“A Horrible Place for a Miscarriage”: Nurses' Experiences of Caring for Women in the Emergency Department

by

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Abstract

A woman’s experience of miscarriage has been vastly explored in literature. It is well established that a woman’s physical and emotional responses to miscarriage are influenced by a number of factors and that these same factors have long term effects on the recovery process. In particular, health care professionals and their interaction with these women have been identified to be vital and significant in women defining and assigning meaning to such events. The aim of this study is to explore nurses’ understanding of their practice when caring for women experiencing miscarriage in the emergency department (ED) examined through a descriptive qualitative methodology. The study concludes that the unique context of emergency along with externally and internally perceived influences create no time, space or place for miscarriage.

This study involved interviewing ten emergency nurses from a tertiary care Canadian hospital. Nurses who have cared for women experiencing miscarriage in the ED were purposefully selected to ensure their ability to speak to the phenomenon being examined. Semi-structured in-depth interviews were used to collect data centred on exploring factors that inform and guide their practice. The tensions emergency nurses encountered while caring for women experiencing miscarriage were then identified using content analysis. As a result, two spheres of influence were noted to affect nursing practice. External influences with subthemes that examine: 1) a medical triage system that de-prioritizes non-urgent pregnancy related needs; and emotional care as secondary to biomedical care; 2) an emergency nursing ‘image’; and 3) gendered explanations about who can best care for miscarrying women, and internal influences which include: nurses 1) perceived lack of perinatal nursing knowledge; and 2) personal life context.
The findings of this study hold several implications towards understanding emergency nursing practice. An ED nurse’s confidence in providing care to women experiencing miscarriage can be improved by enhancing nursing education to encompass greater appreciation and understanding of miscarriage and nurses’ role in caring for women. As well, pursuing further research on miscarriage in the ED and cultivating an awareness of the contextual influences on emergency nursing practice may improve the experiences of nurses providing care.
Preface

For the conduction of this research study, ethics approval was obtained from UBC Research Ethics Board (UBC Behavioural Research Ethics Board; Certificate of Approval - H10-02972) and from the Vancouver Coastal Health Research Institute (Vancouver Coastal Health Authority Research Study #V11-02972).
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Chapter One: Situating the Problem

Miscarriage has been described as a traumatic life experience for women, partners and their families (Brier, 2004; Abboud & Liamputtong, 2005; Bryant, 2008). The health care context within which miscarriage occurs can and does shape the quality of care that women receive. According to Washbourne and Cox (2002) a significant proportion of women who have miscarriages find themselves seeking care in emergency departments (ED). The ED context however presents particular challenges for caring for women experiencing a normal aspect of reproduction, that being pregnancy loss. This is not surprising given existing research into how the ED context influences quality of care for patients (Varcoe, 1997; Rodney & Varcoe, 2001; Kilcoyne & Dowling, 2007; Moskop, Sklar, Geiderman, Schears, & Bookman, 2009).

Understanding how the ED context influences this particular experience and the sequelae of miscarriage provides additional insight into how nursing care in the ED can be enhanced to better meet the needs of diverse patients, particularly those of women who are experiencing pregnancy loss.

Personal and Professional Context

My research goal of developing knowledge about emergency nursing practice for women experiencing miscarriage is motivated by several factors. First, the personal experience of providing support to my sister who had a miscarriage in our local emergency department led me to question why emergency nurses act or behave in the manner that they do when caring for miscarrying women. The news of my sister’s pregnancy, to what would have been her long anticipated third child, was happily received by the whole family. In her fourteenth week,
however, she was involved in a motor vehicle accident that while it did not leave her with any immediate or obvious injuries, she had cramping and spotting that persisted for several days.

After a visit to our community ED, she was discharged by the emergency physician who confirmed that her baby had no heartbeat. She was informed that she was to miscarry, that miscarriage is normal and that it would just happen naturally. The fetus was later passed while she was in the bathroom at home. She was bleeding profusely, and it was then decided that she be brought to another emergency department in her hopes of receiving better care. At that time, I had the opportunity to witness how she was assessed and triaged, the lack of reassessment during her stay in the emergency department, along with the absence of compassion by health care professionals (HCPs) and the inadequacies of patient education provided prior to her discharge.

Throughout this ordeal, I became more conscious of the influences that emergency context and culture have on patient care for these women. Analyzing my sister’s experience of miscarriage from differing perspectives, as a 1) concerned family member; 2) disappointed recipient of health care services; and 3) frustrated, experienced emergency nurse; I recognized a heightened awareness towards inconsistencies between my own expectations of good emergency nursing care and the realities of emergency nursing practice.

Second, since then, I began to question my own practice and the practice of colleagues in the ED towards women experiencing similar circumstances. The impetus for this study was strengthened through discussions with other emergency nurses about their understanding or lack thereof; on the complexities of caring for miscarrying women and the influences that organizational and personal culture or contexts have on the way care is delivered. In addition, the
lack of literature examining the influence of ED culture and context on emergency nursing practice further substantiated the need for the study.

While attending the University of British Columbia and working towards completing my Master’s degree in Nursing, the opportunity arose for me to refine my experiences and concerns into a researchable problem through this thesis project. Thus, the project was conceived through my personal and professional experiences, through what I have learned about proper care in formal and informal education in the ED, and through my inquiry into the state of knowledge regarding nursing care of miscarriage in the ED.

**Purpose of the Study**

The purpose of this study was to explore nurses’ understanding of their practice when caring for women experiencing miscarriage in an ED and to propose how emergency nursing care could better meet the needs of women. With this in mind, the study had 3 research aims. This included: 1) developing an understanding of nursing care for women experiencing miscarriage in the ED; 2) investigating how the emergency context and culture impacts nursing care for women; and 3) proposing implications for optimal care from a nursing perspective.

**Overview of Thesis**

The following is a brief overview of how the thesis has been organized. In this first chapter, an outline of the problem and justification for the need for the study is provided. A brief description of the origin of the research question and purpose of inquiry was also explained to support the selected research design and strategy for data analysis. In Chapter Two, a review of literature is described regarding miscarriage, the role of health care professionals, nurses’
perspectives on caring for women, the emergency context and miscarriage in the ED. This analysis was conducted to establish what is known about emergency nursing practice, to build our understanding of the context being examined and to identify gaps in current research.

Chapter Three explains the theoretical orientation that underpins the study and explores the research design, recruitment and sampling method, data collection method, data analysis, research rigour, ethical considerations and strength and limitations of the current inquiry. In Chapter Four, findings of the study are examined based on a content analysis conducted. Last, Chapter Five discusses implications of the findings, recommendations towards policy and practice conclusions for the study.
Chapter Two: Review of the Literature

A review of the literature is essential for this study to build the context of the present inquiry and provide an overview of its need based on what is currently known about nursing care of miscarriage in the ED. To appreciate the significance of understanding emergency nursing practice towards women experiencing miscarriage, the literature review has been organized to explore the following: 1) what is known about miscarriage and its meaning to women; 2) the role of health care professionals in a woman’s experience of miscarriage; 3) nurses’ perspectives on caring for women; 4) the emergency context; and 5) miscarriage within the context of the emergency department.

Miscarriage and its Meaning to Women

Miscarriage is best defined as a spontaneous termination of pregnancy before viability or the ability of an embryo to exist outside the womb (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). It is identified as the most common form of pregnancy loss and highlighted as an experience that should not be trivialized by any means (Nikcevic, Kuczmierczyk, Tunkel, & Nicholaides, 2000, Abboud & Liamputtong, 2005, Gerber-Epstein et al, 2009).

Studies generally quote the prevalence rates of miscarriage or spontaneous abortion to be between 12-25% (Nikcevic, 2003; Abboud & Liamputtong, 2005; Carter, Misri, & Tomfohr, 2007; Sejourne, Callahan & Charbrol, 2010). In 2005, Statistics Canada reported that 8,494 or almost 2% of all pregnancies in Canada ended in “fetal loss” defined as stillbirths and abortions collectively (Statistics Canada, 2005). Although precise statistics for the prevalence rates of miscarriage in Canada are difficult to obtain, a study by Caelli, Downie and Letendre (2002) stated that approximately 40,000 women and families are affected by miscarriage in the United
States with “similar numbers relative to the population” existing in Canada (p. 127). Caelli et al. (2002) also recognized that a significant number of miscarriages are still statistically unaccounted for, therefore suggesting a potentially higher prevalence rate than what may be cited in research.

The meaning of miscarriage to a woman has been frequently explored over the past three decades. Letherby (1993) stated that the meaning women ascribe to miscarriage is influenced by “commitment to and expectations of individual pregnancies as well as the specific medical, social and material circumstances” that surround the event (p. 166). Corbet-Owen & Kruger (2001) further described miscarriage in relation to pregnancy and motherhood as a socially constructed experience thereby eliciting different meanings to different women. They explain that pregnancy may be viewed as a positive and desired experience, or as a negative unwanted event, translating to differing reactions when miscarriage takes place (Corbet-Owen & Kruger, 2001). A woman experiencing miscarriage is said to induce a myriad of emotions that range from trauma, loss, sadness, grief and relief, all with varying intensities (Abboud & Liamputtong, 2003; Brier, 2004; Swanson, Connor, Jolley, Pettinato, & Wang, 2007; Brier, 2008). In addition, miscarriage is also seen as contributing to a woman’s feelings of inadequacy or failure to meet her social role as a woman and expectations as a wife (Corbet-Owen, 2003).

A significant amount of literature examined the effects of miscarriage on the physical and mental health of women. In most studies, the experience of miscarriage is acknowledged as a physical, emotional and psychological stressor with considerable consequences to a woman’s health and well-being (Letherby, 1993; Nikcevic, 2003; Abboud & Liamputtong, 2005; Sejourne et al., 2010). Most of what has been written on miscarriage represents it as a complex event clouded by a mother’s grief, guilt and self-blame, along with high rates of psychological
morbidity (Letherby, 1993; Nikcevic, 2003; Brier, 2004; Abboud & Liamputtong, 2005; Brier, 2008; Sejourne et al., 2010). Miscarriage has been consistently linked to high levels of psychological distress in women resulting in feelings of confusion, stress, trauma and culpability (Van, 2001; Neugebauer & Ritsher, 2002; Brier, 2008; Swanson et al., 2007). Several studies have also found spontaneous abortion to be a traumatic event that substantially increases a woman’s risk for depression, obsessive compulsive disorders, post-traumatic stress, grief and anxiety, (Nikcevic et al., 2000; Neugebauer & Ritscher, 2002; Klier, Geller, & Ritsher, 2002; Brier, 2004; Abboud & Liamputtong, 2005; Gerber-Epstein et al., 2009; Swanson et al., 2007; Brier, 2008; Sejourne et al., 2010). The mental health impact of miscarriage can be noted in the early weeks following miscarriage extending to months even years after the event (Klier et al., 2002; Neugebauer & Ritsher, 2002; Brier, 2004; Swanson et al., 2007; Brier, 2008). Given the impact of miscarriage on the physical and emotional well-being of women, findings from these studies help bring to light opportunities for health care professionals to address these potential outcomes.

The Role of Health Care Professionals

Despite the abundance in research regarding women’s perception of miscarriage, studies claim that the impact and significance of this phenomenon on women still persistently eludes the health care professionals’ awareness (Corbet-Owen & Kruger, 2001; Abboud & Liamputtong, 2005; Gerber-Epstein et al., 2009; Murphy & Philpin, 2010). Wojnar, Swanson and Adolfsson (2011) stated that “societal awareness of the impact of miscarriage and expectations for mourning subsequent to the early loss of a nonviable pregnancy continue to lag in western cultures” (p. 554) and further suggested that this may account for the lack of empathy and support for families, partners by health care professionals. Health care professionals and nurses
in particular, have a direct influence in women defining their experience of miscarriage as positive or negative (Abboud & Liamputtong, 2005; Bryant, 2008; Gerber-Epstein et al., 2009; Murphy & Philpin, 2010). This denotes value for HCPs’ to possess greater understanding of the meaning women associate with miscarriage to meet their needs when seeking care.

Some studies have looked at the nurses’ responsibilities to meet both the physical and psychological needs of women and their families (Stead, 1996; Washbourne & Cox, 2002; Bryant, 2008). Bryant (2008) specified some of these physical needs of women to include: obtaining detailed medical and obstetrical histories; providing intravenous access and intravenous fluids; ensuring adequate analgesia and anti-emetic; monitoring and assessing changes in patient’s condition; acquiring appropriate blood work; and ensuring proper referrals to medical and health care staff in an efficient and timely manner. In addition, the nurses’ responsibilities when caring for a woman experiencing miscarriage encompass more than just attending to their medical concerns. The role of health care professionals and nurses towards addressing the psychological needs of these patients has also been documented in many studies. Various research states that HCPs play an essential role in the recovery and coping of women and their families after the experience of miscarriage (Tsartsara & Johnson, 2002; Nikcevic, 2003; Abboud & Liamputtong, 2005; Mansell, 2006; Swanson et al., 2007; Bryant, 2008; Gerber-Epstein et al., 2009). Studies reported that the lack of emotional support provided by HCPs during the time of miscarriage as well as lack of patient education prior to discharge of mothers, partners and families, result in increased incidences of post-traumatic stress disorders, depression, and anxiety (Jacob & Harvey, 2000; Corbet-Owen & Kruger, 2001; Brier, 2004; Abboud & Liamputtong, 2005; Swanson et al., 2007).
Even with increased acknowledgment of the distressing effects of miscarriage however, “training for dealing with women’s emotional care is absent and depends largely on the compassion and understanding of individual health professionals” (Lee & Slade, 1996, p. 240). Patton, Wood, Bor, and Nitsun (1999) concluded that receiving adequate psychological care in hospital can directly affect a woman’s emotional adaptation following a miscarriage. Lee and Slade (1996) also found that HCPs who validate the physical and emotional experience of miscarrying women contribute positively to health outcomes compared to those who view miscarriage as another medical condition. Bryant (2008) reported that HCPs still focus strongly on the woman’s physiological needs during miscarriage while emotional needs are often neglected. Similarly, Corbet-Owen and Kruger (2001) found that the psychosocial and psychiatric outcomes related to miscarriages are often ignored or overlooked.

There are mixed reviews from women who have experienced miscarriage regarding satisfaction with hospital care provided. Some studies stated that women’s experiences with care are generally positive (Paton et al., 1999; Jacob & Harvey, 2000), however these same studies along with many others demonstrated that women were dissatisfied with the treatment and care provided to them by HCPs specifying concerns such as long wait times (Sehdev & Wilson, 2000; Adolfsson, Larsson, Wijma & Bertero, 2004), lack of knowledge (Patton et al., 1999; Jacob & Harvey, 2000; Corbet-Owen & Kruger, 2001; Tsartsara & Johnson, 2002), as well as a lack of information provided and the lack of empathy or compassion (Patton et al., 1999; Jacob & Harvey, 2000; Corbet-Owen & Kruger, 2001; Tsartsara & Johnson, 2002; Wong, Crawford, Gask & Grinyer, 2003; Adolfsson et al., 2004, Brier, 2008). Wong et al. (2003) also noted that variability in care and skill demonstrated by HCPs significantly added to frustrations by women with health care services.
Although there are studies that have examined the satisfaction of women who have miscarried with the care and interventions provided by medical professionals in the hospital settings (Lasker & Toedter, 1994; Patton et al., 1999; Nikcevic et al, 2000, Harvey, Moyle, & Creedy, 2001; Tsartsara & Johnson, 2002; Wong et al., 2003), little is known about the actual experiences and interactions of these women with health care professionals and limited nursing literature exist on the role nurses play in caring for women experiencing miscarriage. This implies that health care professionals and nurses are failing to meet the needs of these women and their families.

**Nurses’ Perspectives on Caring for Women**

It was crucial for me to review literature related to nurses’ perspectives on caring for women experiencing miscarriage as this helped frame my understanding of nursing care and my analysis of nursing practice in the ED. Currently, there is substantial research that examines the HCPs’ perspectives on a woman’s experience of miscarriage and on their management of care. In most studies, the definition of HCP is inclusive of doctors, nurses, and other health care providers (Corbet-Owen & Kruger, 2001; Murphy & Merrel, 2009; Murphy & Philpin, 2010), although other studies focused primarily on the nurses’ viewpoints (Adolfsson et al., 2004; Bryant, 2008; Murphy & Philpin, 2010; Evans, 2012). This review of the literature discusses studies that examine both HCPs, and nurses’ key perceptions about care for women.

Consistent in all studies reviewed is the notion that health care professionals view miscarriage as commonplace (Moulder, 1994; Corbet-Owen & Kruger, 2001; Adolfsson et al, 2004; Wallbank & Robertson, 2008; Murphy & Merrel, 2009). Murphy & Philpin (2010) emphasized that “miscarriage to health professionals is a common part of their everyday work
but to the woman it is usually a unique experience with the loss of that particular baby” (p. 538). Many studies noted that nurses and health care professionals become desensitized to the uniqueness of this experience because it is a reoccurring event in their practice (Corbet-Owen & Kruger, 2001; Wallbank & Robertson, 2008; Murphy & Merrell, 2009; Murphy & Philpin, 2010). Nurses and doctors who are expected to handle and examine the fetus or products of conception while managing patients miscarrying become accustomed to what they might see, the expectations of care and the similarities in experience (Murphy & Merrel, 2009). In addition, nurses and other HCPs also perceive the physiological changes that take place during miscarriage as normal and predictable (Adolfsson et al, 2004; Murphy & Merrel, 2009; Evans, 2012). The physical recovery associated with miscarriage is regarded by nurses as “uneventful” (Evans, 2012, p. 35) and therefore treatment and management of women is looked upon as minor (Adolfsson et al, 2004, Murphy & Merrel, 2009, Evans 2012).

Historically, literature on miscarriage has focused strongly on its psychological effects on women neglecting to provide sufficient guidance and attention to HCPs on the physical needs of women (Murphy & Merrel, 2009). Interestingly however, despite this shift in perspective, nurses still tended to disregard the emotional needs of women while their physical needs are given preference in patient management (Jacobs & Harvey, 2000; Corbet-Owen & Kruger, 2001; Wallbank & Robertson, 2008; Bryant, 2008; Murphy & Merrel, 2009, Evans, 2012). According to Murphy & Merrel (2009), health care professionals perceive their primary role as “helping the woman safely through the physical consequences of miscarriage, effectively treating and safely discharging her” (p. 1586). Wallbank & Robertson (2008) found that nurses felt more confident in their ability to meet the physical care of women versus delivering appropriate counselling or
psychological care. Evans (2012) also agrees that HCPs tend to place their efforts towards the physical aspects of miscarriage more so than the emotional consequences.

Evans (2012) further recognized that nurses expressed discomfort in dealing with miscarriages because of feelings of lack of preparedness to care for these patients. Wallbanks and Robertson (2008) referred to this as “role uncertainty” (p. 104), defined as a perception that nurses felt incompetent to care for a woman experiencing miscarriage. According to Neugebauer and Ritsher (2002) miscarriage should be viewed as a “form of bereavement and not simply as an obstetrical event” (p. 21). Nurses identified that there was a knowledge and training deficit on how to support the emotional needs of women and the provision of bereavement care, making them inadequately equipped to handle this challenge (Evans, 2012). Alternatively however, studies also argued that miscarriage should not be generalized by HCPs as a negative event (Adolfsson et al., 2004; Murphy & Merrel, 2009). Studies stated that despite the prevailing perspective of miscarriage as bereavement, nurses should consider that women’s care needs, reactions and responses to the experience may differ and that a universal response of bereavement care may not be appropriate for all women (Swanson, 1999b; Murphy & Merrel, 2009).

In many clinical areas, nurses viewed the care and needs of a woman experiencing miscarriage as less of a priority in comparison to other circumstances taking place in that same health care setting (Wallbank & Robertson, 2008; Bryant, 2008; Murphy & Merrell, 2009, Evans, 2012). Nurses rationalize that emotional and psychological needs of women experiencing miscarriage are less urgent than the physical needs or medical priorities of acutely ill patients such as those requiring major surgery or emergency cases (Jacob & Harvey, 2000; Murphy & Merrell, 2009; Murphy & Philpin, 2010, Evans, 2012).
Murphy & Merrell (2009) also best described the nurses’ perception of tensions in practice as differences between “how they would like to practice and what was actually possible” (p. 1587). Nurses noted that although they had awareness of the emotional sequelae of miscarriage, contextual limitations such as time and financial constraints, prevented them from delivering optimal care to meet women’s needs. An example of this was the lack of opportunity to be able to sit and listen to the concerns of the patient and her family and provide sufficient time to demonstrate emotional support because they were too busy with the demands of other patients on the unit (Murphy & Merrell, 2009).

Nurses and HCPs also shared their views on being emotionally available and responsive to women when they provide care. While the dominant notion was that displaying any type of emotional response or reaction to miscarriage was considered inappropriate or unprofessional behaviour (Begley, 2003; McCreight, 2005; Wallbank & Robertson, 2008) nurses recognized that displaying empathy was acceptable behaviour (McCreight, 2005; Wallbank & Robertson, 2008). Stead (1996) claims that nurses should “set aside their professional authority when necessary and show a human face” (p. 185).

The Context of Emergency Departments

Review of literature about the context of the emergency department is essential to help enlighten us on potential relationships between emergency nursing practice for women and the context in which miscarriage care takes place. Examining literature concerned with the context of the ED not only contributes to our own awareness of the unique challenges faced by health care professionals in this setting but also allows us to understand any deficiencies in nursing practice attributed to this clinical environment. Though little has been written focused primarily
on the overall context of the ED, many studies have touched on different aspects of this context and have looked at how these factors may affect nursing practice.

Hospital-based emergency departments have evolved during the past 2 decades to provide not only acute emergency care but also safety net care for indigent patients, public health surveillance, disaster preparedness, observation and procedural care (e.g., blood transfusions), occupational care, employee health, and in many cases, primary health care (Moskop et al., 2009, p. 605).

Emergency departments are dynamic clinical settings. Its position within the realm of the health care system places it in a unique position to accommodate the various health needs of the public. Multiple studies noted that there has been continued growth in the responsibilities emergency departments have taken on to offset the deficiencies in our health care system (Robinson, Jagmin & Ray, 2004; Kilcoyne & Dowling, 2007, Moskop et al, 2009). In addition to being frontline caregivers in emergency cases, EDs accommodate all types of patients, from the emergent to the walking wounded, without regard for their social context or ability to pay. Also, EDs have now become the go to place for primary health care services and non-urgent needs particularly when family practitioners are too busy or patients seek convenience of accessibility or want faster diagnosis (Robinson et al, 2004, Moskop et al, 2009).

Mainstream research into the context of emergency departments has focused on ED overcrowding. ED overcrowding is defined as occurring when “the identified need for emergency services exceeds available resources for patient care in the ED” (Moskop et al, 2009, p. 606). Robinson et al. (2004) identified many key nursing issues and trends that affect emergency departments and noted that increase in patient volume linked to increase in patient acuity have resulted in over capacity and overcrowding in most EDs. Other studies also acknowledge that emergency departments are bursting at the seams to accommodate the needs of the public given the diverse services it is now expected to provide and other factors such as
nursing staff shortage and decreased inpatient beds (Magid, Asplin & Wears, 2004; Johnson & Winkleman, 2011).

The overlap between overcrowding as a contextual feature of the ED and other contextual aspects of this health setting is evident as research shifts its focus to the consequences associated with this issue. Research focused on ED overcrowding has also branched out to examine its effect on nursing practice and care delivery in the ED. Kilcoyne & Dowling (2007) highlighted the influence of ED overcrowding on nursing practice through an interpretive phenomenological approach. They identified that overcrowding resulted in a lack of space, elusive care, and powerlessness for both patients and HCPs (Kilcoyne & Dowling, 2007). Moreover, health and safety concerns, infection control issues, poor service delivery, a lack of respect and dignity towards patients, failure to meet basic human needs, not feeling valued, moral distress and stress or burnout were also identified as undesirable consequences (Kilcoyne & Dowling, 2007). These outcomes have also resulted in adverse effects in the quality of patient care (i.e. delays in interventions, poor pain management, increased mortality), patient and staff safety, clinical practice and overall satisfaction with EDs in regards to health care experiences and as a workplace setting (Robinson et al., 2004; Kilcoyne & Dowling, 2007; Knapman & Bonner, 2010; Johnson & Winkleman, 2011).

Through the years, research related to the context of the ED has expanded, beginning to explore the ways in which ethical concerns and underlying assumptions about care delivery are shaped by the contextual constraints of the practice environment, influencing nursing practice and patient care. For example, scarcity in health care resources in the ED not only contributes to a practice environment that “makes it increasingly difficult or impossible for health care professionals to respect basic moral norms” (Moskop et al., 2009, p. 607), but also forces nurse
to make difficult ethical choices in everyday practice (Rodney & Varcoe, 2001, Moskop et al., 2009).

In a study by Moskop et al. (2009), moral consequences of serving emergency patients within the context of the ED were discussed in relation to the abilities of HCP to deliver safe, just and adequate patient care. Several examples of violations towards the rights of patients to maintain patient confidentiality, receive equal distribution of resources (i.e. patient beds, access to health care) and the basic right to quality treatment are threatened by the context in which care takes place. Moskop et al. (2009) argued that the context of the ED forces HCP to sustain practice that mostly attends to patients with the greatest need by implementing the principle of access to health care based on urgency, risking delays in treatment and reduced attention for medically stable patients with emergent emotional needs.

A study by Varcoe (1997) that examined the relationship between the social context of the ED and the way in which care is shaped for women who are experiencing abuse, she exposed the dominant practice of efficient physiological processing of patients using minimal resources which resulted in moral conflict for nurses providing care. According to Varcoe (1997), efficient processing of patients was evidenced by a focus of interventions on physiological concerns and immediate consequences of the health concern rather than the overall health of the patient. In addition, Varcoe (1997) also stated that the ideology of scarcity in the ED setting influenced the ways in which violence for women was managed and dealt with by HCP, as nursing practice shifted to a mind frame of giving care based on perceived deservingness (Varcoe, 1997).
Miscarriage in the Emergency Department

Miscarriages are noted as common presentations in EDs (Washbourne & Cox, 2002; Pearce & Easton, 2005; Bryant, 2008; Indig, Warner & Saxton, 2011). In a study conducted in the United Kingdom by Murphy and Merrel (2009), an estimated 50,000 in-patient hospital admissions annually were related to women experiencing miscarriage. According to Mansell (2006), 25% of approximately 1000 women who present with miscarriage in hospitals are managed exclusively in the ED.

Many authors argued that EDs are not the appropriate place for miscarriage to take place (Stead, 1996; Mansell, 2006; Bryant, 2008;). Stead (1996) stated that several factors in the ED environment affect nursing care for women experiencing miscarriage. The busyness and demands of ED patients, the intensity or pressure associated with clinical situations and understaffing all contribute to the quality of care provided to women (Stead, 1996). Likewise, Wallbank and Robertson (2008) identified organizational factors (i.e., time constraints and the lack of organizational support or resources) as other key factors that influence nursing practice for women. On this premise, we can anticipate that women’s experiences of miscarriage in the ED, and the outcomes of such experiences will be shaped by various contextual forces including interactions with people, policies and nursing practice.

Stead (1996) also recognized that in order for ED nurses to respond effectively to the care of women, they have to be understanding of the woman’s perspective on experiencing miscarriage and her unique needs. Similar to the previous discussion on nurses’ perceptions of miscarriage, studies examining the management and care in the ED of these patients support that emergency staff and ED nurses collectively view miscarriages as a common occurrence
(Zaccardi, Abbot, & Koziol-McClain, 1993; Stead, 1996). Stead (1996) stated that miscarriages were a daily event in some EDs hence the lack of appreciation by HCP for the uniqueness and individuality in meaning of this experience to a woman. Other studies stated that ED staff do not share the same view as women on this experience as pregnancy loss as it is perceived as just another case or procedure in contrast to women who feel that they have lost their child or a part of themselves (Zaccardi et al., 1993; Standing, 1997; Mansell, 2006).

In conducting this review, it also became evident that there is a lack of guidance in literature on how women experiencing miscarriage in the ED should be treated. Mansell (2006) stated that the perception of emergency departments as being unsuitable for women may explain this trend in research. In addition, studies have associated lack of proper guidelines and deficit in knowledge of proper care to inconsistencies in practice or role ambiguities by emergency nurses when caring for miscarrying patients and their families (Cameon & Penney, 2005; Mansell, 2006). Some of the inconsistencies in emergency nursing practice noted focused on 1) the nurse’s role in providing emotional support to women (Zaccardi et al., 1993; Stead, 1996; Bryant, 2008, Marquardt, 2011); 2) amount of patient education and information provided to women and their families (Stead, 1996; Pearce & Eaton, 2005; Marquardt, 2011); 3) proper disposal and management of products of conception (Ramsden, 1995; Cameron & Penney, 2005; Mansell, 2006, Marquardt, 2011); and 4) appropriate counselling (Ramsden, 1995). Despite these inconsistencies, women and families continue to look to emergency departments for care when faced with the trauma of miscarriage.
**Gaps in the Literature**

Emergency nurses are frontline care givers for women experiencing miscarriage. Though the negative effects of miscarriage on a woman’s overall well-being has been well examined and studies recognize the impact HCPs have on the meaning women associate with that experience, little is known or understood specifically about emergency nursing practice for women experiencing miscarriage in the ED or the factors that influence nurses’ interactions and behaviours when providing care. This thesis hopes to address this gap in knowledge by considering the emergency nurses’ perspectives on providing care to women within this unique clinical setting and attempts to appreciate contextual features that affect the provision of optimal care.
Chapter Three: Research Methodology

Methodology

Theoretical Orientation

The purpose of the current project, to investigate nursing practice in the ED for women experiencing miscarriage, is based on several assumptions about how nurses’ experiences and their practice are shaped by the broader context of their work. These assumptions about nurses, nursing practice and the context that underpin the research have been drawn from Doane & Varcoe’s (2005) description about people as contextual social beings;

1) Nurses are not separate from their world but are situated in and constituted by it (p. 7-8);

2) Nurses have practice experiences that are unique and at the same time have shared meaning with others (p. 7-8);

Studying nursing care of women experiencing miscarriage necessitates a methodological approach able to capture subjective meanings in context, individual and disciplinary knowledge and experiences, and able to account for how the ED nursing context is shaping care for women. Therefore, a qualitative descriptive design was selected for the study.

Qualitative Descriptive Design

A qualitative descriptive design was used to explore and describe emergency nurses’ understanding of their practice when caring for women experiencing miscarriage in the ED. Researchers that engage in descriptive qualitative studies strive for both descriptive and interpretive validity as described by Maxwell (1992) and Sandelowski (2000). This means that
the researcher seeks to accurately represent the participants’ accounts of the phenomenon being examined and the meanings participants associate with the event (Maxwell, 1992; Sandelowski, 2000).

Sandelowski (2000) defines qualitative descriptive inquiry as offering a “comprehensive summary of an event in the everyday terms of those events” (p. 336) yet entailing “interpretation that is low inference” (p. 335). My purpose in using the qualitative descriptive method was to produce results that demonstrated a clear description and interpretation of an emergency nurses’ understanding of her practice with women experiencing miscarriage in the ED based on her own accounts and perspectives on the event.

According to Magilvy & Thomas (2009), qualitative descriptive designs utilize smaller samples than other qualitative methods and uses convenience or purposive sampling in selecting participants. In essence, this method of inquiry necessitates that all participant have experience with the phenomenon being scrutinized. The process of generating data generally includes observing or interviewing participants (Sandelowski, 2000; Magilvy & Thomas, 2009). Data analysis was also described as a process of:

making sense of a phenomenon and understanding it so we can describe it from the other’s perspective, and the results of the analysis do not reveal themselves easily or quickly. Over time, by reading, re-reading data, listening to audio-recordings, reviewing field notes, maybe clarifying with participants what we are learning, the analysis and findings reveal themselves in the form of categories, patterns and themes (Magilvy & Thomas, 2009, p. 299).

Sandelowski (2000) stated that qualitative content analysis is the best strategy for data analysis in a qualitative descriptive study. This strategy involves active analysis of verbal and visual data focused on summarizing informational content with “no mandate to re-present data in any other terms but their own” (Sandelowski, 2000, p. 338). However, she also acknowledged
that although the qualitative content analysis process may be utilized in the initial course of analyzing data, it is not uncommon to modify or discard this method to guarantee the best fit to data collected (Sandelowski, 2000). The method of data analysis used in this study was a content analysis which will be described further in the data analysis section.

Sample

For this project, purposive sampling was utilized to recruit participants. It was purposive because I screened potential participants for experience in caring for a woman miscarrying in the ED who could speak to the phenomena of interest and allowed for intentional selection of participants based on this specific criterion. The eligibility for potential participants included: 1) nurses who have provided care for women experiencing miscarriage in the ED; 2) nurses from diverse backgrounds and nurses from a range of practice histories; 3) nurses who spoke fluent English. Nurses were included if they had provided care for women across any of the 4 stages of spontaneous abortion as defined by White & Bouvier (2005): a. threatened abortion; b. inevitable abortion; c. incomplete abortion; d. complete abortion.

The sample size for the study was 10 participants (Table 1). Potential participants were recruited from the ED of a tertiary care Canadian hospital. Nurses were made aware of the study via an announcement on the department’s weekly online newsletter. Study information (see Appendix A – Study Information Sheet) which summarized the purpose of the study, the researcher’s contact phone number and email address was also distributed into the nurses’ mailboxes on site. This allowed nurses to notify the researcher if they were interested in joining the study. Consent to participate (Appendix B – Consent form) was explained and obtained prior to conduction of the interview.
**Data Collection**

For this research, semi-structured in-depth interviews were used for data collection. This method of data collection provided participants the opportunity to draw upon past experiences and current understandings of their practice. The semi-structured in-depth interview format was selected for several reasons. While achieving anonymity within the interviews was not possible, the benefits of this method were seen to outweigh this limitation. Utilizing in-depth interviews with open-ended questions allowed participants to express themselves, disclose details and explain their experiences fully to the interviewer. This approach also permitted the researcher to seek clarification regarding what participants were describing.

The semi-structured method was also selected to allow adaptation of the researcher’s questions (Appendix C – Interview Guide) in response to participant’s comments. This ensured some flexibility in questioning while allowing the researcher to redirect or focus on questions related to the purpose of the study. The semi-structured interview approach was also chosen as it allowed for dialogue to generate narrative data considered richer than written response data.

All interviews were conducted by the student researcher to uphold privacy. Interview notes were collected and the interview was recorded and transcribed verbatim by the researcher.

**Data Analysis**

Content analysis was the interpretive approach to analysis utilized in this project. Sandelowski (2000) stated that qualitative research is characterized by “simultaneous collection and analysis of data whereby both mutually shape each other” (p. 338). In keeping with this principle and the guidelines set by Polit & Beck (2008), data analysis took place concurrently with data collection. Analysis began during data collection and verbatim transcription of the
interviews. Each transcript was read and re-read in its entirety to gain a general sense of what nurses were saying about their experiences of caring for women experiencing miscarriage.

Transcripts were then carefully read and analyzed individually to identify a category scheme of prominent themes and patterns. DeSantis & Ugarriza (2000) defined themes as:

A theme is an abstract entity that brings meaning and identity to a current experience and its variant manifestations. As such, themes captures and unifies the nature or basis of the experience into a meaningful whole (p. 362)

Appendix D (Sample Data Analysis) provides an example of how data from one participant’s transcript were preliminarily organized under determined thematic headings. Thematic headings were then reviewed and revised with the guidance of my thesis supervisor and with the feedback provided by my thesis committee. The process of structuring themes and subthemes to reflect key constructs of the study goals was also discussed to enhance findings. For example, clarity was provided on how privileging medical emergencies represents a subtheme of the culture and context of the emergency department.

Research Rigour

To construct quality data, several strategies were employed to support trustworthiness in this study. The framework used was based on Lincoln and Guba’s (1985) proposal for developing trustworthiness in qualitative inquiry, which included four criteria: credibility, dependability, confirmability and transferability.

One of the most important steps for establishing credibility was to devote sufficient time to engage with participants before and during interviews to develop rapport and create an environment of openness. Adequate time was provided prior to interviews to explain the goals of the study while encouraging honest communication. The time necessary to obtain faithful and
comprehensive data was also invested to build a trusting relationship with each participant. Interviews were scheduled based on each participant’s availability. Though interviews were generally 45-60 minutes in length, ample time was provided during interviews to obtain a thorough understanding of their views. I anticipated that discussing experiences of caring for women who have had miscarriages could be emotion filled, therefore sufficient time and space was provided for participants to share their experiences without feeling rushed or pressured to finish their responses within a certain time frame.

Each participant was invited for one interview, and was informed that a follow-up interview may be scheduled to gather additional data or confirm the researcher’s interpretation if necessary. The credibility of the research was augmented by member checking or seeking feedback from study participants to verify emerging themes and interpretations from the data collected. This ensured that interpretation of data was in line with the realities of the participants’ experiences while data was being collected.

Credibility and confirmability of the study was enhanced further through the maintenance of researcher reflexivity. I sought to represent the data closest to its original form by paying attention to how my preconceived notions, assumptions and experiences about the phenomenon (i.e., my assumption that women experiencing miscarriage in the ED experience suboptimal care or receive care from nurses in a negative way) influenced my understanding of what is being said. Writing field notes also provided me an opportunity to see how my own perspectives on the topic were shaping my analysis.

Consistency and dependability were addressed by maintaining an audit trail or detailed notes of decisions made throughout the research process, in particular, judgments made in
relation to data collection and data analysis. An example of such would be decisions as to what data was included or disregarded for analysis. Accuracy in recording and transcribing data collected also enhanced dependability and credibility. This was achieved by assigning participant codes, and having the interviewer complete both tasks of recording and transcribing to avoid transcription errors.

Transferability of the proposed research focused on ensuring that the study findings provided a rich and accurate description within the time and context the data was collected. This did not imply that findings were readily transferable to another context; rather, the insights may or may not have applicability in similar contexts. In this study, transferability meant that nurses’ understandings of their practice might be relevant for contexts beyond the ED.

**Ethical Conduct of the Study**

Ethical considerations were an imperative part of this research. On that basis, several ethical considerations were addressed prior to commencing the study. Based on the ethical principle of the right to self-determination (Polit & Beck, 2008), participants were treated with respect and given full autonomy and control regarding decision and choices made to participate in the proposed study. Free and informed consent and the right to full disclosure were respected and provided to all prospective participants without any form of coercion or element of force. Written consent (Appendix B) was obtained from those eligible and willing to participate in the study, and information regarding the purpose and nature of the study (Appendix A) were discussed prior to the interviews.

A person’s right to privacy and dignity were respected by facilitating opportunities for participants to determine circumstances (time, place) under which private information was
shared and disclosed. The right to confidentiality was also enforced through rigorous methods of protecting the participant’s identity in data collection and preservation of data. Codes were created and assigned to represent each participant and the data collected from that specific subject so that identities would be protected and no information could be linked to a specific individual. Care was also taken during public dissemination of the results so that confidentiality was maintained. Data was kept in a secured filing system requiring passwords and lock and key, and will be discarded appropriately after research has been completed. The right of participants to be protected from harm and discomfort was also addressed. Harm and discomfort was defined to include physical, psychological and psychosocial distress that may be attributed by participation in the study. I anticipated that a nurse’s experience of caring for a woman that is experiencing miscarriage in the hospital setting might lead to increasing psychological distress, anxiety and job dissatisfaction. Accordingly, participants were given the freedom to withdraw from the study without penalty.

Ethical approval was also obtained from the University of British Columbia Behavioural Research Ethics Board and from Vancouver Coastal Health Research Institute.

Strengths and Limitations

The purpose of the present study was to gain an understanding of emergency nursing practice and care of women experiencing miscarriage in the ED. In re-evaluating the research design, strengths and limitations were recognized. First, the selected design, a descriptive qualitative design was seen as strengthening the research as it was well suited to the research aims. The use of a purposive sampling strategy to select participants who could successfully represent the goals of the study was also noted as a source of strength in the study. Criteria for
inclusion and exclusion were carefully devised in an attempt to obtain quality data. Specifically, the inclusion of a criterion requiring participants to have cared for a woman that has experienced miscarriage in the ED enabled collection of data that is appropriate. The determined sample size of 10 also strengthened the research as data saturation was achieved.

The data collection method also contributed to the strength of the research. Semi-structured questioning allowed the participants flexibility in their responses and the interviewer to elicit information required to answer the research question. Methods to increase reliability of information and trustworthiness of the study such as providing sufficient time, researcher reflexivity, auditing and method of analysis also strengthened the research.

Despite strengths discussed, there are several limitations to the study that must be noted. First, as this research is a thesis project required for completion of a master’s degree, time constraints associated to finishing the program in a timely manner and financial constraints related to budgetary allowances for photocopying study information, consents, transportation to and from interview sites and transcription services should be acknowledged.

Second, being a novice researcher created some limitations in my understanding of the research process, particularly experiencing difficulties in the data analysis process which was new to me. It was challenging for me to synthesize and make sense of the overwhelming amount of data and organize my findings. Analysis has therefore evolved with the assistance of my thesis supervisor, Dr. Helen Brown, and the feedback provided by the thesis committee members.

Lastly, data collection was limited to one urban emergency department. As context is said to have an impact into our meaning making of lived experiences, the richness of qualitative data may change when the research questions are posed to a different group of ED nurses, i.e.,
emergency nurses working out of a rural ED. Conducting the research in other settings could illuminate additional contextual features relevant to how nurses’ understand and carry out their care for women who have miscarriages in the ED.

In the next chapter, I present finding that focus on the various forces of nursing practice that affect care of women experiencing miscarriage in the ED. These forces are organized into subthemes that speak to either an external or internal influence perceived by nurses as shaping their care for women. The external influences include: 1) prioritizing and triaging of medical emergencies; 2) the ED nurse image; and 3) gendered explanations for optimal care. Internal influences take into account: 1) Perinatal clinical expertise; and 2) Personal life context.
Chapter Four: Findings

In this chapter, I present the study findings of the study that will contribute to nursing knowledge about how to best care for women experiencing miscarriage in the ED. An overarching theme in the data will be described followed by several subthemes that depict how the participants understand what shapes their care for women. The primary influence nurses described was related to how patient care is organized and delivered in the ED. Specifically, the participants understood the following forces operating within the ED context to impact their care for miscarrying women: no time, no space and no place. The participants spoke of several dimensions of emergency care that colluded to create no time, no space and no place for miscarriage: a medical triage system that de-prioritizes non-urgent pregnancy related needs; the tendency to view emotional care as secondary to biomedical care; an emergency nursing ‘image’; and gendered explanations about who can best care for miscarrying women. Two other areas that nurses described as shaping their care for miscarrying women in the ED were the perceived lack of perinatal nursing knowledge and their personal life context. These latter two findings were deemed less about the ED context and will be discussed as contextual factors external to the practice of emergency nursing (see Figure 1).
Figure 1 How Influences Shape and Impact Emergency Nursing Care for Miscarrying Women

External Influences: No Time, No Space, No Place for a Miscarriage

All nurses in the study identified the ED context as shaping their care of women experiencing miscarriage. The nurses recognize the uniqueness of the ED clinical setting particularly for how it shapes the quality of nurse-patient interactions. While many aspects of the ED context were described in the data, my analysis focused specifically on those elements that the nurses understood as having a primary influence on their care for miscarrying women. An overarching element of the emergency context that shaped nursing care for women was the sense that the ED was “no place for a miscarriage”; the participants described the ED as creating no time, no space and no place for meeting women’s emotional or physical needs. The nurse participants spoke of the strong influence that the emergency context has on the way nursing care is provided to women. The hectic pace and unpredictable nature of emergency nursing work meant that
providing the support, privacy and time for women to come to terms with a threatened or actual pregnancy loss was often deemed to be of a lower priority than medical emergencies. Almost all of the participants understood their inability to meet women’s needs due to the number of assigned patients at any given time, constraints in physical space and general environment as impacting their care for women. The participants described how the task and triage orientation makes a certain kind of space for patient care; and the space and place needed for miscarrying women just cannot be created in the emergency environment. One participant identified that

… the time pressures of looking after so many patients, you don’t have adequate time to sit down and talk to these [women] patients about their feelings…. We are so task focused about having to get things done in a speedy manner… (P003)

The busyness of the ED and accompanying time constraints made it more difficult for nurses to conscientiously dedicate adequate time to address the physical and emotional needs of miscarrying women. “… We are inundated with patient volume… we’re constantly getting, we’re treating people. Time is always a factor” (P010). Nurses are regularly challenged to balance the provision of emotional care to a wide range of patients with the medical priorities that demand their immediate attention.

…it’s so busy that a lot of the times, you don’t even have time to focus on like that side of nursing which is providing support, emotional support… especially in the treatment setting where you have more than one patient, sometimes you have twenty and you’re running around trying to get things done (P002).

Several nurses spoke of how they believe women experiencing miscarriage in the ED are disadvantaged because they are placed in an environment with limited resources (i.e. physical space, human resources). For example, participants described that the ED is not the ideal place for women due to the limitations in physical space to allow for the proper assessment, intervention and the provision of privacy. One participant noted:


It’s not a calm kind of quiet place where you might want to be if you’re miscarrying and there’s no, none of that is provided to the women, like the women may get a room with a closed door but you’re not, there’s people constantly opening the doors and walking in… (P001).

While the physical space and the lack of time available for nurses to provide non-urgent care are central to how the participants understood their care of miscarrying women, the broader context for how care is delivered and is therefore impactful for pregnant women was also impacted by the prioritizing and triaging of medical emergencies. In fact, the very spaces and places that nurses and other health care providers create (beyond the physical elements) were described as significantly influenced by how emergency care is organized and delivered; that is, through the prioritizing and triaging of medical emergencies.

**Prioritizing and Triaging of Medical Emergencies**

The nurses viewed priority setting based on patient acuity as the dominant force operating within emergency nursing practice. Emergency nurses and physicians described how through their education, training and practice, they attend and provide care to the sickest patients first. In this study, all ED nurses stated that when considering priorities of care, the focus must first be on patient’s symptoms and the maintenance of stable vital signs. According to one nurse: “… it’s the emergency thing, we tend to focus on the vitals…. We look at the numbers, and then of course pain, but, that’s what we go towards, that’s what we’re conditioned to do in the emergency department” (P002).

Most participants mention the “ABC Philosophy”, a way of thinking that is inherent in the emergency culture. Nurses explained that in general, their approach to care is focused primarily on ensuring the stability of a patient’s airway, breathing and circulation (ABCs), then assessing medical prioritization: “Like all emergency nurses, what guides me is the ABC. So
long as the priorities of ABC’s are covered, the rest of it, pain management or you know social
type, things, secondary” (P010). Another nurse stated,

You deal with what is emergent, at, for the time being. You deal with the ABC stuff and
we do that. Then after dealing with that… you have to remember that, the patient also,
has to, we have to talk to the patient after. (P009)

In addition, most nurses acknowledged that, upon initial assessment of patients, there is
less concern for issues that do not pose an immediate threat to the loss of life. For example,
nurses conceded that priority is given to patients that are hemodynamically unstable instead of
miscarrying women that do not show any outward signs of physiological instability. With the
focus on physiological stability, several nurses confirmed that there is a cost for miscarrying
women. Women’s emotional needs and the significance of the pregnancy loss can be “easily
missed or neglected” (P010). One nurse stated:

when they [miscarrying women] come to emergency we don’t really give them a lot of
attention, we don’t really give them a lot of caring. It’s just like, it’s not a priority for us
cuz they’re walking coming to the emergency, unlike when they’re coming with the
ambulance and massive bleeding. Then we look after them. (P008)

The participants all described how the “physical” needs take precedence over emotional
concerns when prioritizing patients. When triaging or deciding who should be seen first,
emotionally or psychologically distressed patients are of lower priority compared to those
experiencing physiological distress. ED nurses are better able to appreciate potential outcomes or
decompenation resulting from physical injury compared to the emotional sequelae miscarriage
may attribute to a patient’s well-being:

… sometimes, the emotional part of nursing or the emotional supporting kinda falls by
the way side. It’s an awful thing to say, but a lot of times what guides my nursing
practice… the physical patient. Not the emotional part of it. (P002)
While the participants indicate that medical priorities and triage systems of care ought to be the approach to care provision in the ED, they also recognized how this way of organizing care leaves miscarrying women with high emotional needs and some physiological dynamics requiring non-urgent care, in a position of disadvantaged when seeking care in the ED. The participants were well aware that optimal care for women was undermined in the ED context because of the appropriate focus on medical priorities and the mismatch with women’s needs during miscarriage.

**De-prioritizing miscarriage.**

Almost all the nurse participants described miscarriage as a low priority in the ED. Specifically, the de-prioritization took the form of normalizing the occurrence of miscarriage. Nurses collectively described miscarriage as a common event in emergency with each case possessing similar presentations and little variance: “it was like, oh, another miscarriage kinda thing…. Just treated them like another gen [general] surg [surgery] patient or abdo [abdominal] pain” (P001). Another nurse explained miscarriages are not considered a priority because there are, for the most part, no surprises, which is an important contrast to how other emergent care needs are understood within the ED ‘culture’:

> There are many instances where I’ve cared for a woman experiencing miscarriage in the department, most of them are generally the same. They all come with vaginal bleeding times X many hours, maybe a day or two. They all have abdominal pain, and that’s really about it…. there is a stigma there yes, there is a culture where you know, it’s just another miscarriage. (P010)

Thus, the fact that miscarriages are considered predictable relegates their urgency to a lower priority than other patient conditions. Several nurses also described miscarriage as a “normal” life event, an ordinary occurrence in comparison to other events that take place in the ED. One participant described miscarriage as lacking the “spectacularity” and urgency of more
traumatic cases seen in this clinical setting: “because they’re not really bleeding heavily, we’re just gonna say, oh that’s normal” (P008). This tendency to ‘normalize’ miscarriage was not seen to be problematic in terms of how the nurses provide care and, in fact, reinforced their views that miscarrying women in the ED may in fact indicate a ‘gap’ in the system for women seeking care for a normal pregnancy experiences.

Several other participants normalized miscarriage by viewing it as a spontaneous condition with no immediate remedy. Because the participants understood there to be no medical management when the fetus is less than 20 weeks gestational age given limited viability, this further contributed to seeing miscarriage as a low priority. Medical management is a central component of emergency nursing practice and within the context of “nothing can be done”, there was a consequence for how the need for care was interpreted. One participant questioned why women even come to the ED if there is no medical management available in early pregnancy: “sometimes when they [nurses] see a woman that’s just having some cramping and bleeding, they’re the attitude of well you know, she’s only 8 weeks pregnant, we can’t do anything anyways, so why would she even come here.” (P006).

Another participant expressed a “hopelessness” associated with miscarriage in the ED, likely because there is little that can be done for women within a space where managing and treating patients is the primary focus.

I think there’s something about miscarriages, especially those in the emergency department that [um] has a certain hopelessness to it…and that is different than watching an old person die (P004).

This participant contrasted miscarriage with an older person’s death; indicating that the former takes its natural course whereas there is an inevitability to the natural course of death. The tendency to compare and contrast miscarriage to other patient illness and care needs indicates the
importance of how nurses’ interpreted the place of miscarriage in emergency practice. Another nurse said that: “… in comparison to cardiac or trauma, it’s [miscarriage] very low on the list of importance…not a big priority…these other little things, don’t get much attention” (P001).

Similarly, one participant the consequences of miscarriage as negligible compared to fatal costs of other traumatic cases and commented:

They’re [miscarrying patients] not as in much danger as other patients, that I think we tend to look them over. They’re having a process that a lot of the times, won’t affect them physiologically, it will not threaten their life… we won’t pay attention to them as much because there’s a person right beside them who’s short of breath, you know who is being threatened that way, like physiologically. (P002)

**Emotional care as beyond ED nurses’ scope of practice.**

A related feature of how nurses view miscarriage to be a low priority was evident in the nurses’ data. The ED context and medical triage that structures nursing care was understood as allowing negligible time, space and place for the emotional trauma associated with miscarriage. One participant indicated that working with limited resources requires prioritizing patients’ needs based on physiological – and not psychological or emotional needs. This dilemma places nurses in difficult position of making decisions about who is more deserving of care:

It’s hard for us as nurses to dedicate our resources as a nurse to someone who is physiologically stable when someone else needs our help to stabilize their vital signs. When you can’t see someone’s vital signs going down or they’re bleeding from somewhere, it’s harder for us to then actually sit, and take the time and do that [attend to emotional needs of miscarrying women] (P004).

In other interviews, several participants described that being too busy with medical emergencies almost justifies their lack of attention to meeting the needs of miscarrying women. One nurse claimed that busyness “…legitimize my ability to say to a colleague, ‘Oh do you mind checking in on her I’m really busy with another one…’” (P004) because the woman miscarrying
was viewed as physiologically stable. Participants spoke of miscarrying women being able to “handle” delays in treatment because they are physiologically stable. How participants prioritize miscarrying women’s needs is shaped by the ED context of care which ‘trickles’ down to particular judgements about the emotional needs in contrast to physiological ones.

Although all of the participants noted that emotional support is a key component for optimal care of women experiencing miscarriage in the ED, they collectively agreed that the emotional consequences of miscarriage were beyond the domains of emergency nursing practice. Several participants claimed that emergency nursing practice is unlike other areas of nursing that aim for holistic care; in the ED, there is a different culture of care: “The culture in emerg it’s see, stabilize, and carry on…. We’re taught throughout nursing school, look at the patient, try to provide holistic care, but it doesn’t really apply down here” (P007).

Another participant echoed the same impression of emotional care being irrelevant in this clinical setting, emphasizing the difference in what has been taught in nursing school regarding the delivery of holistic care compared to the realities of nursing practice in the ED.

Your main purpose in triage is to take their name, take their vital signs, assign them an acuity scale… we have the benefits of doing the medical part of it, but also there’s the emotional part of it that they drilled you on in nursing school but in real life we actually, we’re actually not using it (P002).

The medical triage focus, the de-prioritizing of non-urgent pregnancy loss and emotional care considered beyond the scope of ED nursing practice also were connected to another theme in the data; that being, how the participants understand the image of the emergency nurse who privilege efficiency over other domains of nursing competence.
The ED Nurse Image

Several of the participants spoke about how the image of emergency nurse influences the way they act and behave towards women experiencing miscarriage in the ED. Descriptions of an ED nurse were evident in the data, particularly in relation to how attending to the emotional needs of patients should be accommodated. One participant described the popular persona of emergency nurses:

We’re the action part of the hospital, we’re known for thinking on the fly, we’re known for doing things that, in a pinch, we’re known for being able to roll with the punches when it comes [down] to [it], when we’re getting lots of patients…. we’re not really known for sitting by the bedside and helping anybody out, emotionally. (P002)

This same participant went on to say that ED nurses are accustomed to being emotionally distanced from patients, able to remain focused on physiological emergencies rather than having concern for the degree of holistic care integrated into their nursing practice. Several other participants extended this understanding of ED practice by indicating that showing empathy and emotion to women experiencing miscarriage in the ED is unconventional; the ED requires nurses to be capable of carrying on with their nursing duties while not succumbing to the emotional effects of lamentable circumstances. As one nurse explained:

We’re [emergency nurses] not very good at showing emotion because we think we should be stronger than that, that we’re emerg nurses we should be able to put up with anything so you know, done with that patient ok, need to move on cuz I’m an emerg nurse and that’s what I do. So, I don’t think emerg nurses let themselves be affected by that stuff…. I don’t think emerg nurses think they can do that. (P006)

Participants also indicated how a dominant discourse of efficiency pervades care for women, rendering emotional care for women to an even lower priority. Many of the nurses recognized that emergency nursing practice is generally driven by a need to prioritize efficient
movement of patients through the department over meeting emotional needs that accompany non-urgent medical conditions.

Despite how the ED nurse image was articulated in the data, when discussing care for miscarrying women, several nurses spoke of the importance of enlisting their ‘triage’ mindset to not be “...so quick to push them [miscarrying women] out” (P006). Despite identifying with an efficiency mandate, one participant state “these women may need a little more time, to sort of come to terms with what’s happened” (P006).

Several other participants indicated that an important skill set for being a ‘good’ ED nurse meant you were seen as someone who could manage patient flow through the department. Managing turnover and backlog were described as qualities of the ED nurse that were at times more valued that the capacity to provide quality patient care. One participant stated:

… you’re always worried in the back of your mind, I’ve already taken up the time. I’ve been in this room for an hour and what about the flow… it constantly goes through your mind how you’re slowing down things. (P007)

The ED nurse was described as one who values “efficiency before emotion” that is translated into their priorities when caring for women. For example, several participants described departmental strategies for improving patient experiences in the ED were being driven to a greater extent by investigations of tracking patients, improving patient flow in the ED and time to discharge ratios rather than patient satisfaction with actual nursing care. These dominant discourses and systemic processes contributed to how the ED nurses’ described themselves and their work: “… we don’t really have the time, to sit there…. And now with these new projects focused on [measuring] the timeframe of when you refer the patient, when the patient gets up to the floor” (P007).
In summary, the participants described what they understood to be the interconnected dimensions of ED nursing work that shapes their care for miscarrying women in the ED. For the most part, the participants describe these dimensions as external forces that became internalized and enacted, however the participants also described that a lack of perinatal educational preparation likely colluded with other factors to leave them feeling less than able to meet women’s needs within the context of the ED. Finally, the participants also spoke of how female nurses were better “suited” to caring for miscarrying women.

**Gendered Explanations for Optimal Care**

All nurses shared that it is common practice in the ED for female nurses to take on the care of a woman experiencing miscarriage. While considering the assumptions that underpin this judgment, the predominant notion that female nurses are better equipped at relating to women because of socially and culturally defined gender roles (i.e., feminine roles and experiences with motherhood or pregnancy) became apparent in the analysis. Most participants assume that female nurses are more capable of developing emotional bonds with these types of patients and more comfortable with the event of miscarriage: “I could be working in the treatment with a couple of other people who are mothers, and we’ll be all, we’ll be comfortable with it [miscarriage] and fine” (P007). Another nurse describes the unique connection female nurses have to women experiencing miscarriage:

Well it’s kind of, it’s like a deeper understanding of what they’re going through, you know the loss of a child that they may have actually been, spent years trying to get pregnant and the kind of the upset there, so we have that kind of connection as a woman. (P003)

All three male participants describe tensions when caring for women experiencing miscarriage. These participants claim that motherhood and pregnancy are life experiences that
are unique to women and are crucial to being able to meet and understand the emotional needs of the female patient. The male nurses in the study recognize pregnancy and motherhood as distinct events that are difficult for men to fully appreciate, putting into question their responsiveness to the needs of a woman miscarrying:

… being male, I sometimes, I don’t know if I, you know, that I can provide adequate support for somebody miscarrying, it’s something that I would never experience in my life…. I can never fully know what it’s like to have to go through miscarrying. (P002)

Another male nurse also points to how the social constructions of gender shape their perceived skills and ability to respond to and meet the needs of women:

… I don’t feel comfortable being male and not really even understanding what it’s like to be a pregnant woman losing, losing a child you carry…. Yeah I think women will probably have a better um, will be better equipped than men. (P004)

Contrary to the male nurses’ perception that female nurses are better able to respond to care needs of women, some female participants argued that they are just as oblivious to the emotional repercussions and trauma associated with miscarriage as their male counterparts.

Remarkably, although a number of participants claim that female nurses who have experienced childbirth or pregnancy are able to better relate to a patient’s feelings of emotional loss, female nurses who have experienced such events claim otherwise. These nurses also admit to a lack of appreciation towards the true impact of miscarriage to women and their families or understanding of the consequences of their nursing actions, reiterating the same concerns as their male colleagues:

Now, being a mom, I can tell them of what to expect. I’ve never experienced a miscarriage myself, but I do know what the process of carrying baby is like, and going through actual birthing process…. I’ve never experienced a loss of a baby so honestly I don’t know what that feels like. (P007)
Internal Influences: No Time, No Space, No Place

Perinatal Clinical Expertise

The participants described how the lack of clinical expertise to provide care to women experiencing miscarriage shapes their personal sense of competency. Nurses believe that there is insufficient education or exposure in the undergraduate and specialty program to enable them to deliver effective care to this patient population. The inadequacy of basic nursing curriculum on the experience of miscarriage and the care required by women play a central role in feelings of unpreparedness to deal with the emotional symbolism of loss reflected in their practice.

Nurses also recognized that specialty training had little focus – if at all – on caring for a woman experiencing miscarriage. One participant described how education and training for emergency practice was limited:

I’m sure we went through some neonatal paediatric courses kind of here and there… but I don’t remember much emphasis on the actual psychosocial aspect of it [miscarriage]… I try to think about TNCC [Trauma Nursing Core Curriculum]… as far as psychosocial aspect of that type of loss with trauma I don’t remember that as well either (P004)

The nurses described having limited exposure and training with obstetric and maternity patients in this clinical setting. Nurses repeatedly describe uneasiness in providing care because of the lack of clinical orientation, experience and awareness of best practice standards or protocol with these types of patients. For example, nurses shared varying degrees of knowledge in handling products of conception and in how emotional support could be best afforded to women and their families:

… I just didn’t know what to do and I kinda felt bad, and plus products of conception, or is, I think the placenta had to be sent somewhere, I remember asking where do I put the placenta in? I honestly will say that a lot of people are not comfortable with dealing with miscarriage… they don’t know what to do, they don’t know if the person miscarriages what to do with the products, or I’m sure a lot of them don’t know that those products
have to go to pathology. And I’m sure a lot of them don’t know how to explain to a patient that you are going to be experiencing… (P007)

Nurses’ opinions also differed in their interpretation of optimal care and best practice. One nurse explained: “… I’ve seen people [nurses] panic when we’ve had like a pregnant woman or you know come in…people panic because we [nurses] don’t know, but of course we are, we do get these patients” (P001). Nurses also had difficulty verbalizing what optimal care and best practice was, suggesting that nursing practice is based on previous experience of what they have seen and learned from others.

Participants stated that their lack of clinical expertise in miscarriage also contributes to unsupportive and awkward nursing practice and interactions with patients. Interviews confirmed that nurses limited their interactions with women as a result of not knowing how to handle the situation effectively. A nurse described how she engaged with women experiencing miscarriage:

In the past, I probably wouldn’t have said anything, cuz I wouldn’t have a clue, it all seemed very sad but I just do my thing and then walk out and didn’t offer anything because, I didn’t know… I didn’t know what I should say and it’s easier to just do the hand on physical stuff and then walk away (P001).

Along with other claims found in interview texts, emergency nursing practice was based on pure clinical management or what ED nurses felt most comfortable doing when responding to the needs of these women.

**Personal Life Context**

Many participants noted that the personal life context of a nurse is a strong contributor to the quality of nursing care put out to women. As nurses touched on several personal life contexts that influence their practice, for the purpose of this thesis, I will focus primarily on personal
values/beliefs and emotional fatigue as the dominant forces that affect nursing practice in the ED.

Differences in a nurses’ values and belief system was identified in a number of text as influencing the way they behave, act and interact with women experiencing miscarriage. Several nurses noted that these factors are correlated to their cultural upbringing and religious background, helping shape their nursing practice and care for women experiencing miscarriage.

As expressed by one participant:

I moved to Canada when I was eleven so I feel like, I am, I bring a lot of my own culture and values when it comes to the way I relate to people as well as my practice (P004).

Many participants acknowledged that their personal view of miscarriage may carry religious or cultural undertones which influence their perspective on the significance of the pregnancy loss in relation to “… is it a fetus versus a child, or a baby” (P005). A nurse’s personal perception on the value of life lost appears to guide their care approach and appreciation of a mother’s grief or experience.

Other nurses also note that personal values informed nursing actions. For example, one nurse shared her anxiety when her religious sense of obligation to baptize an unborn child was challenged by practice norms:

I suggested to my colleague about baptizing the … the products of conception…. In the Philippines we use to do that, we just like automatically baptize like these products of conception. But then I was told that we have to ask permission first cuz we don’t know what religion they would be. And I did. And then they said no… in my religious background, I thought of just doing it, without, even though they said no. But I was kind of, really hesitant and I was confused. Not confused, but was not comfortable not doing it for the baby. (P009).

This example speaks to the tension some nurses’ experience when personal beliefs clash with clinical practice.
Emotional fatigue is another aspect of a nurses’ personal life context that influences nursing practice in the ED. Nurses talked about the effect of emotional fatigue that affects their ability to demonstrate compassion in their nursing practice for women. These findings suggest that nurses’ dealing with their own “emotional baggage” and physical exhaustion, make them less responsive to delivering the empathy needed by women experiencing miscarriage. Two examples drawn from the interviews support this analysis of the findings:

I probably have more compassion on my first day shift than I do on my last night shift. I think also what I bring to the table as far as I have a good day or am I coming in with my own baggage and with my own problems and definitely understanding that when I’m dealing with stuff it’s harder for me to step outside of my shoes and put myself in someone else’s situation and look at it that way… that being said, I also have my professional role that this is my job. But I think I definitely put less emphasis when I’m overrun by these, by my own, of my own experiences that I bring to it… (P004)

Another nurse also commented:

Hopefully I’ve had a good day and I’m good that day also, because if you’re mad at the world for some reason unbeknownst, I think it’s a tone that comes in, and they just may think you’re rough… hopefully that just goes in the backburner… (P005)

Comments as such those above speak to the significance of one’s personal life context as a facet to understanding nursing practice for women experiencing miscarriage in the ED.

**Summary**

ED care for women experiencing miscarriage is understood by nurses as influenced by a complex interplay of external and internal factors. The findings from this study illustrate how, for the participants, the emergency context acts as an external influence on their care for women and one’s personal context acts as an internal factor shaping care for women. In subsequent chapters I discuss the findings and situate them within the context of relevant literature and
discern key implications for emergency nursing practice and potential for enhanced care for women.
Chapter Five: Discussion and Recommendations

The overall aim of the study was to investigate emergency nurses’ experiences of caring for women experiencing miscarriage. From the data I constructed themes to depict how various dimensions of emergency care converge to shape nursing care and made decisions about which dimensions appeared to exert the greatest influence on how the participants described and enacted their care. The primary influence on nurses’ descriptions was how the ED context influences the organization and delivery of care generally and in relation to caring for women experiencing miscarriage specifically. While the participants spoke of the ED context as an ‘external’ influence, they also described various internal dimensions, such as their own beliefs and life experiences. The findings in the previous chapter are described within these two domains of external and internal influences; however, it is important to note that this is an oversimplification of how people, contexts and experiences are interconnected. In this chapter I will discuss the findings in an integrated manner to show how the various factors shaping nursing care for women are individual, intrapersonal and contextual and together govern nursing actions and the degree to which they perceive their ability to provide holistic care to miscarrying women. Although these influences are not the only factors that shape nursing practice in the ED, these findings are crucial as a starting point to assist emergency nurses at being better able to actualize optimal care for women experiencing miscarriage.

In this chapter, I will discuss the implications of my findings in relation to existing knowledge under the theme of “Make time, space and place for miscarriage”. This discussion will focus on three key areas, notably: 1) reprioritizing miscarriage, 2) putting back emotional care into emergency nursing practice and 3) expanding ED nursing competencies. I will also
discuss policy and practice recommendations for improving nursing practices and health care experiences for women as well as provide suggestions for future inquiry in this field.

**Nursing Practice in the ED**

Nursing practice in the ED is a complex phenomenon that is not only guided by ethics and convention, but is also influenced and inseparable from the context in which it takes place. Understanding the significance of the ED context is critical for naming the driving forces that shape patient care as a means for evolving and enhancing care for safe, competent and ethical care and optimal health care experiences and outcomes for patients and their families.

In relation to my investigation of literature on emergency nursing practice, what is known about nursing practice in the ED can be summarized as follows:

1) Nursing practice in the ED is context dependent (Byrne & Heyman, 1997; Kilcoyne & Dowling, 2007); how nurses interpret their role is fundamental to understanding how they organize their work and interrelate with patients;

2) Aspects of the physical environment (i.e. busyness, ED overcrowding, lack of health care resources) play a part in “motivating quality and productivity in functioning” of nurses thereby influencing nursing practice (Kilcoyne & Dowling, 2007; p. 25);

3) Nurses generally practice in congruence with the dominant ethos found embedded in their clinical environment, such as: a) “Efficient processing” – nursing approach centred on providing urgent physical care, maintaining patient flow in the ED and emotional distancing (Varcoe, 1997; Goransson, Ehrenberg, & Ehnfors, 2005); and b) Holistic individualized care being viewed as idealistic (Byrne & Heyman, 1997;
Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Coetzee & Klopper, 2010; Hooper, Craig, Janvrin, Wetsel & Reimels; 2010; Yoder, 2010).

These claims from the literature are consistent with the findings of my study; that is, how emergency nursing practice for women experiencing miscarriage is shaped by the organization of care, medical prioritizing, and the physical environment. Given what is known about nursing practice in the ED and the needs of women experiencing miscarriage, the mismatch between the structural and professional resources available in the ED and care required by women demands further inquiry and action. Despite the fact that the ED is not necessarily conducive to the needs of miscarrying women, studies note that a large number of women experiencing miscarriage still seek care in emergency departments especially during afterhours (Washbourne & Cox, 2002; Bryant, 2008; Warner, Saxton, Indig, Fahy & Horvat, 2012). Bearing this in mind, it is critical to consider how care in the ED can better meet the needs of these women. While making time, space and place for miscarriage in the ED is both possible and appropriate within the current health care system, questions about where and how to best meet the needs of women also requires attention.

Make Time, Space and Place for Miscarriage

Reprioritizing Miscarriage

In this study, ED nurses perceive miscarriage as a spontaneous, normal physiological process and a natural occurring phenomenon in their workplace. Nurses who normalized miscarriage did so assuming that the event was less catastrophic in relation to other things happening within the department and that few complications would arise from treating this experience as a medical event. This nursing practice for women is strongly validated in previous
studies. Numerous studies identified normalization of miscarriage as common belief not only in nursing but in other health care disciplines and within other clinical settings (Corbet-Owen & Kruger, 2001; Adolfssson et al., 2004; Murphy & Merrel, 2009). According to Murphy & Philpin (2010), there exists a fundamental difference between the perspectives of a woman versus a health care professional towards the experience of miscarriage. They state that most HCPs accept it as an ordinary occurrence in everyday work while such experiences hold more significant physical and emotional impact to a woman (Murphy & Philpin, 2010).

In nursing practice, nurses’ normalization of miscarriage is problematic for several reasons. Studies such as McCormick (1997) suggested that nurses are adept at creating the ethos of the unit, referring to written and unwritten rules about how nursing practice is understood and enacted. Therefore, when nurses’ embrace the dominant discourse of normalizing miscarriage, this creates risks for nurses’ to downplay and potentially miss the significance of the event for women, their partners and families. This in turn is reflected in the way care is prioritized and provided to women. Despite mounting evidence on the physical and mental health effects of miscarriage, treatment and management of women is still consistently trivialized in practice as nurses’ continue to normalize miscarriage (Wallbank & Robertson, 2008, Murphy & Philpin, 2010). Apart from undermining its potential medical complications, nurses tend to discredit miscarriage as a prevalent woman’s health issue and the associated consequences to a woman’s mental health.

These findings of the study hold important implications for improvements in nursing practice and patient outcomes. First, nurses need to develop a critical awareness of the dominant attitudes in their clinical environment that influences their own assumptions towards miscarriage care. Through further education about the impact of miscarriage on women and the care
required, nurses’ can learn to appreciate their role in returning women to good health and well-being post miscarriage. As acknowledged by multiple studies, health care professionals strongly influence women in defining their experiences of miscarriage as positive or negative (Abboud & Liamputtong, 2005; Gerber-Epstein et al., 2009; Murphy & Philpin, 2010). By shifting nurses’ understanding of miscarriage as a dismissible event to a life-altering experience that potentiates valid physical, mental and emotional repercussions, emergency nursing practice may be enhanced for this population.

**Putting Back Emotional Care into Emergency Nursing Practice**

Women experiencing miscarriage have specialized care needs. Studies state that best practice should reflect an individualized approach with nurses being cognizant of the associated emotional and psychological needs of the woman and her family (Brier, 2004; Abboud & Liamputtong, 2005; Bryant, 2008). Evidenced in this study is the fact that emergency nursing practice is primarily concerned with prioritizing and providing for a patient’s physical aspects of care while there is a tendency to view acts of comforting or attending to emotional needs as secondary or time consuming. These findings are well in line with what is currently known in literature. This sentiment is echoed in Varcoe (1997) and Byrne & Heymann’s (1997) study that claims: nursing practice in the ED is dominated by a philosophy of prioritizing urgency of care based on medical complaints and the physical stability of the patient with little regard for the social and emotional context of nursing or the patient. In addition, Byrne & Heymann (1997) also assert that holistic and individualized emergency nursing care speaks to a more idealistic than realistic approach to care, again, another notion supported by findings in this research.
When nurses normalize miscarriage and focus mainly on the physical aspects of care, they underestimate the emotional care required and discount the woman’s experience of pregnancy loss through miscarriage. Viewing emotional care as secondary to meeting physical needs creates barriers to the delivery of holistic and optimal care necessary for women who, as previous studies claim, rely on nurses’ emotional and psychological care or support to cope with the experience and reduce the probability of mental health consequences (Corbet-Owen & Kruger, 2001; Swanson et al, 2007; Bryant, 2008).

To situate the reprioritizing of emotional care, it is important to note other aspects of the ED context that shape nursing care. Overcrowding and the lack of sustainable resources are contextual features that also continue to threaten the quality of nursing practice in meeting the emotional needs of women and contributes to validating the need to prioritize medical emergencies over less urgent presentations. In addition, factors like time constraints associated with caring for multiple patients and busyness of the department is noted as a contextual feature of the ED which shape nursing practice to become more task-oriented rather than holistic in nature (Moskop et al, 2009; Murphy & Philpin, 2010). Moreover, due to the scarcity in health care resources and services, and in following with the principle of just distribution guiding care in the ED (Moskop et al., 2009), prioritizing patient care has become based more on which patient is deemed to have the greatest need. These challenges are of critical importance as nurses in this study navigated the need for caring for patients that are critically unstable while balancing the emotional needs of a woman experiencing miscarriage. These are also key considerations when exploring the implications of putting emotional care back into the priorities of ED nursing practice. Providing emotional care, however, is not just about nurses finding it within themselves to do so; emotional care is as much a structural and organizational priority. Having time to
provide emotional care requires a reprioritization of resources and valuing of nursing work that can promote healing in many disease, illness and trauma situations. As efforts are now being made to better accommodate the needs of mental health priorities in EDs (Marynowski-Traczyk & Broadbent, 2011; Morphet, Innes, Munro; O’Brien, Gaskin, Reed, & Kudinoff, 2012), the same efforts could benefit women with pregnancy related urgent needs. For example, efforts could be made to provide a dedicated space as part of, or completely detached from the ED, for women experiencing gynaecological issues and pregnancy loss that is equipped with resources to address their specific needs, (i.e., social workers). This would ensure that appropriate and competent care would be provided, particularly in supporting the emotional aspects of their care.

**Expanding ED Nursing Competence**

The findings of this study indicate how gendered assumptions, clinical expertise and the nurses’ personal life context all shape nursing care for women experiencing miscarriage in the ED. These findings show that though each facet bears differing degrees of influence, each play a role in nurses’ feelings of self-competence and put to question their efficacy in being able to provide for both the physical and emotional needs of women.

**Challenging gendered explanations.**

It is evident in this study that the nurses assume female nurses are more appropriate and qualified to provide nursing care to women experiencing miscarriage. This supposition is based on the presumption that male nurses lacked the capacity to appreciate the lived experience of miscarriage and the aptitude to deal with such situations. All male nurses in the study confirm this generalization with statements expressing concerns that care for miscarrying women is beyond their capacity to care and by often putting into question the capacity for responsiveness
to women`s needs. This is also apparent when male nurses question their appropriateness in being involved with gynaecological examinations, a routine practice with women experiencing miscarriage, and state that they do not feel confident in providing emotional support. Accordingly, nursing practice becomes reflective of this thinking and care is organized in a way that female nurses automatically take on the care of women that presented with this clinical complaint.

Patterson & Morin (2002) investigated the experiences of male student nurses working with mothers in a maternal-child rotation draws similar trends and assumptions to those found in this study. Although their study focuses specifically on male student nurses versus male nurses being examined in this inquiry, similarities stem from male participants having to encounter and participate in unfamiliar maternal experiences. Patterson & Morin (2002) affirm that male nurses` insecurities and fear of rejection when providing care for women is due to their self-perceived lack of knowledge and understanding of a woman`s experiences. Additionally, male nurses desire for competence and efficiency was often challenged by gender stereotypes, and perceptions that this clinical area is strictly a woman`s domain.

These findings are of relevance and warrant further exploration as male nurses and miscarriages are both a constant in emergency nursing practice. Male nurses` feelings of being out of place, given the nature of the clinical situation, needs to be re-examined so that future strategies may be implemented to support their perceived lack of knowledge, comfort or understanding of the miscarriage process. Evidence also supports the need for male nurses to become more engaged and exposed to the experience of caring for women experiencing miscarriage rather than the automatic relegation of miscarriage care to female counterparts. This
approach may also assist male nurses in developing the comfort and professionalism expected when performing nursing assessments with unbiased gender perspectives.

**Enhancing perinatal expertise.**

The nurses in my study recognize that their work experience, education and training vary. These variances, representative of clinical expertise, resulted in different approaches to nursing practice and delivery of care to women experiencing miscarriage. Findings from my study indicate that nurses generally felt inadequately prepared to care for women due to a lack of knowledge regarding pregnancy loss, or a lack of experience in dealing with childbearing women.

The significant differences in knowledge and skill level to care for a woman experiencing miscarriage also translated to variations in how nurses perceived their care. Previous education and work experience affected nurses` confidence in knowing his/her approach to care reflected best practice. Collaborative practice between nurses and LPNs in the ED also contributed to inconsistencies in nursing practice due to the differences in scope and training. Miscarriage cases were also considered non-typical for the patient population where the study was conducted. The resulting lack of experience and practice in managing such patients contributed to discrepancies in nursing practice.

Of further interest, nurses’ uneasiness with providing care for women was also noted to be disguised in dialogues as an issue of “busyness” or outcome of overcrowding rather than examining underlying issues of confidence in their own nursing skills and competence. Nurses’ claim they have a tendency to misuse the issue of overcrowding as a means to justify deficiencies in nursing care associated with a lack of education and training. Some nurses describe distancing
themselves from women or withholding and limiting nurse-patient interaction because they feel uncomfortable and unprepared, thus questioning their own capacity to care. These findings draw attention to the importance of undergraduate and specialty training in preparing emergency nurses to appreciate the emotional and medical needs of women and the unique and individualized needs from such a significant loss.

The findings from this study are significant since little is known regarding the correlation between educational preparedness, exposure of ED nurses to miscarrying patients or feelings of clinical expertise and the effects on the quality of care provided to women. Comparisons however may be drawn from the study by Ojofeitimi, Asekun-Olarinmoye, Bamidele, Owolabi, & Oladele (2009) that assessed HCP’s knowledge on stillbirth and its influence on their nursing care for women. Ojofeitimi et al. (2009) concluded that an inadequate level of knowledge on stillbirth among HCPs resulted in poor nursing practices, negative patient care outcomes, and a lack of education and proper counselling for women and their families. Towards my study, this may similarly imply that the lack of formalized and standardized methods of education or training for ED nurses contributes to less than optimal care for women. This realization gives us an opportunity to recognize gaps in knowledge and training regarding care for women experiencing miscarriage and the need for emergency nursing to implement standardized protocols for management focused on providing competent physical or emotional care and education to women.

**Promoting personal reflection.**

In this study, a nurses’ personal life context is identified as playing a crucial role in informing emergency nursing practice for women. My findings indicate that most nurses
consider their own personal experiences as affecting their nursing care. Specifically, life experiences such as pregnancy and motherhood were identified as directly influencing nursing practice. Nurses acknowledged that these events contribute to their own appreciation and understanding of the emotional trauma associated with hoping, wanting, then losing a child. Nurses in this study also noted that they tend to be more patient and compassionate with women experiencing miscarriage after they themselves have experienced pregnancy or childbirth, and found it easier to connect emotionally with the women through this lived experience.

A study by Varcoe (1997) draws parallel conclusions about the significance of personal experiences on nursing practice. In her examination of nursing practice in relation to violence against women, she concluded that a critical analysis of one’s personal experiences contributes not only to creating personal knowledge about the experience but also assists us to identify how our own biases and assumptions influence our judgments and become the basis for practice. Nurses must recognize that

… an essential step to developing critical consciousness in nursing is for individuals to examine their own personal interest in regard to dominant interests with the goal of unmasking and operating with a critical awareness of ideology (Varcoe, 1997, p. 374)

Findings of my study similarly emphasize the need for nurses to be critical of their own context to be able to provide optimal care to women experiencing miscarriage. By promoting reflection and self-awareness of personal assumptions, values and beliefs, nurses are forced to examine how such influences shape their practice and helps instil a sense of control over how care can be enacted. These findings underline the importance of knowing your own experiences and moving away from the assumption that the meanings you ascribe to an event hold true to others experiencing the same experience.
Policy and Practice Recommendations

Based on the findings of this study, recommendations on how to improve emergency nursing practice will be discussed in relation to policy, research, education and practice. Within each category, strategies focused on how to empower emergency nurses’ in becoming more competent and responsive to the care needs of women and their families will be provided.

Community Based Care for Non-urgent Pregnancy Related Care

While I have indicated how the ED can better meet women’s needs, it is critical to also note why the ED may not be the appropriate place given the nature of the health or illness experience. This has profound implications on nursing practice given that women continue to seek health care services in the ED when they are miscarrying with few alternatives, if any, particularly during afterhours. This position may be construed as an inadequacy in the current health care system.

One suggestion in response to this need would be to establish community-based care for non-urgent pregnancy related issues. This would not only provide a safe alternative for women to seek care in an environment that is structured with sufficient resources and their specific needs in mind, but also relieves the ED of the onus of being the sole provider of care when they are already working beyond their capacity. The feasibility of this solution targets not only contextual issues of overcrowding and shortage in health care resources but falls in line with the assumptions around organizing care based on more efficient movement of patients in the ED making it appealing to organizational stakeholders.
Expanded Emergency Nurses Competencies

In discussing strategies to expand emergency nurses’ competence, this study not only highlights the need for improvements in education, but also encourages a focus on expanding emergency nurses’ clinical competence through specialty training and the integration of competencies in CNA specialty. The goal of each initiative is focused on establishing standardization of core competence for the care of women experiencing miscarriage.

Emergency nursing specialty training.

Given the diversity in nursing education, emergency specialty training and the experiences brought forth by emergency nurses into their practice (Table 1), a number of educational initiatives can be taken to overcome the gaps identified by emergency nurses’ regarding their understanding of miscarriage and the expectations of care. In this section however, improvements are targeted specifically towards emergency specialty training.

First, greater attention and awareness is encouraged at the specialty training level by improving their focus on pregnancy and obstetrical care within their program structure. Emergency nurses acknowledge that there is a lack of opportunity to learn about miscarriage, specifically identifying weakness in their foundational knowledge about the associated physical trauma and emotional symbolism of loss. They also recognize that miscarriage as a health challenge is often overlooked and rarely addressed in specialty training, resulting in emergency nurses feeling unprepared to care for these women. This can be addressed by encouraging curriculum change at the specialty training level, to integrate the topic of miscarriage as a core concept through a maternity or obstetric focused course.
Specialty training in emergency nursing should also consider the need for nurses to be educated and informed of the prospects and realities of caring for women experiencing miscarriage in the emergency setting. Emphasis should be given on the significance of miscarriage as a woman’s health issue, particularly during their childbearing years, given its high prevalence rate and its substantial impact on women’s health to underscore this need.

In addition, core competencies in CNA specialty regarding care for women experiencing miscarriage should also be reviewed, developed, examined and integrated. This ensures accountability and promotes an individual’s sense of duty towards garnering sufficient knowledge about proper care approaches for miscarrying women. These strategies will safeguard the public interest in receiving competent care and provide emergency nurses’ better guidance in delivering care that is effective and empathetic to women and their families.

**Education in the ED.**

The need of emergency nurses to be more educated on the issue of women experiencing miscarriage in the ED can also be addressed further through the development of in-house programs or educational sessions that are supported by the hospitals that employ them. This study recommends that orientation for new emergency nursing staff include: 1.) explanations of guidelines and hospital protocol for the management of women experiencing miscarriage; 2.) clarifications on the expectations regarding management or disposal of products of conception and 3.) education and awareness of the available resources for coping, emotional support, grief counselling.

Clinical educators and nurse leaders are also encouraged to be more proactive in increasing ED staff awareness on the impact of miscarriage to women and their families. This
can be achieved by incorporating miscarriage as a topic for discussion and review during emergency education days or through the development of additional in-services hosted by the department. Such activities can provide opportunities to promote consistency in emergency nursing practice and to increase professional accountability and responsibility towards care provided. Dedicating time and effort to educating emergency nurses on proper care for women also validates the significance of miscarriage as a health issue, dispelling ED nurses’ perception of miscarriage as being less important.

**Future Research**

Future research should be undertaken to expand our understanding of what is required for optimal care for women experiencing miscarriage in the ED. By identifying women’s specific needs, nurses will be better equipped to develop specific strategies to improve nursing care. Although much research is focused on the emotional and psychological effects of miscarriage on a woman, little is known about what women need within acute care contexts that are not tailored to the needs of the perinatal patient. A study that aims to understand what women require during treatment and prior to discharge, would help emergency nurses and medical professionals decipher what needs should be prioritized.

Future studies may also examine what women value most when being cared for in the acute care setting and build an understanding towards what encompasses good patient education, interaction and follow-up. This would also enable hospitals to create best practice standards and protocols for emergency practice. In addition, as needs of each woman experiencing miscarriage in the ED vary and are influenced by their own personal context, research likewise can be directed towards the developing a needs assessment tool that emergency nurses can utilize to
potentially assist them in adapting nursing care to meet the individualized needs of the woman. Development of such a tool may eliminate uncertainty about what care to provide, acknowledged by most ED nurses as a factor hindering their ability to deliver competent and optimal care.

Additional research is also needed to assess, confirm or dispute the suitability of emergency departments as a health care setting for women experiencing miscarriage and the competence of practice. As most women come to emergency departments when experiencing miscarriage, it is important to evaluate the appropriateness of services provided to these women and consider patient satisfaction with health care experiences in the ED. Research focused on assessing whether women’s needs are met and then contrasted with studies about nurses’ experience in caring for women would be beneficial to develop common goals in care. Inquiry into the appropriateness of 24 hour community based care centres that support the needs for non-urgent pregnancy related care may also be reasonable.

To address ED nurses’ concerns on the issue of male versus female nurses caring for women, research examining the role of gender in care delivery may be warranted. Research identifying factors that male nurses consider as barriers to realizing optimal nursing care for women should be pursued. Research examining what knowledge and skills male nurses require to prepare and support them in their role of caring for women experiencing miscarriage in the ED will also assist in eliminating role uncertainty.

**Conclusion**

Optimal care for women experiencing miscarriage in the ED can only be achieved when the complexity of external and internal factors shaping nursing care are understood. Making time, space and place for optimal care necessitates transformations in practice that challenge
assumptions about emotional care, the normalization of miscarriage and what is required for best practice within the ED context. Improvements on an organizational level can augment individual efforts to ensure quality nursing care is provide to women experiencing miscarriage in the ED. Paramount is changes within the organizational culture of emergency nursing practice that currently places greater value on the speed by which patients are brought through the department rather than the effectiveness or appropriateness of nursing care received. As most emergency nurses noted, most projects supported by the hospital organization were geared towards assessing the timeliness of the emergency department in seeing, assessing and discharging patients. Equal attention should then be paid towards targeting the provision of timely yet quality nursing care.

On an individual level, several changes can also be implemented to instigate more positive nursing practice for women. Challenging our own personal biases and the ideologies we have knowingly or unknowingly inculcated into our nursing practice is an excellent starting point towards our realization of the idealized holistic approach to care. Emergency nurses may act as advocates for women experiencing miscarriage in the ED by highlighting the impact of the context of nursing in providing optimal care. Suggestions can be made towards the creation of projects that examine quality assurance rather than quantity control (i.e. studies focusing on assessing whether appropriate teaching or follow up was provided prior to women being discharged – applicable to other patient situations) to those in position of power. It is also important that individual hospital administrators and nurse leaders take an active role in impressing onto nursing staff that meeting organizational goals of quicker turnover should not mean sacrificing quality in care provided to patients or taking short cuts. As noted in this study, faster service does not necessarily equate to improved hospital experiences or better nursing practice for women.


Caelli, K., Downie, J., & Letendre, A. (2002). Parents’ experiences of midwife-managed...


Neugebauer, R., & Ritsher, J. (2002). Depression and grief following early pregnancy


*British Journal of General Practice,* 53, 697-702.


Appendix A: Study Information sheet

*Understanding Emergency Nursing Practice towards Women experiencing Miscarriage in an Emergency Department*

You are being invited to participate in study entitled **Miscarriage and Emergency Nursing Practice** that is being conducted by Katherine Gavino. Katherine is a graduate student in the School of Nursing at the University of British Columbia and you may contact her if you have further questions by calling 778-772-1888 or by email at gavino@interchange.ubc.ca.

As a graduate student, I am required to conduct research as part of the degree requirement for my Master’s of Science in Nursing. This study is being conducted under the supervision of my thesis supervisor Dr. Helen Brown, and the thesis committee Dr. Gladys McPherson and Dr. Sheila Turris. You may contact Dr. Helen Brown at 604 822 7445 or helen.brown@nursing.ubc.ca.

**Purpose of study:** The purpose of the research is to explore your understanding of your practice as an emergency nurse when caring for women experiencing miscarriage in the emergency department (ED). The study aims include:

1. Developing an understanding of nursing care for women experiencing miscarriage in the ED
2. Understanding how the emergency context impacts nursing care for women experiencing miscarriage
3. Understanding what facilitates and constrains optimal care from a nursing perspective

**Why is this important?** Literature supports that nurses provide majority of the physical and psychological care needed by women experiencing miscarriage in the hospital setting. However, research is still required to determine how emergency nurses in particular can recognize and respond to the unique needs of these women while providing nursing care in a specialized health care setting.

**Potential participants of the study:** Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences. The eligibility criteria for potential participants include:

- nurses who have provided care for women experiencing miscarriage in the ED
- nurses from diverse backgrounds and a range of practice histories
- nurses who speak fluent English.

Participants will be provided consent form for their records

**Potential benefits:** The potential benefits of your participation in this study, as shown to be the case with this type of research are the opportunity to make sense of past experiences, see
current experiences in new ways, and imagine productive ways of moving forward in your future nursing interactions, care practices and relationships with women experiencing miscarriage in the emergency department.

Thank you for your time and interest.

If you have any concerns or questions during this study, please feel free to call Katherine Gavino at 778-772-1888.
Appendix B: University of British Columbia

Study Information and Informed Consent Form

I, _________________________ (full name of participant), understand that I am being asked to participate in a research study at Vancouver General Hospital that is being conducted by Katherine Gavino, a graduate student in the School of Nursing at the University of British Columbia, supervised by Dr. Helen Brown, Dr. Gladys McPherson and Dr. Sheila Turris.

The purpose of the research study is to understand nurses’ practice when caring for women experiencing miscarriage in an emergency department and examines: 1. what knowledge and skills inform nursing care for women experiencing miscarriage; 2. how the emergency context impacts nursing care for women; 3. what facilitates and constrains optimal care from a nursing perspective; and lastly, 4. how nursing care practices can be enhanced for women experiencing miscarriage in the emergency departments.

In providing consent to participate in the research study, I voluntarily agree to be interviewed for approximately 60-120 minutes about my experiences as an emergency nurse who has cared for a woman that has experienced miscarriage in the emergency department. The interview will be recorded and will occur at my time and place of my choosing to ensure privacy and confidentiality. No identifying information will be included when the interview is transcribed and no known risks are associated with participation in this study.

I understand that to be eligible for participation in the study I must be a practicing emergency nurse, able to speak English fluently.

I understand that I may withdraw from participation in the study at any time without penalty.

I acknowledge that details of the study have been explained to me and that I have read and understand this consent form. My questions have been addressed and a signed copy of the consent shall be provided to me. If however I have further questions, Katherine may be reached at 778-772-1888 or by email at gavino@interchange.ubc.ca. My questions have been addressed and a signed copy of the consent shall be provided to me.

____________________________________  _________________________
Signature of Participant                  Date

____________________________________  _________________________
Signature of Investigator                  Date
Appendix C: Interview Guide

**Interview Questions based on aims of Research:**

**Aim 1.** To develop an understanding of nursing care for women experiencing miscarriage in the ED

**Question:** Do you remember an occasion when you cared for a woman experiencing a miscarriage in the emergency department? Can you tell me about this experience and how you cared for this patient?

**Question:** What do you think guides or informs your nursing practice when caring for a woman experiencing a miscarriage?

**Aim 2.** How the emergency context impacts nursing care for women

**Question:** How do you believe the emergency context influences your nursing practice in caring for women experiencing miscarriages?

**Aim 3.** What facilitates and constrains optimal care from a nursing perspective

**Question:** As an emergency nurse, what do you feel constitutes optimal care for women experiencing miscarriage in the emergency department? What do you think facilitates or constrains the delivery of optimal care for these women in the ED?

**Aim 4.** How nursing care can be enhanced for women experiencing miscarriage in the emergency departments.

**Question:** Can you recall a time when you felt you did not meet a particular woman's needs when experiencing a miscarriage? Can you tell me what might have been going on for you or how the environment impacted your care? What in your experience would indicate 'good' care for women experiencing miscarriage?
# Appendix F: Sample Data Analysis

<table>
<thead>
<tr>
<th>Participant</th>
<th>Contextual Features of the ER</th>
<th>Understanding of ER Practice</th>
<th>Language Use/View on Miscarriage</th>
<th>Optimal Care</th>
<th>Implications/Recommendations</th>
</tr>
</thead>
</table>
| 006         | -“busy place”/noisy          | -personal experience with miscarriage  
- Drawing on own lived experience. Practice informed by “how I was treated when it happened and what worked for me and what didn’t work for me”. Allows you to really look at yourself and oh my goodness before | -miscarriage often leads to self-blame  
-miscarriage viewed as “a woman that’s just having some cramping and bleeding”  
-Gestation, how far along a baby is has emotional consequences on both nurse and patient/family. | -Reassurance  
-Extra support  
-Develop empathy  
-Addressing education opportunities and assisting with proper follow up care  
-And armed with a plan | -Women need reassurance “that they didn’t do anything wrong”  
-Lack of training  
-“sometimes our social workers aren’t even consulted” – effective utilization of resources  
-Addressing /attacking perceptions and prejudgment.  
-Changing the view of -miscarriage as a hopeless “only 8 weeks pregnant, we can’t do anything anyways, so why would she even come here”  
-Recognizing your own learning needs “this is not your area of expertise”  
-Knowledge on post-care support  
-Acceptance that showing emotion is ok – as a nurse and mother. |

*** NOTE: Lack of exposure to maternity population contradicted by statement that miscarriage is common place in emergency***
Table 1 Demographic Characteristics of 10 participants

**Participants’ demographics:**

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<td>46-55</td>
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B. **Female vs Male**

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<tr>
<td>Male</td>
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C. **Years of Nursing experience**

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D. **Year of Nursing experience in emergency**

<table>
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E. **Part-time/Full-time**

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