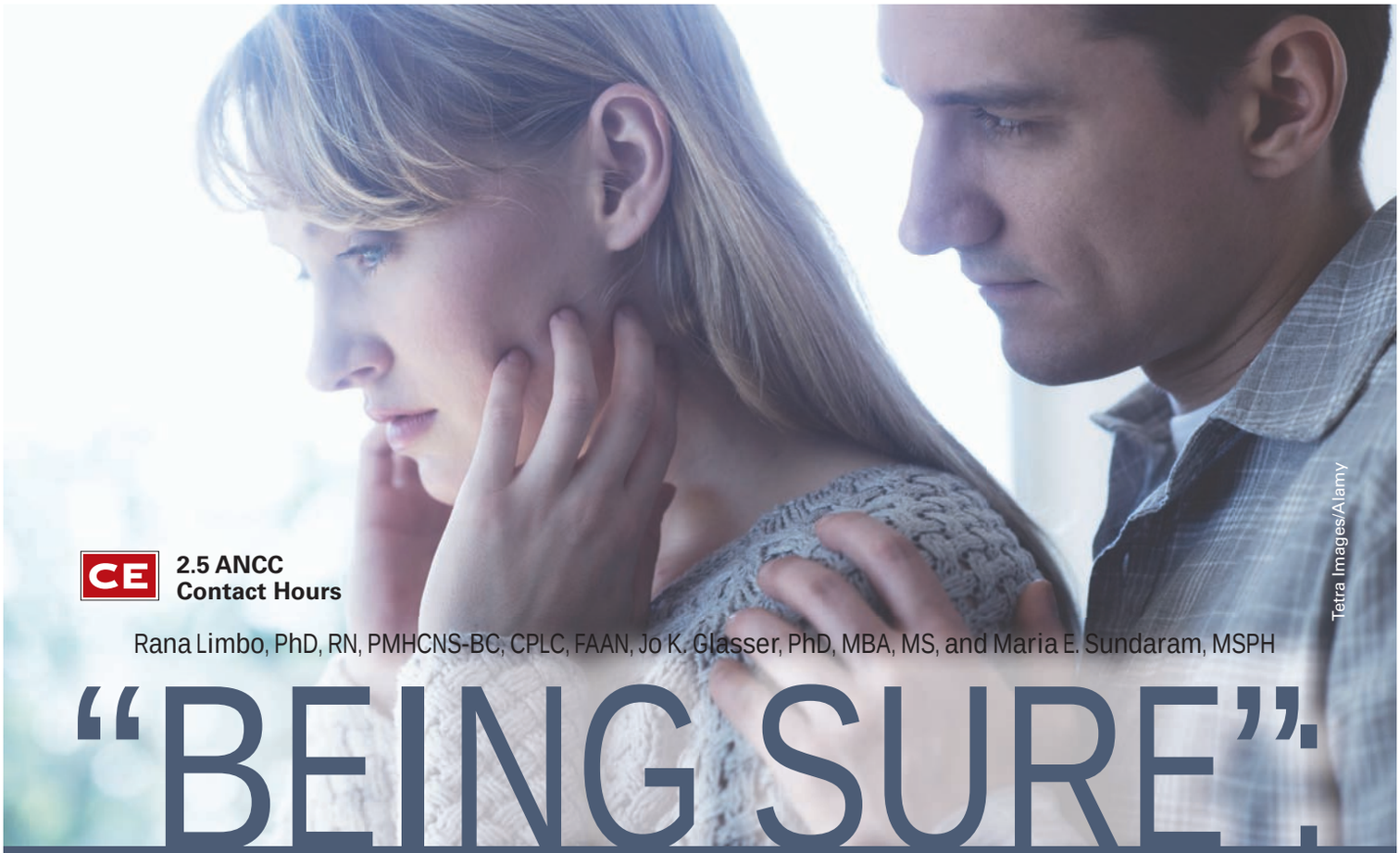

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CE **2.5 ANCC Contact Hours**

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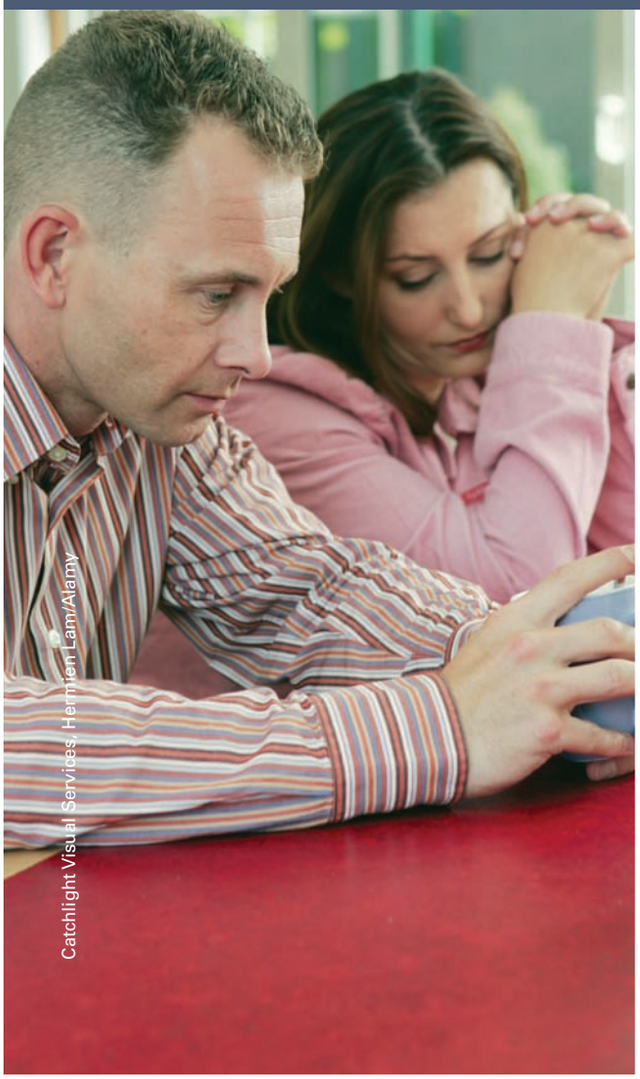
"BEING SURE".

Women's Experience with Inevitable Miscarriage



Catchlight Visual Services, Hermien Lam/Alamy

Abstract

Purpose: To extend understanding of women's experience of miscarriage by exploring their approach to decisions about what to do after learning a miscarriage was likely.

Study Design and Methods: Using dimensional analysis, a technique generic to grounded theory, we analyzed interview transcripts of 23 women who experienced miscarriage (before 14 weeks gestation) at a midwestern medical center. We explored women's experiences by focusing on (1) how they came to know they were having a miscarriage and (2) how they decided what to do next. Both are key, yet relatively unexplored, constructs of early miscarriage.

Results: *Being Sure* emerged as the central process for women as they made decisions about what was happening to them, and about their treatment options. Participants needed to be sure that they were having a miscarriage (that the pregnancy was truly over), and also be sure that they were choosing the right treatment option for them (surgical, medical, or expectant management).

Clinical Implications: Nurses caring for women in the throes of an inevitable miscarriage can use the information in this article to support women in their quest toward Being Sure. Helping women thusly encompasses assisting women to understand their symptoms, come to terms with the inevitability of the pregnancy loss, and be comfortable with which treatment they choose for the miscarriage.

Key words: Certainty; Medical decision making; Miscarriage; Qualitative; Ultrasound

This article details a research project aimed at finding out what women who experience an inevitable miscarriage go through in making treatment decisions. Women in the first 14 weeks of pregnancy may learn their pregnancy is not progressing as planned due to symptom recognition (e.g., bleeding, cramping, absence of the usual signs of pregnancy), or through technology (absence of heartbeat or fetal tissue on sonogram). The latter is generally more compelling and leads women to work with their healthcare provider (HCP) to determine what to do next. The former, although not as compelling, still often results in the woman calling her HCP, or adopting a vigilant "watch and wait" stance. The stories told by these women provide nurses, physicians, nurse midwives, and others who care for them with a poignant reminder that the experience for women is rarely "just a miscarriage" and that treatment decisions are made amidst shock and grief.

Miscarriage, also referred to as a spontaneous abortion in much of the medical literature, denotes a nonvoluntary ending of a pregnancy prior to 20 weeks gestation (Cunningham et al., 2010, 2005, 2001; Silver, Branch, Goldenberg, Iams, & Klebanoff, 2011). The term "spontaneous abortion" may be stigmatizing due to its use of the word "abortion," which for most people implies ending a pregnancy by choice. In response, several influential medical organizations (American College of Obstetricians & Gynecologists, American Society for Reproductive Medicine, Royal College of Obstetricians & Gynaecologists) use the term "miscarriage" in written information for both providers and patients when referring to early, nonvoluntary pregnancy loss (see www.acog.org; www.asrm.org; www.rcog.org). Miscarriages are often clinically categorized as "threatened," "inevitable," "incomplete," or "missed" (Cunningham et al., 2010, 2005, 2001). In this article, we focus on inevitable, or certain, miscarriage. Between 10% and 25% of confirmed pregnancies end in miscarriage (Silver et al., 2011), with 87% of miscarriages occurring in the first 10 weeks (Goldstein, 1994).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Although significant interdisciplinary literature exists regarding women's experience of miscarriage, how women facing an inevitable miscarriage choose a treatment option has yet to be explored. The purpose of this article is to extend understanding of women's experience of miscarriage by exploring their approach to decisions about what to do after they have learned they would likely have a miscarriage.

When faced with inevitable miscarriage, women have three treatment options:

- wait for miscarriage to occur spontaneously (expectant management);
- undergo a surgical procedure (suction curettage); or
- use medication (misoprostol) to hasten the miscarriage.

Schauberger, Mathiason, and Rooney (2005) found that among women with a nonviable pregnancy (diagnosed by endovaginal sonogram after first-trimester bleeding), 41% chose expectant management, and the remaining 59% chose surgical intervention. The decision is a difficult one for many women and may have persistent and pervasive psychological consequences (Neugebauer et al., 1992; Wieringa-de Waard et al., 2002) because the consequences of decision making at the time of a miscarriage extend well beyond short-term treatment. Feeling coerced or rushed can lead to regret and increased stress (Mozingo, Davis, Thomas, & Droppleman, 2002). Despite physicians' personal preferences for how to manage an inevitable miscarriage, no research exists that suggests that any one option is preferable to the other two in the absence of a preexisting medical condition in the woman.

Many researchers, however, have illuminated the breadth and depth of what women and couples experience with miscarriage (Côté-Arsenault & Dombeck, 2001; Hutti, 1992; Murphy & Merrell, 2009; Swanson, 1999; Swanson, Chen, Graham, Wojnar, & Petras, 2009; Swanson-Kauffman, 1986; Wojnar, Swanson, & Adolfsson, 2011). Swanson's work in the 1980s led her to develop the term *meaning of miscarriage* (1999), which emphasized the variety of complex and nuanced cognitive, emotional, and spiritual dimensions of miscarriage. For example, Swanson noted that women experiencing miscarriage may have feelings of physical pain, guilt, grief, or being cheated; or, some may view miscarriage as a positive life experience. In a study of 87 women, most of whom miscarried in the first trimester, approximately 75% believed the loss of their pregnancy was the loss of a baby, implying personhood to the pregnancy (Limbo & Wheeler, 1986); these findings were also described by Hutti (1992). The extent of the meaning of a miscarriage is underscored by the degrees of personhood, which parents

"When we had decided to go through with the D&C, it was the night before the surgery and my husband said to me, 'Are you sure that their equipment wasn't wrong? . . . Is there a chance that you're still pregnant and we're . . . almost aborting our baby?'"

who have experienced a loss in the past attribute to the current pregnancy (Côté-Arsenault & Dombeck, 2001). For some parents, this meant honoring the life of their expected child by holding a memorial service or funeral.

Following miscarriage, women may also fear future losses (Côté-Arsenault, Bidlack, & Humm, 2001), have a higher incidence of depression than women who have not had a loss (Neugebauer et al., 1997), and suffer emotional distress in the face of a widespread cultural belief that early pregnancy loss is a minor life event (Wojnar et al., 2011). Wojnar et al. (2011) advanced theoretical and clinical knowledge about miscarriage in their creation of a conceptual model titled, "Confronting the inevitable." Data from several studies informed the authors' description of that model, which featured lack of control as its central theme. The researchers identified six common experiences: "coming to know, losing and gaining, sharing the loss, going public, getting through it, and trying again?" (p. 544). The complex, highly emotional, and often physically painful experiences related by women who miscarry provide a road map of sorts for nurses who want to understand how to help. For example, the term *coming to know* refers to a woman's realization that something is wrong. The model also includes physical events such as pain, cramping, and bleeding, as well as issues women might never have considered, such as figuring out what to do if the miscarriage happens while she is sitting on the toilet.

Study Design and Methods

This study used a two-phase qualitative design with dimensional analysis. Phase 1, which we report in this article, consisted of a telephone interview within several months of the miscarriage. Phase 2 consisted of research follow-up within the first year after the miscarriage using journal entries and another telephone interview at approximately 1 year after the miscarriage.

Data Collection

Following consent, participants completed a demographic data form, *Information About You and Your Family* (Pridham, Sondel, Clark, Green, & Brown, 1995), modified for women experiencing pregnancy loss. We conducted telephone interviews, lasting 30 to 45 minutes, using a process-oriented interview guide, which we revised as women in earlier interviews identified conditions of knowing they were going to have a miscarriage and what treatment option they would choose. The interview began with *"Tell me about how you learned that you were going to have a miscarriage [or going to miscarry]? What was going on for you?"* It continued with *"Think back to when you learned that you were going to have a miscarriage [going to miscarry?]. What went into knowing what you were going to do next? What things helped you decide what to do next?"*

Sample

Nurses in an ob/gyn outpatient setting at a midsized midwestern medical center recruited women who met the following inclusion criteria: (a) experienced a miscarriage at fewer than 14 weeks' gestation in the previous 2 to 4 weeks, (b) needed to be offered and decide on a treatment option, (c) were at least 18 years old, and (d) spoke English. The study was approved by the medical center's Institutional Review Board.

Using purposive sampling, we interviewed women whose interviews represented (1) the range of management decisions available (surgical, medical, or expectant management), (2) a broad range of education and income levels, (3) a range in the number of living children, and (4) some participants with prior history of pregnancy loss (Table 1). Data saturation was reached at the point of 23 interviews, at which time we stopped interviewing new participants.

Analysis

Dimensional analysis was used, which is an analytic technique used by researchers to identify processes and conditions present in everyday, yet complex, situations. It is a flexible strategy that can be used with an existing data set or when data collection and analysis are concurrent, as in grounded theory (Bowers, 1988; Schatzman, 1991).

Using a line-by-line analysis of transcribed data, we identified dimensions and related conditions. We completed approximately five interviews before beginning to formally analyze data. Informal analysis, which consisted of listening to each participant describes her experience and reviewing notes taken during each interview, began with the first interview. After the initial interviews, interviewing and analysis occurred concurrently.

Toward the end of the data collection, we assembled transcript data that addressed both coming to know the miscarriage would happen and making a choice about what to do regarding treatment. The principal and coinvestigator worked with three members of the research team separately and together to compare interpretations. Their discussion led to new ideas or extensions of earlier

When faced with inevitable miscarriage, women have three treatment options: wait for miscarriage to occur spontaneously (expectant management); undergo a surgical procedure (suction curettage); or use medication (misoprostol) to hasten the miscarriage.

ideas, and finally, an identification of a central *process* of ***Being Sure***, the dimensions of certainty about the miscarriage and related treatment options, and the conditions that influenced them. These steps increased trustworthiness of the study.

Results

The final sample consisted of 23 women who met the study criteria and completed the telephone interview. They ranged in age from 23 to 40 years, with a mean of 31 years. The participants were well educated and had financial resources. The mean education level was technical or vocational school graduate, with a mean annual household income between $50,000 and $70,000. Of the 23 women, 15 decided on surgical intervention (suction curettage) to complete the miscarriage, 1 selected medical management (i.e., pills inserted into the vagina), and 7 chose expectant management. We used early interview transcripts (participants 1, 2, and 3), interview notes, and tables created from the participants' own words to identify how women talked about learning they would miscarry and, subsequently, what they would do next. *Certainty* or *uncertainty* was the dimension that emerged for both categories. In subsequent interviews, we asked women to elaborate on the breadth and depth of their decisions. Investigators also reread and searched transcripts for the words *sure*, *knew*, *certain*, and *uncertain* to explore additional conditions of decision making. We chose those words because many participants used one or more of them to explain their state of mind.

Being Sure

The central process found was ***Being Sure***, which had two dimensions: (1) the need to be sure that a miscarriage was imminent and (2) being sure that the treatment choice (medical, surgical, or expectant management) was the correct one for them. ***Being Sure*** includes deciding on fetal viability or the potential for it. Conditions that influenced a woman's certainty or uncertainty included medical technology, personal intuition, physical symptoms, the thoughts and opinions of others, and family considerations.

Being Sure of the Diagnosis

All participants discussed the need to be certain that they were really experiencing a miscarriage. Overall, women considered the perceived consequences of their decisions and drew on past and current experiences in ***Being Sure***. We found five primary conditions of ***Being Sure*** of a miscarriage below:

- physical symptoms,
- intuition or feeling,
- receiving information from others,
- ultrasound confirmation, and
- additional resources.

One woman stated, *"I would have been worried about doing anything too soon, in case maybe we were wrong on the dates, and maybe it was just my imagination that something was wrong."* When women talked about the need for certainty, they linked being sure with pregnancy viability. They described the stakes of being sure in terms of the potential for life or living matter in the uterus. Fifteen women used the word *baby* or *child* and considered their miscarriage a loss that resulted in sadness. However, four women, all of whom had diagnoses of either *blighted ovum* (the sac is empty) or *no heartbeat* used words or phrases that were unrelated to a separate living entity such as a baby: *"It's for sure there is no life amongst this pregnancy matter. So what we need to do then is have a D&C to take it out..."* and *"All they found was a sac; they didn't find a baby at all."* One woman seemed to equate being human with a heartbeat and used the impersonal *it* when she referred to her pregnancy: *"It's not like it was ever a human, it never had a heartbeat, it was the beginning of the baby."* Some women, with clear confirmation, expressed anticipatory grief, others did not. But as women became sure that the miscarriage was inevitable—by physical symptoms or ultrasound—most felt shock, fear, and sadness.

Physical Symptoms

The process of coming to know that the miscarriage was inevitable varied among participants. Half of the women experienced physical symptoms such as spotting or bleeding/clotting, which they interpreted as evidence that there was a serious problem with the pregnancy: *"Then when it went to a slow spotting, you know, not much of anything then I didn't think anything of it. . . . But then I was at a dinner Monday night and all of a sudden I felt a gush and went, 'Uh-oh.' And then I went to the bathroom and there was clotting again and I'm like, 'Oh, this is not good.'"*

Another participant had the same experience, describing a physical sensation that heightened her sense of inevitability: *"When I went to get out of the car I felt something pull away and I just knew right then something was wrong."*

Intuition or Feeling

Other participants described a sense or feeling that there was something wrong that contributed to ***Being Sure***: *"I think that because I had a prior ectopic. . . I don't know if it's just kind of an intuition or what it was, but I felt like something was wrong the whole time."* Another woman described her intuition as "*I just kind of had a bad feeling; and in that week after that first ultrasound,*

all my pregnancy symptoms went away. So then I really knew that I wasn't [pregnant]."

Those who had had prior pregnancies also reported comparing their symptoms and noticing differences from their previous experiences. "*I didn't have the tenderness in my breasts . . . when I was pregnant, my hair got really thick; but this time, I was losing hair*" and "*Having been pregnant before . . . I was really nauseous. . . . This time, even before I was told that it wasn't growing. . . I didn't really feel pregnant.*" For these women, their intuition or feeling seemed to serve as a warning to them, lessening the shock or surprise when the physician confirmed the diagnosis of miscarriage.

Receiving Information From Others

Having support or a "listening ear" from HCPs, family members, and/or friends was a condition of ***Being Sure*** for most women. The most helpful responses from others were those which the women themselves initiated (e.g., phoning a friend to ask about the amount of bleeding) or from trusted HCPs. Women who had a prior relationship with their HCP (physician or nurse midwife) reported having greater confidence in their provider's diagnosis than those who did not have such a relationship. When we asked what led to the trust one participant had in her physician's diagnosis that the miscarriage was inevitable, she replied, "*The comfort level, because I had been seeing [this physician] for so long, and she knew my whole history and what we had gone through trying to have kids, and what we went through with the miscarriage.*" Another participant expressed concern about the knowledge base of those who provided care during her miscarriage: "*I wanted to make sure that they [her health care providers] were sure that they weren't removing a viable pregnancy, or ending a viable pregnancy.*" Women who expressed a higher level of trust in their HCPs seemed to experience a greater sense of certainty about the accuracy of the miscarriage diagnosis and the choice of a treatment option.

Ultrasound Confirmation

Most of the women had an ultrasound and identified the test as heightening their level of certainty that they were having a miscarriage. Being certain about the inevitability of miscarriage contributed to them feeling sure that a surgical or medical treatment option would not remove a viable pregnancy. One woman said, "*They did the ultrasound, and I was looking at the screen as they were doing it, and I already knew. I could see there was nothing there.*" Likewise, a woman with three living children said, "*Having had three children already, I knew that that little heartbeat thing flickers and flickers and jumps and jumps, and moves very rapidly on the ultrasound, and I didn't see that, and so I started to cry, and I knew.*" Another participant, for whom this was the third miscarriage, noted that when her bleeding got heavier, she requested an ultrasound. She stated, "*That was the final 'for sure,' knowing that I was going to have another miscarriage, having that ultrasound again.*" One participant linked not seeing her ultrasound results with continued questioning about the diagnosis: "*There was no chance [to see the ultrasound results]. Just to actually see it for myself—I think that would have just made me feel a little bit better. There would be no question then for me in my head, 10 years from now.*"

Another woman reported that her partner expressed fear that the ultrasound results were incorrect: "*When we had decided to go through with the D&C, it was the night before the surgery and my husband said to me, 'Are you sure that their equipment wasn't wrong? . . . Is there a chance that you're still pregnant and we're . . . almost aborting our baby?'*"

Interestingly, women who reported family members with doubting responses, as with this woman's partner, seemed to use that input as "a" factor in deciding what to do, but not "the" factor in deciding on the treatment. The following quotation provides an example of a participant's momentary doubt after two family members questioned her about whether her doctor was sure: "*Then [my husband] . . . asked, 'Is [the doctor] sure that . . . there's no baby . . . that it's not gonna grow?' and I said 'Yeah.' He said, 'Well, that's fine.' But you know it was kind of hard when we got home [after surgical intervention] because my husband's mom . . . said, 'Oh, are they sure? Did they take it too early?' Well, I was sure all up until that point, but when she said it I thought, well, what if? And then I thought, no . . . this baby wasn't gonna progress, but there was a few seconds that I was like . . . what if I should have chose another option?*"

Additional Resources

Several participants described seeking additional resources to increase their level of certainty. One woman, a healthcare professional herself, researched the scientific literature. Others consulted resources for more general audiences: "*That book, What to Expect When You're Expecting . . . I was just reading through it . . . and there was a part on the non-forming pregnancy, and I happened to stick on it, and I was like, 'Oh, gosh, wouldn't that be horrible . . . to be pregnant and have it not be forming right,' and I'm like, 'Oh, I bet that's me.'*"

One woman reached out to a friend via telephone to ascertain whether she was bleeding too much. Her friend had experienced two prior miscarriages. "*I also wanted to ask her, like, 'How do I know if this is bad, or what's good and what's bad, and how do I know if I'm bleeding too much?'*" Her friend provided details of what she considered too much bleeding and when she needed medical help for heavy bleeding.

Being Sure of the Treatment Option

When the women talked of the importance of ***Being Sure*** of the correct treatment option for them, they wanted:

- confirmation of certainty by their HCP
- self-confirmation
- HCP advice
- to avoid a procedure that could be construed as abortion

Conditions that influenced choosing surgical or medical intervention over expectant management included having other children at home and not wanting to miscarry in front of them, wanting to avoid the unpredictability of having a

"I would have been worried about doing anything too soon, in case maybe we were wrong on the dates, and maybe it was just my imagination that something was wrong."

miscarriage happen naturally (e.g., away from home), and being sure of nonviability (e.g., from an ultrasound) so having a D&C allowed them to be finished with the process. Only one participant remained uncertain that a D&C was the right choice after having three confirming ultrasounds. Participants described conditions that led to a treatment option.

Confirmation of Certainty by HCP

Some women who chose to have a D&C reported being more sure after the procedure, based on findings by medical staff: *"[The doctor] being able to say that . . . 'There is no life in the pregnancy matter. Yes, we see pregnancy matter there, but there's no life.' And so then it's okay; there isn't a possibility of the ectopic pregnancy, it isn't a possibility of . . . miscarrying a twin. This is definitely a true miscarriage."*

Self-Confirmation

In the process of confirming for herself that she required medical treatment, one woman described her thoughts immediately prior to inserting pills into her vagina to induce contractions (medical treatment): *"So I'm sitting here looking at these pills and I put them in the applicator and it was very difficult because in my mind what was going through is, hmmm, I'm killing my baby here. But then I kept having to remind myself I don't have a baby, you know, there is no baby there that I'm killing um and that, you know, was final."*

Likewise, another participant shared a similar perspective: *"It's the same procedure that they would use in an abortion clinic, and I'm very against that, and you know, ... [crying] although my baby's not alive, that's still what they're doing."*

HCP Advice

Women noted whether their expectations for treatment were consistent with that of their providers. For instance, one woman said her doctor advised her to not intervene: *"You know, it wasn't really an option. She just said, 'The best thing to do is to wait.'"* The woman said that although this was the first time she had seen this doctor, the doctor's advice to wait was consistent with the woman's own inclination. Another woman described her physician as somewhat insistent on a specific treatment option that was not in keeping with what the woman herself wanted to do. She prevailed and was sure about her decision.

Avoiding a Procedure That Could Be Construed as Abortion

The possibility that the pregnancy was still viable influenced some women's choice of expectant management. A participant described why she chose to not intervene: *"I just think that if it's supposed to happen it would happen on its own. I don't like the whole idea of scraping or sucking something out. It seems too abortion-ish. Even though I know it's not. And then they're like, well, there is a small chance it's alive, and then you suck it out—that just freaked me out, too."*

Although most women did not use the term "abortion," they wanted to be sure that the pregnancy was not viable before they chose a surgical or medical treatment option. This participant described what seems to be internal conflict about choosing surgical intervention: *"You know and um, I even asked the doctor, I asked, 'Is this the same thing as an abortion?' And he's like, 'I don't perform abortions... you're just terminating the pregnancy, you know, but I'm not, this is not an abortion.' But um, to me it felt like an abortion, I was getting rid of the baby."*

Expectant Management as a Trial Option

Women who chose expectant management cited several reasons for doing so. These included HCP advice, avoiding a procedure that could be construed as abortion, and using expectant management as a trial option before an invasive treatment (surgical or medical management).

Many of the women who chose expectant management were open to the possibility that if the miscarriage did not happen spontaneously within a certain timeframe, they would have a D&C. One woman's words provided a typical example: *"I had thought about doing the D&C if it, if um, the, if I didn't actually miscarry on my own in a week."*

Another participant's answer is noteworthy for its collection of decision-making conditions that other women had noted singly. She used the term "baby" (viability), praised the use of a repeat ultrasound to increase certainty that the miscarriage was inevitable, identified the need for "everybody" to be sure (HCPs and patient and family), used a percentage necessary for certainty, and wanted to allow time for expectant management as the treatment of choice. *"In a way that I knew the baby and I was very appreciative that we were going to do the second ultrasound, so that everybody was sure. I mean it'd be a horrible thing to go through without being a hundred percent positive, so um, you know I thought well, this will give me a week to come to terms with it, in so many words and especially to give my body a time to do a natural miscarriage if it's able and ready."*

Even with expectant management, a treatment option that allows for the highest level of certainty, one woman described difficulty in determining if what she passed in the toilet was actually the products of the miscarriage,

and if so, what she and her husband should do. She said, *"What bothered me is that things happened in the toilet."* The interviewer asked, *"Did you flush?"* The woman responded, *"We didn't right away. . . . I asked [my husband] to do it and I talked to him and um . . . So that was, it was hard to do that."* She further elaborated, *"He's like, 'What do we do . . . we have to flush the toilet somehow.' . . . I don't know if there's tissue...I don't, you know I didn't know what to look for."*

Another participant reiterated the uncertainty she experienced about whether the miscarriage actually happened and the difficulty in interpreting the appearance of tissue that was passed. *"They [clinic staff member] said, 'If you can bring any tissue in we can examine it,' and no one had ever told me that before. . . . That's one thing I wished they would have told me. . . . I think I would have felt better if I would have brought tissue in and if they could have determined anything from examining it."*

Likewise, one woman who thought she had miscarried was still bleeding. She went to lunch with a friend, and after going to the bathroom, her friend asked her, *"Did you check it?"* The participant went on to say: *"She's like, 'Well, actually yeah, you probably should be able to see if you're fully miscarrying...Did you reach into the toilet and you know grab onto one and feel it and see if you could see or feel anything?' And I'm like, 'No.' And she's like, 'Oh, okay.' I'm like, 'Well, crap I should be carrying a strainer around with me. Then I'm peeing in a strainer.'"*

Implications for Nursing Care

Nurses who read this study can use its results to give compassionate, attentive, and appropriate nursing care to women who find themselves in the difficult position of having a miscarriage. This study has demonstrated that women have many concerns about miscarrying, and their primary apprehension deals with ***Being Sure***. Women need nurses who will help them in this process, and understand what their trepidations are in choosing the best treatment.

Findings from this study are consistent with the literature, as well as with anecdotal accounts of miscarriage from the 1980s to the present that include pregnancy viability and fetal personhood as key concepts (Côté-Arsenault & Dombeck, 2001; Hutti, 1992; Limbo & Wheeler, 1986). Whether in the emergency room, outpatient clinics, surgical areas, or through telephone triage, a nurse is likely to interact with these women during some part of the experience. Using the findings from this study, it would be important for the nurse to help the woman by assessing her level of certainty that she is (1) having a miscarriage and (2) sure that what she has chosen is the right treatment for her.

Nurses can play a key role in helping patients to ***Be Sure.*** Women reported that interpreting the extent of symptoms was part of coming to terms with the inevitability of the miscarriage. Nurses can review with women what symptoms might occur (e.g., bleeding), advise women to use a container to catch any tissue that is passed, and to seek validation or examination by their HCP when symptoms change. An ambulatory or outpatient nurse could be present when the HCP describes treatment options. This nurse can gently guide a woman's reflection on what would work best for her and her family, such as:

- *"Is there one option or another that seems to be a better fit for you?"*
- *"In the past, what resources have you used to make decisions about something that may not have a clear answer?"*
- *"What will help you decide? What is important to you in knowing what to do next?"*
- *"When you look back on this time months or years from now, what do you think will be the most important thing to consider?"*

Regarding follow-up and after care, the authors recommend at minimum one contact from a nurse after a miscarriage, and more if indicated. A critical question the nurse can ask is this: *"Looking back, how do you*

Table 1. Participant Demographic Characteristics

Characteristic	*N*	Total Responses	%
Miscarriage was first pregnancy	4	23	17.3
Has living children	18	18	100.0
Pregnancy was planned	19	23	82.6
Had previous miscarriage	7	23	30.4
Had prior ectopic pregnancy	1	22	4.5
Lives with partner/ husband	23	23	100.0
Healthcare payment plan			
Commercial health insurance	12	23	52.1
HMO	11		47.8
Racial/ethnic group			
White/ Euro-American	22	23	95.6
Asian	1		4.3
Religious preference			
Roman Catholic	8	23	34.8
Protestant	9		39.1
Other Christian	1		4.3
Hindu	1		4.3
No preference	4		17.4

> "I wanted to make sure that they [her health care providers] were sure that they weren't removing a viable pregnancy, or ending a viable pregnancy."

feel about the decision to [watch and wait/have a D&C/use vaginal medication]?" It is likely that the woman will comment on ***Being Sure***. A continuing response of doubt, guilt, uncertainty, or "*I wish I would have had one more ultrasound*" can alert a nurse to the potential need for further follow-up (phone call, appointment with HCP, or even psychological counseling).

Women in this study defined for nurses and other members of the interprofessional team the process of ***Being Sure*** that a pregnancy is not viable before they can comfortably move forward with a final treatment decision (surgery, use of vaginal medication to induce contractions). Nurses can be instrumental in determining whether a woman is ready to proceed with treatment by asking several questions. Here is an example: *"I've learned from other women like you who have been diagnosed with an inevitable miscarriage that they need to be sure that they will have a miscarriage and that the treatment decision is the right one. How is that for you?"* One woman needed three ultrasounds and indicated during her interview that she wished she would have had one more. This scenario underscores the fact that a nurse may need to readdress a woman's level of certainty, understanding that ***Being Sure*** is a process.

The concept of "symptom recognition," generally linked to patients with heart failure and self-care (Riegel & Dickson, 2008), is relevant to the data from this study. HCPs and women's choices of treatment options depend to a certain extent on change in symptoms. If bleeding increases, with or without passage of tissue, women should be told to contact their HCP. Increase in cramping is also a symptom of more uterine activity, with the likelihood of the miscarriage happening sooner rather than later (Cunningham et al., 2010, 2005, 2001). Nurses working with women at risk for miscarrying could suggest that women keep a "miscarriage comfort package" available when using the toilet (see Table 2), monitor blood flow based on number of pads used in an hour, and note changes in intensity and frequency of cramping. Women in our study described both the *extent* and the *meaning* of symptoms, trying to distinguish among spotting, bleeding, and clots and wondering how much bleeding warrants concern.

The findings from this study link ***Being Sure*** with fetal personhood, thus extending Côté-Arsenault's and Dombeck's findings to the area of decision making regarding treatment when women learn they will miscarry. Nurses who understand that nonviability of the pregnancy is on most women's minds once they are aware of the possibility of miscarriage are in a position to help assess the woman's level of certainty that the pregnancy is gone. Nurses can then inform other HCPs (e.g., nurse midwives, physicians, ultrasonographers) that a woman may need more time or more testing to move forward with a final treatment decision. Some women felt comfortable with the option to "watch and wait," but when their bleeding increased or they experienced other signs of pregnancy nonviability, they then wanted to end the pregnancy through surgical means. In other words, ***Being Sure*** is a dynamic process, centered on viability.

Clinicians may assume that the finding of *blighted ovum* predicts that a woman will feel relieved because there was no baby. That was true for some women in our study. However, others who had assigned fetal personhood deeply grieved the loss of potential for a baby and some still needed an additional ultrasound to be sure that the first ultrasound was correct. These findings suggest that medical data or a medical diagnosis does not dictate a mother's perception of the meaning of her loss. Before and during pregnancy a woman anticipates having a baby; therefore, many women become attached to the baby in their minds. Additional nursing interventions are in Table 2.

Future Research

Study findings also point to possibilities for future research. Only one of our participants did not mention ***Being Sure*** because her symptoms of bleeding were so compelling, her fear so high, and the results so physically and emotionally stressful that she wasn't left to wonder what to do or whether she was having a miscarriage. We suggest that when future researchers explore women's experiences of miscarriage, they explore *trauma* in addition to *loss* (Lobb et al., 2010). One potential participant who signed the consent form ultimately declined to do the interview because she was traumatized by the hemorrhage she experienced following miscarriage and did not feel able to talk about it. Future research on women who miscarry may also extend the work of Côté-Arsenault et al. (2001) in pregnancy after perinatal loss and Beck (2011) in subsequent childbirth after previous traumatic birthing experience by exploring the effects of trauma at a very early stage of pregnancy (e.g., miscarriage with subsequent hemorrhage at 10 weeks gestation).

Each participant discussed the meaning and role of symptoms. We used some of these data in our analysis; however, further exploration of symptom recognition in women who miscarry may be fruitful in helping HCPs develop more tailored interventions and guidance. Research may also help women who use symptoms to define their level of certainty to a more precise and detailed understanding of what both signs and symptoms mean for their decision making.

Table 2. Clinical Nursing Care When Informing Patient of Miscarriage

Guideline	Details
1. Assess woman's level of *Being Sure*	*"Are you feeling comfortable with your decision to [have a D&C, use misoprostol, watch and wait]?" "Is there anything else you need from us as your health care providers to help you be sure?"*
2. Provide written information on what to expect when undergoing expectant management	Information to include: • expected rate and amount of bleeding, • description of appearance of pregnancy tissue, • anticipated level of pain, • directions for collection and storage of tissue, and • directions for bringing tissue to clinic or hospital for analysis.
3. Provide a miscarriage care package for all women undergoing expectant management and thoroughly explain its contents and use	Items to include: • a plastic collection container to place under the toilet seat ("potty hat") in case tissue is passed while the woman is on the toilet; • sanitary pads for increased blood flow before the miscarriage (explain that blood flow usually decreases substantially once the miscarriage occurs); • two blue plastic-lined pads to protect the bed or chair if bleeding is heavy; • plastic gloves to wear for handling tissue that is passed; and • a small plastic jar for tissue (explain that if the volume of tissue passed is too large for the small jar, the patient may place it in a plastic container with a tight-fitting lid or a sealable bag). Suggest that she consult with her HCP to determine what can or should be done with the tissue.
4. Be cautious and gentle when giving information	Attempt to gain an understanding of the patient's perspective on the inevitable miscarriage (e.g., whether she views this as a loss; whether she uses the term *baby*) before giving brochures about perinatal loss or mementoes such as a baby ring. If brochures are provided, let the patient know that she may read them now or at a later time of her choice. Try to understand and anticipate the patient's individual feelings and needs.

Conclusion

Researchers have identified terms similar to ***Being Sure*** in other perinatal and pediatric settings (Kavanaugh, 1997; Meert et al., 2009).The findings from the current study frame a process of ***Being Sure*** about miscarriage and treatment decisions, influenced by intrapsychic, sociocultural, physical, and experiential conditions. Pregnancy viability was the foundation for ***Being Sure***. Women needed to know that their pregnancy would not result in a baby before they could make a treatment decision to end the pregnancy. These findings are new but may not be uniquely relevant to miscarriage; they are possibly applicable to deciding on treatment options in other end-of-life care settings. Ultimately, for all the women in the study, ***Being Sure*** was linked to the deepest of human relationships, to loving, hope, and wanting the best as parents for a child. ✣

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