Simulation Script

Grief Counseling for Early Pregnancy Loss

Location: Outpatient Consultation Room
Characters:
Doctor: A trainee (resident physician).
Patient: Portrayed by a Nurse Standardized Patient (Nurse-SP) as "Ms. Li".

Case Profile:
28 years old, first pregnancy. Ultrasound at 6 weeks of gestation confirmed an intrauterine pregnancy with fetal cardiac activity. Now at 9 weeks of gestation, she presents with minor vaginal bleeding. Current ultrasound shows: intrauterine pregnancy, CRL 20mm, no fetal heart activity. The patient is anxious and unaccompanied by family.

Task: The doctor needs to explain the diagnosis and management options to the patient, and provide emotional support.

Opening (Building Trust & Role Clarification)
Patient: Holds the ultrasound report, knocks and enters.
Doctor: Hello, are you Ms. Li? Please have a seat. I'm Dr. Chen, consulting with you today. Did you come alone today, or is there a family member with you?
Patient: I came by myself today, Doctor.
Doctor: I see, that's perfectly fine.
Observation Point: Whether the doctor actively introduces themselves and shows concern for privacy and patient comfort.

Assessing the Patient's Understanding and Emotional State
Doctor: Can you tell me if you've had any recent discomfort? For example, abdominal pain or vaginal bleeding?
Patient (in low spirits): I noticed a little vaginal bleeding this morning when I urinated. Just a very small amount, no abdominal pain.
Doctor: Any other discomfort?
Patient: Last week I felt nauseous and had no appetite, but that's gone away in the last few days.
Doctor: I'd like to understand first, you've just seen this ultrasound report. What is your understanding of the result right now?
Patient: The sonographer said there's no heartbeat... but I haven't felt any major discomfort. How could this happen? Could there be a mistake?
Doctor (nods, speaking gently): I understand this is very difficult to accept. Let's look at the results together first, and then I'll explain everything in detail to you.

Observation Point: **Whether the doctor assesses the patient's emotional and cognitive state, and responds with empathy while giving space.**

Explaining the Diagnosis and Cause (Layman's Terms & Avoiding Patient Self-Blame)

Doctor: Based on these two ultrasound results, the absence of a fetal heartbeat indicates that this pregnancy has not continued to develop. Medically, we call this a "missed miscarriage," meaning the embryo stopped developing very early on.

Patient: Did I do something wrong? I worked overtime a few days ago. Did my tiredness cause this?

Doctor: That's a question many patients ask. In fact, spontaneous miscarriage or early pregnancy loss in the first trimester is not uncommon, occurring in about 15-20% of pregnancies. In early miscarriages, over 50% are due to chromosomal abnormalities in the embryo itself. This is part of natural selection and has very little to do with your work, diet, or emotions. Please try not to blame yourself.

Patient: Did I come too late? If I had seen a doctor earlier, could my baby have been saved?

Doctor: That's not related. Most spontaneous miscarriages are due to abnormalities in the embryo itself, and in most cases, it's a one-time, random event.

Patient: Then what exactly caused my baby's loss?

Doctor: As we just mentioned, over 50% of early miscarriages are due to chromosomal abnormalities in the embryo, which is part of natural selection.

Patient: Chromosomes? Does that mean there's something wrong with me?

Doctor: No. Chromosomal abnormalities in the embryo are usually random errors. In most cases, they are not related to the parents' chromosomes. Only in a minority of cases is it related to a balanced translocation in the father's or mother's chromosomes. For couples with recurrent miscarriages, we usually recommend chromosomal testing. As this is your first miscarriage, we don't routinely recommend chromosomal analysis of the pregnancy tissue. However, if you wish to understand the cause of this loss as much as possible, you can request chromosomal testing on the tissue after the miscarriage.

Patient: What's the use of doing this chromosomal test?

Doctor: It can help us understand the cause of this miscarriage and estimate the risk for future pregnancies.

Observation Point: **Whether the doctor explains the diagnosis and cause in simple language and alleviates the patient's sense of self-blame and guilt.**

Acknowledging Emotions and Expressing Empathy

Patient: Will I be able to have a normal baby after this miscarriage?

Doctor: I understand your concern. Most women who experience one miscarriage can go on to have a normal pregnancy. Generally, the chance of having two consecutive miscarriages is less than 2%. Of course, we can also do some evaluations later to help you prepare better.

Observation Point: **Whether the doctor expresses empathy and gives the patient space.**

Presenting Management Options and Shared Decision-Making

Patient: So, what should I do now?

Doctor: Yes, we need to discuss how to proceed. For this situation, we have three management options:

Medical Management: Using medication to help the uterus expel the pregnancy tissue. Suitable for those who prefer a more natural process.

Surgical Management (D&C): A quicker procedure to complete the process. Suitable for those who wish to resolve it promptly.

Expectant Management: Waiting for natural expulsion, but the timing is uncertain.

I can explain the pros and cons of each method in detail. You can also tell me your thoughts, and we can decide together.

Patient: I'm afraid of pain, and I want to get this over with quickly.

Doctor: Then we could consider medical management. Its success rate is around 80%. The process is similar to a heavy period but may involve cramping and bleeding. If you agree, I can arrange for you to be admitted for observation.

Patient: Is having a miscarriage safe? Could there be any complications?

Doctor: It is safe in most cases. A small number of people may experience incomplete miscarriage requiring a D&C, infection, or a slightly increased risk of difficulties in future pregnancies or ectopic pregnancy, but the incidence is very low.

Patient: I can't decide what to do right now. Can I go home and discuss it with my husband first?

Doctor: Of course. This is not a situation that requires urgent intervention. However, during the waiting period, a small number of people may experience heavy bleeding. If you have signs of heavy bleeding, you need to come to the hospital immediately.

Observation Point: Whether the doctor explains the pros and cons of each option and demonstrates shared decision-making.

Explaining Follow-up and Future Support

Doctor: Regardless of the option you choose, we will schedule a follow-up in 1-2 weeks to confirm that everything has passed. After that, we will also assess your physical recovery and, if necessary, recommend some tests to prepare for a future pregnancy.

Patient: After this miscarriage, when can I try to get pregnant again?

Doctor: Once your menstrual cycle returns to normal, and you feel emotionally ready, and you and your partner feel you want to try again, you can start preparing for pregnancy.

Observation Point: Whether the doctor explains the follow-up plan.

Summarizing and Confirming Understanding

Doctor: Today, we mainly confirmed the diagnosis of a missed miscarriage and discussed three management options. You are leaning towards medical management. You can go home and discuss the final decision with your husband, as well as whether to have the tissue tested. We will arrange the next steps based on your decision. Do

you have any other questions?

Patient: No, thank you, Doctor.

Doctor: You're welcome. Please contact us anytime if you have any emotional or physical discomfort. We are here for you.

Observation Point: Whether the doctor summarizes the key points of the consultation and confirms understanding.