Not an Emergency: Discovering the Narratives of Emergency Department Nurses Who Care for Women Experiencing an Early Miscarriage

by

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Abstract

Early miscarriage presents a conundrum for women, their support people, society, and healthcare providers. Early miscarriage has been the topic of a plethora of research since the early 1980s. The early research focused on women's experience and sought to illuminate the challenges they faced accessing care and support. While research is abundant about early miscarriage and women's experiences of this in the decades that have followed, solutions to the challenges women face when they access care have not been found. Finding potential solutions to these challenges requires an examination of those who provide care. The 24-hour character of the emergency department (ED) and the urgent and often unpredictable nature of the symptoms associated with an early miscarriage make it a frequent point of care for women. ED nurses thus provide a significant amount of this care to women. However, the research describing ED nurses' experiences of caring for women with an early miscarriage has not substantively revealed the unique experience of the ED nurse in providing this care.

RNs who worked or had worked in the ED were invited to participate in this study, by engaging in a semi-structured interview. The stories of eight ED nurses who have cared for women experiencing an early miscarriage were examined and analyzed using narrative inquiry—specifically, Dr. A Frank's methodology of dialogical narrative analysis. The ED nurses' stories revealed four narrative resources common to all of the stories: *the reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do.* The stories also revealed two underlying narrative plot types that tied the narrative resources together: *You're not an emergency* and *Seeing the fetus*.

The ED nurses in this study described a conundrum they face with miscarriage in the ED. This arises from the fact that they perceived miscarriage to be out of place in their practice in the

ED. Specific challenges they revealed include lack of education, lack of policy and procedure, the medicalization of birth and death, the perception that miscarriage is a not an emergency, and the impact of seeing the fetus. The work of the ED nurses was another notable finding from the stories. On the surface, the ED nurses' stories focused on their psychomotor skills, medical interventions, and what they could not do for these patients. This trivializes the ED nurses' vital role in facilitating care for these women. However, woven throughout these stories was how much the ED nurses were indeed doing for their female patients. This incongruence lies in the fact that the ED nurses themselves did not appreciate the "work" they were doing with women patients and speaks to challenges that other nurses may face in their practice. The ED nurses' work and how they value their work is fundamental to answering these questions and extending our understanding.

While there is some support of these findings in recent publications, this research project does not mitigate the few studies that currently amplify the ED nurse's voice. Hearing accounts of this work and giving it a voice opens the possibility of a new narrative for ED nurses, one through which they can find redemption and agency as they navigate the experience of caring for women having a miscarriage in their ED practice.

Preface

This thesis is an original work by M. Patrice Drake. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board. The approved application is identified as “Coming together: Discovering the narrative of registered nurses who care for women experiencing an early miscarriage, No. Pro00070595, March 8, 2017.”

Dedication

This dissertation is dedicated to the women and birthing persons who have experienced miscarriage and to the registered nurses who care for them and their families.

Acknowledgements

"Let yourself be silently drawn by the strange pull of what you really love. It will not lead you astray." (Rumi)

My career as a perinatal nurse has endowed me with privileges that shaped whom I have become as a registered nurse. I have been present at births and deaths and sometimes both at the same time. It has always been a privilege, and I have been honoured to have been a part of both. It is this privilege that sparked my passion for studying perinatal loss. My doctoral studies allowed me to spend so much time with one of my great loves and to give back to the perinatal nursing world that gave me so much. This dissertation was indeed a "labour" of love.

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Glossary of Terms

Stories are about individuals and how they experience their world and recount it to themselves and to others. Individuals' stories can be their own original ones, or they can be those they have pieced together from other stories they have heard and retold from their perspective (Frank, 2010).

Narratives are collections of stories. "A narrative includes multiple stories featuring characters who share some problem or developmental trajectory" (Frank, 2010, p. 199).

Narrative resources are the words, phrases, tropes, and so forth that storytellers use to tell stories. Narrative resources also help people to recognize and understand stories that they hear from other storytellers. Storytellers acquire these tools through telling, retelling, and listening to the stories of their experiences. A narrative resource is like a thread that links stories together. Narrative resources are gained through telling and hearing stories, as people attempt to make sense of experiences (Frank, 2010; 2013).

Narrative types (or typologies) emerge from thinking with stories and narratives. Typologies are the underlying plots that bring together the narrative resources or threads of the story. They bring together individual stories to express what is common among a group of storytellers who share an experience (Frank, 2010; 2013).

Narrative habitus is the inner library of stories that storytellers curate over time and experience. They draw from this library to understand events in their lives and to retell their stories (Frank, 2010).

Chapter 1

In November of 2020, Meghan, the Duchess of Sussex, wrote of her experience of miscarriage in the New York Times. Her words described in a very public forum what is often a private and often silent experience:

> Losing a child means carrying almost unbearable grief, experienced by many but talked about by few. In the pain of our loss, my husband and I discovered that in a room of 100 women, 10 to 20 of them will have suffered from a miscarriage. Yet despite the staggering commonality of this pain, the conversation remains taboo, riddled with (unwarranted) shame, and perpetuating a cycle of solitary mourning (The Duchess of Sussex, 2020)

Miscarriage gained a bit more celebrity with the Duchess's story, but women's stories of miscarriage have been told for a long time.

A simple search of the *Globe and Mail* reveals many stories written by women who have either experienced a miscarriage or who know women who have experienced a miscarriage. The stories' titles often include the words "silent," "secret," "taboo," or "survived" to describe the women's experiences. The language used to describe the experience indicates a broad and acceptable spectrum of words. For example, one definition of the word miscarriage is "corrupt or incompetent management," wherein someone made a mistake or carried out a plan inappropriately, or there was an injustice (Merriam-Webster, n.d.). Another example is the "spontaneous expulsion of a human fetus before it is viable, especially between the 12th and 28th weeks of gestation" (Merriam-Webster, n.d.).

For a woman experiencing a miscarriage, the news that her pregnancy has ended brings about shock, guilt, heartache, shame, and even loneliness. This loss is not only the expulsion of a

fetus, or a spontaneous abortion or a blighted ovum. It represents the loss of her anticipated baby and all the hopes and dreams attached to that baby. Women face a loss from a miscarriage that was unplanned and often not revealed to the world because the social protocol says not to share pregnancy news too early (such as before 12 weeks) because something like this could happen.

In 2012, a story in MacLean's magazine highlighted several celebrities who publicly shared their pregnancy loss and how this created an openness to talking about pregnancy loss. However, the article was subtitled, "Devastated by perinatal deaths, parents reach out in sometimes disturbingly public ways" (Kingston, 2012). The author questioned if oversharing could affect the grieving process and make it difficult for those around a woman to support them in their grief. The sense was that women would get over things more quickly if they were judicious in what they shared; further, others could be more comfortable which would make it easier to support women in these circumstances. A long-standing medical narrative tells women they could have done nothing to prevent the miscarriage, so they should rest and try again. As Reinharz (1988) stated, "The only assistance obstetricians tend to offer a miscarrying woman is the scraping of her uterus, an explanation that 'we do not know what caused it, but rest assured that it was not your fault,' and the advice to 'try again in 3 months.'" (p. 88).

The intent here is presumably one of providing support for women, but they may actually perceive this to be dismissiveness about their experience. What families look for are reasons why the miscarriage happened, the risk of it happening again, and how they can prevent it from happening again (Quenby et al., 2021). Pregnancy and birth have become medicalized, even pathologized, to improve mothers' and babies' outcomes (Martel, 2014). The Canadian Family-centred Maternity and Newborn Care (FCMNC) guidelines (Public Health Agency of Canada (PHAC), 2021) acknowledge that birth is a healthy, natural process, but at the same time

acknowledge that medical interventions should be used by healthcare providers (HCPs) as necessary to reduce risk of morbidity and mortality (Public Health Agency of Canada [PHAC], 2017). However, medicalization alone is not sufficient to improve outcomes for women and babies given the understanding of the importance of comprehensive maternal–newborn care that focuses on much more than medical interventions; this includes, for example, prenatal education, labour support, prenatal nutrition, and community supports.

Since the early 1980s, there has been a movement to acknowledge that miscarriage is a significant event for women, one affecting their physical, psychological, and emotional health. This movement coincided with the women's movement and the advocacy for a gentler approach to pregnancy care and a more "natural" birth. Researchers such as Layne (2003a; 2003b) brought to light the challenges facing women who experience pregnancy loss and the intersection of the experiences of pregnancy and pregnancy loss. In particular, she highlighted the juxtaposition of women's feminist movement of empowerment regarding birth with the absence of support for women who experience pregnancy loss (Layne, 2003a; 2003b). Other researchers, such as Swanson (1986; 1991; 1999a; 1999b) and Hutti (1992; 1998; 2017), have advanced research that describes both the impact of miscarriage on women and families and the role of HCPs in supporting women and families as they navigate the experience of pregnancy loss. However, despite a substantive body of literature that describes women's experiences, health systems may not have uniformly used women's experiences to inform clinical practice. An editorial from *The Lancet* (2021) entitled "Miscarriage: Worldwide Reform of Care is Needed" reinforces this observation that miscarriage remains a challenge within the healthcare system:

> For too long, miscarriage has been minimized and often diminished. The lack of medical progress should be shocking. Instead, there is a pervasive acceptance. (p. 1597)

Pervasive acceptance is not an appropriate reason for the lack of knowledge mobilization to support the care of women who experience miscarriage and the nurses who provide care to women. Instead, developing an understanding of where women go for care and who provides that care is an essential step in changing practice.

Seeking Care for Miscarriage

Settings where women seek care during a miscarriage include primary care clinics, reproductive care clinics, birth centres, early pregnancy loss clinics, and emergency departments (ED). The symptoms of miscarriage, including pain and vaginal bleeding, often necessitate women's access to care in the ED (Glicksman et al., 2019). The 24-hour coverage offered by the ED also makes it a common site for care during a miscarriage (Punches et al., 2019). Varner et al. (2020) identified that in Ontario, peripregnancy use of the ED occurred in 39.4% of all recognized pregnancies. They also identified that peripregnancy use of the ED was higher for women who experienced a threatened miscarriage (84.8%) or a miscarriage (73.7%) than for stillbirth, live birth, or therapeutic abortion, as patients with these health concerns would receive care in perinatal units. Indig et al. (2011) reported that in Australia, problems in early pregnancy, including miscarriage, accounted for 1.2% of all ED visits. These statistics suggest that the ED is a common site for women to seek care for a miscarriage. I posit that to explore the experience of miscarriage in the ED we must understand the ED as a site for care; this entails understanding the experience of those that provide care in the ED, specifically ED nurses.

The Emergency Department and Nurses

The modern ED has been in existence since the mid-20th century. What was initially a room where patients could receive care for minor cuts and bruises grew into a place where expert clinicians worked with military precision to save people's lives (Holleran, 2016). The wars in the

20th century, particularly World War Two, the Korean War, and the Vietnam War, brought about the understanding of prioritizing patient care based on the severity of illness and acting rapidly to preserve or create hemodynamic stability (Holleran, 2016). As emergency medicine evolved, recognition of the ED nurse as an integral part of the emergency care team was part of that process (Holleran, 2016). Over time, the role of the ED nurse evolved as well, with nurses became proficient in triaging patients, intervening with life-saving resuscitation efforts, performing a variety of patient interventions, and supporting physicians in providing care to those who sought care in the ED (Holleran, 2016).

Nurses in the ED receive patients at the triage desk when they arrive for assessment and provide a significant portion of the care patients receive while in the ED. Triage is a function unique to ED nurses, which facilitates the patient care and affects the activities of the entire ED (McNair & Solheim, 2016). Although physicians diagnose and treat medical conditions, ED nurses remain with patients and their families throughout their ED experience and are the consistent providers of care (Cypress, 2014). The unique skill set of ED nurses and their prominent role within the ED often finds them working to their full scope of practice.

However, this autonomy is not without its challenges. ED nurses face several stressors as a part of their role. Dealing with patients and their families in critical situations puts ED nurses at risk for negative and even violent encounters with patients and families (Alomari et al., 2021). In addition, challenges that are endemic to the ED, such as overcrowding and long wait times, increase the risk of these negative encounters, while understaffing and increased workloads further complicate these challenges (Alomari et al., 2021). MacPhee et al. (2017) stated, "Therefore, heavy workload could cause nursing tasks to be left undone and increase nurses' interruptions, which could impact patients' care and their health outcomes" (p. 982). The ED is

often described as chaotic with quickly changing acuity, rapid turnover of patients, and increased levels of anxiety experienced by patients and their families who arrive in a medical crisis (Punches et al., 2019). When a woman arrives in the ED with the symptoms of a miscarriage, the ED nurse navigates yet another challenging situation in the milieu of their ongoing shift (Punches et al., 2019).

Miscarriage is often a medicalized event that is not necessarily viewed as urgent or life-threatening or as the death of an anticipated baby (Punches et al., 2019). In the grand scheme of the ED, a miscarriage may not be perceived as being as serious as a stroke or a myocardial infarction (Merrigan, 2018). The result, albeit inadvertent, could be that ED nurses (and other ED staff) portray to the woman that her loss is not important or urgent; as a result, the woman feels that her sense of loss is underestimated and minimized, leading to dissatisfaction with the care she receives (Bacidore et al., 2009; Punches et al., 2019). While the reaction of the ED nurses may be more complex than simply a lack of compassion, they may not have the requisite knowledge, skills, and resources to provide the care that women need during a miscarriage (Merrigan, 2018).

ED nurses know how to preserve health and safety, and they guided by policies and guidelines to help them do this for most diagnoses. However, miscarriage often finds the ED nurse managing care without the usual policies and protocols. The result is that physical care is prioritized by the nurse and women's emotional care is often overlooked (Merrigan, 2018). Moreover, the chaos and busyness of the ED are perceived to interfere with the ED nurse's ability to provide comprehensive care for women. The resulting perception may be that the ED nurse lacks compassion and empathy for women experiencing a miscarriage (Gergett & Gillen, 2014; MacWilliams et al., 2016). Although the expectation is that ED nurses provide

comprehensive care to women who are experiencing a miscarriage, actually fulfilling this responsibility may be challenging. Several factors contribute to this: the small volume of research describing ED nurses' experience of providing care, a lack of practice guidelines for the care of women who experience a miscarriage in the ED, and a lack of education to support ED nurses to provide care for these women (Emond et al., 2019).

Emond et al. (2019) identified that while some health systems have created clinical practice guidelines for miscarriage, little of these have been adopted to support care in the ED. Emond et al. point to the Canadian Pediatric Society's practice guidelines for perinatal loss (Hendson & Davies, 2018), which focus on later perinatal losses but without specific guidance for miscarriage. EDs may have processes in place to manage miscarriage from a clinical perspective, including diagnostic tests, symptom management, and even surgical intervention; however, what is missing is a plan to provide comprehensive care that meets the unique physical, mental, and emotional needs of women both at the time of care and after discharge from the ED (de Montigny et al., 2020).

ED nurses are present with women throughout their ED visit—right from the triage desk until discharge—and provide them going-home instructions. The ED nurse plays a leadership role in caring for women in the ED who are experiencing a miscarriage. There is a plethora of research that describes women's expectations for care during a miscarriage (Adolfsson et al., 2004; Bellhouse et al., 2018, 2019; Black, 1991; Freeman et al., 2021; Hendson & Davies, 2018; Hutti, 1992; Swanson-Kauffman, 1983; & Wojnar et al., 2011), yet a paucity of research was also found that described the ED nurses' experience in providing care. This juxtaposition is both compelling and concerning in equal measure. I posit that analyzing ED nurses' stories could be enlightening as to the influence of various discourses on miscarriage, nursing care, and

perceptions of the barriers to providing care to women. Additionally, what is also not well understood is the care ED nurses actually provide for women experiencing a miscarriage in the ED. Understanding the miscarriage experience from the ED nurses' perspective is essential to providing high-quality, evidence-informed care. Given the abundance of firsthand accounts and existing research evidence over decades, knowledge of how nurses can best support women experiencing miscarriage merits another look. Gaining insight into the experiences of ED nurses caring for women experiencing a miscarriage, within the conditions of the ED, is warranted and timely.

Research Questions

The purpose of this research project is to hear and understand the stories of registered nurses who work in the ED and have cared for women who experienced a miscarriage. The following research questions guide the study:

1. What stories did registered nurses who practise in the emergency departments tell about their experiences of caring for women experiencing an early miscarriage?
2. How did the stories of registered nurses who practise in the emergency departments make the experience of early miscarriage intelligible?

What follows in Chapter Two is an exploration of the literature explicating further some of the available evidence, as pointed to above, along with additional sources. Some authors tried to shed light on early miscarriage through personal narratives, critique, research studies, and media coverage. However, the ED nurses' experience of caring for women experiencing a miscarriage continues to present challenges; thus, research to understand why is long overdue.

Chapter 2

What Do We Know About Miscarriage?

The previous chapter opened the door to miscarriage and its vicissitudes. There are many. However, what remains startling is the sheer length of time that women and families have had difficulty securing appropriate care during a miscarriage. The review of literature presented in this chapter highlights the experience of women seeking care for miscarriage in emergency departments (ED) and the ED nurses who take care of them.

To uncover the available literature related to miscarriage required a thoughtful process. Existing terminology and definitions presented a significant issue. The Public Health Agency of Canada defines perinatal loss in the Family-centred maternity and newborn care: National Guidelines (Chapter Seven: *Loss and Grief)* as loss that "includes infertility during the preconception period, fetal death during pregnancy (miscarriage, ectopic pregnancy, induced abortion, and stillbirth) and infant death in the first year of life (neonatal or post-neonatal death)" (PHAC, 2020, p. 7-2). The literature describing these types of perinatal losses is often generalized, with a significant portion focusing on losses that occur after 20-weeks gestation. Guidelines such as those from the Public Health Agency of Canada, described above, and the Canadian Pediatric Society (Hendson & Davies, 2018) also focus on losses that occur later in pregnancy, such as stillbirth and neonatal death. Initially, I explored perinatal loss using the terms *perinatal loss or stillbirth or perinatal death or miscarriage or bereavement* and did not limit the databases. While I found more than 200,000 results, these search terms provided limited results focused exclusively on miscarriage. Certainly, perinatal loss or pregnancy loss may be a more inclusive term to describe this type of loss, but I sought to focus on miscarriage that occurs before 14-weeks gestation.

To help focus my search on miscarriage, I consulted with librarians at the University of Alberta and the University of Prince Edward Island (UPEI). With their guidance, I completed another search using the terms *miscarriage or abortion spontaneous or pregnancy loss* and used the *Cumulative Index of Nursing and Allied Health Literature (CINAHL), Google Scholar, Medline, and PubMed* to aid in the search. Initially, the search focused on the period from 2000 to 2016. My awareness of sentinel works written about miscarriage by Dr. K. Swanson (Swanson, 1999a, 1999b; Swanson-Kauffman, 1983, 1986,) and Dr. M. Hutti (Hutti, 1992) resulted in a search to find these articles, which therefore went beyond the years of 2000–2016.

While the literature revealed an abundance of studies about women's experience or perspective of miscarriage, the focus of my work was with ED nurses; I thus sought to narrow the search further and used the terms *nurse or nurses or nursing* AND *miscarriage or abortion spontaneous or pregnancy loss.* This search, focusing on the years from 2016 to 2020, revealed research describing nurses' experience providing care for women who have had a miscarriage. The challenge with this search was, as before, the lack of focus on miscarriage and exclusively on ED nurses, with several articles including all types of pregnancy loss, other health care professionals, and parents/women. I added *emergency room or emergency department* to the search to narrow the search, using the years 2016 to 2020. I retrieved 42 articles from 2010 to 2016 that included the ED, nursing, and miscarriage. Since 2016, there has been an increase in published research about miscarriage in the ED. The experience of ED nurses and miscarriage is becoming more visible in the available literature, with 35 articles noted in this period. Even with this increased visibility, the experience and perspectives of the ED nurse remained limited within the available literature related to miscarriage in the ED.

Setting the stage before undertaking this study was essential to determine what knowledge existed about miscarriage. What follows is a discussion of what is known about miscarriage—specifically, the ED as a place for care, the ED nurses' experience as they care for women having a miscarriage, and the experience of women seeking care in the ED during a miscarriage.

Defining Miscarriage

Discovering the literature that describes miscarriage presented challenges, as described above. Notably, the challenges with terminology and definitions to define miscarriage were not unique to this project, as they were described in a scoping review by Freeman and associates (2021) about women's experience with health care during a miscarriage. These authors stated, "It should be noted that there is some ambiguity and variation on how early pregnancy loss and miscarriage are defined within the literature, challenging the ability to summarize findings related to the topic" (p. 2). A review of the definitions corroborates this statement, as various sources have slightly different parameters to define early miscarriage.

Miscarriage can be defined as early (occurring before 12-weeks gestation) or late (occurring between 12- and 20-weeks gestation; Moyle-Wright, 2011). The American College of Obstetricians and Gynecologists (ACOG) (n.d.) describes early miscarriage as a loss at fewer than 13 weeks. Other sources describe early miscarriage as occurring before 14 weeks (Allison et al., 2011). Freeman et al. (2021) defines early miscarriage as a loss before 13-weeks gestation. Miscarriage is thought to occur in an estimated 15 to 20% of all pregnancies (Society of Obstetricians and Gynecologists of Canada [SOGC], 2015). Other estimates are that miscarriage occurs in 11 to 22% of pregnancies (Ammon Avalos et al., 2012). About 80% of all miscarriages are also known to occur in the first trimester of pregnancy or before 13 weeks (ACOG, n.d.),

making early miscarriage the most common type of miscarriage. For this study, early miscarriage was defined as pregnancy losses that occur at 14 completed weeks or less of gestation. For consistency, henceforth I will use the term miscarriage to refer specifically to pregnancy losses less than or equal to 14-weeks gestation. Where appropriate, literature that refers to early miscarriage in particular will be identified.

Statistical data describing miscarriage were also challenging to discover. The last data set available from Statistics Canada, produced in 2008, includes miscarriage in summative data describing stillbirth, miscarriage, induced abortions, and unspecified abortions. Assessing the portion of these data that represent miscarriage has been difficult. Miscarriage is described as a "frequent" or "common" complication of pregnancy throughout the literature. The available statistics related to ED visits described in Chapter One suggest this may be a reasonable supposition. Anecdotal comments in the literature from healthcare providers (HCPs), along with the findings of this study, suggest it is a common complication in pregnancy. The lack of data to accurately describe the frequency of miscarriage raises concerns that it may be impossible to say whether miscarriage is a frequent or infrequent occurrence. In a recent series in *The Lancet*, Quenby et al. (2021) recommended that data describing the occurrence of early pregnancy loss across countries is needed to facilitate research and policy development. Coomarasamy et al. (2021) similarly state the following:

> We recommend that early pregnancy services document and report monthly tallies of miscarriage to a national registry, and then every country reports annual miscarriage data similarly to the reporting of stillbirth. Such data will facilitate efficient care organization, better allocation of scarce resources, research, and international comparisons. (p. 1673)

From a global or international perspective, comparing data between high income countries and low-and middle-income countries is challenging because of differences related to access to medications and equipment (e.g., ultrasound), and priorities and limitations (Coomarasamy et al., 2021). Despite the lack of specific statistical data reporting on the prevalence of miscarriages, abundant literature describes miscarriage as a frequent occurrence that is sometimes minimized and requires more knowledge mobilization about the provision of care. This description of miscarriage as frequent or commonplace is somewhat contradictory: on one side, miscarriage is frequent and minimalized, but on the other hand, miscarriage is frequent, so there should be more knowledge mobilization about how to provide care. Understanding what is known opens the possibility to understand what may be missing, which consequently affects nursing care.

Studying Miscarriage

While a substantive body of published literature on miscarriage exists, it presents another conundrum regarding this topic. The published literature on perinatal loss can be grouped into four categories.

1. Early pregnancy loss including miscarriage or spontaneous abortion, and ectopic or induced abortions before the age of viability, which is usually 20-weeks gestation, noting that the World Health Organization (WHO) suggests the lower limit of viability is 22-weeks gestation (Al-Alaiyan, 2008).
2. After 20-weeks gestation, including stillbirth and neonatal death.
3. Women and their partners.

4. Healthcare providers (including physicians, midwives, and nurses). Many clinical practice guidelines focus on losses later in pregnancy or the early days and weeks after birth (Hendson & Davies, 2018; PHAC, 2020).

Literature describing women's experience with miscarriage and their care needs is considerable and reflects an ongoing acknowledgement of women's needs to navigate this experience. This literature spans several decades, with the same conclusions as illustrated in Freeman et al. (2021) and Cosgrove (2004). Freeman et al.'s scoping review identified three major themes that describe women's experience with the health care system, including "issues related to communication, challenges within healthcare environments, and inadequacies in aftercare" (Freeman et al., 2021, p. 3). Similarly, Cosgrove published a feminist literature critique about pregnancy loss. She noted similar issues to Freeman et al., namely, the prevalent medical management of pregnancy loss, a lack of education to prepare HCPs to provide care, and a noted lack of follow-up by HCPs to women after their loss (Cosgrove, 2004). In the 15+ years since publication of this article, the conclusion has not changed. What is known about miscarriage is garnered from research that dates as far back as the 1960s; yet, we have much more to learn about the experience. The following discussion will highlight what is currently known and understood about miscarriage.

Miscarriage Over Time

An article published in *Newsweek* in August of 1988 discussed the prevalence of miscarriage in women in the United States (US; Beck et al., 1988). The article included women's stories and described the grief they experienced when their pregnancy ended. The authors also described women's experiences with HCPs' dismissiveness and the unhelpful platitudes from friends and families. They identified the risk of depression due to hormonal changes, the lack of

explanation as to why the miscarriage happened, and that the women felt responsible. They also talked about how women were beginning to speak out about miscarriage and desired a different type of care.

In the'80s and'90s, researchers such as Dr. Kirsten Swanson (1986; 1991; 1999a; 1999b) were also hearing the call of women to understand the experience of miscarriage. This early work focused on the woman's experience of miscarriage, an examination of grief in relation to miscarriage, and what a woman's care needs were following a miscarriage. This work provided a foundation for further research to develop guidance regarding supporting care for women experiencing early miscarriage, such as Swanson's work. In 1983, Swanson published her dissertation, *The Unborn One: A Profile of the Human Experience of Miscarriage*. This began a period of sustained research in this area, including descriptive research (Huffman et al., 2015; Swanson 1991; 1999b; Swanson-Kauffman, 1986) as well as randomized controlled trials (Swanson, 1999a; Swanson et al., 2009). More recently Swanson, in collaboration D. Wojnar and others, added her previous phenomenological studies to develop a conceptual model of miscarriage, positing that the model "provides evidence that there may be universal challenges associated with miscarriage and its aftermath, at least for these participants" (Wojnar et al., 2011, p. 538).

Swanson's findings were echoed and extended in other studies completed during the late 1980s and early 1990s. For example, Black (1991), and Bansen and Stevens (1992) shared similar findings in their study of miscarriage. Black (1991) reinforced the importance of partner support during and following miscarriage, and also described that individuals' experiences of miscarriage vary among women. Bansen and Stevens (1992) described the importance of support and care from HCPs, and that women's guilt was identified as a significant emotion. In other

research, Adolfsson (2011a) built on a study conducted in 2002 to 2003, which had offered a plan for providing care for women experiencing miscarriage. This plan was found to not meet the needs of women seeking care from the health care system in Sweden. Adolfsson used Swanson's theory of caring (1993) to redesign the care plan; when knowledgeable practitioners implemented such plans, women who had experienced miscarriage reported that this improved their care.

Hutti (1992) published work on perinatal loss and miscarriage from 2000 to the present decade. Compared to Swanson's (1986; 1991; 1999a; 1999b) early work, it is evident that Hutti (Hutti, 1992; Hutti et al., 1998) elaborated on what Swanson described, producing new findings about the influences on parents' perceptions of the experience of miscarriage. Hutti et al.'s (2017) more recent work developed a tool based on their previous work to "predict women who may experience future intense grief associated with perinatal loss" (p. 128). In a meta-analysis to examine psychological reactions to miscarriage, Adolfsson (2011b) also described women's grief reactions after miscarriage, as well as the prevalence of depression and other psychiatric morbidity following miscarriage. In an earlier study, Adolfsson (2010) explored women's experience of miscarriage using interpretive phenomenology and examined their perspective from a past, present, and future orientation. Women reported the impact of (a) past experiences on their perception of the miscarriage experience, (b) the present, when they sought care during the miscarriage and the lack of support they received from HCPs, and (c) the future, where they spoke of mourning the loss of their baby and the fear of becoming pregnant again and losing another baby. All these studies reflect similar findings about the human experience of miscarriage.

Swanson's (Swanson,1991, 1999a, 1999b; Swanson-Kauffman, 1986) and Hutti's work (Hutti, 1992; Hutti et al., 1998; Hutti et al., 2016; Hutti et al., 2017), as described here, both serve to validate women's experience as a way to guide care. Both Swanson and Hutti have also developed tools to assess the impact of miscarriage on women and their partners. Hutti (1998; 2007) developed the perinatal grief intensity scale while Swanson (1991; 2007; Wojnar et al., 2011) developed models of caring, as well as a conceptual model of miscarriage. Both the scale and the models have been used to inform interventions with women and couples who experience miscarriage. Swanson and Hutti, and their collaborators, have compiled works that describe women's experience, outline women's care needs, and provide guidance for nurses who care for women experiencing a miscarriage. However, despite their sustained research, knowledge mobilization has not occurred to a significant extent. We need to ponder why this is, as well as why this whole field is fraught with difficulties in developing guidelines to assist the practising nurse.

To understand what is known about the experience of having a miscarriage, it is pragmatic to examine what is known about where women go for care (the ED); what is known about the HCPs who deliver care (ED nurses), and the experience of those having a miscarriage (women). Finally, the discourses that influence the place, the HCP, and those who are having a miscarriage must be examined.

The Emergency Department

Women seek care in various settings during a miscarriage, including primary care clinics, reproductive care clinics, and EDs. There are stories of tragic, even horrific experiences noted by women when seeking care in EDs. The ED is a common site for care during a miscarriage, and often this is the only place that women can seek care because, if they are under 20-weeks

gestation, they find themselves too early in their pregnancy for obstetrical services (MacWilliams et al., 2016). In Ontario, Canada, researchers examined peripregnancy ED use by pregnant women through a retrospective population-based cohort study (Varner et al., 2020). Between 2002 and 2017, there were 2,728, 236 recognized pregnancies in Ontario; 39.4% of these women visited the ED (Varner et al., 2020).

The most common diagnoses were first-trimester complications, including threatened abortion, unspecified hemorrhage in early pregnancy, and miscarriage (Varner et al., 2020, p. E309). Varner et al. (2020) identified that of those Ontario women who visited the ED, 84.8% came with a threatened miscarriage, followed by 73.7% with a miscarriage. A study completed in Australia described characteristics of women who sought care in the ED for a miscarriage, to identify predictors of service delivery outcomes (Indig et al., 2011, p. 257). This study revealed that women who sought ED care for a pregnancy complication accounted for 1.2% of all ED visits in Australia. In the US between 1993 and 2003, miscarriage accounted for 1.6% of all visits to the ED (Wittels et al., 2008). Given the available data about miscarriage in the ED, it may be prudent to consider how the ED setting itself informs nurses' and women' perceptions of miscarriage in such sites.

The contemporary ED is often portrayed as an embattled part of the hospital, whose staff are challenged to be gatekeepers to a system that can often neither manage nor facilitate the flow of patients through this department. Issues of overcrowding and long wait times are prevalent in the literature, aspects that inform the practice of emergency care and are often the subject of negative news stories (Ospina et al., 2007; Person et al., 2013; Van den Berg et al., 2015). A lack of primary care providers and inconsistent access to those providers make the ED a primary care service source for many people (Bond et al., 2007; Van den Berg et al., 2015). The ED is

assumed to be a place for urgent care, where life-threatening injury or illness is cared for efficiently by skilled HCPs. Person et al. (2013) also identified organizational culture as a factor in the challenges facing EDs and indicated that efforts should be directed at improving working conditions and fostering opportunities to build relationships to improve care and outcomes. They stated, "Each ED can create its own culture, meaning it can create underlying beliefs, traditions, and values beyond what is written down as organizational values" (p. 222). This statement is worth considering with respect to how the ED's "culture" affects ED nurses and how they can provide care.

Registered nurses (RNs) are on the front lines in the ED, as they are often the first contact point for those accessing services since they triage patients by assigning acuity. In Canada, nurses use the Canadian Triage and Acuity Scale (CTAS) to classify patients and direct care. CTAS is a five-level scale (with level 1 as most urgent) based on a standardized set of data prioritizing patients in the ED (Bullard et al., 2017; Fernandes et al., 2013). This tool is used to assign a standardized acuity score to patients to ensure that the most ill or injured are seen first. Women experiencing a miscarriage at less than 20 weeks are prioritized based on their vital signs and the amount of vaginal bleeding: they could be assigned a level 3, which is considered an urgent score, mandating they receive a check in 30 minutes and expect to see the physician at that time; or, they may be classed as a level 5, which is non-urgent and calls for seeing a physician within 2 hours. While CTAS is a valuable tool to standardize and prioritize care, it may not meet the unique needs of women or prioritize their care in the best way. Miscarriage in the ED is a challenging experience and understanding what this journey looks like is essential to this discussion.

Women's Experience of Miscarriage in the ED

Women present to the ED when they perceive or know something is wrong with their pregnancy. As mentioned earlier, the ED may be the only place that women can access care. MacWilliams et al. (2016) describe women's decision to seek care because they were concerned for the welfare of their baby as a central theme in women's experience. One of the themes they discovered was *"Not an illness. A different kind of trauma*." This theme was expressed by women when describing their experience in the ED and shared their feelings that they did not feel they belonged in the ED and were not a priority for the HCPs.

Women perceive an emergency with the impending threat to their pregnancy; however, the ED does not necessarily accept miscarriage as a threat to women's health and safety or view miscarriage as an urgent situation (Baird et al., 2018; Larivière-Bastien et al., 2019). Based on their symptoms, acuity level, and the perceived non-urgent nature of miscarriage, women may wait for lengthy periods in the ED before receiving care. Other investigators revealed that women were negatively affected by the chaotic and unfriendly environment of the ED (Baird et al., 2018; Larivière-Bastien et al., 2019; Merrigan, 2018). For instance, women were "traumatized" by long waits, insensitive staff, and the perceived indifference of staff. Adolfsson (2010) also described women being "traumatized" by long wait times and the dismissive attitude of HCPs in the ED. Some women even reported wondering whether their outcome might have been different if they had received care sooner (Baird et al., 2018, p. 115).

Warner et al. (2012) extended these findings by also identifying the importance of privacy, where a lack of privacy was reported as resulting in significant distress for women. The women acknowledged that their condition might not be severe enough to warrant a bed, but "when they were provided with a bed or private place away from the general waiting area, they

were very grateful" (Warner et al., 2012, p. 89). Punches et al. (2019) described women's "using the public restroom and fears of losing the baby in the toilet as well as crying in front of other Patients…" (p. 64) when they were waiting for care and did not have privacy either in the waiting area or if they had to use a public bathroom. Edwards et al. (2017) reported a similar finding—that women found standing at the triage desk in the waiting room made them feel "anxious and exposed" as they told their story to the nurse (p. 295).

Some high-profile cases have been reported across the country, in which women who suspected they were having a miscarriage did so publicly in the ED waiting room (Canadian Broadcasting Company [CBC], 2006, 2010; Henderson, 2007). There is a familiar trend in these cases: an overcrowded ED, long wait times, and a lack of protocol to address the unique experience of miscarriage (MacWilliams et al., 2016). Women described humiliation and fear as they bled heavily and lost their pregnancy. In each case, the health authority investigated and intended to put processes in place to prevent this from happening again. However, in June 2020, a woman sat alone for hours in a Canadian ED while suffering a miscarriage (Sweet, 2020). The woman came to the ED with spotting and due to Covid-19 restrictions had to wait alone for several hours. She not only sat alone without support but was eventually sent home with little guidance as to what to expect or what to do for follow-up (Sweet, 2020). Unfortunately, as recently as March 2021, a woman was left waiting for hours before being transferred to a facility equipped to provide the care she needed for the miscarriage she was experiencing (Smith, 2021). Challenges like those identified by Warner et al. (2012) and Punches et al. (2019) continue to be the reality for many women seeking care in the ED during a miscarriage.

Significantly, women lack information and expert care at critical points in their ED experience during a miscarriage, which affects their perception of care (Larivière-Bastien et al.,

2019). Larivière-Bastien et al. (2019) described three critical junctures where women needed information: when they were informed of the miscarriage; when they were offered treatment options; and at discharge, regarding aftercare and follow-up (p. 672–673). Women reported a lack of information about what to expect; further, they felt that their HCP knew they were having a miscarriage but did not share this information with them while they waited for care (Punches et al., 2019).

Emond et al (2019) have discussed the gaps between what women experiencing a miscarriage are looking for in their ED care and what they actually receive. In particular, they mentioned that women sought emotional care because of the loss, but their care was often focused on physical care. They also commented on the lack of patient education including written and verbal information about what to expect. In a Canadian study by MacWilliams et al. (2016), women described feeling unprepared for what would come next, when they left the ED following a miscarriage. This lack of information included what to expect with follow-up care, their emotions, and any physical symptoms. Women in this study also described feelings of isolation intensified by lack of support and information and the suggestion to move on from the miscarriage as if it were a minor event. In an Australian study, Warner et al. (2012) reported that only two of 16 participants said that they were offered follow-up counselling following their miscarriage. Those who did not receive follow-up identified that even though they experienced prolonged emotional distress, they would have appreciated follow-up to see how they were coping with the loss. Women in this study also reported that they would have appreciated more information about miscarriage and what to expect, including grief. Participants also stated that they did not receive test results and were not fully informed about their pregnancy status during their ED visit and discharge.

de Montigny and colleagues (2020) conducted a review of 198 patient records of women who received care for spontaneous abortion, threatened miscarriage, ectopic pregnancy, pregnancy without the embryo, and molar pregnancy was conducted in four EDs in Quebec. This study highlighted some of what women reported about their experiences in seeking care—where 40% of women saw multiple care providers, anywhere from two to seven nurses. The researchers reported that on average, the women came to the ED twice for care during their miscarriage, with less than half coming only once to the ED. One in five came three or more times (p. 5), and only 0.5% met with social workers. Women waited for an average of four hours and nine minutes to be seen by a physician, with the waiting time ranging from 19 minutes to approximately 20 hours. Care followed a standard of practice; however, HCPs did not document the women's understanding of the care and expectations, nor was there documentation of any psychosocial care. The researchers concluded that while miscarriage consumed substantive time and resources, the care was not provided efficiently, nor was it meeting women's psychosocial needs.

Edwards et al. (2017) spoke about a "threads of care" theory to guide the care of women in the ED (p. 295). In their study, women, their male partners, and nursing staff were interviewed to understand their experiences of miscarriage in the ED. Their threads of care theory include five stages of moving through the ED: "presenting as one, wanting recognition and inclusion, seeking support and understanding; leaving as one, and moving on" (p. 295). For each thread, the woman and her partner's experience were described, as well as that of the nurse. These detailed descriptions offered some insight into the complexity of the experience for both families and nurses.

While there is research that describes the experience for women seeking care in the ED when they are having a miscarriage, there is still a paucity of research describing the experience

of the ED nurse, as "few studies have focused on the practices and experiences of emergency nurses, even though they are the front-line care providers for these women" (de Montigny et al., 2020, p. 2). While the analysis of the ED nurses' stories revealed that gaps in care exist, the ED nurse and the female patient are still navigating the experience of miscarriage together. This mutuality was an important discovery that will become more evident in the findings and discussion of my study, but also supports the necessity of understanding the ED nurses' perspective of miscarriage as I have reviewed the literature.

ED Nurses and Miscarriage

While the studies described in the previous section address the woman's experience in the ED, notably, the experience of ED nurses is not substantively addressed within these studies. Furthermore, few studies were found in the literature over the last many decades that speak to the experiences of nurses working in the ED who care for women having a miscarriage. More recently however, research into the ED nurse's experience in providing care to women is burgeoning (Catlin, 2018; Edwards et al., 2017; Merrigan, 2018). Catlin described an interdisciplinary summit of HCPs to "explore the needs of women who present with an actual or potential pregnancy loss to the emergency department" (p. 13). The findings from the summit formed the basis for guidelines that describe the importance of recognizing pregnancy loss as an "emotional emergency" and that sensitive care is essential (p. 14). They also describe the importance of supporting families through interventions such as "seeing and showing after miscarriage"—where families are offered the opportunity to see and hold the remains after a miscarriage (p. 16).

Nurses are the continuous presence in most care settings as they admit, care for, and discharge patients throughout their stay in the hospital. In the community, nurses provide care in the home and in nurse-led clinics. Nurses also provide the preponderance of the care for women experiencing a miscarriage. Hutti et al. (2016) compared the experience of obstetrical (OB), surgical, and ED nurses caring for women. This study involved focus groups with registered nurses (RNs) (N=24), with the questions guided using Swanson's "theory of caring" (Swanson, 1991). Data analysis was accomplished by "using a continuously, emergent process of data collection, data reduction, data display, and interpretation of data" (Hutti et al., 2016, p. 20) The researchers discovered five significant themes within the data: "strategies for coping in the moment, situations that make care easier, situations that make care more difficult, priorities of care, and negative feelings associated with care" (p. 21).

Distinct differences emerged in each of the themes depending on the clinical area of the nurse. For example, *flipping the emotional switch* is a subtheme of the main theme, *strategies for coping at the moment* (Hutti et al., 2016, p. 22). *Flipping the emotional switch* describes the need to go from one patient or one room to another and switch emotions depending on the patient's situation. ED and surgical nurses described being quite adept at this when caring for women experiencing miscarriage, given that they do this regularly with other patient situations (Hutti et al, 2016.). The OB nurses, however, described being more challenged by moving from positive situations of birth to the sadness of the miscarriage. While flipping the switch is more difficult for OB nurses, they reported being more likely to address the emotional care needs of the woman—while surgical and ED nurses tended to focus on physical comfort and sharing information (Hutti et al., 2016).

Merrigan (2018) described the need for education for ED nurses, which includes not only medical care but also understandings of the meaning of miscarriage, therapeutic communication strategies, discharge teaching, and creating memory keepsakes. These educational topics were identified as helpful to support ED nurses to care for women experiencing a miscarriage (p. 28). Merrigan also acknowledged that miscarriage may not have the same priority as other diagnoses in the ED; thus, nurses often focus on the physical needs of women and may not offer the emotional care they often need. They spoke to the challenge ED nurses face: they know these women need more from them, but they may not be able to provide what they need in the busy ED (Merrigan, 2018). The researchers in Merrigan's study described a process where they identified the learning needs of staff and created policies, such as respectful disposition of remains, discharge follow-up, and education, to support ED nurses to provide quality, family-centred care for women who have experienced a miscarriage.

Punches et al. (2019) report a similar finding, stating that "psychological needs of the hemodynamically stable woman experiencing a pregnancy loss are often overlooked" (p. 64). Another significant difference is that OB nurses reported feeling prepared to care for women experiencing miscarriage, while ED and surgical nurses identified that they did not have the requisite education or training to provide care for such women (Hutti et al., 2016). Engel and Rempel (2016) reported that ED nurses and obstetricians were the most likely to come into contact with women experiencing a miscarriage (p. 89). However, despite the frequent encounters, not only did ED nurses feel unprepared to provide care, but they were also less likely to provide information and mobilize support for women (Engel & Rempel, 2016, p. 57). Emond et al. (2019) have discussed the gap in care created by the absence of care guidelines for ED nurses when working with women who are experiencing a miscarriage. Similarly, to develop

grounded theory pertaining to this care context, an Australian study examined the experiences of nurses, and women and their partners who presented in a non-metropolitan ED for the care of a miscarriage (Edwards et al., 2017). Five categories were identified, with associated subcategories for women, partners, and nurses. One category, seeking support and understanding, had the subcategory of arbitrary practices. One category, seeking support and understanding, had the subcategory of arbitrary practices. One way in which this was expressed was "being aware of women's distress," which spoke to the impact of this awareness and how important it was for ED nurses to provide the best care possible. Edwards et al.'s study revealed as well that nurses also felt limited in what care they could provide, based on their lack of education, insufficient protocols, and poor resources. Nurses in the ED have certainly described challenges in caring for women experiencing miscarriages, such as overcrowding in the ED, lack of resources to manage overcrowding, and lack of resources to provide the holistic care that women require in the ED (Bacidore et al., 2009). With a focus on dealing with life-threatening conditions, ED nurses are challenged to provide care that meets women's unique needs in an environment that may not be suited to meet those needs (Larivière-Bastien et al., 2019).

A review of 198 patient records of women who received care for spontaneous abortion, threatened miscarriage, ectopic pregnancy, pregnancy without the embryo, and molar pregnancy was conducted in four EDs in Quebec by de Montigny and colleagues (2020). This study highlighted some of what women reported about their experiences in seeking care—where 40% of women saw multiple care providers, anywhere from two to seven nurses. The researchers reported that on average, the women came to the ED twice for care during their miscarriage, with less than half coming only once to the ED. One in five came three or more times (p. 5), and only 0.5% met with social workers. Women waited for an average of four hours and nine minutes to

be seen by a physician, with the waiting time ranging from 19 minutes to approximately 20 hours. Care followed a standard of practice; however, HCPs did not document the women's understanding of the care and expectations, nor was there documentation of any psychosocial care. The researchers concluded that while miscarriage consumed substantive time and resources, the care was not provided efficiently, nor was it meeting women's psychosocial needs.

Clinical practice statements are available from the Canadian Pediatric Society (Hendson & Davies, 2018) and the SOGC (Leduc et al., 2006) to guide the care for women experiencing pregnancy loss. However, they provide medical guidelines and do not adequately address supporting families and guiding nurses as they navigate miscarriage with their patients (Hendson & Davies, 2018; Leduc et al., 2006). I was unable to find a *best practice* guideline designed to specifically support ED nursing practice and offer consistency in care for miscarriage. This lack of practice guidelines does not imply insufficient literature (research evidence) to support practice. Instead, the practice guidelines that exist and the body of literature available focus on perinatal loss in general; as such, they focus on later pregnancy loss, with a narrow focus on miscarriage (that is, less than 14-weeks gestation).

The Public Health Agency of Canada released *Loss and Grief* (Morin et al., 2020) as part of the updated *Guidelines for Family-Centred Maternity and Newborn Care* (2021). This chapter focuses on pregnancy loss and neonatal death, offering guidance for healthcare practitioners. However, the focus is on pregnancy losses that occur later in pregnancy (stillbirth and neonatal death), with little to guide the care of women experiencing a miscarriage earlier in pregnancy. This lack of focus on a "common" complication of pregnancy creates a chasm between women's needs and ED nurses' ability to meet those needs for women. The lack of consistency and clarity about what the experience of miscarriage means to women, coupled with a lack of guidance for

ED nurses providing care for women experiencing a miscarriage, creates a potential for negative consequences for both.

Accounts of the challenges both ED nurses and women patients face when experiencing miscarriage are widespread in the literature, although positive stories can also be found (Watson et al., 2019). Nevertheless, the predominant narrative is that something is missing, and care must improve. Since 2016, the literature has increasingly emphasized the role of the ED nurse to meet these care needs. Further, it is reasonable to posit that multiple social and political discourses affect the understanding of miscarriage. Critical analysis is necessary to excavate these important discourses that influence women's experiences and ED nurses' practice. This exposure, in turn, will shape knowledge mobilization and inform solutions to address the care gaps for women experiencing a miscarriage in the ED.

Miscarriage Discourses

Miscarriage is a complicated experience. Despite an abundance of research devoted to describing miscarriage, mobilizing this knowledge to provide support for women who experience miscarriage is inadequate. Silverman and Baglia (2015) articulate this gap well:

> However, this research's availability does not mean that there is a discourse that has resulted in a better understanding of or an open dialogue about pregnancy loss. Indeed—and it has been said many times in many ways—miscarriage and infertility are silent losses, losses that women and men have frequently suffered and survived in solitude. We believe that one possible reason for this silence is the lack of personal narratives in the vast body of literature. (p. 3)

It is possible that our understanding of miscarriage is being influenced by something other than scholarly work, given that this extensive body of related research has not resulted in substantive

changes in practice. Some influences may be found in the discourses that exist about miscarriage, since they guide what we know about a topic and how we use what we know to bring knowledge to life (Seale, 2004). As Seale (2004) noted, discourses inform what is acceptable to say about a topic (what is "ruled in") while at the same time defining what is not acceptable to say (what is "ruled out"; p. 346). Textual and research discourses on a topic shape those that are actively deployed in social and cultural contexts. (Seale, 2004). For the ED nurse, discourses describing miscarriage may influence how they understand and offer care for miscarriage. The following discussion will describe some of the discourses found in the literature that may inform our understanding of miscarriage.

The Social Norms of Miscarriage

Women experiencing a miscarriage are often met with a confusing, even absent, set of social and cultural norms in addition to standard medical practices that may add to the distress they experienced as a result of their loss. The lack of social norms to mark pregnancy loss may lead women to feel silenced because they cannot speak about their loss; if they do, they are often met with platitudes or false assurances that they did nothing to cause the miscarriage. Bellhouse et al. (2018) identified the importance of social support for women as they grieved their pregnancy loss. Family and friends may play a crucial role in supporting women, which women have described in stories of positive support. However, in this study, women also described a lack of support from others, which may be due to society's discomfort with others' grief so that providing the support women need after a miscarriage may be challenging.

Importantly, many women begin to assume the role of mother from the time they confirm their pregnancy. They connect with the unborn baby as a person and the loss through miscarriage is the symbolic loss of a baby, the loss of motherhood, and the loss of hopes and dreams ascribed

to the future baby (Adolfsson et al., 2004; Engel, 2020). Adolfsson et al. (2004) used interpretive phenomenology to "identify and describe women's experiences of miscarriage" (p. 545). Their analysis revealed five subthemes (*feeling emotionally split, bodily sensation, loss, grief, and abandonment*) and one central theme (*guilt and emptiness*) (Adolfsson et al., 2004, p. 350). Women go from planning for a future with a new baby to feeling a loss of control of their body and a sense of emptiness and despair. Similarly, the findings of Bellhouse et al. (2019) described the psychological impact of miscarriage, including grief and loss, depression and anxiety, isolation that includes guilt and loneliness, helplessness, self-blame, and loss of motherhood. Engel (2020) described the baby as occupying space, both physically and emotionally, for the woman, and when that space is made empty, the woman may be left to navigate this new space on her own. Sadly, according to Engel, this new space lacks the norms and customs that accompany other types of death: often, nothing is visible to others of the pregnancy or the baby, so the woman cannot claim something tangible to mourn, and as a result, others have nothing to associate with the woman's loss. Likewise, Adolfsson et al. (2004) stated,

> The women want their feelings confirmed, since no one sees them as they are and how bad they feel inside. They want to know, and they want to regain their control. What they do not want to hear, and feel is "It's not important for you. It's only a miscarriage" (p. 550)

We are left to ponder what informs the belief that miscarriage is just something to *get over*? As Martel (2014) stated,

> Mothers face a socially sanctioned expectation to "get over the loss," with the idea that the expression of mourning must be appropriately condensed in response to such a short life. (p. 328)

This belief may be attributed partly to the science that exists about when life begins (at conception or at birth?) and the associated discourses from the anti-abortion movement and women's reproductive rights movement (Layne, 2003a, 2003b). Miscarriage, with its negative outcome and lack of control, did not find a substantive place in the discourse surrounding woman-centred birth (Layne, 2003a; 2003b). In fact, Kingston (2012) suggested that society has overshared pregnancy loss and pointed to "fetal fetishization" as contributing to the assignment of personhood to the fetus. This assignment of personhood characteristics requires complex social, cultural, and anthropological attributes, but with such assignment, prospective parents end up confused when the pregnancy ends in loss: they have nothing to represent the person they knew as their baby (Keane, 2009).

The bereavement that accompanies reproductive loss occurs without the actual acknowledgement of a death (Martel, 2014). Goopy et al. (2006), when talking about a perinatal loss in general, including miscarriage, stated that "although they [women] felt they were a mother, they were a mother without a child, and did not have tangible evidence of their motherhood" (p. 11). The medical, statistical, social, and cultural aspects of miscarriage appear to overshadow women's emotional needs, as they require a specific, even unique type of care and support when a pregnancy is lost (Andipatin et al., 2019).

ED nurses are a microcosm of the general population and, as such, would be influenced by these complicated discourses, which add to the conundrum faced by ED nurses and women when they come together for care. Understanding how the social affects the professional is vital in understanding how to change practice. Biomedical discourses may offer yet more clarity.

Miscarriage and Biomedical Discourses

Biomedical discourses unquestionably inform the experience of pregnancy loss (Andipatin et al., 2019; Martel, 2014). Andipatin et al. (2019) investigated this aspect, interviewing seven women to discover the discursive resources they drew on to understand their pregnancy loss experience. Miscarriage occurs with enough frequency that understanding why it occurs may not be valued; this perspective, in turn, may lead to the normalization of pregnancy loss (Andipatin et al., 2019). During miscarriage, women's care often focuses primarily on the physical and overlooks the emotional, which could minimize the magnitude or complexity of the loss experience (Bellhouse et al., 2018; Andipatin et al., 2019).

Martel (2014), taking a critical approach, described the shift in how births are managed as necessary to demonstrate the success of a population or country. This is because the birthrate is synonymous with economic success and productivity. Martel asserts that the "pregnant body and the fetal body are knotted in a relation of responsibility [through discourses of] antenatal care and the construction of perinatal mortality as a biological site for state intervention" (p. 336). Martel argues that care of the pregnant body ensures safe passage for mothers and babies; meanwhile, perinatal mortality is an indicator of population health, managed by antenatal care. Moreover, the care of the pregnant body consumes resources, but their allocation is made on the premise of a positive outcome and prevention of adverse outcomes.

However, women's role in the successful production of offspring is negated with miscarriage, with the result that the woman is marginalized and may feel defective (Corbet-Owen & Kruger, 2001). Watson et al. (2019) reported that women experienced exclusion, as once they were "not pregnant anymore they did not matter to anyone" (p. 8). Women became the vessel that carried the successful contribution to growth of the population, and therefore their

care managed to ensure a successful birth as the unborn life was protected and valued. Significantly, birthrate, as a number, focuses on success. Mortality rates favour discovering the implications of these rates on the population, rather than their impact on the individual. Even with the advancement of care for women and unborn infants, interest is still mostly on managing care to secure a healthy birth (Martel, 2014). Martel (2014) contends that although the focus is on understanding why a miscarriage may occur, this knowledge also improves the birth rate and reduces mortality rates. What is missing though is the sociocultural acknowledgement that a death has occurred, and that grief is an outcome for women (Martel, 2014).

Kevin's (2011) article "I Did Not Lose My Baby…My Baby Just Died" describes the influences of the competing discourses of death, fetal personhood, and the medicalization of miscarriage. These discourses, both hidden and overt, are keenly felt by women; we can presume they are also felt by the ED nurses who provide care to women. As Kevin stated, "Furthermore, medical discourses that [are] often fetal-centric and silent on early miscarriage remain powerfully limiting determinants of women's capacity to express their experiences of pregnancy and theory [of] pregnancy loss" (p. 850).

The previous paragraphs have addressed fetal personhood and biomedical discourses. The following paragraphs will elaborate on the medicalization and normalization discourses that may influence women's care during a miscarriage.

Normalization of Miscarriage and Medicalization of Care

Women's and healthcare professionals' perceptions of miscarriage add to the challenges both face when they meet in care settings. The limited available data would suggest that miscarriage occurs with a frequency that would assume a level of understanding and competency by HCPs to support these women. However, from the perspective of both the women

experiencing the loss and the HCPs tasked with providing care for them, this frequency does not appear to equate with practices reflecting a robust understanding of the miscarriage experience. Importantly, while HCPs may view a miscarriage as an everyday event, women may not perceive miscarriage as a frequent or common pregnancy complication. Women may only become aware when it happens to them. Bardos et al. (2015) surveyed 1084 men (45%) and woman (55%), who were 18 years or over via an online crowdsourcing web service from across the US, about public perceptions of miscarriage. The survey included 23 questions related to these perceptions, with 10 of these items targeted to whether respondents may have had a miscarriage. The majority (55%) of the respondents believed that miscarriage was not a common pregnancy complication. Another study conducted in Ireland (McCarthy et al., 2020) found that of its 967 participants, only 699 could estimate how common miscarriage is, and of those 699, 60.8% believed miscarriage occurred in less than 20% of pregnancies. This lack of understanding is interesting given that 15 to 20% of pregnancies are reported to end in miscarriage, and 80% of those occur before 14-weeks gestation.

These studies by Bardos et al. (2015) and McCarthy et al. (2020) reveal that while the words “frequent” and “common” appear in literature describing miscarriage, the public continues to lack an understanding of the frequency of this event. However, HCPs convey to women that miscarriage is a common outcome of pregnancy, suggesting that the impact may be minimized and not viewed as a significant event (MacConnell et al., 2012; McLean & Flynn, 2012). On this aspect, Adolfsson et al. (2004) stated, “When a miscarriage occurs, the woman is often in acute need of medical assistance. However, an everyday event at a gynecological ward is often frightening and unexpected to the woman” (p. 544). The frequency of miscarriage may thus contribute to a dismissive approach to care for women, resulting in them feeling they did not

receive the care they needed. Regarding this, Bardos et al. (2015) reported that "only 45% of participants felt that they had received adequate emotional support from the medical community" (p. 7).

In a large Canadian study, 596 people in Ontario completed a survey about their care and support experience following a pregnancy loss or infant death (Watson et al., 2019). The quantitative data gathered in this study revealed a number of positive things about women's experience with HCPs: 47% of respondents reported that they were treated with kindness and respect at the time of the loss, and 35% felt supported at the time of the loss. These data also showed that participants (49%) reported that they experienced stigma (described as "insensitive comments") from HCPs. The qualitative data from this study were also compelling as they highlighted the impact of the HCPs' perceptions of miscarriage as an everyday event. Women in the study reported feeling that it may be expected for the HCP provider, but it is not an expected outcome for women. As with the quantitative data, the participants revealed that the normalization of loss by HCPs contributed to the stigmatism and silence that women experience during and after a miscarriage. Bellhouse et al. (2019) similarly found that "women often felt their experience of miscarriage was dismissed or diminished as healthcare providers viewed it as a common medical occurrence and routine part of pregnancy" (p. 141).

Normalization of miscarriage and medicalization as the approach to care appears to be the standard that guides practice, one whereby HCPs dismiss miscarriage and normalize the event. Further, HCPs medicalize miscarriage by their use of medical terms and jargon; for the women experiencing miscarriage, this negates their experience of the loss (Due et al., 2018). Freeman et al.'s (2021) scoping review of the women's experience with the healthcare system during miscarriage supports these findings. Freeman and associates wrote of studies describing

the negative impact of women not being aware of how common miscarriage is in early pregnancy. Women's lack of knowledge about miscarriage and HCPs' normalization of it create a space where negative encounters are fuelled by a lack of mutual understanding (Freeman et al., 2021). Bute (2015) summarized this well in a collection of narratives about miscarriage:

> Is miscarriage so commonplace and so rarely life-threatening that treating those who suffer is a mundane event? Is miscarriage a generality that triggers a standard set of diagnostic and treatment procedures so ingrained that it becomes second nature? A miscarriage is typically a shocking and unexpected event for the patient (Brier, 2004; Maker & Ogden, 2003), but perhaps not for healthcare providers. (p. 41)

Clearly, normalization and medicalization are problematic for women experiencing a miscarriage. In a large study conducted in the UK by Simmons et al. (2006), the researchers noted that women faced medicalization from two perspectives. They found that medicalization afforded the HCPs and women the opportunity to be aware of pregnancy sooner; however, the advances in these technologies left women feeling that their intuition about their pregnancy was ignored. They also noted that the medicalization arose from the perspective that women knew nothing could be done, and that HCPs may have normalized miscarriage and offered little in terms of interventions related to their care. Medicalization may also create "mixed messages" from HCPs to women, in that miscarriage is normalized while all that is offered is medical interventions (p. 1943). The loss becomes a medical event with procedures to manage it, resulting in medical waste, rather than a baby's death (Andipatin et al., 2019; Martel, 2014).

However, pregnancy loss is not ordinary and expected for women and is more than just a medical event. The influence of the biomedical discourse, according to Andipatin et al. (2019), has implications for both how women perceive the experience and how HCPs provide care.

Andipatin et al. described the implications of this framing: “Biomedical language or discourse on reproductive loss is echoed in medicine, popular culture, epidemiology, and demography. However, research suggests continued silences pervade these domains, ultimately culminating in a ‘culturally sanctioned non-existence’ of pregnancy loss” (p. e554–555). For example, women are not typically offered explanations for why a first-trimester loss occurs. It is presented as common, and the suggestion is that the frequency does not make it realistic to uncover the cause in every case. Women are discouraged from asking why, and HCP providers are not required to explain. This lack of questioning creates a sense of powerlessness for some women, who are left to imagine the cause.

This lack of accountability to describe why a miscarriage has occurred may be founded in the normalization of miscarriage. Women perceived an emergency, but HCPs did demonstrate that same sense of urgency, the miscarriage becomes a non-urgent, routine occurrence. The risk for women is that they cannot grieve appropriately, and they may be silenced because of the lack of acknowledgement. Andipatin et al. (2019) also asserted that the normalization of miscarriage by HCPs may also be a coping strategy they offer to help relieve the guilt that women may experience due to miscarriage. They describe the *social awkwardness of loss* that is perpetuated by society’s discomfort with death and dying, which spills over into the experience of women and pregnancy loss. This broader theme consists of three subthemes: *lack of acknowledgement* of the lost pregnancy (p. e556); *lack of cultural scripts* (e557), which resulted in uncomfortable encounters with others; and *unhelpful actions or words* (e557), which inadvertently minimized their loss experience.

Miscarriage explained by using biomedical discourses does not reflect the unique and complicated nature of this experience. However, biomedical discourses are pervasive and

influence the social discourses that women need to navigate a miscarriage. Regardless of how well-intentioned an HCP is and how strong the social supports around women are, the result of these discourses can have detrimental consequences for women as they experience miscarriage (Andipatin et al., 2019).

Regrettably, while the available evidence uncovers a common experience for women, a resolution to address women's need during a miscarriage is not clearly articulated in the literature. Women continue to receive care that medicalizes and normalizes miscarriage while not addressing the complex processes described in the literature. Women suffer in silence and experience shame and guilt or are expected to just get over it and move on from the loss. In a Swedish study, Adolfsson et al. (2004) described the central theme in women's descriptions of their miscarriage as guilt and emptiness. Adolfsson (2010, 2011b) confirmed this in her later work as well. In this study, the women experienced abandonment from HCPs, but the investigators also suggest that women abandoned themselves when they blame themselves and do not want to make others uncomfortable; thus, they suffer alone.

The preceding paragraphs introduced some of the challenging discourses women work against as they navigate the experience of miscarriage. Women come into contact with the healthcare system seeking care and support during a miscarriage. In *Communicating Pregnancy Loss: Narrative as a Method of Change,* Silverman and Baglia (2015) brought together a series of narratives from women who had experienced miscarriage and infertility. The women's stories documented the challenges they faced in their encounters with the healthcare system. In Bute's chapter they articulated these encounters as: "No one was rude, or judgmental, or overtly uncaring. But no one connected with me, no one asked for or listened to my story of trauma; no one truly witnessed my profound suffering. And that made all the difference" (p. 43)

Women and their families look to nurses and other HCPs for guidance to navigate the experience of miscarriage. It is not entirely clear if nurses and HCPs understand the implications of their care to women when they are having a miscarriage. Unfortunately, understanding the implications of care by ED nurses is not well covered in the literature, despite a good deal of it that describing women's experiences. More concerning is that it does not appear to have resulted in a notable change in how care is provided to women experiencing a miscarriage, a shift that would ameliorate the impact of care inadequate to these women's needs.

Perhaps going to the place where women seek care during a miscarriage is the place to begin—the ED—as it has been noted as a common place for women to seek care during a miscarriage. Understanding the ED, as a place, is necessary to understand where women receive care during a miscarriage; further, it is necessary to understanding the perspective of ED nurses working in this hospital setting.

Something is Missing, So Where to From Here?

Several factors influence nurses' experience, which specifically includes ED nurses and their ability to offer appropriate and meaningful care. These encompass the following: education and preparation to understand perinatal loss and bereavement; policy and guidelines to guide their care; adequate resources (both human and knowledge-based); and emotional support for nurses in the aftermath of the perinatal loss by their patient. Women's experience of miscarriage would appear to echo these needs. Women desire care from practitioners who are knowledgeable, do not trivialize their loss, and provide individualized care. Women want to receive care in a setting that is appropriately resourced and has providers that demonstrate they care about them. The ED nurse experience is not well documented, however. But what is documented points to a lack of education, resources, and the medicalization of miscarriage as

barriers to care. Reprising my statement at the beginning of the chapter, we are presented with a conundrum in the topic of miscarriage. I posit that if women look to ED nurses to provide expert guidance when they present to the ED for care during a miscarriage, then the ED nurses' journey with miscarriage is a place to begin.

Chapter 3

Methods

As a result of the literature review, two research questions were developed, focused on hearing and understanding the stories of registered nurses (RNs) who work in the emergency department (ED) and have cared for women who experienced a miscarriage. The research questions used to guide the study were the following:

1. What stories did RNs who practise in the ED tell about their experiences of caring for women experiencing an early miscarriage?
2. How did the stories of RNs who practise in the ED make the experience of early miscarriage intelligible?

Dialogical narrative analysis (DNA), as developed by Dr. Arthur Frank, is the methodology for this study. It offers the opportunity for the researcher and the participant (storyteller) to uncover together the meaning of the experience in a way that does not close the door to further analysis of future stories; rather, the methodology opens the possibility for ongoing analysis and understanding. This interpretive openness and mutuality are key elements of DNA and make it an appropriate way to understand the ED nurses' stories of caring for women experiencing a miscarriage (Blix et al., 2013; Bowers & Moore, 1997; Frank, 2012). The exploration of ED nurses' stories may offer insights into their experiences, with the opportunity to rewrite or retell their stories about miscarriage while working in the ED (Frank, 2010, p. 87).

A description of how the research process for this study unfolded will be provided in the following sections. DNA guided the data collection, analysis, and understanding of ED nurses' stories of caring for women experiencing a miscarriage. A detailed discussion of DNA will be presented below.

Unfolding the Research Process of This Study

The following paragraphs will outline the research process undertaken to complete this study with ED nurses.

Ethics Approval

I received ethical approval from the University of Alberta Research Ethics Board (REB) in March 2017. I also received ethical approval from the Prince Edward Island REB and the University of Prince Edward Island REB, both in May 2017.

Subsequently, some minor changes were made to these applications to reflect small adjustments to the recruitment criteria and the consent. These changes are explained in the next section. The revised REB applications were approved shortly after resubmission

Setting, Participants, and Recruitment

I initially drew my sample from RNs who currently worked in the ED in the four provincial hospitals that had EDs. I approached each of the hospital's nursing directors and the nurse managers of the EDs and asked permission to invite the nursing staff from their units to participate. Initially, I contacted the directors and managers via email to enlist their participation (see the script in Appendix A). I offered to arrange a time to call and discuss the project (see the phone script in Appendix B). The directors of nursing and the nurse managers responded to the email indicating their support, so phone calls were not required.

Following confirmation that they agreed to allow recruitment to occur in their facility, I asked the nurse managers to circulate an email on my behalf to all RNs employed in their respective EDs. This email (see Appendix C) invited the RNs to contact me if they were interested in participating in the study. Also, recruitment posters (see Appendix D) were

delivered to the units and posted by nurse managers, inviting RNs to contact me directly if they were interested in participating.

As inclusion criteria, I asked that these RNs must have cared for women who had experienced an early miscarriage. For this study, we defined early miscarriage as a loss that occurs at or before 14 weeks. There were no limitations or exclusions based on gender, education, or years of nursing experience. This purposive sample was a deliberate attempt to focus recruitment on an area where many women would access care during or following an early miscarriage. The ED may be the first and only point of entry for many women, given the gestational age (Bacidore et al., 2009; Warner et al., 2012).

Recruitment was initially slow, so I made amendments to the REBs to broaden the participant description and recruitment strategies. The changes were as follows:

1. Changed nurses currently working in the ED to also include nurses who had previously worked in the ED.
2. Added a request to contact the College of Registered Nurses of Prince Edward Island (CRNPEI) to advertise in their newsletter and on their Facebook page.
3. Added a request to contact the PEI Nurses Union (PEINU) to advertise on their Facebook page and webpage.
4. Changed nurses who worked in ED on Prince Edward Island (PEI) to nurses registered with CRNPEI.

Gathering Stories

Gathering stories for this study began following approval from the appropriate REBs. I created an interview guide (see Appendix E) with one initial question and associated probing questions to support the conversation between the participants and myself (Riessman, 2008). I

conducted two pilot interviews using the interview guide to estimate the length of the interviews. These two pilot interviews helped me to identify the interview length, prepare for the interviews, and increase my comfort level with the recorder and the questions.

Eight nurses participated in this study. All eight participants were currently registered with the CRNPEI at the time of their interview. At the time of their interview, five participants were working in the ED and three had previously worked in the ED. All eight had worked in EDs in Canada. The age range of participants was 20 to 55 years of age. I chose to be selective in the demographic information presented here to preserve the confidentiality of the study participants.

The consent process began when potential participants contacted me, indicating their interest in participating. In advance of the interview, I provided each participant with the information letter and consent form for their review (see Appendix F). I asked the ED nurses to review these documents and contact me if they were still interested in participating. We then set a time to meet to review the consent and conduct the interview, at which time I also provided participants with further information about the study. We reviewed the consent form, and I gave them an opportunity to ask and answer questions; if they agreed to participate, they then signed the consent form.

After obtaining informed consent and permission to audiotape our conversation, I invited participants to describe their experience caring for women experiencing an early miscarriage. I clarified the definition of early miscarriage for the participants at the beginning of the conversation. I conducted one interview per participant, with interviews ranging from 35 minutes to 75 minutes long. Participants had the opportunity to review their verbatim transcript and to

withdraw any information they did not want to share. However, none of the participants requested changes to their transcripts or asked to withdraw content.

Data collection continued until I believed I had reached saturation. I was aware by the end of the eighth interview that I was getting no new data from the participants, so I did not seek or interview any further participants after that point. I proceeded to explore the stories gathered faithfully using Frank's (2012) DNA method, which challenges researchers to not speak about their subjects, but to speak "with" them (p. 33). Thus, DNA offered a guide to help me speak with the ED nurses' stories and support my analysis.

Rigour

In research, rigour is necessary to move the work towards scientific, credible, and potentially influential research. Narrative research is not necessarily about finding the truth and considers multiple realities. Every storyteller will tell the story differently, and each story will reveal a distinct perspective. Frank (2010) stated the following about this aspect:

> Stories have the capacity to balance multiple truths that have respective claims to expression. The more dialogical the truth—or the more polyphonic, in Bakhtin's sense of blending multiple voices into harmony in which they are never entirely merging but retain some distinctiveness—the greater the capacity of stories to tell the truth that there are multiple truths. (p. 41)

Riessman (1993) proposed four criteria to support validation in narrative research: persuasiveness, correspondence, coherence, and practical use, which are outlined below.

Persuasiveness

Persuasiveness is the ability of a piece to convince a reader that the story is possible, or to persuade them it is the truth: "Good narrative research persuades readers" (Riessman, 2008, p.

191). The readers, thus, agree with the interpretation of the story by the researcher. This agreement comes from how successfully the author has clarified theoretical knowledge within the story. The writer is creating an "ah-ha" moment for the reader.

Here, I used the current state of knowledge to connect RNs' stories, both individually and collectively. The literature review was current and comprehensive, demonstrating what is known on this topic and what is missing. I used this knowledge to inform the questions in the interview guide, ensuring that I could support or refute the research by what the stories revealed. I taped my interviews with participants to examine the exact words they spoke, which increased the persuasiveness of my analysis (Riessman, 2008). I highlighted elements that were not present in the literature and used the stories to substantiate these elements.

Correspondence

Correspondence requires a return to the storyteller to confirm the researcher's interpretations. Riessman (1993) stated that storytellers should have an opportunity to see our documentation (transcription), comment on our documentation, and comment on our subsequent interpretation of their story. Participants received a copy of their verbatim transcript and were offered the opportunity to change or delete any part of them.

Coherence

Riessman (1993) referred to the criteria established by Agar and Hobbs (1982) regarding examining three types of coherence in narrative research—global, local, and themal. Later, Riessman's (2008) questioned the relevancy of these criteria with specific types of narratives. However, these criteria were appropriate for this study. *Global* coherence refers to the storyteller's goals in telling the story, which may render an account of experience and justify their actions in the experience (Riessman, 1993). *Local* coherence refers to when the narrator

uses linguistic devices to relate the parts of the story or to compare and contrast the experience, reality, or expectations (Riessman, 1993). *Themal* coherence is the recognition of narratives that repeat throughout the story and are recognizable as themes (Riessman, 1993). These themes may form the basis around which to create the narrative.

My research questions were vital as I applied these criteria. I made certain assumptions based on my own experience and the available evidence, which I have written about in the discussion and throughout the analysis. It was important during data collection that I revisit these questions and my assumptions to ensure that they reflected what the participants shared (global coherence). I acknowledged how the participants told their story and how the participants highlighted their experiences through language (local coherence). My analysis documented the common narrative resources in each story and between stories (themal coherence) which I accomplished through a timely and thorough review of audiotapes and transcribed interviews.

Pragmatic Use

This criterion refers to the utility of the result to be interpreted and used by others (Riessman, 1993). I have included detailed accounts of how I collected and analyzed the data and its occurrence throughout the study. My dissemination plan will allow me to share my research process, my preliminary findings, my final findings, and my recommendations. I ensured that what is shared is done in the spirit of full disclosure, as is ethically appropriate.

The results of this process will be described in detail in Chapters Four, Five, and Six. Chapter Four includes the detailed results of the analysis process described above. This chapter further discusses narrative resources and how the ED nurses used them to tell their story. Chapter Five has more detailed exemplars from individual nurses' stories that illustrate the stories' narrative resources. The use of exemplars is highlighted in Blix et al. (2013) and

supported by Reissman (2008). Finally, Chapter Six describes the narrative types and ties the narrative resources together to understand the underlying plots of the ED nurses' stories.

Dialogical Narrative Analysis

DNA "understands stories as artful representations of lives; stories reshape the past and imaginatively project the future" (Frank, 2012, p. 33). Stories are the voices of many, told by one. The fundamental concern of DNA is in understanding that every story has multiple voices, which help to co-construct an individual story. DNA requires that the analyst brings together the various voices to make them resonate with each other and create a common story from those who share an experience (Frank, 2012). Socio-narratology, as described by Frank (2010), is the theory that underpins DNA, which claims that stories serve as actors to connect stories for people. Moreover, stories teach people how to tell other stories and how to listen and change over time with different storytellers; stories are never final (Frank, 2010). It is the *socio-* that we study in DNA— that is, stories are the actors that play out the experience and reveal "how stories make life social or how stories reveal the loss of what makes life social" (Frank, 2010, p. 112).

The stories people tell about their lives are compilations of their perception of experiences, their past experiences, and other stories they have heard. The analysis must pay homage to the intricacy of the story, as told by the storyteller. DNA requires that the researcher approach the story with an open-mindedness to allow the available stories to ebb and flow. This fluidity ensures that stories that call out to be told will find their voice. The researcher then assembles the chosen stories for DNA. Frank (2012) stated, "The dialogical analyst freely admits that the collection could be assembled and sorted in multiple ways, yielding different analyses" (p. 43). Frank's (2010) contention is that narrative analysis is never final. However, for research, the project is concluded knowing that other stories and other narratives exist. The following

section will describe the dialogical process used to learn from the stories told by ED nurses about caring for women experiencing pregnancy loss in the ED.

Process of Interviewing ED Nurses

The ED nurses' interviews began with this question: *Can you tell me about your experience with women who have had an early miscarriage in the ED?* The nurse storytellers shared their stories about caring for women, with few interruptions from me except for a few probing questions for clarity or to pursue other stories that the nurses introduced as they shared their experiences. The final question in the interview was this: *Do you think others might tell the story differently?* Over the eight interviews, I added some additional probing questions as the stories revealed common elements. One such change was asking the nurse, as the first question, to describe their role in the ED. This description became important for the analysis and will be described in more detail later. The interviews were semi-structured, but this allowed the story to evolve as the ED nurse told their story of caring for women with an early miscarriage. Allowing the story to unfold as the storyteller experienced it reflects critical questions of DNA (Frank, 2010, p.33):

- Who is speaking in the story?
- How do they help or hinder each other?
- How do we know if this is a story or not?
- Why did the storyteller choose to tell this story, and how does this story help them?
- What is at stake for the storyteller in telling this story?

Frank (2012) stated that DNA is "concerned with how to speak *with* a research participant rather than about him/her" (p. 34). In this study, the interviews' conversational style offered the ED nurses control over what was shared and over the structure of how they told their story.

After each interview, the audiotapes were transcribed verbatim. A transcriptionist transcribed four of the eight audio-taped interviews, and I transcribed the remaining four. Each transcript included pauses, inflections, colloquialisms, and other language tools to ensure that the transcripts were truly verbatim. These inclusions were essential to support my analysis of the stories, while also ensuring they were written to reflect how the participants told their stories. I provided each participant with a copy of their verbatim transcript. Participants were offered a face-to-face meeting, email exchange, or phone call as methods to provide feedback. None of the participants chose to add or remove anything from their transcript. I reviewed all eight transcripts, comparing them to the audiotapes to ensure accuracy. During the analysis, I returned to the audio-recordings to re-listen to what was said and thus confirm I had heard the participant correctly and in the correct context. The transcripts had all identifiable information removed, and the participants were given pseudonyms. Each transcript was password protected and shared with my supervisors.

Analysis of the ED Nurses Stories

Analysis began with examining the transcripts and application of DNA outlined by Frank (2012). "Method" is not a term used by Frank (2010) in the sense of a structured step-by-step approach; instead, DNA proceeds in a fluid way that reflects the story's breath. This fluidity hindered my understanding of the stories I had gathered. Therefore, my challenge as a doctoral candidate was to find a structure to guide my work. In the volume *Varieties of Narrative Analysis*, Frank (2012) provided a guide to performing DNA, which included several questions to consider during the process. The questions were not specific to my research questions, so I needed to adapt the process and questions to relate to my research about miscarriage and ED nurses. To this end, I created an analysis guide for my work (see Appendix G), which helped

direct me as I read and understood the stories, assisting me to elucidate the narratives that described these ED nurses' experience. This process is reflected in other narrative studies. Blix et al. (2013) used DNA to discover the narratives of the Sami People in Norway. They described reading and re-reading to become "reacquainted" with the transcripts, and then they began searching for stories. Stories were apparent in the interviews, and some became clearer in the reading of the transcripts; further, stories became evident with more reading. Frank (2005) states that "the purpose of DNA is not to locate themes as finalizing descriptions or statements about who the research participants are, but rather, to capture individual struggles in all their ambivalence and 'unfinalizability'" (as quoted in Blix et al., 2013). Stories are much more than data, and in fact, Frank would caution against referring to them as such. But what constitutes a *story*?

Riessman is a sociologist who has written extensively about how to use various narrative methodologies across disciplines. In her text *Narrative Methods for the Human Science* (2008) she described storytelling as a process in which "a speaker connects events into a sequence that is consequential for later action and the meanings that the speaker wants listeners to take away from the story" (p. 3). If storytelling is the connection of events, then stories are the outcome of this connection. Frank (2010) suggested that the terms "story" and "narrative" are often used synonymously, so that distinguishing between the two can be challenging. In this project, this understanding is necessary to bring ED nurses' experience into focus. Frank states that "a *narrative* includes multiple stories featuring characters who share some problem or developmental trajectory" (p. 199). The ED nurses' stories are their interpretations of events based on their experiences. The individual stories inform a narrative to help us to understand the broader experience of ED nurses. In other words, for this work, the stories are told by the

individual ED nurse, while the narratives will reflect their collective experience. Specific ED nurses' stories were chosen as exemplars in Chapter Five—not to generalize their experience but because they best represented the experience of the participants. This approach was like Blix et al. (2013) in their study of the Sami People of Norway. They state that choosing stories for focused attention is, according to Frank (2012), "based on 'practical wisdom gained through analytical experience'" (p. 42).

Appendix G (Analysis guide) outlines the questions used to guide the analysis of the ED nurses' stories. Examples here include the following: *What narrative resources* [defined below] *do the storytellers use to shape the story? Who were the storytellers that shared a mutual understanding of the story*? I asked these questions repeatedly in an iterative process of reading and re-reading the transcripts from the nurses. Importantly, this did not reduce the stories to data, but the stories remained fluid (the breath trope proposed by Frank) while the stories' meaning became clearer. The process also offered me the opportunity to think *with* the stories rather than *about* them. The questions created opportunities to explore the stories individually to collectively bring them together—that is, this process allowed me to think across the stories to see what was shared and what was unique about each story and storyteller. In Chapters Four, Five, and Six, I will provide details of the analysis included in the exemplars from the ED nurses' stories. The following few sections will provide a brief overview of the questions used to guide the analysis.

The Resource Questions

The first series of questions guided the discovery of how the nurses told their stories. Frank (2012) offered a series of questions to use when practising DNA. In Chapter Four, the narrative resources identified in the nurses' stories will be examined more closely but the concept of the narrative resource will be introduced here.

The narrative resources the ED nurses used were critical to understanding the stories and uncovering the common experience of the nurses. *Narrative resources* are the words, phrases, tropes, and so forth that storytellers use to tell stories (Frank 2010; 2012. Narrative resources also help people to recognize and understand stories that they hear from other storytellers. Storytellers acquire these tools through the telling, retelling, and listening to the stories of their experiences. A narrative resource is like a thread that links stories together.

Narrative resources are gained through telling and hearing stories in attempts to make sense of experiences. In this project, the recognizable characters, plot lines, metaphors, comparisons, and explanations that the participants used changed the collection of individual stories, revealing the narrative resources and a shared narrative of the nurses' experience. The *characters* included the ED nurses, physicians, and women patients experiencing a miscarriage in the ED. The *plot* centred around the interaction between the ED nurse and the woman coming together in a crisis. A common *trope* in the ED nurses' stories was the "*worst is first"* metaphor. These elements of the stories were recognizable across the multiple stories, identified as narrative resources that shaped the ED nurses' stories.

These narrative resources represent not only the experience of the ED nurses who shared their stories for this study but potentially all the stories they told before this project. The narrative resources are the bits of the story that say to the listener "*I have heard this before* or *that has happened to me too.*" As the nurses told their stories, they used similar narrative resources to tell the story of caring for women who experienced a miscarriage in the ED. I was attentive to how the nurse told particular parts of their story, such as their tone, inflection, and emotion. I also considered how many times they referred to a particular occurrence or episode. I also relied on what I garnered from the literature about ED nurses' experience with miscarriage.

As more interviews were completed, the stories circulating between and among the ED nurses became more apparent.

The following discussion provides a demonstration of how the analysis of the ED nurses' stories were performed. As the number of interviews grew, narrative resources became more apparent. Initially, I identified many narrative resources, but this number changed as the analysis continued. What was interesting was that not only did the number of narrative resources change, but they also collapsed. By this I mean that as my understanding of the ED nurses' stories increased, and as I "listened" more to what they said, the narrative resources became more defined and more representative of stories that circulated within this group of ED nurses; this, in turn, better informed my understanding of the story. In the end, there were four narrative resources that the nurses used to tell their stories: *the reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do*. I began to understand that these narrative resources are the tools that the ED nurses use to make sense of their experiences and communicate their experiences to others. These will be described in more detail in Chapters Four and Five.

Other Questions for Analysis

After discovering the narrative resources used by the ED nurses as the first step of the analysis, the analysis opened further through the circulation questions, affiliation questions, identity questions, and questions about what is at stake (Frank, 2012, p. 44–45).

Circulation Questions & Affiliation Questions

The *circulation questions* reveal who the ED nurses tell their stories to. Given that the ED is a closed system, how did they tell each other the story? Did they use codes or tropes that made the story recognizable to only them? Understanding how the ED nurse tells the story, and to

whom, helps us understand what may be recognizable to others, while revealing what aspects are unrecognizable. Continuing with questions, another is this: What is the consequence of telling the same story within the closed system of the ED? This question also created space to explore whether the story is unrecognizable to those outside of the ED. What is the impact of this disconnect on the ED nurse?

The *affiliation questions* ask about who shared a mutual understanding of the ED nurses' stories. Such questions build on circulation questions and ask who is affiliated with the group and who is rendered an outsider? A fundamental concern here is "who" was excluded from the "we" who share the story. (Frank, 2012).

Identity Questions

These questions explored how the stories taught the ED nurses who they were. Frank (2010) proposed the term *narrative identifying,* which he defined as "emphasizing that sustaining an identity is never final…. [It] also suggest[s] the reciprocal processes of narratives making available possible identities and people identifying themselves through narratives" (p. 49). Frank (2010) also said that stories teach us who we are through the process of interpellation. According to Frank, interpellation "most simply means calling on a person to acknowledge and act on a particular identity" (p. 49). That is, we are motivated to assume an identity and act on that identity. For this project's purpose, I have referred to this as the *ED nurse's stock identity*. This identity was a powerful character in the ED nurses' stories. Further, it is essential to understand the influence of this identity to explore who the ED nurse could become for women having a miscarriage in the ED.

What Is at Stake Questions

The final question—*What is at stake by telling the stories?*—offers us insight into how the ED nurses held their own in the way they did. Holding "their own is done in response to vulnerability that is either spontaneous or strategic and reflective" (Frank, 2012, p. 45). Stories become a way to convince people of how they need to be, and in the stories of the ED nurses, the arrival of a woman with a miscarriage creates a situation that may be out of place in the ED and may not fit as well as other presentations in the ED. As a result, the ED nurses' stories revealed what was at stake for them in their encounters with women and what they did to reduce the risk they perceived.

Narrative Types

The analysis process continued, as I discovered the *narrative type(s)* in the nurses' stories. Frank (2013) defined *narrative type* as "the most general storyline that can [be] recognized underlying the plot and tension or particular stories" (p. 75). Narrative types are a way to categorize information to make sense of a phenomenon of interest and thus expose the plot that ties together the *threads* of many stories (Frank, 2010). For this work, I will refer to these threads as narrative resources (described above). The narrative resources come together to reveal the core narrative type that describes the storyteller's experience.

Using Frank's (2013) definition of narrative type as described in his book *The Wounded Storyteller,* I considered that a narrative type was an elemental plot or story that brings together the narrative resources and makes what the stories are saying more apparent to the listener. For example, *chaos* is a narrative type found in stories of illness (Frank, 2013). The *chaos* narrative type tells of lack of control or spinning out of control. This type of narrative typically has a plot that "imagines life never getting better" (Frank, 2013, p. 97). The chaos narrative is also often

the most difficult to tell; thus, it often gets lost or is not heard. This narrative reflects the suffering of the storyteller and while this is difficult, it is necessary to understand the experience. The chaos story reflects the loss of the "voice of the storyteller as a result of the chaos, and this loss then perpetrates the chaos" (Frank, 2013, p.115).

To further demonstrate what a narrative type is, in the context of this study, I introduce the *not an emergency* thread. *Not an emergency* was first revealed as a narrative resource, but as the narrative unfolded, it became clear this was the deep, intrinsic plot that informed the narrative resources. This plot was the anchor the nurses used to hold their own in the story and make themselves less vulnerable. It reflected the "chaos" that the ED nurses experienced when they cared for women in the ED. The following chapters will explore in more detail how the narrative types influenced how the ED nurses described their experience. If the *chaos* narrative described above lacks control or is spinning, then the *quest* narrative is the antithesis to the chaos narrative. (Frank, 2013). Quest narratives are manifestos or stories that reveal a truth, one which may have been suppressed but must be told (Frank, 2013, p. 121). The ED nurses' stories also contained elements of the quest narrative to describe their experience of caring for women. Chapter Six will provide a more thorough description of narrative types.

The stories people tell about their lives are compilations of their perceptions of experiences, their past experiences, and other stories they have heard. Frank (2012) suggested that stories are never a single voice but a choir of voices from the past and the present. My intention with this analysis is to make every effort to pay homage to the story's intricacy, as told by the ED nurses. DNA required that I as the researcher approached the story with an open-mindedness to allow the available stories to ebb and flow, thereby ensuring the stories that called out to be heard were acknowledged. I endeavoured to assemble the stories for DNA. Some

stories were set aside—not lost, but instead left for another day. Frank's contention is that narrative analysis is never final, but for research, the project is concluded knowing that other stories and other narratives exist. This project is a snapshot of the ED nurse's experience, through with we can begin to understand their experience of caring for women with a miscarriage.

Chapter 4

Analysis of the Narratives

Eight nurses shared their stories of caring for women experiencing an early miscarriage in the ED. These stories provide a glimpse into the work of nurses, the ED as a place, and the challenges these nurses faced in providing care in this unique environment. These stories coalesce to create narratives that will help to not only understand the ED nurses' experiences but also to inform education, policy, and practice. To understand these narratives, I began with an analysis of the stories using Frank's method of dialogical narrative analysis. A series of questions guided the beginning analysis of the stories and helped to uncover the narrative resources within the ED nurses' stories.

Narrative resources are the tools storytellers use to tell their story. These tools were familiar across stories and assist the listener and the storyteller to understand or recognize the story. Chapter Five includes more of the ED nurses' stories to highlight exemplars of the narrative resources as used by the participants to tell their stories. Later in Chapter Six, the discussion of the narrative types underpinning the stories will continue. Together, these analyses opened the opportunity to understand the ED nurses' experience of caring for women experiencing an early miscarriage in the ED. I will begin with my own standpoint about caring for women with an early miscarriage.

Animating My Desire to Study Miscarriage

Stories can begin with once upon a time and go on to quickly tell us about the main character in the story. In this collection of stories as told by ED nurses, as the listener, I was part of the story. Frank (2012) in particular called me to describe what animated my interest in early miscarriage. In my own clinical practice, I was profoundly affected by experiences of caring for

women experiencing perinatal loss and was privileged to be mentored by ED nurses who placed a value on providing expert care to women experiencing such a loss. As I moved forward in my career, I became aware of negative experiences explicitly related to miscarriage. I had colleagues who commented on such events with, “They are only six weeks.” There were physician colleagues who requested that their patients be cared for in the birthing unit because they felt women benefited from the care of perinatal nurses who had the expertise to care for women experiencing an early pregnancy loss. Finally, friends, acquaintances, and the media shared negative experiences with miscarriage in the ED.

So, I asked, “Why?” I needed to assert that I believed then and I believe now that ED nurses, no matter where they practise, are compassionate and put patients first. I do not mean to imply compassion and “patient first” is a soft skill—rather, it is the quintessence of nursing. In part, this view reflects my standpoint (Frank, 2000). Standpoint as described by Frank (2000) “both reflects one’s unique experience and asserts membership in a community of those who understand shared experiences in mutually supportive ways” (p. 356). The acknowledgement of my standpoint and even the participants’ standpoints does not mean we all share the same experience with miscarriage. I understand Frank to say that we must acknowledge what we share, to know where we differ and how similarities can both support us in understanding and navigating the experience. I am not an ED nurse, but I share with the participants in this study the experience of being a RN in the contemporary healthcare system. We all have provided care for women experiencing miscarriage, albeit in different practice setting: them in the ED and me in a perinatal setting. Both settings have challenges when it comes to providing care for women suffering a miscarriage. We share some similar problems but knowing the reality of day-to-day practice became an essential part of my analysis of the stories. Reflecting on this standpoint, I

asked myself this question: What engendered my desire to ask ED nurses to share their stories with me?

In this project, one of the participants, Faith, reminded me of the maxim "first do no harm"; that resonated with me and reminded me of my impetus for doing this work. I had reflected on my experiential knowledge of many years as a perinatal nurse, and then I went to the literature on the topic. I found several things that further sparked my desire to pursue this research topic. I discovered that there was more research regarding care for women experiencing pregnancy losses after 20-weeks gestation than there was about care for women experiencing pregnancy loss before 20-weeks gestation. I found that women I spoke to in my practice and in my private world told stories of their experience of miscarriage with ED nurses and the healthcare system. The media also shared stories that described negative experiences women had when they sought care in the ED (CBC, 2006, 2010). ED nurses told other stories about their experience caring for women suffering a miscarriage. While there were positive stories, there were also negative stories from both perspectives and these stories illustrated that ED nurses and women often struggled to navigate this experience.

But why start with ED nurses? ED nurses are the first point of care for women arriving in the ED for care. Women depend on ED nurses to guide them through this experience, so I needed to understand the ED nurses' perspective. I also had the shared experience of being a nurse, so I shared some perspective with the ED nurse. In describing his journey to write *The Wounded Storyteller: Body, Illness, and Ethics*, Frank (2013) described that the disconnect between the literature about the experience of illness and his experience as a patient was profound. My experience was similar; I saw a disconnect between my practice as a perinatal nurse and what I knew from friends, family, and the literature.

Furthermore, I had learned of narrative inquiry and in doing so realized that the stories of ED nurses and women might be difficult to tell and even more difficult to hear. Frank (2010) offered the concept of the narrative resource—or those things that help make a story recognizable so it can be told or heard. I could then ask these questions: What narrative resources do ED nurses use to tell their stories? How could these narrative resources help illuminate the ED nurse's experience? This epiphany was the spark that ignited my interest. Going back to my standpoint, I must ask, "What do I know about the experience of the ED nurse and how does my experience inform our mutual understanding of caring for women experiencing early pregnancy loss?"

What Do I Know About the Day to Day?

Frank (2010) speaks to the importance of fieldwork in understanding the context of the storyteller. The listener must have some understanding of the experience to be able to hear the relevant stories that call out to be told by the storyteller. While I had clinical expertise in providing care to women as a perinatal nurse, I did not understand the "everyday circumstances in which people learn and tell stories" of miscarriage in the ED (Frank, 2012, p. 38). Nonetheless, although I did not have field experience in the ED, I did have context for the experience of miscarriage. This knowledge followed an examination of the literature and available evidence that revealed not only challenges for women but also challenges for ED nurses. As I entered into conversation with the ED nurses, I had preconceived ideas of what I would hear. I expected negativity, justification, and trivialization. This expectation was based on knowledge and perception of the experience of women who sought care in the ED.

Significantly, during my first few interviews I listened intently for this content but when I stopped listening for this story and heard what the ED nurses said, I began to hear their stories

differently. The narrative resources began to reveal themselves and the ED nurses showed their experience through their stories. They began to expose their challenges, and their strengths and their standpoint were also exposed as the narrative resources became clear. The ED nurses were troubled by the women presenting with a miscarriage in the ED, just as I was. Our standpoint was similar, but what was the difference? The differences are significant, because as Frank (2010) tells us, standpoints are not static and opportunities to change standpoints come from the discovery of new resources to tell the story differently. The creation of new narrative resources will help ED nurses tell or understand their stories differently. We thus need to understand what narrative resources ED nurses use to tell their stories.

The Narrative Resource Questions

Storytellers (ED nurses in this case) use narrative resources to tell and understand stories. These narrative resources circulate within groups and create the framework for the stories that are told. ED nurses in this study used several narrative resources to build understanding about their experience of caring for women experiencing miscarriage. The following questions were used to identify narrative resources used by the participants:

1. What narrative resources did the storytellers use to shape the story?
2. What narrative resources shaped how I as the listener understood the story?
3. How were the narrative resources shared between different groups?
4. What limited the storytellers' use of those resources or were they limited in what resources they could use?

Shaping the Story

Storytellers draw on their repertoire of narrative resources to shape how they will tell their story. Time offers the opportunity for us to add to our inner library, or narrative habitus,

(Frank, 2010) of stories. This is also true of the ED nurses who shared their stories for this project. The experienced nurse may have a more extensive repertoire of stories than a more junior nurse to draw on when they are making sense of an experience such as miscarriage. This vault of stories could offer the nurse the narrative resources from which they can draw to navigate not only their day-to-day experiences but also the new experiences they may need to process and understand. These narrative resources include both the nurses' individual experiences and the experiences of others gained through shared storytelling.

We can assume that the ED nurses, as storytellers, draw from many resources to tell their stories—including their experiences, their practice, the current policies and protocols of the institution where they work, their stories of ED medicine, and their undergraduate and postgraduate education. In this project, the ED nurses who shared their stories revealed several narrative resources that were common across most of the stories. The narrative resources shared most often were *the reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do*. For the remainder of this chapter, I outline these narrative resources. Later, in Chapter Five, I will offer more in-depth insight by showing these narrative resources through the stories of the ED nurses who participated in this study. In Chapters Four, Five, and Six, gender-neutral pronouns may be used with some participants. Participants will be referred to as she or her, he or him, and they or them.

The Reality of the ED Narrative Resource

The ED as a place reveals itself as a character in the ED nurses' stories. Therefore, understanding the character of the ED is essential to understanding how the stories of miscarriage are told by the ED nurses in this study. The character comes through in the stories where the ED is consistently described as busy, overcrowded, with limited resources, and meant

for true emergencies. The ED nurses also described the ED as a place where process and efficiency are held in high regard. This narrative resource supports the ED nurses to explain their experience of working in the complex environment. While listening to the ED nurses' stories, *the emergency department* began to sound like the name of the person and its voice is loud in the stories. Robin described the ED as busy, where miscarriage is not a priority:

> *So, you're like, kind of there, waiting…and then you call them in and put them in [minor treatment] and the doctor sees them…. It's really the hard part, in that you are told that if you're less than 20 weeks, it's NOT an emergency. It's the emergency department and the acuity we have these days. It's so busy that it sometimes has to be that. You're not an emergency; you're stable so come up to the desk anytime you need. I'll check your vitals and we will go over things, but it is going to be a long wait.*

The busyness of the ED can be extended to the desire for efficiency, to manage the busyness and the potential for disaster. The ED nurses described being "socialized" into always being ready for the next disaster. Robin described how the ever-present threat of the emergency that may come at any time creates angst for the nurse:

> *Hopefully, we can do better than, okay, we can draw some blood and send you back out to the waiting room. I don't even know what more we could do, but in the culture it's not an emergency and we don't like pregnancy-related issues. We don't deal with them so let's just do the bare minimum. I think we don't see them as a priority. You're so trained—even in our triage courses and stuff—worst comes first. You want to see the small non-emergent things [get] out of the way, like x-rays and blood work and stuff. Once that stuff is done, I can go right into emergency nurse mode and start treating that chest pain that walks through the door. You need to triage the people in front of you and*

> *then start preliminary treatments so that they move through the department quicker because we might have an ambulance come, and another ambulance, then a stroke. And I won't be able to do anything with them again. If I don't do it now, efficiently, then not everyone's care is going to be done properly. You just really want to get it out of the way, so it's done because it's not an emergency. It's not an emergency, but it's an emergency for them.*

In addition to always being ready for the next "real" emergency, several of the ED nurses told stories that reflected the pressure to move the patient through; to keep things moving. There are descriptions of a culture that is built on "worst is first*"* and the need to move anything minor through quickly, in anticipation of the potential, upcoming disaster. This perspective includes the perception that miscarriage is a minor event. This is not unique to miscarriage but may reflect the challenges of the contemporary ED. However, it is difficult to ascertain what the real tension for ED nurses is. It is Faith who further explained this in her "sore toe" story, where she described that if something is perceived as minor it gets the minimum of care, regardless of the resources available, because something more urgent might come in:

> *Yeah, it's almost like, in my mind, if there's no patients in the waiting room and someone comes in with a sore toe and you're not doing anything, well you may as well bring them into a room and give them the best sore toe treatment the world has ever known because you're not doing anything else. [But] I don't think that's the way it goes. I think they just have a sore toe, and this is an emergency department, so they can wait out there for a few minutes. You know what I mean? The norm becomes based on when things are in crisis mode.*

The balancing of priorities in any context in health care is challenging. But the ED nurse faces a unique set of challenges in the contemporary ED: the arrival of a woman with a miscarriage may not present any more of a challenge than any other patient who falls into the actual or perceived category of a non-emergency. Narratives that focus on the *reality of the ED* are prominent in the ED nurses' stories. Notably, they speak *to the place*, but what about what happens *in the place*? The *medicalization of miscarriage* narratives offers some answers to this question.

The Medicalization of Miscarriage Narrative Resource

The *medicalization of miscarriage* represents a complex set of phenomena for both women and ED nurses. Frost et al. (2007) stated, "The medicalized approach detracts from the complexity of this experience and contributes to a sense that miscarriage is being trivialized and its seriousness for the woman denied" (p. 1005). These authors discussed the scientization of death and the related implications when caring for women experiencing miscarriage. The medicalization of miscarriage may reduce the experience to simply an outcome, so that HCPs may not recognize the complex physical and emotional experience associated with the loss of a pregnancy (Frost et al., 2007).

For the ED nurses who shared their experiences here, the medicalization of miscarriage was how they described the care they provided to women. It was all they could do. But was it? The *medicalization of miscarriage* narrative resource may, in fact, be part of a cover story as told by ED nurses in this project. A "cover story" serves to deceive the reader or lead them away from what is real or the truth (Frank, 2010). The ED nurses wove a tale that led the listener away from the reality of their ED practice. The ED nurses' stories in the next chapter will illustrate this further, but it is important to understand how this narrative resource helps ED nurses in telling their stories and assisting them in reconciling their experiences.

In the quote below, for example, Robin articulated the focus on the medicalization in the care for a miscarriage. Robin said that this works well for other issues, but questions if this works well for miscarriage. The tale here was the focus on efficiency and pragmatism, but we can see again in the last line that this troubles Robin:

> *Urine pregnancy test and beta-hCG. That's what we focus on. We don't really focus on the person, what they're going through or what they might go through. We just get a urine sample to do a pregnancy test: the test is positive, so I want to draw some blood work because they are going to want a repeat in a week and they're not just going to ask me to do that. I'll get it done while you're here at my triage desk, so I won't have to come back to you later. Because it's all about efficiency, getting things done quickly so that you can move onto the next patient. It works really well for other medical issues. I feel like it might be good to dip their urine, send them to the waiting room, and pull them back up a little later to check back with them, draw their blood and see how they're doing, [if there is] any change and there probably is no change. They would probably appreciate getting checked back in on. It's hard.*

Medicalization as a cover story is an important one. Robin illuminated this in the last line of the quote above, saying, "*It's hard*." If we consider what Robin expressed in an earlier quote, when she said, "*It's not an emergency, but it's an emergency for them,"* we begin to see a crack in the armour of the pragmatic, skilled ED nurse. The minimalization of miscarriage is tempered by compassion and a recognition that this is difficult for women. This struggle was common among several of the participants, but this persona was best articulated in Robin's story and will be explored further in Chapter Five. The narrative resource of medicalization also brings into focus that ED nurses may not know what else to do for women. The nurse may believe that they

do not have much to offer women and it is “hard” for them. But why do they believe they have nothing else to offer women? The *lack of a plan* narrative resource may offer some insight.

The Lack of a Plan Narrative Resource

The ED nurses here alluded to the fact that they do not have a box or algorithm for miscarriage. Indeed, their stories describe a lack of protocol or plan for women who are experiencing miscarriage in the ED, but they revealed a struggle with this. In the quote below, Hope highlights that, unlike many other conditions, there is no protocol for miscarriage, explaining the trouble this creates for ED nurses. Hope’s story included images of the view from the triage desk and reveals empathy for the woman who is miscarrying:

> *I don’t know if it’s compassion on the part of the person who is triaging them. I think that’s horrible [for patients]: you need to be somewhere, and you need to know we care about you. I cannot imagine sitting there thinking that a potential baby is currently dying, and I am bleeding out in the waiting room with a kid who is snotting over there and an old man coughing. I cannot imagine that being myself sitting out there. I wouldn’t want that. I don’t know if some people are more crass, don’t think like that, or don’t care as much, or what the difference is really, because there is no protocol if someone is possibly miscarrying. There is no 5-step thing that you do: If they are over 20 weeks there is protocol that they have to go upstairs first, to labour and delivery, and confirm it’s not something to do with the baby. And [then they come] back down. There is[something] for that [circumstance], but if you’re under 20 weeks there is really nothing special that is laid out for what we do with you.*

Ruth referred to the ED nurse as a fixer. She believed that ED nurses had a plan for every eventuality that arrives in the ED. Her frustration is almost audible:

> *Why is it different from caring for your diabetes people? Because you just lost a life that's just a dream, just a whisper of something that is gonna be great for these people. And so, I think we're, ED nurses are just, ahh, you kind of get programmed into that, fix, fix, fix, fix, fix: Here, this is happening, do this if this is happening. And we have to because that is how we save a lot of people, but I think it falls very much short when you are in a situation where there's an inevitability, right? Nothing you can do is gonna work, physically. And so that's it. That's the end of our line for our work. It's like, don't, there is no script. There is no guideline; the story ends there.*

Other participants, like Robin, referred to the boxes that exist to guide care for clients accessing care in the ED. The problem or challenge she has with miscarriage is that there is not necessarily a standard box or plan:

> *Yeah, which is a lot of what the ED is. It's about starting these drips, drawing these bloods, put in an IV, do an ECG, listen to their chest. You have a list of things you want to do for each person. You want to put everyone in a box. You want to put ankle fracture in a box, you want to put your STEMI* [myocardial infarction] *in a box, you want to put your COPDer in a box, you want to put your CHFer in a box. The miscarriage less than 20 weeks, they're in a box.*

A woman arriving with a miscarriage presents the ED with a situation that often has no associated plan, compared to other health concerns that do have plans. However, this lack of a plan may not be unique to miscarriage. Faith expressed earlier in her sore toe quote that even when there was time and resources to prioritize something minor, it might not happen in anticipation of the next emergency.

It is essential to reiterate that miscarriage is usually not life-threatening, but other conditions in the ED are and therefore must take priority. It is reasonable to posit that given the lack of a formal plan, or even acknowledgement of the place of miscarriage in the ED, it may become something that remains on the periphery. Thus, it might not be addressed in the same way as other conditions. This concept has multiple layers. The first is the reality and imperative that "worst is first" in the ED. The importance of prioritizing care to threats to health and safety cannot be diminished or negated. However, we presume that women and families desire to have HCPs who appreciate the meaning of their loss. They desire care that not only attends to their physical needs but is also compassionate, sensitive, and attentive to their psychosocial needs.

The literature refers to the silent nature of pregnancy loss, which is multilayered given the challenges that can be associated with women's reproductive care (Bellhouse et al., 2018; Silverman & Baglia, 2015). The ED nurses in this project did not tell stories that suggested their intent was to silence women. Instead, these give voice to some of the challenges women face, along with the ED nurses' struggle to find solutions for them. However, it would be remiss to not consider the influence of these struggles within the *lack of a plan* narrative. Simply put, why is there no plan and what prevents its creation? The ED nurses cited here clearly articulated the value of a plan for miscarriage in their practice in general, which would undoubtedly be advantageous for women and ED nurses. It is clear however that ED nurses are providing care, so how do they describe this care? The *nothing I can do* narrative resources offer some insights.

The Nothing I can do Narrative Resource

The narrative resources shared by the nurse participants are multilayered. As each layer is peeled back, more is revealed from the stories about the ED nurses' practice. Reflecting on the above-mentioned material, it is reasonable to say that miscarriage presents a conundrum for the

ED nurse, despite telling me that women who are miscarrying frequently presented in their practice. The ED nurses revealed that they struggle to "fit" women who are miscarrying into their practice, and this creates troubles for them. The question remains, why is this such a struggle for these ED nurses?

The script that healthcare providers follow says that unless they have a life-threatening complication associated with the miscarriage, women are treated medically. They are told by HCPs that there is "*nothing I can do."* Yet for some ED nurses, particularly those who are early in their career, there is a tension or trouble that arises with what they know they should do or what they were taught, and what the reality of practice is. The rationing of compassion and care is troubling to ED nurses and creates a disconnection between providing care and following the processes of the ED. Faith's story below is, in part, a continuation of her "sore toe" story. She described the disconnect she felt because what she learned and thought she knew were not what she witnessed or experienced in her practice.

> *I think it is [a] kind of culture. In Emerg, there is—especially the longer people are there— there does seem to be a tone of bitterness towards anything minor. And miscarriages are falling into something minor [even] when what we were taught in school is that it is potentially the most major day this person is having. There is a huge—you're like, wait a second, nursing school says, and woman's stories say, and everything I read in literature says [something important is happening]. But real work says, and the doctors say [not so], and the triage system even doesn't put these people on a high level of acuity because they're not potentially [serious]. They're not, you know, depending on their symptoms.*

Faith spoke of "bitterness" and as she described the conflict, the bite or the pain in her story is apparent. Faith struggled to reconcile what she knows is right with the reality of her practice. In contrast, ED nurses with more experience, like Robin, described the challenge of providing care for women and the limits to what can be done for a woman experiencing a miscarriage, compared to other conditions in the ED:

> *I don't get that feeling with [patients with] abdominal pain because I assess them, they're fine, and I have an idea of what I think it is: I've drawn their blood work, they're gonna be seen and this will all be resolved. But with the miscarriage, you don't get to do that. You don't get to help them. I guess probably the thing is I don't feel like I am helping them at all. I really just feel l like I am giving them information and facilitating some stuff for the physician and they're going to be on their way. But I myself have nothing to offer in the way of helping them through this crisis.*

Ruth described herself as "highly skilled" and confident in her craft. She can react quickly because of this expertise to preserve health and safety. Unfortunately, miscarriage often does not fit this narrative so presents a challenge for Ruth:

> *From a nursing standpoint, we can't accept that very well, that there is nothing we can do. There should be something. We are highly skilled. We are highly educated. We have resources and in the bigger centres, everyone could come to us and help, but nobody could do anything. I find that very humbling but still frustrating and I would honestly first try to get someone to take over and I would always say, "I don't know what to say." I think everyone would say, "I don't know what to say." Nobody knows what to say it is catastrophic for this person. Then what do I do? Show me what to do to be better at taking care of these women. Well, I would go in, give you a warm blanket or make sure*

> *the partner is there. Is there anyone you want to call? Are you having any discomfort? What else are we doing to do? Because that is what we do for everybody and they seemed so special to me, you know. This is not just—you have a belly pain or appendicitis or something like that. That is what we would do for everyone—we would take their vital signs, make sure they are okay, that they have a support network with them, did they need to call anybody? But with this, [it] was like, what else can I do? What else can you do for this person? So, I felt very helpless. I think that was the overwhelming feeling I experienced.*

The ED nurse practises in an environment that depends on policy and protocol to standardize care, and to provide safe and efficient care that saves lives. They are educated to assess quickly what puts health at risk, to intervene quickly, and to mitigate or eliminate the risk to health. As was discussed earlier, ED nurses cannot "fix" a miscarriage. Once it begins, there is little to nothing to do to stop the process from unfolding. How does the "can't fix it" story affect the nurse and how they provide care? The inability to fix the situation weighs on the nurse. Mary and Joy spoke of the challenges of not being able to fix the situation for women experiencing miscarriage. Their sense of helplessness seems to not only be that they cannot stop the miscarriage, but also that they cannot prevent the trauma for the woman. Mary stated the following:

> *You're helpless. Other than giving them emotional support, there is nothing, there is nothing you can do. You can't stop it. You can't fix the situation. [As] I nurse in the emergency department, that is what you want to do. You want to fix the situation.*

Joy mentioned that she was troubled by the fact that for so many things in the ED they can provide a fix, but with miscarriage they cannot:

It makes you feel that you haven't provided; well, you have done all that you can, but you want to do more. Especially as emerg nurses, you want to fix it. Somebody comes in with hypertension and you give them something for their blood pressure and they're fine. Somebody comes in with cardiac arrest and we have the stuff to fix that, but we can't fix what's going on with this woman or tell them what's happening or why it's happening. It's challenging and you want to do more for them.

These are stories of conflict between the system and the ED nurses. This push and pull illustrates the challenges that ED nurses' face in providing care to women experiencing miscarriage in the ED. Some of the challenges may be endemic to the ED but miscarriage stories in particular seem to trouble ED nurses. The ED nurses talked about not knowing what to do, that they are limited in what they can do, and they often do not have time to do what needs to be done. The ED nurses revealed they have clinical expertise in many things and have a plan for most things, but it seems that they may not be prepared to provide care in the ED to women experiencing miscarriage.

These ED nurses made clear through their stories that they cannot offer a fix for miscarriage, that there is no plan to guide their practice, and they are unsure of what to say to comfort and support women. What does this reveal? One obvious answer is a lack of policy and protocol exists in comparison to what is the norm in the ED for other health conditions. Taking a broader view of the situation, it is worth considering when, where, and where, and how are ED nurses prepared to care for women experiencing miscarriage? The ED nurses revealed their inner struggle to provide care for these women. They highlighted the empathy and compassion they have for women, and they demonstrated that they took ownership of the deficiencies in the care

they did provide. The question is, why are ED nurses not prepared? Why do they struggle when faced with caring for women experiencing miscarriage?

Why this remains a challenge may be more than simply a process issue. The reality is that ED nurses do have the requisite knowledge to know how to care for women. However, the absence of processes to guide care for women experiencing miscarriage in the ED may arise from lack of education or awareness amoung healthcare providers. It is useful to consider the history of ED nurses here, specifically inquiring into when they learned how to care for women experiencing miscarriage Faith told me earlier of the distress she experienced when what she learned in nursing school about caring for women experiencing miscarriage was different than the reality of her practice in the ED. She went on to describe the lack of education and orientation for ED nurses related to miscarriage:

> *I don't feel like that's really something anyone knows about, or I certainly don't. Working in Emerg as a new grad, that was nothing, we never talked about that. The most I have learned about miscarriage was in third year; it was more in the context of [the] labour and delivery unit, or, like, a Unit 4 experience, not so much an Emerg [situation]…. There was nothing [in orientation]. Orientation was being paired with a nurse who already works there, so if the ED nurses who already worked there don't know, then you're not going to learn…It's not going to be taught to you if you're just being taught by senior staff.*

Mary shared a similar tale when she spoke about not receiving any specialized training to care for women experiencing miscarriage beyond what she learned in nursing school:

We don't have anything for that really other than what you learn in school. There is no further education at the emergency nursing level for how to prepare somebody or to do education on a miscarriage.

In the ED nurses' stories, they did not present themselves in a leading role; in fact, they often did not acknowledge the significance of the nursing role. However, in listening to the ED nurses' stories, it was revealed that they do provide a significant amount of care to women experiencing miscarriage. This lack of recognition for the significant role of the nurse was apparent in the stories. This project does not offer the opportunity to substantively explore the ED nurses' understanding of the value of their work, but it is essential to acknowledge these phenomena, given the significant role articulated by the ED nurses in this project. The ED nurses' stories make clear that despite all their training and education, miscarriage presented a conundrum in the ED and the ED nurse believed they have little to offer women. This plot is common across all the stories.

These are the resources that shape how the ED nurses tell their stories (Frank, 2012, p. 44), but what resources inform how the listener understands the story?

Listening to the ED Nurse

For this discussion, I will begin with myself as the listener. Earlier, I described how my desire to examine the experience of the ED nurses caring for women experiencing miscarriage was animated. I identified my own experience as a perinatal nurse caring for women with miscarriage and contrasted this with what I knew about the care of women in the ED. These experiences and associations provided the resources I needed to appreciate the ED nurses' stories. I also shared with the ED nurses an understanding of the role of the RN, which includes education, ethics, responsibilities, and challenges. Based on these aspects and some of these

shared resources, I can assume some things about the ED nurses' practice and could hear their stories through all these lenses. My lack of commonality with the participants was with miscarriage occurring in the ED.

As noted, I entered the interviews early in the process with preconceived notions about what I would hear. I appreciated that the ED, as a place and with how it functions, created challenges for ED nurses; however, I did not have tacit knowledge of the real-world experience of practising in the ED. Consequently, I was compelled to learn more about the ED. Research and reading offered me new resources to understand the challenges and complexity facing EDs and the ED nurses who work there. Importantly, I could hear more from the ED nurses' stories armed with these resources. Many of the ED nurses interviewed indicated that the education and orientation they did receive was not enough to guide them in caring for women experiencing a miscarriage. I will discuss these views in more detail in Chapter Five, but this personal evolution in my familiarity with EDs helped me to hear the ED nurses' stories in a more meaningful way. I had to build on my resources to hear the ED nurses' stories, but I am not the only listener of these stories. More resources can be uncovered by asking, "Who else hears the story of the ED nurse or who else is affected by their story?"

Anyone Else Listening?

In addition to the ED nurses and the researcher, other important storytellers may be a part of the narrative resources in these stories. Women and families who seek care for miscarriage also have resources that shape how they comprehend the story (Frank, 2012, p. 44). Headlines such as "Calgary Woman Left to Miscarry In Crowded ED Waiting Room," "P.E.I. Miscarriage Prompts Changes at ED" (CBC, 2006; CBC, 2010), and "Seeking Help During Early Pregnancy Loss Can Mean Waiting Hours in a Halifax ER" (Smith, 2021) reflect the resources that may

influence how women and families comprehend the story of miscarriage in the ED. A simple search of the *Globe and Mail* and the term miscarriage reveals a plethora of editorials and personal accounts of the experiences of women when a miscarriage occurs. The literature related to miscarriage, as discussed in Chapter Two, also includes accounts from women and HCPs portraying negative experiences when accessing care in the ED. It is essential that HCPs acknowledge these stories.

Robin shared that reading such stories about positive or negative care women received in the ED has an impact on ED nurses, before they connect with women for care. We could posit that the availability of negative stories potentially creates a barrier for women and ED nurses, one they must overcome as they try to connect when a miscarriage occurs. The danger is that both could become caught up in their own story, so that their stories become "recorded but will remain unheard" (Frank, 2010, p. 79). I thus revisit why I chose to do this research, as it is the heart of my inquiry: the ED nurses and women are both telling stories of less-than-ideal encounters, but while the stories are told, they are not necessarily being heard. So how do we tell the story differently? We must now examine which stories circulate, what other narrative resources could lead to a different story, and what prevents those narrative resources from being invoked in the stories?

How Do We Tell a New Story?

I was privileged to hear eight interviews with ED nurses. Each of these interviews contained stories with recognizable elements so that as I listened, I found myself thinking, "Yes, I have heard this before." My experience with narrative research has been such that sometimes when I was been listening to or reviewing a transcript, I had to confirm who the storyteller was—

because the story sounded so familiar. Why is this so? An overview of the character types, plot lines, and scripts is a place to begin.

Who Were the Cast?

The characters in a story are essential. They draw us in, and we see them as the heroes, the villains, or even as an insignificant character. Regardless, the characters in the story are critical to understanding the journey that the story sketches. ED nurses are the central character in the stories told as part of this project. Other supporting characters were also revealed but the central character was the ED nurse, which was crucial to keeping the project aligned with the research questions. I needed to orient myself to the role of the ED nurse; to do this, I asked them to describe their role in the ED.

It is important to note that I did not ask the first two storytellers to describe their role in the ED. Only after transcribing the interviews and reflecting on Frank's (2010, 2012) methodology did I realize I needed this context. Therefore, this was the first question I asked for the next six interviews. This question allowed these participants to describe the background against which they played a character in the story. Each of the storytellers described themselves in a similar way. The focus of their description was on what they did in the ED. Mary, Joy, Hope, Faith, and Charity identified triage as their first role when describing what they did in the ED. This is an important clarification, one that will become clearer in later sections because of its impact on their experience of caring for women:

> ***Mary:*** *So, I'm involved in being anything from the triage nurse or caring for people who are actually in the department, as well as doing interventions or treatments or what not.*
>
> **Joy*:*** *As the RN we are responsible, we do the triage assessments. So, when somebody comes in, we take them in and we assess them, their story, we get their vitals, and then we*

give them a triage acuity level and then we also do primary nursing. We work as a team, but we do primary nursing as well. I would be responsible for six emergency patients at once.

Hope: *So, I work triage, fast track, and observation. Triage, of course, being when they come in first, getting their story, and seeing where they would be appropriated to. Fast track is more clinical, and we try to get you in and get you out and observation is where we keep you overnight or unfortunately if the hospital is over full that's where we put you if you have no place to go. Or just patients that we think are going to be heavy care or need more resources… I work mostly observation, fast track and because I work nights there really isn't a triage nurse designate, but when there is it is occasionally me and we do just about everything.*

Faith: *I work as an RN in Emerg, and I have been there for 3 years now. I work in triage, triaging new patients that come in using a guideline and sorting them based on their, on their acuity. I work in [minor treatment] which is a minor treatment area for more fast-flowing patient care. I work in observation, which is more of our medical admitted and sometimes surgical patients, and also in trauma and critical care, which are our more critical areas. Yeah so, I work in those five different areas on any given day.*

Charity: *I was a registered nurse in emerg, and I worked in various areas. So, I could work anywhere from triage to critical care to trauma or a float nurse. Many times, I could triage someone who may or may not be having a miscarriage and other times I could be dealing with somebody who is having a miscarriage and has to go in with the physician to do some testing as well.*

The ED nurses, as the main characters in these stories, described themselves in more of a supporting role. Their stories revealed that although the ED nurse navigates the experience of the women who were miscarrying, they were often encumbered in this goal by the process and efficiency of the department and the accountability to physicians, patients, and nurse colleagues. We can see the ED nurse being in the position of having many masters—the tension this creates can be heard in the stories. Given this description of the ED nurses' role, I will explore how the ED nurses told the story of caring for women. In particular, what are the stories that inform the plot of the ED nurses' stories of caring for women experiencing miscarriage?

What was the Plot and Script?

The plot across ED nurses' stories is not a simple one. It has twists, turns, and subplots that mirror the complexity of the setting. On any given day, the ED nurses are faced with a multitude of stories, and they play different roles in each story. The plot of the miscarriage stories is not simple either. The ED nurses' stories revealed a common script, one in which a woman arrives seeking care for a miscarriage, but the perception of the ED nurses is that emergency is not the place for them. Yet, they are not far enough into their pregnancy to access services in the labour and birth unit. Neither can their symptoms typically be managed in a clinic or primary health care provider's office. As well, the timing of the onset of their symptoms does not necessarily coincide with the hours of a clinic, even if they could present there. As well, some women do not have a primary health care provider. Thus, their only option for care may be to present in the ED, when the ED nurse enters the story to triage the woman.

The ED nurses communicated that miscarriage is not an emergency in the ED and women may have to wait for care either in a private room or in the waiting room. This waiting entails several steps, as follows:

- They wait in the waiting room with others.
- If they are placed in a treatment room, they wait.
- They have their blood drawn and have a urine sample collected to confirm pregnancy and they wait.
- They might have an IV started and they wait.
- They wait only to be told there is nothing that can be done and follow up with your family doctor.
- They are not an emergency, so they wait.

This flow of events was the same in most of the stories that respondents told for this project.

While ED nurses acknowledge this is a difficult experience for the woman, in the milieu of events in the ED, it may not be possible for miscarriage to be a priority. Other threats to health and safety must take precedence over a miscarriage. The ED nurses are faced with coordinating care for the woman who is having a miscarriage and also for other patients seeking care. A miscarriage becomes a non-emergency, as the ED nurses told me that over and over; yet at the same time, they are troubled by how little they believe they can offer to women having a miscarriage in their ED. The ED nurses' stories spoke not only to there being nothing they can do for women, but also to *not knowing what to do* for the woman. What is challenging to ascertain is which of these statements is the biggest issue for ED nurses in this study. For example, many of the ED nurses told me that there was nothing they could do for women—suggesting that the commonly held belief is that a miscarriage is an event that, once in motion, cannot be stopped. This is a reality because the woman's pregnancy is not viable and as such there are very limited options to intervene and change the outcome. However, vaginal bleeding for any reason does require intervention and management. Many of the ED nurses described that

they practise in a world where they have a plan for everything. Miscarriage does not have a set plan for nurses to follow.

Most of the ED nurses who shared their story described that they are not prepared to provide care to women experiencing miscarriage. Only two ED nurses identified some education on miscarriage in their undergraduate education, but there was little to no mention in the interviews of substantive postgraduate or clinical education on this topic, which would support them when they specialize in emergency nursing. The result is a cover story that tells of miscarriage as a non-emergency: this is an attempt to mitigate their lack of ability to intervene successfully, as well as lack of relevant education and a clearly articulated nursing role. Yet, the same ED nurses described providing care for women despite the absence of formal policy, formal guidance, and formal education. The juxtaposition of these stories is important to understanding the perspective of the ED nurses who shared their stories. Their stories describe a scenario that has them providing care for women and navigating the experience for women and even for their colleagues; yet they do not always acknowledge what they are doing for women and the importance of their work.

I previously discussed the story elements that circulate about miscarriage in the ED, evident in the ED nurses' accounts as recognizable characters, plots, and scripts. These ED nurses who shared their stories identified challenges and revealed the push and pull of the tensions they experience caring for women experiencing a miscarriage in the ED. They spoke about their feeling that there was nothing they could do. The futility of this narrative was certainly a source of tension for the nurses. Repeatedly, this story spoke to the reality that they could do nothing to stop the miscarriage, they could not intervene to change the outcome, and that often no plans were in place to help women navigate this experience.

The ED nurses identified in their stories their lack of educational preparation to care for such women. These parts of the story were not easy to hear initially, but the depth of what they meant to the particular ED nurse and how they formed their understanding of their story or their place in the story was profound for me, as the listener. These stories revealed narratives about the image of the ED nurse: their struggle to maintain efficiency in the chaos of the ED, their desire to provide expert nursing care to all their patients, but also to help these women.

Setting aside all the layers and focusing on what the story is saying creates an opportunity to change the story and create new narrative resources. The raises of the question of whether the ED nurses need a story that talks about a plan or a story that talks about education to understand how to implement the plan. Perhaps they need a story to acknowledgement that even without a plan, ED nurses are coordinating care for women experiencing miscarriage. These stories could then contain the narrative resources for ED nurses to tell the story differently and potentially create a new ending. The opportunity to tell their stories for the purposes of this research is a first step to opening the dialogue, while addressing what might be preventing the new narrative resources from becoming how the story of miscarriage in the ED is told. Undoubtedly, a new set of narrative resources could change how the story is told and understood in a way that is beneficial to both ED nurses who provide care and to the women they care for. The question now becomes this: What do we need to know to create new narrative resources? We need to understand the story and the storytellers.

The preceding discussion provides an overview of what the ED nurses revealed in the stories they shared for this project. These narrative resources are integral to our understanding of the ED nurses' experience of caring for women experiencing miscarriage. Moreover, they suggest possibilities for new narrative resources to change the story. The barriers to changing the

narratives become clearer when we consider who tells what story to whom. Therefore, how stories circulate in the group is an essential part of this analysis.

How Do the Stories Circulate Within the Group?

Stories go around. Frank (2012) tells us that medical professionals are a part of a "self-enclosed storytelling community" (p. 44). Many of the ED nurses' stories revealed how they may be sequestered because of their role. The most profound example of this is the story of reading or hearing of women's negative stories of care in the ED during a miscarriage. Robin articulated how the media portrayed one side of the story and Robin, who was bound by confidentiality, was unable to defend the care. Robin gave this account:

> *If that's how they interpreted it, I understand they were really upset, but that's not how I lived it. Your hands are tied and [one] cannot ever write that story. Another one for the books that the ED messes up again and lets this person suffer. But do you really think the ED nurses who are caring for you would think like that or care for you that little?*

Robin's words might not only be a glimpse into how ED nurses are sequestered by protocol and rules, but also how powerless an ED nurse might feel when faced with this situation in practice. The public does not see or understand the ED from the same perspective as the ED nurse who works in this setting and holds confidential information. The image of nurses being accountable to many masters is highlighted here again, as ED nurses are caught in the middle in many ways. Who can ED nurses tell their story to?

The stories for this project might be the ones shared between colleagues but not revealed to the world. What is the impact of these stories? It is possible that these stories and the narratives that develop perpetuate the ED nurses' feeling of being unable to do anything to help women. These stories may also be the ones that the new nurse hears from the senior nurse—

folklore, so to speak—and the struggle continues. The stories they share with each other could be those that form the narratives influencing practice. The ability to tell stories is also influenced by who listens to our stories and to whom we tell stories. HCPs often tell their stories in code, which is understood by the group (Frank, 2012). However, can members break the code or offer a new translation? What happens when the code is broken, or it is translated differently?

I asked participants, "Does another person's story make it easier or harder for you to tell your story?" When Joy was asked this question, she responded by telling me that she viewed this as her role and her responsibility as an RN, and that her life experience was a factor in her perspective:

> *No, I don't think so. As an RN, you are responsible for your own practice and not the practice of others. There are definitely times when you [cannot provide that kind of care]. I don't think any nurse would intentionally not want to look after a patient properly. I think [they would]. It just depends on their perspective. I know, like I said before, I probably would have done the same things as well during pregnancy. She has two healthy kids. It's not a big deal, they will be fine, they can try it again. But it's hard to see somebody who isn't seeing the emotional side of early miscarriage as one of your colleagues. So, I guess it would affect how you would tell your story.*

In contrast to Joy, Faith had a different perspective. Faith described that it is easier or more difficult for nurses to tell their stories to other nurses depending on who they are with—specifically, whether the other nurse(s) had a similar experience with miscarriage and whether they were comfortable with each other:

> *I think it makes it harder. Like, if I was talking to my coworkers and they were sitting in the room right now, I would be nervous to tell my perspective—wondering if it was going*

> *to match up with what their perspective was. If I was sitting with three of my coworkers who were pretty good friends and I know we see eye to eye on most things, it would probably be very easy to go back and forth and share stories, knowing we are all on the same mindset towards a particular thing…Or, if we had been there on the same day when something did not go well. If we had both cared for someone who was miscarrying and both had the same experience…if I knew our perspective was the same you could talk for hours probably and back and forth, back and forth, and share all these stories. Very positive. Yeah, if certain people were in the room or certain people who have stronger perspectives or just different ways of doing things or especially if they have more experience, I would be nervous to say because I am new…because I don't know everything they know, and I haven't cared for everyone that they have cared for.*

Another question the ED nurses were asked is. "Who might tell the story differently?" Hope offered the following when asked this question, speaking to the experience of being a junior nurse in the ED and how work and life experience influences how she tells her story:

> *Maybe less passionate, the older ones. They think it's just another person who is having a miscarriage, that they have seen 20,000 [times] at this point. It's not interesting to them. It's not something new or novel and I feel some of them just get very disheartened about most things. Basically, if you're not dying, why did you show up to the emergency department?*

Robin's story reflected the perspective of a more experienced ED nurse. When Robin was asked how she could have told the story differently at a different point in her career, she responded as follows:

Initially, I think I would have been appalled or even just shocked. Okay, you are having miscarriage, this is an emergency and emerg beats you down to be, like, when did the symptoms start? Are you having any heavy bleeding? I'll test their urine and draw some blood and send them back out to the waiting room. Before, I would be running back to grab one of the ED nurses: okay, this is what's going on, we need to get this woman into a room. They would be, like, "no." It's hard for the patient and it's hard for the nurse.

The different points of view from these ED nurses may highlight what prevented new narrative resources from being mobilized to change the stories of miscarriage in the ED. They also offer some insight into the potential for new codes or new translations. The stories in circulation and the ability of ED nurses to tell the stories is essential to understanding the power the stories have to affect practice. So far, the focus has been on the stories and the narrative resources the ED nurses used, but what about the nurse storytellers themselves? What do we know about them and why do we need to know about them? Affiliation and identity questions offer a way to examine the storyteller. Thus, I next inquire into how the storytellers are linked and what their affiliations are. Further, what did the stories reveal to us about the storytellers?

How are the Storytellers Linked and What Did the Stories Tell Us About the Storytellers?

Affiliation questions, according to Frank (2012), ask about who is affiliated with the particular group and understands the stories shared by that group. Earlier, I discussed the importance of fieldwork and identified what I shared with the storytellers. Our similarities are that we were all RNs and we all had experience caring for women experiencing miscarriage. this is where our similarities ended. ED nurses share a unique set of stories with not only their nurse colleagues but also other members of the healthcare team. The ED, as mentioned above, is a closed system in many ways and the unique lived experience of ED nurses is told within the

walls of that system. Some, like Robin, told me that parts of their stories cannot be shared outside of the ED group, and this is a source of conflict. They often referred to what is going on behind this "closed door." The conflict arises because those who are not affiliated with the group (for example, women more broadly, and the media) do not have access to confidential stories of the ED. As a result, the public is "rendered" external to the ED nurses' group and therefore is unlikely to share the same narrative resources to tell stories that complement the ED nurses' stories.

The potential that arises from the lack of shared stories may be a source of conflict. The ED nurses, women, and the general public represent only part of the affiliations that affect the narratives about miscarriage in the ED. Others that have already been touched on are the junior nurse and the senior nurse. The junior nurse's experience made manifest a struggle to reconcile what is important in caring for women experiencing miscarriage with what is expected of an ED nurse. The senior nurse's perspective highlighted that the ED "beats you down"—that it may demand that the ED nurse ration compassion and energy to manage the chaos and challenges of the ED. Both groups struggled but their differing perceptions or views of the situation add to the complicated story. While they are both affiliated with the group of ED nurses, their experiences and stories are different, and this difference may offer an opportunity to change the story and influence practice. The "we" in this story is the ED nurses; in many ways, all others are excluded from that group. Nonetheless, the ED is viewed as a closed group; therefore, we can assume both junior and senior ED nurses share a common story about miscarriage and a unique perspective on that experience. What does that perspective teach ED nurses about who they are? *Identity questions* offer some insight.

Frank (2010; 2015) has written that stories teach us who we are. The ED nurses I spoke with described what Frank (2010) calls a "stock identity." Ruth described the ED nurse as the fixer who has a plan for everything: the highly skilled and educated nurse who is looked to for their expertise. Most of the ED nurses told stories that went in a circle: miscarriage is not an emergency, worst is first, there is nothing we can do, but we know it is hard and we want to do more. ED nurses also told me that either it is not an emergency, or, more specifically, it is not an emergency in the ED. This cover story (to be discussed later in Chapter Six) may be an example of how the narrative has taught the nurses who they are. The ED nurse is a fixer who always has a plan. Ruth talked about the patient versus the diagnosis; the following remarks highlight the identity of the fixer of the illness versus the nurse caring for the patient:

> *I don't know, but I think there is a, there is a mentality sometimes in the ED that it is easier to stay detached and do what we can do in terms of A goes to B goes to C goes to D. Here's what is happening: can't breathe, intubate; can't breathe, put them on the ventilator, you know; have a clot, get the clot busted. Like, that kind of talk about the fluidity, the flexibility of the ED nurse, because it is just controlled chaos all the time. Then you put something that is so heart-wrenching into their day, where people are so mechanical in how they approach scenarios. Like, almost detached from the patient: we have an MI [heart attack] in six, we have a GI bleed in five, there is an asthma in two, you know. Not like, there's a three-year-old with asthma, this is the sixth time they have been in this week, right. And so, kind of just clinically - yeah, protecting and just making them [into] a disease entity versus a human with big feelings and big-time stories and stuff like that.*

Ruth also described an ED nurse caring for a woman experiencing a miscarriage as one who cannot fix it, who does not have a plan, and one who cannot offer substantive expertise:

> *After all these years, and after all my education and after all my encounters…that makes me too sad that I can't go in there and be sad in front of my mom—the mom—and show that I don't have the answer. [Laughs] That is not what ED nurses are. They are very—I know what the answer is, here is what you are gonna do, you know, Here's the plan…That's what I feel like. This is, it's raw and you're fully exposed and there is nothing you can do, and they still wait for something from you. And that is not something you know how to give, what it is they are looking for, what they want.*

Many of the ED nurses who shared their stories, shared a pragmatic, skilled, even expert persona. Yet Ruth reveals how this persona can be stripped down, so that the ED nurse can be left exposed. The stock identity, as an armour, is penetrable, and when that happens the ED nurse becomes vulnerable.

The juxtaposition of these identity characteristics may offer the opportunity for the nurse to explore a new identity. In one instance, the ED nurses described how they did provide care to women, yet the stock identity of the ED nurse may have prevented them from acknowledging the positive care they provide to women. But does the stock identity also prevent them from providing the care they would like to provide to these women? Perhaps something else is at work here, because ED nurses did describe providing care to women despite these barriers. The opening of this possibility creates space to imagine a new or complementary role or identity for the nurse in caring for women experiencing miscarriage in the ED. With possibility comes risk, though. This points to the question of what is at stake for ED nurses if they are open to the possibility of new stories and new narrative resources to tell their stories.

What was at Stake by Telling the Stories?

Frank (2010) described the work of narratives, and what they do to animate life. One of the five questions that I asked, according to Frank is this: "Who is holding their own in the story, but also, is the story making it more difficult for other people to hold their own?" (p. 77). "Holding one's own" begins with narrative identity—that is, who a person is and what they value about themself. As the storyteller works to hold their own in a story, inevitably this work can make it difficult for others to hold *their* own in their stories. The ED nurses' stories of miscarriage contain several examples of them holding their own at the expense both themselves and others. Most of the ED nurses told the story of miscarriage as a non-emergency and they shared that they are not necessarily prepared to care for these women—both from a policy perspective or from an education perspective. The telling of these stories would appear to protect the nurse from the conflict or trouble they revealed in the stories. In the previous section, In the previous section, Ruth articulated this well when she talked about feeling sad that she couldn't offer her "mom" patient a clear answer.

The participants told the pragmatic ED story of miscarriage, but a backstory exists where they reveal they would like to do more or at the very least offer more to women. Faith also articulated this well. Her story is filled with the struggle to reconcile what she knows is right and what the ED requires of her:

> *I wish, I always wish, I could push pause for a second, take the person into a quiet and calming room and just have a long chat about how her loss has affected her life and, you know, what I am. Working in Emerg isn't the place that it happens and maybe it will never be the place where these long conversations happen, really. But if it can be*

something that doesn't add trauma, and doesn't make it worse, then you can set those people up where they can have those longer time-taking conversations.

The prevalence of these narrative resources within the ED nurses' stories suggests that they "convince ED nurses of what they have to do" (Frank, 2012, p. 45). However, changing how ED nurses tell the story would require change in practice and policy at an organizational level. What is more striking is that there appears to be a need for a change in perspective of the role of the ED nurse in caring for women experiencing a miscarriage. However, these are grand changes to consider and in the busyness of the day and with the demands of the system, the status quo is maintained.

Stories, according to Frank (2010), may be told in response to vulnerability. Most of the ED nurses shared that there was a need to improve the care of women who seek care for a miscarriage in the ED. However, in their library of stories, there may not be a story that informs a narrative that would support them to discover a new way to provide care for women. The stories that are told by ED nurses say that miscarriage is not an emergency in the ED, and they cannot do anything to help. These stories reduce the tension ED nurses may feel, thereby possibly reducing their vulnerability. However, the telling of these stories does not limit the possibility of new stories. The ED nurses could discover they are less vulnerable to the impact of the stories in circulation when they find new narrative resources to tell different stories. In fact, this potential opens possibilities by bringing to light new questions: What is at stake for the ED nurses, or what do they have to lose or gain by changing the story? Who will benefit or who will lose? Perhaps, changing the story could create a new way of doing things that finds ED nurses feeling less vulnerable and more empowered to lead the care of women experiencing miscarriage.

Stories, as representations of life, are never concluded. It is not the intent of this work to presume I have insight into the minds of the nurse storytellers. I have been privileged to hear eight different stories and had the opportunity to hear collectively and individually how these individuals described their experiences of caring for women having a miscarriage in the ED. Frank (2013) would caution against this and, in fact, has said that this privileged position requires that the researcher not assume—but rather, acknowledge—the privilege of being able to enter into conversation with storytellers and attempt to understand those stories as the storyteller intended to tell them. However, for the purposes of research, making conclusions and offering some understanding in a finite way is necessary.

The preceding paragraphs offered the opportunity to methodically analyze ED nurses' stories to inform a conclusion. The systematic analysis of the stories offered some insight into the narrative resources that shape how ED nurses understand their experience of caring for women experiencing a miscarriage in the ED. However, to understand these nurses' experiences more fully, we need to hear even more of these stories. The narrative resources introduced in this chapter—*reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do*—can be best understood by considering them within the context of the storytellers. To this end, Chapter Five will offer a closer look at three of the ED nurses' stories. The aim is to uncover how learning about the story resources enhances comprehension and insight. I inquire further into what helps to explore new stories and imagine new ways of understanding.

Chapter 5

The Ties that Bind: The Stories of Miscarriage in the ED

The previous chapter offered an overview of the narrative resources that the ED nurses, who shared their stories for this project, used to describe their experiences in the ED caring for women experiencing a miscarriage. There I theorized the ED nurses' stories through an analytical lens. In this chapter, I will show the ED nurses' stories as they were told to me, to represent the ED nurses as storytellers and their use of story to understand their experience. Eight ED nurses shared their stories; while these stories differ, they were similar in significant ways. The significance can be found in the narrative resources the ED nurses used to tell their stories. The process of listening to these stories is more than just a summary analysis. The voices of the storytellers and their words are essential to understanding the ED nurses' experiences.

Frank (2013) has called researchers to think with stories, as a means to go beyond treating stories merely as data and drawing inferences from them. Rather, he suggests that thinking with the stories positions them as "materials that I use to model theorizing—and living—with stories" (p. 23). As described in Chapter Four, the most common narrative resources used by the ED nurses were *the reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do*. These are notable because they occur across most of the stories participants shared for this project. Supporting these resources does not position them as "the truth," but merely that they are what the ED nurses used to describe their experiences. We also need to understand what these narrative resources may represent. We will begin this chapter with Faith's story of caring for women experiencing a miscarriage in the ED.

Faith' Story

We see a lot of women come through triage with different complaints in their early stages of pregnancy. Often coming in with cramping, bleeding, usually their main concern is whether or not they are miscarrying. Triage and less acute areas would be the main areas where we see these patients. I remember as a nursing student doing one of our projects on perinatal loss, and I remember at that time reading all of the dos and don'ts of nursing care for these women. Like reading different stories, and we had a lady in our group that actually had an experience with a loss. And they shared their story, and it was very serious and very moving.

Then I remember graduating and working in Emerg and having my first patient as grad or not as a preceptored student, but as an actual nurse on my own, who was between 10- and 12-weeks pregnant. They were in a less acute area, and I wouldn't have known very much at that time. I probably had nine other patients and basically just doing their orders and trying to get things done. But I knew I had this lady who was potentially miscarrying, and I was thinking of this project and all the things—of how big of a deal it is and how we just learned about the benefits of being able to talk with women and having this be an open thing and all the things you can do to make the process less traumatic. What would you do in the birth unit?

Anyway, I went in with the doctor because they needed a female present with them in the room to do their exam and this lady had miscarried and they basically were pulling out the fetus that they had miscarried. I remember being like, "Oh my goodness, this is a devastating thing," and I was crying, they were crying. To me, it was the biggest deal ever, the worst thing I had seen at that point in Emerg. We had to take the fetus, put it in

a specimen container and send it to the lab for testing. The lady and the husband were there, and the doctor is a person of very few words, and they just said they were sorry. They walked out of the room, and I walked out of the room and the family went home. That was it. So, it was just… I mean they didn't need any further treatment in Emerg, they weren't bleeding anymore, or they weren't really in that much pain anymore. They basically left and were given follow-up instructions…

Unless they have an ectopic pregnancy needing emergency intervention, what they're gonna have done is blood work and an ultrasound to tell them if they are or are not miscarrying. They will either go home to miscarry or stay if they're in critical condition or something. They're pretty much told, "There is nothing we can do." So sometimes I feel like it's portrayed [like] you didn't even really need to come in because there's nothing we can do for a really early miscarriage, besides telling them it's happening… don't know who drives this…mindset of, "This is Emergency and we are going to do emergency interventions, and everything else is kind of peripheral." The physicians do that, and the ED nurses fall into that. And not that I don't see people being compassionate towards the patients, it's more so just what you had learned is necessary—to make it the experience that it needs to be for people. That doesn't really happen. They're just gone and discharged home. Unless they go seek out help to process what just happened to them, they will probably carry on like, as if, oh well, I guess it's not really something they're supposed to [do].I...

Day to day, you see people coming in with bleeding, cramping and usually these people are semi-urgent patients who wait and have a beta level drawn and a urine dip. If they're really early on, they kind of just go home and wait. If they're far enough along to

have an ultrasound, they may go for an ultrasound later that week or the next day. Or if they're in severe pain, they may go then. Then, you don't actually know either. That's another thing I found working in triage—is that I would be moved by the fact [of] whether or not they were miscarrying. To them, this is the most serious day they're having, potentially in a woman's whole life. That could be their point of crisis that they look back on, like that was the worst day, the day that I miscarried, and you send the people into fast track to get the bloodwork done and then you are off shift and going home and you never really know if that lady was miscarrying. Or, if they didn't, I wonder if they are, okay? No idea…Zero idea what happens after. I always wondered that; I'd always be like; how did that lady do in room 4? Did they end up sending them for an ultrasound? Oh, I don't know, they're gone home. Just kind of like [unknown], and you're like, okay.

It's very like… I feel like it's not a big deal. The norm among people is that it's not a big deal.…You kind of just fall into the next thing. It's not that it's overlooked or that it doesn't matter. I feel like people certainly feel sorry for the people [women], but there's no actions that really follow that. It's like, "Oh, that's too bad, they're going home." It's not *like, "Oh, that's too bad [and] therefore we have a policy for potentially miscarrying women where we do this and this."*

Faith's story contains all of the narrative resources identified from the ED nurses' story: *the reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do*. While this story is unique to Faith, it does reflect common elements, which clarifies the experience of the nurse who cares for a woman having a miscarriage in the ED. What did the other ED nurses say? What is unique in the other stories and what is similar? The narrative

resources are present in all three of the stories, which were told from the unique perspective of each nurse storyteller. Robin, Faith, and Ruth offered exemplars of their experience of caring for women with a miscarriage. Each invoked the narrative resources in their own stories to shed light on the experience of the ED nurse with women who experience miscarriage. Here are Robin's story, and more of Faith's and Ruth's stories.

Robin's Story

Robin's stories were a compilation of accounts of a skilled, pragmatic ED nurse who could compartmentalize to get the work done; nevertheless, they were also stories of a nurse who was troubled by what she could not do for patients who presented for care. The push and pull of these stories offer insights into the reality of the ED nurses' experience of caring for women experiencing miscarriage. The following are excerpts from Robin's story, beginning with an orientation to how ED nurses encounter women in the ED:

> A lot of people will come in with a very typical story of they are having some cramping, some spotting, their period is late, they could be pregnant. We have a lot of really good medical directives so we can just run a urinalysis with a beta pregnancy test and find out if they're pregnant. Then we draw beta. A lot of them find out they're pregnant, but then you're also breaking the news to them that based on their symptoms they are probably miscarrying. They are literally just in shock when you see them. They're like, "I'm pregnant, but not gonna be pregnant."
>
> *We sit at the triage desk and it's mostly the triage nurse that has to deal with this. You're sitting there with your co-worker and there are 2 stations. You see the whole waiting room and for me when I test their urine and they say they had 2 pregnancy tests a few weeks ago, they had that spotting earlier in the week then you test their urine, and*

you know they're not pregnant now. It's really hard. They're coming up and asking when they'll be seen or if they should stay, it's hard to say to them that I really think they should stay if you're concerned. Knowing what I know after dipping their urine is really upsetting. I have to say it with a smile and concern not to alarm them. You don't want them to be upset or interpret anything from their nonverbal. Is that bad or is that good? [You want them}to get that news in a private setting compared to a public one. I find it just really hard

Robin described the typical presentation of a woman arriving for care in the ED. This was consistent across the ED nurses' stories and reflects how frequently ED nurses care for women experiencing miscarriage. As discussed in Chapters One and Two, accurate statistics about the frequency of miscarriage are difficult to find; however, ED nurses' stories shared here would suggest that miscarriage occurs frequently in the ED. Yet despite this frequency that the ED nurses described, we were given a glimpse into how the woman with a miscarriage troubles Robin. Robin described how experiences with miscarriage are "not good" and "it's really hard." What is hard is that Robin knows something that the woman does not. This position of privileged knowledge will be important: it resurfaces later in Robin's story and is significant in terms of their experience. Robin identifies this initial encounter as challenging, but in this next excerpt we see that swing back to the pragmatic ED nurse and the medicalization of miscarriage:

Our only experience with early pregnancy is not good. It's either finding out they're pregnant and the emotion that come with that or that they're losing their pregnancy or pregnancy complications and [for]some people it's [after]multiple [loses] and they know it's happening. You just kind of say it probably is a [miscarriage]if it's what they were experiencing before. [We tell them] it's really busy right now if you can

take your seat and they will call you as soon as they're ready. You try to be compassionate and also knowing that it's just not possible to tell them we will bring them right in. This is obviously a lot they are going through. It's not a medical emergency, but a lot of emotional trauma for them and you hear stories of women who say it was traumatic…

We draw an initial beta and it's the emergency department so you're telling them they're not an emergency, this is not a life-threatening condition, so they're going to be waiting a while.

Robin established the medicalization here: "just run a urinalysis with a beta pregnancy test" and "we draw beta." This is a bit of a plan—some tests the ED nurses can offer initially and throughout the story. Robin revealed concern and compassion for the woman and the situation, but at the end there is an almost abrupt return to a medicalized, even minimalized approach to miscarriage as a non-emergency in the ED. Robin was the participant who articulated this push and pull as a reality of practice. The practical approach Robin articulated may be a cover story in that it was an attempt to lead the listener away from the reality of the ED nurses' experience.

Robin may have practised this cover story over time, yet the subplot of compassion and conflict was evident: essentially the message is that "miscarriage is difficult for women, but it is not an emergency, and there is little I can do." We also see in these excerpts the articulation of the *nothing I can do* narrative resource, tied into the *medicalization of miscarriage* narrative resource. Robin again said the ED nurse possesses knowledge that the woman does not, and this is part of that position at the triage desk. This position is significant, both physically and philosophically. We can also see the lack of plan or protocol to support the nurse who has this knowledge:

We draw the beta and everything and then the doctor comes and meets with them and stuff… It's really tough because you're telling them they're not an emergency, they're gonna be waiting, or they don't even know yet. You know they're pregnant and probably miscarrying, but they don't, so they wait maybe 4 or 5 hours to see the doctor. [The] doctor tells them this news and they leave, and they have to come back in 3 or 4 days for a repeat beta to be told that either they're not pregnant or "You are still pregnant." It's really challenging because again they're waiting and it's the emergency department so it's like… "Take a seat" …even if they are potentially having spotting or having to go the bathroom in the waiting room to change a pad or asking you that they didn't think they would be here this long, [and] do we have any extra pads? They didn't think they were going to have to be there for this. They don't have the supplies, or they're not prepared mentally or with the right things.

So, it's really hard when you're sitting in triage and if you don't have someone in front of you, you can see everyone. You're looking like, no change in him, there's a COPDer, he's no problem and I know something that they or their partner doesn't know. It's a really crappy feeling, because [with] other stuff like COPD I can get this guy puffers, I got the all clear from the doctor, we can do a chest x-ray, so when they are seen it is going to be really quick for him. We will put him on the COPD pathway. There's an easy admit, so it will be quick. But with the miscarriages it's not. There's not a lot you can do for them except watch and wait.

As Robin moves through the story, the ongoing focus is on the medicalization of care for women and the perceived lack of focus on the woman. Robin also highlights the reality of the ED throughout the account. Robin's story is told in a circular way: it is hard, but we can only do

medical things, but I must be efficient because an emergency could come, but come see me if you need anything, but it is "hard" and there is nothing Robin can do but watch and wait. This ED miscarriage management strategy is supported in the literature; women who are hemodynamically stable are not likely to be assigned an elevated level of priority in the ED (Zavotsky et al., 2013). Robin described being "socialized" into always being ready for the next disaster. Robin further said that not only do the patients in front of ED nurses present challenges in the busy ED, but the ever-present threat of the emergency that may come at any time creates angst for the ED nurse as well. The next disaster looms in the wings and the non-emergent things need to be dealt with in anticipation of that disaster.

> *Is it that I don't know what to do for them or is it that I don't see them as a priority? I think it's because you don't see them as a priority. You're so trained, even in our triage courses and stuff, acuity [means] "worst comes first." You want to see the small non-*e*merge*n*t things out of the way, like x-rays and bloodwork and stuff. Once that stuff is done, I can go right into emergency nurse mode and start treating that chest pain that walks through the door. You can have eight people in front of you, where you need to triage all of them. You need to do your best to go through…and then I need to start preliminary treatments so that when they move through the department things go quicker. Because [I] might have an ambulance come, and another ambulance, then a stroke, and I won't be able to do anything with them again.*
>
> *If I don't do it now, efficiently, then not everyone's care is going to be done properly. You just really want to get it out of the way, so it's done because it's not an emergency. It's not an emergency, but it's an emergency for them. You don't know how long they had been trying or how exciting this could be for them. [Is is] at this point, as I*

> *am more into my career that you think about it less and you don't see it as abnormal, as you first did. At this point, it's just routine practice for the ED here. Just because it is routine practice doesn't mean its good practice.*

Robin's physical view when caring for women would seem to be from the triage desk. Many of the ED nurses who shared stories did describe their encounters with women from the perspective of the triage desk. What is interesting about this view is the associated perception of power. Earlier, Robin described sitting at the triage desk and knowing that a woman was pregnant, although the woman might not know. The triage nurse is responsible for facilitating the order in which people will go through the doors and receive care. The tool triage nurses use to prioritize care is the Canadian Triage and Acuity Scale (CTAS; Bullard et al., 2017). In the absence of a protocol to guide care for women experiencing miscarriage, ED nurses refer to CTAS to guide their decision-making when they are triaging patients and setting priorities. Robin mentioned the triage scale briefly above, but later in her story, she said the following:

> *We are dealing with CTAS, which is the Canadian Triage Acuity Scale and the guidelines, and we are following guidelines strictly. So, what are they [women having a miscarriage]? They're a CTAS level 5, which is the lowest acuity, which they would never be, they would be a 4. [The situation may be this:] I am sorry, right now we have three CTAS level 2s. Those are high acuity, emergent. Sorry, we need to deal with those before we can pull away a doctor to deal with this. It's really frustrating but …I get a lot of those feelings just trying to manage the waiting room, when you're helpless and you wish this person could get seen and they're nice, sweet, and kind, and they don't want to be here, but there's nothing else they can do.*

> *I really wish they could be seen, [but] they're not sick enough. So, you're like, you're going to be out in the waiting room. So, it's more about managing my expectations for the person, like, a lot of the time they are okay… [They may think], "I don't know what's going on in the back end and I don't even know how I'm triaged or what that means, or do they care? I just want to be seen eventually." You get that with people when you say you are just on the bar where they are not emergent, but I would really like them to be seen. It's probably more for my emotional benefit than anything. I know they're not going to die; I know they will get through this, but it will make me feel better. It will make me less upset if they get seen.*
>
> *The worst part is that it's going to be quick. It's not going to take the doctor long to explain this and go over what they're going to have to follow up with. Maybe 15 minutes but if they did that four times, that's an hour. That's two emergent patients they could have seen in the meantime. It's all resource management.*

It is important to note that, in fact, the CTAS score places miscarriage (described as pregnancy < 20 weeks) as a CTAS of level 2, 3, or 4 (emergent, urgent, or less urgent respectively) depending on the presenting symptomatology (Bullard et al., 2017; Manos et al., 2002). It is not clear, however, how CTAS influences the care of women experiencing miscarriage. While there is limited research related to the use of CTAS and miscarriage, there is research related to the inherent challenges associated with triage scales. Aacharya et al. (2011) stated that "the aim of triage is to improve the quality of emergency care and prioritize cases according to the right terms" (p. 16). Their research suggested that while the triage system in several countries is used to ensure timely care for patients, it also creates situations of ethical conflict for those who use the scales, stating that "emergency staff continues to be confronted on

a face-to-face level, with the care for individual patients in need, whom they might not be able to help" (p. 17).

Robin told me of both the inability to offer appropriate care and the perception that ED nurses did not care about the woman having a miscarriage in the ED. Robin did not refer specifically to an ethical conundrum but did illustrate that the CTAS provides something to guide care—in the absence of any other plan to care for miscarriage. However, the use of CTAS as an existing protocol might be a contributor to the challenges faced by ED nurses as they provide this care to women. Another aspect is that the ED nurse at the triage desk may be in a perceived position of power by those seeking care. However, for the ED triage nurses themselves, the issue is one of whether this position reveals responsibility without the requisite power to change outcomes or alter the plan. Robin articulated the challenge an ED nurse faces when they are caught in the middle between the perception of the woman experiencing the miscarriage and the reality of the ED:

> *We had a patient who was later in their pregnancy, and I was working, and they were still less than 20 weeks, but they were left to miscarry in a waiting room for quite a while. Naturally, they were upset. They went to the media about it and that was really hard because, knowing behind the scenes, that day was hell. It was like we would love nothing more than to put you in a room, but it was one of those days [where], if your arm isn't going to fall off or you're going to acutely die, we just don't have room…Yes, we know, we didn't do this on purpose. It gets hard when you see those negative comments…You see all those comments where people say you're not doing anything, but actually I was doing a lot.*

Robin was asked if there were times things could have been done differently in response to the negative media attention. Her response is moving and brings into focus both the challenge of the place and the challenge of the circumstance:

> *I don't know if I really do. That story is so wrong. That's all I can really say. People will be talking about it in the media and ask me if I was working that day. I say that story was wrong, and I can't go into any more detail, but they have a very different interpretation than I do. That's how I have to be comfortable with that. That's how I feel like it happened, and that's how they feel like it happened. We will have to agree to disagree.*
>
> *It's mostly like the partner or the spouse that will come up, not usually the woman, and ask if they're going to get seen today. This has been going on for four or, so hours and their partner is stressed, which makes them stressed. They're dealing with a lot of emotions and take it out on the triage nurse who is in front of the house. This is the person accessible to me to be upset with. You get a lot of anger. I don't take it personally and if they have to yell at me to channel that, I will let them. But there's nothing I can do; I triage you and put you into the order of acuity and wait for the sliding doors to open for your name to be called. I don't have any control when they are going to call your name. [It's] just like a lot of process issues.*

Robin' story was rich with the experience of caring for women experiencing miscarriage in the ED. Robin's struggle with her identity as an ED nurse and the desire to do more for women is underscored by the compassion she described throughout her story. Robin also highlighted many of the narrative resources that were noted across the other ED nurses' stories shared in the project. Most notable were the narrative resources of *the reality of the ED* and *the medicalization of miscarriage*. Robin's practice experience as an ED nurse offered a unique

perspective, in that it revealed images of the stock identity of the ED nurse. The final excerpt summarizes Robin's story well and puts the experience into perspective. When asked what she would tell a new nurse now about how to care for a woman experiencing a miscarriage, Robin responded with this commentary:

> *It has become the standard and it [the current process] would be what I would tell a new nurse now. The same people would have told me it [miscarriage] was not a medical emergency, and this is what I want to do: Make sure you get a urine sample and put them in the waiting room and follow up with them periodically.*
>
> *You're talking about getting a urine sample, you're talking about drawing a beta, but you're not talking about how it must be emotionally hard on them. You don't get into those. You don't… [ask], "Do you have any questions?" We don't get into that discussion and [instead] just focus on the medical or procedural things, which is a lot of what the ED is.*
>
> *We are all in that position—where you're sitting there and I don't know what's going to happen, what's going on. And they're just waiting on the whim of these ED nurses to call their name through those doors and say they're now urgent enough to be seen. They're sitting there, and I feel responsible when I'm triaging, that you're thinking this person is going to be called ahead of them so then it will be at least another hour before anything happens.*
>
> *People will come up and yell at us like it's life or death today. And [when] it's that busy that if you don't have a risk to life or limb, you're not going to be seen anytime soon. You have to tell people that. That's the wording you have to use sometimes to get through to people. I feel like it makes them feel like their problem is not life-threatening.*

> *[They must think], "But I'm just gonna sit here and miscarry and no one's going [to help me]."*

Robin's statement, "but I myself have nothing to offer in the way of helping them through this crisis" is a powerful remark that makes her experience accessible; it illuminates, in a very raw way, the challenges ED nurses face in providing care. Despite the challenges, it appears that Robin does recognize the role of the ED nurse in the facilitation of care for women seeking care in the ED. The question is whether Robin's power and responsibility are congruent or whether this is the source of conflict. Is it the role of the nurse in the ED to facilitate care that reflects the needs of women experiencing miscarriage? Robin offered us one perspective. The next exemplar is from Faith, who offers yet another perspective.

More of Faith's Story

We heard from Faith at the beginning of this chapter. Throughout her transcript, Faith shared rich stories about her experience caring for women experiencing miscarriage in the ED. Her perspective as a nurse with fewer years of experience than Robin and Ruth may reveal where the story begins for ED nurses; conversely, Ruth's and Robin's stories may reveal where the story can go. Faith begins in a similar place, at the triage desk, where she described the typical presentation. She expressed that women with miscarriage were her least favourite kind of patient to come to triage. Her feeling about this again spotlights the minimalist and medicalized approach to miscarriage. She told me that there was nothing she or anyone in the ED could do to stop the miscarriage and she was troubled by this.

Faith was troubled, but the source of her trouble was not immediately obvious. Robin did not necessarily identify the sources of the trouble, but Faith went on to reveal the conflict she experienced between her education and the tacit (or lack of) knowledge in the ED. In a previous

section, Faith described one early experience with a miscarriage, and how distressing this was given that she believed was best practice:

> *I remember looking at the fetus in the specimen container and thinking, like, that, so in Emerg, this isn't that big of a deal. Where's the disconnect there? Because everyone is carrying on like nothing just happened. How did it feel for me? To me, I was like, okay, this is a big thing, we need to sit with them, there needs to be all of this… I was talking and I thought to myself, maybe Emerg just isn't the place where that happens. But I just learned of all the things that are supposed to happen to make this less traumatic. They've gone home now, and I remember from that point on, realizing that to the physicians who see that [miscarriage] all the time, that these patients are patients who are not dying with something. I don't like that.*

The trouble that Faith revealed may further reflect *the reality of the ED* and a focus on *the medicalization of miscarriage.* She articulated the clash between best practice for care after a miscarriage and the *reality of the ED*. Faith was asked if the approach to care in the ED is led by one HCP. The following exemplar extended this to miscarriage and demonstrates how problematic Faith found the medicalization of miscarriage as the focus of care to be:

> *It feels very wrong, feels like you're doing something wrong. I feel that way about a lot of minor things that come in. It feels sort of like an injustice, that you're kind of like, that's the culture here. For me, it doesn't mesh well with what you know inside. I don't know if care in the ED is driven by any one health care provider or the mindset of "This is Emergency*, and *we are going to do emergency interventions and everything else is kind of peripheral.*" *The physicians do that, and the ED nurses fall into that. And not that I don't see people being compassionate towards the patients, it's more so just what you*

had learned is necessary—to make it the experience that it needs to be for people. That doesn't really happen. They're just gone and discharged home. Unless they go seek out help to process what just happened to them, they will probably carry on like, as if, oh well, I guess it's not really something they're supposed to [do].

That was my first experience and day to day, you see people coming in with bleeding, cramping and usually these people are semi-urgent patients who wait and have a beta level drawn and a urine dip. If they're really early on, they kind of just go home and wait. If they're far enough along to have an ultrasound, they may go for an ultrasound later that week or the next day. Or if they're in severe pain, they may go then. Then, you don't actually know either.

Faith is the storyteller who best demonstrated that the care provided to women experiencing miscarriage may not be unique. She expressed that anything perceived be to minor receives this minimalist type of care because something needing the maximum care may arrive at any time. If we are to consider this story and Faith's conflict over her knowledge of how care should be provided to women, we begin to see how ED nurses may be challenged to provide care for miscarriage in the ED. The earlier example that Faith gave—of how a sore toe might be handled and that it depends on the current state of the ED but may also be shaped by the policies and practices of always assuming a crisis is coming—provided a clear glimpse into how handling miscarriage in the ED follows the same protocols.

Faith pointed out that in her training she had learned about the importance of offering privacy to such patients, although these standard protocols might obviate that choice:

I do remember in my training, the person orienting me, telling me, "You know, if it's at all possible, if we think someone may be miscarrying, that they should be in a private

room. They should have a quiet private place even if it's not going to get them to see the doctor faster." I remember that being kind of communicated, that that should be, it was the only kind of guideline or intervention. It was really if we can get them out of the waiting room and somewhere private.

While Robin spoke about efficiency as a barrier to care, Faith similarly referred to time. Time and efficiency in the ED, as a place, are predominant in the stories. Faith shared some of her challenges with time and efficiency, but she also clarified the role of the registered nurse (RN). Many of the ED nurses in this study articulated that there was nothing the nurse could do for women who were miscarrying, which is clearly found in these exemplars focusing on medical interventions. Faith, however, asserted there is a role for the RN. This is important, because in all of these exemplars, there is a lack of acknowledgement of the key role the ED nurses are playing in providing care. Faith also began to highlight the lack of education and orientation to be able to provide expert care to women. She described this as spanning generations of ED nurses in the ED.

What do I think contributes to attitudes toward early miscarriage in the ED? I think it's time. In Emerg, everything is so rushed, and [the goal is to] treat the sickest and make the sickest survive. Everything else kind of gets that treatment; it's not just early miscarriage that would get that treatment. Stuff like broken arms and minor car accidents. Anything that's not super critical or life-threatening. If a woman came in and was in labour and far along in their pregnancy and in very serious condition, they would probably get the most treatment. They would have five ED nurses around them and two doctors and immediate intervention and all of the compassion in the world.

I think it is partly because you have so many people coming through the door, you're trying to weed out what needs the most resources. But also, maybe people just not knowing what you can do, even just as a nurse. Not even what the physician would need to do, but even just in the RN role, what we could do to make that process better. Even if it's not something like blood work or investigations, even if it is just certain conversations you could have with the patient before they leave or certain pamphlets you could give them before they leave. Things that aren't really going to take three hours off your shift, but [it] may make a difference…

Faith went on to describe what she did to provide care to women, despite time, policy, and the lack of a plan or support. She also describes the potential to do more, but that it would likely entail encountering conflict when she tried this. Yet, nurses *are* doing more, and this further affirms the essential role the ED nurse plays in providing care for women experiencing miscarriage.

How I manage this [care] depends on the day, I find. On days when I feel like I'm putting my best foot forward and coming to work with energy and enough sleep and whatever, I feel like I would be more likely to go against [standard protocol] and to just push a little bit harder from the patient's side of things. On a night shift at 3am, if everybody around me is saying, "It's not a big deal" I would be okay; I would be less likely to say something, but those are also the shifts that I would go home feeling not as good about how I did. On the shifts where I did push and provided the care that went against the norm, you might get an eye-roll…

I think people get uncomfortable because it sets a standard too, and then they don't want to have to do that every time…That's the vibe I get. Well, if we are going to

> *start being that compassionate toward everybody who comes in with PV bleeding, well you know, that's a lot of people… But no, I don't think it's impossible, that's for sure… If you're taking it upon yourself to just do it, people are less likely to get an eye-roll. It would be an issue if you're trying to tell someone else that they had to do that…If I'm working in triage and it's really my call at the time, people aren't really going to argue unless it affects their area, which it doesn't usually.*

With these remarks, Faith acknowledged a key role for the ED nurses, but again she did not speak to a formal plan, but an individual nurse approach.

A plan has the potential to not only support ED nurses to provide care but also may benefit women experiencing a miscarriage in the ED. Faith also drew attention to the benefit of the plan and how this could support both ED nurses and these women at any time of the day. There is a sense in her words that a plan would bring comfort to both these patients and the nurse. For Faith, this would also bring closure to the encounters with women experiencing a miscarriage in the ED:

> *I think if we had information, teaching about loss and miscarriage. Even, like, separating it from medical treatment of women with miscarriage to just nursing care for women with…I feel like we get caught up in—all they need done is blood work, and that's done…then that is the only skill with your hands that you need to go in and do. But as a nurse, the whole picture, is there anything else we think needs to be done…And clarifying there is more we can do for women. I mean if they are miscarrying there may not be something medically you can do to stop it, but there is a nurse role that would come into play that I don't think people really even know what to do [about].*

Faith's comments bring to light the lack of education ED nurses have regarding the care of women and how having this education would support them to provide care. The simple question that arises is whether ED nurses possess the knowledge and expertise to confidently care for women experiencing miscarriage in the ED. As we consider this question, it is useful to point Faith's perspective that education and a plan would help her to support women seeking care in the ED. Faith clarified that this effort does not have to be a grand gesture:

> *I think if I had a conversation with a woman before they left [about] whether they had miscarried or not, if I had a conversation with them and hand them something like a pamphlet or like a resource or a card with a resource, I feel that I would know that at least I acknowledged, "It was not a good day for you, and this is a very small resource." … Even if it's not a grand gesture or [a] big, long conversation where they cry and tell you about how it's affecting their life or something. But if you could just hand them something and have a conversation with them before they leave. Then, at least you've kind of closed the visit with something that recognizes what just happened and not just, they walk [out], and you are looking at them and they are looking at you…*
>
> *I would like it, if it was just something that had to be done every time someone came in or someone miscarried or there was something that automatically [happened] if this is a woman in their pregnancy. And this is what we do: we go get this pamphlet and go talk to them and then they go. Just like an automatic kind of [thing] and it would give you direction when you're kind of lost, when you don't know what to say, or don't really know what you are supposed to do...*
>
> *Sometimes you just want the action. Want the doctor to write you orders so you know what to do. If you had it in your mind that this is what we do, put them in a private*

room, we do this, give them this, we talk about this and tell the doctor this, and done…If it is 3:00 in the morning you do the part of the care for the patient the same way as if someone came in with arm pain, [when] you do your assessment and put them in room 5. That's just what you do, whether it's 5:00 in the morning or 2:00 in the afternoon, busy day or a slow day… It wouldn't have to be a very big thing, could just be a small little sheet you give them or something to guide a conversation.

Faith talked about learning more of what her role was as an ED nurse, including reconciling miscarriage as one of the many things that create challenges for her in practice. It is worthwhile to consider what Faith's fresh and strong perspective offers regarding changing ED practice. This underscores that other perspectives may also offer additional valuable insights. Ruth's story is told as a retrospective and offers further examples of the narrative resources used throughout the stories collected here.

Ruth's Story

Ruth's story, like Robin and Faith's, contains the common narrative resources notable across the stories told so far. Ruth's offered compelling examples of how ED nurses can tell their stories, demonstrating also how these narrative resources are embedded within these stories.

Ruth explained that when presented with a choice she would choose a trauma over a miscarriage because she could potentially have success with the trauma. Ruth spoke about saving her "energy" for a situation where she can have success. This reflects what Faith also discussed, about more experienced ED nurses "saving" compassion and doling it out carefully. This aspect again reflects the vulnerability of the ED nurses and how their stories serve to protect them, as Ruth detailed:

So, I remember I would try to trade off, try to get out of there, try to get other ED nurses to take it. [This was] always because it didn't matter, [even] when I got more senior and learned more and had greater preparation behind me, greater education, I still felt very helpless. I didn't know what I could do for the person. I didn't know what I could do to make it better. It seemed fatalistic to me. They are going to lose this baby and there is nothing we can do about that.

I have some measure of success there [with other presentations to the ED]. I could have potential for success. Right. And that person, whatever I do, is gonna be one step further ahead to regaining their life. Nothing I'm gonna do with this woman is gonna bring that child back.

In the previous chapter, I introduced Ruth's description of the nurse as a fixer. This is part of the stock identity of the ED nurse, which is understood to be troublesome for the ED nurse when faced with caring for a woman with a miscarriage. The exemplar below is more of Ruth's story of the fixer and her struggle to understand why the ED can provide expert care for everything else, but not for a miscarriage:

The exemplar below extends Ruth's story of being, or wanting to be, the fixer, and her struggle to understand why the ED can provide expert care for everything else, but not for a miscarriage:

How do you approach the next part, that's what's going on in their minds and thoughts? That's not on the algorithm. Stabilize and send home. Right?…I think part of the thing about ED is you know you don't like to have anything, any lose ends, and so when she's stable clinically that's when the bow has been tied. [and] out you go. Delivery, that is it. You came in for care, [we] gave you care, out you go…To get the next

person in. Same as what we do for everybody else. When we deliver our care, they go. [We don't engage with] …the ramifications of what will come next for that person.

Ruth went on to describe herself, and other ED nurses, as being "haunted" by how little she or they could do for a woman experiencing a miscarriage in the ED.

And my older ED nurses would say, when we would talk about it, they said, "When I say haunt, I really mean haunt. Don't put me down there. I would see the little 14 weekers in my head and I would just be like, 'I can't help you.'" But some of my older ED nurses would say. "You know, it is something you come to accept, and you know, you're young, you know. We don't always win." [Yep], that's not winning. I get that I can't stop this, but that was it for the care, when you know that's a very small part of what is going to happen in the next few weeks.

So that was always bothering me. I know that I am too late for that, and I can't help that, but you just left them uncared [for] except for this small little piece of their body. We didn't care for anything up above their belly button or below. Like, it's out—that's great. It's like you are choking on a peppermint, out it comes, ok great, there is nothing else to do. While there is stuff to do [laughs], right? That's what I always found.

The *nothing I can do* narrative resources were clear in Ruth's story, as she talked about how little she can do and even how the care a nurse is able to provide becomes limited to "this small little piece of their body." Ruth attempted to explain why there is nothing she can do to help. However, she was simultaneously troubled by the care that is provided. Ruth presented this not necessarily as a reality but as a conundrum; why could ED nurses not do anything more for these women? Ruth also clarified that this story defined her experience. Despite providing care at the time for women, she was left with the lingering feeling of not being enough. Faith and Robin

alluded to this struggle, but it was Ruth who spoke to the long-term impact of this experience in her story:

> *My elders I would say…"That's just what we do" and…"They'll have to follow up somewhere else." I can't believe…we prided ourselves on such great care. Oh, look, we got this person in from home to the door in X amount of minutes and they had a thrombolytic and clots busted, and away they go and they're not in an arrest anymore. And stroke care, we gave a clot buster and now they are back 'cause it is a short window. …And now it's like we can't really do anything about that. Stabilize and let them go home.*
>
> *Sometimes I feel like it is almost a failure for them to not have the answer for [this]. There is no box, so we're trying to create a box and it's a very small box. Vital signs stable, no bleeding, go back to your family doctor, away you go. Instead of a big box. There is a lot more we could be doing. It's like, why do you have a* sane *nurse? Why do you have a nurse that is trained in sexual assault that comes into the emergency department? That is a specialized approach to a terrible thing that happens. But the person who is taking on that job is highly trained in that one particular area of violence and sexual violence.*
>
> *Well, there must be ED nurses that are highly trained in miscarriage and what that means and…right? Where are they? Why can't we get them? Why can't somebody take that on as their expertise and teach us about that? Or fine, get upstairs and get some of the OB ED nurses and see if some of them can help us.*

Ruth's stories were raw and the pain she experienced was so well articulated. While Faith spoke to what could be done differently, Ruth talked of the barriers the ED nurse experiences

when they want to do something differently. The stock identity of the ED nurse is so evident in her story, but the loudest part was that the ED nurse is troubled by the lack of action but seems to be floundering in how to do anything differently.

Ruth's story also calls out *the medicalization of miscarriage* and *the lack of a plan.* Ruth challenged ED nurses to be the catalyst for change despite feeling powerless to make change. Her advocacy is evident for the role of the nurse in leading care in the ED for women experiencing miscarriage, yet it is clear she may not acknowledge how much she did do for these women. Indeed, in the following remarks, we see evidence of how this lack of acknowledgement combined with the narrative resources of *nothing I can do*, and *the lack of a plan:*

> *I think it is all in the ED nurses' minds—how [and] what it means to do, to be involved in a miscarriage or post-miscarriage care. And I think a lot of it is compartmentalized to medical management and then that is the end of our job. But like you said, I don't really accept that a lot of the time. So, looking for answers, that is one of the things that is frustrating for ED nurses anywhere; you know something is not quite right. You try to find the answer where there is no answer to be had: in this case, about how best to go about that... and you look for that.*
>
> *And each time you try to do a little better, 'cause unfortunately you get lots of practice with these kinds of patients and you just try to do better. [For example,] I wish I had done that last time, or this seemed to be helpful last time, or you learn things about throwing things in the garbage…You learn some things, that you don't have all the answers, but you can figure out some pieces of it…It's been, honestly, 33 years this year as a nurse and it is something that is still unresolved in my own professional identity. I just can't wrap my head around it…What is the best you can do?*

> *I don't know what that is because I don't think I ever reached that, 'cause it's...a lot of it is not anything I can control, which is ED's [rule] number one [laughs]. We are control freaks, micro-managers, control your anything, your body functions. And this is something beyond our control. And I don't know if it's that kind of futility—that we can't and don't know, and every scenario is going to be different, but the same. Some moms don't want to talk. Some moms do want to talk so. Yeah, it's still unreconciled with me. I would still avoid them like the plague really, I would.*

Ruth stripped down the role of the pragmatic ED nurse who is prepared for everything, to one that is a more vulnerable character—a character who, over time, finds themself stripped bare without a way to cover up or fix the problem—but still appears to bear the responsibility. As quoted earlier in Chapter 4, Ruth had talked about feeling extraordinarily sad—both about the actual feelings and also about not being able to share these with or show these to the woman who was experiencing the miscarriage. Ruth's perspective captures the essence of the struggle:

> *And are you willing to open yourself up for that? Like, you peel yourself down and just wait. Sometimes they yell at you. The helplessness. The patients yell at you because they are so sad and scared and, or they don't talk to you. Or they cry, right. You don't, how do you want me to respond to that? There is no response, you're right. It's maddening and tearful. But that is what, I just feel like that's of all things I have taken care of, it's like walking out naked in the middle of the square. It is like you're just...I don't know. I don't know how to fix this.*

Ruth's words capture the essence of the struggle, which creates the conundrum for not only ED nurses but women and families who try to navigate this complicated experience. She

highlights that there a long-term impact of bearing the responsibility over and over in absence of a plan or acknowledgement of the nursing role.

Understanding the narrative resources that ED nurses used to tell their stories of caring for women experiencing miscarriage opens the possibility of new resources that can change the understanding of the experience. These narrative resources reflect the tensions that move the plot of this story along. Chapter Six will extend the analysis further and discuss the narrative types found in the ED nurses' stories. Frank (2013) stated that "the rationale for proposing some general types of narratives is to sort out those resources" (p. 76). Typology development offers a way to answer these questions and create opportunities for new understandings for ED nurses. However, as "typology" and "narrative type" can be used interchangeably, I will henceforth use the latter term. The narrative types emerging from ED nurses' stories could be limitless. Thus, the value of narrative types is that I can set aside the ED nurses' stories and return to them later to explore other narrative types.

Chapter 6

Narrative Types: You're Not an Emergency and Seeing the Fetus

My intent is that understanding of the ED nurses' stories has evolved over the discussion so far. Chapter Four discussed the narrative resources that ED nurses used to describe their experience of miscarriage in the ED, whereas Chapter Five showed more of the ED nurses' stories, in their own words, to further reveal their experience. As described in the methods chapter, the discovery of these resources came about through an iterative process, one that relied on the systematic approach outlined by Frank (2012), which involved reading and re-reading the interview transcripts. This process not only revealed what narrative resources the ED nurses have available to them, but also opened the possibility of new narrative resources. The process also revealed the limitations imposed by these resources.

At this point, I will explore how well served these ED nurses are by their stories and how the stories allow the nurse to "hold their own" (Frank, 2010). It is necessary to consider that holding one's own is an attempt for the storyteller to stay true to who they are or who they know they should be. Frank (2012) tells us that humans "struggle between dignity and vulnerability." In other words, we know what we should do, but it is not always easy to do this; this is dignity. Therefore, we struggle in the face of this dissonance, which is the vulnerability (p. 3). The stories that we tell help us to reconcile this struggle and support us to make sense of the related experiences. These supportive stories become companions—whether friends or foes—to help us navigate life's experience, and become the means by which we understand and respond to our experiences (Frank, 2012). Typology development will enable discovery of how ED nurses can hold their own in a story. Additionally, "the dialogical test of a typology is whether it enhances people's capacity to hold their own in circumstances of vulnerability" (Frank, 2012, p. 49).

Narrative types will help build understanding of how the narrative resources limit the storytellers (Frank, 2012). Narrative types can also be useful to the storytellers, the ED nurses, by offering them insight into how their stories inform their practice. Moreover, they challenge these storytellers to consider why they do not tell different stories (Frank, 2012). Frank (2013) describes a narrative type as "the most generalized storyline that can be recognized underlying the plot and tensions of particular stories. People tell their own unique stories, but they compose these stories by adapting and combining narrative types that cultures make available" (p. 75). Understanding how the narrative resources come together (*the reality of the ED*, *the medicalization of miscarriage*, *the lack of a plan*, and *nothing I can do*) will reveal the underlying plot and illuminate more the ED nurses' experience with miscarrying patients.

It is important to restate that identifying a typology or narrative types is not a finite process but an opportunity to conclude this piece of research. This process does not eliminate the possibility of revisiting these stories with a different focus of analysis to see if other narrative types would be revealed. Certainly, it may be possible to discover other narrative types in the future. Here, two typologies revealed themselves from this study: the *you're not an emergency* typology and the *seeing the fetus* typology. The first typology was revealed in a significant, prominent way in the stories told by the ED nurses in this study; the second typology revealed itself more subtly, and while it was not present in every story the fetus earned equal significance over the course of the analysis. The remainder of this chapter explores the typologies of *you're not an emergency* and *seeing the fetus.*

You're Not an Emergency

The emergency department (ED) is described by those who work there as a challenging place to practise. The ED nurses revealed that they were always busy and often felt like they did

not have enough resources to meet the demands of the department. They also said that they were always braced for the next emergency to come through the doors. Given that the ED is busy and can be chaotic, a miscarriage is not necessarily an emergency in the way that other conditions are in this setting. The ED nurses did acknowledge that a miscarriage is often a sad and devastating time for women; they would prefer to find women who are miscarrying a private room and have them assessed promptly by the physician. However, they also described a reality where the acuity of the department does not always allow ED nurses to make women experiencing miscarriage a priority.

The ED nurses who shared their stories for this project reiterated these facts, but still they shared how miscarriage troubled them. This begs the question of whether they actually believed that women experiencing miscarriage were not an emergency. Listening carefully to their stories reveals the answer—which is a definite "yes." *You're not an emergency* was the underlying plot that tied all the narrative resources together, and made the stories make sense. In these stories, the ED nurses sometimes used the actual words that "miscarriage wasn't an emergency," although at other times, this was more indirectly stated. Regardless, *you're not an emergency* offered some insight into how miscarriage created challenges for the ED nurses.

The ED nurses' stories were told in similar ways using the narrative resources described in Chapters Four and Five. The narrative resources were the threads that brought the story together, making the plot clearer. Miscarriage was not viewed as an emergency in the ED in the same way as other diagnoses are. ED nurses' stories of caring for miscarrying women presenting in the ED begin with an initial assessment at the triage desk using the Canadian Triage Acuity Scale (CTAS). The ED nurses referred to CTAS by name or simply as the woman being assigned a priority.

To unravel what the nurse storytellers were saying at this point requires careful listening. The ED nurses began to weave a tale where, after describing the initial assessment, they proceeded into a story that was riddled with pragmatism, frustration, conformity, confidence, but most importantly, compassion. Women arrived, they are triaged, and the script goes to the search for a private space. It is here that the symbolism of physical space is important. In Chapters Four and Five, the location of the nurse at the triage desk could be understood as a position of both power and powerlessness: power, in that the nurse decides who goes through the doors next; powerless, in that the nurse at the triage desk cannot control what goes on behind that door. The nurse is caught in between.

The next symbolic physical space is the private room. Most of the ED nurses described the desire to find the woman a private space. Even in the pragmatic and confident excerpts, where the ED nurses spoke of feeling that they could do nothing for these women and their situation was not an emergency, they talked about finding them private space. This quest for private space was described as a challenge for ED nurses, and they told stories of requiring women to wait in the waiting room until space was available. The "spaces" in the ED filled up with other patients who were a higher priority than the women experiencing a miscarriage. This is the reality of the ED; however, this does not appear to decrease the tension described by the nurse.

The ED nurses may have to sit facing the woman in the waiting room who is publicly experiencing a miscarriage, while they had limited options to improve this situation. Robin talked about the fact that ED nurses have to physically face the woman; however, when negative stories appear in the press about women having to sit and miscarry publicly, the ED nurses cannot defend their position. The ED nurses' desire to find the private room to provide care, and

demonstrate dignity and respect for the woman, is left unfulfilled. The processes and structures of the ED require the ED nurse to "nurse"—follow the processes and protocols in the ED—without question. In most cases, miscarriage does not present danger to the health and safety for the mother, so these women are not assigned a high priority in the ED. Furthermore, in the ED, there may be other patients who are experiencing a life-threatening event. This is a reasonable expectation, and in a clinical site where worst is first, this is also a reasonable process.

The nurse storytellers described the problem of balancing the acute needs of all patients with the available resources. The story on the surface reads like this: "We want to find you a private spot, but if something more serious comes, we won't be able to find you a room." Despite the challenges in finding a more secluded space for women, Naomi spoke of her desire to find a woman who is experiencing a miscarriage a private room, a desire rooted in empathy for the woman:

> *I mean, in most cases we could, but in some cases, there were crazy days and women did sit out in the waiting room longer than you would wish for them to sit out there. But I think most people had some empathy around the situation and try to get them back into those rooms as quickly as they could.*

Joy offered a similar account, which makes evident her empathy for the woman while also providing a glimpse into the challenges ED nurses face:

> *A lot of times women who are going through this would have to wait in the waiting room until the physician could assess them. We try our best. We know they are going through something quite painful emotionally and physically, so we typically try to find them a spot, but we don't necessarily always [succeed].*

Faith and Joy described that while they followed the process of assessment and triage as part of their nursing responsibility, they were limited in what care they could provide (such as finding a private room). Faith's account, presented in Chapter Five, similarly described the limited interventions ED nurses could offer in the ED. Faith revealed that it not only limited intervention from a psychomotor perspective but also from a judgment perspective. While Faith's description was limiting, Joy's narrative, by contrast, described a situation where the nurse was able to find a room and sit with the woman. In that story, Joy qualified her efforts to provide care by saying that finding such a space could not happen every time due to the pace and acuity of the department. Again, her comments return to the nursing process of the ED:

> *Recently, I cared for a woman who knew they was having a miscarriage…[She] arrived alone and was in a lot of discomfort. We gave them something for that, but I could tell [she] wasn't doing well…[she was] on the verge of tears. We were able to find them a room. However typically, if we have a woman come in who is stable and we are busy, then they might have to wait in the waiting room based on their acuity.*
>
> *I was able to go in and spend time with them to talk, which was difficult, but they needed to talk about what was going on. I don't necessarily get the opportunity to do this every time. If I had a patient in the next room that was extremely ill and potentially going into cardiac arrest, I might not have had the time to sit down and talk to them. It depends on how busy the department is. If we are really, really busy and we have a lot of high acuity sick patients, then women who are going through this would have to wait in the waiting room until a physician could assess them.*

These accounts described a standardized approach that appears to justify how the ED nurses apply the process. In addition to this common story of the initial assessment and triage,

Hope described a "typical" presentation; a woman presenting for reassurance that all was well with her pregnancy and at the same time presenting with fear that it may not be well:

> *I do find a lot of people come in panicked because there is spotting. Then, they hear the heartbeat and leave. That's it, that's all they wanted. They just wanted to know their baby, the fetus, is in there, alive. They always leave so happy and so relieved. They think the end of the world is happening; we get them in, and they hear the heartbeat and 10 minutes later they are leaving, and we haven't done anything for them otherwise. No blood work, nothing [else] is necessary. They are healthy otherwise and are just a little bit concerned.*
>
> *We can ease that concern quite easily because we have portable ultrasound. So, those ones are always nice because you don't know when you[will] get them. And they say, "I'm pregnant." And also, how far along they are. And [they add], "I'm bleeding." It could be a nothing, it really could, because apparently from the amount of people I've seen that have a heartbeat afterward, it is common enough. Yay sure, its reason for concern and you should follow up and what not, but there's a lot of people who have nothing come of it.*

Robin described the insecurity a woman may present with in the ED and also described the acknowledgement of the struggle women face when they seek care for a miscarriage. She validated the woman's concern, but quickly, she moved to the fact that it is not an emergency:

> *Through the emergency department we actually see a lot of people that don't even know that they're pregnant or think they may be pregnant and [have] their first signs. A lot of people will come in with a very typical story of, they are having some cramping, some spotting, their period is late, they could be pregnant. We have a lot of really good*

> *medical directives so we can just run a urinalysis with a beta pregnancy test and find out if they're pregnant. Then we draw beta. A lot of them find out they're pregnant, but then you're also breaking the news to them that based on your symptoms they are probably miscarrying. They are literally just in shock when you see them. They're like, "Oh okay, I'm pregnant, but not gonna be pregnant." Most of these people that come to the emergency department, half of them don't have a family doctor, so they have no one to follow up with them. We draw an initial beta, and it's the emergency department, so you're telling them they're not an emergency, this is not a life-threatening condition, so they're going to be waiting a while.*

When I listened to what these ED nurses described, the tension between the roles the ED nurses must assume surfaced strongly. On one hand, they want to reassure a woman who is experiencing a complication with her pregnancy, but on the other, they may have to deliver the news that the pregnancy is ending. Both roles are required in the midst of a busy department that may not be equipped or prepared to offer all that a woman needs in either situation. In both instances, the miscarriage is not necessarily a priority, but it still requires time and care from the ED nurse.

This situation is exacerbated because the ED nurses are unable to provide the care they would like to because of acuity, space, and resources. The justification is that *we are busy*, *you are not an emergency, so there is nothing I can do; but I know this is difficult for you and I want to find you a quiet spot*. The ED nurses find themselves torn between what they can do and what they must do in the ED. Faith, for example, described how ED nurses seek to find the balance between how to prioritize care and resources, and how to ration their compassion for all their patients:

> *Miscarriage doesn't have many nursing interventions, like IV's that need to happen, so in the ED nurses' mind, it is in a minor category. So, it is either major or minor, and all their resources are going to major. Everything is from that lens—that is, this person could die, this person won't die no matter how long they wait in the waiting room. And it's like, I'm going to save all my compassion for over here and everything else is just going to get put out there [the waiting room] because they don't need to be here.*

Ruth further described trying to reconcile the assignment of priority to miscarriage versus other conditions and how finding this balance was troubling in her practice:

> *And when I would hear that a miscarriage was in minors, WHAT? How could that be minor? It was minor in the way that there was nothing we could do. Just going to have to stabilize them, make sure they were not bleeding and then get them home. It was minimal input, that's what I kept [thinking]…And there just didn't seem to be anything around how we are going to approach this, right? And it was only what we knew, so the worst comes first, yup. So, if there was something going on, [a] higher level of acuity…attention was drawn over there. So, the mom might have to wait hours before the doc got back in or something…There is no priority there for you. Everything else is a higher priority. And in terms of you, well if it's down in minors, it's pretty much run of the mill, in and out kind of thing.*

Faith and Ruth both described how they were troubled by the priority assigned to miscarriage, as well as how difficult it was to find the right balance of care given the acuity concerns in the ED.

The ED nurses told stories of having little recourse in providing care or how they were limited in the type of care they could provide to women experiencing a miscarriage. Their stories contained an account of either trying to do more or at least wanting to do more. However, they

continued to maintain that the ED was not the place for this health concern, and it was not an emergency. My assumption is that ED nurses have passed this story down through many generations of ED nurses, given the pervasiveness of these similar stories among my eight participants. As told by the ED nurses, it is thus likely that this story is the one defining care for this population. These assumptions bring into question whether these practices and beliefs may have more to do with culture and history, than with best practices in nursing care.

The shared tensions or complicating factors that trouble the ED nurses are manifest in their common stories. The following exemplars from the participants acknowledge that there is more the ED nurse could do. Charity described how she provided care despite the ED demands:

> *I would certainly make it a priority, and I would explain to the patient that it's extremely busy and, "I honest to God, have no spots to put you [in] right now, and when the next available spot is ready, I will put you in there." We have a few little spots that we can put people—like, behind the triage desk, there's a stretcher, we have two quiet rooms, and there is a sub-care area. It should not take any longer than, I'll just say a half hour, and it depends on the day, but there should realistically be a spot to place these people. And I would just say, "If anything changes, please come up, and I promise I am working on an area. Sit nice and close to the desk and if you feel if anything changes, make sure you come up." I always make sure to make eye contact with them, sitting in the waiting room, to let them know I am honestly working on something.*

In an exchange or situation like this, the ED nurse becomes more vulnerable; notably, this is perhaps the narrative that ED nurses do not share with others. Their vulnerability is evident because, as quickly as they go off-script, they return to it and describe the need to always be ready for the next real emergency. ED nurses described being not only educated but "socialized"

in the ED to always be ready for the next disaster, as the quote from Robin in Chapter Five, subhead "The Reality of the ED Narrative Resource" made clear. This constant state of preparedness for an emergency creates angst for the ED nurses. Faith's "sore toe" story, also described in the same section of Chapter Five, further demonstrated how this mindset shapes care for all the ED patients. Faith explained this conservative approach to resources in more detail:

> *Most days we don't have an extra room for something like that. We are using our extra rooms like that for someone who is acutely suicidal or in a mental health crisis, or even people waiting for blood work results, or our medical patients are in the TV room waiting for a second troponin. I don't think that happens all the time. I think it could happen more than it does so… I do think the standard of how we treat the people coming in is not always based on the resources we have at that moment; it's based on things that are in crisis. How little we can do for them because it's so busy, not how much we can do because right now it's not that busy.*

Faith acknowledged the rationing of compassion and the saving of energy for the potential emergency, since miscarriage is not a condition that ED nurses can fix. They do not have a plan or the preparation to care for a miscarriage. In Chapters Four and Five, the ED nurses spoke about the impact of negative media that described women's experiences of miscarrying in the ED and how this does not reflect the reality of what the ED nurse experienced in those situations. Given all of this, the ED nurses need to find a way to reduce their vulnerability: to reconcile what they do with what they should do. Thus, the *you're not an emergency* typology offers the ED nurses an "out," so to speak; it is a way to decrease their tension and help them reconcile their actions.

This typology appears to mitigate the constraints the ED nurses work against when they are providing care to women. As they struggled to mitigate these constraints, their stories reflected their commitment to the ED processes but were interspersed throughout with their desire to do something more for women—even as they could not quite articulate what "more" was. Robin spoke about the competing priorities ED nurses faced when trying to balance the needs of the patients, the department, and general expectations of an ED nurse:

> *You want to flip that room to get the next patient in and start your checklist and work up for that next person. It's always over capacity so there is always a struggle for room…It's all about efficiency and processes, and they're always trying to implement new processes to speed things up, so you want to keep your wait times down and get your visits out quickly. They're always stressing that you want to provide great care and that's always a priority, but it's all about if we need to do anything else for them, any more procedures? They've [the patient has] gotten all their news; the doctor has followed up okay, so it's time for them to go. That's it. The doctor will say, "Follow up with your primary care provider." And if they don't have one, if they have any other questions, come back to the ED.*

The ED nurses not only described their limited options in providing care for women experiencing miscarriage, but they also told stories of being afraid to care for women coming to the ED with a miscarriage. Hope recounted an experience as a new ED nurse, which demonstrates that it is not only miscarriage that is minimized in the ED, but anything that is viewed as a non-emergency. We see a return to the pervasiveness of *you're not an emergency* as a narrative type and how it troubles ED nurses who are learning the stories of the ED, as Hope pointed out:

> *They [ED nurses] think it's just another person who is having a miscarriage that they have seen 20,000 at this point. It's not very interesting to them. It's not something new or novel, and I feel some of them just get very disheartened about most things. Basically, if you're not dying, why did you show up to the emergency department? That's how some of the older nurses gave a mentality of, "Why are you here? We are not going to do anything." Whereas, I have the time, let's comfort you, because obviously that is distressing for you. And to them, half of them have had miscarriages themselves, and some of them are like, "Well, I survived it, you're fine," kind of thing. Whereas I haven't had any pregnancies, so I don't know what that would be like. I can only imagine.*

The early career ED nurse told the story of the trauma of caring for the woman experiencing a miscarriage. This story revolved around a disconnect between Hope's formal knowledge and her burgeoning tacit knowledge. In contrast to this, the experienced ED nurse told a tale of the trouble they experienced and the tacit knowledge they had of the ED. The experienced ED nurse referred to the negative stories that are publicly available (print, social media, and so forth) describing them as heartless or providing less than adequate care. This person revealed that while it might appear to those in the waiting room that the ED nurses are not prioritizing care or doing little to alleviate pain and suffering, the reality is that behind the doors, they may be dealing with one or more life-threatening situations. However, they are not at liberty to share this aspect of the story since it is private and confidential; thus, they bear the burden of the criticism literally, as they sit at the triage desk, and figuratively, as they read the public accounts of perceived poor care. Charity offered insight into the challenges of the ED and that the ED nurses' perspective is privileged: they know what is going on, on both sides of the door,

but the patients do not. Charity validated her frustration but still acknowledged the challenges of the ED:

> *It's difficult because it's hard to explain to somebody that we are not taking their concern seriously when there could be somebody having a heart attack in the next room who needs that bed. I know it's happened before, and people have voiced to the media that we have treated them horribly and made them wait in the waiting room…I feel like that is their perception and it's probably a good one because they have no idea what's going on in the back rooms. Totally, 100% I think that is valid. We try our best because of those situations to make sure that we try to put them in nice and quiet environments, even if it's not actually an exam room, even if we don't have one right away. It's difficult with the high acuity... so depending on the day, it can be crazy.*

The ED nurses' stories reveal several tensions that created challenges for them in providing care to women experiencing a miscarriage. These stories showed that they empathized with the women who present with a miscarriage, but they were unable to prioritize them in the queue, in the same way they could prioritize other patients. Yet the ED nurses knew they needed to do something for these women; they nonetheless tried to manage their care within a structure that did not really have a formal mechanism that enabled them to support these women. Striking a balance between the process and policy of the ED and reconciling the struggle to be compassionate in such an environment calls out from their stories.

ED nurses also spoke to the less formal culture that exists in the ED. The ED nurses who desired to make miscarriage a priority found themselves facing inner turmoil as they struggled to reconcile the ED process and providing care. In several instances, the study participants, as the protagonists in their own stories, acted alone or even in opposition to the accepted protocol or

process. Ruth articulated her frustration with the lack of allocation or perceived allocation to caring for women experiencing miscarriage:

> *Why they talk about it [laughs], which makes me hilariously upset, [is] the time consumption that it takes ED staff to cope with a miscarriage is too great. There is too much time invested in these miscarriages that come in. We need to put them somewhere else, so the ED crew is freed up to do ED things.*

Naomi described not only the challenge of competing priorities but also the struggle with not being "present" for women at the time when they needed her to be available for support:

> *We tried to be as present as possible but I think… when I reflect back, I am sure there was [a] moment…when maybe I was rushing, or maybe not being as present as I could be because in the back of mind I [was] thinking I have to [go to] the next room and start an IV or the I have to go to the next room to start blood—you know, whatever it might be, …I am sure that being present and being there fully engaged in their care was sometimes a challenge.*
>
> *But yeah, I mean certainly, distractions, thoughts of what else you need to be doing, rushing, that kind of stuff. I mean certainly…if I was the person who was identified as being on the resuscitation team and if a resuscitation came in, then you are pulled from that and then how does that impact that family? So yeah, there are certainly lots of things that can result in not… providing the best care to those people.*

The ED nurses experienced internal conflict, as well as with the system, and reported the lack of education or orientation to guide their care of women experiencing miscarriage. The ED nurses in the stories struggle with being the hero, to either the system or the woman, or being the

anti-hero to both. The plot of the story creates what would appear to be a futile quest for the ED nurse, yet the ED nurse forges on and lives to fight another day.

The *you're not an emergency* narrative type, then, reveals an underlying plot that informs the ED nurses' stories. This is to say that the narrative resources that the ED nurses used to describe their experience of caring for women experiencing miscarriage can all be linked back to miscarriage as a non-emergency. Throughout the analysis of the ED nurses' stories, *you're not an emergency* was clearly apparent in the stories. However, this raises the question of why the story of miscarriage is a story of a non-emergency. What would make miscarriage a priority? What if there was something to see or if what was lost became tangible? Thus, the next section turns to s*eeing the fetus* as a typology, a plot twist that may change the story.

Seeing the Fetus

Miscarriage is not only a conundrum for the ED, it is also a condition that is not well recognized in our society and in health care more generally (Bellhouse et al., 2018; Lancet, 2021; Lang et al., 2011). Miscarriage is often a taboo subject, and as a result, society's experience and expertise in navigating the experiences are limited. A plethora of literature describes both the negative experiences of women who experience a miscarriage and the experience of women trying to achieve recognition and validation of the loss they experienced. While none of the ED nurses overtly diminished the experience of miscarriage, they highlighted how, in the ED, the experience is minimized by downplaying its importance. The stories the ED nurses have shared talked about the reality of the ED, lack of preparation or protocol, and that ED nurses do not feel they have much to offer women in the ED. However, if we put aside process, place, and practice, what does a miscarriage look like to the ED nurses? They are witnessing a physical loss, which surely has an impact on them, with the potential for the intangible to become tangible. The ED

nurses' stories do reveal common narrative resources, which I have covered extensively to this point. However, a less familiar story was also shared by some of the ED nurses—in particular, their experiences when a woman passes the products of conception, such as the fetus.

The stories discussed so far focused primarily on why the ED nurses could not provide care to women experiencing a miscarriage, but they have not revealed what the ED nurses may have witnessed when a woman experiences a miscarriage in the ED. Frank (2010) suggested that in the analysis of narrative, we need to "notice which details might have been expected but are omitted" (p. 107), which is certainly relevant here. In fact, a description of the actual care the nurses' provided to women as they experienced a miscarriage is mostly missing from these stories; when they told their stories, they contained limited descriptions of what the ED nurses actually witnessed. This may be because there is little to see or discern in the early part of the pregnancy—merely a mass of tissue and clots that in no way resembles a baby.

Most of the ED nurses did not describe this experience, but those who did, included a detailed description; this level of detail brings into view the impact that the remembered image has had on the ED nurse's view of miscarriage. The ED nurses who saw more than the mass of tissue and clot and, in fact, saw a fetus with discernible human features described being affected by this experience. They talked about expecting to see little but were surprised at what they could see. Hope spoke of her experience with this:

> *But it just shows how far along those cells went to being almost alive, to human-sized. I found it more sad I guess, because I guessed you just bleed and it was over—there's bleeding, there's nothing obvious. You can't make out an eye, or tell where the head is, or stuff like that, but you 100% can....*

> *People who had brought in, like, an intact yolk sac, like amniotic fluid and you can make out the anatomy of everything and one was around 10 weeks, one was 11 weeks, and the other was 12. So, I have seen that kind of variation too in size. It was very far apart, but it has definitely stayed with me… It then shows how I can make out the fingers, you can make out the eye, you can see the curvature of the spine. It was actually quite amazing what you can see for how tiny it is. It fits into the very circle of the palm of your hand, but you can make out what is eventually going to be human if things had gone well.*

This account demonstrated the nurse's wonder, as well as perhaps surprise and shock about what was lost; it sheds light on this individual's struggle—when she realized the potential pregnancy has been lost and when she understood the importance of the pregnancy to the woman. Ruth also spoke of the conflict she felt when faced with taking care of the fetal remains. She was conflicted about the ambivalence, and sometimes disregard, for the value of what the woman had passed. Ruth told the story of wanting to protect or respect the remains—a mass of cells or products of conception that mattered—and the conflict she faced when her colleagues did not follow the same storyline. Ruth described the other ED nurses' actions as either contradictory or merely not supportive. She sought to extend care of the woman to the fetus; often, this was a contradiction to the customary practice, as she explained:

> *I remember one of the first times…a more senior ED nurse was with me and the fetus, expelled while the mom was with us, and they [the senior nurse] just wrapped it up in blue pads and threw it in the garbage. I thought I was going to have a stroke…Oh my gosh…I was left to clean up the room and I took the blue pads out of the garbage, and I put them up on the bed for a while [as] I was tidying the room. Don't throw that in the*

garbage, don't. I don't know where it goes, but I remember walking around the unit and started talking to a couple of other people with this blue pad in my arms or my hands thinking, "Is there a better place I can put this? Or can somebody take this and put it in a better place?" Not through it in the garbage…Oh my gosh, this woman would have cherished [this] life that they would have given birth to, and we tossed it into the garbage in their presence.

The visible things are the products in the garbage and that one, the one that was 14 weeks, I remember I took it to the desk. It was still in its sac, and I took him to the desk. And I had the little creature here still in their bubble, like fully not destroyed in any way and I said…I remember, here's the formaldehyde jar…Right, Ruth you need to put him in quickly. It's like, umm, I can't do that. They said, "Come on." No, no, don't do that. They were like, "You have to; it has to go to the lab." No, no, no, don't do [that], please...please don't do that... They had to take, take this little creature and put it in. Where did it go? They put the jar in a brown bag. Did you put him in? Are they in there? Yeah. Okay.

"I'm gonna sit here," I said, and I felt like it was my job to protect him 'cause they can't just leave him on the counter in a brown bag...That was early on... Yeah, that kind of chain of custody [laughs] you know, that's what it was like. …You wouldn't leave your kid alone in the store. That's what I [was] always thinking, like no, no, no, I can't go anywhere. I always felt…it's just so bizarre. It's like when they come for this child, it should be like, "You know, you're taking [something] so precious, like this gift and [it should be] honoured." Don't you dare throw it in your wheelie basket with all the other

> *junk, your charts and stuff like that. Like, this was something that was to be cared for... [something] special you know.*

Ruth's story of the fetus being carelessly wrapped in the blue pads and tossed into the garbage is echoed by women in a study by Engel (2020):

> So, the doctor walked in and had this bluey. She [nurse] goes "I think that's it, right there" and he just looked at it and she just folded it up and threw it in the garbage right in front of me. For probably a solid two years, just to repeat that would upset me. For her, it was just tissue. I wouldn't have wanted them to wrap it up and give it to me to take home but to throw it out in front of me—that was mine! (Jessica) (p. 23)

The power of these similar stories from a nurse and from a woman who experienced a miscarriage in an ED illustrates that the fetus has meaning and needs to be honoured in a way that protects both the patient and the nurse.

In other stories, the ED nurses found themselves suddenly attentive to recognizing a lost human life. They saw the fetus but were not sure if the woman herself had had the opportunity to see what they had seen. This was a glimpse into an alternative to *the medicalization of miscarriage* and *nothing I can* narrative resources; specifically, what appeared to have been missing from the other stories was the acknowledgement that "something" was lost. Indeed, most of the ED nurses' stories shared here did not contain an acknowledgement of a tangible loss. However, in one of the stories the loss became tangible, it became something, Naomi articulated this well when she described the privileged position of the ED nurse and the realization of the power of the position. She acknowledged that this was difficult and that retreating to the stock identity rather than risking being vulnerable was more palatable to her:

I think some people, some ED nurses, avoid it as much as they could because it wasn't an easy thing. It wasn't easy, it wasn't easy to take a fetus in some cases, pull it out of a formalin bottle because the person who put it in the bottle didn't think that the family would want to spend some time with it. So, I think some people simply would downplay this, I guess.

However, for the Naomi, who allowed herself to be vulnerable, this decision made way for a different story—an opportunity to explore who ED nurses might become (Frank, 2012) in dealing with women having a miscarriage in the Ed. Naomi's account demonstrated an alternative, where the woman and her family were able to see what was "theirs" and be a part of an experience that only the ED nurses had previously had access to:

I think it was after experiencing a few losses and seeing babies or fetuses that were intact…and you could look at it. I think what the eye-opening thing for us [was] and I remember this for myself. A lady passing the fetus and us putting it in the formalin and looking at it and saying, "Look, there's it's fingers, there's it's toes." And after doing that thinking, we are all very intrigued and interested by this, and yet we have never shown the mother or the father...And I guess, just wishing that had come to us earlier. That we should be giving [them] the opportunity to see this. This is theirs *and here we are … I remember going into the back room where the formalin bottles were, us, like 5 or 6 [nurses] going back there and examining it and you could see so much of it at 20 weeks, right? And then, then having that thought, "WOW, why aren't we, this isn't even ours and we haven't even offered it to them."*

I think if we had just come to that conclusion or that awareness earlier, then maybe I think, I think it was our first step [to] developing the kit [perinatal loss kit].

Then, maybe a second step, [would be] moving toward dedicating a room that was a bit more home-like and relaxing maybe.

Not every ED nurse told a story of seeing the fetus following a patient's miscarriage; the ones that were shared are unquestionably powerful, however. These accounts were even more compelling in that they paralleled references in the literature to fetal personification and parents' feelings. For instance, the process of visualization afforded by the ultrasound photograph participates in parents assigning personhood to their unborn child, making the pregnancy real for the prospective mother. This, in turn, heightens the significance of the loss of the pregnancy (Keane, 2009). In the stories of my participants, it appears that seeing the fetus affected both the women and the ED nurses in a way that moves the experience from a merely medical event to something else.

This unique narrative reveals a character type or role that some of the ED nurses slipped into, revealing much about what they can become. This unique storyline offers an opportunity for the ED nurses to resolve the trouble they experience in the *you're not an emergency* narrative type. Naomi used the story of the fetus to demonstrate her pride in providing care that showed she could do something for these women. In particular, she identified a potential new role for the ED nurse—changing practice, educating new ED nurses, realizing the pregnancy may have meaning to the woman, and recognizing the importance of exploring this as part of the care they provide to their patients:

I think it allowed for the ED nurse to kind of [feel] "Hey, I did something. I did something well there. I provided good care." Whereas before, it was probably [more like], "Oh gosh, we literally took that fetus and put it in a formalin bottle —to we don't even know where—in pathology somewhere in the hospital" And we are dealing with a

grieving mom or a mom in shock. But we probably haven't taken steps to make sure that [her] grieving and that shock isn't as impactful as it could be or couldn't be.

The stories of seeing the fetus were told from three perspectives. Hope told the story as an epiphany: she thought women bled, they miscarried, and that was the end. However, she saw what was lost and saw that it was something more than a non-event. Ruth believed there was something special unfolding and witnessed a disrespect of these special remains; this troubled her, so she protected what was lost. Naomi offered a similar perspective to Ruth and Hope but took the experience further. She revealed how seeing the fetus and acknowledging that something was lost opened the possibility for a different way to provide care for women and their families. Naomi acknowledged how it was difficult for some ED nurses to provide this type of care, but she spoke about how rewarding it was. Her story reveals the potential for a different identity for the ED nurse, one that differs from the stock identity and typical role of the ED nurse articulated throughout this project. The impact of seeing the fetus may be a significant turning point and is worthy of further analysis in future research. It may also become part of a knowledge mobilization strategy related to this project.

What is the Rest of the Story?

Not an emergency and *seeing the fetus are* the underlying plots and typologies that unite the various narrative resources the ED nurses used to share their experiences, which helps generate understanding of the stories of the ED nurses who cared for women experiencing miscarriage in the ED. However, it is worth considering also what these stories offered the ED nurses themselves, as well as the women they cared for. Fundamentally, they offer insight. This insight may bring into focus what was not intelligible before, thus becoming a means to open dialogue to explore this further. Clearly, the role of the ED nurse is significant when women

arrive for care during a miscarriage. The ED nurses are empathetic to the loss that women are experiencing, but they struggle to reconcile what they are not doing for women: it is "hard on their heart" as Joy said.

While highlighting this aspect, the ED nurses largely did not acknowledge how critical their role indeed is and how much diligent care they are, in fact, providing—despite the barriers within their practice. Ideally, ED nurses will find their way to a more confident stance, to further facilitate the care they can provide. The question becomes how to bring this to fruition. Moving this work forward certainly demands a discussion of the fundamental and philosophical barriers that impede ED nurses from assuming leading roles, which will facilitate delivering quality care to these women. Additionally, practical approaches must support ED nurses to provide meaningful care to women experiencing miscarriage in their departments. Informed caring may offer some insight into how these typologies can collectively guide the practice of the ED nurse.

Informed Caring

Kirsten Swanson (1991) developed a middle-range theory of caring, using three phenomenological studies conducted in perinatal settings. She identified five caring processes—*knowing*, *being with*, *doing for*, *enabling*, and *maintaining belief*—and defined caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 354). Central to defining informed caring in a nursing context is appreciation of the breadth and depth of nursing knowledge, which Swanson elaborated on: "Those we serve, how we serve, and why we continue to serve, mandate an impassioned integration of science, self, concern for humanity and caring" (p. 353).

ED nurses in this study spoke to how little they could do for women and that miscarriage was not an considered to be an emergency. *You're not an emergency* almost silenced the stories

they told about what they were doing for women in the ED and revealed "how and why they serve" with skill and expertise. *Seeing the fetus* spoke about how the ED nurses' perspective changed when they saw what was lost and revealed their "concern for humanity and caring." Both of these typologies showed a picture of the ED nurses' work that even they may not have realized they were sharing that is, the invisible work of nurses. Swanson's theory of caring may offer further insight into how these typologies inform ED nurses' practice.

Swanson's (1993) theory acknowledges that caring demonstrated by nurses is often seen as superlative or as an act of service and gentility. However, this one-dimensional understanding of nursing does not acknowledge the breadth and depth of nurses' knowledge, and the elements that inform *caring.* In nursing interventions, caring is assumed to be a gesture of kindness, since the scientific knowledge underpinning chosen interventions is not readily apparent to non-nursing or other non-medical practitioners (Swanson, 1993). Swanson contended that therefore much of nurses' work is dismissed, with the intrinsic and vital importance of nursing work, supported by nursing science, overlooked.

The typologies (*you're not an emergency* and *seeing the fetus*) reveal how caring in nursing practice can shift with changes in experience and tacit knowledge. Examining Swanson's caring processes and the typologies may offer further insights into ED nurses' experiences with miscarriage.

Maintaining Belief

Maintaining belief is the foundation of caring according to Swanson (1993); it allows the nurse to determine "what matters and where to address care" (p. 354). Many of the ED nurses identified that what matters in the ED is the next emergency; thus, anything that is not an emergency may be dismissed. Their lack of preparedness related to miscarriage meant they

struggled to not only provide care but to even acknowledge *when* they were providing care to women. By contrast, those who told the stories of seeing the fetus voiced how their nursing practice changed from these experiences; seeing what was lost mattered to them and affected their nursing approach. Perhaps acknowledging what was lost could provide the impetus to shift from you're not an emergency to *you're experiencing something significant; here is what I can do to help*.

Knowing

If *maintaining belief* is the idealistic part of caring, *knowing* is the reality. Knowing "avoids assumptions" and focuses on the client's "lived reality" when they are presenting for care (Swanson, 1993, p.355). The ED nurses in this study identified their expertise in all things related to "emergency," but they expressed that they lacked expertise in caring for women experiencing a miscarriage; moreover, miscarriage may not fit in the ED. ED nurses are caught between trying to understand the experience of miscarriage and trying find a place for miscarriage in the ED. This lack of fit was also evidenced in that these ED nurses were unable to acknowledge the care they did provide to these women patients. Perhaps hearing the stories of the ED nurses who saw miscarriage become an emergency or who saw the fetus may offer insights for ED nurses to rethink their perspective. It is possible that the tacit knowledge garnered from practice could combine with new formal education about miscarriage to change the underlying plot of ED nurses' stories of miscarriage.

Being With

Being with is the element of the caring process that "conveys to the client that they and their experiences matter to the nurse" (Swanson, 1993, p. 355). In their stories of negative media attention, ED nurses described feeling that their lack of attention or presence was misinterpreted

because no one understood the competing priorities they dealt with during every shift. Yet, the ED nurses also described watching and being present to women if they had to sit in the waiting room. This watching and presence could be described as empathy and compassion directed toward these women despite the challenges; yet it is not clear that the ED nurses recognized it as such. They did, however, speak to the positive experiences of having time to sit with women and be present in the loss with them, as well as how meaningful these encounters were for them. Seeing the fetus caused the ED nurses who shared such a story to pause, creating a moment for them to see what was lost and what mattered to them. Opportunities to pause and to be present to their female patients who are miscarrying may potentially change the practice of ED nurses, better meeting both their patients' needs and their own. Such moments do appear to be fundamental to changing the efficiency and the urgency of caring practices.

Doing For

Doing for is simply doing for others what they cannot do for themselves (Swanson, 1993, p. 356). ED nurses may believe that they "focus on medical problems and not emotional ones" (Engel & Rempel, 2016, p. 55). Doing for, from the perspective of the ED nurses, was shown as performing medical interventions but little else. Acknowledging that miscarriage is out of place in the ED is important given that the ED nurses suggested that the site of the ED was wrong and miscarriage care was out of their scope. The ED nurses' real or perceived barriers to care—including space, time, efficiency, and resources—may limit *doing for* women experiencing miscarriage. Nevertheless, women may need to visit the ED during a miscarriage, which means that building capacity within the ED and facilitating ED nurses' care for these women is most definitely necessary.

Enabling

The final caring process described by Swanson is *enabling,* which she defines as "facilitating the other's passage through life transitions and unfamiliar events" (Swanson, 1991, p. 162). The ED nurses struggled to guide women because they felt they lacked the requisite knowledge and skills related to miscarriage to provide them with appropriate care. Further, while the ED nurses believed that miscarriage was a frequent occurrence in the ED, they also recognized that it may be the first such experience for the woman undergoing this. Frequency, even normalization, may have created indifference for some ED nurses. However, for the woman, she was losing her baby; obviously then, indifference or normalization was not comforting.

The ED nurses who did have time to help the woman navigate the experience and worked in an ED with a plan for miscarriage expressed satisfaction with the care they provided. *Seeing the fetus* was therapeutic for both the ED nurse and for the family, a moment in which they could acknowledge that something important was lost. This validated the experience and the loss for the family, but it also validated the ED nurses' time, interventions, and focus on the women potentially helping with their transition through their loss and grief.

The caring processes offer a way to change the plot of the miscarriage story by writing a new story. In the stories of the participants, *seeing the fetus* was the quieter of the two underlying plots; exploring why this is may be fundamental to making change. As well, ED nurses hearing these stories may offer some clarity for ED nurses about the important and vital role they play in providing care for women as they navigate the experience of miscarriage in the ED.

The End

The participants' personas, narrative identities, search for redemption, pursuit of or lack of agency, and their fears and trepidation were all part of the puzzle in understanding the experience of the ED nurse caring for a woman experiencing a miscarriage. These eight ED nurses shared their stories, while invoking similar narrative resources along the way: the reality of the ED, the medicalization of miscarriage, the lack of a plan, and the nothing I can do. Additionally, many of the stories focused on what the ED nurse could not do for these women.

However, as I listened, I heard how much ED nurses were actually doing for the women. McCreight (2005) described the lack of research and resulting guidance for ED nurses who care for women experiencing a miscarriage. She spoke of the value of the ED nurses' knowledge but underscored that it must be honoured by others for ED nurses to be able to honour it in themselves. McCreight also referred to "stories being stocks of situation knowledge" (p. 441) The stories shared for this project were filled with the ED nurses' experiences of caring for women experiencing a miscarriage. The gratitude I have for these stories is rooted in how the ED nurses revealed their work—although regrettably, the ED nurses themselves may not recognize this nursing work.

The narrative resources and narrative types revealed how the ED nurses saw themselves, how they understood their stories, and how they reconciled their experiences. Unfortunately, they lost sight of their work in the personal narratives they shared and the narratives they heard from others. However, acknowledging their influential role is key to changing practice. Rather than hearing what ED nurses are not doing, the revelation is that ED nurses do indeed coordinate and navigate these women's care. This revelation is critical to this discussion, inviting discourse that acknowledges the work ED nurses are doing to provide care to women who are miscarrying.

This new dialogue brings forward a potential new narrative, one that has ED nurses leading the care of women experiencing a miscarriage, but in a mutually meaningful way. For this, I am grateful and offer my appreciation to these stories and storytellers.

The next chapter will include an exploration of some of these barriers as they relate to the place of birth in society and the work of ED nurses, as well as a discussion of the practical ways to move forward. Identifying both the facilitators and barriers to care will increase awareness of how to better align the experiences of ED nurses and women undergoing a miscarriage in an ED. Ideally, this will create opportunities to establish a community of practice to support both.

Chapter 7

Discussion

The ED nurses who shared their stories here provided insight, from their perspective, into the experience of miscarriage for women in the ED, while also exposing what it is like to be a nurse providing care to these patients. The stories revealed the narratives that informed the ED nurses' practice and exposed commonalities, suggesting that this may be the experience of other ED nurses. The value of shared experiences in qualitative research, such as this study, lies in their contribution to the knowledge base that other similar actors may draw upon. The following discussion will therefore proffer thoughts about the ED nurses' experience with miscarriage in the ED, while contextualizing the issues that may support and hinder their care of these women.

A Plan for Everything and Everything in Its Place

The ED nurses in this study described a conundrum they faced with miscarriage in the ED, which arises from the fact that miscarriage was out of place in their practice in the ED. They further confirmed that they were highly skilled and had a plan for everything: everything except for miscarriage. The ED nurses reported a lack of policy, protocol, and education to guide their practice, which supports the belief that miscarriage was a misfit in the ED. Understanding this perception of misplacement may offer some insight into ED nurses' challenges when they encounter a woman experiencing a miscarriage. Moreover, understanding these challenges is critical to understanding the experience of the ED nurse.

Education Challenges

The ED nurses spoke of their knowledge and skill to manage any emergency. However, their stories about miscarriage did not reflect the same confidence. The ED nurses talked about not having substantive formal education about miscarriage beyond their undergraduate nursing

education to direct their care for these women. This lack of formal training was evident in the narrative resources of *the lack of a plan* and *nothing I could do*, in that they did not necessarily have the requisite formal knowledge about miscarriage to guide their work. Given this lack, they depended on their tacit knowledge to guide their practice, which was acquired from nurse mentors and also from women who came into their care. These stories framed this gap in formal education as a shortcoming.

However, the ED nurses also displayed considerably more knowledge than they realized. This included an appreciation for the experience of losing a pregnancy, and an intimacy in their encounters with these women that demonstrated their emotional responses to the events and the people involved. Despite their perceived lack of education about miscarriage, they understood that this loss was difficult for women and that they had a responsibility to mitigate the women's distress. This knowledge is invaluable in creating opportunities for change. Formal education about caring for miscarriage will be essential, but without policy and procedures to support educational initiatives, the ED nurses may continue to struggle with the care they provide to those experiencing a miscarriage.

The lack of a plan creates both challenges and opportunities for the ED nurse. For example, those who shared their stories focused their ability to care for women experiencing a miscarriage on the medical interventions available. This focus discounted the breadth and depth of their knowledge and expertise. The valuable tacit knowledge and skill, beyond the psychomotor, was not acknowledged by the ED nurses. Empirical science is fundamental to nursing practice but has also made for nursing challenges in that the reliance on empirical scientific data sometimes happens at the expense of other nursing ways of knowing (Thorne, 2020, p. 4).

Nonetheless, in the current push by the nursing profession to reflect multiple ways of knowing that underpin the core values of nursing practice, a turn may be underway towards greater reliance on data or knowledge that may not be generalizable and is based only on opinion or belief (Thorne, 2020, p. 4). These ED nurses' stories about caring for women experiencing a miscarriage did not particularly rely on empirical knowledge related to miscarriage. Their stories instead reflected a practice focused on efficiency and psychomotor interventions. The care was predicated on the systems in place to ensure efficiency and whether they were successful in maintaining the flow of patients through the ED. These ED nurses' stories also showed that they based their care of women on generational knowledge passed down from previous experienced ED nurses who worked in the ED, rather than on in-depth empirical knowledge of women experiencing miscarriage.

Notably, their stories did not reveal a formal, comprehensive understanding of the miscarriage experience beyond the physical care needs of such women patients. However, there was an acknowledgement of these women's emotional, psychological, and spiritual care needs. The ED nurses acknowledged these needs but did not believe they had the knowledge and skill to meet them. Going back to Swanson's (1993) caring processes described in Chapter Six, these ED nurses' stories represent an opportunity to consider changes in practice, since they demonstrate how nursing care is actually being provided to these women. That ED nurses were providing this care in small ways—without formal education, policy, and procedures—is a meaningful and hopeful glimpse into what is possible. Significantly, the ED nurse participants told stories of their struggles with providing care for these women, reflecting an awareness that something was missing. Hence, opportunities to acknowledge what they did well, coupled with more substantive

education and support, creates space for future positive changes so support these women and their ED nurse caregivers.

Lack of a Plan Challenges

The ED nurses talked about the need to always be ready for the next emergency: they always had a plan. They needed to be efficient and move people through the department in case an emergency arrived. They may have provided appropriate care for patients but in a way that "rationed" the nurses' time and energy. However, that care may not address the patient's needs. Completing the task list or following the protocol to maintain efficiency may influence the nurses' ability to be patient centred. Miscarriage in the ED exacerbates this challenge for the ED nurse.

The ED nurses described that there was no plan or procedure to guide their care for women experiencing a miscarriage. The literature does contain guidelines, but as noted, they focus either on later losses or are only focused on the physical care of the patient (Hendson & Davies, 2018; Morin et al., 2020). Early career nurses struggled with the juxtaposition of knowing that they needed to do something more, but they were unsure about what "more" was in the case of miscarriage. ED nurses who were later in their careers still described their struggle when people presented with miscarriage, but they could also quickly move to the medicalized approach and frame the miscarriage as not an emergency. One of the ED nurses described that "the ED beats you down." The contextual meaning here was that, while once they may have prioritized miscarriage as an emergency, it eventually became a non-emergency for them.

This change follows along with the prevailing theme across the stories that caring for people with miscarriage, or even miscarriage itself, is perceived to fall outside the parameters of ED care. The ED nurses frequently referred to the "other"—the birth unit or a women's health

unit—that would be better equipped to care for a person experiencing a miscarriage. This view, coupled with the lack of appropriate education and a plan for treatment, means the experience of miscarriage is at risk of continuing to remain silence. The ED nurses' stories included accounts of how the only interventions they believed they could offer to a woman were medical procedures and little else. This approach of offering only minimal options was positioned as an attempt to justify the limited care they believed they could offer persons experiencing a miscarriage, specifically, venipuncture, pain management, intravenous therapy, and sometimes a dilation and curettage. This approach helped the ED nurses describe their perception of how they provided care for women. I posit that the discourse informing this reductionist approach is the medicalization of not only miscarriage but the medicalization of birth.

Medicalizing Birth and Death

The medicalization of miscarriage is well documented in the literature (Due et al., 2018; Freeman et al., 2021; Jensen et al., 2019; Linnet Olesen et al., 2015), but it is compelling that medicalization is a part of birth stories as well. In the early part of the 20th century, there was a notable shift from home birth to birth in hospitals, attended by medical experts (Tew, 1998). Interventions to manage birth and reduce the risk to women and infants, along with advances in technology, were employed to reduce morbidity and mortality (Tew, 1998). An unexpected result was that birth became pathologized; women's "powers" were insufficient to rise above the challenges that birth could present (Tew, 1998, p. 9).

This medicalization of birth and the associated narratives often discounted the ability of women to be active participants in their birth experience, so they became increasingly passive during the birth process (Andipatin et al., 2019). As noted in Chapter Two, morbidity and mortality associated with birth are important population health indicators (Martel, 2014;

Andipatin, 2019); thus, the medicalization of birth and miscarriage were intended to reduce the risk and improve positive outcomes. This is rather ironic, however, as Davis-Floyd (2001) pointed out:

> The underlying ethos behind the routine application of so many unnecessary procedures to birth is fear of death. These procedures keep fear at bay by giving both practitioners and birthing women the illusion of safety: they minimize risk while, in fact, they often generate more problems than they solve. (p. S10)

Controlling the birth process reduces the chance of pathology and death for the childbearing person and the infant. Yet for miscarriage, the opposite happens, as nothing can be done to stop the miscarriage and the inevitable occurs. The literature review highlighted that miscarriage is considered common and without risk in most cases and therefore not in need of the same attention that birth requires to ensure safe passage for mother and infant. However, whether miscarriage is indeed common and without risk is open to some question, and better understanding of these aspects is vital to changing nursing practice.

The writing on miscarriage, including the grey literature, describes this event as "frequent"; however, the sources to support this claim and to quantify the frequency of miscarriage are not plentiful or robust. It seems that calling miscarriage frequent or expected may be primarily based on anecdotal evidence. Recently, some work in Canada has examined peripregnancy visits to the ED but ascertaining accurate statistics from ED census data is difficult (Varner et al., 2020). Varner et al. (2020) found that "the most common emergency department diagnoses were for conditions arising in the first trimester: threatened abortion, unspecified hemorrhage in early pregnancy and spontaneous abortion" (p. E309). They also

found that of the recorded pregnancies in Ontario, only 8.1% ended in miscarriage. This statistic varies from the 15 to 30% amount frequently referred to in literature about miscarriage.

It is possible that miscarriage is not a common event in pregnancy after all, but rather, is a common presentation in the ED. Further, three aspects converge to inform the gaps in care for women experiencing a miscarriage in the ED: the medicalization, normalization, and trivialization of miscarriage documented in the literature, the inaccurate statistics to confirm that miscarriage is expected, and the fact that miscarriage may be frequently seen in the ED. Even more, while miscarriage may be well researched from the woman's perspective, how to improve care for these women may not be as well articulated. A lack of knowledge mobilization about miscarriage undermines support for care during a miscarriage in the ED. Specifically, while several participants told similar or familiar stories, less common stories are also worthy of attention. The ED nurses who told these "other" stories revealed a shift in the context of their practice, wherein they moved away from the normalization of miscarriage—that miscarriage is not an emergency and there is nothing they can do. These stories highlighted that the mainstays of ED practice, such as preserving hemodynamic stability and preventing loss of life, were inadequate when ED nurses were faced with miscarriage. These unique stories also shifted from "a nothing to see here" narrative to one of witnessing what was lost. These unique storylines therefore offer valuable insight into how to engage ED nurses in practice change.

Miscarriage Can Be an Emergency

One participant described this scenario of caring for a woman who was experiencing a miscarriage: approaching the woman as she usually did, finding her a private room, drawing some blood, and starting intravenous fluids. This is a common approach, based on the assumption that routine care is appropriate. However, when the ED nurse put her hand on the bed

to stand up, she felt a wet spot—the spot was blood, and the patient was hemorrhaging. For this ED nurse, miscarriage became life-threatening at that moment, and she reacted as she would with any patient who was hemorrhaging in the ED. A hemorrhage was something ED nurses have a plan for, even though no plan exists for miscarriage.

Significantly, the physiological changes associated with pregnancy and birth put women at risk for several things, including hemorrhage. A systematic review by Saraswat et al. (2009) found that patients with a threatened miscarriage were likely to experience antepartum hemorrhage of unknown origin. They also concluded that higher levels of perinatal mortality and adverse maternal outcomes were associated with antepartum hemorrhage. Circling back to the medicalization of birth, the risk of hemorrhage is accounted for and risk reduction strategies are in place. Ironically, as described by the participants in this study, miscarriage care does not acknowledge the same risk, despite data that demonstrates this risk. Minimizing the potential severity of miscarriage therefore creates risks for the woman undergoing this experience. In addition to safety concerns however, this trivialization by health care providers (HCPs) separates the experience of miscarriage from the experience of birth. They are both life experiences on the journey of childbearing. Martel (2014) highlighted this relationship:

> On one hand, we see a surge in discourse that speaks to the reduction of infant mortality as the paramount moral concern amongst any decent nation. On the other hand, we see no indication that reproductive loss is thought of as a socioculturally meaningful death that one might grieve or that medical staff might acknowledge. (p. 341)

ED nurses dismissed the physiological risk associated with miscarriage in the way they told their stories. They described miscarriage as a non-emergency, for which they could offer little to nothing to change the outcome. The literature corroborates this phenomenon (Baird et al.,

2018; Larivière-Bastien et al., 2019; Merrigan, 2018). ED nurses minimized not only the women's experience but also their own experience with miscarriage. However, in the story above about the woman hemorrhaging, the experience changed for this nurse. Now, miscarriage was an emergency and could be again. The question thus becomes one of how often miscarriage becomes an emergency, and who holds the stories to illuminate this part of the experience.

Bringing the Fetus into View

Over the past four decades, the advent of reproductive technology, changes in family demographics, and the abortion debate have given rise to the trend of fetal personhood and to "the prominent fetal patient" (Layne, 2003, p. 16). The fetus, as patient, has evolved, with the proliferation of technologies that can visualize the fetus and provide it with interventions. Fetal personification has also resulted in discourses that disembody the woman and her body, focusing instead on the fetus (Anolak et al., 2019; Kevin, 2018; Layne, 2003). Mitchell (2001) described that as ultrasound technology has evolved, HCPs no longer have to rely on a woman's descriptions or experience of her pregnancy to ascertain the fetus's health. Ultrasound gives them a window to see, examine, and manipulate the fetus without her participation (Mitchell, 2001). Thus, the woman and the fetus become two separate entities in many cases.

In preparation for birth, the mother is the vessel that ensures the safe passage from embryo to fetus to infant at birth. In describing miscarriage, Martel (2014) noted the following:

> The actualization of death-in-birth delegitimates the state's intervention because it embodies the inevitability of death and the limits of techno-medicalization. It transforms the productive pregnant body into the unproductive grieving body and provides no immediate site for the circulation of capital (p. 341)

The product of the pregnant body is an infant. In miscarriage, a woman becomes a grieving body without a product or success. As a result, women are set adrift by the same people who helped them personify the fetus, with no corresponding norms to acknowledge the loss. When the woman and fetus are positioned as separate entities, this means that when the fetus is lost, the woman faces what Layne (2003a) referred to as the "realness problem of pregnancy loss" (p. 17). The fetus was real when it could be seen and even heard (fetal heartbeat), but there is nothing tangible in the absence of these elements.

ED nurses who care for women experiencing a miscarriage are not immune to this intangible nature of miscarriage. The stories shared for this project did not reveal what the ED nurses witnessed when a woman experienced a miscarriage in the ED—although this story was expected, it was missing. The omission of this type of description begs the question of whether this was deliberate, it was not part of the story, or the ED nurse did not have the narrative resources available to tell it? Three ED nurses saw more than just a mass of tissue and clot; they saw a fetus with discernible human features, which they shared in their stories. The fragility of life, the trauma of seeing the loss, and the balance of seeing the fetus with wonder and surprise were missing from other stories. Understanding why it was absent from the other ED nurses' stories is unclear but may be explained by appreciating how the fetus is viewed during pregnancy and pregnancy loss.

The ED nurses who did tell stories about seeing the fetus struggled to reconcile what happened to the fetus and woman after a miscarriage. One ED nurse, Ruth, described being "haunted" by how care was provided to women experiencing a miscarriage. She found herself conflicted about the ambivalence, and even sometimes disregard, for the value of what these women had lost. She told a story of wanting to protect or respect the remains of the fetus but

experiencing conflict with her colleagues who may not have shared her protective stance. However, respectful disposition of the remains following a miscarriage is vital to demonstrate to women that what they have lost is respected. Limbo & Kobler (2010) stated that perception, place, and protection inform respectful disposition, stating that "miscarriage has severed the mother's ability to provide protection, and she must now look to others to fulfil this work" (p. 20).

Those ED nurses who talked about the fetus coming into view described it as a powerful experience that changed how they approached women who experienced a miscarriage. Seeing the fetus compelled them to face the humanity of the loss. For women, ultrasound images of their fetus bring into view something they could only previously imagine, enabling them to personify their baby. However, when the baby dies in-utero, the images that confirmed life become still and silent. They no longer bring anything into view, once it is confirmed that the pregnancy is lost. One ED nurse described viewing the fetus with a colleague in a soiled holding room and marvelling at what they could see. As they examined it, they realized that the parents needed to be witnessing the fetus. This realization was an impetus for a practice change in that ED, where they chose to acknowledge pregnancy loss and created a set of guidelines to support both nurses and families to navigate the experience.

Bringing the fetus into view both in the stories and in the ED nurses' experience created a pause. It was a moment that could feel like catching one's breath. The pause allowed the fetus to become part of the conversation, established recognition of the miscarriage as a loss, and enabled time to grieve. It allowed time to reflect on what has been lost and provided a transition to holistic and compassionate care. While only three ED nurses spoke to the impact of seeing the fetus, those accounts emphasized the power of this experience. This power can be a catalyst in

motivating ED nurses to provide care differently to women experiencing miscarriage. Listening to all of the ED nurses' stories, it is evident that they are leading women's care; it is the work of nurses that may create the opportunity for future change.

Recognizing the Work of ED Nurses

The ED nurses who shared their stories described in detail their experiences of caring for women with miscarriage. The vivid picture of organized chaos, with multiple competing priorities and the tales of many masters, painted a picture of their day-to-day practice in the ED. These multiple priorities required the ED nurse to manage their time, energy, compassion, and expertise. The ED nurses spoke about how they frequently saw women having a miscarriage or feared that they were having a miscarriage. However, despite the normalization and medicalization of miscarriage in the ED, the condition being out of place in that setting, and the limited interventions they could offer, the stories contained much of what the ED nurses *were doing* for women. Based on these stories, it is evident that ED nurses provide much of the care to women experiencing miscarriages. *The reality of the ED*, *nothing I can do*, and *the lack of a plan* narrative resources helped the ED nurses articulate the challenges they faced. However, the ED nurses told stories of providing care to women, but that they did not realize was care. These ED nurses' lack of appreciation of the care they provided to women, including its value and impact, is certainly troubling—as it is work that can make a significant difference for pregnant women experiencing a miscarriage.

The ED nurses' stories of providing care focused either on what they could not do for these patients (*nothing I can do*, and *the lack of a plan),* or on only psychomotor aspects of care they could offer. If they had time in the chaotic ED, they would sit with the woman to offer comfort, but this was often not possible. The ED nurses acknowledged that women needed more

from them, but they did not feel they could offer the woman more of their time in the ED. They would retreat to the descriptions that focused on the medical interventions and that miscarriage was not an emergency. The ED nurses told stories of caring for women having a miscarriage and recognized that the experience was often challenging and meaningful for these women. They also identified that they desired to do more to validate these aspects of the experiences for them.

The ED nurses said that while they wanted to be present for these women, the emergency in the next room often had to be prioritized. Frequently, they could often not find them a private space because of the patient census, nor did they have time to sit and provide the emotional care they knew that women needed. In other words, they struggled to be present with these women—takes many forms and is not just about being physically present. It can be demonstrated by actions such as putting the call bell in reach and answering the bell if the patient calls. Being present with a patient demonstrates that the patient and their journey matters to the nurse.

The ED nurses believed they were not as present as these patients needed them to be. However, another interpretation of their stories reveals that they did much to be available for them. For instance, the participants said they tried to find a private room for them. In their position at the triage desk, they would tell these women that although they do not have a space for them at that moment, if they needed anything to come to the nurse right away. They continued to observe them in the waiting room. When they had time, the ED nurses sat with women or followed them to the doors as they went to the surgical suite for a dilation and curettage. Then, the ED nurses described worrying about the women after they left the ED or were transferred to the operative suite, where the ED nurses believed there was a lack of follow-up.

These details demonstrate, without a doubt, that the ED nurses valuable care extended beyond merely the physical, addressing some fundamental needs these women had, such as feeling safe, feeling informed about what is happening to their pregnancy, and having those feelings validated. Unfortunately, the ED nurses appeared challenged to recognize their work in their own stories. They also struggled to acknowledge their advocacy for women despite the barriers they described in their practice. Nonetheless, they nursed and implemented their scope of practice as ED nurses. The ED nurses' focus on psychomotor skills and medical interventions, however, trivializes the ED nurses' vital role in facilitating care for women. The ED nurses spoke of not having time to give to women experiencing a miscarriage as "hard on their heart." Their cover story was that they could do nothing for women, there was no plan, and it was not an emergency. Understanding what informs this side of the ED nurses' stories is essential to changing ED nursing practice. Swanson's (1993) theory of caring may offer some insight to help understand what the ED nurses' stories revealed about their work, and how they valued their work in relation to caring.

Understanding the discourses describing ED nurses' work is necessary to grapple with why they trivialize or devalue their own work. The power structure within acute care hospitals is often rooted in patriarchal practices, with physicians at the top of the power structure and ED nurses lower in that structure (Urban, 2014). ED nurses' work environments are fraught with challenges, including short staffing, overcapacity, and increased acuity (Urban, 2014). ED nurses often end up in a servant role, with little power; nevertheless, they continue to provide patient care despite the challenges inherent to their practice, and while potentially being considered an expendable resource or a source of cost-saving (Urban, 2014, p. 70). Urban (2014) described how nurses make "lists" for physicians, outlining the patient care needs based on specific nursing

assessments, yet the nurses require "orders" from the physician to proceed with care based on their own assessments. This hierarchy leaves nurses in a difficult position, where they must manage or navigate care challenges with little power to influence the situation. Further, nurses may become caught in a vulnerable position, where they must make the best of situations for the institution's benefit, often without support or recognition of their work (Urban, 2014).

Allen (2018) offered an interesting conceptualization of nursing work, using translational mobilisation theory (TMT). While this theory has not been used in this study, Allen's discussion of the theory's application to nursing practice demonstrated how the complex nature of organizational and operational systems affect nurses' work, which does have some relevance here. Nurses are often called on to direct a patient through various departments and providers, which entails mediating the organization's needs and facilitating the patient's unique needs. As they do so, their "panoptic view" (p. 40) of the patient trajectory through the system enables them to merge all the perspectives with their knowledge of organizational, patient, and nursing to form a plan (Allen, 2018). This nursing perspective helps to ensure processes happen when and where they should, that the necessary resources are available to enable them, and that all the parts work to achieve the goals of the interaction (Allen, 2018).

Allen (2018) suggested that nurses have a pivotal role in organizing healthcare, a role that is understudied. We know that ED nurses serve many masters, and as a result, their work becomes even more challenging and less efficient than it needs to be. Allen's insights into nurses' work highlight the enormous coordination of care and the complexity ED organizational policies needed in the care of a woman experiencing early miscarriage. These factors no doubt contribute to the "*you're not an emergency*" narrative type. However, in short, ED nurses also want these women in a more hospitable place.

The discourses cited by Urban (2014), along with Allen's (2018) analysis of nurses' work, have influenced nursing practice. Since they are not new conversations, the ED nurses may well have incorporated them into their own stories so that they take a more passive approach to their own practice. Such a take reflects the ongoing power structures in medical institutions, rather than the best evidence. In some ways, this stance could be generational powerlessness, which has been handed down from nurse to nurse.

In contrast to this, I posit that the ED nurses' stories shared here tell quite the opposite perspective. The narrative resources that the ED nurses used as they told their stories highlighted the challenges they faced; overcapacity, understaffing, under-resourced, and the need for efficiency. Despite these challenges, the ED nurses shared accounts of providing care for women experiencing miscarriages and of facilitating their transition through the department while ensuring they received the best care possible in the environment. Miller (2006) described "good work in nursing" (p. 471) and how challenges and strengths inform the nurses' ability to do their good work. They defined good work "as work that is technically and scientifically effective as well as morally and socially responsible" (p. 471). Nurses' work is thus characterized from a holistic perspective, where both science and the art are the foundation of interactions with clients.

Miller's study found that the "mission of work" for nurses included "making a difference, treating others with respect, honesty, and compassion, supporting patients and their families, and being present for patients" (2006, p. 475). She described obstacles to good work, including "nurse shortages, demands on time, conflicting values among peers, and lack of autonomy" (p. 478). Miller (2006) also described that quality patient care is predicated on communication, collaboration, effective leadership, and adequate resources for nurses (p. 484). Miller (2011) also

described that the quest to do good work and maintain high standards of care may put nurses at risk for burnout. Many of the attributes of Miller's good work were reflected in the ED nurses' stories. As well, the ED nurses' desire to provide quality care works in concert with adequate resources to make good work a reality for them while being cognizant of the risk of burnout.

Listening with these stories has revealed that ED nurses may be the ones to lead the care for women experiencing a miscarriage in the ED. Going forward, the ED nurses' ability to support women experiencing miscarriage demands that they embrace and capitalize on their abilities and expertise in helping women navigate this experience. They must also recognize and value their abilities and expertise, so a better understanding of how to help them with this will no doubt also improve the care for women experiencing a miscarriage in the ED.

What Else is at Stake?

It is essential to consider the implications of the lack of policy, protocol, and education for ED nurses who care for women experiencing a miscarriage in the ED. The ED nurses' stories contained little to suggest that moral distress was a significant factor related to miscarriage. Considering the narrative resources that the ED nurses used to tell their stories, the risk of moral distress to the ED nurse associated with miscarriage is a potential risk. Moral distress can happen when an ED nurse's ethics around care provision in a particular incident(s) may lead them to experience guilt and remorse (Austin, 2012). Moral distress can negatively affect the ED nurse, professionally and personally, when adverse experiences become compounded over time.

Fernandez-Basanta et al. (2020) completed a meta-ethnography "to synthesize nurses' and midwives' experiences of caring for parents following an involuntary pregnancy loss [miscarriage]" (p. 1486). This study did not identify moral distress but instead focused on the challenges nurses and midwives faced navigating pregnancy loss in their practice. Focusing on

ten studies, they identified an "overarching metaphor to describe nurses' experience [of] caring in the darkness," which was supported by five themes: "forces that turn off the light, avoiding stumbling, strength to go into the darkness, groping in the darkness [and], wounded after dealing with darkness" (p. 1493). These themes contained risk factors for nurses and midwives who cared for women experiencing pregnancy loss.

These themes resonated strongly with the ED nurses' stories shared in this study, particularly the lack of organizational support, the lack of preparation and knowledge, and a focus on physical care while avoiding emotional engagement. Similarly, the ED nurses in this doctoral study also explained how, despite the limitations, they forged ahead and provided care that was focused on being present and engaged with the women experiencing the loss, which also parallels accounts in Fernandez-Basanta et al.'s (2020) meta-ethnography. However, those researchers found that the challenges of "navigating the darkness" had a "personal cost to nurses and midwives," with nurses describing negative physical and emotional symptoms as a result of the challenge they faced in caring for those experiencing pregnancy loss (p. 1497). The ED nurses in this study did point to risk factors for moral distress associated with caring for women experiencing a miscarriage, considering their narrative resources of the *reality of the ED*, *nothing I can do*, and *the lack of a plan*. It is essential to acknowledge this risk to support the need for a proactive, nurse-led approach to developing guidelines for caring for women experiencing a miscarriage in the ED.

The first research question for this project asked what the ED nurses' stories revealed about their practice with women experiencing a miscarriage in the ED. The eight nurse storytellers shared their experiences to reveal their unique perspectives, along with familiar and shared narrative resources. Their stories and the analysis further exposed their experiences.

These stories collectively reveal the power and privilege of the ED nurses' role in caring for women experiencing a miscarriage in the ED. Despite the lack of resources, amid chaos, and without a plan, the ED nurses explained that they guided women through a miscarriage.

The lack of resources and workplace structures reduced the visibility of what these nurses did for their patients who were having a miscarriage, but the realities of the ED did not apparently preclude them from helping to navigate these women's care. However, attending to educational and workplace needs would enhance the visibility of the nurses' work with such patients. ED nurses are doing so much more than medical interventions, but they require a formal plan and education to support, articulate, and enhance all the things they do. Moreover, while miscarriage may not always be an emergency, it does require care from compassionate, skilled care providers.

While we cannot generalize all ED nurses' experiences from the stories of these participants, it is reasonable to assume that they resonate with other ED nurses. These ED nurses' stories brought to light what troubled them, while also offering them a place to start reimagining their practice and how they provide care for women experiencing a miscarriage. This reimagination may also offer ED nurses an opportunity to reflect on their work and the value and influence they have to provide care and affect patients' experiences.

I would be remiss not to acknowledge my own story as I come to a close here. My inner habitus of stories drew me to this research and guided me throughout as I listened and learned from the stories shared here. I am also grateful for my own stories and my journey as a perinatal nurse. I was reminded that my story and other nurses' stories include another character pivotal to the plot; childbearing women who experience perinatal loss. I was recently approached by a woman in a department store who identified herself as a woman I had cared for early in my

career. She told me how I helped her and reassured her as she cared for her newborn. She had a previous stillbirth, and somehow, I had helped her navigate this experience after her loss. I remember little of that encounter, but this woman's words are ones I had heard before, and the feeling I had was not new.

This encounter reminded me of two things. First, I did this research for a reason and disseminate this knowledge will be valuable. Second, what nurses often perceive as trivial or just being kind is often the most powerful thing they can offer to those they care for in their practice. I believe that patients and families assume nurses are adept at their psychomotor skills or those seeking health care do not trouble themselves to worry about such aspects, since they do not know the best practice or standard of care. However, as I reflected on my conversation in the shoe aisle, I was struck by the fact that the woman did not say I was great at my assessments or gave a great needle. Instead, she told me how I helped her feel more comfortable with her new baby and calmed her fears. The ED nurses who shared their stories spoke more about what they could not do, rather than highlighting the skills or procedures they could offer women. However, when I listened to their stories, I heard that they were the navigators of women's care, and despite a lack of protocols, procedures, and education, they nonetheless provided meaningful care. This strength must be capitalized on to move forward with the new policy, procedure, and education created by nurses.

Implications

The results of this study extend the burgeoning area of research related to the ED nurses experience of caring for women with a miscarriage. As research in this area continues to proliferate, it is important to be mindful that the voices of ED nurses, through their own stories, is still limited within the extant research. The narrative resources identified (*the reality of the*

ED, *the medicalization of miscarriage, the lack of a plan*, and *nothing I can do*) have been identified in other studies (Edwards et al., 2017; Larivière-Bastien et al., 2019; MacWilliams et al., 2016; Merrigan, 2018). More recent works supports the narrative type of *you're not an emergency* (Larivière-Bastien et al., 2019; Merrigan, 2018).

This narrative study is one of few to focus on the ED nurse's experience as the sole storyteller. Here, the participants explored their experience through their autobiographical story, with the stories reported from their perspective, thus elucidating how they lived it, as they perceived it, and as they needed to share it. A unique finding of this study was that the ED nurses apparently did not acknowledge their own care work when working with women experiencing a miscarriage. Edwards et al. (2017) found that even though ED nurses knew women experiencing a miscarriage needed more care from them, they could not do this because of the "constraints and restrictions of their practice context" (p, 298).

No studies speak specifically to the ED nurse's work in providing care despite the chaos, lack of education, and lack of a plan/protocol. "Silence" is a predominant word in many narratives about miscarriage for both women and ED nurses. ED nurses' care of women experiencing miscarriage may have gone unrecognizable by both women and ED nurses themselves. Hearing the story of this work and giving it a voice opens the possibility of a new story for ED nurses to find redemption and find agency as they navigate miscarriage in their ED practice.

Limitations

Stories are never final. The listener may hear them differently at different times, and the storyteller may tell them from another perspective. The stories shared here, and the analysis of the narratives for this dissertation were finite. These stories can be heard repeatedly, and new

understandings are possible for the participant and the researcher. I do not presume to have finished this story for ED nurses; instead, I hope to have opened the possibility to seek alternative narratives to support the nurses as they care for women experiencing a miscarriage.

This study did not include the women's perspective of their care in the ED following a miscarriage. The women's experience was garnered from the literature as thus no personal narratives from women were included in this study to corroborate the ED nurses' perspective. Therefore, this dissertation does not create a complete picture of what is intelligible about miscarriage. In addition, limited research has been conducted into pregnancy loss within the two spirit, lesbian, gay, bisexual, transgender, queer, plus (2SLGBTQ+) community. This perspective is not well represented in the literature. Understanding pregnancy loss from these populations' perspectives is integral to providing inclusive care to all pregnant people. Wojnar (2007) identified unique challenges experienced by lesbian couples related to pregnancy and pregnancy loss, such as who will be the birth parent, and who will be the social parent or decide on a sperm donor. She also identified those experiences that are not tied to sexual identify but rather are universal when referring to pregnancy loss, such as the sorrow and loss that accompanies miscarriage. Wojnar and Swanson (2006) highlighted the challenges faced by lesbian couples related to miscarriage, including marginalization, given the lack of social normative structures to support lesbian couples in the world of pregnancy and pregnancy loss, which is designed for heterosexual couples. Craven (2019) described similar experiences of members of the 2SLGBTQ+ community, in which the lack of inclusive practices continues to marginalize families during a difficult time.

It does not appear that the experience of Black, Indigenous, and people of colour (BIPOC) is represented in the literature either. It is not clear if this study addresses the

experience of members of the 2SLGBTQ+ community, nor the experience of the BIPOC community. It remains important to gain understanding of their experience and if it differs from that of white, cis-gendered, heterosexual women.

Recommendations for Research, Policy, Practice, and Education

The participants' narrative resources and the typologies of *you're not an emergency* and *seeing the fetus* point to the need to create an intervention to support ED nurses who care for women in the ED. The ED nurses' stories shared for this project contain the framework to develop a grassroots education program led by ED nurses for ED nurses. This education program should be developed based on the tenets of family-centred maternity and newborn care. As such, they should include women and their support persons in the creation of policy and education interventions. In tandem with creating an education program, policies that support ED nurses' education and practice are necessary. Interprofessional collaboration to create education and policy will be essential to provide comprehensive care to women and their support persons.

Future research is also needed to gather the narratives of women who seek care in the ED. These stories could reveal the narrative resources that women use to describe their experience; when examined alongside the ED nurses' stories, the opportunity for mutual understanding and improved care may be realized.

Finally, further research is needed to explore the impact of the ED nurses' visualizations of the fetus to build on this unique perspective. ED nurses' experiences seeing the fetus may offer an opportunity to align their meaning of pregnancy with the women's meaning of pregnancy to facilitate mutual understanding.

Conclusion

Returning to my narrative beginning and reflecting on why I chose to research this topic, I find myself changed. I have spoken of my preconceived notions about what I expected to hear, which arose from my own stories from practice. I addressed these initial expectations through the reflexive practice of thinking with the stories from the ED nurses. I learned three important things from these nurses. First, I learned that miscarriage matters. I knew it mattered, but this work proved to me that the perspectives of women and ED nurses are needed to complete the picture of what happens in the ED for women experiencing early miscarriage. ED nurses care about women who present with a miscarriage seeking care in the emergency department. Second, I learned that ED nurses provide care to women despite a lack of education, resources and space, and a lack of policy and protocol. They work as part of collaborative teams that provide care to women. The ED nurses who shared their stories revealed that they are often in a leadership role in the provision of care to such women but do not necessarily acknowledge their own leadership. Finally, ED nurses need resources to continue to meet the needs of women experiencing a miscarriage. They deserve education, policy, and procedure to support their practice. These resources need to be created with ED nurses.

Ending with Gratitude

This dissertation has been a journey, not only with the stories of the eight ED nurses but with my own stories of caring for women with pregnancy loss. I am grateful for my own stories and my journey as a perinatal ED nurse. I am also grateful to the ED nurses who shared their journey with miscarriage and am humbled to have recorded their stories. Frank (2010) suggested concluding the analysis of stories by writing an appreciation for the story and the storytellers. To that end, I extend a heartfelt thank you to the storytellers. It was a privilege to hear eight ED

nurses tell their stories and share their authentic experience of caring for women experiencing a miscarriage. To quote Brené Brown (2021), “When we deny our stories, they define us. When we own our stories, we get to write a brave new ending.” This research is a beginning, and the brave nurses who shared their stories will contribute to a new ending, one that will hopefully have influence in the lives of other nurses and those who bear children.

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Appendix A

Email Script for Directors of Nursing and Nurse Managers

Hello <INSERT NAME>

Thank you for agreeing to help facilitate participant recruitment for my research study titled, *Coming together: Discovering the narrative of registered nurses who care for women experiencing an early miscarriage.* As per our phone conversation, please find attached an email invitation that can be forward to the registered nurses on your unit. I have also attached a copy of the recruitment poster that I will bring to the unit for display. I am appreciative of the opportunity to have access to your staff to conduct this research. When the study is completed, I will be happy to present the results to you and your staff and look to opportunities to work together to integrate the findings into practice.

Please do not hesitate to contact me at any time with questions and concerns.

Respectfully,

Patrice Drake BSc, RN, PhD(c)
Doctoral Candidate, Faculty of Nursing
University of Alberta
mdrake@ualberta.ca
902-218-3457

Appendix B

Phone Script for Directors of Nursing and Nurse Managers

Hello <INSERT NAME>

This is Patrice Drake.

The purpose of my call today is to talk to you about a research project.

I am a Doctoral Candidate, Faculty of Nursing at the University of Alberta.

- The study is titled *Coming together: Discovering the narrative of registered nurses who care for women experiencing an early miscarriage.* The purpose of this research project will be to hear and understand the stories of registered nurses' caring for women experiencing an early miscarriage.
- This study has received approval from the University of Alberta Research Ethics Board, University of Prince Edward Island Research Ethics Board, and the PEI Research Ethics Board.
- This research will provide an opportunity for better understanding of the real-world experiences of registered nurses caring for women experiencing early miscarriage. The findings are expected to facilitate registered nurses' skills and confidence in providing care for women.
- My purpose in calling is to request permission for access to registered nurses working in the emergency room to participate in a research study about their experience(s) when caring for women who have had an early miscarriage.
- I will be seeking to interview 6-8 registered nurses from across Prince Edward Island who have cared for women experiencing early miscarriage.

- To recruit registered nurses on your unit, I would like to forward an email to you that you could circulate to your staff. This email would contain instructions on how to contact me if any of your staff would be interested in participating.
- I would also like to post recruitment posters on the respective units and these posters would also contain instructions on how to contact me if any of your staff would be interested in participating.
- Do you have any questions about the study?
    - **No**:
        - Would you be willing to help facilitate recruitment and forward an email to the registered nurses on your unit?
        - Would I be able to post the recruitment posters?
    - **Yes:**
        - Answer all questions
        - Would you be willing to help facilitate recruitment and forward an email to the registered nurses on your unit?
        - Would I be able to post the recruitment posters?
- **If yes to being willing to participate:**
    - Thank you very much for your support. I will forward a follow-up email that contains the email for your staff as well as a copy of the poster.
    - I will drop by the unit within the next few days to drop of the posters.
- **If no to being willing to participate**:
    - Thank you for your time.

Appendix C

Email Script for Nurse Participants

Hello

I would like to invite you to participate in a study that asks for the stories of registered nurses who currently work in the emergency room, or have worked in the emergency room, about their experience caring for women experiencing an early miscarriage. Your participation is critical for this study to be a success.

Pregnancy and birth represent significant events in women's lives. It could be argued that the most commonly held belief about pregnancy and birth is that it is a joyful time of celebration. While this may be true for many, it is not true for all women. One experience of pregnancy and birth that may not fit within the joyful, celebratory story is early miscarriage (in this study defined as before or during the 14th week of pregnancy). Early miscarriage as a type of perinatal loss occupies a small portion of the available literature despite the frequency with which early miscarriage occurs. Women and registered nurses report challenges in their encounters related to the experience of early miscarriage and these challenges have been noted to impact care and outcomes.

I am recruiting registered nurses who have stories about their experiences caring for women experiencing an early miscarriage in the emergency department. We are interested in all points of view. The stories may be of your own professional experiences with women or observations of the care provided to women. You will be asked to participate in up to two face-to-face interviews with me. These interviews will last 30-60 minutes.

If you are interested in hearing more about this study or you are interested in participating, please contact me at either 902-218-3457 or mdrake@ualberta.ca

You may also contact my supervisors, Dr. Diane Kunyk, (diane.kunyk@ualberta.ca or 780-492-9264) and Dr. Brenda Cameron (bcameron@ualberta.ca or 780-492-9264).

Sincerely

Patrice Drake BSc, RN, PhD(c)

Doctoral Candidate, Faculty of Nursing

University of Alberta

mdrake@ualberta.ca

902-218-3457

Appendix D

Recruitment Poster

UNIVERSITY OF ALBERTA
FACULTY OF NURSING

Do You Have Any Experience Caring for Women Experiencing an Early Miscarriage in the Emergency Department?

I am a registered nurse and Doctoral Candidate in the Faculty of Nursing from the University of Alberta. You are invited to participate in a study that asks for the stories of registered nurses, who currently work in the emergency department or have worked in the emergency room, about their experience with women who have experienced an early miscarriage (before or during the 14th week of pregnancy).

We are interested in all points of view in our study. The stories may be of your professional experience(s) with women or observation(s) of the care provided to women in these situations.

If you would like to know more about this project or would like to participate, **please contact Patrice Drake at (902) 218-3457 or** mdrake@ualberta.ca

You may also contact my supervisors, Dr. Diane Kunyk, (diane.kunyk@ualberta.ca or 780-492-9264) and Dr. Brenda Cameron (bcameron@ualberta.ca or 780-492-9264)

If you decide to participate, we will arrange an interview (either face-to-face or by telephone) at a time that works with your schedule. Your participation will be held in the strictest confidence. Please also consider sharing this research project with someone you know who may have an experience they would like to tell us about.

Thank you,

Patrice Drake BSc, RN, PhD(c)
Doctoral Candidate, Faculty of Nursing
University of Alberta
mdrake@ualberta.ca
902-218-3457

Appendix E

Interview Guide

Thank you for agreeing to participate in this interview. Your input is essential and invaluable to this project.

The purpose of this interview is to document your experience of caring for women who have had an early miscarriage. I am using a research methodology called narrative inquiry. Narrative inquiry uses stories to understand experiences.

This interview ought to seem like a conversation and should take no more than 30–60 minutes to complete. Also, I may be contacting you a second time to revisit this first interview and further clarify your experience. I am audio-taping the interviews to ensure that what you say is accurately documented.

There is no right or wrong answer as this is your story and your experience. Tell me in a way that is most comfortable for you

Do you have any questions about the project or the consent?

No – Thank you. We can sign the consent and I will give you a copy. I would like to remind you that you can withdraw your consent at any time.

Yes – [*Elicit questions or concerns]* I would be happy to review the consent with you and/or answer any questions you may have about the project. When you are confident that your questions have been answered, you can decide about participating and the consent.

If still no – Thank you for your time. If you change your mind, please feel free to contact me.

Once informed consent has been obtained

I am going to start the audio-recorder now. You may ask to have it turned off at any time during the interview or if you would like a break. Please remember that you do not have to answer any question that you feel uncomfortable with.

Audio-recorder on

I will begin with a question. Please ask if you want to have the question read again.

Opening questions

1. Would you please start by telling me about your role as a registered nurse in the emergency department?
2. Please tell me a story about a time in your practice in the emergency department when you cared for a woman or women, with or without their families, who experienced an early miscarriage.

Probing questions

3. How long did it take you to tell this story as you have just told it?
4. How might others tell this story differently? Do these stories make it easier or harder to tell your story?
5. Would you have liked to have had a different ending to the story?
6. Would you have told this story differently at a different point in your career?

Final question

7. Is there anything else you would like to share that we have not yet talked about today?

Audio-recorder off

Thank you for your time and for sharing your story. I would like to contact you again to revisit this interview and clarify any questions that may arise as I work on my study. Your responses are

confidential, and you cannot be identified; however, after I interview other nurses there may be other questions that I would like to ask you that I didn't ask in this first interview.

Appendix F

Information Letter and Consent Form

UNIVERSITY OF ALBERTA
FACULTY OF NURSING

INFORMATION LETTER and CONSENT FORM

Study Title: Coming together: Discovering the narrative of registered nurses who care for women experiencing miscarriage.

Research Investigator:

Patrice Drake BSc, RN, PhD(c)
Doctoral Candidate
Faculty of Nursing
5-319 Edmonton Clinic Health Academy
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Supervisors:

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Dr. Brenda Cameron, RN
Faculty of Nursing
5-319 Edmonton Clinic Health Academy
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brenda.cameron@ualberta.ca
780-492-9264

You have been invited to participate in a study that asks for the stories of registered nurses' who currently work in the emergency room or have worked in the emergency room about their experience(s) caring for women experiencing an early miscarriage (up to and including 14-weeks gestation). Your participation is critical for this study to be a success.

Pregnancy and birth represent significant events in women's lives. It could be argued that the most commonly held belief about pregnancy and birth is that it is a joyful time of celebration. While this may be true for many, it is not true for all women. One experience of pregnancy and birth that may not fit within the joyful, celebratory story is early miscarriage (in this study defined as before or during the 14th week of pregnancy). Early miscarriage as a type of perinatal loss occupies a small portion of the available literature despite the frequency with which early miscarriage occurs. Women and registered nurses report challenges in their encounters related to the experience of early miscarriage and these challenges have been noted to impact care and outcomes.

This study is recruiting registered nurses willing to share stories about their experience(s) caring for women experiencing an early miscarriage. We are interested in all points of view. The stories may be of professional experiences with women or observations of the care provided to women.

The results of this study will be used to support my dissertation to fulfill the requirements for my Doctor of Philosophy (Nursing).

Purpose
The purpose of this research project will be to hear and interpret the stories of registered nurses' caring for women experiencing an early miscarriage. I believe that these stories will provide an opportunity for better understanding of the real-world experience of caring for women experiencing early miscarriage, which will increase nurses' skill and confidence in providing care for families and improve care for women.

Study Procedures
If agreeing to participate, you may participate in one or more interviews with Patrice Drake.

These interviews will be audiotaped and then transcribed. Your names and other identifying characteristics will not be included in the transcribed interview.

Each interview is anticipated to take 30-60 minutes.

After your interview(s) has been transcribed, your interview will be re-written to remove anything that will identify you. This document will be shared with you so you can choose to clarify or remove any part of the information that you have shared.

Benefits
You are not expected to receive any benefit from participating in this research study. This study's findings may help other registered nurses and the profession of nursing to improve care practices related to early miscarriage.

Risks
There are no anticipated risks if you choose to take part in the interview. It is possible that our discussion may raise uncomfortable memories or feelings. You do not need to answer any questions that you are uncomfortable with.

Voluntary Participation
Your participation in this research project is completely voluntary.

Freedom to Withdraw
After agreeing to be in the study you can decide to withdraw. If you do decide to withdraw, all your information will not be included in the study.

The last date for withdrawing your information will be four weeks following the interview. This is when the interview will have been transcribed and analysis initiated.

Confidentiality & Anonymity
What you say during the interview will be kept confidential within the law, by investigators.

Direct quotes arising from the interview may be used in final reports and presentations but will be stripped of your identifying characteristics. Your story will be presented with the stories of other registered nurses.

All audiotapes and transcripts will be kept locked in a filing cabinet at the University of Prince Edward Island School of Nursing for 5 years and will then be shredded. During this time, only the Principle Investigator and their supervisors will have access.

The analysis and findings of this study will form the foundation for my emerging program of research. It is possible that there may be benefit in re-examining the findings from this study in future work in this field. If so, then the University of Alberta Research Ethics Board 1, the PEI Research Ethics Board, and the UPEI Research Ethics Board will first review the study to ensure the information is used ethically.

Additional Contacts

If you have any questions about the project you can contact Patrice Drake, (mdrake@ualberta.ca), 902-218-3457.

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This study has been reviewed for its adherence to ethical guidelines and approved by the Health Research Ethics Board at the University of Alberta, the Prince Edward Island Research Ethics Board, and the University of Prince Edward Island Research Ethics Board. If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Research Ethics Office at (780) 492-2615, the Prince Edward Island Research Ethics Board at **(902) 569-0576, or the** University of Prince Edward Island Research Ethics Board at **(902) 620-5104.**

Appendix G

Analysis Guide

Consider

- Why did I want to study early miscarriage?
- What did I know about the day to day of the nurse who works in the ED?
- I needed to listen to the stories that called out to be told.

Needed to begin with the narrative resource questions

- What narrative resources do the ED nurses use to shape the story?
- What narrative resources shape how I, as the listener, understand the story?
- How were the narrative resources shared between different nurses or other HCPs?
- What limited the ED nurses' use of those resources, or are they limited in what resources they can use?

Asked the primary resource questions to see what may influence the creation of new resources

- What are the stories that are already circulating?
- What was familiar about those stories (recognizable characters, plot lines, genre choices, and common metaphors)?
- If there were other narrative resources available, would the story have been different?
- Would the ED nurses have had opportunity to pursue a different storyline?
- What prevented the alternative narrative resources from being pursued or introduced?

How did/do the stories circulate within the group?

- Whom did the ED nurses tell their stories to?
- If HCPs are a closed system, how do they tell their stories? What codes do they use?

How are the storytellers linked or what are their affiliations?

- Who were the ED nurses that share a common understanding of the story?
- Who didn't understand the ED nurses' stories or who was rendered an outsider?
- Who was excluded from the "we" who share the story?"

What did the stories tell us about the storytellers?

- How did the story teach the ED nurses who they are?
- How did the ED nurses use the story to explore who they might become?
- I need to remember that stories are made up of stock identities.

What was at stake by telling the stories?

- How did the ED nurses hold their own in the story, by telling the story in the way that they did?

- How did the stories convince the ED nurses of who they needed to be and what they had to do to hold their own?
- I must remember that holding one's own is a response to being vulnerable.
- What made the ED nurses vulnerable?

What typologies or narrative types are revealed to us for this project?

- An iterative process of using the questions above
- Re-reading of both transcripts and answers to the above questions to do the following:
  - Understand how the available range of narrative resources limit the storytellers
  - Assess how well served are the ED nurses by their stories
  - Determine how the typology helps the ED nurses hold their own

What is the ending of THIS story, knowing that there are others to be told?

- Write an appreciation for the story and the storytellers
- Who does this story bring together and who is moved outside by the story (and what is the consequence of this)?
- Recognize the power of imagination to affect people's storied lives.

*Adapted from Frank, A. W. (2012). Practicing dialogical narrative analysis. In J. A. Holstein & J. F. Gubrium (Eds.), *Varieties of narrative analysis* (pp. 32–50). Sage. https://dx.doi.org/10.4135/9781506335117.n3