We aren't doing well enough for women experiencing pregnancy loss, a common and devastating experience that is a significant life event for many people. The Independent Pregnancy Loss Review, published in July 2023, highlights the stories of people who are 'traumatised by their care experience and feel angry and dismayed at the total lack of compassion and support afforded to them during such a distressing time'.1 This review offers recommendations to improve care for women and their families experiencing pregnancy loss, and includes specific advice for primary care. What can we do better in general practice to support women with pregnancy loss?

TERMINOLOGY
Throughout the review, and in this article, I use the term pregnancy loss, instead of miscarriage, a term that some women feel does not describe their lived experience of losing a baby, and suggests that, somehow, the woman's body has 'failed' to carry the baby.2 Terminology around pregnancy loss can be emotive. Some parents will refer to the loss as a miscarriage, or talk about their baby, and some will talk about the fetus, but, in practice, we need to follow the lead of parents and reflect their choice of language. If practitioners are in any doubt about what and how to say it, the Pregnancy Loss Review suggests asking parents which language is preferred.

DIAGNOSIS
Diagnostic pathways for pregnancy loss are not straightforward for women or clinicians to navigate, especially as care provision varies widely across the country. Early pregnancy assessment units (EPAUs) are specialised units set up for women with complications in the first trimester of pregnancy. The Pregnancy Loss Review looked at all EPAUs in England, and found a wide variation in opening times, referral gestation, and referral processes. Some EPAUs only accepted women from 6 weeks' gestation, while others had no early cut-off, accepting women from conception to 14 to 20 weeks' gestation. Where EPAUs do not accept referrals under a specific gestational age, women are often managed in primary care and again with a high variation in care and use of biochemical markers such as serial urine pregnancy tests and serum bHCGs. This is supported to an extent in the current National Institute for Health and Care Excellence (NICE) guidelines, which suggest that, if a woman is less than 6 weeks pregnant and bleeding, to consider use of 'expectant management'.3

In terms of how women access EPAUs, most required a referral from a GP, A&E clinician, or another health professional, with an appointment-only attendance policy. A few EPAUs allowed patient self-referral, or self-referral if the woman had a history of recurrent, molar, or ectopic pregnancy, and others provided a walk-in service. EPAU service provision, unfortunately, seems to be a bit of a postcode lottery. Because practice varies so widely, the Pregnancy Loss Review suggests that, depending on location, women are being ‘bounced’ between GPs, A&E, 111, and gynaecology services. In an attempt to try to standardise to best practice, the review suggests that women should be able to self-refer to an EPAU with pain or bleeding during pregnancy regardless of gestation.

Variation in opening times also acts as a barrier to women trying to access early pregnancy services. A qualitative study of women’s experiences of using EPAUs highlighted that difficulty obtaining appointments, availability of appointments, and opening hours were the most commonly raised barriers. Women wanted to see EPAUs open at the weekend to allow flexibility around work and childcare.4 NICE already recommends that early pregnancy assessment services should be open 7 days a week. Most EPAUs are already falling below these recommended guidelines, so does a 24/7 EPAU offer a practical ask for every trust? And, in terms of how services are delivered, some women find co-location of EPAUs alongside maternity and gynaecology units distressing.4 The Oxford EPAU provides a model of the good practice recommended in the review in terms of location and referrals — the unit is located in the community, and allows self-referral for all women less than 16 weeks' gestation.5 In this EPAU, GPs made only 20% of referrals with 59% self-referrals from patients. For EPAUs wanting to redevelop their services, this model might be worth a close look, and might change the traditional route of ‘GP referral’ to an appointment-only service.

AFTER THE PREGNANCY LOSS
The Pregnancy Loss Review suggests...
several touchpoints where general practice can act to support women and their partners following a pregnancy loss. The first recommendation is a simple one, that GPs should email, or post a letter of support to, individuals experiencing a pregnancy loss. This letter serves two purposes, first to acknowledge and offer condolences for the pregnancy loss, and second to signpost to local and national support organisations. This recommendation can easily be incorporated into standard practice, and the review includes letter templates that can be downloaded and used by practices. Why is this important? Many bereaved parents feel unable to absorb verbal information or support immediately following a loss, so having some written information to hand can be of value. This letter can also include an offer for the woman and her partner to come in for an appointment to discuss aspects of their physical and mental health following a pregnancy loss. Some women might need pain relief or anti-emetics following a pregnancy loss, but it’s not just physical health that matters here. A prospective cohort study in London found that women experience high rates of anxiety, depression, and post-traumatic stress following an early pregnancy loss. The review suggests that a post-pregnancy loss appointment in general practice should be a ‘person-centred consultation’ as an opportunity to discuss any unmet needs. This is reflected in research that suggests that women wanted their pregnancy loss to be treated like a ‘real’ pregnancy, with someone checking in on their physical and mental health, and offering support … to prevent women ‘falling through the net’ at a difficult time in their lives.”

LONGER-TERM CARE
Some women will experience more than one pregnancy loss. The definition of ‘recurrent miscarriage’, like so much else of pregnancy loss care, is variable, and some services define it as two, or three, pregnancy losses, with some organisations limiting the definition only to consecutive losses. The Royal College of Obstetricians and Gynaecologists (RCOG) has recently updated its definition of recurrent miscarriage to three losses at any stage and has dropped the requirement for these to be consecutive. The review suggests that after two pregnancy losses women should be offered an appointment in primary care for blood tests including a full blood count, thyroid function tests, and any other necessary investigations. The review also suggests that, following three losses (which do not need to be consecutive), GPs should refer women to a consultant-led appointment at a recurrent miscarriage centre. However, the RCOG guideline suggests that there is scope for women to be referred to recurrent miscarriage services after two losses if there is clinical suspicion of an underlying cause, or among women in their late 30s or older. Women who get pregnant again after a pregnancy loss have a higher risk of experiencing pregnancy-related psychological distress, pregnancy-specific anxiety, and depression. There is very little evidence about what support should be offered to women in subsequent pregnancies following a miscarriage. A recent ‘empty’ systematic review found no randomised controlled trials specifically looking at interventions to reduce stress in pregnant women with a history of miscarriage. It’s worth being aware of previous pregnancy losses among a patient list, as women or their partners may present to general practice needing more support through subsequent pregnancies. This links to one of the review recommendations, which is the creation of an NHS-wide flag system in the clinical records of anyone who has experienced a pre-24-week pregnancy loss.

FINAL THOUGHTS
Pregnancy loss is something that has affected many of us personally and through our clinical work. In current practice, when a baby dies before 24 weeks, the existing pregnancy care pathway disintegrates, with wide variation in care across NHS trusts. And with variation comes examples of good care, alongside examples of inadequate care. This review has provided an opportunity to reflect on how pregnancy loss care can be improved and standardised across the NHS and general practice. Women and their families deserve a minimum level of care, with compassion, at a difficult time, and it’s worth keeping that at the forefront of our minds when we deal with pregnancy loss in practice.

Nada Khan, CBE
Nada Khan is an Exeter-based National Institute for Health and Care Research Academic Clinical Fellow in general practice, OPST4/Registar, and an Associate Editor at the BJGP. Email: nadakhan@nhs.net

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