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Women's experiences with early pregnancy loss in the emergency room: A qualitative study

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ABSTRACT

Objectives: To understand the reasons why women present to the Emergency Room (ER) for Early Pregnancy Loss (EPL)-related care, how they perceive care and counseling there, and their overall experience during and after their visit.

Study design: This qualitative study utilized semi-structured telephone interviews. Participants were recruited in a large urban ER; women who experienced EPL were interviewed by telephone about their experiences 1–3 weeks after their visit. Audio recordings were transcribed and coded by two independent coders.

Main outcome measures: This qualitative study utilized semi-structured interviews without the use of formal outcome measurement tools.

Results: Of the sixty-seven women recruited, ten completed the full telephone interview. Interview participants' responses were grouped into four categories: Feelings about EPL, reasons for going to the ER, experience in the ER, and experience after leaving the ER. Women had mixed feelings about their ER experiences; many reported chaos, lack of information or lack of emotional support, while a few felt informed and supported. Many did not know much about EPL before their experience.

Conclusions: ER care for women experiencing suspected or confirmed EPL may not be addressing the emotional needs and knowledge gaps of women. Patient education, emotional support, and clear plans for outpatient follow up are critical. Further research is needed to guide interventions to improve care.

Introduction

Nearly 1 in 5 pregnancies end in miscarriage, usually in the first trimester of pregnancy up to thirteen weeks gestation [1]. Also known as Early Pregnancy Loss (EPL) [2], miscarriage is often a difficult time for women and can be as devastating as stillbirth [3]. Yet despite its frequency, EPL remains an understudied component of women's health care.

Most EPL-related research to date has focused on management options and clinical outcomes. Multiple studies have examined the safety and efficacy of treatment methods when administered in hospitals, Emergency Rooms (ERs) or office-based settings, and found that all treatment locations are safe for patients [4–6]. In addition to clinical outcomes-based EPL research, more recent studies have begun to evaluate women's experiences of shared decision-making, satisfaction, and patient-centered outcomes. Studies show that patient engagement and preference are more important to overall satisfaction than specific type of management plan [7–10]. Several reviews have concluded that women should be involved in the decision-making process about choice of treatment modality [10,11]. In one review encompassing multiple clinical settings, women who were unsatisfied with their care reported perceived negative attitudes from providers, insufficient information, and inadequate focus on emotional wellbeing in follow-up care [12].

Although these studies offer insight into women's satisfaction, there is a paucity of qualitative data about women's experiences with EPL, particularly in the ER setting. One qualitative study of men and women's experiences in a hospital in Ireland identified multiple pertinent themes, including loss, misperceptions of miscarriage, hospital environment, support and coping, and others. Women in that study described their ER experience as 'one of the hardest aspects of the miscarriage experience' [13]. ERs are a major source of EPL-related services in the United States [14]. The New York City ER in our study

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sees approximately 750 women per year with first trimester bleeding, representing approximately 0.8 percent of total visits [personal communication October 2014, [15]. Urban ERs in the United States provide care to a large volume of patients, and a typical visit can take several hours with frequent delays while waiting for providers, labs, or imaging [16].

The objective of this study was to better understand the reasons why women present to the ER for EPL-related care, how they perceive care and counseling there, and their overall experience during and after their visit. By better understanding the patient experience, ER and outpatient-based healthcare providers can gain perspective that will help guide the provision of compassionate and patient-centered care.

Methods

Eligible participants were English-speaking, in the first trimester of pregnancy (< 13 weeks), and presented to the ER with abdominal pain, cramping, or vaginal bleeding. Recruitment was done between December 2014 and April 2016 by trained ER-based study personnel, based on convenience sampling during times when ER-based study personnel were available. A brief quantitative survey was administered at the time of recruitment, which focused on basic demographics and reasons for presenting to the ER. As many women do not receive a diagnosis at the time of presentation to the ER, recruitment was done based on the presenting symptoms above.

One to three weeks following recruitment in the ER, consented participants were contacted by phone to assess EPL status and eligibility for the telephone interview. Patients who had experienced EPL were eligible for the full interview. Participants whose diagnosis was still pending were re-contacted 1–2 weeks later. Participants who did not have EPL were excluded from further participation. All participants, regardless of outcome, were offered a New York City public transportation pass as an incentive at the time of the follow up phone call.

Semi-structured telephone interviews were conducted by trained research staff after additional verbal consent was obtained. Interview guide domains included: reasons for presentation to the ER; sources of medical information; influences on the decision to go to the ER; overall satisfaction with ER care; perception of engagement in the decision-making process; usefulness of medical information provided in the ER; and perception of and satisfaction with follow-up care. The interview guide domains were developed based on existing literature and the clinical expertise of the authors. Though it was not pilot tested, it was reviewed by women's health researchers before being finalized. Interviews lasted approximately 30–45 min, and were audio-recorded and professionally transcribed after all identifying data were removed. All files with identifiers were kept in a password-protected folder.

The study was approved by the Institutional Review Boards of The Institute for Family Health and the study ER's affiliated School of Medicine. Particular attention was given to the anticipated vulnerability of women participating in this study, with acknowledgement that study recruitment and participation was soon after or sometimes during the pregnancy loss. The ER-based study personnel were given initial, then bi-annual trainings by research staff that included discussions about language and sensitivity. Women meeting eligibility criteria were only approached for consent when in private settings, and the consenting personnel were not otherwise involved in patient care. The ER-based quantitative survey contained only essential information to limit participant burden. Follow-up interviews were conducted by phone in a private office. Researchers were prepared to refer participants to local medical resources for support if needed, though this was not utilized.

Dedoose© (SocioCultural Research Consultants, LLC, Manhattan Beach, CA) data analysis software was used to organize and manage qualitative data. Two members of the research team with Master's level training in qualitative methodology coded the interview transcripts independently using qualitative description [17–19]. New codes were added as new themes were identified from the data. These codes were revised iteratively as data analysis continued. Coding began immediately after transcription and was done on an ongoing basis as interviews were completed. The two coders reviewed one-another's coded transcripts to ensure consistency. Codes were grouped into repeating ideas and were categorized into overarching themes. When the full dataset was coded, these themes were shared with the research team. The team looked for additional relationships between codes and for the most salient themes. After further refining the codes and overarching themes, the full dataset was re-coded and then representative quotes were selected for each theme.

Table 1
Presenting symptoms and reasons for going to the ER (N = 67).

Symptoms[a]	n (%)
Vaginal bleeding-light spotting	37 (55.2)
Cramping	25 (37.3)
Abdominal/pelvic pain	22 (32.8)
Nausea	17 (25.4)
Back pain	16 (23.9)
Vaginal bleeding-heavy like a period	11 (16.4)
Vaginal bleeding-heavier than a period or with clots	9 (13.4)
Reasons went to the ER[a]	
Thought it was an emergency	27 (40.3)
Convenience	17 (25.4)
Didn't want to wait for an appointment	14 (20.9)
Doctor sent to the ER	8 (11.9)
Recommendation of family or friends	7 (10.4)
Didn't know what else to do	7 (10.4))
Time of day	5 (7.5)
Don't have a doctor	5 (7.5)
Received information or advice about symptoms they experienced before going to ER	
Yes	44 (65.7)
No	22 (32.8)
Don't know	1 (1.5)
Where they received information (n = 44)[a]	
Internet	20 (45.5)
Health professional	17 (38.6)
Family	12 (27.3)
Friends	8 (18.2)

[a] Totals may not sum to 100 because categories are not mutually exclusive.

Results

Participant characteristics

A total of 67 women were recruited in the ER and completed the initial survey. Participants' symptoms and reasons for presenting to the ER can be found in Table 1. Most (55%) experienced vaginal bleeding/light spotting. Other common symptoms included cramping (37%) and abdominal/pelvic pain (33%). Nearly half (40%) went to the ER because they thought they were experiencing an emergency, 25% because it was convenient, and 21% because they did not want to wait for an outpatient appointment.

Ten participants who completed the ER survey went on to participate in the full telephone interview. Those who were not interviewed (n = 57) either declined to participate (n = 5, 8.8%), did not have EPL (n = 13, 22.8%), only spoke Spanish (n = 1, 1.8%) or could not be reached after three attempts by text and/or voice call (n = 38, 66.7%). Of the 10 participants who were interviewed, nine had a primary care provider and seven had medical insurance. Half of the interviewees were college graduates. Further demographic information for the interview participants can be found in Table 2.

Interview participants' responses were grouped into four thematic categories: Feelings about EPL, reasons for going to the ER, experience in the ER, and experience after leaving the ER.