An Exploration of Mothers' and Fathers' Experiences of Hospital Care During Second Trimester Miscarriage in the National Maternity Hospital.

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The National Maternity Hospital
Vita Gloriosa Vita ~ Life Glorious Life

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Abstract

Title

An Exploration of Mothers' and Fathers' Experiences of Hospital Care During Second Trimester Miscarriage in The National Maternity Hospital.

Background

Second trimester miscarriage is often under reported and lacks recognition in both clinical practice and the literature. Second trimester miscarriage is defined as pregnancy loss between 12 and 24 weeks gestation. A recent study conducted in The National Maternity hospital found the rate of second trimester miscarriage to be 0.8% of all deliveries (Cullen et al., 2016). Little is known about bereaved parents' experiences of hospital care during a second trimester miscarriage in Ireland.

Aims and objectives

The aim of the study was to explore parents' experiences of hospital care during a second trimester miscarriage. This study aimed to report on parents' experiences of services from the time of diagnosis of the second trimester miscarriage through to follow up care received.

Methods

A focused ethnographic design was used to complete this study. A series of semi-structured interviews were completed with 14 bereaved parents (nine mothers and five fathers) in a variety of locations. The data was analysed using thematic network data analysis. Ethical approval was granted by both the Hospital and University Ethics Committees.

Findings

Two global themes emerged from the data collected from bereaved parents these included; c*linical care needs and relational and social experiences of miscarriage*. Clinical care needs highlighted parents' experiences in relation to medical care, hospital facilities and information. Parents were overall satisfied with their medical care and highlighted the need for adequate pain relief and the importance of the follow up appointment. This theme highlighted the importance of being separate from other pregnant women and babies and also the need for improved facilities for both mothers and fathers. Clinical care needs also describes parents' experiences of the

information they received from medical professionals. Both mothers and fathers explained the need for clear communication from health care professionals and the desire to find out why the miscarriage occurred. The second global theme of relational and social experiences of miscarriage highlighted the parents' experiences in relation to compassionate care, bonding and connecting with their baby and their experiences of support in the aftermath of miscarriage. This theme highlights the importance of compassionate care during a second trimester miscarriage, particularly, sensitivity and empathy. Parents explained the importance of spending time with their baby and shared various ways they remember their baby. Parents also highlighted the need for support both at the time of the miscarriage and after discharge from the hospital.

Conclusion and implications

The findings from this study adds to the limited research available in relation to parents' experience of second trimester miscarriage and adds new insights to existing research into parents' experiences of miscarriage and stillbirth. Though the sample is small the findings provide valuable information for clinical practice and highlight a number of potential areas for future research.

Dedication

This thesis is dedicated to the memory of every baby born in the National Maternity Hospital following a stillbirth or miscarriage and to their parents.

.....I did not die young

I lived the span of my live

Within your body.

And within your love.

There are many

Who have lived long lives.

And have not been loved as me.

If you would honour me

Then speak my name.

And remember me among your family.

If you would honour me

Then strive to live in love

For in that love I live.....

Christy Kennelly

Poem displayed on a memorial at the Holy Angels plot in Glasnevin Cemetery, Dublin, where babies who were stillborn or died soon after birth are buried.

Definitions

Bereavement liaison midwife: a midwife who works as part of the bereavement team in the National Maternity Hospital, who is responsible for the coordination of care for bereaved parents. Also responsible for the development of policies in relation to bereavement care, staff education and involved in research in the area.

Bereavement team: in the National Maternity Hospital the bereavement team consists of the bereavement liaison midwives, the director of Midwifery, chaplains, medical social workers and clinical midwife managers from the antenatal ward, fetal assessment unit, neonatal unit and the gynaecology ward.

Miscarriage: pregnancy loss up to 24 weeks gestation, with a fetus weighing less the 500 grams (The Royal College of Obstetricians and Gynecologists (RCOG), 2011).

Neonatal death: the death of a baby from the time of birth up to 28 days of life.

Perinatal loss: the loss of a baby before or after birth, including stillbirth and neonatal death.

Recurrent miscarriage: 'the loss of three or more consecutive pregnancies' (Royal College of Obstetricians and Gynaecologists, 2011, p.2).

Second trimester miscarriage: 'pregnancy loss after the 12th and before the 24th completed week of pregnancy' (The Health Service Executive (HSE), 2014, p.4)

Stillbirth or Intrauterine fetal death: a baby born after 24 weeks gestation, with no signs of life and weighing 500 grams or more (Institute of Obstetricians and Gynaecologists, Royal College of Physicians Ireland and the Health service Executive, 2011).

Termination of pregnancy: refers to any procedure (medical or surgical) that results in the termination of pregnancy (The Health Service Executive, 2016).

Glossary

ABA: An Bord Altranais, now known as NMBI (Nursing and Midwifery Board of Ireland)

HSE: Health Service Executive

NHS: National Health Service

NMH: National Maternity Hospital

RCOG: Royal College of Obstetricians and Gynaecologists

WHO: World Health Organisation

Chapter one

Introduction and background to study

1.1 Introduction

Second trimester miscarriage is often under reported and lacks recognition in both clinical practice and the literature. There are varied definitions for second trimester miscarriage and terms used to describe miscarriage in current literature. Miscarriage is defined by The World Health Organisation (WHO) (2001) as the premature expulsion of an embryo or fetus from the uterus up to 23 weeks of pregnancy and weighing less than 500g. Internationally there are different views on how second trimester miscarriage is distinguished from miscarriage and stillbirth. In Australia and America pregnancy loss before 20 weeks is considered a miscarriage and a stillbirth is defined as fetal death after 20 weeks (The American College of Obstetrics and Gynaecology, 2009; Lee, 2012). The Royal College of Obstetricians and Gynaecologists (RCOG) in the UK define miscarriage as pregnancy loss up to 24 weeks (RCOG, 2011). The World Health Organisation (2013) explains that the wide variations in the definitions of miscarriage, abortion, stillbirth and neonatal deaths make the ability to accurately record and compare rates of late miscarriages very difficult. There is no legal requirement to register infants born before 24 weeks gestation or weighing less than 500grams, thus the prevalence of second trimester miscarriage is difficult to determine. The Health Service Executive (HSE) (2014) defines second trimester miscarriage as pregnancy loss 'after the 12th and before the 24th completed week of pregnancy' (HSE, 2014, p.4). For the purpose of this study the HSE definition of second trimester miscarriage was utilized. A recent study conducted in the National Maternity Hospital found the rate of second trimester miscarriage to be 0.8% of all deliveries (Cullen et al., 2016). This equates to approximately seventy women per year who experience a second trimester miscarriage in the National Maternity Hospital. The needs of parents bereaved by second trimester miscarriage are complex and poorly understood in the current literature.

Pregnancy loss can present unique problems which can make the process of normal grieving more difficult (Mander, 2006). The birth of a baby is usually a time filled with joy; however, when a mother delivers a stillborn baby or the infant dies soon after birth this joy is replaced by sadness and despair (McDonnell, 2003). The loss of a baby at or around the time of birth can bring a sense of bewilderment for grieving parents, when new life and death occur together this can create a unique grief response (Mander, 2006). There is limited research examining parents' experiences of hospital care during second trimester miscarriage, there is a body of research examining parents' experiences of miscarriage in the first trimester and perinatal loss (stillbirth or neonatal death). Parents' distress following miscarriage can be intensified by dissatisfaction with aspects of care received (Stratton and Lloyd, 2008). According to the recently published Standards for Bereavement Care following Pregnancy Loss and Perinatal Death in Ireland (HSE 2016) hospital staff must strive to provide the best possible care to all bereaved parents experiencing a pregnancy loss and a deeper understanding of the needs of parents bereaved through second trimester loss is required in order to improve care delivery.

Research examining parents' experiences of hospital care before, during and after perinatal loss report that the majority of parents were positive about the quality of care they received from medical staff (Paton *et al.*, 1999; Lasker and Toedter, 2007; Lee, 2012; Downe *et al.*, 2013; Basile and Thorsteinsson, 2015). Interactions with medical professionals are of vital importance to women when experiencing a pregnancy loss (Rowlands and Lee, 2010). A number of studies highlight the importance of good communication for medical staff and the distress caused to parents when a lack of sensitivity is shown to them (Paton *et al.* 1999; Saflund *et al.*, 2004; Fenwick *et al.*, 2007; Murphy and Merrell, 2009; Musters *et al.* 2013; Mulvihill and Walsh, 2013). The current study aims to ascertain parents' experiences of hospital care during second trimester miscarriage to inform bereavement care within the National Maternity Hospital and throughout Ireland. This study focused on hospital care due to the researcher's clinical experience, findings from a previous study conducted in the National Maternity Hospital (Cullen et al., 2016) and other evidence in the literature. From clinical experience working with parents who experienced a second trimester miscarriage the researcher was interested in learning more about parents' view of the care provided and ways to improve care for these parents. Findings from a quantitative study by Cullen et al. (2016) highlighted that the

care provided to women who experience second trimester miscarriage needed further examination. One recommendation from this study was to investigate parents' experiences of hospital care, including pain relief and length of hospital stay. Literature examining parents' needs during a second trimester miscarriage is limited and often studies examine second trimester miscarriage along with other forms of perinatal loss. Therefore, the specific needs of parents experiencing a second trimester miscarriage remain unclear. Furthermore, there is a dearth of literature which examines fathers' experience of miscarriage and perinatal loss. To inform this study an extensive literature review was conducted, including literature examining miscarriage at all gestations, stillbirth and neonatal death. The literature review is presented in Chapter two.

1.2 Background to the study

This study is the second phase of a research project conducted by the Bereavement Research Group (originally named the Mid-trimester Loss Research group) in the National Maternity Hospital. Phase one of the study (Cullen et al., 2016) explored of the prevalence and patterns of care for women presenting with mid-trimester loss (also known as second trimester miscarriage) in the National Maternity Hospital and involved a three year retrospective chart audit (2011-2013). The current study is a follow on study. Most specifically the first phase of the study identified the number of women who experience a second trimester loss at the hospital and the varied care provided to these women. The current study focused on how a cohort of these bereaved mothers and their partners felt about the care they received following a second trimester loss. The National Maternity Hospital is a large tertiary referral centre in Dublin, Ireland where over 9000 babies are born each year.

1.3 My journey through this research project

My interest in the area of miscarriage and bereavement in maternity care was first awakened during my time as a nurse on the gynaecology ward in the National Maternity Hospital. Here I cared for women who experienced miscarriage and early pregnancy loss on a daily basis. I also on occasion cared for women following a stillbirth or early neonatal death. During this time I assisted in the planning and organisation of the annual remembrance service. I was struck by the large number of

bereaved parents who attended and the appreciation they showed to the staff that looked after them. The experience I gained here encouraged me to apply for the Higher Diploma in Midwifery. During my time as a student midwife I cared for a number of bereaved parents and while it was a challenging experience I found it to be very rewarding also. Student midwives are offered the opportunity to complete a one week elective placement during their training program. I elected to spend a week with the clinical midwife specialist in bereavement and gained a wealth of knowledge from observing her practice during that week. Following the completion of the Higher Diploma in Midwifery I worked in the labour ward of the National Maternity Hospital. I thoroughly enjoyed this experience and spent over three years working very happily in the labour ward. Towards the end of my third year in the labour ward I successfully applied for the position of research assistant and worked with the bereavement team to complete the research project 'An exploration of the prevalence and patterns of care for women presenting with Mid-trimester Loss at the National Maternity Hospital' (Cullen et al., 2016). The current study is a follow on study. Throughout the process of completing this project I worked closely with the bereavement team and this further developed my interest in this area. One outcome of this study was a recommendation for further research examining mid-trimester loss (or second trimester miscarriage) including parents' experiences. This phase of the research aims to explore parents' experiences of second trimester miscarriage. When commencing this project I was working on the ante-natal ward and gained valuable experience in caring for bereaved parents. This experience also gave me a greater insight into the challenges faced by midwives when caring for bereaved parents. From experience in clinical practice I observed that a lack of time, space and privacy can all act as barriers to providing good quality care to bereaved parents. During this time I became more passionate about improving bereavement care within maternity care and to develop my career in the area of bereavement. Mid way through the current project I was offered the position of Bereavement Liaison Midwife which I commenced in January 2016. During this time I have further developed my knowledge and experience in caring for bereaved parents and my passion for providing high quality care for bereaved parents continues to grow. It is my hope that the findings of this research study will lead to improvements in care for parents who experience a second trimester miscarriage and to provide a platform for further research.

1.4 Structure of the thesis

The thesis has five chapters, in Chapter one a brief outline of the study is presented, the literature review follows in Chapter two. The empirical research and the key theories on grief relevant to this study are discussed. Chapter three discusses the research design and methodology used for the current study. The chosen research methodology, ethical considerations, sampling, data collection, data analysis and rigor are all discussed. The findings are presented in Chapter four in relation to two global themes. Finally Chapter five presents a discussion of the findings, the strengths and limitations of the study, conclusion, recommendations and a dissemination plan for the study.

1.5 Study aim and objectives

Study aim

The aim of the study is to explore mothers' and fathers' experiences of hospital care during second trimester miscarriage. In particular, this study will report on mothers' and fathers' views on the care received in the hospital from the time of diagnosis of the second trimester miscarriage through to follow-up care.

Study objectives

1) To report on mothers' experiences of services from the time of diagnosis of the second trimester miscarriage through to follow up care received. In addition, this study will focus on the length of hospital stay, preferences for place of care, experiences of pain management during labour and birth and experiences of follow up care.

2) To report on fathers' experiences of services received by both his partner and himself from the time of his partner's diagnosis of the second trimester miscarriage to the follow up care received.

3) To inform the development of bereavement care services within the National Maternity Hospital for parents experiencing a second trimester miscarriage.

Chapter two

Literature review

2.1 Introduction

The Literature Review discussed in this chapter commences with a discussion on the prevalence of second trimester miscarriage, risk factors associated with second trimester miscarriage and hospital care during miscarriage. Next the theoretical approaches that have informed our thinking about grief and bereavement are discussed; such as the contemporary theories of grief and bereavement (Stroebe and Schut 1999; Worden, 2009) while also drawing on the earlier work of Freud (1925), Bowlby (1980) and Parkes (1972). The psychological aspects of pregnancy loss and fathers' experiences of miscarriage and are then discussed. The chapter concludes with a discussion of the literature in relation to health care professionals' experiences of pregnancy loss. The search strategy used to inform the thinking behind the study design and method used is outlined below.

2.2 Search strategy

The search of the literature review was conducted using both keyword searches and subject heading searches in a number of databases. The databases searched were PubMed, CINAHL plus (EBSCO), EMBASE (Elsevier) and filtered for English language only with no time restriction. A combination of the key words listed below was used as part of the search strategy. Medical care which included the following key words: second trimester miscarriage, late miscarriage, spontaneous abortion, mid trimester loss, medical care, treatments, pain relief or analgesia, hospital care. theories of grief and loss which included the following key words; grief, bereavement, theories, models. Parents' experiences of perinatal loss which included the following key words: mothers' experiences, fathers' experiences and parents' experiences of perinatal loss, second trimester miscarriage, miscarriage, still birth, neonatal death and hospital care.

Seven studies were identified which focused specifically on second trimester miscarriage. However, these studies provided quantitative information regarding the prevalence, risk factors and medical treatments for women who experience a second trimester miscarriage. No qualitative study was identified specifically examining second trimester miscarriage. Some studies (approximately 12) were identified which explored the experiences of women who had a second trimester miscarriage along with women who experienced early miscarriages or stillbirths. Due to the lack of research focusing on second trimester miscarriage, the literature examining miscarriage at all gestations, recurrent miscarriage, still birth and early neonatal death were included in the literature review.

2.3 The prevalence of second trimester miscarriage

There is no agreed occurrence rate for miscarriage either during the first or second trimester, with varied rates quoted in the literature. The rate of second trimester miscarriage is estimated at 1-2% of recognised pregnancies (Edlow *et al.*, 2007, Wyatt *et al.*, 2005). Blohm *et al.* (2008) found that miscarriage occurred in 12% of all pregnancies and one quarter of women who had been pregnant by 39 years of age had suffered at least one miscarriage. Research with a sample of 5806 women by Hure *et al.* (2012) found a miscarriage rate of 25 per 100 live births. The majority of miscarriages take place during the first trimester of pregnancy (HSE, 2014). Westin *et al.* (2007) found that in low risk women, the risk of pregnancy loss in the second trimester was 0.5%. A recent study conducted in Cork found that the rate of pregnancy loss between 14-24 weeks was approximately 0.5% (Morris *et al.*, 2014). A more recent study conducted in a large Dublin maternity hospital reported a rate of second trimester pregnancy loss of 0.8% (Cullen et al., 2016).

2.4 Risk factors associated with second trimester miscarriage

While there is a dearth of research examining risk factors specifically for second trimester miscarriage there are a number of research studies examining risk factors for miscarriage, recurrent miscarriages and stillbirths. Several risk factors have been associated with an increased risk of miscarriage and or stillbirth; these include increased maternal age, obesity, smoking, caffeine intake and alcohol consumption.

Nilsson *et al.* (2014) suggests that by reducing risk factors before and during pregnancy up to 25% of miscarriages before 22 weeks gestation could be prevented.

Increased maternal age has been identified as a risk factor for pregnancy loss (Garcia-Enguidanos *et al.*, 2002, Maconochie *et al.*, 2006; Arck *et al.*, 2008; RCOG, 2011; Nilsson *et al.*, 2014). In an observational study conducted in Denmark, maternal age of over 30 years was associated with an increased risk of miscarriage up to 22 weeks gestation (Nilsson *et al.*, 2014). Maternal age over 40 was linked to a 5 fold increase in the rate of miscarriage in the first trimester by Maconochie *et al.* (2006). Similar results were noted by de la Rochebrochard and Thonneau (2002), who found that maternal age over 35 years and also paternal age over 40 years was associated with a higher incidence of miscarriage.

Obesity is also identified as a risk factor for miscarriage and stillbirths (Lashen *et al.*, 2004; Tennant *et al.*, 2011; Rittenberg *et al.*, 2011; Nilsson *et al.*, 2014; Hawkins Bressler et al. 2015). Tennant *et al.* (2011) and Hawkins Bressler et al. (2015) found a two to three times increased risk of miscarriage and stillbirths in women who were obese when compared to women with a normal BMI. This is supported by the results of studies by Rittenberg *et al.* (2011) and Lo *et al.* (2012) which also found an increased risk of miscarriage in women who are obese. Research also suggests that women who are underweight have an increased risk of miscarriage (Arck *et al.*, 2008; Nilsson *et al.*, 2014). However, the generalisability of some of these studies can be questioned. Both Hawkins Bressler et al. (2015) and Rittenberg *et al.* (2011) looked only at women who became pregnant after fertility treatment. Tennant *et al.* (2011) investigated only one geographical area of England. Further research investigating the link between obesity and miscarriage in wider populations is required to confirm these findings.

Cigarette smoking has been associated with an increased risk of miscarriage; however, RCOG (2011) advise that there is inadequate evidence to support this. Smoking was not found to significantly increase the risk of miscarriage by Maconochie *et al.* (2006) or Nilsson *et al.* (2014). Alcohol consumption during pregnancy was found to be an important risk factor for miscarriage by Nilsson *et al.* (2014). This is supported by Maconochie *et al.* (2006) who found that regular alcohol consumption was associated with an increased risk of miscarriage. In contrast to these findings a literature review by Simpson (2007) concluded that alcohol use in

pregnancy has little effect on miscarriage risk. Further research examining risk factors specifically for second trimester miscarriage would be valuable.

Literature examining the risk of miscarriage associated with caffeine intake is inconsistent. Nilsson *et al.* (2014) found that caffeine consumption increased the risk of miscarriage. This is in contrast to the findings of Maconochie *et al.* (2006) who found there was not an association between caffeine intake and miscarriage. Li *et al.* (2015) conducted a meta analysis of studies examining caffeine intake in pregnancy and concluded that caffeine intake is associated with an increased risk of pregnancy loss. Moreover, the risk of pregnancy loss increases with increased levels of caffeine intake (Li *et al.*, 2015).

Risk factors for miscarriage include increased maternal age, obesity, cigarette smoking, alcohol consumption and caffeine intake. However, there is limited research examining these risk factors specifically in second trimester miscarriage.

2.5 Caring for bereaved parents

Miscarriage is seen by women as sudden, surprising and upsetting experience (Murphy and Merrell, 2009). The hospital admission has been identified as a critical part of the women's experience of miscarriage (Murphy and Merrell, 2009) and can greatly influence the women's recovery after a pregnancy loss (Stratton and Lloyd, 2008). In order to give the best possible care for women and their families who experience a pregnancy loss, the health care services provided must consider both the physical and psychological needs of the parents (Schott and Henley, 2007).

2.5.1 Clinical management

When a woman experiencing a miscarriage presents to a health care professional or if fetal demise is diagnosed, it is necessary to put in place a plan of care. Considering the limited material available on second trimester miscarriage, it may be difficult to determine which course of action will provide the best holistic treatment (Schott and Henley, 2007). Options for management are expectant management, medical management or surgical management. The woman's overall condition, her medical and obstetric history and her own preferences should be all considered when deciding on a management plan (HSE, Clinical Practice Guideline, no: 29, 2014).

The most favorable method of managing second trimester miscarriage continues to be debated (Saraswat *et al.*, 2014).

For the majority of women internationally, the chosen method of management is induction of labour rather than surgical management, as it allows for the normal process of labour, a complete fetus, and negates the need for surgically skilled personnel (Bryant *et al.*, 2011). Moreover, medical induction of labour allows for fetal autopsy, which can be valuable in investigating the cause of pregnancy loss (Saraswat *et al.*, 2014). In their study examining the safety of surgical evacuation versus labour-induction for fetal anomalies and fetal death, Bryant *et al.* (2011) found that surgical management was associated with fewer complications than labour-induction, which most commonly resulted in retained placenta or pyrexia. Furthermore, they deemed surgical management to be more preferential to women. In contrast a study conducted by Burgoine *et al*. (2005) comparing grief resolution after medical and surgical management for second-trimester pregnancy termination for fetal anomalies indicated that there was no difference in grief resolution among women who underwent either medical or surgical management, though caution is needed when interpreting the findings given the small sample size and lack of generalisability to other pregnancy loss groups. Similar results were found by Kong *et al.* (2013) who investigated outcomes after surgical, medical and expectant management of miscarriage. No significant differences were found between medical and surgical management in relation to psychological well being.

HSE (Clinical Practice Guideline, no: 29, 2014) recommends the use of mifepristone in combination with a prostaglandin for induction of labour for women who have been diagnosed with a second trimester miscarriage. Misoprostol is the usual prostaglandin used and has been found to be safe and effective. It is associated with side effects such as nausea, vomiting and fever. When compared with oxytocin, misoprostol gives a shorter time from administration to birth but has a greater incidence of side effects (Elami-Suzin *et al*., 2013). In a review of the literature on the subject of medical management for pregnancy loss before 24 weeks Neilson *et al.* (2012) found that misoprostol is a safe and effective method of induction, but suggest further research to identify the most effective route and dosage regimens. The Guidelines from the HSE (Clinical Practice Guideline, no: 29, 2014) advise that the third stage of labour is actively managed to reduce the risk of post-partum haemorrhage and manual removal of placenta (MROP) is performed when the

placenta is undelivered after an hour. Rates of MROP are often higher in women who have delivered during the second trimester and Morris *et al.* (2014) found a rate of 26% for MROP following miscarriage between 14 and 24 weeks.

2.5.2 Pain management

Abdominal pain is one of the most frequently experienced side effects of the medical management of miscarriage (Saraswat *et al.*, 2014). The need for adequate pain management during miscarriage is highlighted in the literature (Gold *et al.* 2007; HSE Clinical Practice Guideline no 29, 2014). There is little evidence available on what constitutes effective analgesia during miscarriage and very little information on women's preferences for analgesia. Physical pain is experienced by the majority of women who experience a miscarriage (Adolfsson, 2010; Stejourne *et al.* 2010). The majority of the literature relating to this area focused on pain relief during medical induction for terminations of pregnancy and may not necessarily be applicable to the needs of women who experience second trimester miscarriages (Jackson and Kapp, 2011; Orbach-Zinger *et al.*, 2012).

Hamoda *et al.* (2004) investigated analgesia requirements of women undergoing medical abortion up to 22 weeks of pregnancy and found that the majority of women (72%) required analgesia. The most commonly used analgesia was oral paracetomol and codeine (97%), followed by intra muscular opiates (2.4%) and rectal diclofenac (0.3%) (Hamoda *et al.*, 2004). The effectiveness of analgesia used or women's preferences for analgesia was not investigated in Hamoda's study. Westhoff et al (2000) also examined analgesia use in women during medical abortions and found that 27% of participants required narcotic analgesia. The researchers suggest that analgesia use is less in women who have had previous vaginal deliveries and in earlier gestations (Westhoff et al, 2000). A randomised controlled trial by Castro *et al.*, (2003) conducted with women experiencing second trimester labour for elective abortion, examined patient controlled analgesia for morphine and three different fentanyl regimens and they found no difference in effectiveness between the four groups, although patient satisfaction was highest in the group that received fentanyl 50µg. Another study looking at induction of labour for fetal demise deemed it to be beneficial for pain relief to be given at the same time as the induction drug in order to provide as much relief from pain as possible (Jansson and Adolfsson, 2010). Although the current research available is limited, information gathered from these

studies could be used to as a platform for further research in this important area of clinical practice. While research has highlighted that the process of miscarriage is a painful experience and some studies have investigated types of analgesia there is limited information regarding women's experiences of pain and pain relief during second trimester miscarriage.

2.5.3 The care environment

There is some debate in the literature are to where is the most appropriate place to care for women when experiencing second trimester miscarriage? HSE Clinical Practice Guideline no 29 (2014) advise that women should be cared in a ward with no women with uncomplicated pregnancies or healthy babies. Women who gave birth to a stillborn infant in a delivery unit reported distress at hearing other babies crying (Kelley and Trinidad, 2012). Gold *et al.* (2007) found that while women reported increased distress being cared for on a ward with women who have healthy babies, women were critical of care on gynecology wards. Qualitative research examining women's experiences of pregnancy loss up to 28 weeks conducted in Ireland by Mulvihill and Walsh (2013) mirror these findings and report women had varying opinions on the most appropriate care environment. Some women report a feeling of being left alone, when nursed in single rooms, while others valued the privacy of single rooms and were critical of being nursed in busy wards (Murphy and Merrell, 2009; Mulvihill and Walsh, 2013). The national maternity strategy for Ireland advises that women who experience a miscarriage should not be in the same ward as pregnant women; however, the strategy acknowledges that providing this may not always be possible at present (Department of Health, 2016). Further research is needed to identify the best care environment for bereaved mothers.

2.5.4 Communication with medical professionals

The profound psychological impact of pregnancy loss on a woman and the need for sensitive individualized care has been highlighted in the literature (Lee 2012; Downe *et al.* 2013). Interactions with medical professionals are of vital importance to women when experiencing a pregnancy loss (Rowlands and Lee, 2010). Research has highlighted the need for empathetic communication from medical professionals during pregnancy loss and the importance of listening, eye contact and sensitivity

(Paton *et al.* 1999; Saflund *et al.*, 2004; Fenwick *et al.*, 2007; Murphy and Merrell, 2009; Musters *et al.* 2013; Mulvihill and Walsh, 2013).

A number of reports in both Ireland and the UK highlight the importance of communication with bereaved parents. Following a review of a number of perinatal deaths in Midland Regional Hopsital, Portlaoise (a rural based hospital in Ireland) the chief medical officer highlighted a number of communication issues with the hospital staff and bereaved parents. The need for honest, respectful and empathetic communication is highlighted in his report (Health Information and Quality Authority, 2015). These recommendations were echoed by the Morecombe Bay Investigation (2015) which investigated maternity care in one NHS trust. The recently launched Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death also highlight the need for effective and sensitive communication with parents. The standards recommend all staff who work with bereaved parents receive training in relation to bereavement care (Health Service Executive, 2016). Women who experienced a stillbirth valued interactions with health professionals when they took time to sit with them, used eye contact and showed empathy (Kelley and Trinidad, 2012). A number of qualitative research studies report that parents feel anger and distress when insensitive comments are made by medical professionals (McCreight, 2008; Rowlands and Lee, 2010; Kelley and Trinidad, 2012; Downe *et al.*, 2013, Mulvihill and Walsh, 2013). Sensitive and empathetic communication with bereaved parents is also considered vital by midwives (Fenwick *et al.*, 2007). Comments from medical staff such as 'you are young- you can have another' were viewed as extremely upsetting and insensitive by bereaved parents (Kelley and Trinidad, 2012: 8.). Women also reported frustration with the lack of information provided by medical professionals (Stejourne *et al.* 2010), and felt their condition and medical procedures were poorly explained to them if at all (Rowland and Lee, 2010). These findings are echoed by Mulvihill and Walsh (2013) and Paten *et al.* (1999) who emphasize the importance of appropriate communication from staff and describe women's dissatisfaction with the use of medical jargon and poor explanations from staff. The way in which bad news is broken to mothers when a miscarriage is diagnosed is also highlighted as being very important to bereaved parents (Paton *et al.*, 1999; Meert *et al.*, 2009; Mulvihill and Walsh, 2013).

2.5.5 Making memories

Spending time with their baby and creating memories following stillbirth has been identified as very important to parents (Samuelsson *et al.*, 2001; Trulsson and Rådestad, 2004; Saflund *et al.*, 2004; Kelley and Trinidad, 2012; Downe *et al.*, 2013). There is very little literature examining this issue in second trimester miscarriage.

Whether parents should see and hold their baby seems to be a contentious topic in the literature. One study reported higher levels of depression for women who saw their stillborn infant with an increased possibility of disorganisation of attachment in their subsequent child (Hughes *et al.*, 2002) which was linked to unresolved mourning. However, this study has been widely criticised by others who urged caution in removing existing practice (Lovett, 2001; Schott and Henley, 2007). Lovett suggested the negative effect of seeing the baby might have been linked to the psychological care experienced at the time, a factor which was not taken into account by Hughes *et al.* (2002). Rådestad et al. (2009) found that parents who had a stillborn baby after 37 weeks gestation benefited from holding their baby, whereas findings for babies born before 37 weeks is unclear. Further research examining the benefits of and parents' experience of holding preterm stillborn babies and in second trimester miscarriage is required. The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for the management of stillbirths cautions medical professionals against persuading parents to view or hold their stillborn infant (RCOG, 2010). A number of studies have reported that parents feel some persuasion may be appropriate (Kelley and Trinidad, 2012; Downe *et al.*, 2013). Trulsson and Rådestad (2004) reported that women in their study were grateful for the encouragement from staff to see and hold their baby and none of the women in this study regretted seeing their baby. An Australian study by Wilson et al. (2015) found that the majority of parents chose to hold their stillborn baby and reported little regret from parents, regardless of the decision to hold the baby or not. Most authors agree seeing the baby should be a matter of choice and one which should be discussed with the parents openly and supportively (Bowles *et al.*, 2000).

Interestingly Saflund and Wrendling (2006) found that almost half of parents felt that the amount of time they spent with their child after a stillbirth was too short. Along with seeing and holding the baby, many authors feel it is important for parents to organise a funeral or be involved in the process (Stringham *et al.*, 1982; Gold *et al.*,

2007). Some parents felt a strong desire to bath and dress the baby themselves (Downe *et al.*, 2013; Saflund *et al.*, 2004) and were critical when staff didn't allow this (Kelley and Trinidad, 2012). Fathers greatly appreciated tokens of remembrance such as the baby's footprints and photos; moreover many fathers would encourage staff to secure these tokens even if parents declined them at the time (Samuelsson *et al.*, 2001). These findings are supported by Downe *et al.* (2013) and Lee (2012) who found that parents valued good quality photographs, handprints, foot prints and locks of hair and also the availability of these at a later date if they were initially declined. Lisy et al. (2016) synthesized information from 20 qualitative studies and found that items of remembrance are valuable and received with gratitude from parents.

2.5.6 Follow up

Due to the psychological impact miscarriage can have, many authors highlight the need for follow up care in order for women to discuss any unresolved concerns or feelings they may have following the experience (Griebel *et al.*, 2005; Kong *et al.*, 2010a; Mulvihill and Walsh, 2013).

The current recommendation within maternity services is that all women who experience a pregnancy loss in the 2nd trimester should have a follow up appointment with a consultant obstetrician and the results of any investigations should be available at this appointment (HSE, Clinical Practice Guideline, no: 29, 2014). As identified by Nikcevic *et al.* (1998), a follow up appointment was desired by 92% of women, the vast majority of which felt it was very or extremely important to discuss reasons for the miscarriage. In addition, they stressed the need for such appointments to incorporate time spent discussing their feelings with regard to the miscarriage; however, only 30% of those given a follow up were granted the opportunity to do so, a need which was echoed by Belkin and Wilder (2007). A number of research studies suggest that when follow-up appointments were offered to bereaved women they tended to be well supported as indicated by high attendance rates (Athey and Spielvogel, 2000; Cullen et al., 2016.).

Bereaved parents consistently report a desire for follow up support (Stratton and Lloyd, 2008; Meert *et al.* 2009; Stejourne *et al.* 2010). While Stratton and Lloyd (2008) agree that there is a need for follow-up care for bereaved women following a miscarriage they also argue that there is little evidence to support the efficacy or

utility of such practice. In light of this deficit in knowledge, research focusing on assessment, information, follow-up and care delivery in subsequent pregnancies is necessary in order to inform practice and develop appropriate services (Stratton and Lloyd, 2008). Stratton and Lloyd (2008) explain that it is unusual for women to seek help on their own initiative and Mulvihil and Walsh (2013) highlight the need for services to reach out to bereaved parents and advocate a proactive approach to follow up care.

Various forms of medical and psychological follow up care after pregnancy loss are discussed in the literature, including follow up appointments with doctors, midwives, nurses, social workers and psychologists or counsellors. Other forms of follow up including telephone support have also been found to be beneficial to parents (Donavan *et al.*, 2014; Jacobs and Harvery, 2000). Follow up care needs to address both the psychological and medical needs of bereaved parents (Stratton and Lloyd, 2008; Murphy and Merrell, 2009). In a review of literature examining psychological support following miscarriage Murphy *et al.* (2012) concluded that there is insufficient evidence to confirm that psychological support such as counselling is effective after miscarriage. Kong et al. (2014) conducted a randomised controlled trial to evaluate the effectiveness of counselling for women following miscarriage. The authors concluded that routine counselling was not justified for women who experience miscarriage (Kong et al., 2014). The most appropriate form of follow up support remains unclear and further research including parents' preferences for follow up care is needed.

The timing of follow up is debated in the literature, Stratton and Lloyd (2008) suggest follow up should take place with one to six weeks. While the HSE recommend follow up support for women following a second trimester loss (HSE, Clinical Practice Guideline, no: 29, 2014), no recommendation of the timing of the follow up is given. Women report a desire for follow up at varying timings, some reporting a desire for support within a few days while others preferring to wait a few weeks (Stejourne *et al.* 2010).

2.5.7. Parents' satisfaction with hospital care

Due to a lack of research examining parents' experiences of hospital care specifically during a second trimester miscarriage, research examining parents' experiences of

hospital care during miscarriage, stillbirth and neonatal death were reviewed. Research examining parents' experiences of hospital care before during and after perinatal loss report that the majority of parents were positive about the quality of care they received from medical staff (Paton *et al.*, 1999; Lasker and Toedter, 2007; Lee, 2012; Downe *et al.*, 2013; Basile and Thorsteinsson, 2015). Parents' distress following miscarriage can be intensified by dissatisfaction with aspects of care (Stratton and Lloyd, 2008). Almost 90% of parents in one American longitudinal study reported they were either very satisfied or satisfied with hospital care during a pregnancy loss, moreover half of the participants stated there was nothing they wish had been done differently in relation to their care (Lasker and Toedter, 2007). An Australian study found a significant increase in parents' satisfaction with care following stillbirth after the introduction of national guidelines for the management of stillbirth (Basile and Thorsteinsson, 2015). The authors also report higher levels of satisfaction from parents who attended hospitals that follow the recommendations in these guidelines when compared to hospitals who do not follow these guidelines (Basile and Thorsteinsson, 2015). This suggests the importance of not only developing evidence based guidelines for perinatal loss but also the implementation of guidelines in all maternity hospitals. While a high percentage of women in a study by Paton *et al.* (1999) were satisfied with the overall care in a London hospital during a miscarriage, dissatisfaction with care was related almost exclusively to a lack of emotional support from staff.

The time spent in hospital can greatly influence the women's overall experience of miscarriage and her recovery after a pregnancy loss (Stratton and Lloyd, 2008; Murphy and Merrell, 2009). The literature highlights the importance of adequate pain relief, the clinical area the women is cared for in, making memories and follow up for bereaved parents. There is limited research specifically examining parents' experiences of hospital care during second trimester miscarriage and further research is required to understand this group of parents' specific needs to help improve care delivery.

2.6 Theories of grief and loss that inform the care of bereaved parents

Grief is a normal response to any significant loss (Strada, 2013) and is a very individual and personal experience (Mander 2006). Grief manifests itself in a number

of ways including physical, cognitive, psychological and spiritual reactions (Strada, 2013). Discussion about grief dates back as far as the 1600's when Robert Burton published 'The Anatomy of Melancholy' (Archer, 1999). During this time grief was associated with adverse effects on an individual's health and was viewed as potentially fatal (Archer, 1999). Freud's psychoanalytic theory (Freud, 1917/1957) and attachment theory (Bowlby, 1980) has been greatly influential on current theories related to grief (Stroebe and Schut, 2001). Freud is credited with introducing the concept of 'grief work' and proposed that when a loved one dies the bereaved individual is left with the difficult task of severing ties and detaching from energy invested in their loved one who has died (Stroebe and Schut, 2001). Freud believed that failure to complete this 'grief work' could lead to prolonged or pathological forms of grief, this led to an emphasis on the importance of bereavement counseling (Walker et al., 2004). The focus on detaching from the deceased person remains an issue that is debated among grief theorists; however, according to Bunglass (2010) Freud's beliefs in relation to the need to confront grief remains a feature in contemporary grief theories.

Kubler-Ross (1969) developed a model for understanding bereavement based on her experiences with dying patients. The model describes the five stages that people faced with a life threatening diagnosis appeared to pass through, the phases are; denial, anger, bargaining depression and finally acceptance (Kubler-Ross, 1969). While Kubler-Ross provides a useful framework for understanding the adjustment to loss there is no evidence that individuals go through these stages, moreover reactions to loss are very variable and categorizing people experiencing loss in terms of stages may not be helpful (Walker et al., 2004). A number of criticisms of the theories involving phases and tasks of bereavement have been offered in the past (Small, 2001). One such criticism is provided by Corr et al. (1997) who informs of the pitfalls of stage and task approaches to bereavement and is critical of the implication that grief has an ending. Samarel (1995) warns of the problems associated with the way in which Kubler-Ross's theory is used by health care professionals and questions the desired outcome of acceptance for all individuals.

John Bowlby developed the attachment theory of grief and has been greatly influential in the understanding of grief and loss (Small, 2001). Bowlby (1980) cited in Strada (2013) explains that humans naturally form an attachment with others and studied infants separated from their mothers. Bowlby's theory explains the normal

human need to form emotional bonds with others, which begins as an infant between a baby and its parents (Buglass, 2010). Grief is described by Bowlby (1980) as the emotional reaction to the loss of attachments to a loved one he also discussed grief as a series of attachment behaviours which are performed after a loss (Small, 2001; Strada, 2013). The mourning process is described in four phases; numbness and disbelief, yearning and searching, disorganisation and despair and reorganization (Archer, 1999). Parkes (1987) applied Bowlby's theory on attachment to his own work on bereaved women and described the emotional, behavioral and physical manifisatations of grief (Mander, 2006). Parkes also discussed the importance of 'grief work' and believed bereaved individuals are faced with the task of creating a new view of the world after the loss of a loved one (Strada, 2013). Parkes (1998) sited in Buglass (2010) explains the importance of working through feelings of anger, guilt and anxiety during grieving in order to adapt to the loss.

Worden (2009) developed a model of grief which emphasis the importance of working through tasks of grief starting with accepting the loss. The model begins with passive phases of grief and moves onto to active tasks of morning (Buglass, 2010). The tasks include working through the experience of grief, adjusting to the environment without the deceased individual and withdrawing emotionally from the deceased and moving on (Worden, 2009). Stroebe at al. (1993) cautioned against the use of prescriptive models of grief as they do not allow for variations and can lead to judgments about a correct way to grief. The dual process theory was developed in an attempt to integrate existing theories and models of coping with bereavement (Stroebe and Schut, 2010). The theory suggests that bereaved individuals alternate between loss-orientated and restoration-orientated responses and the balance of emphasis changes over time (Small, 2001). This theory recognizes the individual, dynamic process of grieving and explains how the expression of grief can alternate between distress and reviewing the loss and periods of coping and integrating the loss in a meaningful way (Strada, 2013). Buglass (2010) believes that the dual process theory is a more flexible way of understanding of grief. Moreover, the dual process model also provides a framework for understanding complicated grief (Stroebe and Schut, 2010). According to Stroebe and Schut, (2010) when an individual is experiencing complicated grief they focus on either loss-orientated or restoration-orientated responses and avoid the other and poor adaptation is likely to occur.

As previously described grief is a normal response to a loss. Grief can become complicated and the intensity and duration of symptoms can be increased (Glass, 2005). Complicated grief is an abnormal response to grief that occurs in a small number of individuals after the loss of a loved one (Shear et al., 2011). The incidence of complicated grief quoted in the literature varies between 5% and 20% (Love, 2007; Shear et al., 2011). While normal grief does not need professional intervention complicated grief requires professional assessment and intervention (Strada, 2013). Healthcare professionals need an awareness of complicated grief and the possible signs that an individual is experiencing complicated grief (Shear et al., 2011). Strada (2013) explains that there are a number of risk factors associated with complicated grief and recommend that health care professionals should focus on identifying those at risk for developing complicated grief. Risk factors include: history of depression or psychiatric illness, childhood abuse or neglect, a sudden traumatic death, prolonged deaths and lack of support after the loss (Strada, 2013). Shear et al. (2011) explains there are a number of signs of complicated grief six months following the death of a loved one including; frequent intense feelings of loneliness, feeling empty, preoccupying thoughts of the loved one who died, inability to accept the death and persistent feelings of shock, or feeling emotionally numb. Complicated grief can have negative long term effects and has been linked to increased risk of hypertension, reduced quality of life and suicidal ideations and behaviours (Strada, 2013). When complicated grief is suspected, referral to an appropriate professional should be arranged (Love, 2007).

In summary, the traditional views of grief focus mainly on severing bond with the deceased person and outline stages of grief. These prescriptive theories have been challenged in recent years with a more individualized approach to understanding grief being advocated (Buglass, 2010). Klaus et al. (1996) sited in Neimeyer, (2014) believes that establishing ongoing bonds with the deceased is a normal part of the grieving process. Maintaining emotional bonds with a deceased loved one can be comforting for bereaved individuals. Grief is a unique experience for each individual and healthcare professionals need to provide individualized person-centered bereavement support (Buglass, 2010). The theories of grief provides a context for exploring the psychological impact of miscarriage on parents.

2.7. The psychological impact of miscarriage on the woman

Given the overlap in definitions of second trimester miscarriage, stillbirth and miscarriage, the literature review was extended to include all pregnancy loss in order to examine the psychological impact of pregnancy loss on women.

2.7.1 Grief following miscarriage

Grief is a person's emotional, psychological or affective response to loss, which is unique to each individual (Mader, 2006). Grief is the most common reaction to a miscarriage (Athey and Spielvogel, 2000). A review by Brier (2008), reported that grief reactions following miscarriage tended to be similar to those experienced with other types of significant losses. This is in contrast to the opinions of other authors who feel that grief related to miscarriage is unique and often occurs alongside feelings of guilt (Adolfsson, 2011; Wen-Yi Hui *et al.*, 2012). Adolfsson (2011) explains that grief following miscarriage is different to other forms of grief, with wider manifestations and greater feelings of guilt. Not only do women grieve the loss of their baby, but also the loss of hopes to either start or continue their family (Athey and Spielvogel, 2000). The intensity of the grief reaction was found to be similar within the first 6 months following the loss, but eased after this (Brier, 2008).

2.7.2 Mental health after miscarriage

A meta-analysis conducted by Adolfsson (2011) indicated that a large number of women demonstrated psychiatric morbidity 10 days after the miscarriage. Miscarriage has been linked to a number of mental health issues, including depression (Adolfsson, 2011), anxiety (Athey and Spielvogel, 2000), post traumatic stress disorder (Bowles *et al.*, 2000) and even an increased risk of suicide (Gissler et al., 1996). Depression and anxiety are the most common form of psychological problems in women after miscarriage (Wen-Yi Hui *et al.*, 2012), almost half of women who experience a miscarriage report psychological difficulties such as elevated levels of anxiety and depression in the weeks and months after their loss (Athey and Spielvogel, 2000; Lok and Neugebauer, 2007). Following a review of the literature examining anxiety after miscarriage, Brier (2004) found that a significant number of women experience anxiety and recommends routine screening of women for anxiety following miscarriage. Other studies highlight a link between miscarriage and Post-traumatic Stress Disorder and recommend interventions to identify patients requiring

treatment (Bowles *et al.*, 2000; Bennett *et al.*, 2008). An early study by Gissler et al. (1996) found a greater risk of suicide following miscarriage when compared to following a birth. Family support has been found to reduce the incidence of anxiety and depression after stillbirth (Cacciatore et al., 2009; Erlandsson et al., 2011). Support from the father of the baby has also been found to be associated with depression in women who experience stillbirth (Surkan et al., 2009). Women who's partner refused to talk about their stillborn baby were more likely to experience depression (Surkan et al., 2009).

Health professional caring for women experiencing miscarriage need to be aware of the potential for psychological issues and the risk factors for developing these complications (Wen-Yi Hui *et al.* 2012). Risk factors of psychological issues following miscarriage include lack of social support, pre-existing psychological disorders and previous pregnancy losses (Lok and Neugebauer, 2007). Further risk factors were identified by Athey and Spielvogel (2000) which include no living children and lack of information and explanations given about the miscarriage. Rowlands and Lee (2010) advise that women with a history of mental health problems should be given greater support following a miscarriage to assist these women to cope with their loss.

2.7.3 Guilt and needing to know why it happened

Adolfsson *et al.* (2004) found that women frequently blamed themselves for causing the miscarriage. Interestingly, Aldolfsson (2011) found in their meta-analysis that guilt was higher in women who experienced miscarriage than other forms of pregnancy loss. A number of studies highlight women desire to identify the cause of the miscarriage and report that the absence of a cause can make the experience more difficult (Simmons *et al.* 2006; Mulvihill and Walsh, 2013). Kelley and Trinidad (2012) found that parents wanted to understand the reasons for a stillbirth and felt frustration when health care professionals could not provide answers. For some women, when a cause is identified, they can be reassured that recurrence is unlikely in further pregnancies, whereas when no reason can be identified, many couples turn to their lifestyle choices for a reason and many direct blame inwards (Stringham *et al.* 1982; Simmons *et al.*, 2006; Jansson and Adolfsson, 2010). In contrast to these findings Nikcevic *et al.* (2000) found similar levels of anxiety or distress in women who had been given a cause for their miscarriage and in those where no cause was identified. Simmons *et al.* (2006) study undertaken in the UK examined the experience of

miscarriage and reported that self-blame and a need for answers were important issues for couples. Stringham *et al.*'s (1982) study found that when a post mortem was carried out parents of miscarriages of a "normal" infant were gratified for having produced a genetically healthy infant but also resentful that the otherwise healthy infant had not survived.

2.7.4 Effect on relationships

Swanson et al. (2003) found that one year following their loss couples reported that their personal and sexual relationship with each other was more distant. The literature highlights the profound psychological impact of miscarriage on a woman and her partner. When dealing with grief, such difficulties can have an impact on the couple's relationship, either positively or negatively. While the experience may draw some couples closer together by surviving and working through their grief, for others, their grief may become a barrier to communication, thus impacting their relationship (Adolfsson *et al.*, 2004). Gold *et al.* (2010) reported that an increase in relationship problems between couples after miscarriage and stillbirth when compared to a live birth. When couples are dealing with numerous miscarriages, they can sometimes have a sense of ambivalence towards the pregnancy, in the fear they will lose this child also (Serrano and Lima, 2006). One study found such losses can reduce a women's own perception of self-worth, reduce body image and consequently libido, thus impacting on their sexual relationship (Read, 1999). Serrano and Lima (2006) found while the couple's relationship seemed to be unchanged by recurrent miscarriages, the couples reported sexual changes after the events. Although miscarriages can negatively affect the couple's relationship, Lasker and Toedter (1991) suggested that being in a long term relationship can play a protective role against illnesses such as depression following such losses

2.7.5 Psychological effects in future pregnancies

A number of studies found that women who experienced a miscarriage can experience increased stress and anxiety in subsequent pregnancies (Fertl *et al.*, 2009; Woods-Giscombe *et al.,* 2010; Kinsey *et al.*, 2013). Women with a history of miscarriage, regardless of having a living child, were found to have greater anxiety during the second and third trimesters in subsequent pregnancies, when compared with women without a prior miscarriage (Woods-Giscombe *et al.,* 2010). While

women who experienced a miscarriage in an American study reported increased fear of an adverse outcome in subsequent pregnancies, there was no association found between a history of miscarriage and birth experience (Kinsey *et al.*, 2013). A review of the literature examining the psychological well being of women following miscarriage, reports that psychological issues associated with miscarriage (such as grief, anxiety and depression) may negatively impact on future pregnancies (Wen-Yi Hui *et al.,* 2012).

Miscarriage can have a profound psychological impact on parents. Grief following miscarriage is believed to be very different to other forms of grief and can impact on the woman's mental health. Miscarriage can also lead to feelings of guilt, problems in relationships and can impact future pregnancies. Again the literature examining psychological effects of second trimester miscarriage is limited and this is an area that requires further investigation.

2.8 Fathers' experiences of pregnancy loss

Pregnancy loss can affect women differently to men, where women must deal with the physical effects; men must deal with their feelings of loss while also dealing with seeing their partner in pain and discomfort. There is a dearth of literature examining men's experience of perinatal loss, particularly second trimester miscarriage; the majority of the studies identified examine men's experience of still birth or neonatal death.

A small pilot study with ten Irish fathers who experienced early pregnancy loss, reported that all fathers felt more support services should be offered to men (Khan *et al.*, 2004). One early study, conducted in the 1980's, included both men and women and examined satisfaction with hospital care during pregnancy loss at all gestations and found parents were overall satisfied with the care provided (Lasker and Toedter, 2007). Unfortunately results for men and women were not separated and it is difficult to ascertain the fathers' experiences specifically. A number of studies were identified that investigated both parents' experiences of stillbirth and neonatal death (Dyegrov and Mathhiesen, 1987; Saflund *et al.*, 2004; Kelley and Trinidad, 2012; Downe *et al.*, 2013). Fathers' experiences were again not reported separately in most of the studies. All the studies had much less fathers then mothers involved and the number of fathers included was often unclear. A qualitative study by Samuelsson *et al.*,

(2001) investigated fathers' experiences of Stillbirth and found men commonly felt frustrated and helpless during the birth. Samuelsson *et al.* (2001) found that fathers experienced feelings of grief, pride and tenderness when they held their stillborn child and were satisfied with the support provided to them by the hospital. In contrast, an earlier study which found that fathers were dissatisfied with the support received from hospital staff and felt ignored by hospital staff (Dyegrov and Mathhiesen, 1987). These findings were echoed by McCreight (2004) and Murphy and Hunt (1997) who reported that poor communication with hospital staff often made the experience of miscarriage worse for men and that men often felt excluded by hospital staff. The majority of these studies have been published more than ten years ago. Much has changed in the maternity care services in that time and more up to date research examining fathers' experiences of pregnancy loss is needed.

There is some evidence available in relation to men's psychological responses to perinatal loss. Many men who experienced pregnancy loss after twenty weeks of gestation report feeling grief, shock, anger, helplessness and loneliness (Badenhorst *et al.,* 2006). Serrano and Lima (2006) found that after recurrent miscarriages men felt grief and a profound sense of loss. Following a review of the literature Athey and Spielvogel (2000) concluded that men grieve less intensely after a miscarriage and for a shorter period of time when compared to women. These findings are supported by Kong *et al.* (2010b), who found that while both men and women are affected by miscarriage fathers tend to recover sooner when compared to their partners. Men also tend to talk about their feelings about pregnancy loss less than their partners and often avoid the topic completely (Athey and Spielvogel, 2000). Men often report feeling the need to be strong for their partner and provide support to her (McCreight, 2004). One study suggests stillbirth can impact fathers psychologically during subsequent pregnancies and many experience anxiety (Turton *et al.,* 2006). Health professionals need to be aware of the potential for men to suffer intense grief following perinatal loss and may need specific help and support to aid recovery (Badenhorst *et al.,* 2006).

There is a growing body of research examining men's experiences with maternity services during healthy pregnancies, labour and birth. Research suggests men generally view their experiences with maternity care as positive but are often critical of communication with hospital staff (McHugh *et al.*, 2013; Dellman, 2004). Men often

described their experience during labour and birth as distressing and report confusion about their role in the process (Dellman, 2004).

Mulvihill and Walsh (2013) highlight the need for further research examining fathers' experiences of pregnancy loss in order to allow medical professionals to meet the needs of both parents. While some studies include both parents, no research was identified which looked specifically at fathers experiences of second trimester miscarriage. Moreover, the majority of studies that included both parents did not report results for fathers separately. Difficulty in attracting men to take part in research may account for the lack of research in the area. One Irish study highlighted difficulties in recruiting fathers and were unsuccessful in their attempts to recruit any fathers for interviews (Mulvihill and Walsh, 2013). Therefore, there is limited information on fathers' experiences of perinatal bereavement in particular Irish fathers' experiences of second trimester miscarriage.

2.9 Healthcare professionals' experiences of caring for bereaved parents

The delivery of quality care for bereaved parents is challenging and complex (Wallbank and Robertson, 2013) and requires nurses and midwives to remain empathic and engaged with parents to facilitate a healthy grieving process (Kohner, 2007). Providing care to bereaved parents can be demanding and can lead to health professionals being overwhelmed and emotionally burned out, which can negatively impact on patient care (Chan and Arthur, 2009).

Parents who have experienced a pregnancy loss require support and empathy from medical professionals (Paten *et al.*, 1999; Kelley and Trinidad, 2012; Mulvihill and Walsh, 2013). The mindfulness and sensitivity shown by staff involved in their care makes a lasting impression on bereaved parents (Lasker and Toedter; 1994; Kong *et al.,* 2010a). It is recognised that mothers experiencing an early pregnancy loss may not always be afforded the emotional attention they require (Murphy and Merrell, 2009). Women are often discharged home quite soon after a pregnancy loss, and this is often the woman's choice. Due to this short time frame the establishment of a therapeutic relationship is more difficult (Stratton and Lloyd, 2008) and the focus for the nurse/midwife is often on the immediate physical needs and administrative work. Nurses caring for women with early miscarriage (before twelve weeks gestation) reported frustration at the lack of time and continuity of care which can impact this

has on their ability to provide emotional support to women (Murphy and Merrell, 2009).

Caring for families during perinatal loss can affect health professionals, both professionally and personally (Nuzum *et al.,* 2015). Doctors, nurses and midwives who care for women experiencing perinatal loss in the UK, reported significant levels of distress and often experienced feelings of self-blame and guilt (Wallbank and Robertson, 2013). Staff with less experience in bereavement reported higher levels of distress (Wallbank and Robertson, 2013). Providing bereavement support to parents can be stressful for health professionals and the lack of training and physical resources have been identified as key issues of concern for health professionals supporting bereaved parents and their families (Nuzum *et al.,* 2015). Training for health professionals in relation to care following a miscarriage has been described as one of the most neglected areas of healthcare education (Stratton and Lloyd, 2008). Health professionals have highlighted the need for further education in the area of perinatal bereavement support (Chan and Arthur, 2009; Nuzum *et al.,* 2015). Support and supervision for staff working with bereaved parents have been recommended to promote the psychological wellbeing of staff and improve patient care (RCOG, 2010; Wallbank and Robertson, 2013).

2.10 Summary

The chapter firstly discussed the literature relating to defining second trimester miscarriage, the prevalence of second trimester miscarriage and risk factors associated with second trimester miscarriage. Next the literature in relation to caring for women during a miscarriage was presented. The theoretical approaches that have informed our thinking about grief and bereavement were discussed followed by a discussion of the literature in relation to the psychological impact of miscarriage and fathers' experiences of pregnancy loss. Finally healthcare professional's experiences of caring for bereaved parents were discussed.

2.11 Rationale for the study

It is clear from the literature review that the experiences of hospital care received by parents following a second-trimester loss remain for the most part unseen. While an understanding of the needs of the mother with regard to her medical care and the bereavement support required by both the grieving parents and their family may be drawn from the literature pertaining to early miscarriage and stillbirth, more information is required. The purpose of this study; therefore, is to address this identified gap and build on what is already known to support the delivery of bereavement care which will target the specific needs of parents following a second trimester loss in a maternity hospital.

Chapter three

Methodology

3. 1 Introduction

Chapter three discusses the research design and methodology used for the current study. The chapter begins with a discussion of the rational for choosing a qualitative design. Qualitative methodologies that were considered for the current study are discussed next, followed by the rational for selecting a focused ethnography. Ethical considerations will then be discussed and the researcher describes how principles of autonomy, beneficence and non-maleficence, justice and respect were adhered to. The chapter continues with a discussion about sampling, recruitment and data collection. The pilot study and the interviews are then discussed, followed by the data analysis process. Finally the chapter concludes with a discussion on rigor and how it was maintained within this study.

3.2 Research design

The choice of the most appropriate research design is based on the research problem and the study's aims and objectives.

Study aim

The aim of the study is to explore mothers' and fathers' experiences of hospital care during second trimester miscarriage. In particular, this study will report on mothers' and fathers' views on the care received in the hospital from the time of diagnosis of the second trimester miscarriage through to follow-up care.

Study objectives

1) To report on mothers' experiences of services from the time of diagnosis of the second trimester miscarriage through to follow up care received. In addition, this study will focus on the length of hospital stay, preferences for place of care,

experiences of pain management during labour and birth and experiences of follow up care.

2) To report on fathers' experiences of services received by both his partner and himself from the time of his partner's diagnosis of the second trimester miscarriage to the follow up care received.

3) To inform the development of bereavement care services within the National Maternity Hospital for parents experiencing a second trimester miscarriage.

In order to ensure quality in research the most appropriate approach for investigating the research problem needs to be carefully considered (Topping, 2006). There are two distinct types of research designs that researchers can utilise (qualitative and quantitative), which derive from different historical traditions and have different philosophical underpinnings (Lacey, 2006). Qualitative approaches have emerged from the constructivist paradigm whereby reality is viewed as subjective and constructed within each individual, whereas the foundations which underpin the quantitative approaches in research are based on the positivism paradigm that reality is exists and can be studied objectively (Polit and Beck, 2011). Quantitative research collects numerical data and often has a hypothesis which can be tested (Polit and Beck, 2011). Researchers can also choose to utilise mixed method research, which integrates qualitative and quantitative research designs and is becoming increasingly popular in nursing and midwifery research (Fawcett, 2015). Mixed method research is defined as 'the broad enquiry logic that guides the selection of specific methods and that is informed by conceptual positions common to mixed methods practitioners' (Tashakkori and Teddlie, 2010, pp.5). Mixed methods research can be used to gain a wider understanding about the area under investigation and inadequacies of both methods can be overcome through utilising mixed methods (Williamson, 2005). Fox et al. (2013) conducted a mix methods study examine the use of complementary alternative medicine (CAM) for women with breast cancer. The mixed methods approach used in their study allowed the researchers to provide a comprehensive account of the perceptions and experience of CAM among women with breast cancer (Fox et al., 2013).

A number of researchers examining miscarriage and still birth used quantitative methodologies and added valuable knowledge to the area of bereavement care.

Quantitative studies such as Cullen et al. 2016; Hure *et al.* (2012); Westin *et al.* (2007) provide us with information regarding the prevalence of miscarriage. Quantitative research has also provided valuable information regarding the most effective medical treatments for women who experience miscarriage (Bryant *et al.*, 2011; Kong *et al.*, 2013). Carriatore et al. (2009) conducted a quantitative study investigating the effects of social support on anxiety and depression in women who experience still birth. This study adds to the available evidence that social support is important for bereaved parents and the importance of family support (Carriatore et al., 2009). One major advantage of quantitative data is its generalisability of its results (Parahoo, 2006). However, due to the objective, empirical nature of quantitative research it cannot consider individuals' unique experiences (Burns and Grove, 2009).

In contrast to quantitative research, qualitative research is concerned with the detailed exploration of an experience, culture or situation and takes into account the context and complexity of the phenomenon (Lacey, 2006). There are a number of qualitative research studies examining miscarriage and stillbirth (Samuelsson et al. 2001; Adolfsson et al. 2004; Aldolfsson, 2010; Kelley and Trinidad, 2012; Downe *et al.*, 2013; McGuinness et al. 2014). These studies all added valuable information to the area of bereavement care. Kelley and Trinidad, (2012) conducted a qualitative study and provided valuable information regarding parents' and physicians' experiences of stillbirth. This study provides information to inform practice and gives recommendations for future research. In qualitative research the researcher is the most important research tool and requires the researcher to engage deeply with the phenomenon being studied (Topping, 2006). When little is known about a subject a qualitative design in merited (Lacey, 2006). Given the lack of research examining parents' experiences of hospital care during a second trimester miscarriage, a qualitative approach was chosen for this study. The aims of this study were exploratory and descriptive, thus a qualitative method is most suitable to achieve these aims. Furthermore, this study examined the experiences of parents who experienced a second trimester miscarriage, who are a vulnerable group with small numbers; therefore, quantitative methods (which require larger numbers of participants) would be unsuitable.

3.3 Consideration of the qualitative methodologies appropriate for exploring mothers' and fathers' experiences of second trimester miscarriage.

Various qualitative research methods were examined to identify which approach would best meet the aims and objectives of this study, including phenomenology, case study, grounded theory and ethnography.

Phenomenology is concerned with the experiences of people within their life world (Polit and Beck, 2011). Phenomenology is useful when the topic being researched is related to the life experience of humans and when the topic is poorly understood (Streubert and Carpenter, 2011). Phenomenology has been used by a number of researchers examining bereaved parents' experiences (Samuelsson et al. 2001; Adolfsson et al. 2004; Aldolfsson, 2010). Each of these studies added valuable information to the body of research examining parents' experiences of pregnancy loss. There are two main types of phenomenological research used by nurses and midwives; descriptive phenomenology, guided by Husserl (1970) and interpretive or hermeneutic phenomenology guided by Heidegger (1996) as cited in Todres and Holloway (2006).

When conducting a study using descriptive phenomenology the researcher begins by gathering examples of everyday experiences (the life world or lived experience), the researcher then describes and reflects on these everyday experiences (Todres and Holloway, 2006). When utilising descriptive phenomenology the researcher must attempt to suspend their preconceptions about a topic (known as bracketing), this is to allow the researcher to approach the topic with 'fresh eyes' (Todres and Holloway, 2006). Utilising the process of bracketing is required throughout the research process in order to ensure that the researcher's previous knowledge, opinions and beliefs do not influence the description of the phenomenon under investigation (Streubert and Carpenter, 2011). Given the researchers experience in caring for bereaved parents and in working in maternity care as a Midwife, the process of bracketing would be very challenging. Sun et al., (2014) set out to gain an understanding of parents' decision-making process and the experience of seeing their stillborn baby. A descriptive phenomenological approach was used, observation and in depth interviews were conducted and data was analysed using Giorgi's methods. This study added valuable information to a subject matter that little was known about.

However, as the authors acknowledge the generalisability of this study outside of their sample of 12 couples, in Taiwan is limited.

In phenomenology the main data collection method is in depth, open ended interviews with the researcher and participants as co participants, with the researcher having minimal control of the interview (Todres and Holloway, 2006). The aims of this study required questions related to specific areas of the care received by parents during a miscarriage. If open ended questions were used specific issues related to hospital care may not be addressed. Also open ended unstructured interviews can generate a high level of data that is of no use for the study, particularly when the researcher is inexperienced (Holloway and Wheeler, 2002). As the researcher has limited experience in the area of qualitative research, open ended interviews may be more difficult and semi-structured interviews were considered to be a more appropriate method of data collection. In order to fulfil the aims of the study, semi structured interviews were required; therefore, descriptive phenomenology was out ruled as a possible method.

Hermeneutic research is focused on the meaning and interpretation of a phenomenon (Polit and Beck, 2011). Interpretive or hermeneutic phenomenologists advocate the use of 'sensitising' as they believe it is not possible for researchers to fully suspend preconceptions and advise researchers to use their preconceptions positively (Streubert and Carpenter, 2011). Aldoffsson (2010) utilised an interpretive phenomenological approach to investigate women's experience of miscarriage. The researcher used this approach in order to meet the aims of their study which was to provide an understanding of women's lived experience of miscarriage taking into account the past present and future perspectives. Interviews were conducted with 10 women and data was analysed with respect to Heidegger's 'being and time'. The aims of this study are exploratory rather than interpretive; the researcher is concerned with describing parents' experiences of hospital care during a second trimester miscarriage. As hermeneutic phenomenology is focused on interpretation, it was deemed unsuitable as a method for the current study.

Case study is a holistic approach to qualitative research that involves the systematic analysis of multiple forms of data (Gangeness and Yurkovick, 2006). It is an intensive, in-depth methodology and focuses on a single real life case (McGloin, 2008). The case can be an individual, an organisation, a group or other social unit.

Case study methods give the researcher the ability to explore phenomena within real-life contexts (Anthony and Jack, 2009). Case study research requires an extended period of data collection (Polit and Beck, 2011). Due to time constraints case study was deemed to be unsuitable for this study. Moreover, case study research requires detailed descriptions of organisations and people which can make maintaining confidentiality difficult (Clarke and Reed, 2006). Confidentiality is of vital importance when working with vulnerable groups; therefore, case study research was out ruled as a possible methodology.

Another methodology which could be considered as appropriate for exploring mothers' and fathers' experiences of second trimester miscarriage is grounded theory. Grounded theory involves the generation of theory from the data (Holloway and Wheeler, 2002). Grounded theory originates in the discipline of sociology and was initially developed by Glaser and Strauss. Data collection methods in grounded theory are similar to other qualitative methods, in-depth interviews (unstructured or semi-structured) are most commonly used (Polit and Beck, 2011). A unique feature of grounded theory is its use of theoretical sampling in data collection. Theoretical sampling is not planned from the start of the study rather it is proceeds as the study develops (Holloway and Wheeler, 2002). This allows the researcher to deliberately select participants to test emerging theories. The population of the current study is bereaved parents which are a vulnerable group and are small in numbers. Selecting appropriate participants and protecting this vulnerable group is of vital importance, set inclusion and exclusion criteria were deemed necessary by both the bereavement team and the ethics committee in the National Maternity Hospital. Therefore, theoretical sampling was not considered to be a viable option. Furthermore this study was not concerned with generating a new theory and grounded theory was deemed an unsuitable method to address the aims and objectives of this study.

3.4 Rational for selecting a focused ethnography

Ethnography provides a holistic view of a particular culture with historical roots in anthropology (Polit and Beck, 2011). Ethnography distinguishes itself from other forms of qualitative research as it describes a group within its cultural context (Holloway and Todres, 2006). According to Hollaway and Todes, (2006) when aiming to gain an 'insider view' of patient's experience, ethnography is a suitable method to

consider. Rather than studying participants ethnographers aim to learn from members of a cultural group to better understand their world view (Polit and Beck, 2011). This study aimed to learn from bereaved parents in order to better understand their views of hospital care during a second trimester miscarriage. While ethnography was traditionally used to study whole communities or cultures, Higginbottom et al. (2013) explains that it is also widely used to study sub-cultures. Parents who experienced a second trimester miscarriage can be considered as a sub-culture of bereaved parents.

The main features of ethnography are the use of thick description, data collection from observation and interviews, selection of key informants and settings and a focus on culture. Each of these features is appropriate to meet the studies aims and objectives and provide a greater understanding of the experiences of parents during a second trimester miscarriage. One of the main features of ethnographic research is 'thick description', a term used by the anthropologist Geertz (1973) and originated in the work of philosopher Ryle (1949) cited in Hollaway and Todes (2006). Thick description is a detailed description of patterns of cultural and social relationships put into context (Holloway and Wheeler, 2002). It is derived from interviews and observations in the field. Thick description is theoretical and analytical and gives the reader a sense of the emotional experience of the participants and (Hollaway and Todes, 2006). This feature of ethnography was believed to fit with the aims and objectives of this study. The researcher aimed to provide a detailed description of mothers' and fathers' experience of hospital care during a second trimester miscarriage.

Researchers using ethnography seek information in relation to cultural behaviour, cultural artefacts and cultural speech (Polit and Beck, 2011). Ethnographic researchers utilise observation and interviewing as their main data collection methods. Documents in the setting are also examined to allow the researcher to familiarise themselves with the particular culture being studied (Hollaway and Todes, 2006). The data collection methods of ethnography are best suited for this study, the researcher carried out in-depth, semi-structured interviews and read the women's hospital records for further information about their experience. The researcher also kept detailed field notes during interviews to document observed behaviours and body language of participants and a reflective diary was maintained throughout the

research process. Also during interviews parents shared photographs of their baby and other items of significance such as candles and toys.

There are two main types of ethnography described in the literature; macroethnogrpahy and microethnography, also referred to as focused ethnography (Polit and Beck, 2011). Macroethnography focuses on broad cultures and involves multiple data collection methods over a prolonged period of time (Fetterman, 2010). Focused ethnography is used to gain a better understanding of specific aspects of individual's ways of life and is very useful when studying smaller groups of society (Cruz and Higginbottom, 2013). Focused ethnography is problem focused and its findings are generally meaningful and applicable to practice (Higginbottom, 2013). The current study aimed to examine the experiences of a small group of bereavement parents (those who have experienced a second trimester miscarriage) and gain knowledge to improve practice in relation to the care provided to these parents. Another feature of focused ethnography is the involvement of a small number of individuals with specific knowledge (Higginbottom et al, 2013). Due to the sensitive nature of the topics discussed in the interviews and the vulnerability of bereaved parents a methodology that requires a small number of participants was favoured. This is to keep the potential for causing distress to bereaved parents to a minimum and avoid causing unnecessary psychological distress. The features of focused ethnography suit the aims and objectives of the current study and this approach was considered to be the best methodology for the study.

A focused ethnographic approach was adopted by McGuinness et al. (2014) to explore bereaved mothers' experiences of the suppression of lactation following a miscarriage, still birth or neonatal death. Bereaved mothers experiencing engorged breasts were defined as a subculture of bereaved mothers and in-depth semi-structured interviews were carried out to explore the mother's experiences of lactation (McGuinness et al. 2014). This study gives valuable information about an area that prior to this study was poorly understood. Breastfeeding and perinatal bereavement have unique cultural issues and through the use of a focused ethnographic approach the researcher described women's experiences of engorged breast within a cultural context. Similarly the current study was interested in gaining information about a sensitive topic which is greatly impacted by culture. Parents who experienced a second trimester loss are defined as a subculture of bereaved parents and their experience were explored within a cultural context.

The cultural aspect of pregnancy loss has greatly influenced the decision to take a focused ethnographic approach. Miscarriage is often not openly discussed; this can lead bereaved parents feeling compelled to remain silent about their experience and may prevent parents from seeking support (Mander, 2006). A number of research studies highlight the importance of social support after miscarriage (Saflund et al., 2004; Simmons at al., 2006; Gold, 2007; Mulville and Walsh, 2013), Women often report inadequate support from family and friends (Rowlands and Lee, 2010). Family members and friends can often underestimate the effect of pregnancy loss on bereaved parents and their grief is often not recognised by society (McCreight, 2008). Miscarriage is seen as a common occurrence and parents are sometimes subjected to insensitive comments from both medical professionals and family members such as 'you are young, you can have another baby' which can be a source of great emotional distress for bereaved parents (Rowlands and Lee, 2010). Women have also reported feeling that they were denied opportunities to mourn the loss of their baby in public (Mulville and Walsh, 2013). Though the literature examining fathers' experiences of pregnancy loss is limited it has been suggested that men grieve differently to their partners and tend not to talk about their feelings (Athey and Spielvogel, 2000) and feeling the need to be strong for their partner (McCreight, 2004). This may be due in part to the cultural expectation that men need to be strong and should avoid showing emotions.

The aim of this study was to explore mothers' and fathers' experiences of hospital care during second trimester miscarriage. In particular to report on mothers' and fathers' views on the care received in the hospital from the time of diagnosis of the second trimester miscarriage through to follow-up care. Following consideration of a number of different approaches focused ethnography was deemed to be the most suitable approach to meet the aims of the current study. The ethical considerations for the current study will now be presented.

3.5 Ethical considerations

When conducting research with bereaved parents, researchers must be mindful of the potential challenges when dealing with this vulnerable group (Dyregrov, 2004). The literature suggests participation in research can be beneficial to bereaved individuals (Beck and Konnert, 2007; Dyregrov, 2004). Nonetheless researchers

need to be mindful of the potential for psychological distress that may be caused by the involvement in research in relation to bereavement. Nurses and Midwives must always ensure they adhere to good ethical standards when conducting research (An Bord Altranais, 2007). Midwives have a professional duty to design and carry out research that upholds sound ethical principles and protects the rights of participants (Streubert and Carpender, 2011). The ethical principles of respect for autonomy, beneficence, non maleficence, justice, veracity, fidelity and confidentiality must be adhered to by any Nurse or Midwife when conducting research (An Bord Altranais, 2007).Ethical approval was sought from the National Maternity Hospital ethics committee in June, 2015,. The committee responded with some concerns and requested clarification on a number of issues. Their concerns related mainly to the recruitment of parents to the study and advised caution in selecting which women to contact, they advised consulting with hospital staff to ascertain which women should be approached. In response to this the recruitment process was clarified and plans to consult with the bereavement team prior to contacting women were explained. A flow sheet for contacting mothers and fathers was developed to further clarify the process of recruitment (see Figure 3.1 A and B). It was originally planned to make the first contact with women by a phone call, following the ethics committee's recommendation it was decided to change the first contact to a letter sent from the bereavement liaison midwives, who acted as gatekeepers for the study. Following clarification of these issues, ethical approval was granted in July 2015. An exemption from full review was granted by the Office of Research Ethics in UCD in September 2015.

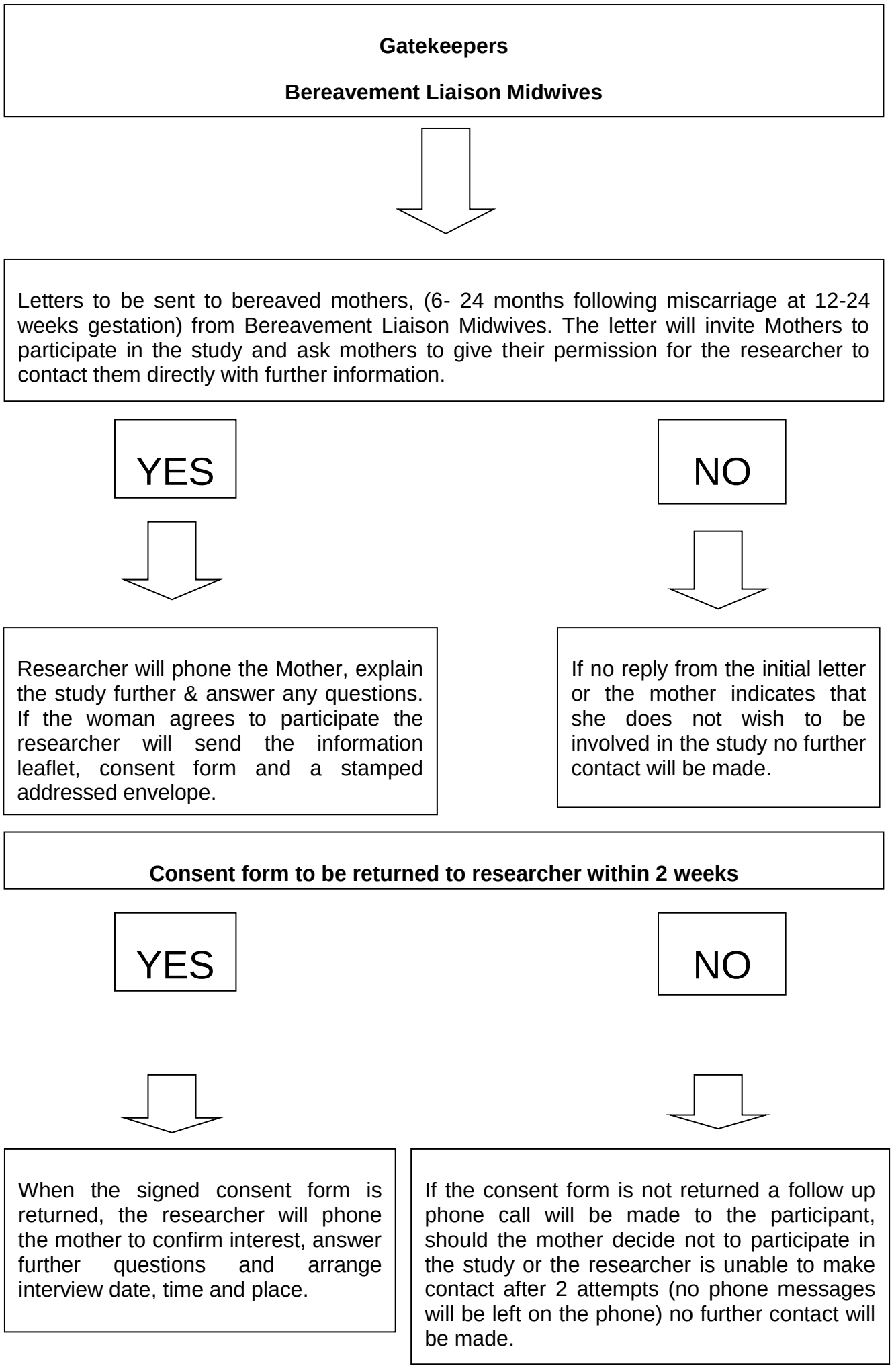

Figure 3.1 A Flow sheet for contacting mothers

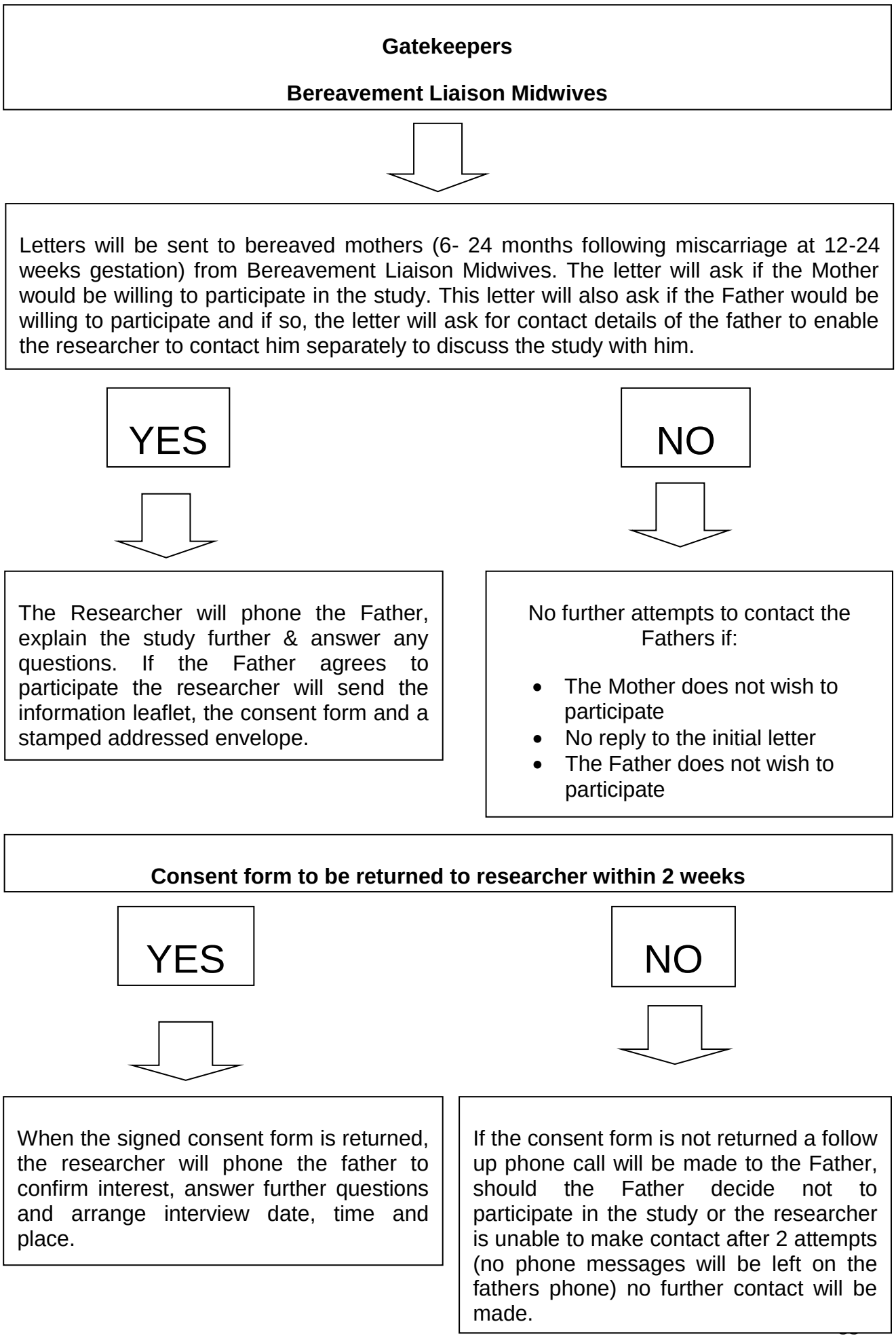

Figure 3.1 B Flow sheet for contacting fathers

The ethical principles of autonomy and informed consent, beneficence and non-maleficence, justice and respect, confidentiality, veracity and fidelity were all adhered to during the entire research process. Each of these principles will now be discussed in detail.

3.5.1 Autonomy and informed consent

When conducting research Midwives and Nurses must adhere to the principle of autonomy to ensure participant's rights to self-determination, full disclosure and to withdraw at any time without consequences are all upheld (An Bord Altranais, 2007). Informed consent is based on participant's rights to full disclosure and the right to self determination (Polit and Beck, 2011). In order to make an informed decision in regards to participating in research participants require full disclosure and the researcher must fully describe the nature of the study, the right to refuse or withdraw participation and the likely risks and benefits (Polit and Beck, 2011). Streubert and Carpender (2011) explain that due to the dynamic nature of qualitative research consent should be treated as an ongoing process rather than a once off event. The consent process for this study was conducted in this manner and consent was sought at multiple stages throughout the research study with participants always given the option to withdraw without consequences.

This study addressed the issue of informed consent using the following approach:

1. The initial invitation letter introduced the parents to study and invited them to return a consent form to allow their phone number to be given to the researcher if they were interested in participating in the study was sent by the bereavement liaison Midwives, who acted as gatekeepers for the study. This avoided coercion by the researcher.
2. Upon receiving completed contact forms the researcher phoned interested participants, further explained the study, answered any questions and advised of their right to withdraw at any time without consequences. If parents were willing to participate in the study the researcher sent out the information letter and consent forms, thereby ensuring participants understood the study and their role in the project.

3. Only parents who completed the initial consent for contact forms were contacted by phone about the study, no further letters were sent if no reply was received. This was to avoid coercion.
4. Participants were contacted by phone after consent forms were received, any questions were answered, consent was confirmed and an interview date was set.
5. Consent was confirmed again at the start of the interview and only those who consented to take part in the study were interviewed.
6. Parents were asked after the interview if they would like a copy of the findings. Parents who requested this were sent a copy of the findings.

3.5.2 Beneficence and non-maleficence

The principles of beneficence (to do good) and non-maleficence (to do no harm) are vital in all research projects but particularly so in research involving bereaved parents. In order to uphold the principle of beneficence research should benefit the individual participants and also society as a whole (An Bord Altranais, 2007). Literature suggests participation in research has positive effects for bereaved parents (Cook and Bosley, 1995; Dyregrov, 2004; Hynson et al, 2006; Beck and Konnert, 2007). Bereaved parents reported positive aspects of participating in research, including the opportunity to discuss their experience and the hope of helping other bereaved parents (Dyregrov, 2004). A number of authors report that bereaved parents viewed participating in research as a positive experience (Mulvihill and Walsh, 2013; Bennett et al., 2008).

Research participants have the right not to be harmed as a result of research participation (An Bord Altranais, 2007). While there were some risks for participants who took part in this research a number of safeguards were put in place to protect participants from harm. The researcher was always mindful of the sensitive nature of the topics being discussed during interviews and interviews proceeded at a pace dictated by the participants. The researcher was aware of the potential of emotional distress and was prepared to pause or terminate the interview at any time should a participant appear distressed or request the interview be stopped. Follow up support with the bereavement liaison midwives was offered to all participants and their contact details were given to participants along with contact details for support agencies relating to pregnancy loss.

3.5.3 Justice and respect

Every research participant has the right to justice and respect, this includes the right to fair treatment, equality and the right to privacy (Polit and Beck, 2011). Participants should be treated with respect at all times and all participants should be treated equally (An Bord Altranais, 2007). Throughout the research study, all participants were treated equally and with respect, compassion and sensitivity. Cultural, social and ethnic diversity was respected at all times. Interviews were carried out on a one to one basis and follow up support was offered to participants after each interview.

3.5.4 Confidentiality

The nature of qualitative research (thick descriptions and small sample sizes) can cause problems in maintaining confidentiality (Streubert and Carpender, 2011). However, researchers must make every effort to ensure confidentiality is maintained. Personal data obtained by the researcher must not be identifiable and data should not be made available to others without consent (An Bord Altranais, 2007).

A number of strategies were put in place to maintain confidentiality for all participants. Data was stored in a locked cabinet, accessed only by the researcher, in the Bereavement office in the NMH. The original data is stored in audio-file format and following transcription as anonymised written data. Descriptive data obtained during the interview and from the mothers medical chart will be anonymised and stored encrypted on the researcher's password protected laptop. Consent forms will be stored separately to the transcripts, audio-files and medical chart data. The audio-recordings will be destroyed following the external examination process all remaining data will be destroyed two years post publication. All participants were given a pseudonym and the researcher was mindful of confidentiality when using direct quotations from interviews.

3.5.5 Veracity

Veracity refers to truth and the right to not be deceived in relation to any aspect of the study (An Bord Altranais, 2007). Participants cannot give informed consent, if any information is withheld (Holloway and Wheeler, 2002). The researcher ensured the principle of veracity was upheld throughout the study by ensuring honest communication with the participants at all times. Information about the study was

never withheld and the researcher fully explained all aspects of the study both verbally and through written information. Participant's questions were answered honestly. The researcher openly discussed both the benefits and risks of participating in the study and made every effort to ensure participants understood the study fully.

3.5.6 Fidelity

The ethical principle of fidelity refers to faithfulness and trust (Holloway and Wheeler, 2002). Participants place trust in researchers and the researcher has a duty to protect them (An Bord Altranais, 2007). The researcher developed a trusting relationship with participants throughout all contact with the participants. The researcher was honest with participants and showed respect and empathy to participants at all times, thus fostering a trusting relationship.

3.6 Participants

The population for this study was women and their partners who experienced a second trimester miscarriage between August 2013 and February 2015 and who attended the National Maternity Hospital. The National Maternity Hospital (NMH) is a large hospital in Dublin which provides maternity, gynaecology and neonatology services. In 2015, 9389 babies were delivered in the NMH (National Maternity Hospital, 2015). The number of Second Trimester Miscarriages is difficult to accurately determine due to a lack of consistency in reporting, the number of second trimester miscarriages in the NMH was estimated at 0.8% of all deliveries in an audit conducted between January 2011 and December 2013 (Cullen et al., 2016). NMH was chosen as the site for this study as the researcher is employed as a Staff Midwife and had the support and permission to conduct the study from the Director of Midwifery.

A number of sampling techniques were considered by the researcher, these included snowball sampling, convenience sampling and purposive sampling. Snowball sampling uses social networks to gather a sample and can be useful for hard to reach populations (Procter and Allan, 2006). One participant may refer others who could inform the research. Due to the sensitive nature of the topic to be discussed and the vulnerability of potential participants it was preferable to contact only select bereaved parents who met predefined inclusion and exclusion criteria. Therefore,

snowball sampling was not suitable for this research study. Convenience sampling is the use of participants who are easily available to the researcher (Procter and Allan, 2006). The protection and care of bereaved parents were of great importance to the researcher and great consideration was needed prior to contacting possible participants. The researcher and the bereavement team considered it inappropriate to contact parents within the first six months after a miscarriage and a number of inclusion and exclusion criteria were drawn up to ensure only the most suitable parents were contacted. Therefore, convenience sampling was not appropriate for this study. Selecting key informants and settings are very important in ethnographic research and as in other types of qualitative research; purposive sampling is used (Holloway and Wheeler, 2002). Specific criteria are adopted to ensure participants are representative of the group being studied (Hollaway and Todes, 2006). Purposive sampling was felt to be the most appropriate method of sampling for this study. A list of inclusion and exclusion criteria were drawn up after consultation with the Bereavement team in NMH. These criteria were then used to select the most appropriate parents to contact.

Inclusion criteria

- Mothers and Fathers who experienced a second trimester miscarriage 9-24 months prior to initial contact
- Mothers and Fathers who were cared for in the NMH during the miscarriage

Exclusion criteria

- Participants with very limited English, this was to ensure participates fully understood the study, could give informed consent and could engage in the interview process.
- Those under 18 years of age will be excluded to ensure all participants were capable of providing legal consent.
- Participants who were pregnant or recently pregnant (regardless of the outcome of pregnancy).
- Participants who were participating in other research.

There is a lack of consensus in the literature in relation to the most appropriate time to contact bereaved parents after their loss (Beck and Konnert, 2007). Some studies included parents who experienced bereavement up to 5 years prior to the research

study (Bennett et al., 2008). In contrast, other studies contacted women within the first 4 months after a bereavement (Saflund and Wrenling, 2006; Lasker and Toedter, 2001; Nikcevic et al., 2000). Research examining bereaved individuals' opinions about participating in research reported that the majority of participants felt that the most appropriate time to be contacted about research was within 2 years of bereavement (Beck and Konnert, 207). A number of studies used a time frame of six to twenty four months (Mulvihill and Walsh, 2013; Mc Guinness et al, 2014). Initially, it was decided to also adhere to this time frame in order to maintain the ability of participants to recall events, but also to give sufficient time to allow for recovery from the loss. After the first invitation letters were sent out the inclusion criteria was changed to between nine and twenty four months. This was to avoid contacting a bereaved mother around the time of her expected date of delivery.

The sample was selected with the help of the Bereavement Team in the NMH. A list of suitable women was drawn up by the researcher and the Bereavement Liaison Midwife using the bereavement team's records of pregnancy losses. The researcher then checked the women met all the inclusion and exclusion criteria; subsequently a list of women to contact was created. Recruitment took place on a phased basis; this was to avoid over recruitment. The bereavement liaison midwives acted as gatekeepers and wrote to potential participants explaining the study and included a consent form to allow their contact details to be released to the researcher . Once the researcher received the signed consent form a phone call was made to the individual to further explain the study and answer any questions. If the individual agreed to participate written information and a consent form were sent. Once consent forms were returned the researcher contacted the participant to arrange an interview venue and time. See flow sheet for details regarding the process for contacting mothers (Figure 3.1A).

Fathers were recruited through the mothers; see Figure 3.1B for flow sheet for contacting fathers. In the initial letter to mothers, they were asked if their partner would like to be involved. If fathers were interested in being in involved in the study, they were asked to complete the consent to contact form and the researcher contacted them by phone to discuss the study further. If the woman did not wish to be involved, her partner was not recruited, but the woman could participate without their partner.

3.7 Data collection

Data collection methods such as focus groups, interviews, observations and reflective diaries can be used in qualitative research. Data collection using an ethnographic approach usually involves participant observation, interviews and examination of relevant documents (Higginbottom, 2013). Fetterman (2010) believes that interviews are the most important data collection method for ethnographers. There are various types of interviews that researchers can utilise, the main types of interviews are structured, semi-structured and unstructured (Tod, 2006). Structured interviews are rarely used in qualitative research as they only provide limited responses and do not provide in depth information (Gill et al., 2008). The aims of this study are descriptive and require in depth information from participants; therefore, structured interviewed were deemed unsuitable. Unstructured interviews are the most detailed and least directed form of interviewing (Tod, 2006). Unstructured interviews are used when great detail and in depth responses are required or where almost nothing is known about a subject area (Gill et al., 2008).

The aim of the study was to report on mothers' and fathers' views on the care received in the hospital from the time of diagnosis of the second trimester miscarriage through to follow-up care. Therefore, the interview needed to allow parents to describe in detail their experience. Some structure was needed during interviews to ensure all aspects of hospital care during a second trimester miscarriage were discussed. Semi-structured interviews allow the researcher to follow unexpected issues raised by participants while also retaining some control over the direction of the interviews (Tod, 2006). In order to meet the aims and objectives of the current study semi structured interviewed were carried out, the women's healthcare record was examined and a reflective diary was maintained throughout the research process. Participants also showed the researcher (usually spontaneously without the researcher asking) items of significance relating to the baby they lost. Parents showed the researcher photographs of their baby, memory boxes, toys and other items of great significance to the parents.

The interview guides were developed following the literature review and with consultation with clinical midwifery staff experienced in the area of bereavement and the researcher's supervisor. The researcher also sought advice from Denise Mc Guinness (Clinical Midwife Specialist in Lactation, National Maternity Hospital) who

recently completed a study involving interviews with bereaved parents (McGuinness et al., 2014a, 2014b). The literature review highlighted that the experiences of hospital care received by parents following a second-trimester loss remain for the most part unexplored. The aims of this study are to address this identified gap and build on what is already known to support the delivery of bereavement care to parents following a second trimester loss in a maternity hospital. Therefore, the content of the interview guides were focused on parents' experiences of hospital care.

3.8 Pilot study

A pilot study was carried out to test the interview schedule and allow the researcher the opportunity to practice interview skills. Pilot studies are not always used in qualitative research, but novice researchers may benefit from rehearsing the interview process with friends or colleagues (Holloway and Wheeler, 2002). A pilot interview was carried with a midwifery colleague with experience working with bereaved parents. This allowed the researcher to listen to the interview process on its completion and gain experience in of interview technique and using recording equipment. After the pilot study some minor changes were made to the interview guide and the researcher felt more comfortable with interview process the use of recording equipment.

3.9 The interviews

The researcher conducted individual face-to face interviews with mothers and fathers. Two interview guides were developed with the assistance of the bereavement team in the National Maternity Hospital. A separate guide was used for mothers and fathers. The researcher was interested in learning about parents' experiences of hospital care during a second trimester miscarriage and questions on each interview guide were aimed at addressing the aims and objectives of the current study. Gill et al (2008) recommends starting an interview with questions that can be easily answered before moving onto more difficult or sensitive topics. Prior to commencing the interview the researcher explained the topics to be covered in the interview to ensure the participant was comfortable to discuss all the topics. The interview commenced with questions about the first contact with the maternity

hospital when the miscarriage was diagnosed and proceeded to discuss the care the parents received from the hospital during the miscarriage through to follow up care. Open questions were asked and probes were used to explore issues important to meet the aims of the study. At the end of each interview an opportunity for debriefing was given and participants were asked if they wished to share anything else. After the interview the researcher had an informal conversation with each participant to ensure they felt no further distress and offer the services of the bereavement team in the National Maternity Hospital.

It is important to establish rapport and trust between the researcher and participants prior to the interview (Gill et al. 2008). A good rapport with participants will allow participants feel more comfortable to discuss personal, intimate details of their experience (Polit and Beck, 2011). The researcher achieved this through telephone calls to participants prior to the interview. At the first phone call the researcher introduced herself, explained the purpose of the phone call and sympathised with the mother or father for the loss of their baby. The researcher explained the research project and answered any questions. The researcher also ensured the participants had her contact details and advised them to contact her if they had any questions or concerns regarding the research project. Good communication skills are vital to the interview process (Polit and Beck, 2011). Gill and Colleagues (2008) believe that listening is the most important skill for researchers to utilise during interviews. The researcher avoided interrupting the participants and allowed them to lead the interview process. In the majority of cases, parents answered questions on the interview guide spontaneously and the interview guide was not adhered to rigidly. The researcher used nonverbal communication to convey sympathy, concern and interest. Also verbal cues and encouraging noises were used to convey understanding and interest (such as Mmmm, yes and I understand).

The majority of interviews were carried out in the participants' home. When arranging interviews the researcher offered participants the choice of attending the National Maternity Hospital for interview or to hold the interview in their home. One couple requested the interview took place at their workplace. A private office was used for the interviews. Another couple requested that the interview took place in the hospital and a private meeting room was arranged for this. On arrival the researcher introduced herself to the participants, explained the study again and confirmed consent. The researcher empathised with each participant on the loss of their baby

and thanked them for participating in the study. If both the mother and father were to be interviewed the researcher asked to interview the couple separately most couples agreed to this and the parent not participating usually left the room for the duration of the interview with their partner. One couple preferred to be interviewed together and this was facilitated. Carrying out the interviews in the participant's home had many advantages, it was convenient for participants and they were comfortable in their own environment. Tod (2006) explains that the comfort of the environment for an interview is vital to ensure participants feel relaxed and at ease. Gill et al. (2008) advise that when interviews take place in the participants' home the participants are usually more comfortable which will result in a more productive interview. However, there was often disruption to the interviews. Phone calls, visitors, pets and children all caused disruptions and distracted participants and the researcher during the interviews. The majority of participants turned mobile phones off and asked the other parent to take the children to another room for the interview, without being prompted by the researcher. The researcher paused the interview if there was a lot of distraction such as a baby or child needing attention and restarted the interview when the parent was ready. Interviews were digitally recorded with participants' consent. Interviews with fathers lasted on average 26 minutes (range 15-35 minutes in duration) and interview with mothers were on average 31 minutes (range 16-68 minutes in duration).

Travelling alone to a participant's home could potentially pose a risk for the researcher. The researcher adhered to the recommendations outlined in the University's guidelines for personal safety during interviews/ home visits (UCD Safety, Insurance, Operational Risk and Compliance (SIRC) Office, 2015). The researcher discussed a safety plan with her supervisor prior to commencing data collection. The researcher ensured she planned her route to the participant's home in advance, informed a family member of the time and location of the interview (without giving the participant's name to maintain confidentiality) and had a mobile phone fully charged in case of emergency. The researcher contacted the participants the day before the interview to confirm with the parents they were happy to participate and to get directions to their home if needed.

3.10 Data analysis

Data analysis in focused ethnography requires the researcher to 'engage in an iterative, cyclic and self-reflective process' (Higginbottom et al., 2013, page 6). Data analysis occurs alongside data collection. Interpretations are continuously challenged and data are revisited on an ongoing basis to plan additional data collection and develop new insights into the data (Higginbottom et al., 2013). There are a number of different approaches researchers can adopt to analysis data in qualitative research. Phenomenologists have developed a number of different approaches to data analysis. According to Polit and Beck (2011) the three most frequently used are the methods of Colaizzi (1978), Giorgi (1985) and Van Kaam (1966). Each of these methods shares similar characteristics. Each method gives a series of steps to follow during data analysis. Colaizzi's method was out ruled for the current study as it requires researchers to ask participants about the findings and this was deemed to be unsuitable due to the vulnerable population involved. Van Kaam's (1966) and Giorgi (1985) methods allow researchers to describe the meaning of an experience. The aims of this study are descriptive rather than interpretive; the researcher is concerned with describing parents' experiences of hospital care during a second trimester miscarriage. Therefore, a phenomenological approach to data analysis was not suitable to meet the aims and objectives of the current study.

Thematic analysis is a flexible approach to qualitative data analysis independent of theory and can be applied across a variety of research approaches (Braun and Clarke, 2006). Thematic network analysis gives the researcher a simple step by step approach to organising a thematic analysis of qualitative data. A number of researchers examining sensitive topics with vulnerable groups have used thematic analysis (Fox et al., 2013; Lee 2012; McGuiness et al., 2014a). Lee (2012) examined mothers' experiences of stillbirth and utilised thematic analysis guided by Braun and Clarke (2006) to provide a greater understanding of women's' experience of stillbirth. Thematic network analysis was utilised by McGuiness et al (2014a) and the authors identified three global themes relating to women's' experiences of suppressing lactation after perinatal loss. Fox et al. (2013) also utilised Thematic network analysis guided by Attride-Stirling (2001). The researchers conducted a mixed methods study examining the use of complementary alternative medicine for women with breast cancer. Thematic network analysis was used to analyse qualitative data from semi-structured interviewed. Thematic network analysis, guided by Attride-Stirling (2001)

was chosen to be the most appropriate method of data analysis for the current study. This approach utilises many of the main features that are common among many approaches to qualitative data analysis (Attride-Stirling, 2001). This approach gives a systematic method of extracting basic themes, organising themes and global themes. Basic themes are the most basic them found in the data, organising themes are categories of basic themes grouped into more abstract principles and global themes are super-ordinate themes summarising the main principles in the data overall (Attride-Stirling, 2001). Attride-Stirling (2001) outlines 6 steps to guide data analysis. The researcher followed these steps when completing data analysis and examples of each step of the process are presented in.

As is advised by Polit and Beck (2011) data analysis occurred alongside data collection and data analysis commenced after the first few interviews. The researcher firstly read and reread the transcripts to become familiar with them. The researcher then followed each of Attride-Stirling's steps to complete the analysis. The researcher used a computer program (NVIVO, 11) to assist in the management and analysis of data. The use of computer programs has a number of advantages. It allows for the storage of large volumes of data in one place which can be easily organised and cross referenced (Lathlean, 2006). Data can be quickly accessed and encourages consistent coding and categorisation. There are a number of disadvantages to the use of computer software (Polit and Beck, 2011). As with any computer programme there is the potential for data loss. The researcher set the programme to automatically save every 15 minutes and backed up the data on a secure online file storage system regularly. It can take time to learn to use a computer package, to assist in this the researcher attended a workshop on using NVIVO programme and utilised online support services provided by the University to learn how to use the software effectively. The researcher made every effort to minimise the effect of possible disadvantages of using NVIVO programme.

3.11 Rigor

Mc Brien (2008) describes rigor as a method of proving the legitimacy of the research process in order to ensure that the findings are representative of reality. Researchers need to be mindful of qualitative rigor from the beginning of the research process (Thomas and Magilvy, 2011). There are a number of models researchers can utilise to address rigor in qualitative research. Lincoln and Guba (1985) provided researchers with a number of techniques to support the rigor of their study (Streubert and Carpenter, 2011). For the current study, the researcher adhered to Lincoln and Guba's (1985) principles of credibility, dependability, confirmability and transferability to ensure rigor. Each of these principles will now be discussed individually.

3.11.1 Credibility

Lincoln and Guba believe that credibility is a vital goal of qualitative research and refer to a confidence in the truth or credibility of the findings produced by a qualitative study and the researcher's interpretations of the findings (Polit and Beck, 2011).

Member checking is another method to ensure credibility and is recommended by a number of authors (Polit and Beck, 2011; Streubert and Carpenter, 2011; Thomas and Magilvy, 2011). Member checking requires the researcher to return to the participants with the researcher's interpretations of the data to ensure participants view the interpretations as an accurate description of their experience (Thomas and Magilvy, 2011). Due to the sensitive nature of the topic being researched and the vulnerability of bereaved parents, member checking was felt to be inappropriate by the researcher and the bereavement team in the National Maternity Hospital was not completed. Parents were offered the option of receiving a copy of the results in the information sheet about the study and at the time of the interview. Two mothers requested the results and the researcher sent the results to these mothers with a letter inviting them to provide feedback if they wished. Neither of the two mothers contacted the researcher with feedback.

Despite the absence of member checking the researcher took a number of steps to ensure credibility in the current study. Streubert and Carpenter (2011) believe that the most important method of ensuring credibility is to have a prolonged engagement

with the subject being studied. Prior to the current study, the researcher carried out another study in the area of second trimester miscarriage and had acquired in-depth knowledge about this area. The researcher also has clinical experience in working with bereaved parents through her work as a midwife and also as a bereavement liaison Midwife in the National Maternity Hospital. After the interviews the researcher listened to the recordings and read and reread transcriptions of the interviews to ensure engagement with the data. The researcher's academic supervisor also reviewed the transcripts and verified the findings. During data collection a number of procedures were followed to ensure credibility. Interviews were audio recorded and were transcribed verbatim to ensure no information was left out. Field notes were kept by the researcher to capture non-verbal communication to add further understanding to the interview transcripts.

3.11.2 Dependability

Dependability is defined as the reliability of the research data over time and is interlinked with the credibility of the study (Polit and Beck, 2011). Dependability also refers to the ability of others to follow the decisions made by the researcher during the research process (Thomas and Magilvy, 2011). A number of methods were utilised by the researcher to ensure dependability. A detailed account of all decisions made in relation to the study was kept by the researcher and a description of the rationale for decisions made regarding the choice of methodology and methods was provided by the researcher.

3.11.3 Confirmability

Confirmability refers to the objectiveness of qualitative research findings. Research findings must be representative of participants experience and free from the researchers own opinion and bias (Polit and Beck, 2011). In order to achieve this, the researcher needs to be engaged in reflection and Thomas and Magilvy (2011) advice the use of a reflective diary. Reflexivity is an important component of qualitative research and focuses on making clear the effect the researcher, methodology and methods have on the research process and the findings (Cruz and Higginbottom, 2013). Reflectivity is a valuable tool to promote understanding of the researcher's role (Jootun et al., 2009) and was utilised by the researcher to promote rigor in the current study. Following each interview the researcher reflected on the interview and

maintained a reflective diary throughout the research process. The researcher also met regularly with her supervisor particularly during data analysis who was able to challenge any assumptions made by the researcher.

3.11.4 Transferability

Transferability refers to the generalisability of the research data and how applicable the findings are in other settings or groups (Polit and Beck, 2011). Streubert and Carpender (2011) explains that the determining the transferability of the findings is not the responsibility of the researcher, rather the reader of the findings makes a judgement in relation to the transferability of the findings. In order to aid readers in determining the transferability of the data a thick description and direct quotes from interviews were presented. Detailed field notes and saturation of data also improves transferability (Polit and Beck, 2011), the researcher kept detailed field notes and achieved data saturation.

3.12 Summary

This chapter presented the research design and methods used for the current study and the rational for the decisions made throughout the research process. Firstly a discussion of the rational for choosing a qualitative design is provided. The researcher discussed qualitative methodologies that were considered for the current study and the rational for selecting a focused ethnography. Next ethical considerations, sampling and recruitment and data collection were discussed. The pilot study and the interviews were then discussed, followed by data analysis and rigor.

Chapter four

Findings

4.1 Introduction

The focus of this study was to explore the experiences of mothers and fathers bereaved by Second Trimester Miscarriage most specifically focusing on their experiences of hospital care. The key findings from the study are presented in Chapter four, thematic analysis (Attride-Sterling, 2001) was employed to analysis the data and thematic networks were designed to represent the two global themes of clinical care needs and relational and social experiences of miscarriage which emerged from the data. The first section of the chapter outlines a brief description of the overall recruitment and response rate, and the demographic/clinical information related to the mothers who participated in the study. This is followed by a presentation of the global themes. Parents were allocated a pseudonym which was used in all references to parents during the study.

4.2 Response rate

Recruitment took place over three phases. The first phase commenced in August 2015, the second phase in September 2015 and the final phase in January 2016 (this gap was to allow for the lead up to Christmas which for grieving parents can be a difficult time in their lives) . A total number of 42 women were contacted (20 in phase one, 10 in phase two and 12 in phase three). A total of nine mothers and five fathers were interviewed. See Table 4.1 for response rates. In phase one a mother responded but was excluded from the study as she was pregnant, the ethical approval for this study stipulated that pregnant women could not participate. Another couple responded and agreed to participate, but the researcher was unable to make contact to arrange an interview. No parents responded in phase two; no explanation

was found. In phase three all six of the parents who responded participated in the study.

Table 4.1: Response rate of parents contacted for the study

Phase	Number of Mothers contacted	Number of Mothers who responded	Number of Mothers interviewed	Number of Fathers who responded	Number of Fathers interviewed
1	20	7	5	5	3
2	10	0	0	0	0
3	12	4	4	2	2

4.3 Description of the sample

4.3.1 Mothers' demographic information

Mothers' demographic information was obtained (with consent) from the mothers health care record. No demographic information was obtained from fathers. The age range for mothers was from 30 years old to 42 years old. Six of the nine mothers were aged 35 or older. The mean age was 37 years (SD= 4.36). The majority of the women were married (n=7), two women recorded their marital status as single in their medical record. Two mothers were homemakers; the remaining seven were employed in professional employment.

4.3.2 Clinical details related to the birth

The gestational age at the time of the second trimester miscarriage ranged from 15 to 19 weeks. The mean gestational age was 16.88 weeks (SD= 1.36). Five of the mothers had one or more children before the miscarriage and three mothers had a healthy baby after the miscarriage. Six of the women were induced after the diagnosis of fetal demise and three women labored spontaneously. Mothers were interviewed from seven to twenty three months following the miscarriage (mean = 14.44 months, SD = 5.17). In order to maintain confidentiality all parents were allocated a pseudonym and referred to by their pseudonym throughout the study. See Table 4.2 for information regarding the clinical and hospital care details for parents who participated in the study.

Table 4.2 Clinical and hospital care details of parents who participated in the study

Participant number	Parents' pseudonym	Place of birth	Place of care	Gestational age in weeks	Parity at the time of birth
1	Michelle	Antenatal ward	Antenatal ward	19/40	0+0
2	Deirdre	Antenatal ward	Antenatal ward	16/40	2+2
3	Sally	Home	Gynaecology ward	16/40	0+0
4	Ciara	Home	Gynaecology ward	16/40	0+1
5	Kelly	High- dependency unit	High-dependency unit & Gynaecology ward	17/40	1+0
6	Jane	Home	Gynaecology ward	15/40	3+1
7	Kate	Antenatal ward	Antenatal ward	17/40	1+2
8	Emily	Antenatal ward	Antenatal ward	19/40	2+1
9	Orla	Antenatal ward	Antenatal ward	17/40	0+0
10	Mark	High-dependency unit	High-dependency unit & Gynaecology ward	17/40	
11	Eugene	Antenatal ward	Antenatal ward	19/40	
12	Jack	Home	Gynaecology ward	16/40	
13	David	Antenatal ward	Antenatal ward	16/40	
14	Emmett	Home	Gynaecology ward	16/40	

4.4 Findings

Two global themes emerged from the data collected from bereaved parents these included; *Clinical Care Needs and Relational and Social Experiences of Miscarriage*. A global theme is considered "the core, principal metaphor that encapsulates the main point in the text" (Attride-Stirling, 2001:393). Each global theme consists of organising themes which have been identified through a series of basic themes. The basic themes provided the starting point for understanding parents' experiences of hospital care during a second trimester miscarriage. The first global theme is clinical care needs and is comprised of three organising themes; medical care, facilities and information. Clinical care needs highlights parents' experiences in relation to the medical care they received during the miscarriage. This theme describes parents' experiences of the hospital facilities, both for mothers and fathers, the importance of

being separate from other pregnant women and babies. Mothers and fathers also highlighted the need for clear information regarding their pregnancy, the medical care they received and the cause of the miscarriage. The second global theme is *relational and social experiences of miscarriage.* This theme describes parents' experiences of compassionate care, bonding and connecting with their baby and support during and after a second trimester miscarriage. Parents highlighted the importance of empathy and sensitivity during this very difficult time. This theme also describes parents' experiences in relation to bonding and connecting with their baby and the importance of support. Parents describe their experience of spending time with their baby and how they remember their baby. Mothers and fathers reported the various sources of support in the hospital, in the community and through counseling. Each theme will now be described in detail starting with global theme one, clinical care needs.

4.4.1 Global theme one: clinical care needs

The first global theme of c*linical care needs* will be presented in relation to three organising themes; m*edical Care, facilities and information.* This first global theme highlights parents' experiences in relation to the medical care received by mothers during a second trimester miscarriage. Parents discussed their experiences of medical treatments received by the mother, pain relief, length of hospital stay, going home to prepare for the birth and follow up. This theme describes parents' experiences of the hospital facilities, both for mothers and fathers, the importance of being separate from other pregnant women and babies. Mothers and fathers also highlighted the need for clear information regarding their pregnancy, the medical care they received and the cause of the miscarriage.See Figure 4.4.1 for an outline of this first global theme.

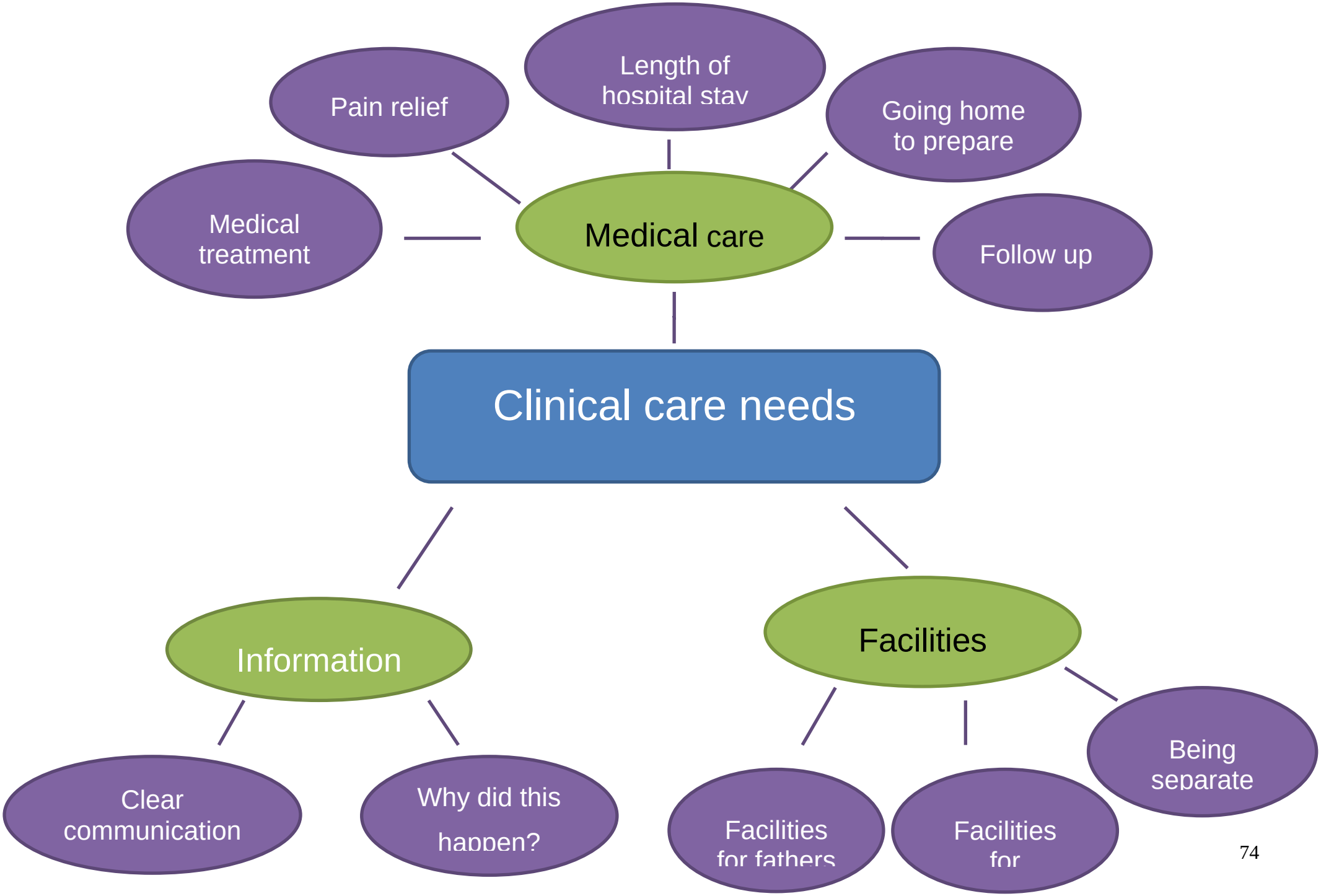

Figure 4.4.1 Clinical care needs

4.4.1.1 Medical care

The organising theme of medical care highlights parents' experience in relation to various aspects of the medical care they received during second trimester miscarriage. The majority of parents interviewed were overall satisfied with the medical care they received. Kelly was very ill when she was admitted to the hospital and was very happy with the way her care was managed.

> *.....I felt like things were under control.....they showed a lot of care and concern..... (Kelly, P5, 17/40)*

This theme will discussed under five different basic themes. These basic themes are medical treatment received during the miscarriage, pain relief, going home to prepare, length of hospital stay and the follow up appointment.

Medical treatment received during the miscarriage

While parents viewed the overall medical care they received as good, parents highlighted a number of issues in relation to the initial medical treatment they received in the casualty department of the hospital. Emmett's partner was brought to the casualty department after she delivered their first baby at home at 16 weeks gestation. Emmett felt that medical staff should have made the decision to take his partner to theatre for a manual removal of placenta sooner.

> *.....from the time that we got in there to a decision being made that she was going to have the operation to have it removed, I thought that was too long....* (Emmett, 16/40, P14).

Jack described being sent home from the casualty department after a bleed and going on to deliver the baby at home the next morning.

> *.....I am not an expert obviously, but he seemed to do the check very quickly and he was always going to say everything was fine, it was grand, next, kind of thing. That is the feeling I got.....* (Jack, 16/40, P12).

A number of parents commented on how busy the casualty department was and described long waits to see a doctor.

> *.....I can't recall exactly how long I was waiting but it was certainly about an hour or two..... it is a very busy area and nobody is really paying too much attention to you because they are all so busy.....(Emily, 19/40, P8).*

> *....it was busy we were just waiting for about an hour and a half then we had the scan....* (Jane, 15/40, P6).

> *.....it seemed to be busy and we were waiting a long time.....* (Jack, 16/40, P12)

Five of the women talked about difficulties in taking bloods and reported numerous attempts by staff before blood was taken successfully.

> *..... it took them half an hour to get it.....*. (Kelly, 17/40, P5)

> *.....they couldn't get the vein. Maybe six, ten times they pricked me and they couldn't get it.....* (Ciara, 16/40, P4)

One woman described the bruises from attempts at taking bloods as a painful reminder of her experience.

> *.... that was the thing I found hardest for a long time afterwards, seeing all the bruises.....so every time I looked for weeks after ..... a physical scar to remind you of what you had gone through..... (Deirdre, 16/40, P2).*

Pain relief

The majority of mothers described the process of labour and birth as painful and described it as ‘severe pain’, ‘horrible pain’, ‘strong’ and ‘extremely painful’. Six of the women experienced their labour and birth in the hospital and the remaining three women delivered at home.

Of the six women who delivered in the hospital, four received pethidine, one received entonox and one had no analgesia. Half of these women were satisfied with the analgesia they received while the other half felt they would have liked other options for pain relief. Three of women who delivered in the hospital were happy with the pain relief they received and trusted their midwife's advice regarding pain relief. Deirdre received pethidine and was felt this was adequate pain relief for her.

> .....*the pethidine was fine and I felt reassured, the midwife said it would be enough, it is not the same as full labour. I trusted her then and she went with pethidine and it was fine.....* (Deirdre, 16/40, P2).

Michelle explained that she didn't want to have analgesia for the labour and birth and reported that the majority of staff were supportive of this. Michelle describes going to the shower for the majority of her labour and felt the hot water was very effective.

> *.....so we ended up going to the shower and delivering completely without pain medication..... We were offered pain relief, but ended up not wanting it and they didn't kind of push it.....* (Michelle, 19/40, P1).

Of the women who delivered in the hospital three women were not satisfied with the way their pain was managed. Kate felt she should have received analgesia sooner than she did, she reported being in severe pain and felt midwifery staff didn't believe her about how much pain she was in.

> *.....I felt she didn't believe me, first of all .....and about how far gone I was and that how I was feeling.* (Kate, 17/40, P7).

Orla received pethidine during her labour, she felt this was too strong for her and would have liked another lighter form of analgesia. She also reported that no other options for pain relief were mentioned and that the side effects of pethidine were not discussed with her.

> *.....probably it was just too strong .....I was just knocked off my feet, I actually couldn't stand ..... everything slowed down.....I probably could have gone for another little bit or else if there was something milder....* (Orla, 17/40, P9)

Kelly was very ill around the time of birth and felt that this impacted on the type of pain relief she was offered. Kelly was admitted to the high dependency unit with sepsis and while she felt that entonox was not enough to manage her pain she understood that there may not have been another option in her situation.

> *.....All I had was gas. I felt the pain a lot. I don't know if it was they were reluctant to give me anything else being what I had, I could appreciate that as well....* (Kelly, 17/40, P5)

Both Mark and David didn't want to comment on their partner's pain relief; they felt that their partner was better able to discuss that.

> *.....Oh god I wouldn't be able to... I think that would be her prerogative....* (Mark, 17/40, P10).

Three of the women delivered the baby at home. Jane described the labour at home as 'very painful', but felt she coped with the pain.

> *..... it was nearly like double period pain. You know nothing that I couldn't cope with.....* (Jane, 15/40, P6)

Two of the women who delivered at home described severe pain during attempts to deliver the placenta when they were admitted to the hospital. Both women felt they didn't receive enough analgesia during this time. One woman received entonox but felt it was ineffective, the other women received no analgesia until she was transferred from the casualty department to theatre for a manual removal of placenta. Emmett describes the pain his partner appeared to be in while doctors attempted to deliver the placenta.

> *..... I don't think … (refereeing to his partner) was on any pain killers at that stage. All I could remember was the howls .....the discomfort that she was in.....* (Emmett, 16/40, P14).

Sally also described the process of delivery of the placenta as 'extremely painful' and that she received no analgesia at that time. Ciara also felt a lot of pain, she was given entonox while medical staff tried to deliver the placenta.

.....I was in serious pain..... I know I was shouting a lot.... (Ciara, 16/40, P4)

It is clear from the mothers' descriptions that labour and birth during the second trimester is a painful experience and mothers have varying opinions on the type of analgesia they received. Also parents report a lack of adequate analgesia after the birth of the baby, during attempts to deliver the placenta.

Length of hospital stay

Almost all of the parents interviewed were happy with the length of hospital stay. Most women stayed in hospital less than 24 hours and were happy to go home when they did. The majority of parents reported no pressure from staff to go home and didn't feel like they were rushed out.

Emmett's partner stayed a total of sixty hours in the hospital after she delivered her baby at home. Emmett was happy with the length of time she was admitted.

....not putting us under any pressure to leave, there was no timeline, it was when you are ready, when you are better, a bit healthier..... (Emmett, 16/40, P14)

A number of parents reported that they left soon after the birth by their own choice. Parents described wanting to go home as soon as possible. Michelle left the hospital a few hours after the birth of their first baby.

We literally got out as soon as..... we just wanted to get out. It was very traumatic..... (Michelle, 19/40, P1)

Deirdre went home the morning after her baby was born. She was happy with the length of hospital stay and was keen to go home. She felt the midwives/ nurses have good judgement about when she was ready to go home.

..... *I could have stayed longer if I hadn't been keen to go but I think the nurses have good intuition...* (Deirdre, 16/40, P2)

Eugene also wanted to leave the hospital with his partner as soon as possible after the baby was born.

We just wanted to go.... (Eugene, 19/40, P11)

Kate went home the day after she delivered her baby and felt that while she wasn't rushed out of the hospital, she would have like the option to stay another night.

> *....I wasn't rushed out I didn't leave until lunch time that day but I think it would be beneficial to have a second night....* (Kate, 17/40, P7).

From the parents' narratives it would appear that opinions on the length of hospital stay are very individualised. The majority of mothers and all fathers were satisfied with the time they spent in the hospital.

Going home to prepare

The hospital policy when an intrauterine death is diagnosed is to administer mifepristone and allow the mother to go home for 48hours. The mother will then be admitted to continue the induction process. Five of the women who were interviewed experienced this care pathway. The remaining four women either laboured spontaneously or were induced immediately due to concerns for the mother's health. Parents described this period of time as very difficult but the time allowed the parents the opportunity to come to terms with the loss. Emily found it difficult going home, but felt it was necessary to allow her to come to terms with the loss of her baby.

> *.....It is just horrendous, you are left for two days knowing your baby is.....but equally I found that period of time you needed to process what was going on.....* (Emily, 19/40, P8)

The majority of parents appreciated the opportunity to go home. Deirdre and Jane both felt it was better for them to go home.

> *.....it was better to go home for me....* (Deirdre, 16/40, P2)

> .....*you actually just want to go home and deal with it.....* (Jane, 15/40, P6)

Some mothers described what they did during this time and found it beneficial to have time to spend with their family and prepare for the birth of their baby. Orla spent time with her family and went shopping to buy things for the baby.

Michelle explained that she appreciated having time to spend with her partner and baby before the induction process began.

> *.....We went to the cinema and we went for a walk.... so it was nice to have that sort of time....* (Michelle, 19/40, P1)

David also explained that being allowed to go home helped him and his partner come to terms with the loss and organise practical things like childcare arrangements.

> *.....it probably wasn't a bad thing....we probably did need that time for it to settle in on us a little bit.....to get to grips with it .....* (David, 1640, P13)

The Mothers had different opinions about the support needed from the hospital during that time. Emily would have liked a phone call or a support visit from the bereavement team. On the other hand Orla felt she received enough support from her family and was happy just to know she had phone numbers for the hospital if she needed to contact them for anything.

> *.....I suppose they had said to phone at any time, but it was from my family I felt very supported.* (Orla, 17/40, P9)

> *.....a house visit or something might have been good.....you are just processing, and then life is going on around you.....So I think a house would have helped.....* (Emily, 19/40, P8)

Overall parents appreciated going home and have time to process what had happened and to take care of practicalities such as shopping for their hospital stay and the birth of their baby and childcare arrangements for other children. It is clear that parents need support during this time; however, parents had different opinions as to what support the hospital should be provided to them during this time.

Follow up appointments

The majority of parents were satisfied with their medical follow up, all but one mother had a follow up appointment after the miscarriage. Most parents viewed this

appointment as important and a valuable opportunity to ask questions. Some parents explained that discussing the circumstances of the miscarriage gave them some closure and helped them to move on.

> *.....So I closed a chapter there...* (Ciara, 16/40, P4)

> *.....that doctor was very good and he told us the information and everything. It gave it a little bit of closure to it....* (Jack, 16/40, P12).

Parents appreciated their questions being answered, particularly in relation to the chance of the same problem recurring in future pregnancies. Both Kate and Michelle talked about the importance of a follow up appointment to get the results of any investigations and to discuss future pregnancies.

> *....it was more a once off happening rather than a genetic thing.....*(Kate, 17/40, P7)

> *......its unlikely that it will happen again so that was really good to know....* (Michelle, 19/40, P1)

Mothers reported that they found it difficult returning to the hospital after the miscarriage. Michelle found it upsetting, but valued the time the doctor gave them and felt the visit was very important. Orla reported that it was very difficult to come back to the hospital for her follow up appointment. She also felt the care she received on the day was very different to her care during the miscarriage.

> *......it was quite the polar opposite.....the care that you received was so gentle and so caring, it was quite different..... everything was like, go here, go there, sit there.....*(Orla, 17/40, P9).

Parents had different opinions about the most appropriate time for the follow up appointment. David felt that the appointment could have been sooner. On the other hand Kate felt the appointment was too soon and suggested six months after the miscarriage might be better.

> *.....that might have been better sooner...I think it might have helped to start closure sooner.....*(David, 16/40, P13).

....It is quite soon after .....I'm wondering if it's too much, but maybe to have one 6 months after the date of the actual miscarriage.....(Kate, 17/40, P7)

It is clear from speaking to parents that they value follow up appointments following a miscarriage. Sensitivity and understanding from staff is very important at these appointments as parents find it difficult coming back to the hospital.

4.4.1.2 Facilities

The organising theme of facilities highlights the issues parents faced in relation to the hospital environment. This theme will be discussed under three basic themes; being separate, hospital facilities for mothers, and hospital facilities for fathers.

Being separate

The majority of parents discussed the importance of being separated from other pregnant women and babies when experiencing a miscarriage. Parents reported distress and upset caused by seeing other pregnant women and hearing babies crying.

.....*you are absolutely allergic to any other pregnant woman*..... (Emily, 19/40, P8)

....I don't personally think I could have coped having to be where other women have their babies.... (Kate, 17/40, P7).

.....You wouldn't want to be near the labour ward.... (Jane, 15/40, P6)

Being separate from pregnant women appears to be very important to bereaved parents during outpatient appointments, casualty visits and when admitted to the hospital. Emily reported the distress she felt when waiting in a crowded waiting room to be seen by a doctor when she presented to the casualty department. Emily felt very strongly about this and told the researcher this was the main reason she wanted to participate in the study as she felt this needed to be improved.

> *.....I was getting more and more upset..... I couldn't really understand why the hospital didn't have a more separated area..... where there are queues and queues and queues of pregnant women happy, as they should be, and you are sitting there knowing.....It is not something a woman in any miscarriage situation should have to do.....*(Emily, 19/40, P8)

Kelly's experience was different to that of Emily, Kelly was happy that she was also kept separate when she returned to the hospital for her follow up appointment. This supports the view that separateness is important for bereaved women.

> *....Even when I went back again a few weeks after it was again I was kept separate....* (Kelly, 17/40, P5)

Mothers were grateful when they allowed to wait in a separate waiting room for appointments.

> *.....they were very good and they didn't make me wait with all the other pregnant mothers they let me into another area. So I feel that's really important.....* (Kate, 17/40, P7)

Parents reported distress at being cared for in the same area as women with healthy pregnancies and hearing babies crying. Parents acknowledged the physical environment of the hospital as an obstacle to this, but felt this is an issue that caused them great distress. David found it very difficult being in the same antenatal ward that they were in when she had her other children. He found it very difficult being surrounded by other pregnant women and the memories of their previous deliveries.

> *.....we had all these kind of pregnant women marching around the place in various stages of labour.....that probably wasn't ideal..... on one hand you have got such good memories a place and then it's very different now….It's a place where, where most people would associate very happy memories .....but not for us on that day.* (David, 16/40, P13)

Michelle found it difficult to be hear the sound of newborn babies crying near to her room.

> *....that was awful hearing babies go past....* (Michelle, 19/40, P1)

Eugene also described the upset they felt when he and his partner left the room and were faced with pregnant women and hearing crying babies going passed the room.

> *..... going out to the toilet and there was pregnant women sitting right outside your door... you could have some kind of separate part .... Because that was literally the hardest thing.....* (Eugene, 19/40, P11)

Deirdre felt that women experiencing a miscarriage should be cared for in another area and suggested a medical ward rather than the antenatal ward.

> *.....where I had the other children so it was strange to go to the same place.....It would be better if it was physically in a different place I do think, a more medical ward* (Deirdre, 16/40, P2)

In contrast, Emily, Kate and Orla were all cared for on the same antenatal unit but were happy with this and felt they were far enough away from other pregnant women.

> .....*The room was perfect, it was away from, the maternity unit was kind of the far side, it was far enough*..... (Orla, 17/40, P9)

> *....I was away from everybody....* (Emily, 19/40, P8)

Four mothers (Sally, Ciara, Jane and Kelly) were cared for on the gynaecology ward and were all happy with their place of care. Kelly was cared for in a large open ward on the gynaecology unit, but was satisfied with that because there were no pregnant women or babies.

> .....It was ok, it was ok because there were no babies..... I could deal with that (Kelly, 17/40, P5)

It is evident from the discourse of the bereaved parents that it is very important for them to be separated from other pregnant women and newborn babies.

Hospital facilities for mothers

Both mothers and fathers highlighted issues with the hospital facilities for mothers and discussed a number of areas that could be improved. Parents highlighted the fact that the hospital building was old but this was not always seen as a negative thing by parents.

> *.....it was you know old fashioned, but strangely comforting because of that....* (David, 16/40, P13)

A number of parents commented on the facilities in the casualty department and reported a lack of space and privacy. Emmett was with his partner when she was brought to the casualty department after delivering their baby at home. He felt the facilities in casualty didn't meet the needs of Sally during that time.

> *.....initially terrible..... I don't know if they were just cubicles for antenatal care or what it was but it didn't seem like there was anything equipped to deal with what she had....* (Emmett, 16/40, P14)

Sally was also unhappy with the facilities in the casualty department. She describes the area where she received her initial medical care.

> *.....It was tiny….there seemed to be people jumping over each other trying to get in and out..... then there was just very little space..... it was really cold. So that wasn't great.....*(Sally, 16/40, P3)

Jack was also unhappy with the facilities in the casualty department and felt the area his partner was cared for in was too small.

> *....Yes it was like a cupboard in a way....* (Jack, 16/40, P12)

Once admitted to the hospital the majority of mothers were cared for in a single room either in the antenatal or gynaecology ward. The majority of parents were satisfied with the overall facilities, but had a number of suggestions that could improve the facilities in these single rooms. These included, an en-suite bathroom, a television and brighter decor. Mothers reported finding it difficult to leave the room to use the bathroom and felt an en-suite bathroom would have been easier.

.....I would have had to go to the toilet just across the way..... it was really, really difficult .....I suppose there isn't much of a choice but there should be..... (Michelle, 19/40, P1)

.....the only thing would be maybe a toilet in the room..... (Orla, 17/40, P9)

.....it would have been nice to have had a bathroom there.... (Sally, 16/40, P3)

Jack felt that a television in the room would have been helpful. His partner was admitted to the gynaecology ward overnight after delivering their first baby at home. Jack reported that he had to leave his partner in the hospital to go home for a short time, but felt guilty that she was on her own and the television wasn't working. Jack also felt the room was clean, but old fashioned and brighter decor might help.

.....the TV, she had it on and it was scrambled, and I felt really bad, she was lonely obviously....it is was bit old fashioned.....it was very clean..... just a bit more brighter it would be less depressing....(Jack, 16/40, P12)

Parents highlighted a number of areas where facilities for mothers could have been improved.

Hospital facilities for fathers

Both mothers and fathers highlighted a lack of facilities for bereaved fathers. Fathers highlighted a lack of facilities for them to stay overnight and minimal toilet facilities for men. The only male toilet for the hospital is on the ground floor a number of fathers discussed this as an issue

....the men's toilet is diabolical really to be honest..... (Jack, 16/40, P12)

If the women stayed overnight in the hospital the woman's partner often stayed overnight with her. Emmett stayed with his partner throughout her hospital admission. He slept on a chair in her room. He was happy to be allowed stay with his partner and didn't mind that there weren't many facilities for fathers.

> *....It is not really about the father or the partner, is it? So long as… (referring to his partner) was happy, I was happy....* (Emmett, 16/40, P14)

Mark didn't want to go home and leave his wife when she was admitted overnight in the high dependency unit. He reported very limited facilities for him.

> *.....I literally went lie on a bench. It would have been nice to have somewhere proper to sleep the bench was really narrow.....*(Mark, 17/40, P10)

Kate had a friend stay with her overnight and explained that she slept on a mattress on the floor. Kate was happy to have someone with her and said her friend was happy to sleep on the mattress.

> *.....Yeh they made up a bed on the floor..... she didn't mind..... I remember having to clean everything away the next morning, but look it was lovely to have her there.....* (Kate, 17/40, P7)

From discussions with bereaved parents it is clear there is room for improvement in relation to the facilities provided for bereaved fathers.

4.4.1.3 Information

The third and final organising theme in the global theme of clinical care needs is information. This theme highlights parents' needs in relation to the information they receive from medical professionals during a second trimester miscarriage. Parents' experiences highlight the need for clear communication and parents' desire to find out why the miscarriage occurred.

Clear communication

Parents discussed the importance of clear communication with medical staff. Parents valued honesty and open communication from medical staff. When asked if they were satisfied with how various members of staff communicated with them the majority of parents answered yes. Some parents highlighted the negative impact when communication with hospital staff was not clear.

Kate valued honest communication from her consultant throughout a difficult pregnancy.

> *….we were told at 12 weeks he was very clear about …He was very black and white about things, which I found hard at the time but I much appreciated later on…..* (Kate, 17/40, P7)

Parents explained the importance of information regarding the process of labour and birth. Most parents reported that they were happy with the information they received from doctors and midwives in relation to their care during a miscarriage. Mark felt everything was explained very well to both him and his partner.

> *….She was explaining everything, the pros and cons and just making sure you know the dangers if she hadn't delivered and those issues and complications….* (Mark, 17/40, P10)

A number of parents described the experience of miscarriage as dealing with the unknown. Emily described feeling that she didn't know what to do and was guided by hospital staff to make decisions.

> *.....The whole thing is so alien and unnatural and foreign, you kind of just go with what people say.....* (Emily, 19/40, P8)

Mark and David also felt that miscarriage isn't talked about and found it difficult to know what is usually done in relation to funeral arrangements for the baby.

> *.....it's just an unknown.....this is a very private thing people don't go to it people don't even talk about it, so you've no idea what's going to happen.....* (Mark, 17/40, P10)

> *.....these are the unknowns with these things; you don't know what to do afterwards...*(David, 16/40, P13)

Some parents highlighted areas where communication could have been better from hospital staff. Emmett reported feeling very anxious and worried about his partner

when she was in theatre. She was in theatre a lot longer than he had been told to expect.

> *…. they said it was going to be like a 10 minute procedure…. but there was zero communication between anyone and myself and after I think it was about 40 or 45 …. I was even more worried ….. Afterwards we found out that an emergency section had to go in but none of that was communicated to me….* (Emmett, 16/40, P14)

Jack and Orla both felt they should have received more information about the analgesia given during their hospital admission. Orla received pethidine but she felt the midwife should have explained better the side effects.

> *….the Pethidine and the understanding of the effects of the Pethidine…..*(Orla, 17/40, P9)

Jack felt that his partner wasn't told how to effectively use the entonox and she didn't get any benefit from it.

> *….they gave her some gas as well for the pain, but for me they didn't really explain to her how to use it properly….maybe if they had told her how to use it properly it might have helped a little bit…* (Jack, 16/40, P12)

Overall parents were satisfied with how hospital staff communicated with them; however, a number of issues in relation to clear communication were highlighted by some parents.

Why did this happen?

The majority of parents discussed a desire to find out why they had experienced a miscarriage. Both mothers and fathers discussed the importance of finding out what happened and the importance of a clear explanation of the results of investigations. Parents reported that finding out what happened helped to give them closure and to move forward after the loss.

Ciara and Jack met with a doctor after their miscarriage who explained the results of the investigations. They both found this very helpful and helped them to move on.

> *….So I closed a chapter there....* (Ciara, 16/40, P4)

> *…that doctor was very good and he told us the information and everything….. It gave it a little bit of closure to it…* (Jack, 16/40, P12)

Michelle also felt it was valuable to know why she experienced a miscarriage and that it was unlikely to happen again.

> *….it was helpful to know…. we had lots of questions….it's unlikely that it will happen again so that was really good to know….* (Michelle, 19/40, P1)

Deirdre also wanted to find out why she lost her baby, she had lots of questions about why she had a miscarriage. Deirdre and her partner also met with a doctor to discuss the results of investigation but no cause was found.

> *…..I wanted to know lots of things…..They were never able to find anything …. I wanted a black and white answer, but it doesn't really come like that….* (Deirdre, 16/40, P2)

Emily was also told there was no cause found for her miscarriage. She found this difficult and felt the doctor should have spent longer explaining the situation at her follow up appointment.

> *…He had very few answers…. that that part of the process was a little bit vague. …it could have been managed a bit better because ….he spent ten minutes….it didn't meet my expectations in terms of what I expected from my baby's autopsy back….* (Emily, 19/40, P8)

For the majority of parents finding a cause for the miscarriage was very important. Parents valued a discussion with medical professionals regarding the possible causes of their miscarriage.

In Summary; the global theme of clinical care needs describes parents' experiences during a second trimester miscarriage under the organising themes of m*edical care,*

hospital facilities and information. Parents' experiences in relation to the medical care received by mothers during a second trimester miscarriage were presented. Parents discussed their experiences of medical treatments received by the mother, pain relief, length of hospital stay, going home to prepare for the birth and follow up. This theme describes parents' experiences of the hospital facilities, both for mothers and fathers, the importance of being separate from other pregnant women and babies. Mothers and fathers also highlighted the need for clear information regarding their pregnancy, the medical care they received and the cause of the miscarriage. The second global theme, relational and social experience of miscarriage will now be presented.

4.4.2 Global theme two: relational and social experiences of miscarriage

The second global theme of *relational and social experiences of miscarriage* will be presented in relation to three organising themes; *compassionate care, bonding and connecting and support.* This global theme highlights parents' experiences of compassionate care emphasising the importance of empathy and sensitivity from staff. Parents described their relationship with their baby and the valuable time they spent with their baby after birth. Parents also explained how they remember their baby and shared mementoes of their babies. Parents' experiences of support from the hospital, in the community and through counselling throughout their experience of a second trimester miscarriage will also be presented. See Figure 4.4.2 for an outline of global theme two.

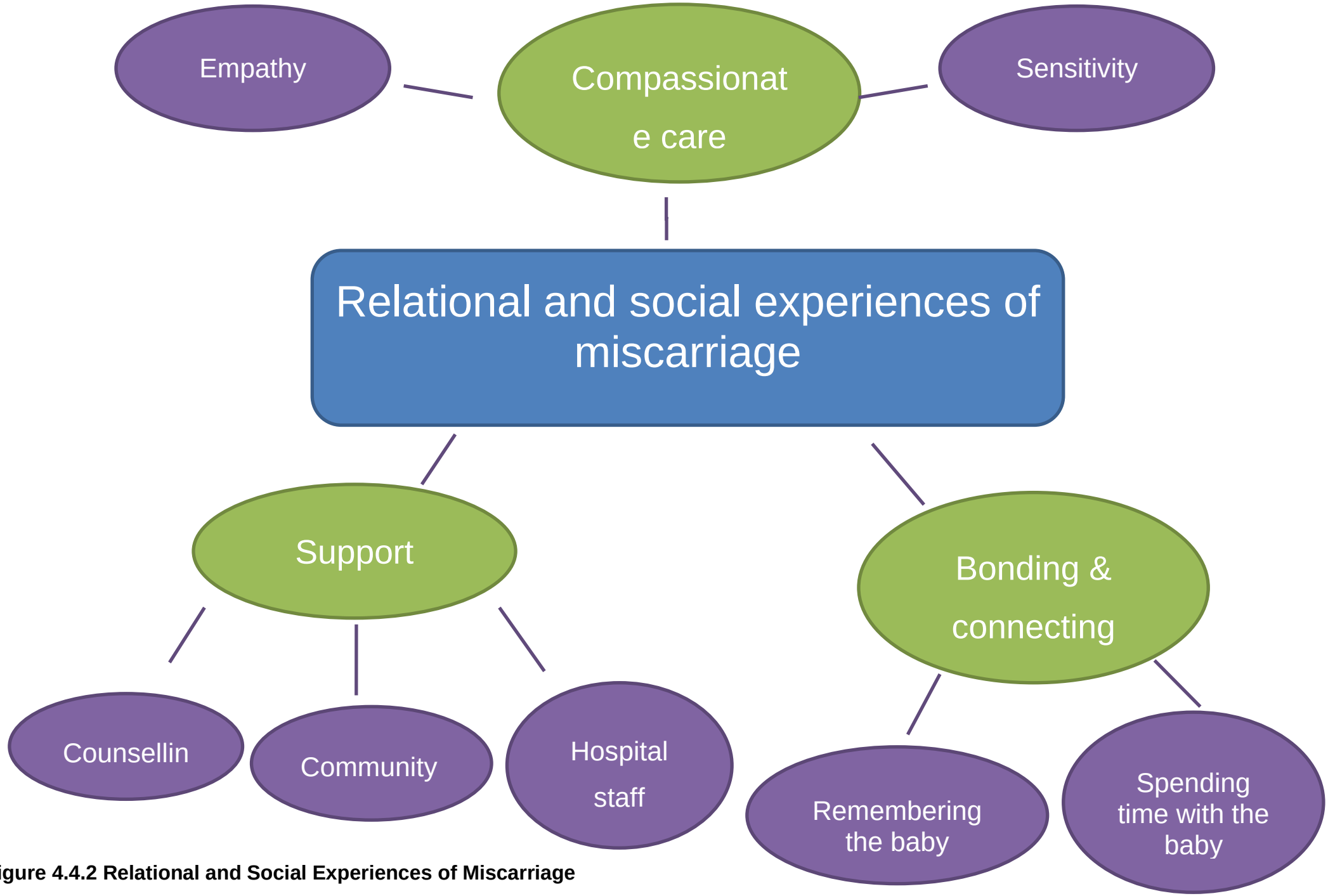

Figure 4.4.2 Relational and Social Experiences of Miscarriage

4.4.2.1 Compassionate care

Parents' experiences highlight the need for compassionate care during and after a second trimester miscarriage. Parents described the experience of miscarriage as a very difficult time for them, but the majority of parents described the positive impact of compassion from hospital staff. Sally experienced a miscarriage at 16 weeks in her first pregnant, she was very grateful for the care and compassion she received.

> *……it made such a difference to how I felt about everything because I kept coming back to how kind everyone was.….(Sally, 16/40, P3).*

Eugene was also grateful to the hospital staff for the care both he and his partner received during the birth of their first baby at 19 weeks.

> *….This whole experience was terrible but we were taken care of…..* (Eugene, 19/40, P11)

Compassionate care is described drawing from two Basic Themes: Empathy and Sensitivity.

Empathy

The majority of parents described sympathetic and empathetic care from all staff in the hospital, including Nurse, Midwives, Doctors and non medical staff. Kate felt that the majority of staff, she met showed empathy towards her and her partner during her hospital admission.

> *….everyone from the cleaner to the head consultant cares…..* (Kate, 17/40, P7)

Parents reported that hospital staff showed genuine empathy towards them during their experience of miscarriage. Parents appeared to greatly appreciate this and often discussed the positive impact that hospital staff had on their experience. Orla describes her experience with midwives on the antenatal ward:

> *…..their manner was lovely…..they were genuinely supportive and sympathetic, they were very good….* (Orla, 17/40, P9).

Emmett also described being grateful for the empathy shown to him and his partner during their experience in the hospital. Emmett felt nurses and midwives cared for his partner in a sympathetic manner and he was very happy with the care they both received when admitted to the gynaecology ward.

> *…..absolutely fantastic…..very sympathetic and did everything, they went above and beyond to look after (referring to his partner) and to make sure that I was comforTable….* (Emmett, 16/40, P14).

Parents discussed the importance of staff acknowledging the loss of their baby. Michelle described the gratitude she felt toward the doctor that cared for her during her admission and valued his empathy and that he acknowledged their loss.

> *….He was the first person that said now your parents….. mentioned her as a baby rather then just as a miscarriage…..* (Michelle, 19/40, P1).

Emmett felt it was important to him that the staff offered condolences when they met him and Sally for the first time.

> *…..a new nurse came in and said, 'very sorry to hear of your loss.' ….. that makes a difference as well….* (Emmett, 16/40, P14).

One mother reported a lack of empathy from one midwife who cared for her during her labour and birth. Kate mentioned a lack of empathy from this midwife a number of times during her interview. This lack of empathy from one member of staff appeared to negatively impact her overall experience during her hospital admission.

> *…..I felt it was that she was over worked, over tired and that wasn't very good….. I did feel that even though she was a nice person that she lacked more empathy…..even though she was still professional I'm sorry but she did definitely lack a bit of empathy there…..* (Kate, 17/40, P7)

It is clear from discussions with these bereaved parents that empathy shown by staff has a great impact on their experience of miscarriage.

Sensitivity

Both mothers and fathers highlighted the need for sensitivity during their experience of miscarriage. Emmett explained that the sensitivity shown by staff had a positive impact on both him and his partner.

> *….it was dealt with such good sensitivity that it made us feel a lot more comfortable …..with that care that made a bad situation that bit more bearable…..* (Emmett, 16/40, P14)

All parents felt that hospital staff knew about their loss, none of the parents interviewed reported that they had to explain what had happened to them while they were in the hospital.

> *….. I was comforted by that, I wanted people to know….(Orla, 17/40, P9)*

> *….I didn't have to explain….* (Kelly, 17/40, P5)

Deirdre felt that staff knew what they had experienced a loss because of the room they were cared for in but appreciated that they didn't have to explain about their loss to any staff.

> *…… once you are in that room people knew pretty much what was happening. That was probably a good thing. I didn't feel that anyone at all had any misunderstanding about what was going on….* (Deirdre, 16/40, P2)

The hospital routinely uses the bereavement symbol developed by the hospice friendly hospital program. This symbol is placed on the door of the room when a woman has experienced a bereavement. Some parents noticed this sign was used and felt it help ensure staff knew about their loss.

> *…..they know what is going on…. they put a sign ….. they won't bother disturbing you and things like that so that was nice…..* (Jack, 16/40, P12)

> *…they started putting a thing up on my door ….. so people know not to come in, that they know what happened to you….* (Emily, 19/40, P8)

Parents also discussed the importance of sensitivity in relation to the care of the baby after the birth. Parents explained that midwifery staff showed sensitivity in relation to their wishes to see their baby and supported them in this. Emmett felt midwifery and nursing staff dealt with their baby very sensitively and was happy with the care they received in the immediate period after birth.

> *… I think the way that was dealt with was brilliant, done with the right amount of sensitivity…..was no time frame once they brought the baby up…...* (Emmett, 16/40, P14)

Jack also felt hospital staff were very sensitive in relation to their wishes after the baby was born. Jack and his partner were unsure about whether to name their baby or not and Jack was happy with how staff approached this.

> *…they said to take your time, think about it, they didn't force anything on us and over time we said we will do something. So it was nice how they approached it….* (Jack, 16/40, P12).

Emily was also happy with the sensitivity and understanding she was shown by the midwife after the birth of her baby.

> *….I wasn't able to spend any time with the baby or anything and she was very kind and understanding….* (Emily, 19/40, P8)

Parents described the impact on them when sensitivity was lacking. Both mothers and fathers reported insensitive comments made by staff that impacted their experience in a negative way. Orla recalled being told to take a cardboard emesis bowl into the toilet to in case she delivered the baby in the toilet. She was advised to place the baby into the cardboard bowl. While she understood it is possible to deliver in the toilet, she felt a more appropriate container could be used and discussed more sensitively.

> *….. I think could be done a little bit more carefully or thoughtfully….*
> (Orla, 17/40, P9)

Some parents mentioned insensitive terminology used by medical professionals. Michelle's labour was induced following the diagnosis of a miscarriage at 19 weeks. She was given medication to induce labour. She explained that staff referred to this as the abortion pill, which she felt was inappropriate.

> *…..I think they used the term the termination or the abortion pill on the first day. And I really didn't think that was appropriate…..*(Michelle, 19/40, P1)

Sally explained that a nurse or midwife discussed putting her baby 'in the fridge', Sally found this upsetting and insensitive,

> *…..She asked about putting the baby in the fridge, and it was just really unpleasant….*(Sally, 16/40, P3)

Emmett reported that one particular nurse made a number of comments that were unhelpful while his partner was in the casualty department.

> *…..just saying things that weren't helpful, they weren't very comforting either….*(Emmett, 16/40, P14)

Michelle was very positive about her care during the loss of her baby; however, she mentioned one comment which caused her upset after the birth during a phone conversation with a midwife.

> *….one comment and it was over the phone ……. I said when can we try again and somebody said what's your hurry? ……I got very upset and very annoyed…..* (Michelle, 19/40, P1)

Two mothers also highlighted a need for sensitivity during their next pregnancy. Both Michelle and Sally reported that hospital staff referred to their next baby as their 'first baby' which caused upset to them.

> *.....if they were saying he is our first that's another huge issue.....* (Michelle, 19/40, P1)

.....everyone kept asking me was it my first baby which maybe it was, but it wasn't.....it would have been nice if people had known, just to stop asking that..... (Sally, 16/40, P3)

Both mothers and fathers discussed the importance of sensitivity when experiencing a second trimester miscarriage. Overall, parents were very positive about how they were cared for during a very difficult time; however, a number of parents described negative experiences due to insensitivity by some staff which added to their upset.

4.4.2.2 Bonding and connecting

Bonding and connecting describes parents' experiences of a short time with their baby and also the ways they remember their baby. The organising theme of bonding and connecting will describe parents' experiences in relation to spending time with their baby and how they remember their baby.

Spending time with the baby

The majority of parents either held or spent time with their baby in the hospital after the birth. Parents often became tearful at this point in the interview but wanted to talk about their baby, some parents proudly showed the researcher pictures of their baby or mementoes such as toys and their baby's foot prints. Kate described how she was encouraged by staff to spend time with her baby. She described how it was hard at first, but she was glad to have spent time with the baby. She also appreciated the way the baby was presented to her in a basket and in a hand knitted blanket.

.....I didn't want to physically hold her because she was so small .....I would hold her in the basket. That was really nice .....At first I found it very hard to look at her..... (Kate, 17/40, P7)

Some parents described their surprise and wonder at how small, but perfectly formed their baby was. David explained how he and his partner held their baby in a knitted blanket and appreciated the time they spent with their baby.

.....Tiny so I suppose we didn't handle the baby directly.....they had kind of a small knitted piece.....it would fit in the palm of your

hand.....you could look quite closely at it and examine it.... (David, 16/40, P13).

Orla was happy she spent time with her baby after birth and held the baby in a little basket, given to her by midwifery staff. She also remarked on how small, but perfect her baby was.

.....was very small, 17 weeks, so although we marvel at how well formed she was, like she was very small.... (Orla, 17/40, P9)

Emmett also appreciated being able to spent some time with his baby. He also described coming back to see the baby in the chapel in the hospital.

.....that was really nice .....in the downstairs chapel, so a little room there where we were able to have a bit of time.... (Emmett, 16/40, P14)

Emily saw her baby, but didn't want to spend time with the baby. She felt staff were understanding of this and respected her wishes.

.....She brought the baby in briefly, I wasn't able to spend any time with the baby....she was very kind and understanding. (Emily, 19/40, P8)

One Mother felt she wasn't able to see her baby after she was born. She thought it would be possible to see the baby at a later stage, but because the post-mortem had started she was unable to do so. She describes not seeing her baby as a big regret.

.....We didn't get to see her and that's my biggest regret ever ever..... right at that exact minute when she came out I wasn't ready..... but we were under the impression we could see her the next day..... Michelle, 19/40, P1)

It is evident from talking to parents bereaved by a second trimester miscarriage that spending time with their baby is very important. Parents who spent time with their baby seemed to value this time.

Remembering the baby

Parents discussed various ways they remember their baby. Pictures and mementoes relating to the baby were often visible in the parents' home. Parents explained how they remember their baby in many ways, including photographs, candles and toys. Kate explained that she put her babies name in the hospital's remembrance book and took comfort in that.

> *.....Even though it was early, regardless I've seen the remembrance book and I have put things for the baby in that.....it is really nice to have that.....* (Kate, 17/40, P7)

Many of the parents have pictures of their baby. Orla and David explained that they had pictures of their baby, which they like to look at from time to time. Ciara showed the researcher pictures of her baby with great pride, she also described making a basket herself for the baby and putting the baby's name on a teddy.

> *.....I decided I'd make a basket myself..... and we did a teddy bear...we put our name and his name and his date on it.....* (Ciara, 16/40, P4)

Parents described ways they honoured and remembered their babies. Jane described how she let off balloons in honour of the baby.

> *.....We had let the balloon up and said goodbye to the baby with the girls so that was our thing.*... (Jane, 15/40, P6)

Michelle described a number of items that help her and her partner to remember their baby. They have a candle with the baby's name on it, photographs and toys. They also have a memory box. Michelle explains that she thinks about her baby every day,

> *.....we think about her every day in a kind of oh you know nice kind of way.....* (Michelle, 19/40, P1)

Jack and his partner went to the annual remembrance service held by the hospital and found it a comfort for him and his partner.

*.....it was a lovely ceremony.....It is comforting knowing that it happens every year and you can go... (*Jack, 16/40, P12)

It was clear was talking to Eugene that his baby was very much remembered and it was important to him that she was part of his family. He showed the Researcher a number of mementoes around his home that honour the memory of his daughter; including candles, photographs and toys.

..... she is still part of our family. She is our little girl..... (Eugene, 19/40, P11)

Parents described various ways they remember their baby, it is clear from talking with parents that the memories of their babies are very important to them.

4.4.2.3 Support

The third and final organising theme in the global theme of relational and social experiences of miscarriage is support. This theme draws on the basic themes of hospital staff, community and counselling. Parents who participated in the study discussed various sources of support; all parents discussed the importance of support from the hospital. A number of parents also discussed the importance of community supports and counselling.

Michelle highlighted the lack of recognition for a second trimester miscarriage and viewed it as more significant than a miscarriage in the first trimester. She felt that a second trimester miscarriage was very different to early miscarriage and required more recognition and support.

.....The term miscarriage goes all the way up to 24 weeks technically, but we kinda say still born because .....It is different to a miscarriage..... if you have to go through full on labour should that not be you get a bit more not sympathy, but a bit of extra support..... (Michelle, 19/40, P1)

David echoed these feelings and explained that in his opinion having a second trimester miscarriage lacked the recognition of a stillborn baby.

> *.....once you get to 13 weeks most people assume you have made it .....it's not a baby until it's 22 or 23 weeks.....you are caught in a kind of a in-between space where there's no kind of real recognition of it as a child or anything like that.....* (David, 16/40, P13).

Support from the hospital

Parents discussed a number of important sources of support within the hospital including, nurses, midwives, doctors, the bereavement midwife and the chaplains. The majority of parents explained the positive impact that the support from hospital staff had on their experience of miscarriage and their ability to cope with such a tragic loss. Parents often reiterated the positive impact of hospital staff at the end of the interviews. Parents' experiences of support are now described under the headings of midwives and nurses, doctors, bereavement liaison midwives and chaplains.

Midwives and nurses

The majority of mothers described receiving a lot of support from nurses and midwives during their hospital stay. Mothers were particularly grateful for midwifery support during labour and birth. A number of mothers asked the researcher after the interview to extend their thanks to the midwife who delivered their baby. Some parents referred to midwives as nurses, though all mothers who laboured in the hospital were cared for by a midwife.

> *…..midwifery staff were amazing..... I didn't feel like there was any rush…..everyone was very calm and quiet and peaceful which was great. You wouldn't have wanted to have felt rushed in there…..* (Deirdre, 16/40, P2)

> *….one nurse in particular, she was amazing, she was really empathetic and she was very kind… she got me through it and it is those kind of people who get you through it….* (Emily, 19/40, P8)

….she was unbelievable. She was absolutely brilliant…. (Michelle, 19/40, P1).

Fathers were also very happy with the care and support received from midwives and nurses during their partner's admission to hospital.

….the nursing staff…..were great and I thought went above and beyond the call of duty to look after us….. (Emmett, 16/40, P14).

….when ever there was something I needed, water for her…..she was right there (Eugene, 19/40, P11)

….they were brilliant, they really were…. (Jack, 16/40, P12)

Both mothers and fathers discussed the support the father received from the hospital. All mothers felt that their partners were included in interactions with staff. Kate and Kelly both felt their partner was well looked after by staff during their miscarriage.

.....he was very much included.....They gave him something to eat that evening and everything.....(Kate, 17/40, P7)

....Oh yeh definitely, he was looked after as well....(Kelly, 17/40, P5)

Doctors

Parents described support received from doctors during their hospital admission. Parents often reported that doctors who they met during their pregnancy came to visit them during their admission and offer their condolences. This support from a familiar doctor appeared to mean a lot to parents.

Kate explained that the consultant who had been looking after her during the pregnancy came to see her when she was admitted.

…. the fact that he would call to the room to say hello, to say he was sorry and see how I was feeling…. That really meant a lot… (Kate, 17/40, P7)

Deirdre was very happy with her care from three different Registrars she was also grateful when the Registrar she had met when she was admitted came to check on her later that night.

> *….. quite late at night one of them came into me. I thought that was very good, very impressive…..* (Deirdre, 16/40, P2)

The importance of visits from the doctors caring for mothers is also highlighted though the expression of disappointment. Emily was disappointed when a doctor who was looking after her during the pregnancy didn't come to see her during her admission.

> *….again my consultant, not that I needed him….I felt could have made an appearance at some stage….* (Emily, 19/40, P8)

Bereavement liaison midwives

A lot of parents valued the support from the bereavement liaison midwives. Some parents didn't recall meeting a bereavement midwife or remembered little information about the support received from them. The majority of parents found the service helpful and reported receiving support visits from the bereavement midwife and phone calls after they went home. Emily explained that the bereavement midwife visited her when she was in hospital and phoned her after she went home which she found a helpful support.

> *…they actually kept in contact which was good….I spoke to her a lot on the phone…. So she was very good and kind that way…* (Emily, 19/40, P8)

Deirdre and Michelle explained they had a support visit during their admission and follow up phone calls for support from the bereavement midwife. Both mothers seemed to be happy with this support.

> *….at least two visits I recall from the bereavement midwives and calls when I came home as well…..* (Deirdre, 16/40, P2)

> *….The bereavement midwife she was fantastic she was absolutely brilliant. There was things we asked her to follow up on this and that and she did….* (Michelle, 19/40, P1)

Jack also appreciated the support he and his partner received from the bereavement midwife both in the hospital and after they went home.

> *…. she rang me as well after to see how we were getting on …..We always knew that there was support there for us …. I was very impressed with her, she was very nice and understanding…..* (Jack, 16/40, P12)

Kelly received support visits from the bereavement midwife during her admission, she was happy that there was support available from the bereavement midwife if she wanted it, but she felt she didn't need it.

> *…..Im quite private with things like grief and all that. It was nice to have that option…. It was just there if I needed it. I was appreciative of that….* (Kelly, 17/40, P5)

Kate felt the support from the bereavement midwives was just while they were in the hospital and felt she had to find support from other sources once she went home.

> *….I understand that's its only a service for just there for the moment in hospital, whether you stop there or go on to do some other counselling or bereavement services elsewhere at home….* (Kate, 17/40, P7)

Some parents valued the support received from the bereavement liaison midwives while others had little or no memory of the service or felt it was only available during their hospital admission. According to hospital records all the women were visited by the Bereavement Liaison Midwife.

Chaplains

The majority of parents were very happy with the support they received from the chaplains. Parents reported receiving both practical and emotional support from the

chaplains. Parents were grateful for the practical information about burial and arranging a service for the baby.

Kate and Deirdre were very happy with the support she received from the chaplain.

> *....she was amazing…Very sympathetic…very helpful….very understanding…. very helpful on a practical level, but really helpful on a supportive level ….* (Kate, 17/40, P7)

> *….a really nice lady, kept coming in as well….she was trying to help us sort out the burial* (Deirdre, 16/40, P2)

David was also very happy with the practical help received from the Chaplain in relation to arranging a burial for their baby.

> *….she was able to answer an awful lot of those practical questions around.....what the choices were….* (David, 16/40, P13)

One mother felt the support from the Chaplain was initially too strong, Orla felt the chaplain seeking emotion from her.

> *…..I felt that it was a little bit strong at times… I felt when I was speaking to her she was nearly seeking more emotion than I was giving. And it was never going to happen…* (Orla, 17/40, P9)

Overall, parents were very positive and satisfied with the support they received from the chaplaincy service in the hospital.

Support in the community

Some parents discussed the support they received outside of the hospital from family, friends and charity organisations. Kate, Michelle and Eugene reported finding support within these organisations. Kate's baby had a condition that is known to be life limiting. She joined a support group for parents who have lost babies with these conditions. She found the support very helpful, she explained that she found discussing her experience with other parents helped a lot. After the interview Kate emphasised the positive impact this support had on both her and her husband.

> *…there is about a 100 women on that….. We do a weekend away and everything, they realise balloons……its really really good. Until I seen that I didn't realise how many women have babies with….*(Kate, 17/40, P7)

Michelle also described the support they received from a charity organisation. She found the support from this organisation very helpful in coping with their loss. She also explained how they are still involved in the organisation and help parents who have experienced a loss similar to theirs.

> *…..We were quite active with the support group….I think maybe if we weren't we might have just written it off as oh it was just a miscarriage, whereas through them we kinda see her as a person. ….now we are the other side able to help people…..* (Michelle, 19/40, P1)

Some parents explained that before they had the miscarriage they didn't realise how common it was as people didn't talk about it. Deirdre explained that a lot of friends told her about their own miscarriages only after her experience.

> *.....a lot of other people talked to me about it afterwards that I had no idea that they had been through so I thought that was good.....* (Deirdre, 16/40, P2)

Ciara is not from Ireland and explained that in her country people don't talk about miscarriage and that she has never met anyone who talked about experiencing a miscarriage.

> *.....miscarriages is very hard back home and then if it does happen, people don't talk about it.....I have never met even anybody who has experienced miscarriage so I don't know how it goes.....we have friends, but they don't talk about it.....* (Ciara, 16/40, P4)

Counselling

A number of parents discussed seeking counselling after their miscarriage. Counselling was the most common response to the question do you think there is another service the hospital could provide? Some parents felt a counselling service

should be available through the hospital or that they should be given a list of counsellors experienced in supporting parents who experience pregnancy loss.

Deirdre and Kate sought counselling after their miscarriage and both felt it would be useful if the hospital provided a counselling service. Deirdre received counselling through her employer. Kate looked for counselling herself in her local area and reported difficulties in finding a suitable counsellor.

> *….even if it was for a maximum of 4 sessions or something it would be a great service…. Not everyone wants it or needs It, but I do feel it is an important thing….* (Kate, 17/40, P7)

> *… I accessed the employee's system programme ….So that was brilliant and I would promote that to anyone that …..I found that really, really helpful….. yes the counselling service would be amazing for people…*(Deirdre, 16/40, P2)

Three fathers also highlighted the importance of counselling, David, Emmett and Eugene felt a counselling service should be provided in the hospital.

> *…the need for counselling…. I think that's probably a gap that really needs to be filled…. that probably helped a lot…* (David, 16/40, P13)

> *….think that if there was a bereavement counsellor…. that would have helped…. we did end up seeing a counsellor ourselves ….. I think if there was a counsellor here who had dealt with those sort of things I think that could have helped ….*(Emmett, 16/40, P14)

> *….we were kind of let go without having spoken to a counsellor, which I thought was kind of a bit hard…* (Eugene, 19/40, P11)

Some parents felt that a counselling service should be provided by the hospital and highlighted this as a service that was missing when they experienced a miscarriage. From discussing the experience of second trimester miscarriage it is clear that parents receive support from a variety of sources in the hospital, in the community and through counselling. Parents appeared to value the support they received in the

hospital and from support organisations. Parents also highlighted their wishes to have a counselling service provided by the hospital.

In Summary the second global theme of *relational and social experiences of miscarriage* captures the organising themes of, *compassionate care, bonding and connecting and support.* This global theme highlighted parents' experiences of compassionate care emphasising the importance of empathy and sensitivity from staff. Parents described their relationship with their baby and the valuable time they spent with their baby after birth. Parents also explained how they remember their baby and shared mementoes of their babies. Parents' experiences of support from the hospital, in the community and through counselling throughout their experience of a second trimester miscarriage were also presented.

4.5 Summary

Chapter four described the response rate, provided a description of the sample and presented the findings from two global themes; *clinical care needs, and relational and social experiences of miscarriage*. Clinical care needs highlighted parents' experiences in relation to medical care, hospital facilities and information. Parents explained their experiences in relation to the medical care they received. Parents were overall satisfied with their medical care and highlighted the need for adequate pain relief and the importance of the follow up appointment. This theme highlighted the importance of being separate from other pregnant women and babies and also the need for improved facilities for both mothers and fathers. Both mothers and fathers explained the need for clear communication from health care professionals and the desire to find out why the miscarriage occurred. The second global theme of *relational and social experiences of miscarriage* highlighted the parents' experiences in relation to compassionate care, bonding and connecting with their baby and their experiences of support from the hospital, in the community and counselling. Parents explained the importance of sensitivity and empathy during a very difficult experience. Parents explained the importance of spending time with their baby and shared various ways they remember their baby. Parents also highlighted the need for support both at the time of the miscarriage and after discharge from the hospital. A discussion on each of the global themes will now be presented in Chapter five.

Chapter five

Discussion

5.1 Introduction

The aim of this study was to examine the hospital experiences of a small group of bereaved parents (those who have experienced a second trimester miscarriage) and gain knowledge to improve practice in relation to the care provided to these parents. The Health Service Executive (HSE) (2014 p.4) defines second trimester miscarriage as pregnancy loss "after the 12th and before the 24th completed week of pregnancy". This definition was used for the current study, which was also informed by previous research on second trimester miscarriage (Cullen *et al.*, 2015), key grief theories (Bowlby, 1980; Parkes, 1987; Worden 2009; Stroebe and Schut, 2010), and related research which focused on the care of bereaved parents in maternity practice (Stratton and Lloyd, 2008; Murphy and Merrell, 2009; Rowlands and Lee, 2010; Lee, 2012; Kelley and Trinidad, 2012; Mulvihill and Walsh, 2013). A focused ethnographic design was deemed an appropriate approach and was undertaken in this study. This approach provided a methodology that is problem focused and has been used previously to gain increased understanding of specific aspects of a person's way of life (Cruz and Higginbottom, 2013; Higginbottom, 2013; McGuinness *et al.,* 2014). Nine mothers and five fathers participated in this study. The age range for mothers was from 30 years to 42 years. The gestational age at the time of the second trimester miscarriage ranged from 15 to 19 weeks. The mean gestational age was 16.88 weeks (SD= 1.36). Parents were interviewed seven to 23 months following the miscarriage. Five of the mothers had one or more children before the miscarriage and three mothers had a healthy baby after the miscarriage. Six of the women were induced after the diagnosis of fetal demise and three women labored spontaneously.

The key findings from the study were presented in Chapter four, thematic analysis (Attride-Sterling, 2001) was employed to analysis the data and thematic networks were designed to represent the two global themes of *clinical care needs* and

relational and social experiences of miscarriage which emerged from the data. Chapter five begins with a discussion of the findings in each global theme. There is limited literature specifically investigating second trimester miscarriage; therefore, the literature related to first trimester miscarriage and stillbirth is drawn upon to discuss the study findings. The strengths and limitations of the study are then presented, followed by a summary and conclusion. A series of recommendations for clinical practice, education for health care professionals and future research areas are outlined and a dissemination plan completes Chapter five.

5.2 Global theme one: clinical care needs

Global theme one contains the organising themes of *medical care, facilities and information.* The findings of this global theme will now be discussed.

Medical care emerged as an important organizing theme in this study, though the majority of parents in this study were satisfied with their overall medical care, some parents did highlight areas that could be improved. Similarly McGuinness *et al.* (2014) also reported that bereaved mothers needed support and advice in relation to their physical care needs following their pregnancy loss. Physical pain is experienced by the majority of women following a miscarriage (Adolfsson, 2010; Stejourne *et al.* 2010). The majority of women in the current study described the experience of labour and birth during the second trimester of pregnancy as painful. The need for adequate pain management during miscarriage is highlighted in the literature (Gold *et al.* 2007; HSE Clinical Practice Guideline no 29, 2014). There is little evidence available on what constitutes effective analgesia during miscarriage and on women's preferences for analgesia. In a recent Irish study, 74% of women who experienced a second trimester miscarriage received some form of analgesia, most commonly intra muscular pethidine (Cullen *et al.*, 2016). Of the six women who delivered in the hospital, half were satisfied with the analgesia they received while the other half felt they would have liked other options for pain relief. This study also highlights the importance of pain management during the third stage of labour for women who deliver during the second trimester. Two mothers discussed a lack of analgesia during attempts to deliver the placenta. Women described severe pain and one partner recalled hearing his partner "howling in pain". There is limited literature

available in relation to pain relief during the third stage of labour, particularly if the baby is born during the second trimester. The HSE Clinical Practice Guideline no 29 (2014) advises that all usual forms of analgesia should be available to women who labour. An individualised assessment of the woman's preferences for pain relief should be carried out prior to commencing induction and reassessed regularly throughout labour, birth and in the postnatal period. The options for pain relief should be explained to the women and pain relief administered as soon as possible if the woman requests it. Over half of the mothers interviewed (5/9) discussed difficulties in relation to having their blood taking blood after the birth. This appeared to heighten their distress and discomfort. When the mothers experienced multiple attempts at taking bloods and were left with bruises this appeared to have a lasting negative impact on their overall experience of miscarriage. This finding supports the view that extra consideration may be warranted when allocating the task of phlebotomy pre and post labour for bereaved mothers.

Five of the women in this study discussed going home after the diagnosis of a second trimester miscarriage to await induction of labour and to prepare for the birth of their baby. The five mothers and one father described this a difficult time, but valued the time to come to terms with their loss and to make practical preparations for their hospital stay and the birth. There is very little research examining women's' experiences of going home after the diagnosis of intrauterine fetal death. Furthermore no research was found which examined parents' experiences of going home to prepare for a second trimester miscarriage. The studies that were related to mothers' experiences of waiting for induction in women who experienced a stillbirth (Malm *et al.*, 2011; Erlandsson *et al.*, 2011). Malm *et al.* (2011) interviewed women who experienced a stillbirth after 30 weeks gestation. Mothers in this study described feelings of being left with unanswered questions and of being in 'no man's land' (Malm *et al.* 2011). Erlandsson *et al.* (2011) found that for some mothers waiting for induction added further stress and psychological trauma to an already very difficult situation. The authors recommend that women should be provided with information from health care professionals and should be involved in decision making (Erlandsson *et al.*, 2011). Peters *et al.* (2015) reported similar findings and recommend that women who experience a stillbirth are involved in the decision making around the timing of induction of labour and suggest that women should be

given a choice to go home before the induction process begins. In the current study, mothers expressed varying opinions on the support needed from the hospital during this time. One mother would have liked more support during this time and suggested a house visit, whereas another mother felt family support was enough during this time. No other studies were found which looked at parents' support needs, during the time between diagnosis of intra uterinedeath and induction of labour.

The average length of stay in hospital for women experiencing a second trimester miscarriage was calculated in a recent Irish study as 36 hours (Cullen *et al.*, 2016). There is little information in the literature regarding the most appropriate length of hospital stay following miscarriage or parents' preferences in relation to the length of hospital stay. The majority of parents in this study were satisfied with the length of stay in hospital. Most mothers were admitted less than 24 hours and were happy to go home when they were discharged. The Standards for Bereavement Care Following Pregnancy loss and Perinatal Death (HSE, 2016), report that if the mother requests early discharge that this should be is facilitated. No guide for the length of hospital stay is provided and this is most likely due to the fact that each mother has different medical needs and requires an individualised assessment of her physical and psychological needs and required length of hospital stay.

The literature highlights the need for follow up care following miscarriage to give women the opportunity to discuss any unresolved concerns or feelings they may have (Griebel *et al.*, 2005; Kong *et al.*, 2010a; Mulvihill and Walsh, 2013). In this study all but one mother had a follow up appointment after the miscarriage and the majority of parents were satisfied with their medical follow up. When follow-up appointments are offered to bereaved women they tend to be well attended as indicated by high attendance rates (Athey and Spielvogel, 2000; Cullen *et al.*, 2016). The timing of follow up is debated in the literature, Stratton and Lloyd (2008) suggest follow up should take place within six weeks. While the HSE recommends follow up support for women following a second trimester loss (HSE, Clinical Practice Guideline, no: 29, 2014), no recommendation of the timing of the follow up is given. The Standards for Bereavement Care suggest a time frame of three months if a post mortem examination is performed to ensure the results of all investigations are available at the time of the follow up appointment (HSE, 2016). Women report a

desire for follow up at varying timings, some reporting a desire for support within a few days while others preferring to wait a few weeks (Stejourne *et al.* 2010). The current study supports the findings of Stejourne *et al.* (2010),in that the parents had different opinions on the most appropriate timing for follow up, some were happy with the timing while others felt it was too soon or could have been sooner.

The organising theme of facilities presented parents' experiences of hospital facilities, this theme highlighted parents' desire to be cared for in an area separate from other pregnant women and babies. Parents' experiences of hospital facilities for mothers and fathers were also described. Almost all parents in the current study discussed the importance of being separate from other pregnant women and babies. Some women were happy that they were cared for on the antenatal ward and felt they were far enough away from other pregnant women. Some parents found it very difficult to be cared for on the antenatal ward. Parents reported distress caused by seeing pregnant women in various stages of labour and hearing babies crying. The literature highlights women's desire to be cared for in an area away from women with healthy pregnancies and babies, but report varying opinions on the most appropriate care environment (Gold *et al.*, 2007; Mulvihill and Walsh, 2013; Peters et al, 2016). Peters *et al.* (2016) conducted a meta-synthesis of qualitative research relating to parents' experiences stillbirth and found that while parents prefer to be kept separate from crying babies and other pregnant women it can be isolating and distressing to completely remove mothers of stillborn babies from the maternity environment.

In Ireland, research examining women's experiences of pregnancy loss found that some women valued the privacy of single rooms and were critical of being nursed in busy wards whereas other women reported a feeling of being left alone, when nursed in single rooms (Mulvihill and Walsh, 2013). All the women in the current study who were cared for in a single room appeared to value the privacy and none reported feeling left alone. Both the HSE Clinical Practice Guideline no 29 (2014) and HSE (2016) recommend that bereaved parents are cared for in a single room, but make no recommendation on whether the single room should be in an antenatal ward or gynecology ward. All of the women in this study who were cared for in the gynecology ward were satisfied with their place of care. One woman in this study was cared for in a room with other women on the gynecology ward, but was happy with

this as there were no babies there. The most appropriate place of care for women who experience a second trimester loss remains unclear, however from a review of the literature and from the findings of this study it appears that parents value being cared for in a single room in an area that is away from other pregnant women and the sounds of babies crying. Parents in this study also highlighted the need for separate waiting areas in clinics and in the casualty departments. Mulvihill and Walsh's (2013) study findings concur with those in the present study; they reported that mothers who experienced a miscarriage found it difficult to be in a waiting room surrounded by pregnant women. One mother described the distress caused by waiting in a room full of happy pregnant women when she was in the emergency department. Other parents commented on the fact that they were kept separate when waiting for scan appointments and for follow up appointments. While the physical environment of the hospital can make it difficult to always facilitate separate waiting areas for bereaved parents every effort should be made to avoid causing further distress and allow parents to wait in another area.

Both mothers and fathers highlighted a number of issues in relation to hospital facilities (i.e. toilet, bathroom, TV, bed for father to sleep in) for bereaved parents. Three mothers suggested that an en-suite bathroom would have helped to make their experience during their hospital admission better. One father suggested a brighter décor in the room would be better. Parents also highlighted a lack of facilities for fathers, including a lack of toilet facilities for men and facilities to stay overnight. This remains an ongoing issue for all fathers in the hospital[1].

Information is the third and final organizing theme which forms the global theme of clinical care needs. The literature describes bereaved parents' desire to know why a miscarriage occurred and the need for clear communication from health care professionals (Nikcevic *et al.*, 1998; Simmons *et al.*, 2006; Mulvihill and Walsh, 2013). Parents in this study also discussed the importance of clear communication with health care professionals and the desire to know 'why did this happen?' Parents in this study describe the experience of miscarriage as 'unknown' and relied on information provided to them by hospital staff to understand what was happening.

[1] . Since the completion of data collection renovations have commenced to improve facilities for bereaved mothers on the antenatal ward. An en-suite bathroom has been built into the single room and the room has been decorated in a less clinical way with bright colours and soft furnishings.

Parents highlighted the importance of open, honest communication and providing information regarding medical treatments. Some parents in this study did report areas where communication could have been improved, but the majority of parents were satisfied with the way staff communicated with them and the information they received. The majority of parents in this study felt that staff communicated with them in a clear manner. A review by Lisy *et al.* (2016) of qualitative research examining parents' experiences of stillbirth recommended that information should be provided to bereaved parents in a clear and understandable way. The literature highlights the need to provide information to parents who experience a miscarriage (Rowlands and Lee, 2010; Sejourne et al, 2010; Mulvihill and Walsh, 2013). In a quantitative study by Sejourne *et al.* (2010) the majority of women (86%) felt they did not receive sufficient information regarding their miscarriage and the medical treatment they received. Women in Rowlands and Lee's (2010) study also reported a lack of information received; however, both these studies investigated women with miscarriage in the first trimester.

Given the limited research examining parents' experience of second trimester miscarriage, the literature relating to first trimester miscarriage and stillbirth is a useful resource to draw upon to help explain some of the current study findings. Previous studies investigating parents' experiences of miscarriage and stillbirth (Rowlands and Lee, 2010; Sejourne et al, 2010; Mulvihill and Walsh, 2013) mirror some of the findings from this study. Parents in this study highlighted the need for information regarding their medical treatment particularly regarding pain relief. Some parents felt that pain relief options could have been explained better by the staff. All bereaved mothers who may experience labour and birth regardless of the gestation need information regarding the analgesia available to them and the benefits and limitations of each form of analgesia. An information leaflet regarding analgesia designed specifically for mothers experiencing a second trimester loss or stillbirth may help to support verbal information provided by staff. Miscarriage is often not openly discussed (Mander, 2006), this can leave parents feeling that the experience is 'unknown'. A number of parents in this study described feeling that second trimester miscarriage is completely unfamiliar to them. Two fathers talked about not knowing what will happen in relation to funeral arrangements. Bereaved parents

need information regarding miscarriage and options for interment provided in a sensitive manner.

A number of studies highlight women's desire to identify the cause of the miscarriage and report that the absence of a cause can make the experience more difficult (Simmons *et al.* 2006; Mulvihill and Walsh, 2013). Parents in this study described a desire to find a reason for their miscarriage and described a feeling of closure after discussing the results of investigations with their doctor. These findings are supported by Simmons *et al.* (2006), who found that many women who experience a miscarriage search for meaning in their experience and have a desire to find the reason for her miscarriage. One woman in this study found it difficult when no cause for her miscarriage was found. The HSE advises that health care professionals should explain to parents that the cause of miscarriage is unexplained up to 50% of the time (HSE, Clinical Practice Guideline, no: 29, 2014). Kelley and Trinidad (2012) found that parents wanted to understand the reasons for a stillbirth and felt frustration when health care professionals could not provide answers. For some women, when a cause is identified, they can be reassured that recurrence is unlikely in further pregnancies, whereas when no reason can be identified, many couples turn to their lifestyle choices for a reason and many direct blame inwards (Simmons *et al.*, 2006; Jansson and Adolfsson, 2010). Parents in this study reported that following a discussion regarding the cause of their miscarriage they felt a sense of closure.

In summary; this first global theme gives valuable insight and adds to what is already known regarding parents' clinical care needs during second trimester miscarriage. Parents' experiences of the medical care received during second trimester miscarriage were overall positive, but highlighted the importance of an individualised approach to pain relief and length of hospital stay and also the value of going home to prepare for the birth and the follow up appointment. Parents highlighted the need to be separate from other pregnant women and babies and also the need for improved facilities for bereaved parents. Both mothers and fathers also explained the importance of clear communication with staff and appreciated, open, honest communication. They described a desire to find out why the miscarriage occurred and valued the opportunity to discuss this with health care professionals. The second

global theme of *relational and social experiences of miscarriage* will now be discussed.

5.3 Global theme two: relational and social experiences of miscarriage

Global theme two is comprised of the organising themes of *compassionate care, bonding and connecting and support.* The findings of this global theme will now be discussed.

The literature provides numerous definitions of compassion and compassionate care. Dewar (2013) defines compassion as the need to recognize and support human vulnerability. Kearsley and Youngson (2012) describe the fundamental principles of compassion as the ability to appreciate the suffering of another and to develop strategies to help alleviate the suffering. Compassionate care has been highlighted as a priority in maternity care, particularly when caring for bereaved parents. The Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death (2016) highlight the need for compassion, empathy and sensitivity for all bereaved parents. Empathy and sensitivity and both described by parents as ways that hospital staff recognized and helped to alleviate their suffering during a second trimester miscarriage.

The majority of parents in this study described empathy and sensitivity by hospital staff throughout their care during second trimester miscarriage and this appeared to have a positive impact on their overall experience. One mother described a lack of empathy from a particular midwife, which appeared to negatively impact her experience. There are a number of barriers to providing compassionate care to bereaved parents. Power (2016) explains that workload and staff shortages can act as a barrier to providing compassionate care. Providing care to bereaved parents can be challenging even for experienced staff and can lead to health professionals being overwhelmed and emotionally burned out, which can negatively impact on patient care and on their own psychological wellbeing (Chan and Arthur, 2009; Nuzum *et al.,* 2015). The mother who reported experiencing a lack of empathy suggested that the midwife looking after her was ‘overworked’ and ‘over tired’. Support and supervision for staff working with bereaved parents are needed to promote the psychological wellbeing of staff and to improve the care they provide to bereaved parents (RCOG,

2010; Wallbank and Robertson, 2013). Youngson (2011) believes that health care professionals cannot provide compassionate care without support. When the work environment is supportive healthcare workers can develop the inner recourses needed to provide compassionate care and can feel safe to bring greater humanity to their work (Youngson, 2011). Parents in this study appeared to greatly value compassionate care from hospital staff, particularly when empathy and sensitivity were shown to them. Maternity hospitals need to strive to create a supportive environment for staff to work in to enhance both the well being of staff, but also to ensure staff have the ability to provide compassionate care to everyone they care for. Youngson (2011) suggests numerous ways to create a supportive environment, including acting against bullying, promoting peer support and shared learning among the multidisciplinary team. Kearley and Youngson (2012) added to the work of Youngson (2011) and put forward the concept of a 'compassionate hospital'. The authors propose that by placing compassion as a core value for hospitals, we can "reduce the suffering of sick patients and restore a sense of well-being, meaning and purpose among health care workers" (Kearley and Youngson, 2012, pp. 457). The 'compassionate hospital' has three main characteristics; a healing environment, a sense of connection among people and a sense of purpose and identity (Kearley and Youngson, 2012). This concept could be utilised within maternity hospitals to improve the quality of care for all families, but in particular bereaved parents and to support health professionals.

Research has highlighted the importance of empathy from healthcare professionals when caring for bereaved parents (Paton *et al.* 1999; Safland *et al.*, 2004; Fenwick *et al.*, 2007; Murphy and Merrell, 2009; Rowlands and Lee, 2010; Musters *et al.* 2013; Mulvihill and Walsh, 2013). Parents in this study appeared grateful when empathy was shown to them. Parents valued healthcare professionals genuine empathy and The Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death (2016) emphasize the importance of empathy when caring for parents who have experienced a second trimester miscarriage from the time of diagnosis of a miscarriage and throughout any interactions with hospital staff (HSE, 2016). There is limited research available regarding parents' experiences of empathetic care specifically during second trimester miscarriage. There are a number of studies examining parents' experience of first trimester miscarriage and stillbirth which can

be used to support the findings of this study. Rowlands and Lee (2010) conducted a qualitative study with mothers who experienced a miscarriage before 14 weeks gestation. The authors reported that a lack of empathy from medical professionals has a profound negative impact on the woman's experience of miscarriage (Rowlands and Lee, 2010). While one mother in the current study did discuss a lack of empathy the remainder of parents in this study describe receiving empathy from health professionals during their hospital admission. This empathy shown to parents appeared to positively impact on their overall experience of miscarriage. This finding is supported by the results of Peters *et al.* (2012) Review examining parents' experience of stillbirth. Parents bereaved by stillbirth appreciate when empathy is shown to them by health care professionals (Peters *et al.*, 2012).

Findings from multiple research studies demonstrate the need for sensitivity when caring for bereaved parents (Lasker and Toedter, 2001; Simmons *et al.*, 2006; Gold, 2007; McCreight, 2008; Rowlands and Lee, 2010; Mulvihill and Walsh, 2013). The majority of parents in this study praised the staff for the sensitivity that was shown to them during their hospital admission. Both mothers and fathers discussed the positive impact of this sensitivity on their experience of miscarriage. The literature tells us that sensitivity shown by the staff makes a lasting impression on bereaved parents (Lasker and Toedter; 1994; Kong *et al.,* 2010a). The results of this study echo this and demonstrate the lasting positive impact of sensitivity shown by the staff. Some parents in this study reported a lack of sensitivity from some hospital staff and this appeared to cause further upset and had a negative impact on their overall experience. A number of studies found that insensitive comments from medical professionals caused anger and distress among parents bereaved by pregnancy loss (Simmons *et al.*, 2006; McCreight, 2008; Rowlands and Lee, 2010; Kelley and Trinidad, 2012; Downe *et al.*, 2013, Mulvihill and Walsh, 2013). Some parents in this study mentioned insensitive comments from staff which they found very upsetting. The use of words such as 'the abortion pill' or referring to putting a baby 'in the fridge' caused anger and distress for bereaved parents in this study. Research conducted in the UK by Simmons *et al.* (2006) and McCreight (2008) mirror these findings, mothers in both studies reported dissatisfaction when health care professionals used the term 'abortion' when discussing their miscarriage. A need for further education for staff caring for bereaved parents in maternity hospitals has been

highlighted in the literature (Chan and Arthur, 2009; Nuzum *et al.,* 2015). Lack of adequate training for staff can act as a barrier to compassionate care (Williams *et al.* 2008). A number of parents in this study reported a lack of sensitivity from staff and the use of insensitive language. Further education for healthcare professionals in relation to sensitivity may be of benefit.

The majority of parents in this study held or spent time with their baby and discussed various ways they remember their baby. From talking to parents bereaved by second trimester miscarriage, it is clear that their memories of their babies are very important to them. Spending time with their baby and creating memories following stillbirth has been identified as very important to parents (Samuelsson *et al.*, 2001; Trulsson and Rådestad, 2004; Saflund *et al.*, 2004; Kelley and Trinidad, 2012; Downe *et al.*, 2013). However, there is very little literature examining this issue in second trimester miscarriage. Rådestad *et al.* (2009) found that holding a stillborn baby has beneficial effects for mothers when the baby is born after 37 weeks gestation. The findings for babies born from 28-37 weeks gestation are uncertain. Rådestad's study focused on stillbirth and did not include women who experienced a second trimester loss. There are limited clinical guidelines in relation to seeing/ holding a baby born in the second trimester or in relation to creating memories. The HSE Clinical Practice Guideline no 29 (2014) advises that parents should be offered photographs of their baby and/or hand/foot prints; however, the guideline provides no guidance in relation to seeing or holding a baby born in the second trimester. The RCOG guidelines focus on the physical aspects of care for women who experience second trimester loss and do not mention spending time with the baby or creating memories. This lack of guidelines for medical staff may be due to a dearth of research in relation to second trimester miscarriage. The absence of guidelines and research investigating this area specifically relating to second trimester miscarriage can make it difficult for staff caring for these parents.

There are a number of grief theories which guided this study and the care received by bereaved parents in practice. Bowlby's (1980) theory explains that individuals need to form emotional bonds with others which begin as an infant between a baby and its parents (Buglass, 2010). Grief is described by Bowlby (1980) as the emotional reaction to the loss of attachments to a loved one. Parents described the

importance of remembering their baby and appeared to value mementoes of their baby. This finding is supported by other studies. Downe *et al.* (2013) and Lee (2012) found that parents valued good quality photographs, handprints, foot prints and locks of hair. Klaus *et al.* (1996) believes that establishing ongoing bonds with the deceased is a normal part of the grieving process. Maintaining emotional bonds with a deceased loved one can be comforting for bereaved individuals (Neimeyer, 2014). Parents appeared to be comforted by photographs and other items of remembrance. Parents also described ways they remember their baby and it was clear from talking to parents that this was very important to them. During interviews parents proudly showed the researcher photographs and other items which reminded them of their baby.

Parents in this study appeared to value support from midwives to spend time with their baby and appreciated the way midwives presented the baby to them usually in a basket or in a knitted sleeping bag. Lisy *et al.* (2016) synthesised data from 20 qualitative studies investigating stillbirth and found that parents value guidance from healthcare professionals about spending time with their baby and in the collection of mementos. The attitude of staff has been found by Rådestad *et al.*, (2009) to influence mothers' decision to hold her stillborn baby; mothers may be more likely to hold their baby if they felt encouraged to do so by staff. Trulsson and Rådestad (2004) and Wilson *et al.* (2015) reported that women in their studies were grateful for the encouragement from staff to see and hold their baby and none of the women regretted seeing their baby. None of the parents in the current study who saw or held their baby disclosed any regret in relation to this. One mother who decided not to see her baby felt regret and described it as her 'biggest regret'. Some parents reported spending just a few minutes with their baby while others had their baby with them for longer periods of time. Saflund and Wrendling (2006) found that almost half of parents in their study felt that the amount of time they spent with their child after a stillbirth was too short. This is in slight contrast to the current study were no parents in this study who decided to see or hold their baby expressed a desire to have spent more or less time with their baby.

Parents discussed the importance of support after a miscarriage and discussed various sources of support both from the hospital and in the community. Within the

hospital parents described support received from midwives and nurses, doctors, bereavement liaison midwives and chaplains. Parents also described support in the community, including charity organizations, family and friends and through counseling. The literature highlights the importance of support following pregnancy loss (Simmons *et al.*, 2006; Sejourne *et al.*, 2010; Rowlands and Lee, 2010; Erlandsson *et al.* 2011; Mulvihill and Walsh, 2013). A lack of social support has been linked to an increased risk of psychological issues following miscarriage (Lok and Neugebauer, 2007). Parents highlighted some areas where support could have been improved, but overall parents appeared to be satisfied with the level of support received from the hospital.

Two parents highlighted the lack of recognition for second trimester miscarriage, these parents felt there was a need for more support compared to a first trimester miscarriage. This lack of recognition of second trimester miscarriage is evident in clinical practice and in the literature. There is minimal research examining parents' experience of second trimester loss and there is no legal requirement to register babies born before 24 weeks gestation. There is an understanding in practice that second trimester miscarriage requires greater support compared with first trimester miscarriage. Support from family and friends have been found to be helpful for parents bereaved by miscarriage and stillbirth (Bennett *et al.*, 2008; Cacciatore *et al.*, 2009; Gerber-Epstein *et al.*, 2009; Erlandsson *et al.*, 2011). In society miscarriage is not openly discussed and parents may not receive the support they need from friends and family. Family members and friends can often underestimate the effect of pregnancy loss on bereaved parents and their grief is often not recognised by society (McCreight, 2008). Miscarriage is often seen as a common occurrence and parents are sometimes subjected to insensitive comments from family members which can be a source of great emotional distress for bereaved parents (Rowlands and Lee, 2010). One mother in the current study discussed support from friends and found it helpful to talk to mothers who also experienced a miscarriage. This study aimed to describe parents' experiences of hospital care and did not directly ask parents about family support received; further research into the importance of family support is required.

Mothers in this study were very happy with the support they received from midwives and nurses particularly during their labour and birth. These findings are echoed in

findings from Erlamdsson *et al.* (2011), who found that midwives were the professional that provide the most support to mothers after a stillbirth. Fathers were also happy with the support they received from nurses and midwives during their partner's hospital admission. In practice nurses and midwives are the health professional who would have the most contact with bereaved parents; midwives provide both physical and emotional care during the mothers' hospital admission. Support from nurses and doctors for women who experience a stillbirth was found to be important for mothers, but it did not influence rates of anxiety or depression among mothers (Cacciatore *et al.*, 2009). Parents in this study were satisfied overall with the support received from doctors. Parents valued when doctors they had met during their pregnancy came to visit them during their hospital admission. One mother reported that her consultant didn't visit her during her admission and this appeared to negatively affect her overall experience, this further highlights the importance of visits from doctors especially those who have built a relationship with the mother during her pregnancy.

Parents were overall satisfied with the support provided by the bereavement liaison midwives and the chaplains. There is limited research examining the role of the chaplain and the bereavement liaison midwives in supporting bereaved parents. In the hospital where this study was conducted all parents who experience a second trimester miscarriage are referred to both services. Both the chaplains and the bereavement liaison midwives provide support to bereaved parents during their hospital admission and following discharge. This ongoing support appeared to be valuable to parents in this study. The literature concurs with this finding and a number of studies report that bereaved parents consistently have a desire for follow up support (Stratton and Lloyd, 2008; Meert *et al.* 2009; Stejourne *et al.* 2010). However, the most effective way to provide support to bereaved parents remains unclear. Some parents in this study appeared to value simply knowing that there was support available should they need it. Stratton and Lloyd (2008) explain women may not also seek support themselves and Mulvihil and Walsh (2013) highlight the need for services to reach out to bereaved parents and advocate a proactive approach to follow up care. In the hospital where this study took place parents bereaved by second trimester loss and given contact details for the bereavement liaison midwives at the time of diagnosis of the miscarriage and advised to contact them should they

wish to talk or find out information on local services. Parents are then visited by the bereavement liaison midwife and the chaplain during their admission and also receive a follow up phone call after discharge. Parents in this study appeared to value this ongoing support and were happy with the support they received.

In a large European study by Sejourne *et al.* (2010) investigating women's wishes in relation to support after a miscarriage reported that the majority of women in their study desired more support following a miscarriage. Mothers is this study felt that important sources of support consisted of having the option of contacting a health professional at any time, an in depth discussion about their miscarriage with a doctor, improved follow up and group therapy with other women who experienced a miscarriage. Similar to Sejourne *et al.'s*, (2010) report, the current study found that parents value discussing their situation with a doctor at a follow up appointment. A number of parents also discussed the value of support groups as sources of assistance. While parents were not directly asked about sources of support outside of the hospital, two mothers discussed the support they received from charitable organisations. Both mothers discussed the benefits of attending support groups and that it helped to know there were other women who had a similar experience. There is limited research available examining the benefits of support groups for parents who experience pregnancy loss or the death of a child. Some small studies examined individuals' experiences of bereavement support groups following the loss of a loved one but not specifically parents bereaved through miscarriage. Maruyama and Atencio (2007) found the in a general hospital setting bereaved individuals can benefit from a bereavement support group. On the other hand, in a study examining mothers who experienced a stillbirth no difference between depression and anxiety were found in those who attended a support group (Cacciatore *et al.*, 2009). The applicability of these studies to parents bereaved by miscarriage is limited and further research is required.

A number of parents in this study reported that they sought counseling following their miscarriage. Some parents felt that counseling should be available through the hospital or at least a list of counselors should be given to bereaved parents. There is limited research available examining the need for counseling for bereaved parents and no research examining this issue in second trimester miscarriage. One

randomised control trial was found which examined the impact of counseling on women's well being after miscarriage. This study was conducted by Kong *et al.* (2014) and found no difference between those who received counseling versus those women who received routine care. The authors conclude that their findings do not support the routine provision of counseling for women who experience miscarriage. While it is clear that bereaved parents require support the need for counseling for all bereaved parents remains uncertain.

In summary; this global theme provides a valuable insight into parents' experiences of relational and social experiences of second trimester miscarriage. This global theme draws on three organising themes including compassionate care, bonding and connecting and support. The parents' experiences highlight the need for health professionals to demonstrate empathy and sensitivity when caring for bereaved families. How parents experience the presence of others during their time in hospital can have a lasting impact on their experience of grief in the aftermath of a second trimester miscarriage. Parents bereaved by second trimester miscarriage value the short time they spent with their baby and appreciate support from hospital staff to see and hold their baby. Parents also value items of remembrance such as their baby's footprints or photographs. There is very little research which examines parents' experiences of seeing and holding their baby born before 24 weeks, this area requires further investigation. Parents highlighted the need for support during their hospital admission and following discharge. Parents valued support provided by the hospital and in the community. The strengths and limitations of the study will now be presented, followed by recommendations for clinical practice and future research.

5.4 Strengths and limitations of the study

The aims of this study were to explore mothers' and fathers' experiences of hospital care during second trimester miscarriage. In particular, this study aimed to report on mothers' and fathers' views on the care received in the hospital from the time of diagnosis of the second trimester miscarriage through to follow-up care. As a consequence the interview guide focused on parents' experiences of hospital care and information in relation to parents' experiences of community health care services such as general practitioners and public health nurses was not gathered, leaving some gaps in our understanding. This study does provide valuable information in relation to parents' experience of hospital care from the time of diagnosis of second trimester miscarriage through to follow up care.

This was a qualitative study conducted with a small number of participants from one hospital in Ireland; therefore, the findings cannot be generalised to other hospitals. A sample of 14 parents (nine mothers and five fathers) participated in the study; while the sample size was small, data saturation was achieved. The study was not intended to be representative of all parents' experiences of hospital care during second trimester miscarriage rather it increases our understanding of a group of bereaved parents.

Purposive sampling was felt to be the most appropriate method of sampling for this study. A number of inclusion and exclusion criteria were drawn up by the researcher and the bereavement team to ensure only the most suitable parents were contacted. The majority of mothers who participated in the study were employed in professional employment with an average age of 37 years (six mothers were over 35 years old). This sample may not be representative of the entire population of women who experienced a second trimester loss in the Maternity Hospital site.

The Researcher was working as a midwife on the antenatal ward at the time the research project commenced, but began working as a bereavement liaison midwife in the hospital during the research process. The researcher's experience in caring for bereaved parents in both the context of the clinical areas and also as part of the bereavement team may have influenced the analysis of the data for this study. A reflective diary was utilised to reduce bias and the research process was described in

depth. The Researcher's academic supervisor was involved in the data analysis process; she reviewed the transcripts and coding system and verified the findings.

Notwithstanding these limitations this study provides valuable information regarding a very vulnerable group of parents and provides important information for clinical practice. The findings also highlight areas for further research.

5.5 Summary

Two global themes emerged from the data collected from bereaved parents these included; Cl*inical care needs, and relational and social experiences of miscarriage*. *Clinical care needs* highlighted parents' experiences in relation to medical care, hospital facilities and information. Parents' experiences of their medical care were described under the first theme, parents were overall satisfied with their medical care and highlighted the need for adequate pain relief and the importance of the follow up appointment. This theme highlighted the importance of being separate from other pregnant women and babies and also the need for improved facilities for both mothers and fathers. Both mothers and fathers explained the need for clear communication from health care professionals and the desire to find out why the miscarriage occurred. The second global theme of *relational and social experiences of miscarriage* highlighted the parents' experiences in relation to compassionate care, bonding and connecting with their baby and their experiences of support during their experience of miscarriage. Parents explained the valuable impact of sensitivity and empathy during a second trimester miscarriage. Parents explained the importance of spending time with their baby and shared various ways they remember their baby. Parents also highlighted the need for support both at the time of the miscarriage and after discharge from the hospital. The findings of this study adds to the limited research available in relation to parents' experience of second trimester miscarriage. Most of the findings are supported by existing research examining miscarriage and or stillbirth. However, new insights into parents' experiences are provided by this study. Limitations of this study include a small purposefully selected sample; however, it provides valuable information for clinical practice and highlights a number of potential areas for future research.

5.6 Conclusion

Second trimester miscarriage is a significant life event for parents. The care parents receive within a maternity hospital during the time of the diagnosis of the miscarriage through to follow up care is of vital importance. Effective clinical care delivered in a compassionate manner which is individualised to meet the needs of bereaved parents following second trimester miscarriage has the potential to impact positively on their experience. The Recommendations outlined below, in clinical practice, education for healthcare professionals and future research drawn from this study, are important steps towards improving future maternity care for this group of parents.

5.7 Recommendations

- Mothers who experience a second trimester miscarriage require individualised medical care and also supportive care from experienced, compassionate medical professionals to ensure both their physical and emotional needs are met.
- All staff caring for bereaved parents should demonstrate empathy and sensitivity throughout any interactions with the parents.

5.7.1Recommendations for clinical practice

Pain relief

- An individualized assessment should be carried out for all mothers in relation to their preferences for pain relief in labour.
- Information should be provided to women in relation to pain relief options available to them.
- Pain relief should be offered women for the third stage of labour, particularly if there is difficulty in delivering the placenta.

Follow up

- Bereaved parents should have a follow up appointment in an area away from pregnant women and babies (ie not in antenatal clinics)
- A sensitive discussion in relation to the results of any investigations and possible causes of miscarriage at the follow up appointment, which should take place within a reasonable time frame.

Information provided to bereaved parents

- Health professionals should communicate with bereaved parents in a clear, honest manner.
- Verbal and/or written information should be given to parents who experience a second trimester miscarriage in relation to miscarriage, the medical treatments they will receive and the sources of support available to them.

Place of care in the hospital

- Women who experience a second trimester miscarriage should be cared for in a single room with an en-suite bathroom when possible

5.7.2 Recommendations for education for healthcare professionals

- Education for health care professionals working in maternity hospitals in relation to the needs of bereaved parents.

5.7.3 Recommendations for further research

Bereaved parents' experiences

- Pain relief options for women who experience a second trimester miscarriage; women's preferences and the efficacy of various forms of analgesia.
- Parents' experiences of going home after the diagnosis of intrauterine death in second trimester miscarriage.
- Bereaved parents' experience of spending time with their baby, following a second trimester miscarriage.
- Parents' experiences of subsequent pregnancies following a second trimester miscarriage.
- The effectiveness of bereavement support groups for parents bereaved by second trimester miscarriage.

Medical professionals working with bereaved parents

- Staffs attitudes and experiences in relation to parents spending time with their baby following second trimester miscarriage.

- Barriers to providing compassionate care for bereaved parents in the maternity care setting and strategies to overcome these barriers
- Healthcare professionals educational needs in relation to providing care to bereaved parents in the maternity care setting.

5.8 Dissemination plan

Passed presentations and publications

- Paper published based on the first phase of this research project. Cullen, S., Power, S., Coughlan, B., Chaney, J., Butler, M. And Brosnan, M. (2016) An exploration of the prevalence and patterns of care for women presenting with mid-trimester loss. *Irish Journal of Medical Science*. Published online. February, 2016. DOI 10.1007/s11845-016-1413-y.
- Poster presentation at the Irish Hospice Friendly Hospital, April 2016. Title of poster presentation; 'Mothers' and Fathers' experiences of compassionate care during second trimester miscarriage in the National Maternity Hospital'.

Future presentations and publications

- Research paper 'Parents' experiences of compassionate care during second trimester miscarriage' to be submitted to the British Journal of Midwifery.
- Research paper 'Parents' experiences of physical care needs during second trimester miscarriage' to be submitted to the Irish Journal of Medical Science.
- Oral presentation accepted for the Nursing & Midwifery Planning & Development (NNPDU) annual conference, INNOVATION Inspiring and Sharing Excellence in Nursing and Midwifery Practice. Title of oral presentation; 'Mothers' and Fathers' experiences of compassionate care during second trimester miscarriage'.

Recent submissions

- Abstract for oral presentation submitted for the 17th Annual Interdisciplinary Research Conference in Trinity College Dublin. Title of abstract; 'Mothers' and Fathers' experiences of physical care needs during second trimester miscarriage'.

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