SUPPORTING WOMEN THROUGH MISCARRIAGE: WHAT DO HEALTHCARE PROFESSIONALS HAVE TO SAY?

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Background

- Miscarriage is common
  - 1 in 4 confirmed pregnancies end in miscarriage[1]
- Many women experience psychological distress following miscarriage
  - Emotions: grief, guilt, anger[2]
  - Rates of clinical depression, anxiety and PTSD are higher after miscarriage[3]

Background

- Women want better support from their healthcare professionals (HCPs):
  - Behaviour that demonstrates a recognition of the significance of their loss[4]
  - Information on “normal” emotional responses to miscarriage[5]
  - Follow-up care[6]

Background

- Research into the HCPs perspective limited: nine papers since 2000
- In Australia:
  - Boyle et al (2000): 123 GPs in QLD[7]
  - Evans et al (2002): 43 hospital-based doctors, nurses and social workers in NSW[8]
- Both quantitative, questionnaire-based studies

Background

What we know

- HCPs understand that miscarriage is often distressing for women
- HCPs perceived barriers to provision of optimal care:
  - Insufficient time
  - Language barriers
  - Resource restrictions
  - Insufficient training

Background

What we don't know:

- HCPs expectations of the duration of distress following miscarriage
- The actual behaviour of HCPs
  - Explanation of miscarriage
  - Terminology
  - Follow-up

Aim

To explore the views and practices of Australian HCPs in caring for women experiencing miscarriage

Methods

- <u>Qualitative study</u>
- Sample:
  - GPs
  - O&Gs
  - ED doctors & nurses
  - Sonographers
- Recruitment
  - VicReN
  - Networks known to researchers
  - Snowball sampling

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MISCARRIAGE SUPPORT

Views and practices of healthcare providers

Miscarriage is a common event occurring in up to one in four pregnancies. This study aims to explore healthcare provider's views and practices in caring for women experiencing miscarriage.

We are looking to interview up to 30 healthcare professionals who routinely come into contact with women experiencing miscarriage including - *O&G's, midwives, general practitioners, emergency department doctors and nurses, sonographers, IVF specialists & counsellors*. Interviews will take approximately 25-30 minutes and can either be done by telephone or face to face. This study has ethics approval (number 1647195.1) from The Human Research Ethics Committee at The University of Melbourne. Any information you provide to us is strictly confidential.

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Methods

- Semi-structured interviews: face-to-face or by phone
- Areas of discussion:
  - Views of miscarriage support
  - Practices in supporting women through miscarriage
  - Barriers or enablers to good care
- Interviews taped, transcribed verbatim, analysed with a general inductive approach. N-Vivo used to assist with data management

Results

Characteristic	*n*
Occupation	
- General practitioner	4
- Obstetrician gynaecologist	4
- Nurse midwife	3
- Sonographer	1
Gender	
- Women	8
- Men	4
Age (years)	
- 30 – 39	6
- 40 – 49	2
- 50 – 59	3
- 60+	1

Characteristic	*n*
Practice location	
- Urban	10
- Rural	2
Miscarriages managed in the last 12 months	
- Less than 5	2
- 5 – 49	3
- 50 – 99	1
- 100+	6

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Experience, training and guidelines

Perceptions of women's emotions

Practice: Explaining miscarriage

Practice: Terminology

Practice: Follow-up

Barriers to optimal care

Results

Experience, training and guidelines	Perceptions of women's emotions	Practice: Explaining miscarriage
Practice: Terminology	Practice: Follow-up	Barriers to optimal care

1. Experience, training and guidelines

- Miscarriages are primarily managed in the public hospital setting by junior doctors

“Because it's seen as a medically quite straightforward consultation, not very junior, but moderately junior staff are rostered there.” (O&G2)

1. Experience, training and guidelines

- Training is focused on physical care – limited to no training on providing support

"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." (GP2)

1. Experience, training and guidelines

- The focus on medical care over emotional care in training is mirrored in the professional guidelines, which are generally exclusively about the physical management of miscarriage

KJ: "In either of your workplaces are you aware of any specific policies or procedures in the support of women who are experiencing miscarriage?"

O&G1: "Not in the terms of psychological support but in terms of medical support."

1. Experience, training and guidelines

- HCPs learn about providing supportive care through experience

"I think I probably have learned a bit by trial and error. I don't feel like I've had formal training." (O&G3)

1. Experience, training and guidelines

- Despite both the lack of training and guidelines, every HCP interviewed felt confident in their ability to provide supportive care to women experiencing miscarriage

KJ: "It sounds like you feel pretty well equipped in providing emotional support to women?"

NM1: "Yeah. Yep absolutely, yeah for sure."

Results

Experience, training and guidelines	**Perceptions of women's emotions**	Practice: Explaining miscarriage
Practice: Terminology	Practice: Follow-up	Barriers to optimal care

2. Perception of women's emotions

- HCPs recognised women can have a range of reactions to miscarriage including guilt, despair, frustration, acceptance and relief

"Some people are so very sad, and I think they take it as a failing… That they've failed… Other people, yeah, I don't know if they didn't want to be pregnant, or, yeah, but they don't seem too affected, well visibly affected." (NM2)

2. Perception of women's emotions

- HCPs believe some women are more likely to be more distressed than others – higher gestational age, no children, IVF conception

"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." (O&G4)

2. Perception of women's emotions

- No consensus on normal duration of distress
- Related to vastly different interpretations of "distress", "grief" or "recovery"

"Weeks? Yeah over a couple of weeks generally." (GP4)

"Sometimes some people it will be short term. Some people it will be forever, the rest of their lives they'll mourn that loss." (NM1)

- This may explain the lack of consensus in quantitative literature

Results

Experience, training and guidelines	Perceptions of women's emotions	Practice: Explaining miscarriage
Practice: Terminology	Practice: Follow-up	Barriers to optimal care

3. Practice: Explaining miscarriage

- Main concern centered around women feeling isolated, guilty, blaming themselves.

“They will always blame - not always - a lot of women blame themselves, that they've done something wrong, that they've eaten something incorrectly, they've stood on their one leg in the corner backwards the wrong way or there's just something.” (NM1)

3. Practice: Explaining miscarriage

- As a result, HCPs almost universally shared two messages with women:
  1. Miscarriage is common
  2. The woman has done nothing to cause it

"I say that… miscarriage is actually a normal part of reproduction and… one in five pregnancies will end in a miscarriage. And it's usually due to factors outside the couples control, so it's nothing they have done or, or not done to cause the miscarriage." (O&G2)

Results

Experience, training and guidelines

Perceptions of women's emotions

Practice: Explaining miscarriage

Practice: Terminology

Practice: Follow-up

Barriers to optimal care

4. Practice: Terminology

- HCPs use a range of terminology when describing miscarriage
  - *"The pregnancy"*
  - *"The baby"*
  - *"The embryo"*
  - *"The fetal pole"*

4. Practice: Terminology

- Choice of terminology was often situation dependent
  - More technical terms for an unwanted pregnancy, or when discussing surgical management

- Despite the huge range, the HCPs' choice of terminology was always motivated by a concern for the women's wellbeing.

Results

Experience, training and guidelines	Perceptions of women's emotions	Practice: Explaining miscarriage
Practice: Terminology	**Practice: Follow-up**	Barriers to optimal care

5. Practice: Follow-up

- Overall, HCPs in public hospitals felt follow-up was outside their role, or there were insufficient resources to provide follow-up
- HCPs who did perform follow-up tended focus on physical symptoms

"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, I think in my review… unless they bring something up." (O&G1)

5. Practice: Follow-up

- Those who assess mental state at follow-up tend to use broad questions – *'How are you going?' (NM2)* – and felt that women would inform them if they needed further support

"I think it's normally, they're able to give it to you, they're giving you a pretty good history, an idea of where they're at." (GP1)

5. Practice: Follow-up

- Only a small number asked specific screening questions, eg *'How has your mood been?' 'Have you been crying much?'*

- None used psychiatric screening tools (eg K10, Edinburgh Depression Scale)

Results

Experience, training and guidelines

Perceptions of women's emotions

Practice: Explaining miscarriage

Practice: Terminology

Practice: Follow-up

Barriers to optimal care

6. Barriers to optimal care

- HCPs mostly focused on external barriers preventing them from providing ideal care: time pressure, language barriers, appointment or operating theatre availability

"Essentially, if I had longer bookings, not every seven minutes, then actually it would be fine. I think I could provide that." (O&G2)

6. Barriers to optimal care

- A small number reflected on the personal characteristics or behaviours of HCPs that might prevent them from providing ideal care
- Two phenomena:
  - “Desensitisation”
  - “Self-protection”

6. Barriers to optimal care

- **Desensitisation:** the idea that with frequent exposure to women experiencing miscarriage, there is a loss of sight of the personal significance miscarriage has for women

"Sometimes I guess you get fed up with seeing the same thing all the time and it's hard for you, for you to maintain your vigour… you have to remind yourself that it's completely new for that person, even though you've seen it a hundred times." (O&G3)

6. Barriers to optimal care

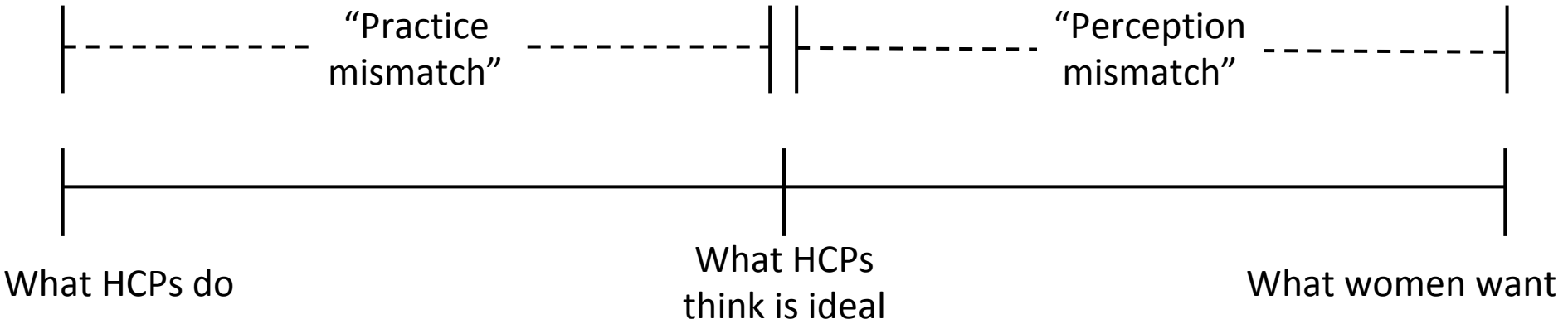
- **Self-protection:** the conscious or subsconscious decision not to engage with the emotional labour of providing support, because to do so would be draining for the HCP

"If you're seeing ten women with miscarriages in an afternoon, and for every woman with a miscarriage 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." (O&G1)

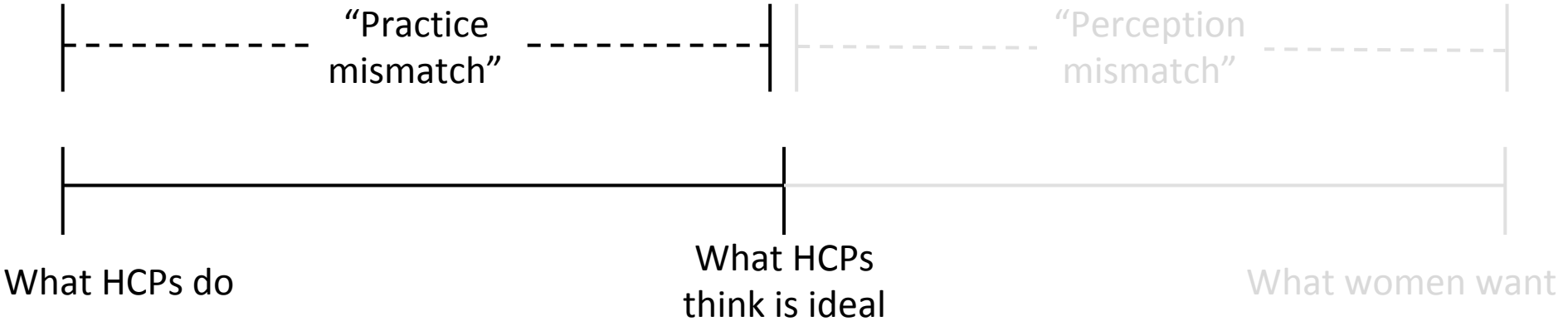
Discussion

- HCPs have limited training and guidelines from which to draw.
- HCPs view their role primarily in terms of the physical management of miscarriage
- HCPs view their support role largely as guilt mitigation.
- HCPs believe that the emotional support they provide could be sub-optimal for various reasons

Discussion

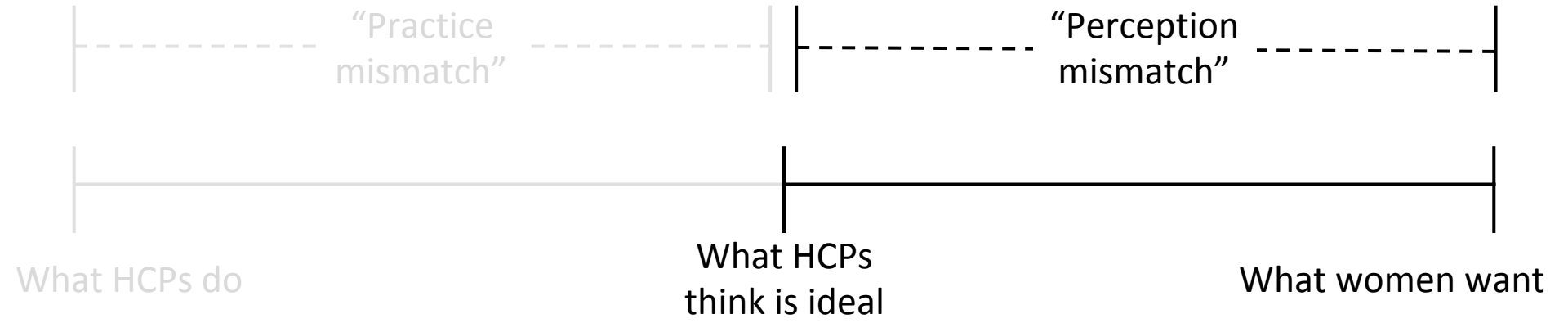

"Practice mismatch"
"Perception mismatch"
What HCPs do
What HCPs think is ideal
What women want

Discussion



- Contributors
  - External barriers eg time-pressures, resource availability
  - Internal barriers
    - Desensitisation
    - Self-protection
- Possible solutions
  - More time, more resources
  - Increased utilisation of external miscarriage support services
  - Varied rosters to prevent desensitisation
  - Strategies to increase HCP resilience

Discussion



- Contributors
  - Training that focuses on medical care only
  - Guidelines that focus on the medical care only
  - Misconceptions about experience and needs of women
- Possible solutions
  - Education – proven to improve HCP understanding of miscarriage bereavement[9]
  - Alteration of professional guidelines to include element of support care

Strengths and Limitations

- Strengths
  - First qualitative Australian study
  - Examined a range of HCPs
- Limitations:
  - Six-month student project

Conclusion

- There's a discrepancy between the care women want and what HCPs are able to provide, due to:
  - Resource restrictions
  - Inadequate emotional support education & training
  - Well-intentioned but misguided assumptions

- Recommendations:
  - Changes to training and guidelines
  - Formalised follow-up system
  - Increased referral to miscarriage support services may augment care

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