

A First Miscarriage and the Received Care at the Early Pregnancy Department: Women's Experiences.

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Samenvatting

Een eerste miskraam en de ontvangen zorg op de polikliniek 'Vroege Zwangerschap': de ervaringen van vrouwen.

Achtergrond: Een nieuwe polikliniek is opgezet voor vrouwen met problemen in het eerste trimester van de zwangerschap. Hier worden onder andere vrouwen behandeld voor, tijdens en na een eerste miskraam. Deze vrouwen hebben verschillende ervaringen en de betrokken professionals wilden hierin meer inzicht. Literatuur toont dat vrouwen verschillende gevoelens en gedachten hebben en het lijkt dat 'grief' ook een rol speelt.

Het doel is om meer inzicht te krijgen in de ervaringen van de vrouwen met een eerste miskraam en 'grief' en de ontvangen zorg voor, tijdens en na de miskraam. Zo kan de zorg op de polikliniek 'Vroege Zwangerschap' worden geëvalueerd en geoptimaliseerd.

Methode: De Grounded Theory Design is gebruikt om inzicht te krijgen in de ervaringen van vrouwen, met behulp van diepte-interviews. Vijftien vrouwen werden geïnterviewd. De opgenomen interviews werden letterlijk uitgeschreven. De data is geanalyseerd met behulp van de constante vergelijkingsanalyse.

Resultaten: Er zijn twee reacties in hoe vrouwen een miskraam ervaren. Er waren vrouwen die het accepteerden dat het kon gebeuren en vrouwen die zich verstrikt voelden in gevoelens en gedachten. Voor deze laatste groep speelde 'grief' een grote rol, alhoewel ze dit niet zo benoemden. De ontvangen zorg werd als goed ervaren. De vrouwen voelden zich begrepen en vonden dat de professionals verstand van zaken hadden. Sommige vrouwen misten zorg voor hun psychologische kant en er waren suggesties om de informatievoorziening te verbeteren.

Conclusie: Twee eerste reacties op het hebben van een miskraam konden worden onderscheiden. Deze reacties beïnvloedden de ervaring met een miskraam; de eerst groep vrouwen kon de miskraam snel achter zich laten en voor de andere groep was dit moeilijker. Voor hen speelt 'grief' een grote rol na de miskraam. De ontvangen zorg op de polikliniek wordt als fijn en begrijpelijk ervaren. De vrouwen waren blij dat deze polikliniek bestaat, alhoewel er suggesties waren om de zorg te optimaliseren, zoals aandacht voor de psychologische kant.

Trefwoorden: ervaringen – vrouwen – eerste miskraam – ontvangen zorg – kwalitatief.

Abstract

A First Miscarriage and the Received Care at the Early Pregnancy Department: Women's Experiences.

Background: A nurse-led outpatient department was established for women with problems in the first trimester of their pregnancy. Here, professionals see, among others, women before during and after a first miscarriage. These women have different experiences and the professionals wanted more insight in these experiences. Literature shows these women have different feelings and thoughts, in which grief seems to play a role, but in what way remains unclear.

The aim is to learn more about the experiences of the women with first a miscarriage and grief and with the received care before, during and after the miscarriage and so to evaluate and optimise the care given at the 'Early pregnancy' department (EPD).

Method: Grounded Theory Design was used to gain insight in women's experiences, using in-depth interviews. Fifteen women were interviewed and these were recorded and transcribed verbatim. Data was analysed using constant comparative analysis.

Results: There are two reactions in how women experience miscarriage. There were women who accepted it could happen and women who felt entangled in feelings and thoughts. For this last group of women grief played a great part in their experience, although they did not name it that way. The received care was experienced as good. The women felt understood and the professionals were knowledgeable. Some missed care for their psychological side and there were suggestions to improve information services.

Conclusion: Two first reactions on having a miscarriage could be defined. These reactions influence the experience with miscarriage, because the first group of women could leave the miscarriage behind and for the other group this was harder. For them, grief plays a great part in the first time after miscarriage. The received care at the EPD is experienced as good and understanding. The women were glad this special department exists, although there were suggestions for optimising care, like attention for the psychological side.

Keywords: experiences – women – first miscarriage – received care – qualitative

Introduction

The most common problem in the first trimester of a pregnancy is bleeding, which occurs in 20% of all known pregnancies. Research shows that over half of these miscarry (Everett 1997). An academic hospital in the Netherlands established a nurse-led outpatient department for women with problems in the first trimester of their pregnancy. This 'Early Pregnancy Department' (EPD) was set-up because professionals indicated these women need special care. Different groups of women are seen; women with a first or a recurrent miscarriage or with hyperemesis. This study focuses on women with first miscarriage, because this group is underexposed in literature.

All care is integrated, so specialised nurses do ultrasounds of early pregnancies and counsel women in choosing a type of management for miscarriage. There are three types of management: surgical management, to evacuate the miscarriage; medical management, to induce the miscarriage with medication; expectant management, to wait for a spontaneous miscarriage (Ankum et al. 2001). The given verbal or written information at the EPD is described in table I. *Insert table I here.*

The women are guided throughout the whole process of miscarriage; before, during and after. 'Before' is the pre-miscarriage period, in which the woman is uncertain of the viability of the pregnancy. 'During' is the period during the miscarriage. 'After' is the post-miscarriage period, in which she recovers from the miscarriage and its implications. The nurses working in this department acknowledged that women have different experiences within the three time-periods. They think would be helpful to know these experiences, to optimise their care.

In 2008 a patient satisfaction survey for women who attended the EPD was conducted. They could rate 19 questions between one and ten. All ratings were above eight, except for waiting time (7.8). In one open question, women could give their comments, which were positive. The topics included accessibility, telephonic consultations, waiting time at department, treatment by nurses and doctors, provision of information, involvement & respect and overall impression. The questions were broad and general and did not address physical and emotional reactions before, during or after miscarriage. So the experiences of women remain unknown.

One emotional reaction around miscarriage is grief. This is acknowledged in the department and seen in literature about miscarriage. Brier (2008) describes grief following miscarriage in his review and defines that 'grief' refers to the affective, physical and psychological reactions to the loss of an emotionally important person. After a miscarriage women display symptoms of grief, like low self-esteem and feelings of hopelessness (Brier 2008). Nevertheless, the review focused on quantitative studies and does not capture the experiences of women. It only addressed grief after miscarriage, and not before or during, as provided at the EPD.

In a complementary literature review, focused on miscarriage and associated grief, 20 qualitative studies were found. It shows that having a miscarriage is complex and emotions like grief play an important part before, during and after the miscarriage. Also physical and psychological reactions take place (Adolfsson et al. 2004, Corbett-Owen and Kruger 2001, Harvey et al. 2001, Maker and Ogden 2003). Searching for a cause of their miscarriage, women often blame themselves (Abboud and Liamputtong 2003, McCreight 2007, Murphy and Merrell 2009). Some women mourn after their loss and create rituals or memories to deal with their loss (Gerber-Epstein et al. 2009, McCreight 2008, Smith et al. 2006).

The received care during or after miscarriage provided by professionals is experienced differently. Women did not talk about the received care before their loss. Mostly negative experiences, such as not feeling understood or not feeling heard, predominate (Gerber-Epstein et al. 2009, Simmons et al. 2006, St John and Cooke 2006). All studies took place in different countries, like United States, United Kingdom, Ireland and Israel; it is difficult to transfer the results, because of different healthcare systems.

Receiving the bad news is a shock for the women. In all studies the doctor told the bad news, and sometimes the women felt no respect for their feelings (McCreight 2008, Paton et al. 1999, Simmons et al. 2006). According to the women, professionals do not understand them nor show empathy, during the miscarriage (St John and Cooke 2006, Wong et al. 2003). The provision of information during and after the miscarriage is poor, women do not know what to expect or how to obtain support (McCreight 2007, Paton et al. 1999, Smith et al. 2006).

There is little literature about received support beside the healthcare and the information is contradictory. Received support from a partner is experienced by some women as helpful and positive, while others felt left alone (Abboud and Liamputtong 2005, Gerber-Epstein et al. 2009).

The design and level of methodology of the studies are weak. The samples were specifically aimed at distinct groups of women, namely lesbian couples, women with fertility problems, Afro-American or Israeli women. Participant recruitment was not, or in little detail described. Furthermore they give no insight in the method of data analysis and do not mention data saturation.

Problem statement

Problem and aim

In practice a link is seen between having a miscarriage and grief, which is reflected in the literature. Women with a miscarriage have multiple experiences before, during and after the miscarriage. Integrated, specialised care for these women is the goal of a new outpatient department in the Netherlands. In 2008 a patient satisfaction survey

was conducted with positive results, but it was broad and general. It is not exactly known how women experience the care of this outpatient department.

This study is executed to describe and understand the experiences of the women with first miscarriage and grief and with the received care before, during and after the miscarriage. This helps to evaluate and optimise the care given at the outpatient department 'Early pregnancy' for women with a first miscarriage, which is the aim.

Research questions

- What is the experience of women who have had a first miscarriage before, during and after their miscarriage and what is the role of grief in this experience?
- What are their experiences with the care they received at the outpatient department 'Early pregnancy'?

Method

A qualitative approach based on 'grounded theory' was used. This study strives to understand the women's experiences and the role of grief within them. The outcome of the grounded theory approach is a full conceptual description of the problem, which fits this study (Polit and Beck 2008, Strauss and Corbin 1990). The study was approved by the ethical committee of the outpatient department's hospital.

Participant recruitment

Women were eligible if they visited the outpatient department between January 2010 and September 2010 for a first miscarriage; spoke and understood Dutch; aged 19 years or older; have had one miscarriage (≤ 14 weeks pregnancy) and had viable pregnancy signs (a heartbeat or a crown-rump length > 6 mm) before the miscarriage. Data saturation was tried to be obtained, by creating a diverse sample with regard to gestational week and number of successful pregnancies.

The eligible women were approached by an information letter. If interested, a woman could send a return-form and was called by the researcher for further information. If she was willing to participate, an interview appointment was made. At the beginning of the appointment, written informed consent was obtained.

Data collection

Semi structured in-depth interviews, which consisted of both a topic-list and open questions, were used to explicit the women's experiences, fitting grounded theory. Table II shows the topic-list and open questions, both based on previous studies. The interviews were held at the most convenient place for the women. Usually this was at the women's homes, sometimes in the hospital. The interviews lasted 30 – 60 minutes. *Insert table II here.*

During data collection memos were made, containing reflections about interpretations and methods to show context of the interviews and enhance the transferability of the study. The interviews were conducted by one researcher (W.F.), who is unconnected to the outpatient department, to enhance authenticity.

Data analysis

All interviews were audio-taped, transcribed verbatim and imported in MAXQDA 10 (Belous 1995-2010), to support the analysis. Data were analysed using constant comparison analysis, which helped to see when data saturation was reached. Data were analysed by one researcher (W.F.), and discussed with a senior researcher (C.G.), to obtain confirmability and credibility.

After three interviews, the open coding started. A code-tree was developed after which the axial coding started. During the analysis the researcher alternated between open and axial coding. Data were analysed concurrently with the interviews. This way insight from analysis was used to guide further data collection, and the credibility of identified themes was checked in subsequent interviews. During selective coding, gaps in some categories occurred, which were filled during new interviews.

Results

Participants

From January 2010 until September 2010, 510 women visited the department. A first selection eliminated the multiple miscarriages and left 95 possible participants with a first miscarriage. However, only 76 medical records were retrievable and checked on two other inclusion criteria: having no fertility problems and presence of viable signs. 39 women met all criteria and were sent a letter. A reminder was used to get maximum response. Of the women who declined, nine gave a reason; recall of unpleasant memories or a new pregnancy at that moment.

Fifteen women were interviewed 0.5 until 1.5 years after their miscarriage. Table III shows the diversity in the demographic data of the women, which helped to reach data saturation. The ages varied from 31 to 42 years. The gestational period at the time of miscarriage varied from 7 to 12 weeks. *Insert table III here.*

The findings are presented in two categories: 'experience with miscarriage' and 'experience with received care'. For both categories, the findings are clustered in the three time-periods; before, during and after.

Experience with miscarriage

The experiences of the women were influenced by their personal context. For example, if a woman had an unstable relationship, this influenced her experiences with the miscarriage. This also goes for women who had a successful pregnancy after their miscarriage. Still, there are similarities between the experiences of the women.

Before

The women reacted in two different ways, when they heard they lost their pregnancy. Three women thought: 'Okay, that was it'. These women aborted after seven or eight weeks and did not 'see' the pregnancy on the ultrasound, because the miscarriage had taken place before they got to the department. They were miserable about losing their pregnancy, but accepted it as something that could happen. It was their first pregnancy.

Others described the period after hearing the news as feeling engaged in a tangle of feelings and thoughts. Some called it an *'emotional rollercoaster'*; a wave of emotions, both positive and negative. These women were at or past the ninth gestational week. After hearing the news the feelings rapidly alternated and contradictory thoughts crossed their minds. They realised their pregnancy was over and disbelieved; the women still felt pregnant, but knew they were not. They thought of all the plans they had made for the future, which were cut short. *'It's like; you have a department sadness, a department anger, a department acceptance, a department 'open door'. That's how I name it. And it's like this, they alternate with one another.(..) Sometimes they are all gone, and sometimes they are there all at once.'* (No 9)

A recurring question for most women was 'Why?'. 'Why did my pregnancy fail? Could I have prevented it?' Some also felt disappointed in their own body and felt failing as a woman. Over time, women could answer these questions and feelings. There is no characteristic or contextual distinction between the women who asked these questions and who did not.

Although the time between hearing the news and having a miscarriage is difficult, most of the women who felt confused, also experienced it as valuable, because they could 'say goodbye' to their unborn child. They could get used to the idea not being pregnant and not having a baby. *'In fact, I think that waiting, for me, was better than having the miscarriage all at once. (..) And now I can already prepare for the loss'* (no 2)

During

During the miscarriage, the type of management caused different experiences. Accepting the miscarriage could happen or having entangled feelings and thoughts, was seen in all types of management.

Five women chose to wait for a spontaneous miscarriage and physically felt the miscarriage. These women felt a kind of 'pop', blood ran down their legs and felt pain. They were prepared by the EPD for what could happen and knew what to expect. During the miscarriage these women were concentrating on the physical aspects. For two women, the miscarriage did not come spontaneously and they had a surgery.

Five women opted for medication, which was experienced differently. One woman felt nothing and did not notice she 'lost her pregnancy'. Other women felt like they were giving birth, with contractions and found it horrible. They did not expect it would occur like this. *'And then I thought, according to me I just had a contraction and I had the*

idea really had to go to the toilet., I had a sort of delivery! Unprepared. (...) I missed not knowing how to prepare, like 'now you can expect this and that means this' (no 8)

Seven women had a surgery to evacuate the pregnancy and did not literally feel the miscarriage. Before the surgery they still felt pregnant and this felt incompatible with the fact that they were about to let their unborn child be evacuated.

After

After the miscarriage the women handled differently. The women who could accept the miscarriage, put it behind soon. They focused on the future and soon went back to work. They tried to become pregnant again, often successfully. They said they went on with their life one to two months after their miscarriage. *'After the first week, then, it was just a little bit less, and less and less and then I did not think about it anymore'(no 4)*

For the women who felt entangled, the feelings and thoughts endured longer. They were home for one to six weeks. After two to three months, they were slowly feeling better. They found it hard to look at other women who were pregnant or had a newborn baby. It hurt to see the happiness of these women and it brought back the memories of their own loss. *'You're sad it did not go well and then you're visually confronted with it' (no 1)* For most women these feelings endured six months, mostly the pain faded away after the due date of their lost pregnancy or after becoming pregnant again.

Most women did something to deal with their loss. The things they did differed, due to personal interests. Some women went on vacation with partner or family, others preserved memories by writing down their experiences or paste in the photos of the ultrasound or burned a candle in church for their lost pregnancy.

The impact of the miscarriage is the same for all women. Eventually they feel like their 'old self' again, with more life-experience. They always carry it with them and they are more conscious of life's value. They are more aware of the risks of pregnancy. Becoming pregnant again, did not affect the impact of the miscarriage, but it helped to get over it sooner. Eight women had a new pregnancy after their miscarriage. These women told they were more cautious at the beginning of their new pregnancy and could not be as happy as with the first pregnancy. Some started to feel happy after the first ultrasound. For others the whole pregnancy was tense. They all said that it would have been worse for them, if that pregnancy also would have failed. *'Jeh, I was not very happy with it, right away. I found it very difficult to be glad again with that pregnancy...well, I was glad, but not happy.'*(No 15)

Support

All women had non-professional support. The support before and during the miscarriage came from people in their close environment, like a partner, priest or mother. This special person was with them and listened to them. It was not always that this person felt the same or reacted the way the women wanted, but the fact that the

person was there, counted. Most support was experienced after the miscarriage. Then, friends, colleagues and acquaintances also played a role.

All women said they needed someone to listen to them and understand them. They wanted to tell their stories. Some women also needed physical signs of support, an arm around them or being held for a while. *'I need someone who listens, that is support for me.'*(No 6)

The reactions from other persons in the women's environments varied. Sometimes the women could share their emotions with friends, which they experienced as support. When people in their environment reacted strange, the women could understand and talk this out, but it also hurt them.

By talking to others about their experiences, the women discovered that there are more women who had a miscarriage, which bonded them. No-one sought contact with a patient organisation, but some searched the Internet. Reading the stories of other women made their own experience less difficult to bear.

Experience with received care

Before

Most women were first seen in another department or hospital, and afterwards in the EPD. So they did not hear in the EPD their pregnancy had stopped, and the experiences were diverse. Some experienced it as terrible, because the professional who told the news did not take their feelings into account. These women felt left alone. Other women experienced that the professional who told the bad news, did it with compassion and respect for their feelings. *'My experience wasn't very nice with the location where the first ultrasound was done. The women responded like a factory production line worker: "here is your baby, but something isn't right. You can go back to the waiting room and you'll get more information" '* (No 5)

Once the women came to the EPD, they were pleased that they did not have to wait among other pregnant women with 'thick' bellies. The existence of a special department, made the women feel less abnormal or alone. The women felt that the professionals were knowledgeable, professionally concerned and took time for them. *'They were all very understanding, they wanted to talk. If anything happened, then I could call. I didn't have to call, but I thought it was good that they said this. Just like an outpatient department that is located in a separate area and the women that you see in the waiting room, they all have the same situation as me. '* (No 3)

There were also negative experiences. Four women missed psychological care, which was not associated with demographic characteristics. These women felt no recognition for their feelings and missed information about where to go for psychological help. *'I sat there with tears in my eyes and according to me the person didn't really know how to respond. (..) I could have used more help with the psychological aspects, I think that would have been good, even if it is just a referral to someone else'* (No 8) One woman felt the nurse and the doctor were not taking the same line, concerning the type of management. She felt she had to defend herself against the doctor.

The information services before the miscarriage were good; the women were able to choose a type of management. One woman missed having statistical data about the risks. During the verbal information, most women felt understood. They stated that after hearing the news, their mind was overwhelmed with thoughts, and they could not remember all the information. They were glad they got written information, to reread at home. Some women were alone at the EPD and wished they were told to bring someone.

During

According to the women, the care during miscarriage was good. The women who choose for expectant management got information about what to expect and what is normal, but could not remember if it was written or verbal information. They had telephone numbers they could call for questions or if something was wrong.

Women who choose for medication had varying experiences. One woman did not know what to expect during the miscarriage; she received minimal verbal and no written information. Others thought the information was not specified enough, but they thought it was nice they could call the EPD during their miscarriage. *'I thought it was really horrible with those pills, and the pain and the blood. And emotionally I found it very difficult too.'* (No 14)

The women who had an surgery, experienced the received care as careful. One woman said there was no privacy in the room before the surgery room, but she did not experience it as offensive.

After

Most women could not remember much of the care after the miscarriage. Four women could recall a telephone call from the EPD in which the professional asked how they were doing. They found this pleasant, because they had the opportunity to ask questions. Two women called respectively two and 11 months after their miscarriage and felt put-off, especially since they were told to call if there was something wrong.

The women were unsure if more professional care after the miscarriage was necessary. They did not miss it, but they also could not tell how the period after the miscarriage would have been, if there had been professional care. They also could not tell what that care should contain. *'Perhaps it would have helped me if they had called again and asked "How are you doing, how's it going?" Something along those lines.'* (No 1)

All women had suggestions to optimise the care. These suggestions were diverse, like improvements for information services and informing other organisations about the impact of a miscarriage. Table IV shows what information services are experienced by the women and what might be improved. *Insert table IV here.*

Discussion

This study indicates a distinction in women's experiences before, during and after miscarriage. There were women who felt engaged in a tangle of feelings, emotions and thoughts. They found it harder to go on with life. Other women felt sad with the miscarriage, but accepted it and moved on with life more quickly.

Almost all women said they received care at EPD was good. They felt understood and felt that the professionals were knowledgeable. Some women missed psychological care before, during and after the miscarriage and felt no recognition for their feelings.

Translating the data caused some difficulty, because the interviews were held and transcribed in Dutch, but the writing is in English. To catch the essence of the women's words, the translation was separately done by two persons, of which one is a Native American speaker. This way, the credibility of data presentation was enhanced.

Because of the vulnerability of the women, permission had to be requested to contact them. This delayed the data collection, but did not affect the results, because data-saturation was still reached, which contributes to the transferability and credibility of the study. The women who did not want to participate, gave fair reasons, like recall of unpleasant memories.

A limitation of this study is the age of the women. All women were older than 30 years, where in other studies, also younger women participated (Maker and Ogden 2003, Simmons et al. 2006). This might affect the transferability, but in the named studies, the majority was also older than 30 years.

This study shows that the EPD, compared with previous studies, is an improvement for women with first miscarriage. Literature indicates that women found it hard to wait among pregnant women, when they are not (Corbet-Owen and Kruger 2001, Gerber-Epstein et al. 2009). It also showed that doctors and nurses mostly do not know how to react and women miss understanding for their feelings (Abboud and Liamputtong 2003, Corbet-Owen and Kruger 2001). The EPD has improved this and women value it, but there are still parts to optimise.

First, the stories of the women about the professionals did not always match. Some women felt understood and recognition for their feelings, while others missed care for their psychological side. This might be a result of different approaches of the different professionals working in the department.

Second, some women wished they were told to bring someone with them to the EPD, when they made the appointment, because the women who were alone, missed someone to share their experiences with.

Third, there were much suggestions made for improvement of the information services. The women could not always remember if and what kind of information they received. Others said it was too minimal. This corresponds to the literature, in which women tell they miss good information (McCreight 2008, Paton et al. 1999). Table IV shows what women wanted to improve.

In literature concerning experiences with miscarriage, no distinction is made between the time-periods before, during and after. Mostly, only the period after miscarriage is mentioned. Looking at the feelings and thoughts after miscarriage, there are similarities between this study and the literature. Some women felt engaged in a tangle of feelings and thoughts (mixed-up), some even named it an 'emotional rollercoaster'. This is also seen in literature (Adolfsson et al. 2004, Corbet-Owen and Kruger 2001, Harvey et al. 2001).

In the introduction grief after miscarriage was defined (Brier 2008). Although women in this study do not mention the word 'grief', the definition of affective, physical and psychological reactions to the loss of a miscarriage can be recognised in the women's description of their feelings after a miscarriage. They were in pain, felt miserable and asked themselves 'why?'. These are all notions of grief, which endured a while before women could go on with life. Some women, however, did not feel mixed-up after their miscarriage and went on with life very soon. This distinction in reactions is not explicitly mentioned in other literature.

One article describes women's experiences with the management types for miscarriage (Smith et al. 2006). It states that the experiences vary widely. This partly corresponds with the experiences of the women in this study. In the literature the medical management is under-exposed, while in this study it caused the most negative experiences.

Conclusion

Two reactions on having a miscarriage were defined. There were women who accepted that it could happen and women who felt entangled in feelings and thoughts. This first reaction influences the experience with miscarriage, because the first group could leave the miscarriage behind and move on with life, while this was harder for the other women. These felt a wave of feelings, including sadness, disbelief and disappointment in their own body. For them, grief played a great part in their experience, although they did not name it that way. They needed time to deal with their loss before they could go on with life.

The received care at the Early Pregnancy Department is experienced as good and customised. The women felt that the professionals were knowledgeable and had time for them. They were glad this special department exists. There were also suggestions to optimise the care, like more psychological aid for the women and extending information services.

Recommendations

It would be good for the professionals working in the department, to read the transcripts of the interviews. This will help them to understand these women.

Furthermore, the information services should be improved and extended. Most of all, it is important to have consistency in the provision of information, because there were women who got verbal and/or written information and women who did not. According to their stories, the content of the received information also varied.

There are also recommendations for new research. Firstly, there seem to be two reactions on having a miscarriage. These reactions seem to predict the way how women deal with the consequences of their miscarriage. Whether it is indeed a predictor and in what way, should be further investigated.

Secondly, women's experiences with the different management methods should be studied. It is clear, from this and previous studies, that women's experiences vary. How this influences their process of dealing with the miscarriage, however, is not.

In short, this study is the first in giving insight in women's experiences with a first miscarriage and with received care at a specialised department. It will help to understand the women, but more research is necessary to give these vulnerable women the best possible care.

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Appendix

Table I Information services at EPD

	Verbal information	Written information
Before making a choice for a type of management	<ul style="list-style-type: none"> ➤ Explanation of the three types of management (spontaneous, medication or operation) with advantages and disadvantages. ➤ Answer questions from the women. 	Brochure: 'Miscarriage or loss of blood' with information about: <ul style="list-style-type: none"> - Causes of vaginal loss of blood - What is (the chance of) a miscarriage? - Examination of the body - Types of management (spontaneous or operation) - When to call for medical help - Emotional recovery - A subsequent pregnancy - Help organizations and books.
After making a choice	<ul style="list-style-type: none"> ➤ Explanation of what to expect when the womb empty itself spontaneously. ➤ Answer questions from the women. 	
	<ul style="list-style-type: none"> ➤ Explanation of how to use the medication and what to expect when the womb empties. ➤ Answer questions from the women. 	
	<ul style="list-style-type: none"> ➤ Explanation of further procedure for the operation. ➤ Answer questions from the women. 	Brochure: 'Day care unit' with information about: <ul style="list-style-type: none"> - Preparation - Day of operation - After the operation <ul style="list-style-type: none"> ○ What to expect after operation? ○ When contacting the hospital? Brochure: 'Sedation' with information about: <ul style="list-style-type: none"> - Sedation <ul style="list-style-type: none"> ○ What is sedation ○ Effects - Procedure around sedation - Complications and side effects - Recovery

Table II Interview questions and topic list

Question 1	What was your experience with the received care at the 'Early Pregnancy Department' around your miscarriage?	
Question 2	How was having a miscarriage for you?	
Experience with received care	Experience with miscarriage	
Provision of information	Emotions/ feelings/ thoughts	
Bringing the 'news'	Grief	
Counselling by the department	Actions/ Rites	
Received care before miscarriage	Blame	
Received care during miscarriage	Timeline/ During of emotions	
Received care after miscarriage	Continuing of life	

Table III Socio-demographic data of the sample

Nr.	Age	Gestational week at mc.	Viable signs seen by woman	Management of miscarriage	Nr. successful pregnancies	Pregnant at interview
1	32	12 weeks	Yes	Spontaneous/ Surgery	0	No
2	38	9 weeks	Yes	Spontaneous	2	No
3	35	11 weeks	Yes*	Spontaneous/ Surgery	1	No
4	31	8 weeks	Yes	Surgery	1 after mc.	No
5	30	10 weeks	Yes	Surgery	0	No
6	38	7 weeks	No *	Medication	1 after mc.	No
7	32	7 weeks	No *	Spontaneous	1 after mc.	No
8	36	10 weeks	Yes	Medication	0	Yes (6 months)
9	42	9 weeks	Yes	Surgery	3	No
10	33	10 weeks	Yes	Surgery	1	Yes (5 weeks)
11	32	12 weeks	Yes	Spontaneous	1 after mc.	No
12	38	9 weeks	Yes	Medication	2	No
13	37	10 weeks	Yes	Surgery	2	Yes (5 weeks)
14	39	10 weeks	Yes	Medication	2	No
15	35	10 weeks	Yes	Medication	1 after mc.	No

mc. = miscarriage; *these women lost their pregnancy between the visit to the midwife and the visit to the EPD

Table IV experienced information services and suggestions for improvement

	Experienced information services	How to improve information services
Before miscarriage: <i>Making a choice for a type of management</i>	<ul style="list-style-type: none"> - Got all arguments to choose among the types of management with advantages and disadvantages. (verbal information) - One woman missed written statistical data about the risks of the management types. - One woman missed being told to bring someone with her to the EPD. She was alone and wished she had brought her partner. 	<ul style="list-style-type: none"> - The statistical data about risks of management types is at EPD in written information, so it must be clearer distributed with verbal support. - When women come first to the EPD, they should be told to bring someone with them.
During miscarriage:		
<i>Spontaneous</i>	<ul style="list-style-type: none"> - Women found information good and useful. Could not remember if it was verbal or written. 	
<i>Medication</i>	<ul style="list-style-type: none"> - One woman found information was minimal and only verbal. Missed information about what would happen if miscarriage began. 	<ul style="list-style-type: none"> - Provide women who opt for medication with a brochure with information about what to expect when the miscarriage begins and support the brochure with verbal information.
<i>Operation</i>	<ul style="list-style-type: none"> - Women found information was good and sufficient. They were glad they got written information, because they could not remember the verbal information when they were home. - The women have a lot of questions, but their head is full of thoughts and therefore they do not hear the answers. 	<ul style="list-style-type: none"> - When providing verbal information, keep in mind that a woman's head is full of the news her pregnancy stopped. She has a lot of questions, but will not remember the answers.
After miscarriage:	<ul style="list-style-type: none"> - Women do not remember they got any information about what to do or how will it be after the miscarriage or where can I seek more help? 	<ul style="list-style-type: none"> - This information is written in the brochure 'A miscarriage or loss of blood'. The nurse might tell what is in the brochure, so the women know where to find it.