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REVIEW ARTICLE

Satisfaction with pregnancy loss aftercare: are women getting what they want?

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Abstract While there is increasing recognition that early miscarriage represents a significant loss experience that often provokes depression and anxiety, women's dissatisfaction with some aspects of care received from healthcare professionals following a pregnancy loss and the potentially negative consequences of this are often less recognized. This review examines available literature to identify what comprises "treatment as usual," how satisfied women are with the typical services they receive from healthcare personnel, and whether these services are consistent with women's self-identified needs. Results are reviewed according to four major themes—patient satisfaction with: attitudes of healthcare providers, provision of information, interventions provided, and follow-up care. In general, women and families who have experienced a miscarriage report low levels of satisfaction in the presence of perceived negative attitudes from healthcare providers, insufficient provision of information, and inadequate follow-up care that did not focus on emotional well-being. Higher levels of satisfaction are reported among women whose providers were emotionally attuned to the magnitude of the loss, provided information, and involved women in treatment decisions when possible. Limitations of current research are reviewed and directions for future research, training, and practice are briefly discussed.

Keywords Miscarriage · Spontaneous abortion · Pregnancy loss · Satisfaction · Follow-up care · Healthcare providers

Introduction

Miscarriage, defined in clinical settings as the spontaneous death of a fetus prior to 20 weeks completed gestation, is an extremely common event, with an estimated 12-15% of clinically recognized pregnancies (and up to 50% of all pregnancies) ending in this type of loss. Approximately one in four women will experience a miscarriage during their lifetime, which in the USA represents approximately 500,000-650,000 miscarriages annually. Despite the significant number of miscarriages that occur, pregnancy loss is not an oft discussed topic in Western culture. This is reflected in the fact that no standard of care exists within the healthcare system for the treatment of and attention to the emotional consequences that many women may experience following such a loss.

Fortunately, the past 30 years have seen an increase in the systematic investigation of psychological sequelae of pregnancy loss—including depressive and anxiety symptoms and disorders (see reviews by Klier et al. (2002) and Geller et al. (2004)), as well as grief (Neugebauer and Ritsher 2005), which is bringing the issue into greater awareness. Controlled empirical studies have clearly documented that women who miscarry experience depression and anxiety at rates significantly greater than sociodemographically similar women without recent reproductive loss (e.g., Neugebauer et al. 1997), but their emotional experience may be marginalized relative to those experiencing other types of loss events. While there is increasing recognition that miscarriage represents a significant loss experience that can provoke depression and anxiety, women often express dissatisfaction

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with some aspect of the care they received from physicians or other healthcare providers following their loss (Borg and Lasker 1989). A study by Cuisinier and colleagues' (1993) demonstrated that women who had experienced a miscarriage were less satisfied with their overall medical care surrounding the loss than women who delivered a stillborn child. These results indicate that early miscarriage may be underestimated by healthcare providers as an event warranting empathic treatment, compared to stillbirth, where this need may be more apparent due to the further physical development of the child and the progression of outward signs of pregnancy. Women's dissatisfaction and the potential consequences for women's adjustment exposes a need for more thorough evaluation of the aftercare and support typically available for women from healthcare providers following miscarriage.

Lee and Slade's (1996) review of the literature on the psychological impact of miscarriage and the implications for specific interventions highlighted the inconsistencies in the literature as well as the need for more systematic evaluation (e.g., through the use of standardized instruments specific to a miscarriage cohort) with respect to patient satisfaction. Despite this, little work has been done specific to patient satisfaction with post-miscarriage care since the time of their review. Recently, Gold and colleagues systematically reviewed approximately 60 articles detailing 6,200 parents' patient experiences with interventions offered in hospitals in the US following fetal death in the second or third trimester and neonatal death in the first month of life (Gold 2007; Gold et al. 2007). In addition to excluding early pregnancy loss, these reviews did not evaluate women's satisfaction with post-loss care. The current review attempts to build on the work conducted by Lee and Slade, as well as add to the work of Cuisinier and Gold.

This review examines available literature to identify what comprises "treatment as usual," how satisfied women are with typical services they receive from healthcare providers, and whether these services are consistent with women's self-identified needs following early pregnancy loss. After a description of study selection procedures, the results are reviewed according to four major themes which comprise the construct of patient satisfaction with miscarriage aftercare: satisfaction with (1) attitudes of healthcare providers, (2) provision of information, (3) interventions provided, and (4) follow-up care. This is followed by a discussion of challenges to interpretation of results, conclusions and suggestions for future research, training, and practice based on the findings of this review.

Selection of studies

Studies included in this review were selected following a thorough literature search using PubMED, PsycINFO, and CINAHL, and combinations of the following keywords: "miscarriage," "spontaneous abortion," "pregnancy loss," "post-pregnancy loss," "satisfaction," "dissatisfaction," "medical care," "patient care," "hospital care," "aftercare," and "care." Reference lists of published journal articles were reviewed to ensure inclusion of relevant research not discovered via the search of online databases. Articles published through November 2009 were reviewed and are included if deemed to have met inclusion criteria. Articles were first reviewed by abstract alone by the authors in order to determine appropriateness for the current study as defined by (1) study population of early miscarriage (defined as in most clinical settings as spontaneous pregnancy loss prior to 20 weeks completed gestation, but with most studies capturing women with losses within the first trimester), and (2) main or secondary outcome of satisfaction with care. Studies that employed "mixed samples" (i.e., miscarrying women as well as those experiencing stillbirth and/or neonatal death) are included in this review when findings are distilled by type of loss and appear to be clinically relevant to an early loss population (e.g., Harper and Wisian 1994). Findings related to patient satisfaction from studies that included stillbirth or neonatal death samples exclusively (e.g., Calhoun 1994) were excluded. If the composition of a sample in a given study is something other than a "pure" miscarriage sample, the characteristics of the sample have been described. While many recent studies have addressed maternal and parental aftercare following a pregnancy loss, there are relatively few that specifically address patient satisfaction with miscarriage aftercare. Therefore, articles that discuss women's experiences of hospital care but did not specifically address women's satisfaction with care were excluded (e.g., Gerber-Epstein et al. 2009; Murphy and Merrell 2009; Smith et al. 2006), as were articles that evaluated counseling-based interventions for post-loss distress with outcomes on anxiety and depression measures without addressing patient satisfaction (e.g., Swanson 1999; Swanson et al. 2009). Individual studies are first described in the context of their primary finding. Secondary findings are referenced if relevant. A summary of the papers evaluated in this review is provided in Table 1.

Patient satisfaction studies

Selected articles are presented according to the four main themes that were identified by the review of all satisfaction studies and which best comprise the construct of women's satisfaction with medical care following spontaneous pregnancy loss. These are satisfaction with (1) attitudes of healthcare providers, (2) provision of information, (3) interventions provided, and (4) follow-up care.

Table 1 Studies included in the current review

Author year; location of data collection	Title	Definition of miscarriage	Population	Sample size	Design	Methods	Aspects of satisfaction addressed
Cecil 1994; Northern Ireland	Miscarriage: women's views of care	Fetal death within the first trimester of pregnancy	Women who had miscarried within the first trimester of pregnancy	N=50; time 1 N=27; time 2 N=22; time 3 N=20; time 4	Ql, L, R	Q, I	A, F
Conway 1995; Australia	Miscarriage experience and the role of support systems: A pilot study	None provided	Women who had miscarried with a gestational age ranging from 6 to 17 weeks with a mean of 10.7 weeks	N=24	Ql, C, R	Q, I	A, info
Cuisinier et al. 1993; Netherlands	Miscarriage and stillbirth: time since the loss, grief intensity and satisfaction with care	A loss before the 20th week gestation	A mixed sample of women who had experienced miscarriage or stillbirth within the last 3 years.	N=143 (73% miscarriage)	Qn, C, R	Q	A, F
Dunn et al.[a] 1991; USA	Explaining pregnancy loss: parents' and physicians' attributions	Stillbirth is defined as fetal death at or beyond 16 weeks gestation, implying that miscarriage occurs prior to 16 weeks	Women who had experienced spontaneous abortion or ectopic pregnancy ("early loss group), and fetal death/stillbirth or neonatal death (late loss group)	N=194 (138 females; 56 males)	Qn, L, R	I	Info
Fleuren et al. 1998; Netherlands	Does the care given by general practitioners and midwives to patients with (imminent) miscarriage meet the wishes and expectations of the patients?	At or before 16 weeks gestation	Women who presented to a midwife or general practitioner with signs of "imminent" miscarriage at or before 16 weeks gestation.	N=200	Ql, C	Q	A, Info
Friedman 1989; England	Women's experiences of general practitioner management of miscarriage	None provided	91% of women had miscarried within the first trimester; 9% miscarried early in the second trimester	N=67	Ql, C, R	I	A, info
Hamilton 1989; Scotland	Should follow-up be provided after miscarriage?	None provided	Women who miscarried within the first trimester	N=72;time 1 N=42; time 2	Ql, L, R	I	Info, F
Harper and Wisian 1994; USA	Care of bereaved parents: a study of patient satisfaction	None provided	Parents who had experienced a miscarriage, stillbirth, premature birth, birth defect, SIDS, and unknown cause of death of a child from the perinatal period to 1 year of age	N=37	Qn, C, R	Q	A, info
Helström and Victor 1987; Sweden	Information and emotional support for women after miscarriage	None provided	Women who miscarried prior to 13 weeks gestation and after 13 weeks gestation	N=117; time 1 N=86; time 2	Ql, L, R	Q	A, info, F
Jackman et al. 1991; Ireland	The experience and psychological impact of early miscarriage	Fetal death within the first trimester of pregnancy	Women who miscarried within the first trimester	N=27	Qn, C, R	Q, I	Info, F
Lasker and Toedter[a] 1994; USA	Satisfaction with hospital care and interventions after pregnancy loss	Stillbirth is defined as fetal death at or beyond 16 weeks gestation, implying that miscarriage occurs prior to 16 weeks	Women who had experienced spontaneous abortion or ectopic pregnancy ("early loss group), and fetal death/stillbirth or neonatal death (late loss group)	N=194 (138 females; 56 males)	Qn, L, R	I	Inv
Moohan et al. 1994; Northern Ireland	The management of miscarriage: Results from a survey at one hospital	None provided	Women who miscarried within the first trimester	N=74	Qn, C, R	Q	Info

Table 1 (continued)

Author year; location of data collection	Title	Definition of miscarriage	Population	Sample size	Design	Methods	Aspects of satisfaction addressed
Paton et al. 1999 England	Grief in miscarriage patients and satisfaction with care in a London hospital	Miscarriage is the unintended ending of a pregnancy before the fetus can survive outside of the mother	Women who received a D&C following miscarriage	N=79	Ql/Qn, C, R	Q (n=58) I (n=21)	A, info, F
Simmons et al. 2006; UK	Experience of miscarriage in the UK: Qualitative findings from the National Women's Health Study	None provided	Women of reproductive age who had at least one miscarriage and completed a questionnaire about childbearing	N=172	Ql, C	Q	A, F
Tsartsara and Johnson 2002; England	Women's experience of care at a specialized miscarriage unit: an interpretive phenomenological study	A natural loss of a pregnancy prior to the 24th week gestation.	Women who used an Early Pregnancy Assessment Unit after a pregnancy loss up to 16 weeks gestation were recruited one month post-loss	N=6	Ql, C, R	I	A, info, F
Tunaley et al. 1993; England	Cognitive processes in psychological adaptation to miscarriage: A preliminary report	None provided	Women who had miscarried between 6 and 16 weeks of pregnancy	N=22	Ql/Qn, C, R	Q, I	Info
Wiebe and Janssen 1999; Canada	Conservative management of spontaneous abortions: women's experiences	None provided	Women who had miscarried prior to 12 weeks gestation	N=50	Ql, C, R	Q	A, info, F

Ql qualitative, *Qn* quantitative, *Ql/Qn* mixed methods, *C* cross-sectional, *L* longitudinal, *R* retrospective, *Q* questionnaire, *I* interview, *A* attitudes of healthcare providers, *Inv* interventions provided, *Info* provision of information, *F* follow-up care

[a] Same data set analyzed by Dunn et al. and Lasker and Toedter

Attitudes of healthcare providers The first general category of patient satisfaction involves women's perceptions of the behaviors, attitudes, and overall helpfulness of the staff involved with their treatment, much of which seems related to women's perception of how well their providers acknowledged the magnitude of their loss. Friedman (1989) assessed satisfaction levels in women 1 month post-miscarriage in terms of treatment and information provided by their general practitioner. Sixty-seven women were interviewed approximately 4 weeks after discharge from the hospital and asked to use a five-point Likert scale to rate their satisfaction with treatment before hospital admission, while in the hospital, and after discharge. Descriptive analyses revealed that while most women were at least "moderately satisfied" with the care and information received prior to admission, 26% and 35% of women interviewed were "fairly" or "very dissatisfied" with the care and information they received, respectively. Women who reported dissatisfaction with their care overall indicated that they perceived a distinct discrepancy between their own and their provider's sense of the importance of the loss. Women who reported being dissatisfied with care received in the hospital had similar concerns, indicating they often were required to wait until the "end of routine operating lists" before their dilation and curettage (D&C) procedure was performed and often were treated by junior staff members. Results from a study by Conway (1995) mirrored those findings, as 79% of the 24 women interviewed for her study reported not being asked how they were doing during their ordeal. This seemed to suggest to the women that the miscarriage was a trivial event, which was highly incongruent with their own interpretation of the experience. Women in Friedman's study also reported anger when physicians remarked that this particular pregnancy was "only in the early stages" and that they could "just try again." Referencing a future pregnancy was deemed similarly unsupportive by miscarrying women in an earlier study by Helström and Victor (1987).

A qualitative study by Cecil (1994) sought to evaluate women's views on the quality of interaction with medical staff in two hospitals in Northern Ireland following a first trimester miscarriage. Fifty women were initially recruited and interviewed directly following their D&C procedures in their hospital rooms. The researchers followed-up with three more interviews over the next 6 months; however, attrition was significant: at time two (2-3 weeks post-loss), 27 women responded; at time three (3 months post-loss), 22 women responded; and at time four (6 months post-loss), 20 women responded. Attitudes on the explanation and discussion of miscarriage, hospital procedures (designation to a particular ward, ultrasound, surgical procedures), and general feelings post-miscarriage were collected via semi-structured interviews conducted by the researcher. The procedure by which women were assigned to a ward for medical treatment following the loss was by convenience (i.e., wherever there was an available bed), as opposed to strategic placement based on sensitivity to the needs of the patient. The desires expressed by women in this study varied and suggest that if possible, a woman's individual needs or preferences should be considered, in addition to her medical circumstances. Overall, women were dissatisfied with the level of care received and articulated the sentiment that healthcare providers either could not or did not recognize the magnitude of their loss.

These findings are generally mirrored by Simmons and colleagues (2006). In a qualitative sub-study using data taken from the UK National Women's Health Study, Simmons and colleagues analyzed essays related to the etiology of the loss collected from 172 women who had experienced "miscarriage" (specific definition of miscarriage is not provided). The UK National Women's Health Study was a large scale, population-based study that surveyed women of reproductive age on various aspects of childbearing, including miscarriage. Participants were given the opportunity to "write in" additional comments on the last page of the survey instrument; and these are the data that Simmons and colleagues assessed. Two of the authors completed thematic analysis of these write-ins. A major theme that emerged from these analyses was the "disconnect" between women and their providers over the magnitude of the loss as reflected in ward assignment (including them with women who were still pregnant or having elective terminations), delivery of news that a loss was occurring, and explanations for the loss; these experiences left women feeling that their providers handled their loss as a matter of "routine" care, though it was not at all routine for the women experiencing a loss. While a major limitation of these data is that the essays were not designed to assess this aspect of satisfaction with care directly, it is notable that it was written about so frequently.

While women in Cecil's (1994) study were generally dissatisfied, women in a study by Cuisinier and colleagues (1993) found that the majority of women (66%) were predominantly or totally satisfied with their overall professional care. The authors of this study recruited 143 women from a large hospital gynecological practice in the Netherlands, 73% of whom had experienced a miscarriage (loss prior to 20 weeks gestation) and the remainder of whom had experienced a stillbirth (after 20 weeks gestation). In addition to completing the Perinatal Grief Scale (PGS), questions about their pregnancy and delivery, the Interpersonal Problem Solving Inventory, and a question about pre-loss marital quality, participants were asked to rate their satisfaction with professional care in four categories: overall, pre-loss (when there were signs of alarm), at delivery, and aftercare. Satisfaction was assessed on a four-point Likert scale ranging from very dissatisfied to very satisfied. At both pre-loss and delivery, 87% of women were satisfied or very satisfied with their care, while in each of these two categories 13% were predominantly or totally dissatisfied. However, while only 13% of women endorsed at least some dissatisfaction with care before and during the miscarriage, the reasons were similar to what other studies have shown in this area. Namely, dissatisfaction occurred when healthcare providers "showed too little understanding of the feelings of alarm many women experienced prior to the miscarriage." Similarly, women experienced dissatisfaction during delivery when healthcare providers "showed too little understanding for the woman's feelings, were too cool or impersonal, or seemed eager to get away as soon as possible." Virtually all of the women in Wiebe and Janssen's (1999) study who reported satisfaction with their care discussed the accessibility and caring attitudes of their healthcare provider. Often, these women's family doctors who managed the miscarriage provided support by calling the patients at home, and making it clear that they could be contacted anytime with concerns. Ninety-four percent reported being "very," "moderately," or "fairly" satisfied with their family physician; 92% reported that they had had adequate opportunities to talk about their feelings either with their family doctor or with hospital staff.

Tsartsara and Johnson (2002) investigated patients' satisfaction with the attitudes of their healthcare providers following an early pregnancy loss. Their qualitative study analyzed data from six women who had been treated at the Early Pregnancy Assessment Unit (EPAU), a specialized miscarriage unit at a hospital in England dealing with early miscarriages (up to 16 weeks gestation). Women were interviewed using semi-structured interviews in their homes at least 1 month following their loss. These results, while generally consistent with other research findings reported herein, should be interpreted with caution as the authors point out that due to the small sample size, they are not generalizable. Women generally reported positive feelings about the nurses they encountered at the EPAU due to the caring qualities they exhibited, their capacity to relate to each woman as an individual, handling their miscarriage with the appropriate amount of sensitivity, and genuinely offering to continue long-term contact after discharge. In addition to reporting satisfaction with the nurses' caring demeanor, women also felt as though the constant accessibility of physical examinations or emotional support was quite reassuring.

In response to the publication of Dutch national guidelines on care for women experiencing imminent miscarriage, Fleuren and colleagues (1998) attempted to ascertain women's satisfaction with and perceived helpfulness of care that followed these guidelines as delivered by midwives and general providers (who explicitly agreed to follow these guidelines). Fleuren and colleagues collected data from 200 women who reported to their midwife or general provider with signs of "imminent miscarriage" at or before 16 weeks gestation. Participants in the study completed a series of questionnaires over 4 weeks that assessed women's satisfaction with perceived knowledge of their provider, empathy and support as demonstrated by their provider, and provision of information related to pregnancy loss and pregnancy loss aftercare. Questionnaires were completed for each point of contact with a provider, beginning with signs of miscarriage, and for each visit thereafter for 4 weeks. Participants were also asked to provide information on how their care could have been improved. The authors used factor analysis to create scales for the aforementioned areas of satisfaction and perceived helpfulness that ranged from 1-4, whereby a lower score indicated less satisfaction or that the participant had not received a particular intervention (e.g., information). The average rating for demonstration of support and empathy was 3.6, suggesting participants found their healthcare providers to be supportive. Furthermore, in a series of regression analyses attempting to identify what constructs accounted for variance in participants' overall satisfaction with their care, the construct of "empathy and support" was found to have considerable predictive value, even beyond total duration of contacts and perception of the providers' technical skills.

Paton and colleagues (1999) examined women's satisfaction with the attitudes of their healthcare providers following miscarriage. Seventy-nine women were recruited from a large teaching hospital in London. The definition of miscarriage was not provided, and exclusion criteria, particularly whether women were excluded due to previous losses, were not articulated. Participants were administered the "Study of Support and Counselling for Pregnancy Loss Questionnaire" (designed for this study by the authors; uses a seven point Likert scale to examine satisfaction with areas such as information giving, staff, and follow-up procedures), the PGS, and the Hospital and Anxiety Depression Scale. The women were given the option of participating in a face-to-face interview or by a questionnaire that was mailed to them. Participants were contacted for participation 4–6 weeks after leaving the hospital, although it is not clear when data collection actually took place relative to their loss. Seventy-two percent of participants reported being satisfied (the highest rating on the scale) with their overall care. Women who reported being satisfied almost unanimously commented on their positive perceptions of healthcare providers' "caring attitude," while women who reported being less than satisfied almost unanimously commented on their negative perceptions of providers (i.e., "lack of emotional support," "matter of fact attitude," "use of medical jargon," and "poor explanations"). Similarly, in a mixed sample study of parents who had lost a child due to miscarriage, stillbirth, premature birth, birth defects, or sudden infant death syndrome (SIDS), Harper and Wisian (1994) found that despite the fact that most parents reported receiving compassion from their physicians, parents also reported the following "harmful" behaviors that occurred during their care. Sixty-five percent of participants indicated their physician made reference to future children, 51% indicated the attitude of their physician was "aloof and distant," 41% reported being prescribed sedatives, and 22% felt their physician seemed "insensitive or unconcerned." It is unclear whether the prescription of sedatives was seen as "harmful" because women felt it was unnecessary, invalidated the grief symptoms they were experiencing, or for some other reason. While Harper and Wisian explored satisfaction with post-loss care among a group with only a small proportion of parents experiencing an early miscarriage, their results are consistent with other findings reported herein which indicate that a provider's attitude can be an extremely important component in a woman's satisfaction with her medical care.

Information The provision of information to women following a pregnancy loss also appears to be a vital aspect of care as well as subsequent satisfaction with that care, particularly information related to etiology of the loss, future pregnancies, and issues around post-discharge care, such as vaginal bleeding. Conway (1995) conducted a pilot study to examine the experience of miscarriage. Retrospective, qualitative data were collected from 24 women who had experienced two or fewer miscarriages within the past 16 months. Conway defined miscarriage according to the International Classification of Diseases, 9th Edition (ICD-9) code 634, which classifies spontaneous abortion within the broad category of "Other Pregnancy with Abortive Outcome" and further sub-categorizes it according to the event/factor that "complicated" the pregnancy, if known. Data were collected using semi-structured interviews (reliability measured by using an independent observer in approximately 50% of interviews) that employed open-ended and yes or no questions covering the women's experiences pre-miscarriage, during the miscarriage event, and post-miscarriage. The majority of women (number not provided) were given an explanation as to why their miscarriage occurred; however, half of these women found this explanation unacceptable. Tsartsara and Johnson (2002) also reported on participants who were dissatisfied with the explanation given, and noted that merely being informed that advanced maternal age was the cause was not deemed helpful as this was something the woman could do nothing about. Further, this was likely to lead to an increase in guilt and self-blame. Participants in Conway's (1995) study also reported that "practical" information, including implications for future pregnancies, vaginal bleeding, and when to expect the return of regular menstrual periods, was missing. Results from Friedman's study (1989) yielded similar results, as did findings from Fleuren and colleagues (1998).

Wiebe and Janssen (1999) reported on patients' satisfaction with the provision of practical information following miscarriage. In their study, 50 women who had had expectant management of a first trimester miscarriage were asked to rate satisfaction with their family physician, hospital staff, the amount of information provided, and follow-up appointments. Only 38% responded that they were "definitely" given enough information about the miscarriage and 28% responded that they had "definitely" received enough information regarding future pregnancies. Receiving adequate information was extremely important to the participants in this study in terms of how much pain and bleeding would occur, what to do with the expelled tissue, and what physical and emotional symptoms should be expected as many women expressed surprise and distress during the process of miscarrying at home.

In a study by Moohan and colleagues (1994), while 87% of the 74 women surveyed prior to discharge reported having been adequately informed about various aspects of their miscarriage, only slightly more than half (55%) received information on subsequent vaginal bleeding, 47% were informed about when to expect their next menstrual period, and 68% were given recommendations about a future pregnancy. The authors acknowledge that information given to these women was inadequate, but that in spite of this, only five women surveyed reported the quality of their care as "poor" or "very poor," suggesting that in this sample, provision of information was not linked to satisfaction with care. Conversely, Harper and Wisian (1994) found that at a median of 10 months post-loss (range 2–60 months) the provision of medical information (e.g., information on genetic counseling, the cause of death, results of the autopsy report, and future reproductive capabilities) was the variable most highly correlated with patient satisfaction and perceived as the most helpful. The timing of information giving in Harper and Wisian's study was not provided. A finding by Helström and Victor (1987) may lend some insight into these discrepant findings. These authors found that satisfaction with information provided at hospital admission regarding physical sequelae of miscarriage decreased after the passage of 3 weeks. A similar trend of decreased satisfaction over time was observed when participants were later queried as to the quality of information (defined as future reproductive capability and experiences in the hospital) they had received at discharge. The authors speculate that the decline in satisfaction may be caused by unwillingness to criticize care while still in the hospital, coupled with later disappointment with follow-up care. This unwillingness to report dissatisfaction while still in the hospital may explain why women in Moohan and colleagues' study reported greater levels of satisfaction despite not actually receiving adequate information. It might also be possible that women do not think of certain important questions during the acute phase of miscarriage and thus do not report dissatisfaction until later. A study by Hamilton (1989) designed to assess follow-up care at 6 weeks following a first trimester loss found that while all participants (*N*=72) were provided with an explanation for their loss, only 17 of the 42 (40%) participants who presented for follow-up care were able to remember any of this information 6 weeks later. These findings seem to underscore the importance of sending patients home with written information to supplement the verbal information provided proximate to the loss.

Receiving an explanation for why the loss occurred was found by Paton and colleagues (1999) to be an important aspect of post-loss care. Dissatisfaction was expressed by slightly more than half (51%) of the participants who generally reported feeling as if no adequate explanation had been given. Interestingly, in this study, women who reported satisfaction with the explanation did not report receiving more complete explanations or medical causes for their miscarriage, but rather accepted the physician's report that causes for the miscarriage were unknown and believed that this indicated truthfulness on behalf of the provider. Twenty-nine percent were dissatisfied with the way bad news was delivered (with 23% being very dissatisfied), particularly the "matter-of-fact attitude" from staff and use of "medical jargon and vague explanations," as well as an insensitive or callous attitude from the medical staff. The importance of the relationship between satisfaction and information on the cause of the loss is further illustrated in a larger study conducted by Dunn and colleagues (1991) who reported on 138 miscarrying women's and 56 of their male partners' desire for an explanation for their loss. While their sample was comprised of various types of loss, the "early loss group" (ectopic pregnancy or spontaneous abortion) reported receiving an explanation for their loss in 72% of cases, and those who received an explanation were substantially more satisfied with their experience. Furthermore, the desire for this information seems to persist over time as 97% of study participants still believed an explanation was "essential" at 1 and 2 years post-loss.

Tunaley et al. (1993) attempted to examine the relationship between miscarriage variables and cognitive processes in 22 women who experienced a loss between 6 and 16 weeks of pregnancy selected from an urban teaching hospital in England. Participants had no history of a prior pregnancy loss and interviews took place 3-6 months after the loss occurred. A semi-structured interview (not well described) designed to elicit aspects of the miscarriage experience was conducted. The Impact of Events Scale (IES) and Profile of Mood States were also administered. While 91% of the sample indicated that being given an explanation for the miscarriage was important to them, Tunaley and colleagues found a non-significant relationship between receiving an explanation and emotional adjustment (as measured by the IES), with the one exception that women who had received an explanation were significantly less likely to experience intrusive thoughts about the loss. Forty-one percent of the participants in this sample attributed their desire for a causal explanation to the fact that they wanted to know if they were directly responsible for the death of the fetus; when explanations for the loss were rooted in medical causes, participants reported lower levels of anxiety.

Jackman et al. (1991) reported on the relationship between psychological distress and patient expectations when experiencing a miscarriage. Twenty-seven women treated in both public and private hospitals who had experienced a first trimester miscarriage within the last year participated in a semi-structured clinical interview and completed the General Health Questionnaire (GHQ) twice; first participants were asked to answer based on their current state, and the second time they were instructed to answer retrospectively based on how they were feeling in the 2 weeks following the loss. With respect to the "medical management" of miscarriage among this sample, it is notable that 78% of participants were not given an explanation as to why their miscarriage occurred. This information is particularly striking as 63% of participants reported some degree of self-blame at the time of loss. Furthermore, 85% of the women in this sample were dissatisfied with information conveyed to them regarding the D&C procedure. Similarly Nikčević and colleagues (2007) reported that 100% of their 66 participants found a 20-min medical consultation with an obstetrician; during which, information from a scan examining the cause of the loss, general health concerns, and future reproductive capability were discussed, as helpful. Women who received the medical consultation experienced a significant decrease in self-blame compared to 61 controls who did not receive the investigatory scan and 20-min session with an obstetrician. Furthermore, those with an identifiable cause of the miscarriage had significantly lower levels of anxiety and self-blame over time than those with an unknown cause (Nikčević et al. 2007). Findings from both of these studies suggest that providing explanations about the etiology of the loss may be important in moderating psychological outcomes, in addition to determining satisfaction with care.

Interventions provided Lasker and Toedter (1994), using data that they collected with Dunn and colleagues (1991) and reported on above, conducted a longitudinal study of 194 parents (138 women and 56 partners) who had experienced miscarriage (including ectopic pregnancy), stillbirth, or neonatal death to evaluate satisfaction with care received up to 2 years post-loss. A total of 145 male and female participants met criteria for miscarriage (defined as a loss prior to 26 weeks gestation, and then further subdivided: spontaneous abortion (0–16 weeks) and early fetal death (16–26 weeks)) within the larger sample of 194 participants. Participants were assessed at 2 months, 1, and 2 years post-loss. At the initial assessment, researchers asked participants to rate their satisfaction with the care they received when the loss occurred using a five-point Likert scale to explain their rating and to report on whether they would have liked anything to have been done differently. Participants were also presented with a list of interventions which varied according to the timing of the loss, and were asked to comment on whether they had received these interventions, how satisfied they were with the interventions, and whether they viewed them as "essential" for someone else in their situation (also on a five-point Likert Scale). At 1 and 2 years following the loss, participants were again asked to rate their satisfaction with the care they received at the time of the loss, and how helpful they still believed each of the interventions they received to be.

Those experiencing a miscarriage reported the following three interventions as essential to helping others in their situation: (1) explanation of the cause of the loss and information on the grieving process, (2) laboratory tests to determine the potential cause of the loss, and (3) seeing the baby after death. Interestingly, across several interventions, participants rated interventions as "essential" even when they had not experienced them firsthand. For parents who had experienced a second trimester fetal death, those who had been offered interventions including having a photograph or keepsakes of the baby, a memorial service, contact by a social worker or support group, or materials on the grieving process and loss were significantly more satisfied than those who had not been given these interventions.

Having received a greater number of interventions was associated with a greater degree of satisfaction with care for participants who experienced a loss prior to 16 weeks gestation; although this relationship did not remain significant at follow-up, there was a trend in this direction. The relationship between number of interventions and degree of satisfaction with care was not significant for participants experiencing a loss between 16 and 26 weeks gestation; however, the authors speculate that this may be due in part to the smaller numbers of participants in that group (n=33) and the more limited variability in experiences.

Interestingly, Lasker and Toedter's (1994) participants' satisfaction with care was not associated with level of grief at 2 months post-loss, but was significantly correlated with level of grief at 1 and 2 years post-loss for parents in the early loss group. At 2 months post-loss, all parents with an early loss, regardless of their satisfaction with care, may have been experiencing a normal heightened grief response. With the passage of time, however, it appears that those who continued to rate their care as more satisfactory were less likely to experience grief. While grief scores tended to decrease over time, evaluations of satisfaction with care remained stable.

While a not uncommon intervention, the provision of information on support groups was not associated with greater levels of satisfaction among 138 women who miscarried (Lasker and Toedter 1994). The authors note that "few" (number not specified) participants attended a support group after their loss. While not specifically addressed by the authors, it may be worthwhile for future studies to examine the method of delivery as well as participants' reactions to receiving and their desire for this type of intervention.

If assignment to post-partum ward versus other hospital service for miscarrying women can be considered an intervention, Paton et al. (1999) found that satisfaction with ward allocation was variable, and seemed to depend on individual needs and preferences of the women. This is consistent with what has been reported in other studies (e.g., Harper and Wisian 1994), and suggests that whenever possible, the decision as to which ward a woman should be assigned following loss should include her specific circumstances, history, and wishes. It is notable too that satisfaction was highest among women assigned to a private room (Paton et al. 1999). Lasker and Toedter (1994) report that in their sample, some of the most common complaints among miscarrying parents were about being located in the labor and delivery area or on the maternity floor.

Follow-up care While it appears that specific follow-up practices vary from study to study, research suggests that most women value and may even expect some form of follow-up care after a pregnancy loss. Tsartsara and Johnson (2002) reported on women (number not provided) who genuinely expected to have follow-up services offered to them following hospital discharge and were disappointed in the lack thereof. Some participants in the study by Simmons and colleagues (2006) reported that a formally scheduled follow-up visit would provide evidence of compassion from healthcare providers.

The women evaluated by Cecil (1994) indicated that the speed of discharge from medical care following miscarriage combined with little or no follow up from healthcare providers contributed to feelings of distress. Cuisinier and colleagues (1993) concluded that the provision of typical post-miscarriage aftercare was lacking with 35% of women reporting predominant or complete dissatisfaction with follow-up care. Many women in their study indicated that they "felt abandoned" by the medical system after being discharged from the hospital and those with early losses reported frustration with the lack of professional support. Other women reported dissatisfaction with follow-up services due to the rushed and business-like nature of the appointment. Compared to women who had experienced a stillbirth, those who had experienced a miscarriage were significantly less satisfied with their hospital aftercare.

Nikčević and colleagues (2007) examined the impact of follow-up medical and psychological consultations following miscarriage. In their prospective study, 66 participants were recruited when a routine scan at 10-14 weeks determined that the woman had experienced a "missed miscarriage," which is the term used to describe a fetal death prior to the expulsion of the fetal remains. All women enrolled in the study underwent a surgical evacuation of the retained products of conception 4 days after the missed miscarriage was diagnosed. Women who had experienced a previous spontaneous or elective abortion were excluded, as were women already receiving psychiatric or psychological care. A control group of 61 women were enrolled in the study and not provided with any additional medical or psychological consultation following the diagnosis and surgical evacuation procedure. All 66 of the women in the intervention group had medical investigations into the cause of the miscarriage and were seen 5 weeks later for a 20-min follow-up with an obstetrician who discussed the results and implications of the medical investigation, general health concerns, and plans for future pregnancies. After the medical consultation, half of the women (n=33) were randomly assigned to receive a single cognitively oriented counseling session with a psychologist. Women were mailed a questionnaire at 7 weeks post-diagnosis and asked to rate on a five-point Likert scale how helpful the medical and psychological intervention had been (1 = not at all; 5 = very much so). The consultations with the medical doctor were rated as being helpful by the majority of the women as 100% of the participants endorsed moderate to strong agreement that the medical consultation had been helpful. Similarly, 94% of women endorsed that the consultation with the psychologist had been at least moderately helpful. Among women who were not offered a psychological consultation, 67% reported moderate to strong agreement that one would have been helpful. After the diagnosis of miscarriage, 23% (n=14) of the control group attended a follow-up visit with their own general practitioner or obstetrician or at their local hospital which was not part of the study. Of the 47 women who received no follow-up care at all, 64% (n=30) expressed that it would have been helpful.

Hamilton (1989) attempted to assess the need for follow-up services post-miscarriage in a sample of 72 women who experienced a first trimester miscarriage. All of the women participated in a structured interview to gather information on social, medical, and obstetric history. Participants were then offered a follow-up interview appointment scheduled for 6 weeks after their miscarriage. Of the 42 women who attended the follow-up interview (consisting of open-ended questions designed to elicit feelings and attitudes towards the miscarriage event), 21% had grievances with the medical care they had received immediately following their miscarriage. Specific complaints included dissatisfaction with the manner in which healthcare providers conveyed the news that a miscarriage was occurring and delays in referral to a hospital from the practitioner's office. Hamilton reports that 64% of the study participants experienced guilt following their miscarriage, and that these feelings were alleviated for some women when it was explained to them that it was unlikely that the miscarriage occurred as a result of any specific action on their part. Participants also seemed to benefit from talking about the loss and being assured that their grief reactions were not abnormal. Hamilton's results seem to indicate that some type of supportive follow-up care for this population would be helpful as the participants seemed to benefit from talking about their experience and receiving reassurance that their own actions did not cause the loss.

Helström and Victor (1987) surveyed 86 women who had experienced a miscarriage regarding their experiences of pregnancy loss both immediately after discharge and 3 weeks later. Participants indicated that questions and unanticipated feelings of grief often occurred within a few days of discharge, and having someone to address these issues would have proved helpful. To this end, half of the participants indicated that some kind of mandatory follow-up visit for women who had miscarried would be beneficial. Furthermore, 64% of women in this study did plan a follow-up visit, and of the women who did not, 39% indicated regret that they had not planned a follow-up visit. In Jackman et al.'s (1991) study, while all but one of the 27 participants attended a follow-up visit 6 weeks after her loss, 70% of participants indicated this visit was "not helpful" because they were not given information about the emotional aspect of miscarriage. Those participants who spoke about their loss at their follow-up visit reported less distress, as measured by the GHQ.

Paton and colleagues (1999) reported that 52% of participants were dissatisfied with their follow-up care. Although routine follow-up care is not provided to miscarrying women at less than 16 weeks gestation at the particular hospital from which women were recruited, follow-up care is expected to be provided by the patient's general practitioner or obstetrician. Despite this arrangement, many women reported feeling lost and unsure about the resources that may be available to help them with the resultant emotional distress. The exception was among women who reported having strong relationships with their general practitioners. Conversely, despite having strong relationships with their healthcare providers, many women in Wiebe and Janssen's (1999) study reported feeling abandoned or left alone by the healthcare community due to the lack of follow-up care. Women in this study cited physical and emotional reasons as a rationale for why follow-up appointments should be made.

The majority of women in the studies reviewed above endorsed the sentiment that a follow-up visit was or would have been helpful if provided; however, Stratton and Lloyd (2008) point out that there is little evidence-based research to support the efficacy of a follow-up visit as most studies do not report decreased mental health symptoms based on a follow-up visit. Given the link established herein between patients' satisfaction with care and receipt of information and follow-up appointments, it appears that a follow-up appointment may be best utilized as an opportunity to review information given at discharge and answer questions arising since the initial care, and to discuss the woman's experience with her hospital care (Stratton and Lloyd 2008).

Challenges to interpretation

There are several issues evident in the studies selected for the current review that present challenges to clear interpretation and synthesis of the existing body of research on patient satisfaction with care following miscarriage. Among the methodological issues are limitations related to sample selection. Many of these investigations utilize small sample sizes. To further compound what may be inadequately powered studies, the samples are often mixed in terms of the type of loss women have experienced. As mentioned above, while some studies adhere to a strict miscarriage sample, many also include women who experienced stillbirth and/or neonatal death without attempting to control for potential differences given that both the experience and treatment of these losses may vary. The different social and cultural practices specific to the gestational age at time of loss may influence the results of research particularly when examining satisfaction with care. Another limitation is that the definition of miscarriage used in published studies is often not articulated, although it is likely to vary greatly from study to study. Miscarriage is frequently defined in research studies as loss prior to 28 weeks completed gestation; yet in clinical practice, some US state laws, hospital protocols, policies and standards, 20 weeks gestation is used as a cut-off. Therefore, even comparison of findings between studies utilizing "pure" miscarriage samples can be difficult due to differing definitions. Many studies utilize convenience samples (e.g., recruited from existing support groups) that may not be representative of the larger population of miscarrying women. Homogenous samples in terms of race, ethnicity, and socioeconomic status are often utilized, which can introduce obvious biases and affect the ability to generalize findings to other groups. Moreover, few studies provide data from a comparison group, further complicating interpretation and generalizability.

Much of the data in these studies is collected retrospectively and there is rarely congruence between studies as to when the assessments take place. Furthermore, a theoretical basis for the specific timing of initial and subsequent follow-up assessments is not always provided. The type of data collected also varies greatly, with studies utilizing quantitative data, qualitative data, or both. In the case of qualitative research methods, the models used to develop interview guides, validity checks, and means of analyses are not always explicitly described. Qualitative studies employing Likert scales may not demonstrate significant variability between such items as "very good" and "good" (e.g., Moohan et al. 1994) which may make results difficult to interpret and generalize. Quantitative studies do not always utilize measures with strong psychometric properties.

Finally, the aspects of satisfaction that were assessed vary among the studies. Specifically, the majority of studies assess multiple areas of satisfaction related to women's experiences with healthcare providers and medical settings, both during and following their miscarriage. Furthermore, the guidelines and operational definitions of "satisfaction" vary greatly, making conclusions about patient satisfaction meaningless outside of the direct context and criteria by which satisfaction was defined in a particular study. Because the rating systems by which satisfaction is defined vary among studies, it cannot be assumed that those women who did not endorse full satisfaction were fully dissatisfied with services received, or that women who endorsed satisfaction were completely satisfied. Despite these limitations, and acknowledging the challenges associated with recruiting adequate samples of women following pregnancy loss, we attempt to distill key findings and summarize the existing literature in this review.

Conclusions

Despite the presence of limitations of the current research, a great deal of information can be gleaned from these studies. "Treatment as usual" varies between studies and medical settings. Common treatments or interventions were described under umbrella terms such as attitudes of healthcare providers, information giving, interventions provided, and follow-up care. Examples of behaviors associated with positive attitudes of healthcare providers were quantified as expression of sympathy and compassion, allowing choices in treatment when possible, and congruence in perceived seriousness of the event between the patient and the medical staff caring for her. Information giving includes details about subsequent pregnancies and future reproductive capability, vaginal bleeding, when to expect a menstrual period, reasons for the miscarriage (including reassurance that the woman's routine activities were not the cause), and the grieving process associated with miscarriage. The presence of, absence of, and delivery of such interventions is associated with greater satisfaction or dissatisfaction with healthcare. For example, a paucity of information throughout the process (from the time it was known a miscarriage was occurring to discharge) led to lower levels of satisfaction with care. Additionally, when patients felt neglected by healthcare staff, or felt that their loss was not viewed as acute or substantial, higher rates of dissatisfaction were reported. Lastly, entering and exiting a medical facility quickly, coupled with a general lack of follow-up care led to lower ratings of satisfaction.

Overall, consistent themes emerged with respect to what women found helpful, namely being informed, being provided with the opportunity to be involved in making choices related to their care when possible, and perceiving their caregivers as compassionate. Similar themes also were identified by Wong et al. (2003) who interviewed 22 women post-loss and led focus groups with healthcare providers in England. As long as some element of these themes were present, women across studies were likely to be at least partially satisfied with their care. While it appears that the more negative behaviors of healthcare providers are experienced by a minority of women, it should be noted that the presence of even one of these negative behaviors seems to have the power to negatively alter women's perception of their pregnancy loss care.

Future directions for research and practice

It would be helpful for future research to attempt to address some of the aforementioned methodological limitations. Perhaps prospective studies can address issues such as convenience samples and retrospective data collection. The use of appropriate comparison groups would also assist in identifying what is helpful for whom and when. Greater specificity about what we do "know" is also required. For example, a perceived sense of understanding and compassion from healthcare staff was associated with a higher degree of satisfaction with medical care. The existing research has not been able to operationalize what specific behaviors on the part of providers constitute compassion. In addition, while data indicates a possible "passage of time" effect for both psychological distress and satisfaction with care, we still need to establish a timeline delineating this effect in order to maximize therapeutic interventions. This timeline may differ depending on the outcome variable, whether it is grief, anxiety, or another variable. While it seems many "interventions" are in place in some form to assist this population, it may be the case that the interventions are not targeting what women want, nor are they truly associated with decreased psychological sequelae. For example, researchers in the UK are currently examining whether the provision of strict medical explanations, psychological counseling, or both are most effective in alleviating psychiatric symptoms. Future intervention studies should consider findings from these qualitative, "satisfaction" studies to determine whether meeting the desires of women (possible causes of loss, ability to carry future pregnancies to term, empathic care and follow-up, etc.) are associated with decreases in psychological sequelae.

While the studies reviewed discuss issues that women found both satisfactory and unsatisfactory within the context of the medical care received following a pregnancy loss, there are still many areas that are left unexplored. Factors such as personal and social resources that may mitigate dissatisfaction with care have yet to be clearly delineated. Future research should focus on whether there are commonalities among women who experience dissatisfaction with health care after a loss. For example, questions that are important to address are whether women who experience more dissatisfaction are more anxious or depressed in general before and/or during their pregnancy, or perhaps whether those whose grief over the loss is greater may be less satisfied regardless of baseline mental health status. If it is established that there are certain characteristics that may predict dissatisfaction, this could be made a point of intervention to ensure that healthcare providers go beyond the minimal standard of care to ensure these women get what they need during their interactions with physicians and medical staff. Future studies could examine more specific subdivisions of satisfaction with care such as the provision of medically relevant versus emotionally relevant information, and physical versus psychological follow-up care.

Additionally, research on the possible onset of psychopathology and grief among women dissatisfied with health care following a pregnancy loss may be useful in recognizing the importance of making a mental health referral. Although there is research on patient satisfaction with interventions and services received following miscarriage, few studies (e.g., Paton et al. 1999) correlate satisfaction with other emotional or psychological sequelae, such as grief. Given that the rate of depression and anxiety amongst women experiencing loss is greater than that in community samples (see Klier et al. 2002; Geller et al. 2004), it seems valuable to delineate how much of a relationship exists between satisfaction with care and subsequent grief or psychopathology. In addition, it is possible that the pathway by which satisfaction and grief or distress are related may be moderated by how the miscarrying woman processes the event.

Other research important to this field may focus on the patient-provider relationship. The provider's recognition of the potential emotional aspects of loss, as well as sensitive and compassionate communication to address patient questions and provide information and referrals for mental health services as appropriate, may greatly impact patient satisfaction and limit women's experience of distress.

To address the fact that patients seem not to retain all verbal information provided to them at their medical visit about what to expect post-loss, and to address the fact that more and more patients seek healthcare information using the Internet, the provision of online resources with reliable and valid health information may prove to be a vital resource. Geller et al. (2006) examined existing internet sites relevant to pregnancy loss and identified eight informative, well-established, and high quality websites. To initiate discussion of the emotional as well as physical aspects of loss that women might expect (including discussion of a referral for social work/psychological/psychiatric services and/or support groups), and as an "information prescription" for women and their families, Geller et al. provide a "stand alone" table of well-established, patient-friendly websites that can be distributed by providers. These informative websites are also a valuable reference and educational resource for healthcare providers themselves.

RTS (formerly Resolve Through Share; see www.bereavementprograms.com) through Gundersen Lutheran Medical Center publishes a series of pamphlets and other information that can be distributed to women and families during their hospital stay or at subsequent follow-up visits with an outpatient provider. RTS also offers trainings across the country to help providers set up bereavement teams and/or support groups in their own facilities. Despite the fact that programs such as these have been noted to be helpful anecdotally, there has been no systematic evaluation. Future research might focus on the systematic evaluation of such programs as RTS in order to discern what aspects of post-loss support services or bereavement groups are helpful to patients.

The training of healthcare providers specific to communication surrounding bad news and dealing with the psychological aspects of pregnancy loss, is another practical area where improvements seem warranted. Kerns, Geller, and Woodland (under review) surveyed a sample of obstetrics/gynecology residents and medical students and determined that these medical trainees reported feelings of discomfort around these issues and desired enhanced training. Through an Interdisciplinary Women's Health Competency Award from the Association of Professors of Gynecology and Obstetrics/Women's Healthcare Education Office, Geller and colleagues have developed an interactive computer-based curriculum to increase awareness of medical and psychological aspects of pregnancy loss and to enhance communication skills and sensitivity to women's experience of pregnancy loss. An applied online training and evaluation component is currently being assessed.

It is important to acknowledge that with the reality of the current medical system in the USA, even if providers were to receive additional training relevant to the emotional and physical consequences of pregnancy loss, there are legitimate barriers that often stand in the way of patients receiving care that they deem satisfactory. These include the limited time that doctors have to spend with their patients, the necessity to triage patients in emergency rooms according to the critical nature of their complaint, and when hospital care is warranted, the lack of resources that might preclude providers from offering women a choice of placement on wards, or providing a mental health referral to an available on-site mental health professional. Based on the studies included in this review, it is evident that similar and/or additional obstacles are present in a number of other countries as well (e.g., UK, Sweden, and Australia). While these obstacles are systemic in nature, they are what sometimes prevent providers from acting in a way that might be more satisfactory to the patient and deserve consideration in order to increase the satisfaction with post-loss care, and thereby potentially limiting the distress of their patients experiencing pregnancy loss, an event which occurs in roughly 10-20% of all clinically recognized pregnancies.

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