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Being Present in Recurrent Miscarriage

Summary

Recurrent miscarriage (RM) affects around 1% of people trying to conceive but remains under-recognised and poorly supported. Midwives play a pivotal role in transforming care by being present emotionally, physically, and professionally, with individuals navigating RM. This article explores the complex emotional, clinical, and systemic aspects of RM through a humanised lens. It highlights the need for compassionate communication, informed decision-making, and practical support tools that uphold dignity during miscarriage. By centring care around presence and autonomy, midwives can foster psychologically safe environments and improve outcomes for those experiencing loss.

Introduction: The Human Cost of Recurrent Miscarriage

Recurrent miscarriage (RM), defined as three or more consecutive losses before 24 weeks, is a deeply distressing experience that affects approximately 1% of couples. Despite its frequency, RM is often accompanied by a lack of understanding, inconsistent care, and an overwhelming sense of isolation.

The pain of RM is not just physical, it is emotional, psychological, and social. Midwives, through their unique position and expertise, have the capacity to be truly present with those affected, supporting not just clinical needs but also human experiences of loss, grief, and resilience.

Midwifery Presence in Clinical Pathways

Midwives bring a blend of clinical knowledge and compassionate practice to miscarriage care. This includes:

- **Holistic Assessment:** Identifying medical causes through appropriate investigations such as genetic testing, imaging, and hormone screening.
- **Referral and Coordination:** Navigating multidisciplinary care involving obstetricians, haematologists, endocrinologists, and counsellors.
- **Advocacy for Early Intervention:** Challenging policies that require three consecutive losses before investigation and supporting early referrals.

Presence in these pathways means not just performing tasks, but doing so in ways that make people feel seen, heard, and safe.

Being with Women: Emotional Impact and Communication

The psychological impact of RM is often underestimated. Individuals report feelings of grief, shame, anxiety, and anger. Midwives can support emotional wellbeing through:

- **Validation of Experience:** Using affirming language that acknowledges the reality and magnitude of loss.
- **Trauma-Informed Practice:** Understanding that RM can result in PTSD, especially where care is fragmented or dismissive.
- **Clear, Compassionate Communication:** Avoiding harmful phrases like “It’s just bad luck” and instead offering empathetic, truthful information with hope and sensitivity.

Being present here means showing compassion, active listening, and staying with people in their vulnerability.

Personal Testimony: Presence Through a Lived Experience

CASE STUDY

Personal reflection

"I'm sorry, there's no heartbeat." Those words will stay with me forever. I went in for an early 8-week scan, full of hope but with a deep feeling inside that something was wrong. Just weeks earlier, a six-week scan had revealed a strong, promising heartbeat. How could this have happened?

I sat there in the scan room, numb and in shock. I was frozen while hot tears streamed down my face. My husband was with me, holding my hand, trying to be supportive, but I could feel his grief too.

I chose to have medical management in hospital because I wanted all the support I could get. I have a complicated medical history, I'm permanently on strong blood thinners, and I wanted to be in a safe environment. But when I asked for help, I was told there was no room, for me and to go home and come back in two weeks. Two weeks? I had just found out my baby had died, and now I had to wait?

I had to carry my dead baby around for two weeks, knowing that as I was walking around, my baby was decomposing inside of me. I was trying to keep them safe, but they were already gone. I felt like I had become a mortuary, carrying this precious life inside me that was no longer living. The pain of that realisation was unbearable.

In those two weeks, as my body began to naturally miscarry, the thought of flushing them down the toilet was indescribable.

I called for help again but was told there was still no room. I used a kitchen sieve to catch my baby, then stored them in a takeout container in the fridge until I could

bring them in during hospital opening hours. Each time I opened the fridge over the weekend, my heart broke a little more each time.

Throughout my experience, I saw first-hand just how compassionate and caring the healthcare workers are, working tirelessly, doing everything in their power to help me, but they are constrained by the resources they have, stretched thin by a system that doesn't provide them with the tools they need.

Two weeks later, heavy bleeding struck. My husband's desperate pleas led to the arrival of paramedics who rushed me to the hospital. I lost a lot more blood, eventually more than half. Every time I tried to sit up, I would pass out. I was in real danger. Despite the incredible care from the hospital staff, I had to be rushed into emergency surgery, and I ended up needing several blood transfusions to survive.

In the weeks and months that followed, I struggled not only to recover physically but also to navigate the overwhelming emotional aftermath. I felt anger at a system that left me to manage such a devastating event with minimal support, that forced me to miscarry in the most undignified way possible.

Miscarriage care must be compassionate, dignified, and supportive, values that should never be compromised, especially in our most vulnerable moments.

When I was given no practical support, I felt vulnerable and alone.

I didn't matter.

My baby didn't matter.

This powerful personal account exemplifies the emotional devastation caused by lack of coordinated, compassionate care. Despite dedicated individual healthcare workers, the absence of systemic support created a deeply undignified experience. The story also reflects midwives' potential to make a difference when resources, policies, and presence align.

PROBLEMS IDENTIFIED

Collection

Women wishing to collect pregnancy tissue for cytogenetic testing or respectful disposal are currently not provided with practical tools, they resort to makeshift household items, such as kitchen sieves, plastic bags, or Tupperware containers. These methods are unsanitary, emotionally distressing, and increase feelings of isolation.

Women seeking cytogenetic testing are often encouraged towards surgical

management, currently the only reliable collection method available, despite medical risks and emotional impact.

Faecal Contamination

In hospitals, cardboard bowls placed in toilets can become contaminated due to unintended bowel movements increased by medication-induced cramping. Seeing pregnancy tissue contaminated causes significant emotional distress

Identification

Distinguishing pregnancy tissue among blood clots is challenging and emotionally distressing for patients.

Transfer

When pregnancy tissue is collected, transferring it into a storage container (e.g. plastic box or bag) is problematic. Handling or pouring the tissue into another receptacle can cause significant emotional distress.

Storage

Without suitable containers provided, women store pregnancy tissue in household items like Tupperware, plastic bags, or tissue paper. Women can usually only bring pregnancy tissue to hospitals during limited hours, forcing them to store it in their home refrigerator.

Transportation

Women in rural areas face lengthy journeys, and those in urban areas often rely on public transport, adding emotional and practical challenges during miscarriage or when transporting pregnancy tissue.

Flushing

Miscarriages frequently occur over toilets, risking accidental loss into the bowl. Some women instinctively flush and later regret it; others deliberately flush but then suffer emotional distress. Many desperately attempt retrieval. These experiences are traumatic, undignified, and unacceptable.

STANDARD CARE AND SUPPORT

Despite growing research, care for RM remains inconsistent, and many individuals report feeling dismissed or unsupported. Several key areas for improvement include:

Current Standardised Clinical Pathways

- Consistent application of diagnostic protocols to identify potential causes.
- Personalised treatment plans based on evidence-based approaches.

Compassionate Communication

- Avoiding dismissive language such as “It’s just bad luck.”
- Acknowledging the emotional impact of RM and validating grief.
- Offering clear, step-by-step guidance on next steps, investigations, and treatment options.

Accessible Psychological Support

- Routine screening for anxiety and depression following RM.
- Integration of counselling services into miscarriage care.
- Peer support networks to reduce isolation and stigma.¹

Research and Policy Change

- Increased funding for RM research, particularly in unexplained cases.
- Policy changes to provide earlier intervention, rather than waiting for three losses before investigation.¹
- Improved workplace policies to support employees experiencing pregnancy loss

Skills in Compassionate and Dignified Miscarriage Care

Midwives possess core and advanced skills that can transform miscarriage care. These include:

Communication as a Clinical Skill

- Using trauma-sensitive, person-centred language.
- Offering time and space for people to ask questions and express feelings.
- Providing written information and next-step planning.

Supporting Autonomy and Decision-Making

- Discussing all options (expectant, medical, surgical) clearly and without bias.
- Providing practical guidance for home management when appropriate.
- Respecting parents’ wishes around testing, disposal, and remembrance.

Handling Pregnancy Tissue with Dignity

Practical barriers to collecting and transporting pregnancy tissue (e.g. for cytogenetic testing or burial) can further distress individuals.

- Midwives can advocate for and distribute appropriate collection kits.
- Presence in this context means making practical, respectful options available before individuals are left to navigate this alone.

Innovation: Tools That Support Dignity

Many people experiencing miscarriage are forced to use household items to collect pregnancy tissue, kitchen sieves, plastic containers, or tissue paper, causing further trauma. Innovative solutions such as purpose-designed miscarriage kits can:

- Prevent contamination and trauma.
- Enable respectful collection and transport.
- Improve the chance of viable testing for future care planning.

Providing such tools signals that individuals and their babies matter.

Compassionate Leadership and Culturally Safe Care

Midwifery presence extends beyond the clinical encounter. Compassionate leadership in miscarriage care involves:

- Embedding loss support into midwifery education and preceptorship.
- Creating psychologically safe environments for both service users and staff.
- Ensuring culturally safe and inclusive practices that acknowledge different beliefs and values around pregnancy loss.

Presence also means ensuring no one is left behind due to ethnicity, language barriers, or socioeconomic status.

Policy and Systemic Change: Midwives as Advocates

To deliver truly present care, systemic change is needed. Midwives can drive improvements by:

- Advocating for national protocols that offer support after a first or second miscarriage, not just the third.
- Collaborating with multidisciplinary teams to offer integrated emotional and clinical care.
- Championing bereavement leave and occupational health policies that support colleagues who experience pregnancy loss.

Being present includes using one's voice and influence to create systems that match midwifery values of dignity, equity, and compassion.

Conclusion: Reclaiming Presence in Loss

Recurrent miscarriage is not only a clinical event but a deeply human experience. Being present means more than offering treatment, it means holding space, listening deeply, and affirming that both the person and their loss matter.

Midwives, through their skill, presence, and advocacy, are uniquely placed to humanise miscarriage care. By promoting dignity, supporting autonomy, and ensuring no one faces loss alone, they can transform a silent tragedy into a supported journey.

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