Improving the Standard of Care for Women with Reproductive Loss: A Literature Review

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Abstract

This thesis will analyze existing literature featuring both the experience of reproductive loss for women, and the standard of care in the medical field that contributes to their experience. Due to the prevalence of a negative mental health impact from reproductive loss, as well as evidence of tension between women and health professionals in their experiences, the medical field lacks a standard of care for reproductive loss that considers not only the physical needs of women, but also their emotional needs. Research on the grief reactions and mental health effects of women following pregnancy loss is limited, as is the exploration and testing of different methods to identify and assist those impacted by reproductive loss. While the healthcare community awaits additional research, professionals can make positive changes to the standard of care for reproductive loss. This literature review explores what is known about the current standard of care for reproductive loss, what women have said about their experience receiving care for reproductive loss, different methods to identify and assist women with reproductive loss, and how these methods can contribute to changing the standard of care in the medical field.

Improving the Standard of Care for Women with Reproductive Loss:

A Literature Review

Pregnancy is indirectly a part of every woman's story, simply because each was carried by their biological mother or a surrogate mother before they were born. More complexly and directly, pregnancy is also a part of many women's stories because they become pregnant themselves. Though a high percentage of wanted pregnancies are carried to term, the number of women impacted by reproductive loss is not insignificant. Reproductive loss can take three forms: miscarriage, stillbirth, or abortion. This paper will focus on pregnancies that are lost either by miscarriage or stillbirth and will exclude losses elected by the mother through an abortion. Miscarriage is the loss of a pregnancy prior to 20 weeks gestation (American College of Obstetricians and Gynecologists [ACOG], 2020), and stillbirth is the loss of a pregnancy after 20 weeks gestation (StatPearls, 2022). This paper will explore what is known about the current standard of care for reproductive loss regarding both the physical and emotional components as well as what women have said about their experience receiving care for reproductive loss. Further, this paper will propose different methods to improve the standard of care for reproductive loss in the medical field that will more effectively assist and support women.

Much of the research that will be examined in this review is phenomenological. Phenomenology is a methodological approach that takes an open-minded, non-judgmental, and curious approach to interpreting people's experiences and their understanding of them. The goal of phenomenological studies is to find answers to the question "what is it like to experience this thing or situation?" by taking an in-depth investigation of the perceptions and perspectives people hold regarding the "thing" or situation being studied (Dainty et al., 2021). A phenomenological approach is helpful when examining reproductive loss, as accounts of the

experiences from women who have experienced reproductive loss offer an important contribution to the conversation of how to improve the current standard of care.

Reproductive Loss: Prevalence, Possible Causes, and Impact

An estimated 26% of all pregnancies end in miscarriage, whether naturally occurring or induced (StatPearls, 2022). This indicates that, of the 3.5 million pregnancies that occurred in the United States in 2020, 900,000 of them were not carried to term (Osterman et al., 2022). The estimate of 26% accounts for women who lose their pregnancy prior to 20 weeks gestation. It does not include the estimated 21,000 babies that are stillborn each year, being delivered deceased after 20 weeks gestation (Centers for Disease Control and Prevention [CDC], 2022). Consequently, nearly one million women in the United States experience reproductive loss each year at different stages of pregnancy.

When examining possible causes of reproductive loss, it is challenging to find a precise reason why each baby did not remain healthy and live to term. Many times, the primary cause remains unknown, even after testing is done on the mother, the baby's tissue, the umbilical cord, and the placenta. Even though the cause of the miscarriage or stillbirth is often a mystery, feelings of guilt follow reproductive loss for some women. One phenomenology-based study indicated that women who are not given a reason for their miscarriage by their doctor will assign a reason themselves, as the impact of losing the expected child, the child's future, and the experience of maternity/motherhood is great (Adolfsson et al., 2004). Though women often attribute their pregnancy loss to something of their own doing, such as working, exercising, or having sex, lifestyle choices of that kind are not known to cause miscarriage. Some women also attribute their pregnancy loss to a recent fall, fight, or stress, but in most cases, those are not likely the cause of miscarriage either. Despite the common belief that pregnancy loss is the fault

of the woman's choices, in almost every instance, in a search of the cause of the loss, there is not a factor found that suggests it was the woman's fault. In fact, chromosomal abnormalities are a leading contributing factor in about half of reproductive losses, especially for miscarriages. During fertilization, if an egg or sperm has an abnormal number of chromosomes, the embryo will consequently have an abnormal number, thus increasing the likelihood of miscarriage. As maternal age increases, the likelihood of chromosomal abnormalities increases. Further, there are select medications that can also contribute to miscarriage. Regardless of the cause of the loss, the presence of guilt indicates that reproductive loss may extend beyond the bounds of a physical experience, becoming an emotional experience for women too (ACOG, 2018).

Research on how women emotionally respond to reproductive loss is limited, but what does exist shows there is often a negative mental health impact that can be long-lasting. Following reproductive loss, many women experience major depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, suicidal ideation, or substance misuse (Davoudian et al., 2021; Faren et al., 2016). Women after miscarriage or stillbirth often grapple with mental health issues for up to nine months, and in some cases, years or even decades after their loss. In a sample of over 160 women in a study conducted by Grauerholz et al. (2021), participants described their experience with reproductive loss as horrifying, traumatizing, and miserable. One participant said, "Eleven years later I am still having issues. Not all the time but coming up to the anniversary [of the miscarriage]. April first is not funny at all. That's the day that changed my life forever." The authors recognize the shortcomings in the current standard of care and propose a more holistic approach for reproductive loss, to include an evaluation of the emotional response to the loss, measuring reproductive grief, assessing the grief responses, and providing treatment accordingly. Evidence of women's emotional response to reproductive loss coupled

with their prolonged grief further indicates the importance of emotional consideration and support from health professionals.

Reproductive loss often lands women under the care of health professionals to ensure her safety throughout the physical process of the loss (Bacidore et al., 2009). Though it is appropriate that a woman's physical health is a priority when she is medically seeking care for reproductive loss, the importance of providing care for her emotional needs remains. To ensure both physical and emotional health are included in health professionals' standard of care for reproductive loss, some changes to the current standard of care are due.

The Current Standard of Care for Reproductive Loss

As a prominent voice contributing to the established guidelines for the standard of care among obstetricians and gynecologists nation-wide, the American College of Obstetricians and Gynecologists (ACOG) outlines information regarding reproductive loss, whether by miscarriage or stillbirth. To reiterate, miscarriage a loss prior to 20 weeks gestation (ACOG, 2020), and stillbirth a loss after 20 weeks gestation (StatPearls, 2022). The protocols differ between miscarriage and stillbirth, as will be illustrated. To understand why the patient experience with reproductive loss ought to include both physical and emotional needs, outlining what women physically experience during reproductive loss from a medical standpoint is important.

ACOG's Miscarriage Protocol

When a woman comes into a medical facility seeking care for her suspected miscarriage and it is confirmed, she is given three options for how to medically handle the loss. ACOG's practice bulletin of 2018 outlines each miscarriage management option, including expectant management, medical management, or surgical evacuation. Expectant management refers to the process of the patient waiting for her body to naturally expel the pregnancy. This option is

primarily offered in the first trimester to help ensure safety and efficacy. The second option, medical management, allows for misoprostol-based regiments of medication to be administered, which are designed to quicken the body's expulsion of the pregnancy. Women who elect either expectant or medical management will likely experience heavy cramping and bleeding, and ACOG recommends that physicians offer educational materials describing how much bleeding is too much while miscarrying from home, as well as prescriptions for the associated pain. Additionally, women are to be advised of the risk that surgery may be required if the baby and all the surrounding pregnancy tissue is not completely expelled. Finally, surgical evacuation refers to removing the miscarried pregnancy by suction curettage, typically under the use of anesthesia. This option is the most immediate and is preferable or even required for women who present severe anemia, bleeding disorders, hemorrhage, signs of infection, or hemodynamic instability. Women who elect the surgical management option are also administered an antibiotic to reduce risk of infection following the procedure. While surgical evacuation offers the most immediate completion of a miscarriage, there is currently no evidence that indicates the three options produce differing long-term outcomes. Nevertheless, after the miscarriage is medically handled, the patient is cleared and can be discharged to go home. Follow-up for miscarriage is limited, but includes either an ultrasound examination to confirm that all pregnancy tissue has been expelled, or bloodwork to measure a woman's hCG levels, as the measurement of those levels assist in determining the status of a pregnancy (ACOG, 2018)**.**

Regardless of which miscarriage management option women choose, ACOG advises health professionals to offer adequate information about the risks and benefits of each management option, as well as education about what they are to expect physically following their miscarriage. Additionally, they note that it is important to include the patient in the process

of diagnosing the miscarriage, as well as individualizing management guidelines to each patient. Despite its stated importance, ACOG does not specify what including the patient in diagnosis or individualizing miscarriage management ought to look like procedurally (ACOG, 2018). ACOG's lack of specification further indicates that emotional consideration surrounding reproductive loss is lacking, even among leading professionals in the obstetrics and gynecology field.

ACOG's Stillbirth Protocol

Another type of reproductive loss is stillbirth, which is a loss that occurs after 20 weeks gestation. Because the baby is larger due to a later gestational age, ACOG presents a different recommended protocol. Unlike early loss that would allow women to avoid invasive medical procedures, a stillbirth requires either a dilation and evacuation procedure, an induction of labor for a vaginal delivery, or in rare instances, a cesarean delivery. The timing and method of delivery depend on the woman's obstetric health history, her preference, and the gestational age of her deceased baby (ACOG, 2020). Many women elect to have an immediate delivery of their deceased baby, consenting to have their labor induced. If it is an option, some women may elect to wait for labor to begin naturally, which is called expectant management and is the same process many women who have early miscarriage engage in. With expectant management, between 80% and 90% of women spontaneously labor 1-2 weeks after the diagnosis of a stillbirth. If the stillbirth occurs in the second trimester versus the third, a dilation and evacuation is the management option associated with the fewest complications. For a dilation and evacuation, under ultrasound guidance and medicinal assistance like that administered for early reproductive loss, the cervix is dilated. With the use of vacuum aspiration and surgical tools, the uterus is emptied of the deceased baby and the surrounding pregnancy tissue. The options

available to women are dictated by their previous obstetric health, whether they are in the second or third trimester at the time they are diagnosed, and what the women's preference is (ACOG, 2020; Chakhtoura & Reddy, 2015).

After delivery, ACOG acknowledges that there is a lack of uniform protocols to evaluate the stillbirth, thus hampering the search for specific causes. With existing protocols, what is known from postnatal examinations often leaves the causes of the stillbirth unexplained. The essential components of a stillbirth evaluation include a fetal autopsy, a gross and microscopic examination of the placenta, umbilical cord, and membranes, and genetic evaluation. A fetal autopsy should include measurements to assess the true gestational age, including the baby's head circumference, foot length, and body weight. Further, photos should be taken of the baby's whole body to document any abnormalities that could be examined more in-depth by a trained specialist. A gross examination of the placenta, umbilical cord, and membranes is an examination of what can be seen macroscopically with the naked eye . A microscopic examination can offer insight about the possibility of infection, anemia, or genetic abnormalities. If there is sufficient parental permission, genetic testing is also performed and can provide information about reasons that could have contributed to the baby's death. Despite extensive postnatal examinations, what is known from them often leaves the causes of the stillbirth largely unexplained (ACOG, 2020; Chakhtoura & Reddy, 2015).

A notable distinction between ACOG's protocol for early pregnancy loss and stillbirth include the need for emotional support and bereavement care. ACOG acknowledges the need for emotional support following reproductive loss the further women are in their pregnancy. Some examples of their recommendations include clear and timely communication of test results, shared decision making, and the acknowledgement of grief (ACOG, 2020). However, as, data on

the mental health impact of reproductive loss on women has shown, support should be included in early pregnancy loss protocol as well because women are negatively impacted at all stages of pregnancy and the majority of reproductive losses occur prior to 20 weeks gestation (CDC, 2022; Davoudian et al., 2021; Faren et al., 2016; Grauerholz et al. 2021; Osterman et al., 2022).

The Patient Experience

Interviews with nearly 60 women who experienced reproductive loss provided an in-depth view of their experiences with medical care. Respondents were asked questions designed to gain an understanding of how they experienced and perceived health care and pregnancy loss. The women's interviews were compared to decipher commonalities, or themes, in their experiences. The analysis revealed three themes, all centered around how the loss was framed by health professionals. The primary consensus from the interviews was that there is tension in the way reproductive loss is viewed by health professionals, with dichotomies specific to miscarriage as a common versus personal experience, a medical versus emotional experience, and an episodic versus an ongoing experience. For participants who felt their experience was viewed as common rather than personal, some stated they felt as though they were wasting their doctor's time, felt no compassion from their doctor, felt rushed, and were talked to about miscarriage as if it was common knowledge. For participants who felt their experience was viewed as medical rather than emotional, some stated that when receiving treatment for their loss, they had no idea what to expect and felt as though their doctor expected them to go back to normal after being "fixed" from their medical problem. Last, for the participants who felt their experience was viewed as episodic rather than ongoing, many stated they received little or no information from providers at discharge about what to expect once they got home, as if the experience would be over after leaving the hospital (Dainty et al., 2021).

Other analyses of patient experiences receiving care for their miscarriage echo the findings of Dainty et al. (2021), indicating that patients' experience in the emergency department following their loss was associated with greater confusion, low satisfaction, poor communication, and a lack of emotional support from health professionals (Baird et al., 2018; Miller et al., 2019). The study by Miller et al. (2019) had a similar design to that of Dainty et al. (2021), as women who experienced early pregnancy loss were interviewed about their experience seeking care in the emergency department of their hospital. The most common takeaway from the interviewees' experiences was that they felt as though they did not receive enough information from their medical providers in the emergency department. They said their visit to the emergency room consisted of a lot of waiting around and a lot of confusion over what was happening to them and what the doctors were doing. The long wait was reason for concern for some women, as they felt worried to wait so long for treatment for what they perceived to be an emergency. Some women felt as though they were not being taken seriously, that the environment was chaotic, and that the staff was unfriendly. Additionally, most of the interviewees reported that due to being fearful and confused about what was happening to them, they desired more emotional support that acknowledged the feelings accompanying their reason for being in the emergency room in the first place—their reproductive loss. They felt as though they could not advocate for themselves and felt uncertainty as to what would happen to them once they were discharged. Though reproductive loss may not be the most severe or urgent health condition in an emergency room or other medical facility at any given time, the quality of patient care and communication by health professionals should not diminish. Miller et al.'s (2019) findings point back to those of Dainty et al. (2021), ultimately boiling down to the fact

that women facing reproductive loss feel as though their loss is treated as common, medical, and episodic, rather than personal, emotional, and ongoing.

Looking Forward: How the Standard of Care for Reproductive Loss Can Be Improved

Though ACOG includes recommendations for emotional support in their stillbirth management protocol that are not sufficient on their own, they introduce many of the changes needed in the standard of care for reproductive loss at every gestational age. In the cited practice bulletin on the management of stillbirth, ACOG draws some of their stillbirth management recommendations from a leading pregnancy and reproductive loss bereavement support organization, Sands, out of Australia (ACOG, 2020). Sands outlines a list of key principles for bereavement care for families after reproductive loss. Their principles, each supported and expanded on by research, offer a framework for implementing emotional considerations in the current standard of care. If the principles were consistently and reliably utilized by medical providers, the existing standard of care for reproductive loss would be improved, and the specific grievances surrounding women's experiences receiving care would be addressed (Sands, 2018). The grievances, as highlighted in the research by Dainty et al. (2021) and reinforced by Miller et al. (2019), include reproductive loss framed by their medical providers as a common versus personal experience, a medical versus emotional experience, and an episodic versus an ongoing experience. The overarching changes needed to the current standard of care include how medical professionals communicate the loss, how they handle the patient's emotional response to the loss, how they equip their patients to be discharged, and how they as health professionals are cared for in order to stay trained and healthy to keep providing care over time (Sands, 2018).

Communicating the Loss

Communicating the reality of reproductive loss to the expecting family is an undesirable task for health professionals. The responsibility is great, as health professionals play an important role in the family's experience of reproductive loss. Parents have submitted reports to Sands documenting their experiences being told about their loss, many of which state that parents remember specific words or phrases spoken by health professionals following their loss. Further, they report that the health professional's words can have an impact on their positive memory of their deceased baby, as well as the choices they make after the loss. One bereaved parent negatively remembered a health professional referring to her baby as a 'fetus that is incompatible with life' long after her baby's passing, illustrating just how direct the language from medical staff can be (Sands, 2018). The Sands report from parents in addition to what has already been discussed from the phenomenological studies by Dainty et al. (2019) and Miller et al. (2021) indicate the breadth of the impact communication from medical staff can have on the patients' experience.

One of Sands Principles of Bereavement Care targets the issue of poor communication in the current standard of care that contributes to women facing reproductive loss feeling like their loss is considered common, medical, and episodic. The suggested principle outlines that communication with bereaved parents should be clear and honest, which helps ensure bereaved parents feel informed, heard, and respected. In their explanation of what the principle of good communication could look like in the clinical setting, they recommend that health professionals refrain from using clinical terms surrounding the loss, such as fetus, embryo, and spontaneous abortion (Sands, 2018). Not only is the use of medical jargon less personal, but it may hinder health professional's ability to reach their patients, as patient knowledge of medical jargon varies (Thomas et al., 2014). Beyond lessening the use of medical jargon, Sands also advises health

professionals to have trained interpreters on hand to ensure that preventable communication barriers such as a difference in language is not the reason someone does not receive quality care. Further, health professionals are advised to use intuitive questioning and actively listen to patients to push beyond the tendency to go on autopilot and forget to be empathetic and sensitive. Lastly, to further follow the principle of good communication, Sands recommends that health professionals be mindful of the environment in which bad news is delivered or challenging conversations are initiated. Choosing private areas over common and crowded spaces can help women feel they have the privacy to react and process their loss the way they need to without the pressure of a large crowd (Sands, 2018). Grief is complex and can lead to losses of normal cognitive functioning in some circumstances, so it is imperative that good communication is present to strengthen the chance that parents feel informed, heard, and respected (Hall et al., 2014).

Two additional principles of bereavement care suggested by Sands that target the issue of poor communication in the current standard of care is that a woman's parenthood should be recognized by health professionals, and both of the baby's parents should be engaged in shared decision making about their child. As could be seen from the summary of ACOG's contributions to the standard of care for reproductive loss, there are a lot of decisions for women to make after learning about the loss (ACOG, 2018; ACOG, 2020). Sands discusses how patients report feeling as though their parenthood is not being acknowledged when decisions about their baby's care are not left in their hands. It should be noted, though, that parents may be overwhelmed in light of the loss and need to be asked time-sensitive questions more than once. The women from the phenomenological study by Dainty et al. (2021) reported that they were aware technical steps needed to be taken after receiving the news that they lost their baby, but they felt their emotional

and cognitive processing was not caught up to a point where they were prepared to make decisions. Consequently, women should be affirmed that it is okay to feel confused or indecisive and should be given patience by their health professional while her and her possible partner work towards making a decision about the next steps for their deceased baby (Sands, 2018). Offering choices to the parents about different courses of action for management of their loss could help frame each outcome in a way that empowers patients to make their own decision and shows parents they can truly engage in shared decision making.

Handling the Woman's Emotional Response to the Loss and Equipping Her to Move Forward

Improving the way health professionals respond to the emotional aspects of women's experiences with reproductive loss and equipping them for what comes after they leave the medical facility is perhaps the most crucial to improving the standard of care. Fortunately, Sands has several principles of bereavement care that offer guidance for how health professionals are to do just that. Sands reports that many women's reproductive loss is their first experience of the death of an immediate family member, therefore it is important for professionals to understand their role in supporting parents as they try to understand and adjust to new feelings, thoughts, and behaviors (Sands, 2018). Handling the emotional response to reproductive loss according to Sands Principles of Bereavement Care and equipping them for what came next could have allowed the women from Dainty et al. (2019) and Miller et al.'s (2021) phenomenological research to feel as though their loss was treated as personal, emotional, and ongoing, rather than a common, medical, and episodic experience.

Two initial principles outlined by Sands that offer guidance to health professionals to improve their emotional considerations and attention to needs of their patients is that health professionals are to acknowledge that grief is individual, and to acknowledge the grief of the woman's partner

and family (Sands, 2018). In a paper examining how women's perceptions and experiences with miscarriage compared to her partners, it was found that both parents felt a variety of emotions at every stage of the miscarriage. The results showed that the emotions differed in intensity, type, and duration between men and women, thus illustrating how the same event can have a different impact on individuals experiencing it (Abboud and Liamputtong, 2003). Sands acknowledges that the grief associated with reproductive loss will differ for each bereaved parent. They urge health professionals to educate parents about how people respond differently to grief, that one parent's form of grief might not be the same as their partner's, and that their baby's death is unique along with the responses to it. Cultural and religious differences across patients should also be noted, as they may impact how certain families experience and express grief (Sands, 2018).

Following loss, some may experience strong, powerful reactions and emotions, and may express them openly. Others may internalize their emotions and channel their grief by doing various activities (Sands, 2018). Further, individuals may experience either all or some of the following changes due to their grief: the strain of previously rewarding relationships, difficulties returning to work due to a lack of concentration, a change in interests surrounding leisure and recreation, and a decrease in social support (Barlé, Wortman, & Latack, 2017). Sands recommends that health professionals inform their patients that there is no perfect way to grieve, and that it is normal if it takes time for the shock and disbelief to wear off. Acknowledging grief as individualized allows for the possible normalization of differences, that way parents can be sympathetic if they differ from their partner. When health professionals acknowledge grief associated with reproductive loss as individual to each family member, they acknowledge that

their patient's child's death is unique and significant, and free up their patient to own their personal experience and response to the loss (Sands, 2018).

Research by Lang et al. (2015) shows that if bereaved parents are able to interact with educated health professionals following their loss with honest and open communication, they have more opportunities to engage in individualized personal, cultural, or religious traditions that help them move forward from their loss. Engaging in meaningful traditions could impact the only memories parents are able to form with their child. Memory making is an avenue Sands regards as vitally important in the actualization of the loss and its associated grief and is the key strategy health professionals can use to recognize parenthood in their patients. Sands reports that a recurring theme they see from patient stories shared with them is the regret of women not spending enough time with their deceased baby and collecting memories with them. Sands offers examples of ways to recognize parenthood through memory making, such as encouraging patients whose deceased baby is born in-tact to unwrap their baby and look at the details of all of their features, gather high-quality footprints, give each parent alone time with the baby, etc. For parents who did not carry their baby long enough for it to be recognizable upon delivery, they should be encouraged to keep ultrasound photos and hospital bands, and to engage in a symbolic ritual, such as planting a tree in memory of the baby (Sands, 2018).

Regardless of whether the loss was a stillbirth or a miscarriage, Sands urges health professionals to encourage their patients to name their baby if they would like to, that way the patients can have more specific memories, and also so that health professionals can refer to the baby by its determined name for the remainder of the women's time under their care. Additionally, they urge health professionals to handle the baby's body with the same level of care and caution that they would if it was living. An example of a practical way health professionals

could initiate memory making would be to ask bereaved parents of later-term deceased babies a question like, “Many families have found that they benefited from the memory of giving their baby a bath, would that be something you might like to consider?” Sands advises that health professionals should be aware that the meaningful traditions held by parents can vary, even if the individuals they are serving have similar religious or cultural backgrounds (Sands, 2018).

Another key principle of bereavement care recommended by Sands to address the patient’s emotional response to the loss is to implement ongoing emotional and practical support (Sands, 2018). Given what is known about the prolonged mental health impact of reproductive loss (Davoudian et al., 2021; Faren et al., 2016; Grauerholz et al., 2021), it is puzzling that Sands research reports over half of all bereaved parents are not given information at the hospital about ongoing support services. To provide women with ongoing support and acknowledge that her experience is not episodic, Sands recommends health professionals talk with their patients about various options for continuing support, with informational brochures to supplement what was discussed. If there are peer-to-peer support groups in the area, online resources, or helplines to call, they should be discussed before women are sent home. Parents who engage in peer support groups report feeling heard, understood, validated, and more hopeful for the future. Another part of ensuring women get as many opportunities as possible to receive support is to implement mandatory follow-up calls after the loss (Sands, 2018). A study investigating the impact of post-discharge follow up calls from nurses found that telephone follow-up calls have the potential to reduce post-discharge problems and meet patient information and communication needs (Woods et al., 2019).

Additionally, ACOG proposes the implementation of interpregnancy care, which is care in between pregnancies and along a woman’s life course with the goal of maximizing her

wellness. ACOG recommends that any woman of child-bearing age who has been pregnant, regardless of the outcome, should receive interpregnancy care. After a pregnancy, if a woman intends to have another pregnancy in the future, she will engage in interpregnancy care with the goal of maximizing her wellness in preparation for her next baby. If a woman does not intend to have another pregnancy, while she is assessing her postpartum needs, the focus of her care would subsequently shift to that of routine well-woman visits.

ACOG lists several key steps in interpregnancy care, specifying whether they are for before the baby is born, during the maternity stay, at the woman's postpartum visit, or during her routine well-woman visits. Some of the key steps include the provision of anticipatory guidance for breastfeeding and if appropriate, information about the associations between certain pregnancy complications and long-term maternal health. During the maternity stay, some key steps include discussing the importance of postpartum care and assisting in determining the timing and location of that care. At the postpartum visit, key steps include reviewing any birth complications the woman may have experienced and what type of resulting follow-up care she needs, as well as reviewing with the woman what her desired plan for contraception is if she has one. Last, during routine well-woman or pediatric visits, some key steps of interpregnancy care are to screen the woman for mental health disorders, and to assess when she hopes to become pregnant next. In sum, interpregnancy care includes components of postpartum care, including continual screening for depression using up to date screening methods, education about future health, and assistance in establishing long-term medical care.

If women with reproductive loss are to reap the benefit of interpregnancy care, needed changes to the standard of care extend outside of the hospital itself. In order to make interpregnancy care a reality for women across the board, ACOG proposes that creative

partnerships should be formed among medical professionals who work with women of reproductive age, and that public policies that promote women's ability to afford and access interpregnancy care should be created to assure a woman's health is holistically addressed, regardless of her potential pregnancy outcome (ACOG, 2019).

Keeping Health Professionals Trained and Healthy

Communicating effectively to patients in a medical setting, especially concerning care that includes bereavement, requires knowing what information needs to be given, how and when to present the information, and how to assess their understanding of the information (Kavanaugh and Paton, 2001). Such a rigorous requirement prescribes the need for healthcare professionals to be trained in bereavement care and cared for themselves if they are to maintain the level of mental health to properly care for others. To allow sensitive, respectful, emotionally informed care for reproductive loss to be consistent, Sands proposes a principle of bereavement care that outlines health professionals' need to be trained in bereavement care in reproductive loss, as well as their need to have access to self-care. Though Sands can only speak for Australia's training, they observe that there are differences in staff education and staff care that lead to inconsistencies in the standard of care across the board. They find the inconsistencies problematic, as Sands believes that all health professionals working with maternal health should be experts in bereavement care (Sands, 2018).

Health professionals may be exposed to early pregnancy loss as frequent as daily, which could lead to a natural desensitization of the adverse experience. Patients' emotional responses and needs are likely overlooked when health professionals normalize the occurrence due to the frequency in which they encounter it (Farren et al., 2016). Sands claims that all staff who care for bereaved parents at every stage of their loss will be affected emotionally, and that many health

professional workers already wrestle with vicarious traumatization, otherwise referred to as burnout (Sands, 2018). Symptoms of burnout are emotional numbing, difficulty making decisions, and little time and energy for themselves (Saakvitne et al., 2000). The natural desensitization to adverse situations surrounding loss gives reason to presume health professionals may experience what the American Psychological Association calls disenfranchised grief. Disenfranchised grief is defined as grief that society limits, does not expect, or may not allow them to express. They acknowledge that examples of disenfranchised grief include but are not limited to the grief of nurses for the death of their patients and the grief of parents with reproductive loss (American Psychological Association, n.d.).

The toll that frequently encountering adverse situations has on health professionals whether by burnout or disenfranchised grief affirm the necessity of Sands principle of bereavement care that states that health professionals should have access to self-care. Practical ways health professionals can be cared for is by medical facilities offering professional development opportunities surrounding bereavement, hosting open discussions about self-care within medical facilities, and providing staff the opportunity to debrief and reflect with one another. Access to self-care would prevent valuable staff members from having to care for others from a place of depleted health and wellness. The current standard of care for women with reproductive loss will be hindered in its improvement if the staff needed to implement the changes are not healthy.

To not only welcome self-care for staff, but to improve consistency in staff education and the subsequent standard of care for women with reproductive loss, following Sands principle of bereavement care to train health professionals in bereavement care is important. To prioritize bereavement training, Sands recommends engaging in the low-cost online bereavement care

training they offer, which allows the implementation of this principle to be feasible. Regardless of if medical facilities can afford Sands formal training, consistently engaging in informal discussions about the quality of bereavement care and ways improvements could be made in each department is a sufficient start. Additionally, Sands recommends inviting someone fully trained in bereavement care to come to their maternity unit to offer educational support to staff (Sands, 2018). Health professionals are trained to be problem solvers, and because their time to meet with each patient is limited, their focus is narrowed towards meeting primarily the medical needs of their patients, and the emotional toll of the job may restrict their capacity to emotionally acknowledge women with reproductive loss. Implementing training and care for health professionals can help mitigate the natural consequences, like burnout and decreased quality of care, from working a job that requires frequent interactions with adverse situations.

Conclusion

This literature review explored what is known about the current standard of care for reproductive loss regarding both emotional and physical components, what women have said about their experience receiving care for reproductive loss, and proposed different strategies to improve the standard of care for reproductive loss in the medical field. Due to the prevalence of reproductive loss and its negative mental health impact on women, as well as evidence of tension between women and health professionals in their experiences, it is crucial that the standard of care for reproductive loss is improved. For health professionals to view reproductive loss as a personal, emotional, and ongoing experience at every stage of pregnancy, the implementation of the *Sands Australian Principles of Bereavement Care*, as recommended by the American College of Obstetricians and Gynecologists for the treatment of stillbirth would be a productive starting point. If implemented, health professionals could more effectively assist and support women.

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