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Expectant or surgical management of miscarriage: a qualitative study.

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Abstract

Objective: To explore women's reasons for selecting either expectant or surgical management of first trimester miscarriage, and to examine the impact of treatment upon them. **Design:** A qualitative study using interviews. **Setting:** The Early Pregnancy and Gynaecology Assessment Unit at a London hospital. **Sample:** Thirteen women diagnosed as having a first trimester miscarriage who had opted for either expectant management (n=5), surgical management (n=5) or who had undergone both (n=3). **Results:** The choice of expectant management was motivated by desire for a natural solution and a fear of operation. Women described how pain and bleeding had made them anxious that something was wrong and how they felt unprepared for how gruelling the experience would be. Some also described how their support had dwindled as the miscarriage progressed. In contrast, women who chose surgery valued a quick resolution and focused on the support from hospital staff, although some commented that their emotional needs had not always been met. **Conclusion:** If expectant management is to be more widely offered women should be told not only the likely clinical effect of letting a miscarriage run its course but also how women experience this.

Key words: miscarriage, expectant, surgery, experience, informed consent

Introduction

Miscarriage occurs in 15-20% of known pregnancies with eighty percent of these occurring within the first trimester (1). Until recently, the standard management involved the evacuation of the retained products of conception (ERPC). This occasionally causes infection, uterine perforation and bowel damage and constitutes a large proportion of the surgical work load for gynaecology in the UK (2). Expectant management is a possible alternative and has been adopted by several clinics across the UK. Trials suggest that expectant management might produce less infection (3) and observational studies show that it usually results in complete evacuation of the products of conception (4, 5). It would seem to be feasible, effective and safe and may be preferred treatment by many women (5). However, little is known about what women expect, or about their subsequent experiences of each management approach. The present qualitative study assessed women's reasons for deciding upon a given treatment and the impact of treatment type upon their subsequent experiences.

Methods

The study was approved by the local Research Ethics Committee. Sixteen consecutive women who had been diagnosed with an incomplete miscarriage within the first 14 weeks of their pregnancy were approached when they attended an Early Pregnancy and Gynaecology Assessment Unit (EPGU) in London. Two declined to take part and one was lost to follow up, leaving 13 women who were interviewed (response rate of 81%). There were no exclusion criteria in terms of previous reproductive history, age, fetal age at miscarriage or type of miscarriage. The women's ages ranged from 22 to 43 years (mean 34). Ten classified themselves as white and 3 as of black African descent. Their clinical characteristics are shown in table 1.

-Insert table 1 about here -

The researcher (CM) sat in on the ultrasound process and was present when the diagnosis was made and all women were then offered the choice of either expectant or surgical management. After diagnosis the women were taken to a counselling room where the

researcher explained the study, gave them an information sheet and obtained informed consent. Three weeks later the participant was contacted by telephone and an interview was arranged. These were conducted on average five weeks after the initial diagnosis and all but one were in the participants' homes.

The interview

A semi structured interview was used. All patients were asked: 'How did you decide how to manage your miscarriage?'. Those who chose expectant management were asked 'Can you tell me how it felt going through the miscarriage at home?', 'What were the good and bad parts of being at home?' and those who chose surgery were asked: 'What was your experience of the different doctors and nurses?', 'Can you tell me how you felt about having the operation?', 'What were the good and bad parts of going into hospital?'. Patients who chose expectant management but ended up having surgery were asked both sets of questions. The length of the interviews varied from between thirty minutes to an hour and were transcribed by the researcher (CM).

Data analysis

The data were analysed manually using the principles of Interpretative Phenomenological Analysis (IPA, 6). All transcripts were read several times by both authors to ensure familiarity with the data. A coding sheet was constructed containing all possible themes and sub-themes for each interview. References to original material were recorded under each theme. From the individual summary sheets an overall list of themes was constructed. With continuous reference to the transcripts, connections between the list of themes were made. All the verbatim transcripts were re-read to ensure that the themes were representative of the original material. Instances of each theme in the transcripts was recorded. Throughout the write-up process, themes and sub-themes were adjusted. Differences in themes between the two authors were discussed and resolved. The relationship between themes and treatment type was then assessed. Data describing the ways in which the women coped, appraised and searched for meaning in their miscarriage

regardless of treatment type has been published elsewhere (7). This paper explores the impact of the different choices of treatment. The sample transcripts in this paper have been lightly edited to remove hesitations unless these are needed to retain the sense. All participant names are fictitious.

Results

The women described their miscarriage experience in terms the process of deciding which treatment approach to have, the experience of the actual miscarriage and the support they received. The themes and categories are shown in table 2.

-insert table 2 about here-

Deciding upon a treatment

Regardless of treatment choice many women stated that they would have liked more time and information to make their decision.

For example one woman said:

‘..as soon as you’re told you’ve had a miscarriage... I don’t think you need time, as in a couple of days time, but like, let it sink in...but it was kind of so quick, you know, it just happened so quickly, I thought, oh no what do I do, what do I do’.
(Brenda, surgical option)

This led some women to feel that they were ill qualified to make such an important choice:

‘they gave me no information from which to make a decision. I kept saying what do you think I should do ...and I just thought who am I to say whether which is the best thing to do, you must know better than I do’. (Claire, expectant option).

The reasons for choice of treatment were related to treatment type. Women who chose expectant management emphasised the importance of a natural solution and allowing the

body to heal itself.

One woman explained:

‘to choose to have a surgical procedure, wasn’t me, isn’t me. If there was a natural alternative then there was far less intervention in that way. I would always go for that option.’ (Georgina, expectant option)

Another woman described how this focus on ‘naturalness’ had been encouraged by a doctor. She remembered how she had thought:

‘I don’t want the operation.... I remember [the doctor] told me ‘don’t be worried you are going to have a good and much better natural abortion. You know the body has its intelligence’’ (Penny, expectant option)

Some also chose expectant management because of a fear of operations:

‘I opted for conservative management because that’s in my nature, petrified of all things surgical’ (Jenny, expectant option)

In contrast, the choice to have surgery was mostly motivated by a desire for a quick resolution:

‘Now I am the sort of person who, once something is finished, I want it finished so that I can move along, so that’s why I chose the ERPC’ Rebecca (surgical option).

This was even the case for Sue who had been planning to have a home birth with little medical intervention:

‘[I was] trying to do things as naturally as possible, but when it came to [the miscarriage], it was just the idea that it could be four or five days of quite heavy bleeding’. Sue (surgical option)

Similarly, another woman who originally had decided to wait a while described how:

‘I think I had a little sort of panic attack... I thought ‘Oh no I have to get rid of this.... I can’t have this in me any longer’’ (Brenda, surgical option).

Therefore, whilst all women felt that they needed more time and information to make their decision about treatment type many had clear expectations and justifications for their choice. In particular, those who opted for expectant management emphasised the importance of a natural solution and several expressed a fear of operations, whilst those who opted for surgery valued a quick resolution.

Experiencing a miscarriage

All women, regardless of treatment type, described the pain and bleeding involved in the miscarriage process. However, accounts varied according to how the miscarriage had been managed.

Women who had had expectant management described the extent of the pain. For example one woman said:

‘For the next couple of days I was awake all night in agony, taking Solpadeine Plus and high doses of painkillers ... I was in agony ‘ (Jenny, expectant option)

One woman who initially opted for expectant management described her pain as follows:

‘I was in terrible terrible pain... when I couldn’t take the pain anymore, it was as if my arms and my legs were becoming very cold and everything was changing.’

She then said:

‘I was beginning to feel like definitely I was dying. That is when I said I’ll have the operation’. (Olivia, expectant followed by surgery).

Many also described the extensive bleeding:

‘I remember bleeding for weeks ...I was bleeding extremely heavily really, just gushing and losing big kind of pieces of clotted blood and was really miserable and really incapacitated, extremely unhappy’ (Claire, expectant option).

The pain and bleeding often made the women anxious that something was wrong:

‘I think that the thing that I was the most worried about was well, it’s so painful what if this is haemorrhaging, what if this is infection’. Jenny (expectant option)

All women who had expectant management felt unprepared for how their miscarriage would feel:

‘The length of bleeding really did bother me. If I had more information on the various stages of the miscarriage that might of helped.’ (Margaret, expectant option)

And:

‘because you think, and this sounds crude, because you get this image of flushing, whoosh, it’s all gone, kind of pulling the chain of the toilet and you think shit it actually goes on for days (laughs) and that was the weirdest thing, that I thought God I was really naive about it’ (Georgina, expectant option).

One woman believed that she had been misinformed about how she might feel:

‘So much blood in kind of shocking amounts and they said that it would be like a really heavy period and I think that that was a bit of an understatement.....maybe a bit more warning about the extent of it would have been useful’ (Gill, expectant option followed by surgery).

Another woman who had opted for expectant management but ended up having surgery felt that she had been poorly informed regretted her initial choice:

‘The painful thing again is they didn’t explain properly. They said operation. I didn’t know it was D&C. If they had told me it was D&C, even if they did that day, I would have agreed. ... I said I am afraid, I don’t want operation’ (Olivia, expectant option followed by surgery)

In contrast, several women in the surgery group reported negative symptoms before the surgery. For example, Alice described how:

‘I was trying to get out of the building without making too much mess on the carpet... I couldn’t get out of the toilet. Every time I moved it just went haywire and I am trying to clean myself up at the same time it kind of ran down my leg into my shoe’ (Alice, surgical option).

But after the surgery was complete, these symptoms subsided and the women were able to carry on with their lives:

‘I got back here on Thursday evening and it was over and you knew that from now on you were just getting better really.There was hardly any bleeding the next day and we went camping at the weekend.’ (Sue, surgical option).

Therefore, the experience of having a miscarriage depended upon the treatment used. Women who had had expectant management described in detail their pain and bleeding which had often made them anxious and worried and left them feeling unprepared and ill informed. In contrast, although the women who had chosen surgery still described the pain and bleeding of miscarriage this was seen as being brought to an end by their

operation, which enabled them to return quickly to their everyday lives.

Social support

Partners, friends, families and health professionals were all cited as providers of various kinds of support. Women who had received expectant management tended to focus on people outside of the hospital:

“We didn’t keep it quiet. Most people do for the first 12 weeks or whatever. In a way we were glad about that because it meant we could share the experience with people around us. They were very supportive and it wasn’t a hush-hush grief that we were going through.”(Gill expectant option followed by surgery)

Several women indicated that this support declined as the miscarriage progressed:

‘Initially my husband, my mother were incredibly sympathetic and supportive, and after however long it was, began almost losing patience by this stage with me being inconveniencing in some way.’ (Claire, expectant option).

Some women also described how they had found it hard to justify the length of their symptoms and believed that surgery would have legitimised their experiences:

‘Its sometimes hard to explain to other people, that its not something that’s a day or two days, and I think that if I had had the surgery ...it is easier to explain to people it would take X number of days...you’re either sick or you are well... its hard to explain that you are neither.’ (Margaret, expectant option).

In contrast, women who chosen surgery highlighted support from the hospital staff. For some, their experiences had been positive:

‘It is the policy at [hospital name] to be very supportive’. (Melissa, expectant option followed by surgery)

And several felt that they had been given appropriate information:

‘When I went to the day unit, they gave me a pamphlet on the ERPC, a leaflet for what I should do afterwards and a leaflet for John, for what he should do for looking after me and everything like that.’ (Rebecca, surgical option).

Some stated however, that they would have liked more emotional support from the clinic staff members:

‘They don’t really pay attention to patients, they just treat them’. (Belinda, surgical option)

In summary, the women received support from a range of sources. However, whilst many of those who received surgical management felt that their information needs had been met by the hospital staff members of both groups expressed a need for more emotional support.

Discussion

All women regardless of treatment type wanted more time and more information. There were, however, many differences according to treatment type. The majority of women chose expectant management through a desire for the ‘natural’ approach. Many, however, felt unprepared for how this natural process may feel in reality and some even expressed decision regret. In contrast, women who chose surgery placed more importance upon the speed of resolution and described how their expectations had been fulfilled with their symptoms subsiding after the operation enabling them to return to their normal lives. Many felt sufficiently informed about the processes involved in having an operation.

The current research and clinical climates emphasise the importance of informed consent and informed decision making (8,9). For example, informed consent is now seen as

central to the process of recruiting patients into research studies or when allocating them to receive a particular treatment option (8). In addition, informed decision making which involves patients and doctors sharing clinical decisions is currently regarded as the preferred mode of doctor patient interaction (9). Both these concepts emphasise the importance of patient information. The present study suggests that the established nature of surgical treatment has resulted in the development of appropriate sources of information. Information about surgery falls within the conventional remit of a clinical unit. In contrast, those who received expectant management often felt ill informed and ill prepared. If expectant management is to be more widely offered as a treatment alternative then information should be given to ensure that both consent and decision making are sufficiently informed and to minimise the possibility of decision regret. Such information should describe the clinical outcomes of letting a miscarriage run its course based upon quantitative research on infections and success rates (4,5). In addition, however, information should also describe how such a miscarriage might feel. This will help both General Practitioners and hospital clinicians to provide more realistic descriptions of how their patients might feel if they chose expectant management. Patients may then be able to feel that their expectations have been met and that their choice was right for them.

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Table 1. Profile of women

	Previous miscarriage	Weeks pregnant	Planned	Wanted	Previous Children	Type of miscarriage	Treatment
Olivia	None	9	Yes	Yes	None	Incomplete	Expectant / Surgery
Brenda	None	10	No	Yes	None	Missed	Surgery
Gill	None	13	Yes	Yes	None	Incomplete	Expectant / Surgery
Belinda	None	9	No	No	Two	Incomplete	Surgery
Penny	None	9	No	No	None	Incomplete	Expectant
Alice	None	10	No	Yes	None	Incomplete	Surgery
Sue	None	9	No	Yes	None	Missed	Surgery
Rebecca	One 2 ectopics	12	Yes	Yes	None	Missed	Surgery

Margaret	None	11	Yes	Yes	One	Incomplete	Expectant
Melissa	One	12	Yes	Yes	None	Missed	Expectant / Surgery
Claire	One	10	Yes	Yes	None	Complete	Expectant
Georgina	None	7	No	Yes	None	Complete	Expectant
Jenny	None	8	No	No	None	Incomplete	Expectant

Table 2: Themes and categories

Theme	Expectant management	Surgical management
Deciding upon a treatment	wanting more time to make decision	
	feeling ill qualified to make decision	
	wanting natural solution	desire for quick resolution
	fear of operations	return to normal
	wanting body to heal itself	
Experience	pain agony feel like dying	pain subsided return to normal
	bleeding extensive anxious that something's wrong	bleeding subsided return to normal

	feeling unprepared	
	feeling misinformed	
	decision regret	
Social support	family, friends	hospital staff
	shared experience	surgery legitimised experience
	support declined over time	wanted more emotional support