

WOMEN'S EXPERIENCES OF MISCARRIAGE IN THE EMERGENCY DEPARTMENT



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Contribution to Emergency Nursing Practice

- The current literature on miscarriage in the emergency department indicates that women are often dissatisfied with the services they have received.
- This article contributes findings of this study that women's difficult experiences with miscarriages are exacerbated by lack of information at 3 critical junctures.
- Key implications for emergency nursing practice found in this article are that through demonstrating compassion, combined with providing clear and detailed information about the course of a miscarriage, nurses can help women cope with this difficult experience.

Abstract

Introduction: Miscarriage is a common event, usually managed in the emergency department. Although studies have examined the impact of miscarriage on women's mental health and the effects of their dissatisfaction with health care received, little is known about the characteristics of the miscarriage experience in the emergency department. The objective of

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this study was to identify characteristics of care management that may have contributed to the difficulties experienced by women presenting with miscarriage in the emergency department.

Methods: Forty-eight women treated at 4 emergency departments in different regions of Quebec, Canada, were interviewed for 60 to 90 minutes. A thematic qualitative analysis of these interviews was performed.

Results: Analyses revealed that participants' experiences were characterized particularly by a lack of information at 3 critical junctures of the miscarriage experience: the announcement of the miscarriage, the course of the miscarriage, and the ED discharge. The topics on which the women lacked information were categorized into 7 subthemes within these junctures.

Discussion: Lack of information throughout the care management of miscarriage exacerbated the already-difficult nature of this event for the participants. Training emergency nurses to give adequate and complete information enables the delivery of compassionate care, potentially making a difficult situation less traumatic.

Key words: Miscarriage; Emergency department; Information; Qualitative study; Women's experience; Emergency nursing

Introduction

The prevalence of miscarriage remains fairly high in Western countries, with 15% to 20% of pregnancies ending within the first 20 weeks.^{1,2} Miscarriage has major repercussions in women, both physically and psychologically, that can last more than 2 years.^{3,4} The mental health effects include increased risk of depression, anxiety, and obsessive-compulsive and post-traumatic stress disorders.³⁻¹⁰ Most studies on factors that negatively affect women's mental health after miscarriage have focused on nonmodifiable personal characteristics such as childlessness, maternal mental health history, and low income.^{3,6} Research on care-related factors that could affect psychological well-being is limited. Some studies have

TABLE

Interview guide: The course of the miscarriage and experience with the health care system

- Can you tell us about the course of the miscarriage (warning signs, etc)?
- Which health services did you use?
- Tell us about these health services.
- What were your needs?
- How were your needs addressed?
- How was the triage experience in the emergency department?
- How did you learn that the pregnancy was over or was about to end in miscarriage? What happened from the moment you knew you had a miscarriage to the expulsion of the baby? How were your questions answered?
- How would you describe the work of the health care professionals (nurses, physicians, others) at the time of discharge from the emergency department?
- If you were admitted in the hospital, tell me about the next hours. What were your needs? What was the response to your needs by health care professionals and by the provision of health services?
- In general, how did the health care professionals (nurses, physicians, others) assist you in this miscarriage experience?

identified quality of services received during miscarriage³ and health care professionals' emotional support, compassion, and sensitivity as protective factors for women's mental health.¹¹⁻¹³ However, studies also have found that women are generally dissatisfied with their care, mainly because of professionals' lack of support, insensitivity, and failure to provide essential information and advice during and after miscarriage.^{12,14-18} Research has also indicated that these deleterious experiences could contribute to depression and have a lasting negative effect on women's mental health.³ Given the importance of supportive attitudes and services for women's well-being, it is essential to understand which elements of emergency management exacerbate women's already-difficult experience of miscarriage.

Methods

SETTING AND PARTICIPANTS

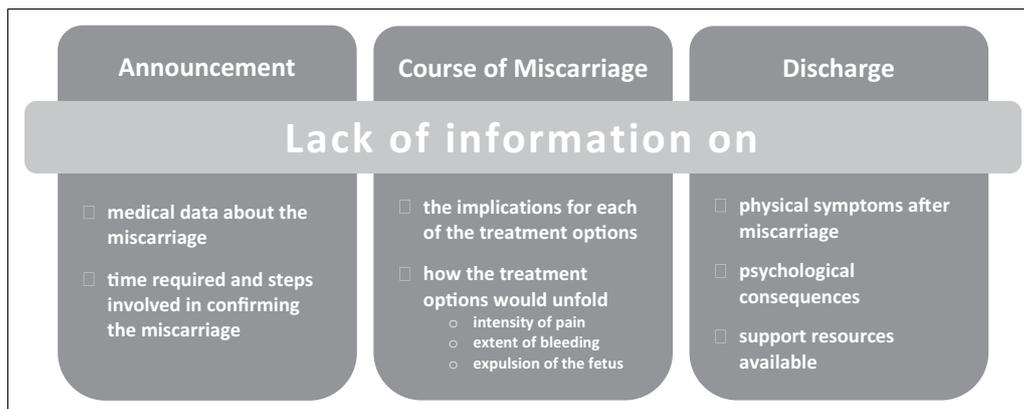
This phenomenological study was conducted in Quebec, Canada, and received Research Ethics Committee approval. The 4 selected facilities represented a range of characteristics in terms of population served (urban, semi-urban, rural) and had a combined 147 ED beds. Participants were recruited by health professional informants (nurses, midwives, physicians) who distributed flyers to patients meeting the following inclusion criteria: women 18 years of age or older, who had experienced at least 1 miscarriage (20 weeks or less) in the past 4 years, had consulted 1 of the 4 emergency departments and been diagnosed with a miscarriage, and could speak and understand French. Posters describing

the study with contact information for this research were also placed in strategic locations throughout the hospitals and posted on social media. Participants expressing interest in volunteering for this study were contacted via telephone by a research assistant to schedule a 60- to 90-minute semi-structured face-to-face interview with a female research team member (Table). Each participant was provided with the opportunity to choose the interview location at either her home or a room at the university. Informed consent was obtained at the beginning of the interview process. Participants were not compensated for the interview, and none of them dropped out. Interviews were audio-recorded and then transcribed verbatim; anonymized and fictitious names were created.

Forty-eight women participated in the study. Almost all (98%) were Canada-born. Ages ranged from 22 to 41 years (mean = 32). Thirty-four worked full time (76%); 6 others were students (N = 2), unemployed (N = 3), or on sick leave (N = 1). Mean family income was 83,000 Canadian dollars. The majority (N = 32; 70%) had experienced 1 miscarriage, 6 (13%) had experienced 2, and 8 (17%) had experienced 3 to 5.

DATA ANALYSIS

The sample size was 48, although theoretical saturation was achieved with a smaller number of participants. Some interviews were carried out by Master's students, so the sample size was larger to allow for learning opportunities. Thematic data analysis was conducted following procedures outlined by Paillé.¹⁹ Six of the 48 interviews were used to create a coding



FIGURE

Topics on which participants lacked knowledge.

grid. Two researchers with expertise in qualitative analyses, perinatal nursing, and bioethics separately reviewed these blinded interviews. The themes emerging from both analyses were reviewed and compared by the entire research team; no major differences were noted. The remaining transcripts were coded by 1 researcher, who adjusted the coding grid to reflect new emerging themes. The team reviewed the analysis to ensure that they reflected participants' experiences accurately. Quotes illustrating themes were translated from French to English by a professional translator and edited minimally to enhance readability. Pseudonyms were assigned to participants. NVivo 11 (QSR International, Melbourne, Australia) was used to manage the qualitative data.

Results

Analysis of the data revealed the experience of women who miscarried in the emergency department was characterized by lack of information at 3 critical junctures: announcement of the miscarriage, course of the miscarriage, and ED discharge. Seven subthemes were identified, representing topics on which participants lacked information (Figure).

JUNCTURE 1: ANNOUNCEMENT OF THE MISCARRIAGE

The first subtheme concerned the absence of medical information when participants were informed of the miscarriage. Participants reported they did not receive satisfactory answers to their questions from health care providers, such as medical explanations about the causes of the miscarriage. Nearly two thirds (N = 31) of participants said that the information provided was either incomplete or not expressed in lay terms:

You don't know exactly what's happening to you, but they don't really have time to answer you. The nurse throws something at you, like 'your hormone level is this much.' What are these hormones? I've been pregnant 3 days; I haven't had time to read all the pregnancy information... I'm an intelligent, educated woman, but I didn't understand anything they told me! (Christine)

The second subtheme involved the lack of information about the steps involved and the time required to diagnose a miscarriage, such as the turnaround time for test results and time for physicians to consult specialists as needed to reach a diagnosis. All participants said the wait was distressing, and the lack of information from health care providers during this timeframe was frustrating.

Every so often I went back to the triage nurse. And what I found really hard was her saying, 'Until you're filling one sanitary napkin per hour, I can't put you through any faster.' I was, like, 'What? I need to bleed more before you'll help me?!' I couldn't stop crying, and there was no one explaining or reassuring me. (Mary)

JUNCTURE 2: THE COURSE OF THE MISCARRIAGE

Once the miscarriage was confirmed, professionals offered 3 treatment options: expectant management (return home and wait), medical management (take medication to trigger contractions and possible expulsion of the fetus at home), or surgical management (curettage in hospital). This third subtheme was raised by one quarter of the participants (N = 11), who said they were not sufficiently informed about the treatment options and their implications and were therefore unable to make informed decisions.

I knew curettage existed. But nobody ever told me about that. He never explained misoprostol, what it could do, what the risks were... Never. And I had read about it, and some of my girlfriends had taken it, and it didn't always go well. So I was kind of afraid about that, but I thought, if I don't have a choice, sure, I'll take it, but I'd rather wait and see. I decided myself to do things this way, but it wasn't offered or suggested or explained in any way. (Sonia)

The fourth subtheme related to the course of the treatment options. Regardless of the option selected, half of the participants complained that they were inadequately prepared and not given explanations regarding pain intensity, bleeding, and fetal expulsion. The majority of those who took medication and passed products of conception at home felt unprepared for the pain; they had not been informed by ED providers that contractions would occur or that these would be painful. About one third of these women said they would have chosen a different treatment option, such as curettage, or sought more support had they fully understood the pain associated with a miscarriage.

I didn't know what it was, or what to do, and I was bent in half, unable to move, unable to call anyone. I was curled up in a little ball on my bathroom floor... they didn't tell me it set things off like that. They didn't tell me about the pain and what I could do, what I could take. If I'd known it was going to be like that, I probably would have asked my spouse to stay with me. I was dizzy, I was throwing up... I suffered. Nobody prepared me for this much pain. So I was a little angry with the doctor because it seemed to me that you can't let someone go home like this. (Cynthia)

Bleeding was another topic inadequately covered. Although participants had been told they would bleed, many said the emergency nurses or physicians did not warn them how much bleeding could occur with the expulsion of fetal tissue or that they might pass blood clots. Given the lack of information about how much blood to expect, women who had returned home described their panic at the heavy bleeding and their decision to return to hospital, sometimes by ambulance. Not knowing what was normal or abnormal made the experience even more difficult than it already was:

But I didn't know what volume of bleeding would be considered dangerous, and at what point you should go to the hospital. I didn't know. Then there's the basic fact that the fetus, when you're expelling it, is pretty

big. But I didn't realize any of this when they told me, "Oh, you go home, you take this, you're going to bleed." (Tina)

Besides pain and bleeding, one third of participants said health care providers should have explained the fetal-tissue-expulsion process. Not having clear information when the expulsion occurred at home amplified these women's distress. In particular, some women reported traumatic situations resulting from not having been sufficiently prepared to know what to do with the fetal tissue after expulsion:

The nurse told me I was going to bleed a lot. But she never said, "There's going to be a fetus that will be expelled, and it will be about the size of a lime. And something will have to be done with it, you'll decide." We didn't talk about that, but it was an important part of the whole process, that I didn't realize until it happened. I didn't know it would happen at home, and I didn't really know what to do, either. I was on the toilet... Was I supposed to flush? Would it block the toilet? They didn't explain much to me. There was blood, but there were also bits of the placenta, and of baby... It was a fairly traumatic experience. (Tina)

JUNCTURE 3: EMERGENCY DEPARTMENT DISCHARGE

The fifth subtheme, 1 of 3 associated with ED discharge, related to physical symptoms after miscarriage. Nearly half (46%) of participants reported receiving little or no information from nurses or physicians at discharge about post-miscarriage physical symptoms. The majority (71%) of those who had continuing symptoms said they did not know whether these were normal or what they should do. They lacked information on symptoms that could indicate a complication (such as excessive bleeding), the effects of hormonal changes, caring for themselves after a miscarriage or curettage, when menstruation would resume, and how long they should wait before considering another pregnancy. Most, in the end, sought answers on the Internet.

Then afterwards... they leave us like this, they send us home, and that's the end of it... I have no follow-up, I can't have an appointment in 2 weeks, a month. I didn't understand anything... whenever something happened, I said to myself: 'Hey, I haven't got any information on that.' Now my cycle is out of whack. Why? I had lots of questions. Why didn't my cycle come back? Why am I still

sick to my stomach? Why am I still in pain 4 months later? (Cynthia)

The sixth subtheme related to psychological effects. Half the participants reported a lack of information on the psychological aftermath of miscarriage. They would have liked to be informed, even summarily, about the emotions to expect. For some, even just being told by nurses that they would mourn would have eased their suffering.

At that point, we have no idea how things will play out afterwards. They could have guided me... 'The next stage will go like this, and if you need anything, there's this or that available.' Yeah, that would definitely have been a good thing, because afterwards, we have lots of questions, too. Is it normal that I don't feel like going back to work? It was a long time before I could start to function normally again. For sure, if I could have had someone to tell me it's normal, that it could take time, that definitely would have helped. (Emily)

In the seventh subtheme, two thirds of participants complained of not being given information about resources available to them after miscarriage. The majority (58%) had no medical follow-up because they had no family physicians and were therefore unable to ask such questions. They would have appreciated receiving information from nurses regarding community-based support.

Parents' groups, and all that. I didn't even know there were any around here. I wouldn't even have known where to look for them. It's the kind of information that, when you miscarry, when you leave the hospital, they should tell you... No one told me anything when I left there. (Linda)

Discussion

The aim of this study was to examine women's experiences of miscarriage in the emergency department to identify specific characteristics of care management that may have contributed to their difficulties. Respondents identified lack of information throughout the process as a recurrent factor that exacerbated the already-difficult nature of this event. Although recent studies have identified this general theme,^{13,14,16,18} the current study identified specific topics on which women lacked information. Our results also highlighted 3 critical junctures in ED care for miscarriage in which lack of information was most acutely problematic. The insights from this study can be used to devise nursing strategies to

improve the quality, frequency, and content of information transmitted during the miscarriage process.

Although lack of information negatively influenced participants' experiences in different ways, they shared the belief that having more information would have alleviated their difficulties. This resonates with the literature review by Geller et al,¹⁵ which found that women who received information from health care professionals on the causes of miscarriage, the physical and emotional symptoms to be expected, and the impact on future pregnancies exhibited the greatest satisfaction with their experiences. Conversely, as reported by other studies, women lacking information were dissatisfied and compelled to use other sources such as the Internet.²⁰ In both MacWilliams et al²¹ and this current study, the majority of participants reported feeling unprepared emotionally and physically at the time of discharge, with long-term effects on their psychological well-being. Providing sufficient and accurate information at all the critical junctures in emergency care thus has the potential not only to improve the experience of women going through miscarriages but also to alleviate their distress.

Some ED characteristics make it a challenging place for nurses to care for women experiencing miscarriages; these include the short time allocated for triage and long wait times, among others.²² Pregnant women presenting to emergency departments expect prompt responses but are often triaged as nonurgent.^{21,23,24} Because loss of pregnancy is not considered an illness or injury, these ED patients fall in a different category, which may explain why nurses and physicians are less prepared and available to inform and care for them. Although patients, in general, expect long ED wait times,²⁵ for women experiencing miscarriages, not knowing whether their pregnancies are viable or what to expect regarding procedures makes the wait much more stressful.

Also, although patients in general often report not receiving enough information in emergency departments,²⁶ this is particularly problematic for women experiencing miscarriages who are under intense and sudden emotional stress and for whom information is vital to gaining a sense of control over events; hence, the great value in nurses' providing clear and detailed information for this population.

Limitations

The first limitation of this study relates to sample homogeneity, as there was little variation in participants' cultural and socioeconomic profiles. Second, women

with difficult experiences may have been over-represented, as those with few difficulties may not have been inclined to participate. Third, although participants were asked whether they had received discharge instructions, and on what topics, they were not asked how these instructions were given—whether orally, in writing, or both—making comparisons difficult. Fourth, although it would have been interesting to verify whether participants felt their voices and experiences were accurately reflected in the subthemes, this was not done. The authors intend to pursue this line of study by exploring women's experience of having attended Quebec's early pregnancy clinic in Montréal, Québec, Canada.

Implications for Emergency Nurses

The results of this study, combined with other research, confirm health professionals' fundamental influence in the experience of women dealing with miscarriage.¹³ In particular, emergency nurses are at the forefront and have the potential—through sensitivity, attentive listening, and provision of information—to lessen the distress of affected women. Research highlights that management of pregnancy loss in the emergency department rarely includes taking into account women's experiences, as confirmed in our study. However, emergency nurses can play a leading role in giving emotional support²⁷ and in providing information. To do this, nurses themselves need better support and training, so they, in turn, can provide detailed and accurate information.^{12,27,28} Nurses' experiences, beliefs, perceptions, and knowledge about miscarriage can influence the content and manner in which they present information²⁹ and how they provide emotional support.^{28,30,31} Nurses perceive the emotional care needs of women experiencing miscarriage more sensitively after engaging in an educational program.³² They also feel more competent responding to these needs and giving information after appropriate training.²⁹ Future studies should explore factors influencing how emergency nurses and physicians can communicate effectively with women experiencing miscarriages.

Conclusion

The experience of miscarriage is a complex phenomenon influenced by many factors. Emergency nurses can improve emergency care for women experiencing miscarriage by listening to their concerns and providing accurate and sufficient information to reduce the physical and psychological effects on individuals, couples, and families.

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Author Disclosures

The authors declare that they have no conflicts of interest to report.

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