Women's experiences of general practitioner management of miscarriage

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SUMMARY. A study of 67 women one month after miscarriage identified significant levels of dissatisfaction with their medical care. There are particular problems in managing miscarriage which is very distressing for many women but a common clinical presentation for doctors. The reasons for women's dissatisfaction with their management are explained. Greater understanding of the experience of miscarriage should lead to better management and suggestions are made for better care for this common distressing experience.

Introduction

SPONTANEOUS abortion is common, occurring in about one pregnancy in five. There have been few studies of the psychological consequences but evidence suggests that many women experience intense emotional distress after miscarriage.[1-6] General practice management of threatened miscarriage shows considerable vairation.[7] This paper reports on women's experiences of the general practitioner's management of their miscarriage and offers guidelines for better management.

Method

The subjects were a consecutive series of women who had been admitted to hospital in Oxford for complete or threatened abortion, and who were treated by evacuation of the uterus. Shortly before discharge from hospital the women were seen by a research psychiatrist (T.F.) who told them about the study and its purpose. A few days later the women received a letter offering an appointment for interview four weeks after leaving hospital.

Interviews were held mainly at the women's local health centre, and in some cases at a local hospital. The interview began with a semistructured enquiry about previous medical, obstetric and psychiatric history; the circumstances of the spontaneous abortion; and the medical care and information received. The interview went on to cover events while in hospital and after discharge.

The interviewer assessed the patient's mental state using the present state examination,[8] which relates to the patient's symptoms during the month before the interview. A computer programme, Catego, determines the likelihood of a patient having sufficient symptomatology to achieve psychiatric 'caseness'. Assessments of depression, personality, marital satisfaction and social adjustment were also completed, and the results of these are reported elsewhere.[9]

Results

Characteristics of the sample

Of 80 women approached 67 (84%) attended for interview. The 13 who refused were similar to the attenders in social class and obstetric history; however, 38% of them were single compared with 13% of the 67 attenders.

The mean age of the interviewed women was 29 years (range 17–42) and of their partners 32 years (range 21–50). In social class, the women resembled women of comparable age from the general population of Oxfordshire. Sixty one of the women (91%) had their spontaneous abortions in the first trimester of pregnancy, and the remaining six (9%) early in the second trimester.

Among the 67 interviewed women, 69% had no history of previous spontaneous abortion; half of this sub-group (23 women) were childless. Among the 21 women who had a history of previous spontaneous abortion, 15 reported one previous miscarriage, three reported two, two reported four and one reported five. Six of these 21 women had no children. In the full sample of 67 women, 19% gave histories of therapeutic abortions.

Experiences of miscarriage

The most common initial sign that there was a problem with the pregnancy was vaginal bleeding (81% of women). The other first indications were pain (12%) and losing the feeling of being pregnant (3%). Three women (4.5%) discovered their pregnancy had not progressed when they attended a routine antenatal clinic.

The majority of women (88%) had consulted their general practitioner, while the remainder (12%) were admitted to hospital without consultation. The length of time from the woman first recognizing a problem to seeing her general practitioner varied, although those with severe bleeding and pain generally consulted earlier. Fifty four per cent of women had been seen by their general practitioner within two hours; 19% between two and 12 hours; 10% between 13 and 24 hours; 15% between one and seven days; and one woman waited 11 days.

The women were also asked about the length of time from the first signs of a problem until they had their operation. This is the period of uncertainty when it is not known whether the pregnancy will be lost. Two women (3%) had their operation within six hours; seven (10%) between seven and 24 hours; 21 (31%) between one and three days; 11 (16%) between four and seven days; 15 (22%) between one and two weeks and 11 (16%) more than two weeks after first noticing a problem with their pregnancy.

Many women found this period of waiting particularly distressing owing to the uncertainty about the outcome of their pregnancy. They felt powerless to influence the likelihood of miscarriage because bedrest was often the only advice given by the general practitioner and this carried little conviction. Complete rest was difficult for the women over a prolonged period of time and this led to feelings of guilt and responsibility when the inevitable miscarriage occurred. Some women, paradoxically, hoped they would miscarry as this would at least put to an end the prolonged period of uncertainty.

Attitudes to treatment from the general practitioner before admission

The women were asked about their attitudes to the care they received from their general practitioner and the amount of information that they were given prior to admission (Table 1).

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Although most women were at least moderately satisfied with the care and information they received from their general practitioner the results indicate appreciable levels of dissatisfaction; 26% were fairly or very dissatisfied with the care they received and 35% were fairly or very dissatisfied with the information they received. The women often felt this was due to different perceptions of the seriousness and importance of the threatened abortion between themselves and the general practitioner. The women felt that their condition was not treated as an emergency or that they were not visited at home frequently enough. They found it helpful when it was explained to them that medical intervention had little to offer in increasing the chances of saving their pregnancy. The women were helped by general practitioners who discussed their distress and grief with them and they were generally angry to be told that it was only an early pregnancy and that they could try again.

Attitudes to treatment in hospital

The women were asked about their attitudes to their treatment in hospital (Table 2). Again the majority of women were at least moderately satisfied with their short time in hospital, although they had some problems in common. The women were often admitted at unsocial hours and, as with their general practitioner, many felt they were a routine case for the junior staff whereas they themselves were undergoing a major trauma. They also complained that their husbands were sometimes not involved in the consultations with the junior doctors. The women had to wait until the end of routine operating lists to have the operation for the evacuation of remaining products of conception and they were rarely seen by the consultant. The women's main dissatisfaction concerned the information and advice which they received on discharge from hospital; sometimes the dissatisfaction was about lack of information about possible complications such as continued bleeding but it was mostly due to conflicting advice on future plans for pregnancy and how long to wait before trying to conceive.

Table 1. Womens' satisfaction with treatment from the general practitioner.

	Number (%) of women	
	Care from GP ($n=62$)	Information from GP ($n=62$)
Very satisfied	24 (*39*)	16 (*26*)
Fairly satisfied	12 (*19*)	15 (*24*)
Moderately satisfied	10 (*16*)	9 (*15*)
Fairly dissatisfied	8 (*13*)	15 (*24*)
Very dissatisfied	8 (*13*)	7 (*11*)

Table 2. Womens' satisfaction with treatment in hospital.

	Number (%) of women ($n=67$)			
	Pre-operative care	Pre-operative information	Post-operative care	Post-operative information
Very satisfied	24 (*36*)	22 (*33*)	22 (*33*)	15 (*22*)
Fairly satisfied	22 (*33*)	16 (*24*)	23 (*34*)	16 (*24*)
Moderately satisfied	10 (*15*)	14 (*21*)	13 (*20*)	12 (*18*)
Fairly dissatisfied	6 (*9*)	8 (*12*)	6 (*9*)	19 (*28*)
Very dissatisfied	5 (*7*)	7 (*10*)	3 (*4*)	5 (*7*)

Attitudes to contact with the general practitioner after discharge

Although there was no routine follow up, in the four weeks after discharge from hospital 46 (69%) of the women consulted their general practitioner. A quarter of these women felt their consultation was for emotional distress, as shown by low mood, anxiety and difficulty in sleeping. The majority of women hoped that the consultation would help explain the reason for their miscarriage and that there would be an explanatory report from the hospital and they were disappointed when this was not the case.

Psychiatric morbidity

The present state examination revealed that four weeks after their miscarriage 32 patients (48%) in this sample were classified as having depressive illness. This rate is about four times higher than that found in the general population.[10] Although a number of associations with caseness were found,[9] there was no association between psychiatric morbidity and increased levels of dissatisfaction with care and information, either from their general practitioner or from the hospital. This implies that other factors are more important in causing distress in these women and that the women's recollections were not unduly influenced by their current emotional state.

Discussion

The main conclusion from this study was that many women who had had a miscarriage were dissatisfied with the care they received. The major reason for this dissatisfaction with both the general practitioners and the hospital doctors appeared to be the mismatch between the patients' and the doctors' perceptions of patients' needs.

The doctor may view miscarriage as a common clinical problem. He or she has little to offer in terms of treatment and may advise bed rest, despite the knowledge that there is no good evidence of benefit. In most cases it seems that the outcome is inevitable and that bleeding in early pregnancy will progress to miscarriage in about half of the cases while in the others the pregnancy will proceed.

The woman and her partner may view miscarriage quite differently from the doctor. For many women the moment that they are aware of their pregnancy they feel that they have a baby inside them. Emotionally the experience of early miscarriage may be as distressing as that of late miscarriage or a stillbirth but it is not recognized as such and is therefore a more unshared problem than the other two losses.

The loss or prospect of losing a baby may also be the first major loss in a woman's life. If she is vulnerable to the development of depressive illness then this major life event may be the precipitating factor. The seriousness of miscarriage to women helps to explain their dissatisfaction when they think doctors are not treating their condition with the importance they feel it deserves. Those women who were told that there was no treatment for their bleeding seemed content with this if it was carefully explained. It seems that total bed rest is extremely difficult to achieve and in some cases it is deleterious because it makes the woman feel responsible for the outcome of her pregnancy. If the woman becomes aware of her continued bleeding when she gets out of bed this may only serve to make her feel guilty when she eventually miscarries.

Nowadays it tends to be assumed that modern medicine can treat most problems; patients often find it difficult to accept that medical management has little to offer. In the case of miscarriage this may explain some of the dissatisfaction women have with their medical management, but it accentuates the need for explanation.

The hospital management of these women is also problematic. They are admitted as 'emergency' cases but are of low priority in terms of medical management. The junior doctors see many miscarriages, so that these women often become routine cases which have to be fitted in at the end of operating lists. The short time the women spend in hospital means that they are often not seen by the consultant in charge of their care and the brevity of their stay makes it difficult for the nursing staff to form a relationship with them. Unlike those experiencing later miscarriage, these women do not receive a routine 'six-week check'. Their care falls largely on the primary health care team.

What can be done to help women who have had a miscarriage? Sympathetic handling by the general practitioner would probably be helpful, and in particular more information to the women about miscarriage when they present with bleeding. Advice about bed rest should be based on evidence of benefit rather than the need to offer some intervention. It seems that it is helpful to admit honestly that there is little treatment available, and it is important to understand that miscarriage is a very distressing event.

After discharge from hospital, women again need information about the risks of future pregnancies and how long to wait before trying to conceive. The length of this period depends on when the couple feels psychologically ready to try for another baby. Women are not normally helped by being told 'You can always get pregnant again' as the majority of women know this; their concern is that if they get pregnant again they will suffer another miscarriage.

Counselling would be helpful in enabling women to come to terms with their experience of loss and this might best be carried out by the health visitor or general practitioner. This counselling would centre on listening, explanation and advice. Listening would allow the woman to express her feelings and worries about the experience of miscarriage. Explanation could deal with the nature and causes of miscarriage and the psychological response. Advice could deal with ways of coping with the stress, and with practical guidance on future pregnancies.

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