practice mismatch”

“Perception mismatch”

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Health professionals’
actual practice

Health professionals’
ideal practice

Women’s ideal
care