Conservative management of spontaneous abortions

Women's experiences

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ABSTRACT

OBJECTIVE To describe women's experiences with expectant management of spontaneous abortions.

DESIGN Descriptive survey using questionnaires with fixed-choice and open-ended questions. The latter were analyzed for themes, using qualitative methods.

SETTING Urban and suburban private primary care family practices.

PARTICIPANTS A convenience sample of family practice patients (59 of 80 eligible) pregnant for less than 12 weeks who had spontaneous abortions without surgery. Response rate was 84.7%; 50 questionnaires were received from the 59 women.

METHOD Women were asked about their physical experiences, including amount of pain and bleeding; emotional effects; their satisfaction with medical care; and their suggestions for improving care.

MAIN FINDINGS The mean worst pain experienced during a spontaneous abortion on an 11-point scale was 5.9. Bleeding varied, but was often very heavy. Satisfaction rate was 92.9% with family physician care and 84.6% with hospital care. Women described the emotional effect of "natural" spontaneous abortions and made recommendations for improving care.

CONCLUSIONS A better understanding of the physical and emotional experiences of the women in this study might help physicians better prepare and support patients coping with expectant management of spontaneous abortions.

RÉSUMÉ

OBJECTIF Décrire l'expérience des femmes avec la prise en charge expectante des avortements spontanés.

CONCEPTION Une étude descriptive à l'aide de questionnaires à choix multiples et de questions ouvertes. Les réponses à ces dernières ont été analysées pour dégager des thèmes à l'aide de méthodes qualitatives.

CONTEXTE Des cabinets privés de pratique familiale de première ligne en milieu urbain et en banlieue.

PARTICIPANTES Un échantillon de commodité de patientes de médecins de famille (59 des 80 étaient admissibles) qui étaient enceintes de moins de 12 semaines quand elles ont eu un avortement spontané sans chirurgie. Le taux de réponse s'élevait à 84,7%; 50 femmes ont rempli le questionnaire sur les 59 choisies pour le recevoir.

MÉTHODE On a posé aux femmes des questions concernant leur expérience physique, notamment la sévérité de la douleur et des saignements; leur réaction émotionnelle; leur satisfaction quant aux soins médicaux; et leurs suggestions pour améliorer les soins.

PRINCIPAUX RÉSULTATS En moyenne, les pires douleurs éprouvées durant un avortement spontané, sur une échelle de 11, se situaient à 5,9. Les saignements variaient, mais étaient souvent très abondants. Le taux de satisfaction était de 92,2% pour les soins des médecins de famille et de 84,6% pour les soins hospitaliers. Les femmes ont décrit leurs réactions émotionnelles à un avortement spontané « naturel » et ont présenté des recommandations pour améliorer les soins.

CONCLUSIONS Une meilleure compréhension de l'expérience physique et émotionnelle des femmes dans cette étude pourrait aider les médecins à mieux préparer et appuyer les patientes face à la prise en charge expectante d'un avortement spontané.

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← FOR PRESCRIBING INFORMATION SEE PAGE 2463

Recent literature supports conservative management of spontaneous abortions, and yet most physicians practising today were trained to do (or refer patients for) dilation and curettage (D&C) when managing spontaneous abortions. In the last few years, evidence from randomized controlled trials and observational studies has shown that surgery is unnecessary for spontaneous abortions of less than 12 weeks' gestation that are not complicated by hemorrhage or infection.[1-6] This means that physicians need more information about the physical and emotional experience of "natural" spontaneous abortions in order to inform and support their patients.

One study, a randomized controlled trial of expectant versus surgical management of spontaneous abortions,[6] described the physical experience of spontaneous abortion and reported an average of 4 days' bleeding and 4 "sick days" among the 19 women randomized to expectant care. Many women experience intense emotional distress during and after spontaneous abortions.[7] In an American study of 44 women interviewed several weeks after miscarriage, 82% felt a sense of loss, and 77% experienced some limitations of daily functioning, which increased with gestation age at the time of abortion.[8] Most of these women had surgery. A British study of 67 women who had D&Cs for spontaneous abortion showed that a substantial number of women were dissatisfied with their care: 32 (48%) women interviewed 4 weeks after miscarriage met criteria for clinical depression.[9]

Although no evidence shows that surgical treatment confers benefit, a 1995 study in Vancouver found 92% of women seeking medical care for spontaneous abortion in a hospital were treated surgically, and 51% of family practice patients had surgery.[5] Surgery adds risks of anesthesia, cervical damage, and postoperative infection; is more costly to the health care system; and might add emotional trauma to an already traumatic event. And yet, when women are given choices, many choose surgery.[10]

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Family doctors wishing to manage women conservatively need to know what the experience is like for women going through natural miscarriages so that they can give these patients the information and care they need. This study aims to describe the physical and emotional experiences of conservatively managed patients and to report women's suggestions on how to improve care.

METHOD

Women participating in this study were part of a study (page 2364) that focused on reducing the rate of surgery in family doctors' practices through physician and patient education. The initial sample was recruited from 56 family practices in Vancouver and two suburbs. In that study, an attempt was made to recruit every woman in those practices who had had a spontaneous abortion between June 1997 and August 1998. Monthly reminders were sent to doctors and their office staff to refer women for the study.

Inclusion criteria were positive diagnosis of pregnancy by urine or serum β–human chorionic gonadotropin tests or surgical pathology evidence of pregnancy. Women more than 12 weeks' pregnant were excluded. Of the 118 patients recruited for the initial study, 80 had conservative management and were eligible for this study; 59 of these 80 were sent questionnaires.

The family doctors of these women attended a seminar on conservative management of spontaneous abortions and were then left to manage their patients according to their own judgment. Women were sent questionnaires if their family doctors gave permission to the investigators. The most common reasons for refusing permission were language barriers (ie, languages other than English or Chinese, the only languages used for the questionnaire) and doctors' perceptions of emotional upset. This study reports on the answers in the 50 questionnaires that were returned.

The questionnaire asked fixed-choice questions, such as "On a scale of 0 to 10 where 0 is no pain and 10 is pain as bad as it can be, what was the worst pain like for you?" and open-ended questions, such as "What could have made the experience better?" Answers to the specific questions were tabulated. Answers to the open-ended questions were categorized by the investigators into themes using the method described in other qualitative research studies[11-13] and a textbook.[14] The two investigators and two research assistants each read each answer and

then in a group meeting arrived at a consensus on the themes arising from them. The process continued until no new themes arose. The remaining answers were categorized according to those themes.

The decision to include fixed-choice questions and open-ended questions was made to elicit the most information possible about women's experiences during spontaneous abortion. The attempt to recruit every patient who had a spontaneous abortion during the study period generated a sample size large enough to include a range of experiences.

Ethical approval was granted by the University of British Columbia's Clinical Screening Committee for Research Involving Human Subjects.

RESULTS

Mean age of the women was 32.4 years; mean gravidity was 2.4 pregnancies; and 82.9% were nulliparous. Gestation age by last menstrual period was less than 10 weeks for 54.3% of the group and between 10 and 12 weeks for 45.7%. The most prevalent ethnic group was white at 71.4% followed by Asian at 11.4%; 22% of the group were on social assistance. There were no significant differences in these sociodemographic and obstetric factors between the study group and the women having surgery.

Women were asked to rate their pain, bleeding, and emotional distress on a scale of 0 to 10: the mean worst pain score was 5.9 (range 0 to 10). The amount of bleeding varied greatly with an average of seven pads used on the heaviest day (range 1 to 25); mean total number of pads used was 23 (range 1 to 55); and total number of days of bleeding was 9 (range 4 to 30). Emotional distress was rated at a mean of 6.0.

Women were asked about how and where they sought help. Mean time before the women sought medical help was 21.7 hours. For first contact, 23 (46.0%) spoke to a doctor on the telephone, 21 (42.0%) saw a doctor at the office, and five (10.0%) went to a hospital emergency room.

The information they were given was "definitely" enough about the miscarriage for 19 (38.0%) and about future pregnancies for 14 (28.0%). Information was given primarily by family doctors to 35 women (70.0%), by obstetricians or gynecologists to seven women (14.0%), and by others, such as nurses or emergency-room doctors, to eight women (16.0%). All 50 had seen a family doctor at some time during their care, and 94% said they were "very," "moderately," or "fairly" satisfied with their family doctors. Thirteen had been treated in hospital (without surgery), and 11 (85%) said they were satisfied with hospital staff. When asked if they had had a chance to talk about their feelings, 46 (92%) agreed they had.

From the answers to the open-ended questions in the questionnaire, the following major themes emerged: information, physical experience, emotional experience, treatment options, accessibility of medical care, actual medical care, emotional support, and personal experience. Recommendations for improvements in care were often given.

Information

Receiving adequate information was extremely important for these women. They wanted to know how much bleeding and pain to expect, how to care for themselves, whether to save the tissue, how long symptoms would last, and the possible effect on future pregnancies. They wanted reassurance that they were healthy. For example, "My doctor explained everything thoroughly—what was happening and what to expect." Women who felt they lacked sufficient information most often said they were surprised at the amount of bleeding and the intensity of pain.

> I was somewhat unprepared for the day my uterus emptied. I went out for a run, and it happened about 1 mile from home. I was not expecting that sort of thing to happen and was scared and embarrassed and uncertain if I would ever stop bleeding. I did, of course, but I could have been better prepared (ie, told what to expect). I somehow imagined I would just have a heavy period.

A few times, diagnosis was made on ultrasound examination, and radiologists and technicians were said to be reluctant to give information. A few women also expressed their surprise and distress at seeing the sac expelled. A warning to expect that would be helpful. Others wanted to know what to do with the tissue: some said their doctors had asked them to save it and bring it in, others were told after the fact that they should have saved it. The main recommendation was for more detailed information. Some suggested a brief discussion of miscarriage at an early prenatal visit, "I think that more information early on in the pregnancy would have made this process less traumatic," and "I must have read it (the pamphlet) 10 times while miscarrying—thankful for small mercies."

Physical experience

Most striking to the investigators was the range of experience from a few cramps and spotting to labour-like pain: "I first started spotting... then went through some of that pain, but it wasn't major pain, just like a

really bad period, but it was kind of cyclical." Another said, "For the first 2 hours the bleeding was far too heavy for pads. I just sat on the toilet and the blood poured out." Also, "It turned out to be more like labour for about half an hour until the sac was expelled." Several comments were made on the issue of prolonged spotting. Many did not understand why this was happening and did not know when it would stop or if it was normal.

Emotional experience

Some women described intense emotions, "I couldn't stop crying; it took 4 months to get over the depression," and "What I ended up doing was calling in sick for a couple of days because I was an emotional wreck, so there was no way I was going in. But then I went into work for a couple of days and ended up taking holiday time just to try to recover physically, and a little bit emotionally as well." One said, "Seeing the sac was very difficult," and another said, "... but the emotional side, for weeks after that, was just not the same. I just couldn't go to the mall because there [were] just too many little ones around."

Treatment options

Women were invariably satisfied with being offered choices of treatment. One woman who had experienced both methods said, "The idea that I could manage the miscarriage myself with guidance available whenever I needed it:... I felt calmer, more confident, less medicated and out of control." Another, who actually had a D&C booked but aborted before the appointment, said:

> My doctor wanted to let things happen naturally, but that can take up to 2 months. Once it's dead—I probably like many others wanted it finished. A D&C or abortion immediately would have helped. It's terribly stressful to have this miscarriage hanging over your head. It's almost impossible to get on with life not knowing when it could happen.

Accessibility of medical care

Virtually all the women who expressed satisfaction with their medical care said their doctors were very accessible. Often, these women's family doctors had called them at home or made it clear that they could come to the office or call anytime with any concerns. Promptly returned calls were also appreciated. Women appreciated short waiting times at doctors' offices and hospitals. One comment was, "I just wish that my own doctor had been on call the night I experienced the miscarriage, rather than someone I had never met before."

Follow-up doctor's appointments were recommended by several women. Many said they felt left alone or abandoned by the medical community despite having good family doctors and felt they needed visits for both physical and emotional reasons.

Actual medical care

Responses in this category ranged from extremely positive to extremely negative. One woman said of her time in hospital:

> It was a barbaric, horrifying experience. I came in about 10 PM in severe pain and didn't see a doctor until 2 AM!! At about 2:30 AM I was given meds for pain—well into the actual miscarriage. I'd also like to mention that being drilled by three different medical students during excruciating pain really does add insult to injury!!

Another said, "She was sympathetic and provided all required information," and, "The news was presented in a warm, caring manner." One woman said she was pleased at being offered the option of pain medication, and others thought a prescription should be given to every woman because no one knows how much pain each woman will experience. One commented that it was a "hassle" getting her WinRho.

There were some problems with ultrasound technicians being insensitive. One recommendation was, "When a woman becomes pregnant following a miscarriage, it is important to understand the 'terror' that she experiences, give a thorough checkup, be patient, and listen to her concerns without appearing frustrated or impatient."

Emotional support

Women said they received support from their family doctors, nurses, a counselor, family, partners, and friends. One said a book on loss was very helpful. Some found hospital staff supportive; others said they were treated "as if a miscarriage is no big deal," and one said she heard the hospital nurses talking about babies, which upset her. Several wished for more sympathy from their husbands.

Recommendations included giving women the opportunity to attend support groups and receive pamphlets on how to handle the grieving process. Women wanted caregivers to understand the extent of their loss and not treat it as a routine event. Some felt they needed time off work for emotional recovery and that this need should be recognized. One said she needed "acknowledgment of the loss—allowing myself time and care to process it."

Personal experience

There were personal issues, such as age and experience, that physicians should be aware of but cannot influence. For example, "I am a 37-year-old woman with two children. I have experienced miscarriage before, so I feel that my understanding of my body and what was happening was a positive factor. Previous miscarriages when I was younger were very different."

DISCUSSION

The amount of pain suffered by these women requires the offer of analgesia. The amount of bleeding is rarely a medical emergency but is often frightening, and women need reassurance and explanation. In this study, family doctors' care was highly regarded by their patients, but the patients needed to have more information about the physical and emotional feelings they could expect. Some of the women recommended that doctors provide written information both early in pregnancy and after diagnosis of spontaneous abortion; others recommended support groups. Women appreciated the option of surgery or conservative management, along with enough information to make an informed decision.

Unlike patients in the study quoted earlier,[10] these family practice patients usually preferred conservative management. This might have been because their family physicians were knowledgeable and supportive of their choices.

This sample was limited in that it included only urban and suburban women who spoke English, Cantonese, or Mandarin. The fact that the doctors involved refused permission to send questionnaires to 30% of the original patients decreased the breadth of the sample. On the other hand, given that halfway through analyzing the questionnaires no new themes emerged, it is likely that most aspects of the experience were explored.

Conclusion

This study gives a better understanding of the physical and emotional experience of "natural" spontaneous abortion. The women in the study recommended providing written information early in pregnancy and at the time of diagnosis and routinely offering analgesia. The information in this study might help family doctors to prepare and support their patients better through the difficult experience of spontaneous abortion.

Key points

- This article used qualitative methods to describe the physical and emotional experiences of women having conservatively managed spontaneous abortions.
- Women wanted adequate information on the amount of bleeding and pain they could expect, on how to care for themselves, on whether to save the tissue, on how long symptoms would last, and on possible effects on subsequent pregnancies. They wanted reassurance that they were still healthy.
- Both physical and emotional pain varied widely; caregivers must anticipate this.
- Emotional support, especially from their family physicians, was highly valued.

Points de repère

- Cet article s'est fondé sur des méthodes qualitatives pour décrire l'expérience physique et émotionnelle de femmes dont l'avortement spontané a été traité de manière conventionnelle.
- Les femmes voulaient obtenir des renseignements appropriés, à savoir la quantité de saignement et de douleur à laquelle s'attendre, la façon de prendre soin d'elles-mêmes, s'il fallait conserver les tissus, la durée des symptômes et les effets possibles sur de futures grossesses. Elles voulaient être rassurées qu'elles étaient toujours en bonne santé.
- La gravité des douleurs physiques et émotionnelles variait considérablement; les dispensateurs de soins doivent s'y attendre.
- Le soutien émotionnel, en particulier de la part de leur médecin de famille, a été considéré très précieux.

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