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Improving the care of women in second trimester pregnancy loss in the NHS

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Summary of the research

Women experiencing **pregnancy loss in the second trimester of pregnancy**, before legal viability at 24 weeks' gestation, face specific difficulties in accessing good quality care during and after their loss in the English NHS.

This qualitative research based in South West England investigated women's experiences of **foetal death, extremely premature labour, and termination of pregnancy for foetal anomaly** (TOPFA) between 13 and 24 weeks of pregnancy.

Drawing on these experiences, the research identifies **opportunities for improvement** to the medical care offered for second trimester pregnancy loss in the NHS. These include clearer explanations from healthcare staff, greater choice around care, improved attention to pain management, increased support during labour and delivery, access to postnatal check-ups, and tailored support during subsequent pregnancies.

Context

Pregnant women experiencing second trimester pregnancy loss before 24 weeks' gestation, including termination for foetal anomaly, are unlikely to be given the option of surgical removal of the foetal body, a procedure which requires specialist surgical skills which are in short supply in the NHS.

The standard NHS management of the situation is therefore labour and vaginal delivery. Where labour does not start spontaneously, such as in termination for foetal anomaly or some foetal deaths, labour may be induced with medication.

For many women, this is a shocking and distressing experience which can be prolonged and very painful. It can also result in complications including blood loss and retained placenta.

However, because pregnancy loss before 24 week viability is defined as miscarriage or abortion, which are commonly understood in early pregnancy to be relatively minor reproductive events, the complexity and intensity of the second trimester experience for women and their bodies can be downplayed.

Since 2017, much attention has been paid to bereavement practices after pregnancy loss in the NHS because of the development of the National Bereavement Care Pathway (https://nbcpathway.org.uk). Whilst this is welcome for many families, this research argues that attention must also be paid to the physical and emotional experience of the event of pregnancy loss itself, not just its aftermath.

Policy recommendations

The research recommends that the care of women experiencing second trimester pregnancy loss should be structured with regard to **consent, choice, and woman-centred care**.

Consent:
- More information should be provided to women about the possible complications of labour and delivery in the second trimester, including possibilities of prolonged duration and pain, retained placenta, and unplanned delivery at home. Clear plans to mitigate these consequences should be put in place.

Choice:
- There should be greater availability of surgical management of pre-viability late pregnancy loss, and more surgeons should be trained to deliver this care. However, this should be accompanied by clear information about the possible consequences for women of surgical management, such as not being able to witness the foetal body after this procedure.
- Women should have greater choice about the healthcare location of their second-trimester pregnancy loss – such as bereavement suite, gynaecology ward, maternity ward, or birth centre - based on their own preference rather than on foetal gestation. The standard of care should be the same in all these locations.
- Women undergoing termination for foetal anomaly should have choices about accepting or refusing feticide procedures.

Physical care:
- Pain relief should be a priority in all care. Hospitals should not rely on paracetamol as pain relief in the second trimester (as recommended by RCOG, 2011). There should be clear and accessible policies for escalating pain control. Pain relief such as gas and air and morphine should be routinely available on all wards where pregnancy loss could occur, and epidurals should be an option for labour as well as for the removal of placenta.
- Women should be offered lactation advice and suppression if required.
- After second trimester loss, women should have priority access to postnatal care by community midwives and maternity units, with a particular focus on retained placenta and infection.
- All women who have experienced labour and delivery in the second trimester up to 24 weeks should be entitled to a 6-week check with their GP. Current NHS funding only provides this for live births before 24 weeks.

Psychological care:
- Attention should be paid to the experience of pregnancy loss in the design of healthcare services, considering issues such as the provision of private space, and whether bureaucratic procedures are isolating or stigmatising.
- Women should be supported to manage their labour by a trained midwife, including in gynaecology settings, and there should be medical staff present at the point of delivery (as recommended by RCOG, 2010a). Women should not have to manage encountering the foetal body alone.
- Those women who wish to have psychological support after pregnancy loss should have access to this after a loss at any foetal gestation, and there should be no time limit on taking up this offer.
- In subsequent pregnancies, women who have experienced pregnancy loss should have additional points of contact with midwives and other medical professionals, and should be able to access additional ultrasound scans and checkups and psychological support. Sharing of information between medical professionals should be improved. Attention should be paid to the timing and location of antenatal care for women who have experienced loss (for example, so they do not have to have ultrasound scans in the same room where they had previous bad news).

Experiences of loss in the second trimester

I think 22 weeks is when you go on to the maternity ward. So I was in the gynaecology ward in a side room. And I had no midwife, I had no-one. I had [husband] and my mum. And I had no idea what I was doing. I'd never had a baby before. I just had…I was just completely clueless. […] And then, you know, my mum was like, 'this doesn't feel right, I think someone should be here making sure you're ok.' And the nurse basically just said 'when it's happened, come and get me and I'll sort it out.'
Bethany, talking about the lack of support in her premature labour at 17 weeks of pregnancy*

I thought it was gonna be like what the lady said, be a couple of hours, a few period pains. God knows I didn't know what to expect. […] It was a shock when I went into what I classed as full on labour. It felt like full on labour.
Amber, talking about how unprepared she was for the pain of labour in termination for foetal anomaly*

So, I've got a friend who's a midwife and she said to me afterwards, 'oh yeah, we expect people of your gestation to have a really long induction.' I was kind of like, 'oh, that would have been helpful to know?' Just so you kind of know what you're roughly dealing with.
Lucy, talking about how unprepared she was for the duration of labour in termination for foetal anomaly*

They said, 'the baby will die when you miscarry. It will be an induced miscarriage. So you will go to the [general] ward.' It's a regular ward. There were old boys walking around with their pyjamas on. There were nurses, there were no midwives. […] It was all very quick, and very sudden, and actually very medical, you know? 'Here's a bedpan. Sit on the loo.' […] It felt like the nurses didn't have any concept of…parenthood, or motherhood, or what it's like to have been…or sort of empathy with the mother, the parental side of it.
Alice, talking about her experience of termination for foetal anomaly before 24 weeks compared to a previous similar experience after viability*

For mealtimes I had to queue up with pregnant people in the ward […] And...I was just like, again, 'got to get through this, got to get through this showing no emotion. Right. Got to eat. Got to queue up with these people.' […] They are asking questions, but 'don't worry! I'm going through this, my baby's dead...don't worry!'
Eva, talking about her very long induced labour on a maternity ward after the foetal death of her son*

As soon as you book in for the termination, they take all your green notes off you, so I'd go in [to the maternity unit for postnatal care] and they'd say 'well, where are your green notes?' And you just have to keep going through the same thing, over and over again.
Joelle, talking about her experience of bureaucracy after termination for foetal anomaly*

* The names of research participants have been pseudonymised in relation to direct quotes but those who requested it are listed below in acknowledgement of their contribution.

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