



Respectful care in women's health

Case study for workshop session

Early Pregnancy Loss: Counselling after diagnosis of Miscarriage

Facilitator copy (see separate Delegate copy)

Instructions for the facilitator

Ask everyone to introduce themselves briefly (3 minutes).

Ask one of the group to be the scribe for the case study.

Read the first three sections to the group (2 minutes).

Please ask a member of the group to read out the case study (2 minutes).

Once it has been read out, turn to the 'Discussion'. The blue notes are there as prompts if you require them to engage people in discussion but do not feel you have to use them if the group engage in the discussion. Try to ensure all members of the group are included and encouraged/invited to share their thoughts and ideas.

Spend 15-20 minutes discussing the questions.

Introduction

This case study is set in Ghana. It explores the roles and responsibilities of health professionals in providing compassionate and respectful care to women after the diagnosis of a first trimester miscarriage.

Learning Objective

To encourage health professionals to consider the emotional and psychological consequences of early pregnancy loss and to undertake a compassionate approach to counselling in women who have experienced miscarriage.

Note on the case study

This case study has been written by Dr Dileep Wijeratne MRCOG and is based upon a role play scenario from the RCOG Essential Gynaecology Skills course.

Case Study

This is the story of Awini, a 28-year-old woman who has attended a rural district hospital in Northern Ghana.

Awini has travelled for 2 hours and has come alone to have her first ultrasound scan in what is her first pregnancy. She has had a scan performed by an ultrasound technician who has confirmed a missed miscarriage at around 9 weeks' gestation. The technician has not told Awini the results.

After waiting for almost 2 hours in a busy waiting room, surrounded by women, many of whom are heavily pregnant, the doctor comes to see Awini and takes her into his consultation room. The doctor is also on duty

for labour ward and gynaecology as well as seeing all of the antenatal outpatients that are attending the hospital. The doctor asks Awini if she has had any pain or bleeding. She answers no. He then tells her that she has had a miscarriage and that her baby has died. When Awini starts to cry, he tells her that the pregnancy was very early and there is nothing to be upset about. He tells Awini that she can go home and if she has not had pain and bleeding within the next month, then she should come back and see him again. Before Awini can ask any further questions, he is called away to labour ward.

Discussion:

1. What are your first impressions of this case?

Allow time for the delegates to give their views on the case. Delegates may have vastly different experiences of dealing with miscarriage but it is likely that most will have had to provide counselling in a busy, high-pressured environment. There may be different opinions in how the miscarriage should be managed from a medical point of view – some may advocate wait and see as in the case study, some may suggest offering immediate medical or surgical management.

2. How should a health professional react to a woman's distress when given a diagnosis of miscarriage?

Wait for responses but prompt if required. They should identify the importance of a compassionate approach. They should identify that women can develop an emotional attachment to a pregnancy at any gestation and that emotional distress should therefore not be dismissed just because the pregnancy is 'early'. They should identify that women may be at risk of negative emotional consequences such as depression even from an early miscarriage.

3. What could be the long term consequences in terms of Awini's interaction with health services that may occur as a result of her experience?

Awini may be less likely to engage with health services in the future. She may not attend for a scan in subsequent pregnancies or indeed for antenatal care if she perceives that the service will treat her with indifference. This could put her life and the life of her bab(ies) at risk in the future. She may not return for follow-up in this pregnancy, placing her at risk from complications such as infection, bleeding and retained tissue (which may lead to fertility issues). She may also avoid engaging with screening services such as those for breast /cervical cancer, again putting her at an unnecessary level of avoidable risk across the whole of her life.

4. How could the doctor have behaved differently?

Responses should include: asking whether she had anyone with her; asking what she had already been told; asking about her previous history (this may have been a recurrent miscarriage for example); not acting dismissively in response to her distress. In spite of being very busy it is still possible to behave with compassion towards patients.

5. What changes could be made in light of how busy the doctor is, to help support women in such situations?

This discussion should focus on 'task shifting'. It may be possible for a nurse to provide counselling or even the ultrasound technician so that they are not solely reliant on the Dr. (The RCOG 'Essential Gynaecology Skills')

course is designed to help with this.) It may be possible to provide information leaflets for patients. It may be possible to provide a more private area for patients to wait, when they have been diagnosed with a miscarriage, away from other pregnant women.

6. What are the key learning points from this case? *Use the 'Learning objectives' as a guide.*

Invite the group to review the Checklist for Respectful Care in Women's Health and ask them to contribute their ideas to put the actions into practice in their workplace.

[End of case study].