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Original Article

Beyond the Clinic Door: Designing Compassionate Digital Support After Early Pregnancy Loss Through the Experiences of Patients, Partners and Maternity Professionals

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ABSTRACT

Background: Early pregnancy loss can generate substantial emotional, informational, and relational needs that persist beyond acute clinical management, while digital support may provide continuity of care if it remains sensitive, clinically credible, and connected to professional services. Objective: To explore how patients, partners, and maternity professionals conceptualized compassionate digital support following early pregnancy loss and to identify stakeholder-informed requirements for an appropriate digital support pathway. Methods: A qualitative descriptive design informed by an interpretive orientation was used. The analytic dataset comprised 15 participant profiles, including seven patients, four partners, and four maternity professionals. Data were analyzed using reflexive thematic analysis with deliberate comparison across stakeholder groups. Results: Four interrelated themes were developed: recognition before information; staged, clinically anchored guidance; inclusion of partners without displacing the patient; and human connection, choice, and escalation as safety functions. Participants did not consider a fully automated application or static information portal sufficient. They favored a digitally enabled pathway that acknowledged the loss before providing information, adapted content to different stages of recovery, allowed control over notifications and potentially triggering material, provided separate support for partners without compromising patient privacy, and maintained clear routes to professional assistance when physical or psychological concerns escalated. Conclusion: Compassionate digital support following early pregnancy loss should be conceptualized as a relational extension of existing maternity and follow-up care rather than a substitute for healthcare professionals. Future co-design and feasibility studies should evaluate the acceptability, usability, emotional safety, accessibility, and clinical governance of stakeholder-informed digital support pathways. Keywords: early pregnancy loss; miscarriage; digital health; compassionate care; maternity care; partners; qualitative research

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INTRODUCTION

Early pregnancy loss is a common reproductive event with consequences that extend beyond the immediate physical management of miscarriage. Although early pregnancy loss is frequent in clinical practice, its personal significance may be profound, encompassing grief, anxiety, depressive symptoms, uncertainty, and concerns regarding future reproductive health (1–3). Qualitative evidence further indicates that the impact of pregnancy loss is shaped not only by the loss itself but also by whether the experience and associated grief are acknowledged by healthcare professionals, families, and wider social networks (4,5). Psychological support after early pregnancy loss nevertheless remains inconsistent, with many women reporting unmet emotional needs and uncertainty regarding available pathways for follow-up care (6).

The transition from acute clinical management to recovery represents a particularly vulnerable period. Following discharge from emergency departments, early pregnancy services, or outpatient settings, patients may receive adequate information regarding bleeding, pain, and immediate warning signs while

remaining insufficiently prepared for subsequent emotional distress, relationship changes, return to work, uncertainty regarding future pregnancy, and decisions about when further professional assistance should be sought (7). Patient-centred early pregnancy care therefore requires more than technically appropriate treatment; patients and their partners value clear information, sensitive communication, involvement in decision-making, continuity, and respectful recognition of their individual experiences (8). Studies of emergency care following early pregnancy loss have similarly identified fragmented care, repeated histories, limited emotional attention, and uncertainty surrounding follow-up as important sources of dissatisfaction and distress (9,10).

Digital health approaches may provide an opportunity to extend support beyond the clinical encounter, particularly because individuals experiencing miscarriage frequently seek health information, reassurance, and peer support online. Women experiencing early pregnancy loss have expressed interest in digital resources that provide credible information, symptom guidance, emotional support, and links to appropriate services, particularly when content can be adapted to individual needs and stages of recovery (11). Online miscarriage communities may also reduce isolation and facilitate the exchange of informational, emotional, and experiential support; however, such environments may expose users to inaccurate information, triggering content, unmoderated advice, and variable standards of support (12). Evidence regarding the effectiveness of formal peer-support interventions after miscarriage also remains limited, indicating that accessibility alone is insufficient and that digital support requires appropriate clinical governance, personalization, safety mechanisms, and pathways to professional care (13).

Support needs extend beyond the individual physically experiencing the pregnancy loss. Partners may experience substantial grief while simultaneously assuming a caregiving role, yet their own emotional needs can remain socially and clinically unrecognized (14). Maternity professionals are likewise expected to provide compassionate bereavement care within environments constrained by workload, time, organizational expectations, training needs, and the emotional demands of caring for bereaved families (15–18). Consequently, a digital pathway designed exclusively around the patient interface may overlook the wider relational and clinical system within which recovery occurs. Partner inclusion must therefore preserve patient autonomy and privacy, while digital communication with healthcare services should complement rather than create additional unstructured workload for professionals.

Despite increasing interest in digital approaches to miscarriage support, limited evidence has examined patients, partners, and maternity professionals together to determine how compassionate post-loss digital care should be structured. Existing evidence identifies important needs relating to credible information, emotional acknowledgement, partner support, continuity, and access to professional assistance, but less is known about how these requirements converge or conflict across stakeholder groups (7,8,11,14–18). This study therefore explored how patients, partners, and maternity professionals conceptualized compassionate digital support following early pregnancy loss, with particular attention to the characteristics such support should include, features that may be experienced as inappropriate or unsafe, and the ways in which digital support should connect users with existing healthcare services.

MATERIALS AND METHODS

Study Design

A qualitative descriptive design informed by an interpretive orientation was used to explore how different stakeholder groups understood compassionate digital support following early pregnancy loss. This approach was selected because the study sought to generate practically relevant design implications while retaining attention to participants' experiences, emotions, relationships, and healthcare contexts. Reporting was informed by the Consolidated Criteria for Reporting Qualitative Research (COREQ), particularly those domains relating to study design, data collection, analysis, reflexivity, and presentation of findings (19).

Participants and Analytic Dataset

The analytic dataset comprised 15 participant profiles representing three stakeholder groups: seven patients with a history of pregnancy loss within the first 14 weeks of gestation, four partners, and four maternity professionals. The professional group comprised two midwives, one obstetrician, and one early pregnancy nurse. Maximum-variation principles were used in constructing the analytic sample so that differences in age, previous pregnancy experience, clinical management, and professional role or mode of clinical care were represented. Participants were identified in the analysis using stakeholder-specific identifiers to preserve anonymity: P for patients, PT for partners, and MP for maternity professionals. No directly identifying clinical information was reported.

Data Collection Domains

The interview guide addressed experiences of information and follow-up after pregnancy loss, emotional support, partner involvement, preferences regarding digital support, privacy, potentially triggering content, communication with healthcare professionals, and perceived safety requirements. Particular attention was directed toward the ways in which digital services might respond to changing informational and emotional needs, support partners without compromising patient autonomy, and facilitate access to professional assistance where concerns exceeded the appropriate scope of self-management or automated support.

Ethical Considerations

Ethical approval for the research was reported as having been obtained from Universitas Prima Indonesia. The study procedures emphasized voluntary participation, confidentiality, anonymized identities, and the right to discontinue engagement with questions that participants found emotionally difficult. Participant identifiers used in reporting reflected stakeholder group only, and no directly identifying clinical information was included in the manuscript.

Data Analysis

Data were analyzed using Braun and Clarke's reflexive thematic analysis (20). The dataset was read repeatedly to support familiarization with stakeholder accounts and to identify patterns relevant to the research question. Initial semantic and interpretive codes were generated and subsequently organized into candidate themes. Analysis deliberately compared the accounts of patients, partners, and maternity professionals rather than assuming consensus across stakeholder groups. Areas of convergence and tension were retained during theme development. For example, proactive contact was valued by some participants, whereas others emphasized the need to avoid unwanted notifications or intrusive communication. Candidate themes were progressively refined to improve internal coherence and conceptual distinction and were subsequently mapped to implications for digital service design. Reflexive memoing was used to distinguish preferences that varied according to individual circumstances from safety-related requirements considered relevant to clinical escalation and governance. The final analysis generated four interrelated themes concerning recognition, staged information, partner inclusion, and human connection and escalation.

RESULTS

The analytic dataset included seven patient profiles, four partner profiles, and four maternity-professional profiles. Four interrelated themes were developed: recognition before information; staged, clinically anchored guidance; inclusion of partners without displacing the patient; and human connection, choice, and escalation as safety functions. Across the themes, participants did not describe a fully automated application or a static information repository as an adequate model of post-loss support. Instead, their accounts suggested a digitally enabled pathway that acknowledged the loss, provided information according to changing needs, preserved user control, and maintained visible routes to human assistance.

Theme 1: Recognition Before Information

Participants described the emotional tone and sequencing of the first digital contact as important components of compassionate support. Patients emphasized that acknowledgement of the loss should precede instructional material, educational modules, or recovery-oriented tasks. P2 expressed this distinction directly: “a checklist should not be first. I required something that would state the fact that it

was a loss and whatever I was experiencing was not something that I was forbidden to experience." The preference was not for extensive sentimental messaging but for concise acknowledgement that recognized the significance of the experience without prescribing a particular grieving response.

Automated pregnancy-related content was identified as a particular source of distress when it continued after a pregnancy loss. P5 described this experience: "The most terrible online experience was receiving a message about what size the baby would be this week. A support system must cease the pregnancy content." Participants therefore viewed the ability to suppress inappropriate pregnancy notifications as a safety-related feature rather than a matter of convenience. At the same time, preferences for post-loss contact varied. P7 stated: "I want to decide how I want to receive the gentle check-in, practical information only; or nothing at the moment." These accounts indicated that compassionate communication required both recognition and control over the timing and intensity of subsequent contact.

Maternity professionals supported the need for acknowledgement but cautioned against digital systems attempting to reproduce human empathy through formulaic messaging. MP1 observed that "when all the messages sound like a template, people will realize that it is automated and they will feel even more alone, rather than less." Across stakeholder accounts, compassion was therefore associated less with the quantity of supportive language than with appropriate tone, timing, recognition, and responsiveness.

Theme 2: Staged, Clinically Anchored Guidance

Participants described information needs as changing over time rather than remaining constant throughout recovery. In the immediate period following pregnancy loss, patients prioritized practical information concerning bleeding, pain management, warning signs, and routes to urgent assistance. As recovery progressed, questions shifted toward menstruation, future attempts to conceive, emotional responses, work, intimacy, and subsequent pregnancy.

Uncertainty about what constituted an expected recovery experience was a prominent concern. P1 described repeatedly searching different online sources because of uncertainty about what was normal and expressed a preference for a single reliable resource responsive to the stage of recovery. P4 similarly emphasized the importance of boundaries around self-management and professional contact: "I did not expect more information, I needed something I could rely on and a clear boundary of when to call someone." Maternity professionals supported this distinction between information and diagnosis. MP3 stated that "the platform must never diagnose and only assist people in identifying red flags and clarifying the typical recovery patterns as well as relating them to the appropriate service."

Participants also described differences in their capacity to process information following loss. Rather than presenting comprehensive information simultaneously, they preferred content that could be accessed progressively. P6 explained: "On some days, I would manage to read everything and on other days, I would hardly have the capacity to read a paragraph so the information must appear in small bits." The theme therefore indicated a preference for clinically anchored information that could be layered according to immediate need, while maintaining clear boundaries regarding circumstances requiring professional assessment.

Theme 3: Include Partners Without Displacing the Patient

Partners described occupying a dual position in which they were expected to support the person experiencing the physical loss while also managing their own emotional response. PT1 explained: "Everyone inquired how she was, and I was glad they cared, but no one inquired what I had seen and how I was coping since I had to be the strong one." Partner-specific digital resources were therefore perceived as potentially useful for addressing grief, caregiving, communication, return to work, and recognition of circumstances in which either member of the couple might require additional support.

Privacy and autonomy were central to how partner inclusion was conceptualized. PT3 described a preference for a separate space in which support could be accessed without creating an additional emotional burden for the patient: "I would utilize support more in order to know that I could read or ask something, without making my partner feel that she had to take care of me as well." Patients generally

supported partner-specific resources when these did not provide automatic access to private clinical information. P3 summarized this distinction: “Provide partners with their own support, though I choose what to share about my medical information.”

Maternity professionals further emphasized that partner inclusion should not be based on assumptions regarding family structure or the desired involvement of others. MP2 stated that “the system must be partner friendly, single patient and same-sex friendly and not necessarily want the family involved. Inclusion is about choices, not presumptions.” Collectively, these accounts positioned partner support as complementary to patient-centred care rather than as an equivalent pathway that displaced the person experiencing the physical effects of pregnancy loss.

Theme 4: Human Connection, Choice, and Escalation as Safety Functions

Across stakeholder groups, participants rejected a model in which digital technology operated as a complete substitute for human care. Immediate and private access to digital support was valued, but participants wanted visible and credible routes to professional or other human assistance when needs became more serious. PT4 described the distinction as follows: “a chatbot would assist at two in the morning, but he would require knowing that there is another person or service behind the chatbot in case things got serious.” Maternity professionals framed escalation as an issue of clinical governance rather than simply user preference. MP4 stated that “when the platform inquires of the desperate distress or excessive hemorrhage, there should be a response channel put into place rather than gathering hazard data without taking any action.” Accordingly, participants conceptualized the digital pathway as an interface connecting self-management, peer support, maternity services, primary care, and mental-health support rather than as an isolated digital intervention.

Choice remained important even where contact was intended to be supportive. Participants wanted control over notification frequency, language, exposure to peer content, and reminders associated with anticipated due dates or anniversaries. Their accounts suggested that greater digital interaction was not inherently more compassionate. Instead, a supportive system was characterized by its ability to reduce contact when requested, provide clearer direction where potential risk was identified, and facilitate access to professional help without repeatedly requiring users to recount the pregnancy loss. Taken together, the four themes indicated that participants conceptualized compassionate digital support as a relational extension of existing care in which acknowledgement, credible information, autonomy, partner inclusion, and human escalation operated as interconnected design requirements.

DISCUSSION

This study explored how patients, partners, and maternity professionals conceptualized compassionate digital support following early pregnancy loss and identified four interconnected priorities: acknowledgement of the loss before information delivery, staged and clinically anchored guidance, inclusion of partners without compromising patient autonomy, and preservation of human connection and escalation pathways. Rather than describing digital technology as a replacement for existing maternity services, participants conceptualized it as an extension of care that could reduce informational fragmentation while preserving choice and access to professional assistance. This interpretation is consistent with evidence showing that people experiencing early pregnancy loss frequently encounter fragmented follow-up, unmet informational and emotional needs, and uncertainty regarding where to obtain subsequent support (7–11). It also extends previous work by demonstrating that digital acceptability appears to depend not only on information availability but also on how digital systems recognize loss, regulate communication, accommodate relational needs, and connect users with appropriate human care.

Recognition before information emerged as an important characteristic of compassionate digital communication. Participants did not reject clinical information; rather, they emphasized that immediate exposure to instructions, recovery tasks, or automated pregnancy-related material could feel insensitive when the loss itself had not first been acknowledged. This finding corresponds with qualitative evidence indicating that validation, sensitive communication, and recognition of grief strongly influence experiences

of care following pregnancy loss (4,5). Patient-centred early pregnancy care similarly depends on respectful communication, involvement, continuity, and acknowledgement of both patients and partners rather than solely on technically appropriate clinical management (8). The present findings therefore suggest that the sequencing and tone of digital communication may be as important as its informational content. At the same time, professional participants cautioned against formulaic attempts to reproduce human empathy through automation. Digital systems should therefore acknowledge the experience clearly and respectfully without implying that automated communication can substitute for genuine interpersonal support.

The preference for staged, clinically anchored information reflects the changing informational needs that can follow early pregnancy loss. Participants prioritized bleeding, pain, warning signs, and urgent contacts during the immediate recovery period, whereas later concerns included menstruation, future conception, emotional adjustment, relationships, work, and subsequent pregnancy. Previous studies have similarly identified uncertainty regarding recovery, inconsistent explanations, fragmented follow-up, and difficulty determining when additional care is required (7,9,10). Interest in miscarriage-specific digital resources has also been associated with access to credible information, symptom guidance, psychosocial support, and connections with healthcare services (11). The present findings add a temporal dimension to these requirements by suggesting that information should not necessarily be delivered simultaneously. Layered content that permits users to access concise guidance first and more detailed material when required may be more consistent with fluctuating emotional and cognitive capacity after loss. Such personalization should nevertheless remain clinically bounded: a digital system may help users recognize warning signs and identify appropriate services, but participant accounts did not support autonomous diagnosis or replacement of clinical assessment.

Partner inclusion represented a substantive component of compassionate support rather than an optional extension of patient-facing care. Partners described simultaneously providing support and managing their own emotional responses, consistent with evidence that partners may experience significant grief while perceiving themselves to be overlooked by health services and social networks (14). Previous evidence on patient-centred early pregnancy care also indicates that partners value appropriate information, communication, and inclusion (8). The current findings refine this principle by emphasizing that inclusion should not result in unrestricted access to patient information or assumptions regarding family structure. Participants instead favored parallel resources through which partners could obtain information and emotional support independently while patients retained control over the disclosure of personal clinical information. This approach may allow digital services to broaden the available support network without weakening patient privacy or shifting attention away from the individual experiencing the physical consequences of pregnancy loss.

Human connection and escalation were particularly important where participants considered clinical deterioration, severe emotional distress, or needs exceeding the scope of self-management. Interest in digital miscarriage tools and online communities demonstrates the potential value of accessible information and peer connection, but digital and peer-based support cannot be assumed to provide effective or clinically adequate responses in all circumstances (11–13). Healthcare professionals participating in the present study expressed concern about digital platforms collecting information suggestive of serious physical or psychological risk without having a defined response pathway. This concern is relevant to broader evidence showing that professionals providing bereavement and pregnancy-loss care already encounter training needs, emotional demands, organizational constraints, and workload pressures (15–18). Digital implementation should therefore specify the boundaries of automated support, the circumstances that trigger escalation, the service responsible for receiving escalated concerns, expected response processes, and arrangements when routine services are unavailable. Without such governance, digital contact could create an impression of clinical oversight that the system is not equipped to provide.

The findings have practical implications for the co-design of post-loss digital services but should be interpreted as stakeholder-derived design requirements rather than evidence that particular digital

components improve clinical or psychological outcomes. Candidate features arising from participant accounts include early suppression of inappropriate pregnancy-related notifications, brief acknowledgement of the loss, user-controlled communication preferences, staged recovery information, clear presentation of warning signs, optional partner-specific resources, privacy controls, and visible routes to human support. The importance of credible information, emotional support, continuity, and professional connection is consistent with the existing literature (6,8,11–13). However, these components require prospective evaluation rather than implementation on the assumption of effectiveness. Appropriate outcomes for subsequent feasibility and implementation work could include acceptability, usability, perceived recognition, decisional confidence, unmet support needs, successful escalation, unintended emotional distress, and the effect of the pathway on service use.

Several limitations should inform interpretation of the findings. The analytic dataset was small and intentionally qualitative, comprising seven patient profiles, four partner profiles, and four maternity-professional profiles; consequently, the findings should not be interpreted as estimates of the prevalence or relative importance of particular preferences. The represented stakeholder groups may not capture the full diversity of cultural, linguistic, socioeconomic, reproductive, relational, or healthcare experiences associated with early pregnancy loss. Digital approaches may also reproduce or intensify inequities for people with limited connectivity, low digital or health literacy, disabilities, language barriers, or concerns regarding privacy and data use. Existing evidence already demonstrates variation in psychological support, healthcare experiences, and digital preferences following pregnancy loss (6,7,11). Future research should therefore include more diverse populations, participatory co-design, explicit assessment of accessibility and equity, and mixed-method feasibility evaluation before conclusions are drawn regarding effectiveness or implementation at scale.

CONCLUSION

Patients, partners, and maternity professionals in this qualitative study conceptualized compassionate digital support after early pregnancy loss as an extension of relational healthcare rather than a replacement for professional services. Their accounts emphasized acknowledgement of the loss before information delivery, clinically credible guidance provided in manageable stages, independent support for partners while preserving patient privacy and autonomy, user control over digital communication, and clear routes to human assistance when needs escalate. These findings provide stakeholder-informed requirements for the design of future digital pathways but do not establish the effectiveness of any specific digital intervention. Further co-design and feasibility evaluation are required to determine whether such approaches can provide acceptable, emotionally safe, accessible, and clinically governable continuity of support following early pregnancy loss.

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