Terminology used in early pregnancy loss

The use of the term 'abortion' to describe an unwanted early pregnancy loss is frequently reported as hurtful to women (Chalmers & Hofmeyr 1989; Oakley et al. 1984). Overtones of 'induced' or 'illegal' abortion often contrast with women's disappointment at the time of the unwanted loss. Some years ago Beard et al. (1985) appealed for attention to be directed to the psychological meaning of the term 'abortion' for women who experience a pregnancy loss unw antedly.

It appears that publications in the *British Journal of Obstetrics and Gynaecology* have taken heed of this appeal. A count of the titles of papers published in this Journal referring to unwanted early pregnancy loss in 1981–2 and 1989–90 revealed a change in terminology used before and after the editorial by Beard et al. (1985) (Table 1). Whereas almost all the papers at the start of the decade used the term 'abortion' in their titles, none of those published later did so.

Little research has, however, systematically examined the meaning of terminology regarding pregnancy loss for women. Some exploratory research in this area suggests that the preferred terminology, at least from the woman's perspective, may be culturally determined.

Cross cultural research into women's preferences for the use of 'abortion' or 'miscarriage' indicates that women from different cultural backgrounds may not be equally concerned about medical terminology with its possible negative emotional overtones. In a study of 106 women experiencing a first pregnancy loss before 28 weeks, 32 expressed a dislike for the word 'abortion', 37 were indifferent to its use whereas 25 preferred it. In this small pilot sample, women of mixed cultural origin disliked the term more than others; White and Indian women were predominantly indifferent to its use and African women expressed a liking for it (Chalmers & Meyer 1991). It is apparent that cultural variations in the meaning of medical terminology may occur and must be recognized by doctors. Further research is needed to explore this issue.

Research and comment has concentrated on the use or misuse of the term 'abortion' for describing spontaneous early pregnancy loss. There are, however, other phrases used when caring for women who lose babies which may also have emotionally negative connotations and which should be examined.

Terms such as 'failed pregnancy', 'incompetent cervix', 'inadequate germ plasma', and 'abnormal chromosomal material' are often used by professionals. Whereas these may have objective medical meanings for the doctor their meaning to the woman may be different. Women may focus on the words 'failed', 'incompetent', 'inadequate' and 'abnormal', all of which are part of everyday English, and apply them, not to their physiological functioning but to themselves, as persons. Feelings of failure, shame, guilt, insecurity and depression are recognized reactions to an unwanted miscarriage (Graves 1987; Leroy 1988; Oakley et al. 1984; Pizer & Palinksi 1986).

The use of medical terminology which carries negative connotations for the lay person may contribute to the development of negative self perceptions, particularly in those already predisposed to think ill of their miscarriage experience.

Womens' difficulty in adjusting to a miscarriage (Chalmers & Hofmeyr 1989; Oakley et al. 1984) may be compounded by the procedure followed with regard to the lost baby. The medical and nursing professions commonly refer to the 'products of conception'. Women, in contrast, tend to think of their loss as a 'baby'. In addition, the outcome of the pregnancy is not usually buried; it is 'disposed of', either by sluicing or incineration. Contradictions such as these emphasize a discrepancy between some women's views of their pregnancy loss and those of their attending professionals; for the women the pregnancy is real and their wishes may be for a burial of the lost baby, whereas for the medical profession the conceptus does not yet warrant such 'human' recognition.

It is possible that recent developments in technology may have exacerbated the difficulty of adjusting to an early pregnancy loss. In some traditional societies (Larsen et al. 1983) women do not acknowledge conception until 4–6 months into pregnancy. In more modern societies women are aware of their pregnancies far earlier: a mean gestational age of 2–1 months has been reported in some groups of western women (Chalmers 1990). This trend towards earlier acknowledgment of conception follows the encouragement of women to seek antenatal care earlier. In addition, the application of technologies, such as sonography, allows early diagnosis of conception. The psychological consequences of these medical developments may well be an earlier identification with the 'baby' by the parents, facilitated by visual and auditory images of the unborn baby. The unwanted loss of this baby could result in disappointment even if it occurs early in the pregnancy.

Many women report not having recovered emotionally from their miscarriage experience months after the event (Chalmers & Meyer 1991). The absence of clear 'rites of passage' may contribute to this inability to adjust. The lack of recognition of the loss as a baby, particularly if the miscarriage takes place in very early pregnancy; the absence of any burial ceremony to mark the recognition of lost life; the inability to identify a place of remembrance such as a burial site; the lack of social recognition of the woman as a mother even if only of a baby that has died and the expectation that mourning is not needed or is inappropriate in the event of early pregnancy loss, may make mourning more difficult.

Recent recommendations regarding the management of a

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Table 1. Terminology used in titles of papers relating to miscarriage in the *British Journal of Obstetrics and Gynaecology*

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<tbody>
<tr>
<td>Abortion</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Cervical incompetence</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Preterm delivery</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Early pregnancy failure</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>0</td>
<td>6</td>
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stillbirth recognize the importance of having something to remember about the baby to facilitate mourning and acceptance of the experience (Barr 1986; Bourne & Lewis 1991). Simply seeing and holding the baby at birth helps: this is further aided by having a photograph or a sonograph for remembrance. It may be that some of these ideas are applicable to earlier pregnancy loss as well particularly when this loss is viewed as stressful by the woman. Some research indicates that seeing the outcome of a miscarriage before 28 weeks, if this resembles a fetus and not a mass of tissue, is regarded positively by the woman (Chalmers & Meyer 1991). Further research is needed to assess whether this finding can be confirmed, particularly among women of differing cultures.

Variations in cross cultural perceptions, as well as individual differences in the meaning of a miscarriage experience, must always be acknowledged, explored and understood when caring for the individual woman. Moreover, changes in practice including those of language and behaviour are worthy of consideration in the process of providing medical and emotional care for women who miscarry.

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**References**


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**Action in international medicine and maternal health care in developing countries**

Action in International Medicine (AIM), formed in 1988, is an international organization whose members are some 88 institutes or academics of medicine and professional organizations based in 28 countries. AIM intends to work alongside international agencies and governments to assist in the provision of health care in developing countries. It will be capable of providing direct support for the professionals of its own member bodies and in addition will be free to assist those working for non-governmental organizations.

The Royal College of Obstetricians and Gynaecologists (RCOG) was among the first of AIM’s members and was represented at AIM’s first World Assembly in Toronto in August, 1991. A report of the Assembly, together with an account of some projects which AIM has already supported has been published recently (Haines 1991). The purpose of the Assembly was to reach agreement on the focus, objectives and resources of the organization. Some of the Assembly’s conclusions had direct relevance to the provision of maternity care. The first of these was AIM’s conviction that the development of district health systems is the key to the improvement of health in many developing countries. It is perceived that there is a crucial deficiency at this point in many health services. Since the Alma Ata Declaration in 1978, primary health care has received much attention and has developed well in many countries. At the same time tertiary care has been the beneficiary of considerable resources. In many countries the result is that while sophisticated obstetric treatment may be available in the main centres, women in deprived and especially rural areas do not have access to basic but life-saving interventions such as caesarean section or operative vaginal delivery. Maternal mortality, the natural outcome of such service deficiencies, now shows the greatest differential of all public health indicators between the developed and the developing nations. It is not surprising therefore that the Assembly in Toronto also identified the Safe Motherhood Initiative as an issue with which AIM should concern itself. The aims of the Initiative backed by the major international development and health agencies have been described. Belsky (1990) reported that the ‘middle level’ of maternity care is contracting both in quality and quantity in the rural areas of many countries and he stressed the importance of promoting community-based maternity care and of providing skilled obstetric care at the first level of referral.

AIM’s World Assembly ended in a decision to issue the Toronto Declaration on Global Health Care, in which delegates and representatives committed themselves to the promotion of a culturally appropriate infra-structure of health care worldwide, such that preventative, curative and rehabilitative services are effectively integrated at the district level. The