GPs dealing with pregnancy concerns: A good practice guide
Developed by the Miscarriage Association

> **"My GP couldn't do anything to change what had happened but she listened."**

From a medical perspective, miscarriage[1] is a common and generally minor complication of pregnancy but for patients and their partners it can be distressing, frightening and lonely.

This may be even more so for ectopic and molar pregnancy, which are much less common and can carry additional complications.

Patients may present with symptoms or worries during pregnancy, or they may come after a loss, or during a subsequent pregnancy. Some may present with other problems, such as anxiety or depression, and it becomes clear that these are related to pregnancy loss.

In all of these situations, your approach can make a positive difference to their experience.

> **"My GP was fabulous. She knew what we'd been through to get pregnant at all and was so supportive."**

We spoke to women and GPs about what helps and what makes things harder. Here's a summary of what they told us.

Listen to the women (and her partner, if present)

Taking a good history includes listening to additional information that she (and perhaps her partner) gives, as well as reading her notes. Not only can it aid diagnosis, but good listening can also make her feel respected and cared for at what might be a vulnerable time.

[1] This good practice guide focuses mostly on first trimester miscarriage. But the principles noted here apply equally to women with second trimester loss, ectopic pregnancy or molar pregnancy, alongside the issues specific to those losses.

If a woman of child-bearing age presents with acute abdominal pain, ectopic pregnancy should always be considered, even if she does not know if she is pregnant.

Consider how she (or they) might be feeling

Everyone reacts individually to pregnancy loss. Some women may accept it and some might feel relieved. But many women (and partners) feel:

- very anxious if they have worrying symptoms (or lack of) in pregnancy
- shocked, distressed, grieving and possibly self-blaming after a loss
- anxious about trying again and/or about future fertility
- very anxious in the next pregnancy

After ectopic pregnancy, women may also feel shocked by the speed of events in diagnosis and treatment, especially after emergency surgery.

After molar pregnancy, women may also feel very frightened by the association with cancer, and very upset by having to delay trying to conceive again because of the follow-up process

> **"Everything happened so quickly I never had time to think about it until after the operation. I had so many 'what ifs' running through my head."**

Show understanding and empathy

You might not be able to meet all her expectations but understanding, kindness and acknowledging her feelings can help.

- Acknowledge the woman's emotional response, whatever it is.
- Say (and show) you are sorry for her/their loss, if appropriate, **but** …
- …be aware that it might make some women feel worse.
- Recognise that uncertainty is difficult to cope with and acknowledge how hard it is to wait – for a scan, or a specialist appointment, or test results.
- Acknowledge the impact of additional factors: loss after fertility problems or treatment; recurrent miscarriage.
- Don't assume that the shorter the gestation, the less the sense of loss.
- Giving statistics might help, but it also might not.

- She might need time off work and require a fit note. Ask her if she wants it to state that this is pregnancy-related illness (which makes it protected time off[2]) or would rather it does not mention the pregnancy or loss.

> **"Sometimes just having someone listen to how you feel, the guilt and the heartbreak, helps to ease it."**

Think about your language

When it comes to pregnancy loss, women and their partners are often acutely sensitive to the words you use or that they hear in hospital. They also might not understand some medical terminology.

- Most (but not all) women think of their pregnancy as a baby. Most (but not all) prefer you to refer to it that way.
- If you're not sure what term to use, mirror what the patient uses (baby, fetus, pregnancy) or ask her what she'd prefer.
- Terms like 'spontaneous abortion' or 'products of conception' are upsetting to most women.
- Try not to minimise the loss. Referring to it as a 'just a heavy period', 'back luck' or saying 'at least you know you can conceive' can actually increase distress.
- You many need to explain medical terminology that she has heard or read elsewhere.

> **"It doesn't matter how far gone you were – it's still my baby I've lost."**

Give clear information about what is happening now…

- Ask what information she/he wants and be guided by the responses.
- If you can't give clear answers, explain why not and refer on to other services and/or specialists as appropriate.
- Provide or refer to written information where that might help.

… and about next steps

Many women will seek information and advice.

Causes and treatment

- Was it something they did/didn't do? That's very unlikely. See our leaflet Why Me?
- Is there anything to reduce the risk next time? Possibly, though some risk factors are immutable. See our leaflet Thinking about another pregnancy.

[2] See www.miscarriageassociation.org.uk/leaflet/miscarriage-and-the-workplace/

- Referral to a specialist clinic. Current RCOG guidance recommends referral for investigations after three or more first-trimester miscarriages, or earlier at the clinician's discretion, and after one second trimester loss. Many women find the first trimester criteria hard to accept and may be especially vulnerable to treatments which are not evidence-based but clear information and support can help.

Management options for miscarriage

- Information about risks, benefits and the physical experience (see our leaflet Management of miscarriage).

- Help and support in deciding which option to choose – more likely to be the one they can best cope with rather than the one they want.

Pregnancy remains

- Information about testing: histology vs karyotyping.

- Histology aims to identify distinguish between normal pregnancy tissue, molar tissue or only maternal tissue (i.e. possible ectopic).

- Fetal karyotyping is usually offered only as part of investigations into recurrent miscarriage.

Options for disposal

- Hospitals will have their own policies & procedures for disposal, which might include disposal as clinical waste (although not in Scotland). It is worth finding out what your local provider offers.

- See our film and good practice guide on this topic.

Give her information about additional support available

> **"Thank you for the follow up call a week after my miscarriage – it meant so much to me".**

Women told us that they often underestimated the impact of pregnancy loss on their mental health. You can help by providing additional information and follow up.

- After a miscarriage (or ectopic or molar pregnancy), try to ensure that information is passed to other services so women are not contacted by midwives or other services after their loss.

- Suggest a follow-up appointment.

- Consider discussing a plan for the next pregnancy (possibly including an early scan).
- Provide information about local/national support services. The Miscarriage Association provides support and information via our website, phone, email and online groups.
- Note our resources on mental health and pregnancy loss.
- Refer to/provide information about professional counselling services where appropriate.

Got more time?

These additional resources might be helpful.

The BMJ Miscarriage: Clinical pointers (requires subscription)

Take a look at the Miscarriage Association's leaflet Your feelings after miscarriage

View other films in this series:

- Ambulance crews
- A&E
- The booking in scan
- Management of miscarriage
- Disposal of pregnancy remains

Consider your needs too

> **"It's difficult explaining how little can be done during a miscarriage. Consultations are hard sometimes."**

Caring for patients with pregnancy loss can be stressful. They are likely to be anxious, distressed, grieving or even angry. They may express wants and needs that you just can't meet.

What's more, you are their central port of call, even if they also have hospital care. However good that care is, it is brief. It's the GP who is going to be looking after them after their loss and in the longer term.

Considering your needs may seem like a pipedream, given the increasing demands of general practice, but we hope the following suggestions might help.

Identify the stressors

These can include:

- dealing with patients' anxiety and uncertainty
    - about this pregnancy, future pregnancies, future fertility
- dealing with distress, grief and loss, especially:
    - if you have been through something similar or
    - if you feel it is out of proportion compared with other issues or patients
- limited consultation time
- being a bridge between patients and other services, especially regarding:
    - referral criteria
    - waiting lists/times
    - budget constraints
- fatigue – physical and emotional

Identify your sources of support…

Your most likely source of support will be your peers:

- colleague/s in your practice:
    - informally and/or individually
    - in practice meetings and/or training sessions
- colleagues working in other practices:
    - you may find it easier to unload, de-brief etc outside your own practice

But you might also consider:

- your partner, if you have one, or a trusted friend
- mentoring or coaching, via your ICB or elsewhere
- talking to us at the Miscarriage Association in strict confidence.

… and make use of them

It's one thing to know where you can find support. It's another thing to do something about it. It's worth considering that your peers may have similar concerns and might also benefit from talking about these issues together.

The comments below, from a GP who had herself been through miscarriage, may be the best example of this.

> **"After my experiences I did a peer teaching session with my colleagues with an emphasis on communication. We concluded that there is no ideal one size fits all explanation or way of expressing condolences in these situations – even a blanket expression of how sorry you are or referring to the baby can be wrong!**
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> **"Also … statements such as 'it's very common' or 'at least you can conceive quickly' can be helpful or hurtful to different women…**
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> **"Basically our conclusion was to acknowledge the woman's emotional response, to ask open questions about what they feel/what information they want next and then to be guided by their responses – rather than just trying to give a perfect one liner that might be more hurtful."**

And finally

Miscarriage is never easy – for the woman or couple involved or for the staff who are tasked with looking after them. You may not get it right for everyone, but patients will always remember your care, kindness and compassion.

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