Understanding the Experience of Miscarriage in the Emergency Department

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CE Earn Up to 8.5 CE Hours. See page 553.

Introduction: Up to 20% of pregnancies end in miscarriage, which can be a significant life event for women with psychological implications. Because the only preventative measure for a miscarriage is risk factor modification, the treatment focuses on confirming the miscarriage has occurred and medical management of symptoms. Although women experiencing a miscarriage are frequently directed to seek medical care in emergency departments, the patients are often triaged as nonemergent patients unless they are unstable, which exposes women to potentially prolonged wait times. Research about miscarriages and emergency departments predominantly focus on medical management with little understanding of how emergency care shapes the experience of miscarriage for women.

Methods: Seeking to describe the experiences of women coming to the emergency department for care while having a miscarriage, interpretive phenomenology—a form of qualitative research—guided this study. Eight women were recruited to participate in semi-structured face-to-face interviews of 60 to 90 minutes in length. Data were analyzed using hermeneutics and thematic analysis.

Results: Five themes emerged: "Pregnant/Life: Miscarriage/Death"; "Deciding to go to the emergency department: Something's wrong"; "Not an illness: A different kind of trauma"; "Need for acknowledgement"; and "Leaving the emergency department: What now?". Participants believed their losses were not acknowledged but instead dismissed. These experiences, combined with a perceived lack of discharge education and clarity regarding follow-up, created experiences of marginalization.

Discussion: This study describes the experience of miscarrying in emergency departments and provides insights regarding how nursing and physician care may affect patient perceptions of marginalization.

Key words: Emergency department; Miscarriage; Ectopic pregnancy; Qualitative research; Spontaneous miscarriage; Loss

Miscarriages, which are defined as pregnancy losses that occur prior to 20 weeks' gestation or at a fetal weight of less than 500 g, are the most common complications of early pregnancy.[1] Up to 20% of pregnancies result in miscarriage, with 80% occurring before the twelfth week of gestation.[1] A miscarriage can be a significant event in a woman's life and may lead to prolonged grief, depression, anxiety, or posttraumatic stress regardless of the gestational age of the fetus.[2–8] Treatment for a miscarriage in the emergency department is primarily focused on ruling out ectopic pregnancy, confirming nonviability, and medical management.[2,9,10] Pregnant women seek medical care in emergency departments because of the urgency and uncertainty associated with their symptoms (vaginal bleeding and abdominal pain) and its potential implications for the viability of the pregnancy.[9,10] Depending on symptom severity, these women also may be concerned for their own physical well-being.[9,10]

Patients in emergency departments often experience prolonged wait times and fragmented care while interacting with multiple health care providers.[11,12] Registered nurses (RNs) in emergency departments have self-identified as needing more education about miscarriages and how to provide supportive care.[13] Fragmented care and lack of supportive care integrated into the patient's visit and discharge instructions may fail to convey a message of

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compassion and empathy to someone in the midst of a miscarriage.

Women who have experienced miscarriages described feelings of loss, emptiness, and guilt.[14,15] Although the emergency care literature provides clinical knowledge about physical diagnosis and treatment for women experiencing miscarriages, little information exists regarding what women experience when they seek and receive care for this event.[1,9,16] Studies exploring care perceptions in women seeking miscarriage care outside the emergency department (clinic, obstetrical/gynecology office, and/or inpatient) have encountered health care professionals (HCPs) who lack empathy, are not sensitive to their situation, and do not acknowledge their loss or provide supportive care and education.[14,15,17,18]

The purpose of this study was to attempt to address the gap in the literature by exploring the experiences of women who have come to the emergency department to get care for their miscarriage.

Methods

STUDY DESIGN AND SETTING

Interpretive phenomenology was used as the methodology of this qualitative study.[19] After receiving ethics approval from the health authority, interviews were conducted with women who had received care for miscarriage at 1 of 3 emergency departments (1 tertiary care center and 2 community hospitals) serving a population of 390,000 located throughout the Halifax Regional Municipality in Nova Scotia, Canada. One hospital was a tertiary care facility with 37 ED beds and 66,231 visits per year. Two emergency departments were located in community hospitals with 25 and 26 beds, respectively, and annual censuses of 37,025 and 36,848.

SELECTION OF PARTICIPANTS AND RECRUITMENT

Eligible study participants were English-speaking women, 18 years or older, who had sought treatment in an emergency department while actively miscarrying and subsequently experienced a completed miscarriage.

Eligible participants were approached prior to discharge from the emergency department by staff RNs and physicians and were provided a letter introducing the researcher and describing the study. Women voluntarily choosing to participate or inquiring further about the study called the phone number listed in the letter or sent an E-mail message to the study E-mail address.

Advertisements were also placed in emergency departments (waiting rooms, washrooms, and gynecology examination rooms), family resource centers, primary care practitioner offices, the early pregnancy assessment unit (EPAU), social media (Facebook) and online classifieds (Kijiji). In addition to describing the study, the consent process also informed participants that the researcher would record their interviews and, although the comments would be used for publication, their identities would remain anonymous.

Eight women ranging in age from 21 to 36 years (mean, 31 years) participated in the study. The participants had diverse obstetrical histories, including multiple miscarriages, a previously planned therapeutic abortion, and previous neonatal death. Five of the 8 women were pregnant with their first child, and gestation at time of loss ranged from 5 to 4 weeks. Time from the loss to the interview ranged from 1 month to 6 years (Table 1).

TABLE 1
Participant demographics

Participant	Age, y	Gestation at time of loss	Parity at time of loss (loss included)	Parity at time of interview	Time between loss and interview
Sheri	34	9 wk	G1 P0 A1	G3 P2 A1	6 y
Isabel	29	7 wk	G2 P1 A1	G2 P1 A1	2 mo
Kristy	30	12 wk and 2 wk	G1 P1 A2	G4 P2 A2	2 y
Alyson	31	14 wk	G1 P0 A1	G2 P1 A1	2 y
Theresa	36	10.5 wk	G1 P0 A1	G2 P1 A1	3 y
Erin	21	5 wk	G2 P0 A2	G2 P0 A2	1 mo
Tammy	31	12 wk	G1 P0 A1	G2 P0 A2	2 y
Janet	36	9 wk and 14 wk	G7 P5 A2	G8 P6 A2	6 y