University College London

Recommendations for the adoption of evidence-based policy language for communicating about pregnancy loss

Context

The language used by clinicians and policymakers has a lasting impact on those who experience a loss during pregnancy. Individuals who have received care for pregnancy loss in the UK report that 'bad' language practice contributed to the trauma of their experience, while others reported the positive impacts of considered language choices on their recovery and wellbeing[1].

Clinicians have long recognised this significant aspect of their care, with numerous calls for terminology reform in maternity contexts[2,3]. Language guidelines, such as those published by the Royal College of Obstetricians and Gynaecologists, have also sought to "create consistency, fairness and inclusivity" via recommended terminological substitutions[4]. **Until recently, however, a lack of empirical data has made it difficult to support and implement such recommendations.**

"[T]he way I was spoken to and my baby was spoken about has had a profound and long lasting impact on how I have handled the loss"
(Lived experience participant)

The research

This brief is based on work carried out at University College London since 2021.

In 2024, following consultation with hundreds of professional and lived experience stakeholders, we published a report[1] which concluded that no "one size fits all" approach to language choice is possible. It called for the development of a trauma-informed framework for clinical interactions during and after pregnancy loss, which **respects and accommodates individual language needs.**

Building on this recommendation, further research[5] addressed contexts where such individualisation is not possible; so-called 'mass communication' (e.g. policy and public health information). Based on quantitative survey data from UK service users, it established a set of words and phrases that would **minimise harm and confusion for the majority in mass communication contexts.**

"I see clients years later who are still distressed by the language that was used"
(Healthcare professional participant)

Key Recommendations

Policymakers need to take steps towards adoption of an evidence-based set of standardised terminology for pregnancy loss in mass communication settings, by:

1. **Eliminating** words and phrases found to cause distress or confusion to a majority of individuals exposed to them from communication in these contexts.
2. **Adopting** existing, alternative words and phrases found to be acceptable to a majority of individuals exposed to them, in their place.
3. **Identifying and implementing** suitable substitutions where no acceptable alternatives exist.

Methodology

391 individuals with experience of accessing UK healthcare services for pregnancy loss between April 2021 and July 2024 voluntarily took part in an anonymous online survey.

Respondents were asked about their recollection and perception of terminology used to describe (a) their experience of loss and (b) their baby, within healthcare settings (such as hospitals and GP surgeries) and outside of them (such as interactions with family or friends). The survey was distributed via email and social media, with the help of partner charity organisations.

Patient and Public Involvement

People with lived experience of pregnancy loss contributed to the development of all the projects feeding findings into this document. Recruited via social media, they contributed via written contributions, online surveys, and focus groups.

Clinicians, clinical academics and charity collaborators formed an Expert Advisory Group, which have met at annual symposia facilitating conversations about challenging aspects of pregnancy loss nomenclature, since 2023.

Key Findings

The research gathered empirical data to investigate
a) **how often** service users were exposed to specific words and phrases in healthcare settings, and
b) **how acceptable** they perceived them to be.

Exposure

Several terms long identified as **inappropriate** in the clinical literature[6] are still recalled in use in UK healthcare contexts in the period 2021–24, but only by <10% of respondents: *Spontaneous abortion, habitual abortion, incompetent cervix, cervical incompetence, blighted ovum, [implantation] failure*.

Uses of outdated terms such as spontaneous abortion may be attributed to health information on surgical management for first trimester loss, which often overlaps with Termination of Pregnancy (ToP) services.

Other terms identified as **confusing, distressing or invalidating** in more recent recommendations and reviews[1] are recalled more frequently, by 25–65% of respondents: *empty sac, chemical pregnancy, non-viable pregnancy, missed miscarriage*.

Miscarriage is the term most often recalled as used to describe losses before 24 weeks' gestation, despite distress reportedly caused by this term's **implied culpability** and **diminishing of the experience**, particularly of loss around 18–23 weeks' gestation[1]. More "neutral"[1] alternatives such as *pregnancy loss* are recalled significantly less frequently.

A wide range of **clinical** terms are recalled being used to describe the baby for losses earlier in pregnancy (prior to 14 weeks' gestation), in 20–65% of cases: *cells, contents of the uterus/other, fetus, non-viable, pregnancy tissue, product of conception, products, tissue*.

Such 'cold' clinical terminology is reported to have a profound impact on some people exposed to it, where it clashes with their own conceptualisation of their baby as a person.

For losses after 14–17 weeks' gestation, **description of the baby which assigns fetal personhood is most commonly recalled**. Exposure to *baby* and *'their given name'* increases sharply, alongside a *stillborn*. Exposure to most other clinical terms decreases to <10% for losses after 18 weeks' gestation.

However, there are exceptions. *Pregnancy tissue* continues to be recalled by 18% of respondents for losses between 18–23 weeks' gestation despite the distress it can cause[1]. *Fetus* is recalled by 42% in this bracket and continues to be recalled by a minority (25%) for losses as late as 40+ weeks.

These findings indicate that recommendations for language use in contexts of pregnancy loss are not reaching UK service providers, or are filtering through only piecemeal, and that nomenclature considered problematic continues to be used.

Acceptability

Unacceptable terms for the experience

Contested terms such as spontaneous abortion, incompetent cervix/cervical incompetence/cervical insufficiency are all considered unacceptable by a clear majority (>80%) of respondents with experience of pregnancy loss. Clinical jargon such as *intrapartum fetal death* and *intrauterine death* are considered unacceptable by a majority (65–80%). *Chemical pregnancy, blighted ovum* and *empty sac* are considered unacceptable by a smaller majority (50–65%).

Acceptable terms for the experience

Pregnancy loss, recurrent pregnancy loss and *ectopic pregnancy* are all considered acceptable by a clear majority (>80%) of those with lived experience of losses across all gestations. *Stillbirth* is considered acceptable by a clear majority of individuals with experience of loss after 24 weeks' gestation.

Terms which divide responses

Miscarriage and *Termination for Medical Reasons* prompt mixed or divided responses, which vary according to gestational bracket at which loss occurred.

Unacceptable terms for what is lost

Clinical terms for pregnancy loss outcomes, such as *products (of conception)*, *contents of the womb/uterus* and *tissue*, are all considered unacceptable by a clear majority (>80%) of those with experience of pregnancy loss prior to 24 weeks' gestation. The terms *non-viable* and *pregnancy tissue* are considered unacceptable by a majority (65–80%).

Acceptable terms for what is lost

Baby and a *given name* are considered acceptable ways of referring to what was lost by >80% of individuals with experience of pregnancy loss, across all gestations.

Terms which divide responses

Fetus is considered acceptable by a majority (69%) of those who experienced loss prior to 14 weeks' gestation. However, a marginal majority (52%) consider *fetus* unacceptable for losses at 14–17 weeks' gestation and this increases steadily to a clear majority (>90%) for losses after 24 weeks.

Recommended/suggested language choices for mass communication contexts

Unacceptable language	Recommended (existing) alternative
Spontaneous abortion	*Pregnancy loss/Surgical management for pregnancy loss*
Chemical pregnancy	*Early pregnancy loss*
Miscarriage (for losses at 18–23 weeks)	*Pregnancy loss*
Intrapartum fetal death	
Intrauterine death	
Intrapartum stillbirth	
Fetal death	
Fetal loss	
Blighted ovum	*Anembryonic pregnancy*
Empty sac	
Fetus (for losses at/after 14 weeks)	*Baby*
Unacceptable language	**Suggested alternative (based on experiencer contributions)**
Incompetent cervix/cervical incompetence/ cervical insufficiency	*Preterm cervical shortening*
Products of conception	Where necessary, for example when discussing removal of placental tissue or uterine lining following an incomplete loss, or in addition to the baby, consider using this language in an additive way, i.e. the baby and other pregnancy tissue
Contents of the womb/uterus	
Tissue	
Products	
Non-viable (both baby and pregnancy)	
Pregnancy tissue	

Reproductive & Sexual Health Communication Alliance

Collaborators

Tommy's
The pregnancy and baby charity

sands

Petals

MISCARRIAGE ASSOCIATION
The knowledge to help

The Ectopic Pregnancy Trust

Antenatal Results & Choices

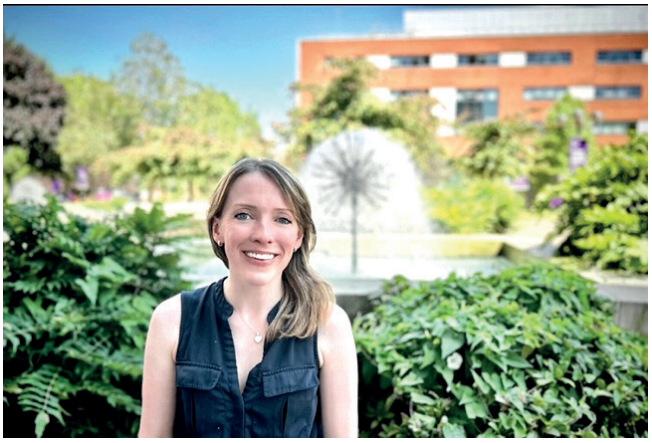
Contact the researchers

Dr Beth Malory
University College London

Email: b.malory@ucl.ac.uk

Louise Nuttall
University College London

Email: louise.nuttall@ucl.ac.uk



[1] Malory B. *Engaging Stakeholders to Explore Linguistic Challenges in Communicating about Pregnancy Loss: Final EStELC Project Report.* Survey of English Usage, University College London; Sept 2024.

[2] Silver RM, Branch DW, Goldenberg R, Iams JD, Klebanoff MA. Nomenclature for Pregnancy Outcomes: Time for a Change. *Obstet Gynecol.* 2011 Dec;118(6):1402–8.

[3] Vimalesvaran S, Ireland J, Khashu M. Mind your Language: Respectful Language within Maternity Services. *The Lancet.* 2021 Mar;397(10277): 859–61.

[4] Royal College of Obstetricians and Gynaecologists. RCOG Language Guide. *Royal College of Obstetricians and Gynaecologists;* 2022.

[5] Malory B & Nuttall L. *Acceptability in Pregnancy Loss Language: Final SuPPL Project Report*. Survey of English Usage, University College London; Nov 2024.

[6] Cameron MJ & Penney GC. Terminology in Early Pregnancy Loss: What Women Hear and What Clinicians Write. *Journal of Family Planning and Reproductive Health Care*, Oct 2005, 1;31(4):313–4.

[7] Malory B, Nuttall L & Heazell AEP. Acceptable Nomenclature for Pregnancy Loss Care: A Cross-sectional Observational Survey. *BJOG*, 2025 Oct 11.