“ED is a double-edged sword”: A Feminist Relational Discourse Analysis of nurses’ accounts of acute care encounters for threatened miscarriage in Aotearoa

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Abstract

Threatened miscarriage (signs of pain and/or vaginal bleeding in early pregnancy) represents a common but complex presentation in emergency care, raising distinct emotional and psychosocial needs. While existing research has documented the often-negative experiences of women accessing care in this context, little attention has been paid to provider perspectives, particularly the nuances of patient-provider relationships and the institutional constraints that shape them. In this study, I adopt a contextualised, relational approach grounded in feminist poststructuralist theory and further shaped by my personal experience of miscarriage.

Qualitative interviews were conducted with nine registered nurses from six Emergency Departments (EDs) across Aotearoa New Zealand to explore their acute care encounters. Using Feminist Relational Discourse Analysis, I delineated an overarching discursive realm: *"ED is a double-edged sword": Compromises of acute care.* This discursive realm captures nurses' struggle to navigate the dominance of biomedical discourse alongside their desire to provide relational, emotionally attuned care. I then generated three discursive patterns that elaborated on this tension, detailing different aspects of their complicated care work: *(1) "We don't love pregnant women in ED": Systemic shortcomings; (2) "You've got to put a cap on it": Professionalism and emotional containment; and (3) "I'm going to take care of you": Situated agency and relational resistance.* Across these patterns, the voices of *discord, humanity, hostility, apprehension, professionalism, caution, tenderness,* and *purpose* revealed the complex and often conflicting positionalities that nurses took up in their care encounters. Their accounts reflected how gendered expectations and institutional pressures constrained care, but also, how they actively negotiated, resisted, and repurposed those constraints to enact situated agency.

These findings contribute to scholarship on reproductive loss, emergency nursing, and feminist health care by amplifying provider perspectives and illuminating the implicit relationality that underpins their practice, considering how the nurses accounted for the moral and emotional significance of potential pregnancy loss. The insights support the revision of ED systems to better respond to the realities of miscarriage, through clinical resources, education and specialised services that facilitate more holistic, adaptive capabilities in the acute setting. Further critical research is encouraged, particularly into diverse provider experiences and Indigenous perspectives.

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Chapter One

Background and Context

1.1. Introduction

While pregnancy typically presents as a time of intense anticipation and excitement for pregnant women[1], obstetric complications can occur abruptly at any stage, introducing urgent care needs for women and their wider social supports (Edwards et al., 2016; Freeman et al., 2024). With almost a quarter of all pregnancies ending in miscarriage, signs of pain and/or vaginal bleeding in early pregnancy (*a threatened miscarriage*) presents as an incredibly common experience – one which introduces not only a clinical, but an *emotional* emergency for many women seeking acute care (Indig et al., 2011; Klein et al., 2012). Local emergency departments are the most common point of contact for women seeking medical support for a potential pregnancy loss in Aotearoa, with registered nurses (RNs) front lining emergency care (Engel & Rempel, 2016; Yang et al., 2022). In this chapter, I discuss the importance of the Emergency Department (ED) setting in attending to threatened miscarriage, considering how this structures the provision of acute care and complex clinical relationships.

As a researcher with my own lived experience of multiple miscarriages, I have felt the enormity of this confusing, complex encounter alongside my own sense-making of the care I received across various clinical settings, and the emotional sediments that were left behind. I will always conceptualise my miscarriages as so much more than a medical event. This is substantiated by qualitative research showing how the psychosocial aspects of the experience are connected to the emotional and moral significance of potential pregnancy loss, as well as implicit socio-cultural meanings. For example, in Mātauranga Māori, *whakatahe* (miscarriage) also represents a profoundly spiritual rupture and a deeply tapu experience for wāhine Māori, where a loss within the *te whare tangata* (womb) is not only physical – it is metaphysical, emotional and communal (Smith, 2012). Furthermore, the intimate connection between pregnancy and motherhood that can be clouded or completely disrupted by the reality of perinatal mortality (Layne, 1990; Parsons, 2010).

For women whose pregnancies end in miscarriage, the personal and psychosocial repercussions can be persistent and often overwhelming (Baird et al., 2018). Research indicates that significant prenatal stressors increase the likelihood of psychological distress, preterm birth and labour difficulties, and postnatal anxiety and depression – demonstrating a significant link between pregnancy complications and broader wellbeing (Barber & Starkey, 2015; Brandon et al., 2008; Littleton et al., 2010). Between

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[1] Pregnancy is not limited to cisgender women, but that is my research focus because (a) of the overall lack of local research on the topic, (b) this is the group most affected, and (c) including gender diversity would likely raise issues beyond the scope of this study.

25-50% of those presenting in EDs experience posttraumatic stress symptoms after miscarriage, alongside common experiences of personal blame, shame, grief, anxiety and depression that can persist for several years and implicate future pregnancies (Baird et al., 2018; Gergett & Gillen, 2014; Lok et al., 2010; McCarthy et al., 2015). In Aotearoa, suicide is the main cause of pregnancy-related death (particularly for Māori and Pasifika) – emphasising fundamental gaps in care pathways and maternal mental health screening practices (PMMRC, 2017). Together, these insights highlight the importance of prioritising women's emotional and cultural needs when experiencing pregnancy complications. They point to the need for acute healthcare providers to consider the "emotional emergency" (Klein et al., 2012) represented by a threatened miscarriage thus prioritising psychosocial aspects of the experience alongside the physiological. This necessitates comprehensive and responsive caregiving, grounded by a more holistic understanding of care, that forefronts emotional needs (See et al., 2020).

Yet, evidence suggests that many women resolutely restrict and suppress their emotional distress in relation to pregnancy complications when accessing acute care (Currie & Barber, 2016). This inclination is reinforced by emergency care's focus on physical symptoms over wider social and psychological needs (Dainty et al., 2021; Edwards et al., 2016), part of the wider medicalisation of pregnancy and childbirth in biomedical environments that minimises psychosocial aspects of the experience (Andipatin et al., 2019; Catlin, 2018). This dynamic is compounded by sociocultural norms and stigma related to gender and expressions of pain and distress, particularly in relation to childbearing, that silence and sideline women experiencing pregnancy complications and miscarriage (MacWilliams et al., 2016; Zucker, 2021).

Therefore, my research focus is on healthcare *provider understandings* of women's emotional needs in the experience of a threatened miscarriage*, and their responses and resistance to* the societal structures that collectively minimise or silence their importance. In this thesis, I adopt a *relational* prospective of care, that encompasses emotional and relational practices and interactions within particular contexts and in relation to wider society, including other social relations (e.g., support people, whānau), norms (e.g., women's expression of distress) and meanings (e.g., pronatalism, motherhood). Naturally, my own interpretation and lived experiences of miscarriage in this setting, alongside my professional work as a Peer Support Worker within Whakatū (Nelson) Hospital Emergency Department, shape and intensify how I interact with this research.

As such, I adopt a relational lens that shifts the focus from a biomedical approach, towards the contextual layers of emotional care and psychosocial support surrounding a threatened miscarriage. This research offers findings specific to Aotearoa's clinical systems and care settings in response to a scarcity of critical knowledge from the provider perspective. These offer insights into how nuanced healthcare relationships (between patients and practitioners) shape patient experiences, outcomes and future relationships with healthcare services (Due et al., 2018; See et al., 2020; Trostian et al., 2022).

In the remainder of this chapter, I contextualise the provision of acute care in cases of threatened miscarriage, focusing on the clinical relationship between patient and healthcare provider. Further, I introduce the research aims and my own positionality, alongside an outline of the research approach that incorporates reproductive justice and critical feminist viewpoints to explore the intricacy of this subject from a unique perspective.

1.2. Setting the Scene: Threatened Miscarriage and Emergency Care

Miscarriage is the most frequent pregnancy complication, and it stories a common, yet complex, experience for all involved, from both patient and provider perspectives (MacWilliams et al., 2016). In medical terms, a miscarriage refers to the unintended loss of an early pregnancy (before 20 weeks' gestation) (RANZCOG, 2019); up to 24% of all pregnancies end in miscarriage, with 80% of these losses occurring in the first trimester (Indig et al., 2011; Wendt et al., 2014). A *threatened miscarriage* (also called a "threatened early pregnancy loss" or “threatened abortion”) generally refers to symptoms of uterine cramping and vaginal bleeding prior to 20 weeks gestation in an otherwise viable pregnancy (NZCM, 2024). Around 25% of pregnancies involve various degrees of vaginal bleeding in the first trimester, with approximately half progressing to an early pregnancy loss (Hendriks et al., 2019).

As such, pain and/or vaginal bleeding represents the most common reason for women in early pregnancy to access an acute health service, whereby local emergency departments (EDs) offer the most common point of contact both internationally and in Aotearoa (Freeman et al., 2024; Yang et al., 2022). Trostian et al. (2022) identified that the decision to present to an ED was often preceded by partner consultations, online searches for guidance, and advice from family or healthcare professionals – however, women experienced uncertainty related to the ED's role in their obstetric care and whether to access this service (Baird et al., 2016; Rojas-Luengas et al., 2019).

In considering why women decide to seek emergency care, despite their reservations, a quantitative survey of 141 American women explored the underlying intent behind these emergency presentations, highlighting a need to confirm the *viability* of the pregnancy (Strommen et al., 2017). This study points to a crucial contrast in perspectives: women present with concerns related to the *future* of their unborn fetus, whereas providers respond primarily to the *current* and acute risk to maternal life as a priority. Sivalingam et al. (2011) highlight the intent of health providers in the ED to rule out any *life-threatening* causes of early pregnancy bleeding; to facilitate this, a basic evaluation usually includes blood samples, ultrasound and a pelvic examination. Critically, this evaluation additionally seeks to rule out an ectopic pregnancy, as the primary cause of maternal pregnancy-related death in the first trimester. While these procedures also pay attention to a developing fetus, most women expected emergency providers to give a definitive understanding of whether a miscarriage was occurring by the end of the visit (Strommen et al., 2017).

In the ED setting, most care is provided by registered nurses, alongside on-call gynaecology and emergency doctors; in contrast, midwives care for women from 20 weeks' gestation within a hospital's maternity/obstetric unit (Freeman et al., 2020). In larger metropolitan areas, Early Pregnancy Clinics/Assessment Units offer an established approach to more specialised care, citing positive patient and service outcomes across Canada, the UK and Aotearoa (Wendt et al., 2012). Currently, an Early Pregnancy Clinic at North Shore Hospital and an Early Pregnancy Assessment Unit at Greenlane Clinical Centre – within Aotearoa's most densely populated Auckland region – provide multi-disciplinary care specific to assessment, diagnosis, management and psychosocial support for women experiencing early pregnancy pain and/or bleeding (O'Rourke & Wood, 2009; Te Whatu Ora, 2025a; 2025b). These specialised clinics aim to offer less time in the ED, more efficient and co-ordinated care, and wider psychosocial resources for women and their partners (Wendt et al., 2014).

However, these services remain limited, and inaccessible to most of Aotearoa's wider population. Instead, general EDs and regional or remote areas lack the resources to offer more tailored, multidisciplinary care and greater psychosocial support for women and whānau (Edwards et al., 2016; O'Rourke & Wood, 2009). While no local research considers the complexity of providing responsive, equitable services for women experiencing miscarriage across different contexts in Aotearoa, there is some available research in Australia. A study exploring services in metropolitan and non-metropolitan areas, cites pervasive challenges such as nursing and medical staff shortages, bed shortages and limited communication skills in professional practice (Edwards et al., 2016). While these findings offer useful insights, further exploration of the care practices and clinical challenges specific to local EDs is necessary, considering their critical role within the acute response to threatened miscarriage and the prevalent health inequities within this setting.

In addition to understanding systemic challenges, a more holistic view is needed that also acknowledges the wider implications of health system responses and outcomes for patients in light of the established link between pregnancy complications and women's wider wellbeing. Prenatal stressors and health threats suggest an increased risk of psychological distress both during and after pregnancy, and distress during pregnancy has also been linked with preterm birth and labour difficulties (Barber & Starkey, 2015; Littleton et al., 2010). Further, stress and anxiety in pregnancy are also associated with postnatal anxiety and depression, which in turn influences broader wellbeing and maternal-child attachment (Brandon et al., 2008).

Acute care in the emergency setting represents a critical juncture for considering how psychological distress associated with pregnancy complications is understood and attended to (Drake et al., 2022). Conceptualising threatened miscarriage as an "emotional emergency" (Klein et al., 2012) demands a more nuanced, affective and relational understanding of how early pregnancy loss is interpreted in clinical settings, and further, how these understandings and assumptions shape provider responses, health care relationships, patient experiences and outcomes.

1.3. Research Rationale, Aims, and Significance

The rationale and theoretical framework for my research was informed by a comprehensive literature review (Chapter 2) to explore existing understandings and approaches to this field, as well as gaps and limitations within the literature (Polit & Beck, 2014). The scholarship on the topic comprises work on the wider social and cultural constructions of miscarriage, and a significant body of research surrounding women's experiences of threatened/complete miscarriage and early pregnancy complications in acute care settings. There is far less critical research from the provider perspective and limited literature specific to patient-provider relationships and power dynamics in this context.

Thus, despite their role as the *main* care provider for the common experience of a threatened miscarriage, there is limited knowledge surrounding the understandings, assumptions and relational practices of ED nurses in attending to early pregnancy complications (Hendriks et al., 2019; Jensen et al., 2018; Freeman, 2020; 2024). Further, more research specific to Aotearoa's unique systems and settings is necessary, to explore how ED nurses interpret, navigate and respond to their patient's wider psychosocial and cultural needs, in considering the emotional complexity of a potential pregnancy loss (Klein et al., 2012; See et al., 2020).

Therefore, I explore ED nurses' accounts of their interactions with women experiencing a threatened miscarriage within a local ED in Aotearoa. My aim is to expand on current biomedical interpretations of provider barriers, systems and clinical scope, towards more nuanced understandings of the care (including the emotional response) provided by ED nurses and the wider aspects of their relational care practices. In particular, I go beyond an individual-level focus (e.g., on patient or provider experiences) to consider the role of the wider socio-cultural context in shaping care – focusing on *discourses, positionality and power relations.* I explore how a group of ED nurses draw on diverse cultural understandings as they make sense of their role and clinical relationships and construct personal/professional boundaries in their accounts about attending to threatened miscarriage, and further, reflect on the implications for the provision of acute care in this context. This research focus is guided by the objective of exploring the relational space *between* patients and providers in the context of threatened miscarriage, within Aotearoa's acute, biomedical environment. Approaching the topic from the provider perspective, highlights the entangled emotional work of caring, including both personal and contextual issues such as compassion fatigue or self-protective processes, and systemic and environmental constraints (Dean et al., 2024; Jensen et al., 2018). I aim to offer insights that can inform the scope, education, and application of ED frontline care providers and their multidisciplinary teams in Aotearoa, to work towards providing responsive, relational, and culturally safe care that supports both physical and psychosocial wellbeing.

1.4. Research Approach

To critically explore the diversity and intricacies of patient-provider relationships, I use an overarching reproductive justice lens to consider the structural conditions and power dynamics that shape the healthcare encounter, foregrounding individual rights and reproductive autonomy (Morison, 2023). Exploring healthcare experiences of a threatened miscarriage considers an array of intimate, complex understandings that are interwoven between patient and provider perspectives (MacWilliams et al., 2016). Most importantly, this work is immersed in deeply personal experiences of potential or actual pregnancy loss, alongside the complex clinical and emotional care provided within an acute healthcare setting (Dainty et al., 2021; Griffin et al., 2021). To centre my approach, I contextualise this project by weaving together existing work on the cultural and social meanings of miscarriage, established patient experiences of emergency care, and providers' perspectives that include observed barriers when working within the systemic constraints of the acute care environment.

Firstly, sensitively attending to women's lived experiences of threatened miscarriage requires a critical approach that challenges the entrenched discourses of pregnancy and motherhood which marginalise women's perspectives and responses to early pregnancy complications (Connor et al., 2015). In doing so, a reproductive justice lens provides a framework to confront systemic issues and structures of social power that constrain women's experiences of accessing emergency care (Morison & Mavuso, 2022). Reproductive justice makes space for diverse patient perspectives across factors such as class, gender and culture, that spotlights limitations for marginalised communities. Further, it actively considers the role of provider assumptions and institutions in creating a fair and just environment that supports individual rights and reproductive autonomy (Morison, 2023).

Secondly, a feminist poststructuralist lens complements this perspective. It adopts a contextualised, *relational* understanding of the layers of psychosocial support and emotional care that are necessitated within the clinical response to a threatened miscarriage. This challenges an existing emphasis on biomedical practice, towards the importance of relational care and interactions that significantly shape women's experiences, outcomes, and future expectations of healthcare services (Due et al., 2018; Trostian et al., 2022). A critical feminist approach also recognises problematic studies that conduct research *on* vulnerable women, by searching for more reflexive and affirmative explorations *with* women in collaboratively exploring affective and embodied experiences (Braidotti, 2008; Fine, 2017). In my research, this actively resists an intrusive enquiry on women's lived experiences of threatened miscarriage, and instead, adopts a focus on the delicate layers of care between patients and providers, illuminating the perspectives of ED nurses. As the researcher, this approach positions me *within* the research endeavour, in co-constructing meaning and acknowledging the inherent partiality and contradictions of creating qualitative insights (Braidotti, 2010; Fine, 2017).

Together, reproductive justice and critical feminist viewpoints foreground the importance of structural conditions, patient-provider interactions and relational dynamics within the healthcare encounter, that inherently shape care for women facing threatened miscarriage in local ED settings across Aotearoa. As such, a critical review of the literature highlights miscarriage as an *unspoken motherhood* that is widely experienced through themes of invalidation and insufficient psychosocial support in the acute response (Freeman et al., 2020). Conversely, provider perspectives grapple with the moral injury and emotional labour of supporting women experiencing early pregnancy loss, alongside perceived barriers and shifting scopes of practice (Freeman et al., 2024). Collectively, these findings build the rationale for a critical exploration of the perspectives, power dynamics, and sociocultural assumptions underpinning patient-provider roles and relationships for women experiencing a threatened miscarriage within a local ED in Aotearoa. Framing this exploration from the provider point of view provides a counterpoint to established patient perspectives, in considering how ED nurses' understandings and interactions can inform recommendations for more comprehensive healthcare provision, in attending to the physical *and* psychosocial wellbeing of everyday women accessing care (Due et al., 2018; Trostian et al., 2022).

1.5. My Social Location and Researcher Positioning

I was drawn back to psychology through my own experiences of miscarriage and motherhood – considering how they still catch at my heart, while complicating how I interpret others' experiences and the associated clinical and psychosocial supports available in our community. Ultimately, I am still grappling with the gap between the lived emotional journey and the emotional *care* I received in an Australian ED setting, and eager to explore how sociocultural assumptions and understandings of motherhood and miscarriage intertwine with and inform healthcare services, provider responses, and resources. While approaching from such a deep personal connection creates ethical and theoretical complexity, it also allows me to lean into feminist poststructuralist ideals, through *relational* research that invites collaborative sense-making, alongside an attention to the social and political systems of powers that collectively shape our shared stories (Fine, 2017; Oakley, 2016).

Through this lens, I locate myself as a cisgender woman, a mother, and through my academic journey… a blossoming feminist scholar. My understanding of poststructuralist feminism foregrounds a reflexive and continual process *in shifting the social conditions for hearing*, through relational co-constructions of knowledge that challenge dominant and subjugating schools of thought (Haraway, 1988; Waitere & Johnston, 2009). This viewpoint posits that it "matters what stories make worlds, what worlds make stories" (Haraway, 2016, p.12). Therefore, I seek to purposefully "de-skill" and re-imagine my bounded roles as a mother/reproductive being/researcher to disengage from familiar frames of reference, and instead, affirm the meaningful differences and contradictions within reproductive knowledge and understandings (Bartky, 1998; Braidotti, 2010; 2019). As such, I uphold a narrative, relational obligation to share *full enough* stories of ED nurses' experiences (Fine, 2017). This approach looks beyond precise reproductions, towards responsive and accountable writing *by heart and from memory*, that seeks to actualise "what we are ceasing to be" and "what we are in the process of becoming" through the shared research encounter (Braidotti, 2019, p.36; Fine, 2017).

From a cultural perspective, this relational approach also aims to amplify Indigenous accounts of women's reproductive knowledge and potential, that has been silenced and sanitised by Western institutions through processes of colonisation (Connor, 2007; Salem, 2016). Here, I must reflect upon and conceptualise my own Pākehā identity as an "invisible privilege" within the dominant culture in Aotearoa, by taking accountability for structural racism and assimilation that maintains the status quo (Black & Huygens, 2016). I am committed to affirming and empowering research that has a shared *kaupapa* (purpose) guided by the principles of Te Tiriti o Waitangi – using approaches and insights that elevate *mātauranga Māori* (traditional Māori knowledge) in reproductive health, improve cultural safety in ED settings, and actively support nurses to reflect on their relational practices and cultural responsiveness. My foundational knowledge in te reo Māori (level 1 & 2; Te Wananga o Raukawa) and cultural supervision from Te Piki Oranga (Māori Wellness Services) will help to guide this practice in a way that is culturally aligned, aware and ethically sound.

Professionally, I have also worked alongside local ED nurses through my role as a Peer Support Worker in the acute clinical setting. I have observed and *felt* the intangible shift in the room when discussing admissions for a threatened miscarriage during the daily nursing team handover. Having been on the other side of the curtain as a patient, I am deeply interested in how this intangible, shared social understanding of miscarriage translates into emotional and relational care – and whether these unique care practices conflict or overlap with clinical systems, established roles and scopes of practice. Considering this from the provider perspective necessarily challenges my own viewpoint and demands critical reflexivity within my research. Further, searching for more developed provider understandings offers an alternative view to the broader accounts of patient experiences, towards systemic insights and recommendations that consider both patients and practitioners within the service encounter. To me, this represents an important step forward in the field, in being able to link meaningful accounts through shared relationships and connections that humanise healthcare in Aotearoa.

1.6. Thesis Outline

Chapter Two: *Literature Review*

This chapter considers a comprehensive review of existing research that is relevant to the research topic. Research has been sourced from article databases to include published journals and postgraduate enquiries that inform the background, relevance and approach outlined in Chapter One.

Chapter Three: *Methodology*

In this chapter, the theoretical framework and related research method and design are presented, including recruitment, participants, data generation, data management and data analysis procedures. Ethical considerations, practices and researcher reflexivity are also discussed, followed by quality assurance and evaluation criteria. Approval was obtained from the Massey University Human Ethics Committee (MUHEC) through a peer review process.

Chapter Four: *Analysis and Discussion*

The key findings are presented in this chapter, using Feminist Relational Discourse Analysis (FRDA; Thompson et al., 2018) to explore raw data from qualitative interviews with nine ED nurses. In response to the research aims and guiding questions, four dominant discursive patterns were illuminated alongside a consideration of their wider theoretical context. Using these discursive patterns, participant voices and "I poems" were also explored to make sense of the participants' unique positioning in relation to the discursive and theoretical landscape. These individual poems highlight unique voices and subject positions, while also contributing a rich, poetic interpretation of the research findings.

Chapter Five: *Conclusions*

Finally, this chapter reflects on the analytic insights and overarching themes in relation to identified literature in this context. Limitations of the research and recommendations for future studies are explored, as well as the key implications of the findings specific to ED nursing practice, clinical settings and patient experiences of accessing care for a threatened miscarriage within a local ED in Aotearoa. Collectively, this chapter offers a summary of my contributions and salient conclusions from the research findings.

1.7. Conclusion

Chapter One has provided the overarching rationale for my research, alongside the importance of my own subjectivity and personal connection to the topic that deepens engagement within the field. Together, the background and context of threatened miscarriage and emergency care sets the scene for a novel and nuanced exploration that forefronts a *fundamental* difference between patients and providers – that is, the balance between the provision of acute, everyday emergency care and the unique, complex emotional needs of women faced with a potential pregnancy loss (Dainty et al., 2021). Together, understandings of the standard clinical response to threatened miscarriage alongside the incidence of associated psychosocial distress, firmly positions the importance of patient-provider relations within local emergency departments. This leads to the aims of the research that will critically explore the discourses, positionality and power relations within ED nurses' interactions with women experiencing a threatened miscarriage in a local ED in Aotearoa.

Further, a conceptualisation of miscarriage as an *emotional emergency*, embeds a focus on affective, relational understandings of early pregnancy complications and how provider assumptions and established responses shape clinical interactions and experiences. As such, a research approach that embraces reproductive justice and critical feminist viewpoints has been proposed, that actively considers how structural conditions and relational dynamics shape patient-provider interactions and the provision of inclusive and appropriate care. Next, a comprehensive literature review explores the existing knowledge surrounding the research aims, considering sociocultural understandings of miscarriage, patient and provider perspectives, relationships, and implications for my own exploration.

Chapter Two

Literature Review

2.1. Introduction

For women seeking medical support during potential pregnancy loss, the care and interactions with providers significantly influence their experiences, outcomes, recovery, and future interactions with healthcare services (Due et al., 2018; Trostian et al., 2022). There is a relatively large body of work on patient experiences – showing these to be largely negative – but far less is known from the perspective of healthcare providers. In this chapter, I review research relevant to nurses' care for women experiencing threatened miscarriage in an emergency department. Firstly, I consider how miscarriage is culturally and socially constructed, before turning to empirical work on women's experiences of emergency care. I then review literature on healthcare provider perspectives and the specific demands of ED nursing, as well as the power dynamics that are embedded in patient-provider relationships. Throughout, I highlight Aotearoa-specific literature and considerations including the role of Te Ao Māori, cultural safety, and the impact of structural conditions in acute care. Together, these bodies of work establish the foreground for my study, and inform a contextualised, relational perspective that is adopted within the Feminist Relational Discourse Analysis (Thompson et al., 2018) that follows.

As such, the literature review is also focused on the discursive context that frames understandings of miscarriage through a social constructionist epistemology. Exploring the layers of sociocultural meaning and established discourse that surrounds miscarriage, motherhood and pregnancy complications allows for a deeper inquiry to *how, why and in what ways* these taken-for-granted assumptions shape clinical relationships and responses in the emergency setting (Riley & Paskova, 2022). Emphasis is given to qualitative, critical and feminist research as those most relevant to a research question that forefronts healthcare provider understandings, assumptions and relational practices.

2.2. Framing Care and Meaning: Cultural and Social Constructions of Miscarriage

Understanding how miscarriage is framed in wider cultural and social narratives and established biomedical discourse is critical to interpreting and understanding the healthcare response to possible pregnancy loss. Overwhelmingly, the research asserts that medical establishments – and society at large – often mute, distort, or fail to comprehensively acknowledge the psychosocial implications of perinatal mortality for women faced with pregnancy loss (Layne, 1990). This section considers the intricate link between miscarriage and motherhood, societal stigma surrounding pregnancy complications and loss, personally situated meanings of a pregnancy, and cultural understandings, specific to Aotearoa's unique bicultural context.

Overlooking a Lost Motherhood

For pregnant women, the link between miscarriage and motherhood can be interpreted as introducing a threatened or incomplete *maternal rite of passage*. Pregnancy loss has embodied moral and emotional significance for many women, representing the loss of hopes and expectations through: "a realisation that part of oneself, one's identity, one's future has disappeared: one's life (and for the pregnant person, one's body) has been ruptured" (Parsons, 2010, p.14). Threatened miscarriage is thus a complex psychosocial, emotional, physical, and temporally extended experience that stretches far beyond a single medical event. For example, taking a phenomenological perspective, Wright (2018, p. 136) refers to *unspoken motherhood* in societal understandings and responses to miscarriage as a failure to acknowledge the "anticipation of gestating, bearing, and rearing a child, and the sudden disruption of that anticipation". She therefore argues for more complex, relational understandings of pregnancy and pregnancy loss that consider meaning and value, in attending to identity formation, interpretative operations, and emotional attachment.

In medical settings across Aotearoa, the deeper significance of pregnancy loss is troubled by a tendency to privilege biomedical constructions of the maternal body and childbirth (Davis & Walker, 2010). As such, women's experiences of accessing care can be disrupting and disempowering when the normative experience and expectation of motherhood is "completely transformed and reconstructed, often in silent, painful ways" (Bhave, 2017, p76; Currie & Barber, 2016).

Stigma and Silencing

In considering the social and cultural narratives that underpin an overlooked motherhood, there is a pervasive aversion to voicing and validating the personal repercussions of potential pregnancy loss in most Western contexts that points to an underlying stigma surrounding miscarriage. This stigma is rooted in taken-for-granted cultural standards and normative ideals of "successful pregnancy" (Bommaraju et al., 2016). Here, expectations placed on pregnancy points to an underlying value system that supports the historical and political structures of Western patriarchal power (Bartky, 1998; Ulrich & Weatherall, 2000). Ingrained ideals conflate *womanhood with motherhood* so that reproduction is not only expected, but also integral to a woman's identity (Browne, 2025). These assumptions serve to silence and conceal everyday experiences of pregnancy complications and miscarriage, sidelining these women through discredit, embarrassment and shame that one's body is reproductively inadequate or inherently "broken" (Zucker, 2021).

Considering the wider social context in which pregnancy loss occurs, Budds (2021) explores regulatory discourses evident in popular Western pregnancy texts. For instance, a "managing risk" repertoire places responsibility on pregnant women to proactively adapt their lifestyle and environment to guard against the risk of abnormal pregnancy or birth complications. Neoliberal expectations of discipline and self-surveillance firmly position blame on women for pregnancy complications and poor health outcomes. Such expectations are reflected in ED staff's dismissive response to women experiencing pregnancy complications and patient experiences of feeling sidelined, silenced, and invalidated (MacWilliams et al., 2016; Meaney et al., 2017).

The "societal shroud of silence" (Dainty et al., 2021, p.1120) surrounding miscarriage is further complicated by the entrenched medicalisation of pregnancy and childbirth, that creates an impression of reproduction as regular and controllable (Catlin, 2018). These societal structures encourage shame and silence surrounding miscarriage when accessing acute care, that clouds and complicates how healthcare providers respond, and how women interpret their experiences. As Saadi (2020, p.942) explores in her own reflexive account of miscarriage in an American context: "With a miscarriage, you mute your experience. You don't know what to say". This response is illustrated in Currie and Barber's (2016) findings from a qualitative analysis of twelve New Zealand women's experiences of medical complications in pregnancy. The researchers report how despite feeling intense emotional distress, these women resolutely contained, restricted and suppressed their emotions within the medical setting. Other evidence suggests that acute care providers may reinforce this response, through an established focus on the physical aspects of miscarriage that overlooks psychological and social needs (Dainty et al., 2021; Edwards et al., 2016). Further, Edwards et al. (2018) indicate that women and their partners are "hyper-aware" (p.299) of provider attitudes and their willingness to offer equal priority to emotional and physical needs within the acute response for early pregnancy complications.

However, current evidence suggests not only that women's experiences of seeking emergency healthcare for early pregnancy support are largely negative, but further, that emergency healthcare providers feel under-equipped to meet the physical, social and psychological needs of patients presenting with miscarriage-related concerns (Edwards et al., 2018; Engel & Rempel, 2016; Freeman et al., 2020). In particular, registered nurses (RNs) who frontline emergency care report a lack of education about miscarriages and direction in mobilising supportive care for women and their families (Engel & Rempel, 2016). Nevertheless, nurses are entrusted with both physical safety in relation to early pregnancy loss, as well as meeting a women's emotional needs (Griffin et al., 2021).

Personal Meanings of a Pregnancy

Alongside the wider social meanings related to pregnancy, motherhood, and miscarriage, a women's circumstances and the meaning given to the pregnancy also shapes the individual response to threatened or actual pregnancy loss. Healthcare interactions can be affected by a mismatch between women's responses to miscarriage and the assumptions of healthcare providers, which are structured by the gendered understandings of pregnancy and motherhood discussed above. This point is well illustrated by Corbet-Owen and Kruger's (2001) exploration of emotional care in response to spontaneous pregnancy loss in South Africa, considering how professional and cultural assumptions can interfere with the provision of sensitive, appropriate care.

Using a constructionist grounded theory, Corbet-Owen and Kruger's (2001) research highlights the importance of patient's diverse familial and socioeconomic backgrounds – developing different meanings surrounding pregnancy loss, and further, different needs within the clinical response. Critically, their recruitment approach made space for women with *unwanted* pregnancies. In these cases, they demonstrate how the societal conflation of womanhood with motherhood created conflict between the physician's assumptions and these women's psychosocial needs. For example, one participant said: "I desperately didn't want this baby… [I was] in a terribly nervous state, I was beside myself" (Corbet-Owen & Kruger, 2001, p.417). On the other hand, echoing the aforementioned idea of "*unspoken motherhood*", the researchers highlight that for participants who positively anticipated their pregnancy, receiving validation to acknowledge that their child – real or potential – has been lost (or was significantly at risk) is critical to their coping strategies (Corbet-Owen & Kruger, 2001).

These findings highlight the importance of research that searches for more diverse patient perspectives and experiences, inviting a reproductive justice lens that broadens beyond the portrayal of women as a homogenous group (Morison, 2023; Price, 2019). They also show how experiences of miscarriage are shaped by the significance a woman gives to the pregnancy. In this vein, Macleod (2016) invites a deeper understanding of the concept of "intentionality" within public reproductive health conceptions of pregnancy, citing the limitations of a central focus on individual cognitions and behaviours around "plannedness" and "wantedness" of a pregnancy. Instead, a "supportability" framework explores the intersections between individual emotions and cognitions, and wider structural and social dynamics that shape interactive health spaces and macro-level discourses, practices and policies. Freeman et al. (2020) also highlight the need for a personalised approach in exploring how cultural discourses and personal circumstances shape the meaning attached to pregnancy loss, as well as expectations of care.

Cultural Meanings

Therefore, an exploration of cultural discourses is integral to understanding the personal meanings attached to pregnancy and potential loss. Recognising and responding to culture is critical to the delivery of quality healthcare and is acknowledged as a key factor underpinning maternal health inequities in Aotearoa, alongside political context, colonialism, maternity care systems, acceptability and geographical access (Dawson et al., 2022). That is, for women seeking urgent maternity support, having access to culturally safe care is critical to positive patient outcomes (Ryan et al., 2017). While *all* people are culturally bound beings, Aotearoa's unique bicultural society acknowledges an emphasis here, on affirming and inclusive Indigenous perspectives.

As such, Le Grice and Braun (2016) explore mātauranga Māori specific to reproduction in Aotearoa that actively acknowledges the impacts of colonial control and marginalisation, utilising a Kaupapa Māori research approach and a pūrākau (narrative) methodology to reorient towards Indigenous lived experiences and epistemologies. Their work highlights the distinctions from Western reproductive knowledge and accounts, considering: 1) contextualisation within familial and social structures; 2) connections between the natural environment, humans and spiritual domains; and 3) a unique, refreshing understanding of feminine and masculine embodiment.

To this end, McLean et al. (2024) explore the importance of incorporating Indigenous *tikanga* Māori (traditional values and cultural practices) within the overly medicalised context of inpatient care for women experiencing *whakatahe* (miscarriage). Within these traditional values, the concept of *te whare tangata* considers the anatomical and physiological changes throughout conception, gestation and pregnancy that provide nourishment and shelter to a baby within the womb, that more broadly centres menstruation as a divine connection between women and their wider whānau and cultural, spiritual and environmental ancestry (Murphy, 2011; Smith, 2012). Through their quality improvement project, McLean et al. (2024) highlight applications of tikanga within clinical practice using Te Whare Tapa Wha (Durie, 1985), such as supporting and encouraging staff to vocalise karakia and *oriori* (sacred waiata), including te reo Māori during care, actively involving whānau, and offering wāhine with the option of *ipu whenua:* a traditional vessel to return pregnancy products to nourish the land and maintain whānau ties to spirituality, ancestry and identity (Le Grice & Braun, 2016).

In particular, *oriori* represents a unique, sacred waiata that is sung in reference to childbirth, and following the loss of a *pēpi* (baby) (Royal, 2021). It is traditionally sung by whānau, *kaumātua* (elder) and *tohunga* (spiritual leader) as an expression of *aroha* (love), that acknowledges whakapapa, lineage and mana of the *tūpāpaku* (deceased). Below, an oriori that belongs to Wairarapa and the descendants of Tuteremoana, Ngai Tara Rangatira (Wairarapa Moana, 2025) that was safely shared by my local Te Piki Oranga cultural advisor, demonstrates the innate spirituality and interconnections between *mokopuna* (descendents) and *atua* (spiritual ancestors and supernatural beings) in Mātauranga Māori understandings of pregnancy, birth and miscarriage. This oriori exemplifies the importance of affirming the spiritual dimension for Māori wāhine and their whānau in the clinical setting, in attending to *whakanoa* (restoring balance) after a deeply tapu experience (Smith, 2012).

Nāu mai e tama, kia mihi atu au;
I haramai rā koe i te kunenga mai o te tangata
I roto i te āhuru mōwai, ka taka te pae o Huaki-pouri;
Ko te whare hangahanga tēnā a Tane-nui-a-rangi
I te one i kura-waka, i tātāia ai te Puhi-ariki,
Te Hiringa-matua, te Hiringa-tipua, te Hiringa-tawhito-rangi;
Ka karapinepine te pūtoto ki roto te whare wahiawa
Ka whakawhetū tama i a ia,
Ka riro mai a Rua-i-te-pukenga, a Rua-i-te horahora;
Ka hōkai tama i a ia, koia hōkai Rauru-nui,
Hōkai Rauru-whiwhia, hōkai Rauru maruaitu,
Ka mārō tama i te ara namunamu ki taiao;
Ka kōkiri tama i a ia ki te aotūroa,
E tama, ē ī!

Welcome, o son, let me greet you;
You have indeed come from the origin of mankind.
From the cosy haven emerged, out from the barrier of Darkness-ajar
Out of the abode fashioned by the renowned Tane-of-the-heavens
On the sands at the Crimson Bowl, wherein the Exalted-one rejoiced,
In the implanting of parenthood, sacred implanting,
heavenly implanting in times remote;
‘Twas then blood welled forth flood-like to the house exit;
Thus like the stars, o son, were you conceived,
Acquired the recess-of–the mine, the recess of the spirit;
You then strived, o son, strived for a Rauru-of-renown,
Strived for a self-possessed Rauru, and strived against the fate Rauru
You, o son, remained steadfast on the narrow pathway to the wide world;
Then, o son, you leaped forth into the enduring world,
O son, ah me!

However, women presenting to an ED have limited (if any) access to specialised cultural and/or midwifery support, and generalised registered nurses who most regularly attend to early pregnancy complications are often perceived as overly rational/technical (Benner et al., 2009; Currie & Barber, 2016). This considers how equipped healthcare services are in understanding and adapting to Indigenous knowledge and cultural needs within reproductive practices (Le Grice & Braun, 2016). According to Māori accounts, hospital environments can evoke anxiety, alienation, discomfort and stress for patients and their whānau, which leads to a more pervasive mistrust in healthcare services (Komene et al., 2024; Wilson et al., 2021). Therefore, in many cases, Māori perceive hospitals as compromising spaces where their spiritual and cultural beliefs and practices are overlooked and marginalised (Espiner et al., 2021; Wilson & Barton, 2012).

Together, this body of literature signals the complexity of the social and cultural context surrounding conceptions of pregnancy and miscarriage. It introduces an ingrained stigma and silencing that contributes to an overlooked motherhood in medical settings, the diversity of patient perspectives and experiences that shape personal meanings attached to pregnancy within the healthcare encounter, and the importance of nuanced understandings and responses to unique cultural needs in Aotearoa. As such, a rich, contextualised research methodology is needed, that has the capacity to explore how these complex discourses are intertwined with shared healthcare interactions and experiences.

2.3. Women's Experiences of Emergency Care

Looking specifically from the patient perspective, there is considerable research on clinical experiences of accessing care for early pregnancy loss and complications. Collectively, the findings predominantly point to the negative impacts of an overwhelming and chaotic environment within the emergency setting, dismissive care, and inadequate information and communication from healthcare providers (Freeman et al., 2020; MacWilliams et al., 2016: Baird et al., 2016).

Most research originates from Australian, American and UK settings, using predominantly qualitative designs with small samples of women (frequently 8-10 participants), and occasionally their partners and healthcare professionals (Freeman et al., 2020); further, many are within the hospital context, including gynaecological wards and early pregnancy assessment units. Broadly, the main insights point to communication issues, challenges and barriers within the healthcare setting, and shortcomings in aftercare services (Freeman et al., 2020). Throughout, the use of in-depth, descriptive research has captured detailed, intimate understandings of how women experience and interpret their healthcare encounter, when faced with potential or confirmed early pregnancy loss. These highlight both the personal meaning of miscarriage, and the significance of how physical and psychosocial needs are responded to and cared for by acute providers. In the remainder of this section, I discuss some of the main findings from this body of scholarship.

Negative Impacts of the ED Environment

Once admitted to an ED for miscarriage symptoms, the physical environment heightens patients' distress through the lack of privacy provided by hospital curtains and the ability to hear other patient monitoring, activity and conversations among staff (Meaney et al., 2017). A comprehensive Australian scoping review by Freeman et al. (2020) across 27 articles collectively describes the ED as busy, chaotic, and lacking adequate amenities to privately address the physical and emotional aspects of a loss. These compromises in the clinical environment impact how women are able to respond to their situation. For instance, accommodations made by ED staff to increase privacy for early pregnancy bleeding presentations can improve women's experiences by allowing them to speak and express themselves more freely, while offering validation of their emotional distress (See et al., 2020). Conversely, lack of consideration of these factors can overwhelm and agitate these women. For example, a participant in Meaney et al.'s (2017) study reflected: "Well, I started roaring crying, I was so upset but all the life was happening all around us, carrying on you know happily in behind the curtains… it was absolutely horrendous" (p.4). These findings suggest that women's healthcare needs and expectations surrounding pregnancy complications are at odds with the functions, priorities and context of emergency settings (Freeman et al., 2020). They also underline the importance of producing critical understandings that consider how providers interpret and adapt to these limitations, when caring for women with a threatened miscarriage.

Generally, emergency clinical staff are perceived by patients as unsupportive, overly rational/technical and anxiety provoking (Baird et al., 2018; Benner et al., 2009). However, in Rojas-Luengas et al.'s (2019) descriptive qualitative study of 30 American women presenting to an ED for early pregnancy complications, participants reported more compassionate care within a specialised nurse-led clinic. This included a stronger understanding of clinical needs and an overarching sense of feeling 'cared-for' that was fundamental to their recovery – highlighting the integral role of an early pregnancy clinic in providing follow-up care after an ED visit. Likewise, Meaney et al. (2017) suggest higher patient satisfaction through an early pregnancy clinic, citing the knowledgeable, sensitive and understanding manner of EPC staff that attended more acutely to their psychosocial needs. This has been noted in local research too. Currie and Barber (2016) report that care received from hospital *midwives* demonstrated compassion and reassurance, allowing women to feel that these specialists genuinely cared and advocated for them within the hospital setting. As such, a skilled and appropriately trained workforce that can offer safe, sensitive, and community-specific care is important in the provision of care for women presenting to EDs with early pregnancy complications (Edwards et al., 2016).

Contrasting Perspectives and Assumptions

In scrutinising the negative themes attached to the ED setting, the research findings speak to a fundamental difference between patient and provider perspectives. Miscarriage represents a unique and significant experience for women faced with the loss of a baby, but is commonplace to healthcare professionals (Dainty et al., 2021). Further, an underlying premise in the ED is that a miscarriage is relatively less important from a clinical perspective. It is not considered life-threatening to a woman unless accompanied by further complications (such as heavy bleeding) and therefore, is dismissed by trained professionals in the ED (Saime et al., 2023). Consequently, they are unable to comprehensively attend to psychosocial implications of an *unspoken motherhood*, and women experiencing a miscarriage in an ED report feeling isolated, silenced, and marginalised by their clinical care (MacWilliams et al., 2016). For instance, Meaney et al.'s (2017) phenomenological study in Ireland supports these findings; irrespective of gestational duration, all participants (both women and their partners) stated the importance of healthcare professionals acknowledging miscarriage as a valid loss.

In exploring the complex divide between patients and provider understandings, a qualitative study of 30 women presenting to a Canadian ED for early pregnancy complications detailed the impact of these clinical assumptions (Rojas-Luengas et al., 2019). On arrival, patients felt as though their symptoms did not warrant attention or care. This was coupled with shaming behaviour from ED staff; for instance, one woman revealed that: "I was already feeling like I shouldn't have been there. Like I was wasting resources" (p.800). Further, in an Australian study, Edwards et al. (2018) highlight how an ED created a clear division between women and their partners, whereby nursing staff consulted and conversed directly with women regarding their pregnancy complications and failed to adequately acknowledge their partners considering the shared experienced of potential pregnancy loss. This calls to attention the importance of surfacing provider perspectives, to clarify the clinical assumptions and understandings that shape patient's experiences of their emergency care.

Research suggests that the problems caused by the mismatch in professional and lay assumptions are also shaped by the physical environment of the emergency department. As a participant in Larivière-Bastien et al.'s (2019) Canadian study put it: "You don't know exactly what's happening to you, but they don't really have time to answer you" (p.672). In the absence of information, patients try to make sense of the ways they are treated by healthcare providers, and research in different locations suggests that they may interpret healthcare provider's demeanour or treatment differently based on the clinical setting (e.g., general ED, ED with an EPC, maternity ED). For instance, many studies find that women do not feel the appropriate sense of urgency is shown by general emergency providers (Wong et al., 2003), yet, in Meaney et al.'s (2017) study at a large Irish maternity hospital, patients attributed this perceived lack of urgency to the chaotic hospital setting, rather than the medical staff. In a suburban Melbourne hospital, See et al. (2020) identified that many women with early pregnancy bleeding expected to be seen *urgently*, driven by the emotional implications of a potential pregnancy loss. However, in a Canadian ED with a specialised EPC, Rojas-Luengas et al. (2019) indicated that woman normalised long wait times, expecting these delays within a high-volume obstetric centre. These differences suggest that women place greater emphasis and urgency on the clinical response within the context of a *general* ED. Further, the nuances within these findings highlight the need to explore the clinical resources, responses, and understandings specific to standard ED settings in Aotearoa.

Communication

When examining the clinical response in this context for women experiencing early pregnancy loss, the predominant theme identified in Freeman et al.'s (2020) review that elicited the most concern was issues surrounding *communication* with healthcare providers: a lack of transparency, sensitivity, emotional support and adequate information. Similarly in Aotearoa, Currie and Barber's (2016) research spotlights the experience of seeking emergency care for pregnancy complications as helpless, fearful and traumatic. A “normal” pregnancy became overshadowed by complications, medical care, and monitoring, accompanied by a complete loss of control, as one participant expressed: "Oh so out of control. I have never seen my husband so white. I was so overwhelmed” (p.36).

Delayed and disjointed care across multiple ED staff often leads to information gaps, confusion and uncertainty (Emond et al., 2019; MacWilliams et al., 2016). This was exemplified by a participant in Baird et al.'s (2018) study of 67 American women presenting to the emergency room with early pregnancy-related concerns who is reported as saying: “They wouldn't even give me an explanation, a paper, like to go over what they did to me or what was done.” (p.115). Due to extended timeframes and fragmented consultations, research also suggests that women experiencing early pregnancy complications had difficulty making decisions and often left the ED feeling unsure of causes, symptoms, outcomes and ongoing management (Baird et al., 2018; Freeman et al., 2020). For instance, a phenomenological study of 48 Canadian women who experienced miscarriage in an ED, highlighted a pervasive lack of information across medical explanations of miscarriage, diagnosis, treatment options and implications, and discharge resources (Larivière-Bastien et al., 2019).

Taken together, these findings point not only to broader communication challenges in the ED environment, but also, specific shortcomings in how miscarriage and pregnancy complications are discussed and conveyed to women seeking emergency support. These relational gaps are accentuated by discrepancies in how acute care providers attend to the personal significance of pregnancy loss and women's wider psychosocial needs (Dainty et al., 2021). Yet, the existing literature fails to weave together clinical experiences with sociocultural understandings and assumptions, in considering how contextual perspectives and established clinical roles and relationships influence women's experiences of emergency care in this context (Riley & Paskova, 2022; Wigginton & Lafrance, 2019).

2.4. Provider Perspectives and Emotional Labour

Qualitative insights from the provider's perspective are sparse in comparison to the extensive body of literature that details patient's experiences. In particular, research is limited to acute care settings outside of specialised obstetrics/midwifery (Griffin et al., 2021). Freeman et al.'s (2024) review aimed to identify and integrate available research, selecting 23 articles that were specific to the scope of practice and role of both midwives and RNs within acute early pregnancy care services in Australia. Also in an Australian setting, Edwards et al. (2018) and Jensen et al. (2016) explore the roles and practices of health professionals supporting women with threatened and confirmed miscarriages. Beyond this, the literature is sparse. A study by Engel and Rempel (2016) aimed to explore the practices and attitudes of 174 Ontario health professionals' surrounding miscarriage (48% working within an ED context), however, this was limited to a survey questionnaire design and predominantly quantitative analysis that lacked individual narratives and experiences.

Such research demonstrates a broad brushstroke approach to provider functions and clinical challenges, rather than offering detailed, qualitative insights that speak to the complexity and intimacy of patient-provider relations surrounding early pregnancy loss. For example, Freeman et al. (2024) categorise their findings into four key areas: care coordination, physical care, psychosocial support, and communication, presenting a holistic discussion of organisational and structural factors within services, qualifications, experience and multidisciplinary support. Overall, their insights highlight the varied role and scope of registered nurses and midwives in consulting, liaising with multidisciplinary teams, providing education and explanation, and coordinating women's immediate and longer-term physical and psychological care within emergency settings and early pregnancy services.

Across Engel and Rempel's (2016) large sample of Canadian multidisciplinary practitioners, participants working in an ED setting cited challenges in the clinical environment. These included fragmented care and communication, busyness, lack of privacy and proximity to others, and limited contact time, with one RN interpreting the effects of these systemic issues: “early pregnancy loss in ED is devastating” (p.55). Further research highlights language barriers and a lack of resources, information and confidence in providing comprehensive and sensitive care (Freeman et al., 2024; Jensen et al., 2018; Saime et al., 2023). However, despite limited training specific to early pregnancy loss, Jensen et al.’s (2018) interviews with 12 Australian health professionals indicated that they still felt competent in their own abilities to offer emotional support. In another Australian study of 25 RNs and RN/midwives, Griffin et al. (2021) also identified that providers expressed the perceived importance on their capacity to perform this work, in “gifting” emotional and psychosocial support to deepen the social exchange with women facing distress from early pregnancy complications. Freeman et al. (2024) interpret these psychosocial skills and resources as: the ability to listen, counsel, validate, address and mitigate guilt, involve and care for partners/families, provide a safe and private space, offer physical presence/touch/appropriate language, and consider the facilitation of memory-making to acknowledge pregnancy loss. These collective findings highlight the importance of further insights specific to the emotional role and responsibilities of RNs in this context, to expand RN’s meaning-making of their role and relational capacity when attending to a threatened miscarriage.

Specific to the emotional work of caring for these women, compassion fatigue and self-protective processes arise as complex barriers (Jensen et al., 2018). For example, participants regularly tasked with caring for women experiencing miscarriage reflected on the risk of becoming indifferent and making a conscious decision to limit more comprehensive emotional support as a system of self-protection. In evaluating this self-protective sense-making, Tancioco et al. (2023) discuss how, when incapable of providing compassionate care, health care providers express a risk of *moral injury* related to the psychological impact of inherently understanding the care needs of patients but being unable to provide adequate care due to systemic and environmental constraints (Dean et al., 2024). Through a series of clinical vignettes from within the emergency setting, Giwa et al. (2021) explore the distress and moral injury that accompanies competing bioethical principles, including aspects such as resource scarcity and triage, duty of care, autonomy and beneficence that relate to provider’s capacity to care comprehensively for early pregnancy complications. Here, the perceived implications are severe, with several clinicians highlighting the similarity between moral injury and post-traumatic stress disorder (PTSD) and defining moral injury as a subset of PTSD.

Griffin et al. (2021) endorse these moral conflicts and pitfalls of heavy emotional work, through explorations of associated stress, burnout and inadequate patient care. Importantly, they distinguish between “emotion work” and “emotional labour”. Empowered emotion work can be understood as a rewarding and self-protective strength, but the increasing challenges of under-resourced services and an outcomes-based clinical culture create the risk of unsustainable emotional labour for ED nurses and carers (Bolton, 2001; Sawbridge & Hewison, 2013). The role played by resourcing is also highlighted by Glicksman et al. (2019) in Canada. The researchers found that within 71 hospital EDs, only 32 had social workers available to counsel patients faced with early pregnancy loss. This suggests that the majority of psychosocial support remains with registered nurses as the primary ED care provider.

Freeman et al.'s (2024) review of Australian settings highlighted the prominent role of registered nurses in acute care provision, despite international recognition that midwives' education preparation, clinical expertise and practice focus is more comprehensive in providing pregnancy care (Freeman et al., 2024; ICM, 2017). Nonetheless, their findings suggest that the role and scope of both midwives and registered nurses aligns with person-centric, psychosocial care. Further, this capacity is often undervalued and underutilised in attending to the emotional aspects of early pregnancy complications, when considering their inherent understanding of timely, individualised and informative practice. However, rather than emphasising the emotional quality and depth of relational care needs, much of the literature from the provider perspective responds to clinical systems and scope of practice.

As such, research from the provider perspective demonstrates a pervasive biomedical focus, that limits opportunities to explore the complexity of emotional and relational care practices associated with threatened miscarriages in the acute setting. This approach is also evident in research exploring patient experiences, considering entrenched provider understandings that tend to maintain clinical (over psychosocial) understandings of care. For example, Strommen et al.'s (2017) quantitative study of patient expectations when presenting to an ED for vaginal bleeding, developed a questionnaire based on physician experience and expert consultation that prioritised clinical systems over social and interpersonal support. This research demonstrates how clinicians favour a functional approach to emergency care, that frames women's needs in terms of clinical procedures and outcomes (i.e., expectations around bloodwork, ultrasounds and diagnosis). Likewise, within the limited literature specific to Aotearoa, postgraduate research has focused on the clinical aspects of nurses' decision-making at triage rather than the patient-provider relationship (Harrison, 2017).

From a cultural perspective, in Aotearoa, McLean et al. (2024) highlight that while clinical guidelines are provided by Whānau Care Services, there is limited content in relation to *tikanga* during miscarriage other than to facilitate or initiate *karakia* (chants, prayers) for wāhine Māori. Further, the authors cite poor knowledge and understandings of cultural safety among clinical nursing staff more broadly, and that none felt comfortable to initiate karakia. Registered nurses who obtain their undergraduate degree in Aotearoa are exposed to understandings of tikanga and its foundations within Te Tiriti o Waitangi (Nursing Council of New Zealand; NCNZ, 2020). However, an increasing reliance on international nurses (44.7%; NCNZ, 2024) suggests that upholding these principles is rare and that further professional development may be required for practitioners trained overseas.

Therefore, while clinical guides and protocols have been developed to support practitioners in early pregnancy loss, research suggests that there is still limited guidance on wider psychosocial practices, and few of these practice guidelines have been adopted specific to care in the ED (Emond et al., 2019; Engel & Rempel, 2016). Further, insights surrounding the emotional, cultural and psychological support for women has been addressed infrequently, in contrast to research focused on clinical practice, scope and medical management of early pregnancy complications and experiences of miscarriage (Punches et al., 2018). As such, there is an opportunity to explore these nuanced social exchanges more comprehensively in this context, including implications of the emotionally loaded work that is associated with pregnancy and miscarriage – in how providers navigate and understand the role of emotional and psychosocial support within the acute care setting.

2.5. Power and Patient-Provider Relationships

In combining patient and provider experiences, the body of critical literature from both perspectives reinforces pervasive themes of fear, distress and uncertainty for patients presenting with a threatened miscarriage, that pathologises and problematises women's experiences of accessing emergency care. Together, the shared insights continue to highlight and reinforce themes of patient's distress and invalidation that are left unresolved in the provider's clinical response, and within the ED environment. These findings suggest a collective perspective entrenched within regulatory discourses of pregnancy and motherhood, which marginalise experiences of early pregnancy complications, reinforcing structures of gendered social power and individualism (Braidotti, 2012; Connor et al., 2015).

The privileging of a biomedical perspective is singled out as playing a significant role in maintaining uneven power dynamics in medical settings, which serve to disempower patients. From a critical feminist standpoint, the repetition of biomedical responses to reproductive issues constrains and constructs women's understandings of their own bodies through problematic discourses of preconception practices, pregnancy, and motherhood (Budds, 2021; Marshall & Woollett, 2000). To illustrate, Andipatin et al. (2019) explores the hegemonic role of biomedical discourses in how pregnancy loss is constructed and understood in South Africa, highlighting how biomedical understandings frame social discourses and responses in the emergency setting. Firstly, they found that medical framing created a dismissive normalisation of miscarriage alongside unanswered questions to diagnostic and investigative procedures. Secondly, they note a surrounding social awkwardness due to the lack of cultural scripts and acknowledgment, and unhelpful statements or actions from medical staff. For example, one participant is quoted as saying that: "So there was nobody fussing over you or nobody trying to explain, you know, why you went through this and what could happen" (Andipatin et al., 2019, p.555). Therefore, it is important to consider the role of entrenched discourses and assumptions in Aotearoa's clinical settings that frame healthcare interactions and in turn, women's experiences of the care they receive for the common occurrence of threatened miscarriage.

2.6. Searching for a Relational Perspective

Collectively, there remains limited knowledge surrounding the assumptions, perspectives and relational practices of registered nurses who frontline acute care in early pregnancy (Jensen et al., 2018; Freeman, 2024). The preceding discussion highlights areas that require more attention. Firstly, it is crucial to attend to an *unspoken motherhood* that exists within the patient-provider relationship and how women and their carers interpret, respond to and resist the societal structures that collectively silence women in clinical encounters. Secondly, it is necessary to extend provider perspectives. There is a need to consider how providers operating within the confines of the ED make sense of their role and available resources in providing responsive and comprehensive emotional care. In Aotearoa, it is important to critically consider how practitioners adapt and respond to the complexity of current ED facilities and resources, alongside underlying societal assumptions that complicate the provision of sensitive, appropriate care for women presenting with a threatened miscarriage. Thirdly, and relatedly, it is essential to give specific attention to provider's processes, expectations and assumptions about diverse cultural needs within Aotearoa's acute care system, as these inevitably shape patient expectations, experiences and outcomes (Freeman et al., 2020; Lyons & Chamberlain, 2006).

Attending to these aspects requires a more relational, contextualised lens and hence a change of focus from a biomedical approach towards the collective layers of emotional care and psychosocial support surrounding a threatened miscarriage. Taking a feminist perspective, as I do in my study, can assist with this. In attending more purposefully to the politics of miscarriage, Browne (2025) highlights that while miscarriage presents a deeply gendered phenomenon, it has received little feminist attention and theoretical elaboration. Hence, there is a need for more relational and reflexive explorations of women's healthcare experiences through critical theories that challenge repetitive, oppressive accounts of women's "suffering" (Braidotti, 2012).

Such approaches also look beyond psychology's tendency to conduct research *on* women, by attending to research endeavours *with* women, and *for* women through more transformative and affirmative accounts of affective and embodied experiences (Braidotti, 2008; Fine, 2017). In doing so, more generative approaches and understandings provide a platform that enables women to reclaim knowledge and agency over their experiences and more specifically, their own bodies (Braidotti, 2008; Mikaere, 2011). Recent qualitative studies continue to conduct interviews *on* women's experiences to extract insights, often when the "subjects" of the study themselves are still raw and vulnerable from the clinical encounter. For example, See et al. (2020) conducted two in-depth interviews with participants within two weeks of discharge for early pregnancy bleeding. Further, integrative reviews continue to combine and distribute collective accounts of negative and traumatic experiences of early pregnancy bleeding and loss in the ED, spotlighting the emotional burden on participants, without creating avenues to positively transform and resist these troubling insights (See et al., 2020; Trostian et al., 2022). The persistence of such research approaches suggests a resistance to step beyond established biomedical and neoliberal perspectives, and towards the political and social relationships and responsibilities that shape women's stories and experiences (Fine, 2017; Oakley, 2016).

Therefore, what is critically missing from the body of literature, is research that seeks to explore relational bonds and complex, *diverse* understandings of early pregnancy complications, highlighting the multiplicity of embedded and embodied understandings that exist (Braidotti, 2010; Harding, 1992). By and large, research in this space fails to position the researcher as an essential part of the research endeavour, in attending to the co-presence of shared reflections and co-construction of meaning, alongside the implicit contradictions and partiality of conducting and creating qualitative insights (Braidotti, 2010; Fine, 2017). In contrast, Woollard's (2020) exploration of pregnancy in relation to applied ethics and epistemically transformative experiences provides a thoughtful integration and interpretation of self: "After first-hand experience of pregnancy, the philosophical literature's understanding of what it is to require someone to remain pregnant and of the value of a human foetus… appeared woefully inadequate" (p.155).

Importantly, a critical approach also embraces a *relational* understanding that deeply considers our relations and attachments to others, while sense-making an underlying fear surrounding pregnancy loss (Browne, 2025). A relational approach extends to the intimate space that exists *between* women and their carers in emergency settings, considering also how providers make sense of both the vulnerability and strength of women presenting to an ED. Critical feminist research epistemologies and approaches make space for more productive, dynamic and relational knowledge production considering the clinical response to a threatened miscarriage, in how it is understood, interpreted and expressed, both within and beyond the research encounter.

Such work provides a necessary counter to existing research on provider understandings that adopts a systemic biomedical perspective, focusing on the *implications* for nursing roles, scope and applied practice, rather than the underlying assumptions and interactions that inevitably shape healthcare experiences and outcomes (de Montigny et al., 2017; Freeman et al., 2024; Jensen et al., 2018). Feminist work taking a more holistic view responds to the complex and evolving needs of women experiencing potential pregnancy loss, supporting a patient-centred and relational perspective (Dainty et al., 2021; Emond et al., 2019). In particular, qualitative research can provide a more complex understanding of provider experiences – exploring practices, perspectives, and contextual factors to identify common themes and insights (Jensen et al., 2018).

Notably in Aotearoa, Yang et al. (2022) explored health professionals' perspectives on the impacts of early miscarriage on women's mental health, service accessibility and support, using semi-structured interviews to underline the extent of the perceived psychological impact and barriers to more comprehensive care. Such studies help to highlight how emergency healthcare providers interpret their patients in complex ways. For example, a maternity mental health psychiatrist reflected that: "It can be anything from bereavement and loss – depending on the stage of the miscarriage, or how much they wanted to be pregnant – through to some women [being] quite relieved, [or] struggling with adapting, [or] adjustment reaction and anything in between, [or] grief, guilt…" (Yang et al., 2022, p.56).

A critical, qualitative approach also allows important reflections to surface that resist societal assumptions, such as the normalisation of miscarriage. For example, Wong et al. (2003) indicate that health professionals in England were aware of the adverse impacts of normalising pregnancy loss. For instance, a general practitioner was quoted as saying: "yeah, that it is and there's nothing wrong and it will get better, but by doing that they are not actually looking at how devastated the woman is" (p.700). Likewise, Griffin et al.'s (2021) qualitative study with 25 Australian registered nurses revealed key insights such as individualising care within the context of a women's values, personal meaning and family needs, and an awareness of their role in preparing patients to return to everyday life after discharge. Further, both Edwards et al. (2018) and Emond et al. (2019) include women, partners *and* nurses in their studies based on a relational understanding of the emergency response, allowing shared reflections such as the need for more detailed resources and written information to support physical and emotional recovery. Collectively, this qualitative research has begun to detail the importance and intricacies of patient-provider relationships within an acute, biomedical environment.

As critical health psychologists highlight, "effective delivery of health care depends to a great extent on the quality of the interaction between health care providers (. . .) and consumers of health care"

(Kreps et al., 2003, cited in Lyons & Chamberlain, 2006, p.203). However, at present, the body of literature on ED presentations for early pregnancy complications and loss still tends to focus on patient/service user *experiences* – an approach that is reflected more broadly by reproductive health researchers (Morison, 2023). Yet, women's *interactions* with others, are pivotal in how the entire miscarriage experience is shaped, interpreted and responded to (Rowlands & Lee, 2010).

The importance of healthcare relations and communication is highlighted by Freeman et al.'s (2020) scoping review of patient experiences of early pregnancy loss. Their review also spotlights inadequate information and emotional support, which implicitly points to wider experiences of isolation and invalidation for women and their partners seeking acute care (MacWilliams et al., 2016; Meaney et al., 2017). However, recent qualitative research still fails to address these patient-provider relations directly. For example, Tancioco et al. (2023) used interview questions with a focus on context, barriers and facilitators to inform clinical implementations strategies, and Yang et al.'s (2022) exploration was centred on associated mental health and access to support services.

Therefore, there is an opportunity to develop insights that attend specifically to patient-provider relations, considering how these structurally inform healthcare encounters and clinical outcomes, often in unconscious, complex ways (Lyons & Chamberlain, 2006). To this end, exploratory work by Griffin et al. (2021) and Edwards et al. (2018) in Australian settings has begun to detail the importance of relational interactions and the complex "threads of care" (Edwards et al., 2018, p.293) between patients, partners and nursing staff throughout their ED admission.

Edwards et al. (2018) adopted a grounded theory methodology to detail five unique stages of care: 1) presenting as one; 2) seeking inclusion and recognition; 3) wanting understanding and support; 4) leaving as one; and 5) moving on. Similarly, Griffin et al.'s (2021) point to the layers of care and emphasise women's emotional needs. Importantly, both studies consider how nurses position themselves in relation to their patients, exploring their personal and professional boundaries, and their own sociocultural understandings of pregnancy, miscarriage and motherhood. Including provider perspectives provides a counterpoint to the detailed understandings of women's experiences, to reflect both sides of the patient-provider relationship and intimate healthcare interactions.

Further, if women presenting to an ED for miscarriage symptoms is frequent and unavoidable, the literature must look beyond the negative impacts and experiences of patients and instead, address the scarcity of knowledge on how to critically understand and address these concerns from the provider perspective more comprehensively (Saime et al., 2023). Specifically, a more holistic perspective will expand on current biomedical interpretations of provider barriers, systems and clinical scope, towards understandings of the emotional emergency a threatened miscarriage represents and therefore, the *emotional response* provided by ED nurses and wider aspects of their relational care. This considers how ED nurses understand and interpret their patients experiencing potential pregnancy loss, their social and cultural assumptions surrounding miscarriage and motherhood, and how they make sense of their role and relational care practices. In doing so, a critical, feminist approach is required, that focuses on reflexive, relational explorations of women's healthcare experiences, alongside a reproductive justice lens that accounts for diverse perspectives and critiques the assumptions, social factors and broader systems that implicate clinical interactions and experiences. These intersecting dynamics call for an approach that can illuminate how nurses' accounts are shaped by broader discourses and power relations, that comprehensively attends to the complexity of care encounters during threatened miscarriage, where emotional distress, systemic pressures, and sociocultural meanings converge. For this reason, I adopted a Feminist Relational Discourse Analysis (FRDA; Thompson et al., 2018), which is well suited to examining how healthcare workers position themselves, their patients, and their practice within wider institutional and cultural contexts.

In doing so, this offers an approach that is contextually attuned, considering local meanings and practices. In this regard, the present body of literature has been predominantly developed within Australian and American contexts, lacking insight specific to patient-provider interactions and psychosocial support within Aotearoa's unique systems, structures and care settings (Blattner et al., 2023; Freeman et al., 2020; 2024). Exploratory research is essential for developing a deeper understanding of this relational space, adopting a contextual understanding of healthcare provision, and focusing specifically on unique sociocultural structures within the emergency healthcare response to early pregnancy complications, through a more holistic view of acute care provision (See et al., 2020). This also responds to Aotearoa's bicultural society, in considering how clinical services understand and adapt to Indigenous perspectives within their practice (Le Grice & Braun, 2016).

2.7. Research Rationale and Questions

In response to the need for *relational* healthcare provider understandings, my research aim is to critically explore reports of social interactions and emotional care within the biomedical setting, considering established roles and relationships, power dynamics and diverse contextual perspectives that structurally inform these healthcare encounters (Riley & Paskova, 2022; Wigginton & Lafrance, 2019). I pay specific attention to an *unspoken motherhood* within reported experiences of miscarriage and access to acute care, considering the medicalisation of pregnancy and childbirth and entrenched social and cultural assumptions attached to miscarriage. My study attends to the complex interplay between established biomedical practices that challenge a woman's agency, privacy, and power and further, ED nurses' own sociocultural understandings and assumptions surrounding the roles and boundaries of emergency care. Such findings are critical to qualitatively exploring and improving patient-provider relationships and the provision of sensitive, culturally safe care in Aotearoa.

Specifically, I investigate participants' accounts of their relational care practices and interactions with women presenting with a threatened miscarriage in a local ED, to provide a nuanced view of underlying structural and systemic themes in Aotearoa's acute care environment. The focus is on ED *nurses' accounts* of their interactions with women experiencing a threatened miscarriage, particularly how they make sense of their role, construct personal/professional boundaries, and draw on cultural understandings. The following questions guide my analysis: (1) What *discourses* do the ED draw on in their accounts, including gender and cultural discourses? (2) How do they *position* themselves, patients, and others in these accounts? (3) What are the implications of *power relations* in the professional relationship/encounter and beyond?

2.8. Conclusion

This chapter highlights the importance of local Emergency Departments (EDs) as a critical juncture in care provision for women experiencing the complexity of potential early pregnancy loss. Further, descriptive accounts of women's negative experiences accessing care were collectively responded to through restrictive, biomedical approaches from the provider viewpoint – citing a necessary turn towards diverse, relationally led interpretations that deeply consider the *emotional* response to women experiencing a threatened miscarriage. This not only addresses a lack of qualitative research from the provider perspective, but further, looks past clinical systems and scope of practice, in actively considering the underlying social, cultural and contextual assumptions that shape clinical relationships and responses to an *unspoken motherhood* in the ED setting.

As such, I aimed to investigate participants' accounts of caring for women presenting with a threatened miscarriage in a local ED, specific to their interactions and relational care practices. To answer the questions above that intentionally explore the nuances of underlying structural and systemic themes in Aotearoa's acute care environment, I used a critical feminist approach (FRDA; Thompson et al., 2018) that endorses qualitative, relational research methods, which I explain in the following chapter.

Chapter Three

Methodology

3.1. Introduction

My research is guided by a reproductive justice perspective, which illuminates wider systems of power and social factors that complicate or constrain reproductive rights and decision-making (Morison & Mavuso, 2022). As I discussed in the previous chapter, this broader perspective situates understandings of miscarriage within wider cultural and social discourses, including the established biomedical discourse, and is critical to interpreting and understanding the healthcare response to possible pregnancy loss. This approach allows a nuanced understanding of how provider's assumptions related to gender, class, and culture, among others, can shape clinical interactions (Morison, 2023).

Within this framework, I utilised a qualitative design to critically explore a group of ED *nurses' accounts* of their interactions with women experiencing a threatened miscarriage in local EDs across Aotearoa. I recruited nine registered ED nurses through personal and professional networks from Whakatū (Nelson) Hospital, Tāhuna (Queenstown) Lakes District Hospital, Hutt Hospital in Te Whanganui-a-Tara (Wellington), Whakatāne Hospital, Tāmaki Makaurau (Auckland) Hospital and Bay of Islands Hospital in Kawakawa. Ethics approval was obtained from the Massey University Human Ethics Committee (MUHEC). A mix of in-person and online semi-structured interviews were conducted using a conversational research style to capture rich, intimate insights from participants during data collection. Feminist Relational Discourse Analysis (Thompson et al., 2018) was used to consider both broad discursive themes, and individually voiced experiences to explore the data's complexity, in how the participants interpret, construct and mediate personal and professional boundaries and identities within their care encounters (Saukko, 2000).

The sections below detail the theoretical framework underpinning the research method and design, to comprehensively address the research question and aims. Further, ethical considerations and researcher reflexivity, data collection and management, and the selected method of analysis are outlined, alongside quality assurance and evaluation criteria.

3.2. Theoretical Framework

My research is situated within a social constructionist epistemology, to critically explore the taken-for-granted assumptions that shape social interactions, relationships and shared discourse within the biomedical setting (Riley & Paskova, 2022). Social constructionism posits that *language produces reality*, whereby our social, cultural and historical context influences our social interactions and communication patterns, which in turn, materially impact how we understand and interpret the world around us (Burr, 2015). This perspective underlines the transformational capacity of language to shape, constrain or challenge accepted truths, considering the embedded social processes and sources of power that privilege and maintain certain realities at the expense of other diverse perspectives and understandings (Gergen, 2009). Through this lens, I aimed to investigate language use and shared discursive patterns as a means to explore how the participants understand themselves and their patients seeking acute care for a potential pregnancy loss. This approach considers the influence of established social processes and underlying professional and cultural assumptions, that shape how they care for and interact with these women.

Within the broad perspective of social constructionism, I adopted feminist poststructuralist theory to illuminate power dynamics, patient-provider roles and relationships (Wigginton & Lafrance, 2019). While perspectives on reproductive politics have always been central in feminist movements, troubling and repetitive figurations of pregnancy and intensive motherhood remain dominant – reflecting neoliberal understandings of individualism, pathologisation and pedagogical practices that generalise and categorise women's embodied experiences (Connor et al., 2015; Neyer & Bernardi, 2011). Instead, a feminist poststructural lens searches for complexity beyond a binary logic, in critically searching for "the variations of women's lives and identities" beyond restrictive patriarchal and essentialist understandings (Frost & Elichaoff, 2014, p.42). This approach allows for a nuanced exploration of how history, culture and society shapes identity and experiences across axes of difference, such as gender, ethnicity, age and class. As such, feminist poststructuralism sits comfortably alongside a reproductive justice lens, that considers more diverse understandings of women and their reproductive decisions (Morison, 2023).

Reproductive justice also considers the role of clinical institutions in complicating or constraining women's rights and reproductive autonomy (Morison, 2023). When approached through discursive analysis, this lens allows a capacity to look beyond a broad systems-focussed approach, in considering the underlying power relations that shape established care practices and individual experiences (Stojanovic et al., 2016). This lens acknowledges that despite an institutional endorsement of patient-centred care, discursively constructed practices of power maintain the capacity to undermine agency and bodily integrity (Morison et al., 2025). A more refined research perspective takes cues from Morison et al.'s (2025) exploration of contraceptive care in South Africa and Aotearoa, which used a narrative/discursive approach to analyse providers' accounts of their experiences of delivering care. Their research highlighted the weight of entrenched discourses of biomedical expertise and medicalised risk, suggesting complex power relations through responsibilisation, confession and surveillance that echo important themes within existing sociocultural understandings of miscarriage and pregnancy complications (Budds 2021; Catlin, 2018).

In exploring these intricate relational and institutional dynamics, a poststructuralist approach openly accounts for the complexity and contradictions within qualitative research and celebrates my immersive role as the researcher (Foucault, 1988; O'Rourke & Pitt, 2007). In the context of women's reproductive health, this acknowledgement of my own partiality was critical to faithfully interpret the intimate, transactional "gifts" shared within the research encounter – making explicit use of self-disclosure, sensitivity and an emotive lens that embraces the research as a collaborative, relational experience (Brinkmann et al., 2020; Oakley, 1998; Runswick-Cole, 2012). This understanding actively accounts for how researcher's own non-work lives can inform the areas in which they choose to study, the nuances of their research questions, and further, how they engage and interpret insights within the field (Greenberg et al., 2021).

This positionality is crucial when taking into account my own personal experiences as the researcher, having encountered multiple miscarriages and early pregnancy complications in my late twenties. The care I received within ED settings across Melbourne, and how I recall and reflect on these experiences, necessarily shapes and informs how I make sense of miscarriage, motherhood and provider's perspectives when attending to women I can so closely relate to in this context. Here, Harding's (1992) feminist standpoint theory takes accountability for these convolutions, by accepting "everyday life as problematic" (p.50) and therefore, the inability to separate ourselves as researchers from the muddled lives and communities of focus – instead, developing actionable feminist research *through* our unique social location and situated knowledges. Yet, Greenberg et al. (2021) highlight the complexities of conducting work that is closely connected to one's personal experience, considering: 1) engaging professional and personal selves; 2) managing power dynamics; 3) integrating rational and emotional understanding; and 4) advancing theory and practice. As such, critical reflexivity is necessary throughout, by adopting a self-aware interrogation of my research purpose, power, emotion, and self, in the same way that I interrogate data (Cunliffe, 2018)

Further, a reflexive stance must also account for my role as a casual Mental Health and Addictions Peer Support Worker at Whakatū Hospital Emergency Department, working alongside the participants of my research in various capacities. While this bears some likeness to ethnographic work, as I am involved in the physical and social world of the community of interest (Miller et al., 2003), importantly, the focus and remit of our roles are unique and do not overlap in the context of this research – I have not been directly involved in providing care for any women with a threatened miscarriage. However, I remain in a complex, privileged position that allows me access to observe and interpret the inner workings of the clinical environment. I have professional relationships with many ED nurses, that sometimes, offers personal glimpses into how they understand and respond to the challenges and complexity of their role and surrounding clinical systems. Therefore, further reflexivity is essential in how I understand the limitations and advantages of my position within this research, considering how I manage power relations, make ethical judgements and construct and interpret my findings (Hoover & Morrow, 2015; Sprague, 2005).

Together, these complex theoretical lenses and a critical reflexivity allowed me to attend to how the ED nurses position themselves in relation to their patients and within the healthcare encounter through discursive analysis. This considered the nuanced implications of implicit power relations and complex systemic and social frameworks, on professional relationships, reproductive rights and clinical practice.

3.3. Research Design

Therefore, my research adopted a social constructionist orientation to critically explore shared discursive patterns within the clinical relationship, whilst being conceptually informed by feminist poststructuralist and reproductive justice frameworks that allow for diverse, detailed interpretations of relational experiences, understood within their wider historical, cultural and sociopolitical context and structural conditions (Morison, 2023; Riley & Paskova, 2022; Wigginton & Lafrance, 2019). As such, my study used qualitative interviews and Feminist Relational Discourse Analysis (Thompson et al., 2018) to consider and critically analyse the ED *nurses' accounts* of their interactions with women experiencing a threatened miscarriage within a local ED in Aotearoa.

3.4. Recruitment

Following ethics approval from the Massey University Human Ethics Committee (MUHEC), recruitment was approached through a mix of personal and professional relationships. Initially, I contacted the Whakatū (Nelson) clinical leadership team (the clinical nurse educator, then the charge nurse manager) to advertise my research internally within my local ED (*see poster in Appendix 1*), however did not receive any response – perhaps, due to the fact that at the time of research, Whakatū ED was undergoing a major refurbishment and also in the spotlight both locally and internationally for being severely under-resourced. Next, I pursued the following channels to extend recruitment both locally and nationally:

1. Used personal contacts with clinical nursing experience to refer and recruit participants locally
2. Used personal contacts in senior nursing positions in Te Whanganui-a-Tara (Wellington), who supported me with the following:

   a. Sharing recruitment posters (*Appendix 1*) and project information with the charge nurse managers in Wellington and Hutt Hospital EDs to advertise for online participants
   b. Shared research via the MidCentral nurse shift-swap facebook page (*Appendix 2*)
3. Used another personal contact to liaise with the charge nurse manager at Wairau Hospital ED in Te Waiharakeke (Blenheim) to promote my research, as a hospital within the wider Nelson/Marlborough region where I could still interview participants in-person
4. Contacted the Chairperson of the College of Emergency Nurses New Zealand (CENNZ) who sought committee approval and shared my recruitment poster with their national charge nurse manager network (*Appendix 1*)
5. Joined the New Zealand Nurses facebook group (with approval) and posted my research to over 3,400 members to further advertise for online participants (*Appendix 3*)

Therefore, using a dynamic process of convenience, snowballing and purposive sampling, I was able to access a relevant sample that was diverse, practical and accessible for my research (Sullivan & Riley, 2023). These activities took place in July and August 2025, and recruitment for the final participants ran efficiently once all of the various pathways were engaged. Using multiple outlets across personal and professional networks throughout Aotearoa, also allowed me to capture a varied sample of ED nurses working in different local areas and emergency settings.

3.5. Participants

Participation in my research was voluntary, and a $40 Woolworths voucher was offered as a koha/acknowledgement of participant's time and input to the research. Inclusion criteria was specific to registered nurses who were currently working (or had recently worked) within the ED setting for *at least six months*, who had actively cared for *at least one presentation* of threatened miscarriage within this context. Importantly, the study excluded nurses who had personally experienced miscarriage to protect these women from the increased complexity and ethical implications of further emotional harm.

Registered participants were provided more detailed information (*Appendix 4*), including a brief researcher bio and contact details to offer context, address participant concerns and build connection prior to data collection (Jacob & Furgerson, 2012). My intention was to recruit between eight to ten participants, considering the comprehensive qualitative insights captured by Edwards et al. (2018) with eleven participants, that captured sufficiently rich data to support pattern-based insights within a related framework of reflexive thematic analysis (Braun & Clarke, 2021). As such, a total of nine participants who met the inclusion criteria and completed qualitative interviews were included.

The initial stages of the research interview were used to capture basic demographics (Magnusson & Marecek, 2015). The sample included registered nurses from EDs within Whakatū (Nelson), Tāhuna (Queenstown), Te Whanganui-a-Tara (Wellington), Whakatāne in the Bay of Plenty, Tāmaki Makaurau (Auckland) and Kawakawa in the Bay of Islands. Their ages ranged from 32 to 59 years old, with a mean age of 42.4, in comparison to the mean age of enrolled nurses in Aotearoa being 50.3 (NCNZ, 2023). All the participants had at least ten years of nursing experience and often worked in a senior capacity (resuscitation, triage, duty manager/charge nurse manager), therefore, the perspectives of new graduates entering the clinical environment and adjusting to the unique pressures of ED in this context were not captured. However, the accrued experience of the participants allowed for deep reflections on their personal and professional learnings in relation to clinical practice, including an understanding of systemic constraints and inequalities for women accessing care in the ED setting.

Their ethnicities included NZ European, Australian, British, Canadian, Taiwanese and Chinese heritage. This reflected a high proportion of Europeans from outside of Aotearoa, despite these ethnicities making up only 7.3% of the national nursing workforce (NCNZ, 2023). Here, the nurses from outside of Aotearoa were able to reflect on different cultural upbringings (for example, a British proclivity to privacy and dealing within distress within a 'short' family structure; Black & Huygens, 2016), as well as adapting to servicing diverse communities in Aotearoa higher in Māori, Pasifika or migrant populations. However, while NZ Māori nurses make up 10% of enrolled nurses in Aotearoa, no Māori ED nurses volunteered for the research. Therefore, the ability for the research to engage more deeply with a bicultural perspective and consider cultural assumptions and practices from a Māori lens was unattainable.

All the registered nurses who volunteered to participate in my research were female. This was not unexpected, considering that 87% of the nursing workforce in Aotearoa is female (NCNZ, 2023). Nonetheless, this has important implications for the research findings, considering the singular perspective it offers on a deeply gendered topic of motherhood and miscarriage. Further, five of the nine participants were mothers themselves, which inherently impacted how they identified with and interpreted other women faced with potential pregnancy loss. Finally, the nurses reported a range of married, partnered, engaged, divorced and single relationship statuses.

3.6. Data Generation

My research used a mix of online and in-person semi-structured interviews to qualitatively explore these ED nurses' nuanced understandings, perspectives and discourses surrounding their relational care and interactions with women experiencing a threatened miscarriage. The three local participants in

Whakatū (Nelson) were interviewed in person, while online interviews allowed for a broader sample of RNs to participate across Aotearoa, as well as offering a more accessible interview method.

In selecting semi-structured interviews, this format bridges the inflexibility of structured interviews and the open-ended nature of unstructured interviews that favour biographical-narrative approaches (Brinkmann, 2013; Runswick-Cole, 2012). As such, this adaptive interview style encourages free-flowing, conversational research interactions and "rich talk" from participants, allowing the interviewer to thoughtfully guide the conversation towards relevant content and reflections (Magnusson & Marecek, 2015). The interview schedule (*Appendix 5*) utilised progressive areas of focus and open-ended questions to develop rapport and deeper inquiry – stimulating detailed participant reflections and accounts that address the complex research aims. For example, "*what do you see your role as in these cases?*" and *"what makes it different to caring for other presentations in ED?".* This also included optional probes to explore these concepts and situations more deeply considering discursive themes and specific interactions, for example, *"how did you describe/talk about 'miscarriage'?"* and *"how did you end the encounter?".*

To ensure thorough preparation, the interview schedule was pilot tested with a peer who had relevant nursing experience; this also provided the opportunity to build familiarity with audio recording equipment and the foundations of ethical research practice (McGrath et al., 2019). In this instance, my peer had community and clinical nursing experience, alongside a masters degree in social work which invited a complex review of clinical resources, assumptions and cultural perspectives. Through this collaborative process, I reviewed and edited the interview guide *(Appendix 5)* to include nuanced probes around patient's demographics and circumstances, wider medical information, discharge processes and adaptive cultural practices. For example, our conversations considered how ED nurses' assumptions surrounding how a patient's age, ethnicity or family status may invite stigma or implicate relational care, alongside the ability to adapt to different cultural worldviews and needs in terms of privacy, permission and access to bodily products.

Interviews took between 45 to 90 minutes, and were conducted at a suitable time for each participant. For the local nurses, this usually took place onsite prior to an ED shift within a break-out room near the hospital cafe, that allowed a convenient, comfortable and uninterrupted space. Online interviews were conducted on both weekdays and weekends from 8am to 8pm, to provide flexibility around participant's current shifts. Participants were offered the option to bring a support person, and kai/light refreshments were offered (or encouraged within online interviews) to observe tikanga and encourage a shared, informal setting. To begin the formal stages of the interview, informed consent was revisited and obtained in person, as well as ensuring that participants understood the measures taken to protect their confidentiality (and limitations thereof) (Sullivan & Riley, 2023). This was followed by a brief overview of the intended research and my role as the researcher (Jacob & Furgerson, 2012).

Each interview progessed with curiousity, care and active listening, following the proposed schedule to establish integrity and consistency across participants (McGrath et al., 2019). Throughout, I paid close attention to cultural safety, power relations, and sensitivity to the societal discomfort surrounding discussions of miscarriage (Dainty et al., 2021; Jacob & Furgerson, 2012; McGrath et al., 2019). For example, I paid attention to power dynamics by assuring participants that the research was positioned from a critical feminist perspective to highlight the complexity of their care work, rather than a critique of their clinical practice. My own experience in Peer Support within an ED setting proved a valuable point of connection, to demonstrate my understanding of the clinical environment when discussing everyday aspects of acute care such as bed capacity, resources, nursing roles and seniority, triage and handover processes. The final stages of the interview provided time to answer questions and set expectations (i.e., right to withdraw timeline, opportunity to review transcription; Sullivan & Riley, 2023), as well as offer suitable resources for psycho-social support (Jacob & Furgerson, 2012). Interviews were recorded using Zoom software (Zoom, 2024), and automatically transcribed with the support of AI software (Otter.ai, 2024). Samsung voice recording software was also used as a back-up for any online connectivity issues or importing errors via Zoom or Otter.ai.

3.7. Data Management

Interview transcriptions were anonymised by using pseudonyms and adapting/omitting identifying details to protect participant anonymity (Riley et al., 2022). Individual transciption records were shared with each participant to review and approve. After *Step 1* in the first analystic phase (reading and listening, to become familiar with emerging voices), the audio recordings were deleted. Final transcriptions and completed consent forms *(Appendix 6)* were password protected and securely stored on Massey University's OneDrive network – where only myself and my supervisor had access to the information. In accordance with Massey University policy, the consent forms and transcribed interviews will be held for five years by my research supervisor and then destroyed. Contact details that included the participant's personal information (e.g., email address, mobile phone number) were also kept confidential, and deleted at the completion of the research project.

3.8. Data Analysis

Within the theoretical framework, discourse analysis was selected to critically explore the ED nurses' contextual understandings and discursive knowledge surrounding their relational care and interactions with women experiencing a threatened miscarriage. This approach provides an established qualitative process to identify how reflective text and talk specific to the ED environment shapes and creates diverse realities for healthcare providers and their patients, and influences how they interact and interpret themselves within this setting (Riley & Wiggins, 2019).

Further, my research adopted *Feminist Relational* Discourse Analysis (FRDA), to stretch beyond broader, collective accounts of discourse by also considering *voice* as a 'key site of meaning' (Thompson et al., 2018, p.99). In doing so, individually voiced experiences represent a political site to analyse the complex interplay between experience and dominant discourse. Anchored by a feminist attention to power and privilege, this approach intentionally explores voice as a central means to construct and mediate identities and situate discourses (Saukko, 2000). As such, FRDA allowed me to not only detail structural systems of power within Aotearoa's acute care practices, but also to illuminate the unheard voices of these ED nurses operating within these systems – actively searching for transformative counter-narratives, identities and negotiations of entrenched, unhelpful discourses (Thompson et al., 2018). This approach presented a critical opportunity within my research, to *identify and mobilise nurses' unique perspectives* in relation to power-laden discursive systems that exist within the healthcare landscape. Illuminating these insights provides a unique avenue to collectively disrupt problematic institutional and professional assumptions resistant to change.

Thompson et al. (2018) offer a comprehensive framework to guide the analytic phases of FRDA, as per below. The first phase seeks to identify broad discursive patterns that actively frame the negotiatied understandings held within individual voiced accounts. Within this process, the broader principles of reflexive thematic analysis remain – to critically identify significant patterns and structural diversity in the data specific to the research topic – that is, the *patient-provider relationship* surrounding a threatened miscarriage (Braun & Clarke, 2021). The second phase traces participants' voices through these discursive realms, to explore how individuals locate and relocate themselves within these structures, considering the implications and personal functions of these complex negotiations. This phase attended directly to the complexity of my research objectives, in considering how these ED nurses actively make sense of their role, construct personal/professional boundaries within the clinical setting, and navigate diverse cultural understandings.

Phase 1: Poststructuralist discourse analysis

Step 1. Reading and listening to the talk: This step required intensive listening, reading and re-reading of the data, to note emerging voices, themes and plots within the stories that are told. It also provided an opportunity to situate myself and my personal connection and response to these stories, considering how I made sense of the collective narrative and connected personal and structural themes. In doing so, my reflexive notes were utilised to account for my initial reactions to arising voices and themes in the data. Alongside this, I made initial notes about emotional tone, contradictions and moments of tension to build familiarity with the transcripts, individually and as a collective body of insights.

Step 2. "Chunking" talk into sections: Here, sections of text from the transcripts were separated to identify systematic patterns of semantic content and latent meaning. Brackets were used to "chunk" specific topics, as speakers changed between meaningful topics within the transcribed talk.

Step 3. Labeling chunks of talk with descriptive codes: Next, each chunk of talk was assigned with a descriptive code that reflected the general topic of discussion, keeping in mind my theoretical interest in discourse, power and subject positions. For example, "reassurance" and "clinical processes" were familiar themes throughout the transcribed data that linked to a subject position of "professionalism".

Step 4. Identifying recurring codes, or in-vivo themes: In the fourth step, similar in-vivo themes or recurring patterns of meaning were grouped together in theme files *across* all of the individual transciptions. Through this interpretative work, theme files were assigned to represent a specific topic area, and these files included associated groups of extracts (chunks) from different participants, using their pseudonyms. Themes were then compared and 'collapsed' to merge themes that spoke to a similar concepts. From the 34 initial descriptive themes, ten final themes were generated: *Advocacy; As a woman; Caring for culture; Clinical processes; Emotions and reflections; Giving information and answer; Miscarriage; Termination and the TM patient; Partners and support people; Relational care practices;* and *The ED environment.*

Step 5. Identifying discourses: Next, the 'discourses', or multiple ways of talking about each theme were identified. A discourse considers "a system of statements which construct and object" (Parker 1992, p. 5), such as a specific type of person or shared understanding of a phenomenon that refers to taken-for-granted knowledge or assumptions. Therefore, identified discourses should meaningfully "hang together" (Thompson et al., 2018, p.105) as a coherent group of assumptions or statements surrounding each theme. This step involved grouping related codes, examining how they clustered, and exploring how they reflected broader institutional assumptions. As expected, discourses were complex and often contradictory – for example, "you get jaded to the everyday of ED" and "I want to acknowledge that there's been a loss" in relation to the broad theme of "emotions and reflections". This process was repeated to identify all the discourses that were evident around each theme.

Step 6. Identifying discursive patterns: This step involved searching across the discourses to identify those that ‘fit’ together, to highlight overarching stories and discursive patterns within the data. For instance, discourses that identified a distinct discomfort with triaging and prioritising threatened miscarriage patients in the ED such as: “ED is incapable with the enormity of it all – it doesn’t feel great” made sense of a positionality where participants felt powerful vs powerless in the ED landscape, as well as discourses related to the constraints of clinical practice: “I like to do things, but there's nothing I can do”. Together, these discourses explored the inherent compromises within systemic assumptions that prioritise medical over “emotional” emergencies and emphasise a biomedical attention to physical symptoms and processes (Saime et al., 2023; Stam, 2014). Here, my supervisor was a critical resource to discuss and debate emerging discursive patterns. Through this iterative process, the final discursive pattern in relation to the above discourses was named: “*ED is a doubled-edged sword: Compromises in acute care*” that spoke to the overarching tension between biomedical and relational care discourses.

Step 7. Theoretical accounting: Finally, the analysis looked to theory and existing research to make sense of these broader discursive patterns. This process considered power, subjectification and genealogy, and the role of these patterns within their wider historical, social and ideological context (Arribas-Ayllon et al., 2017). For example, considering how gendered nursing ideals framed the tension the participant’s constructed between biomedical and relational care discourses present within the overarching discursive realm: “*ED is a doubled-edged sword: Compromises in acute care*” considering traditional “feminine” ideals of compassion and connection set against a more detached “masculine” approach to remain objective and mask emotions within the acute ED environment (Kirk et al., 2021). These broader discursive realms and their theoretical context provided a point of reference for the next phase of FRDA, in tracing how individual voices were positioned within themes, and defined or constrained within complex structures of power.

Phase 2: Analysing emergent voices in relation to discourses

Step 1. Multiple listenings: The second phase of FRDA research is informed by Gilligan et al.’s (2006) *Listening Guide* method – using the discursive patterns identified in Phase 1 to retrospectively identify the diverse layers and voices present within each individual’s expressed experiences. Listening Guide analysis can be utilised alongside other qualitative interviewing methods, and offers a way of “illuminating the complex and multi-layered nature of the expression of human experience and the interplay between self and relationship, psyche and culture” (Gilligan et al., 2006, p.268). First, the researcher must listen for the plot within first-person reflections and accounts. As this was attended to in Phase 1 (Step 1), the analysis progressed to the following three steps.

Step 2. Generating I poems: In this step, "I poems" were generated by underlining statements within each individual transcript that are made <u>in the first person</u>, including each "I", "you" or "me" statement and the accompanying verbs. These extracts were placed in sequential order, and separated specific to the three underlying discursive patterns: *"We don't love pregnant women in ED": Systemic shortcomings; "You've got to put a cap on it": Professionalism and emotional containment*; and *"I'm going to take care of you": Situated agency and relational resistance.* I also selected Lucy's transcript to construct an "I poem" for the overarching discursive realm: "*ED is a double-edged sword": Compromises in acute care*", based on her interview providing the richest talk and emotive content specific to this prevailing discursive realm, rather than diluting the remaining "I poems" of other participants in having to draw extracts from other distinct discursive patterns. According to Gilligan et al. (2006) these individual "I poems" provide a means to capture distinct instances of how each participant speaks about and understands themselves in relation to the broader discursive themes.

Step 3. Listening for contrapuntal voices: Using the "I poems", the third step involved listening for contrapuntal, or contrasting voices within single accounts, that represent "multiple facets of the story being told" (Gilligan et al., 2006, p.262). This aimed to capture the personal *in relation to* the political, using FRDA to deconstruct a individual's discursive positioning and consider how a multi-layered self emerges from an ongoing mediation of experience and discourse (Thompson et al., 2018). For example, within Lucy's "I poem" specific to the overarching discourse: "*ED is a double-edged sword": Compromises in acute care*", I identified a voice of *humanity* in the privilege of caring for critical needs and acknowledging the gravity of individual stories. Yet, this was also accompanied by a voice of *discord*, when negotiating the shortcomings of systemic assumptions, clinical scopes of practice, and constraints of the ED environment. Throughout, my reflexive journal provided a key point of reference to remain rational, in challenging my own notion that the participants *should* respond emotionally and empathically to miscarriage (based on my own experience) – allowing individual voices to arise, in response to their own complex position, personally and professionally.

Step 4. Putting the personal in the political: Finally, a theoretical account was composed, which united the findings about the individual participants in relation to the research aims. In doing so, FRDA actively considers the "personal and political functions of discursive negotiations" (Thompson et al., 2018, p.108) by illuminating powerful counter-narratives within first-person accounts that challenge and interrogate the wider discursive patterns they are set within. For instance, the women's voices of *discord* pointed to an underlying resistance to the barriers and assumptions that restrict them from caring for women with a threatened micarriage in the ED more comprehensively. This helped to develop a view of the kind of nurse they wanted to be, and what care in this context could be, *if* the surrounding assumptions of the acute setting permitted a more holistic approach.

3.9. A Reflexive Approach to Data Analysis

Throughout the qualitative interviews and analytical process above, I kept a reflexive journal to deeply account for my interaction with and interpretation of the data. Here, I noticed that my positionality in relation to the participants was not so much as a woman who had experienced miscarriage, but as a *mother* that felt somehow healed, and whole from my healthy pregnancies. In the closing of stages of some interviews, participants asked me about my personal experiences of miscarriage in the ED and I admitted that I don't recall much of these. I replied: "It feels like I've blocked them out", because they represent such painful periods in my early adult life, that were locked away when I reached the other side, into motherhood. In some ways, my own sense-making aligns with ingrained assumptions that reproduction is controllable and that pregnancy complications can be overcome (Catlin, 2018). Further, I noted how I subconsiously emphasise the idea of distress, loss and disruption that *should* occur within experiences of threatened miscarriage – through pregnancies that were very much wanted, and hoped for in my biographical story. I reflected on how this shaped my questioning, in creating a conversation that leaned into these assumed emotions and perceptions of the threatened miscarriage patient, and in doing so, limited opportunities to explore other subject positions that represent more diverse social and cultural meanings and explorations of reproductive choice and decision-making – for both patients, and providers in their understandings of the women in their care.

Further, I reflected on my identity as a educated, affluent Pākekā living in the dominant culture in Aotearoa, and my experiences of miscarriage in Melbourne within a Western system of healthcare that didn't clash with my own spiritual or cultural needs. I wondered how my identity was perceived by the participants, and also, how this positionality limited the ability to explore different social and cultural viewpoints more deeply. It made me uncomfortable that, like me, many of the participants felt confused or under-equipped when discussing how cultural factors could meaningfully shape care in this context. In this sense, my research findings demonstrate an inherent allegiance to Western biomedical ideologies, through limited understanding of the importance of aspects such as wairua (spirituality) and the appropriateness of the taiao (physical environment) for Māori patients accessing the ED in a bicultural context (Black & Huygens, 2016; Pitama et al., 2014). Therefore, while I strive towards an affirming and decolonising approach to psychological research in Aotearoa, I'm mindful that this was restricted by my own invisible privilege and assumptions, alongside an absence of Māori participants to actively challenge and extend these understandings.

At stages within the transcription process and initial data analysis, as I was deeply immersed in the individual accounts and voices of the ED nurses, there were days I found myself profoundly impacted. I was often brought to tears by the enormity of these insights, in paying heed to women's raw lived experience of miscarriage in the ED and the nurses tasked with the impossibility of how to respond in that moment. This made me acutely aware of maintaining respect for the patient's stories and how they surface within my analysis, alongside a developing appreciation of the nurses' complex and inspirational care work that necessarily shaped how I interpreted the data. Through this lens, I acknowledge the importance of my own emotional response in deepening the integrity of presenting personally relevant research, while taking the time to digest and steady these emotions in connecting to a more rational understanding (Greenberg et al., 2021).

3.9. Ethics

Ethical practice is a dynamic and morally led process, that extends both within and beyond the research materials and method – considering wider social, cultural and institutional understandings and impacts in co-creating research that is responsible, safe and broadly beneficial (Sullivan & Riley, 2023). As such, the foundations of ethical practice were guided by the core principles of the Massey Code of Ethics (2017), considering participant autonomy, justice, beneficence, avoidance of harm, and ethical research relationships. In applying these principles: recruitment processes highlighted the voluntary nature of the study, written informed consent was collected prior to commencing research interviews, and data was anonymised and securely stored to maintain privacy and integrity of research materials and personal information. The potential uses of the research were also expressed to participants when obtaining transcript approval – including academic publications, forums and conferences – alongside the intended benefits of the study: to positively influence responsive, respectful healthcare interactions, experiences and outcomes in the treatment of threatened miscarriages within EDs across Aotearoa. In actively considering potential harms, the Human Ethics Application Risk Assessment Form (MUHEC, 2025) judged the research as *low-risk*, and provided approval (Ethics Notification Number: 4000030424) based on a peer review process with my supervisor. Given that ED nurses are constantly exposed to acute trauma and emotionally heavy work within their normal duties, it was agreed that potential harm within the interview context was unlikely; however, the interview briefing actively acknowledged the sensitivity of this subject and reiterated the right to withdraw at any time or to avoid any lines of questioning, alongside relevant psycho-social support services and resources.

To acknowledge and protect the cultural safety of wāhine Māori participants and their wider communities, the principles of tika, whakapapa, manaakitanga and mana were also considered within the Te Ara Tika guidelines for Māori research ethics (Hudson et al., 2010). To facilitate this, cultural consultation was sought from a local Te Piki Oranga Māori cultural advisor – a specialist Māori health practitioner who delivers a range of primary health and wellbeing services in the local area. This allowed me to proactively consider my cultural and social responsibility and respect for Māori participants (manaakitanga) in considering appropriate protocols, availability of whānau supports, and sensitive adaptations to integrate Māori concepts and values within the interview. Cultural advice also deepened my knowledge of mātauranga Māori understandings of *whakatahe* (miscarriage) and *te whare tangata* (womb) that conceptualise pregnancy loss as a spiritual rupture, and a deeply tapu experience. Further, additional tikanga such as *he kanohi i kitea* (being present, visible and accountable) and *kaua e takahia te mana o te tangata* (avoiding deficit framing and honouring each participant's story as taonga) were highlighted for non-Māori participants. In preparation for any Māori participants, the importance of data sovereignty, bi-lingual resources and a trauma-informed approach that acknowledges colonisation, historical trauma and systemic inequities were underlined. Through this process, my cultural supervisor endorsed my research approach as an ethically sound, culturally aligned, and strategically important kaupapa.

Beyond explicit procedural ethics and cultural considerations, my research also considered a reflexive approach to the wider societal structures and institutions surrounding miscarriage and broader reproductive healthcare interactions. This commitment meant that I took explicit care to manage potential harms in relation to the established social norms that often engender embarrassment, offence or distress surrounding miscarriage and the medicalisation of women's bodies (Dainty et al., 2021; Healy et al., 2021). Further, my research was also attuned to a feminist's relational ethics, which actively manages power relations and takes responsibility for marginalised or vulnerable women and communities (Sullivan & Riley, 2023). As the researcher with lived experience of multiple miscarriages, I also ensured comprehensive supervision and access to my own support systems to manage my wellbeing throughout the research project.

3.10. Quality Assurance and Evaluation Criteria

To ensure depth and integrity within the research findings, data analysis attended to the underlying tenets of discourse analysis – critically searching for *dimensional variability, context and the construction of subjects and objects* through the use of expressive grammar, terminology and figures of speech (Willig, 2017). By applying an FRDA framework, this more deeply considered complex qualitative explorations that "negate grand discursive narratives in accounts of identity, agency, and resistance" (Thompson et al., 2018, p.109). That is, my research findings sought to identify and *magnify* individual voices and experiences buried within the patient-provider relationship (in the context of a threatened miscarriage, in a local ED), towards collective resistance and institutional change. Identifying the importance and diversity of these voices and viewpoints attends to the principles of reproductive justice and feminist poststructuralist approaches in surfacing various perspectives, alongside their complex limitations and lived resistance to structural power dynamics and systemic issues (Frost & Elichaoff, 2014; Morison & Mavuso, 2022). As such, another measure of quality considered the ability for the research findings to explore these structural underpinnings and established discourses with a wider view of their *implications* on provider's and patient's subjective experiences and clinical practice (Locke & Budds, 2020). This attends to reproductive justice ideals, in actively considering reproductive autonomy and individual rights within a fair and just healthcare environment (Morison, 2023).

Underpinning these criteria, is a commitment to critical reflexivity that attends to my inherent connection to the research – *personally* through my lived experience of miscarriage and *professionally* considering my role as peer support worker operating with the shared ED setting. As such, Greenberg et al. (2021) provide a detailed framework to conceptualise and navigate this complexity, considering personal and professional overlaps, power dynamics, integrating emotional and rational understandings, and creating impactful scholarship that advances theory and practice. For example, being transparent and forthcoming with my personal connection to the research through my own experiences of miscarriage, as a means to present a more rigorous methodology and approach to theorising (Wright & Wright, 2019). Thoughtful application of these reflexive techniques allows a step away from *whether* to undertake personally relevant research, towards *how* to do so in way that is responsible, ethical and effective.

3.11. Conclusion

This chapter has provided a detailed exploration of the research methodology, guided by a rich theoretical framework, researcher reflexivity, ethical considerations and integrity to data generation and management. A descriptive, qualitative design was chosen, using Feminist Relational Discourse Analysis (Thompson et al., 2018) to explore the nuances of a group of ED nurses' accounts of their experiences caring for women presenting to a local ED with a threatened miscarriage. The two stages of analysis considered not only the wider discursive patterns evident in how the participants understand and operate within the ED as women and clinicians, but also, individual accounts and important counter-narratives that challenge and navigate these overarching sociocultural assumptions.

Ethics approval for the research project was provided by the Massey University Human Ethics Committee (MUHEC) and judged as low-risk, via a peer review process. Recruitment utilised a dynamic mix of convenience, snowballing and purposive sampling across personal and professional network, to access a sample of nine voluntary participants across Aotearoa. Semi-structured interviews allowed for adaptive, conversational research encounters to generate rich data, and were conducted in-person for the local ED nurses (in Whakatū, Nelson) and via Zoom for participants located elsewhere in Aotearoa.

Cultural supervision was provided by a local Te Piki Oranga Māori cultural advisor to ensure appropriate tikanga for participant's cultural needs, alongside a more developed understanding of mātauranga Māori concepts specific to this research. The Massey Code of Ethics (2017) also guided procedural ethics such as participant autonomy, informed consent, wellbeing resources, privacy and data security. Finally, quality assurance and evaluation criteria considered the underlying principles of discourse analysis and reproductive justice, alongside rigourous reflexive techniques to safely navigate a personally relevant area of interest (Greenberg et al., 2021). The next chapter will outline and explore in-depth findings from this research, alongside an integrated discussion.

Chapter Four

Analysis and Discussion

4.1. Introduction

In this chapter I report on the discursive patterns, voices and "I poems" generated within FRDA (Thompson et al., 2018). This analytic method was utilised to comprehensively meet the research aims, in exploring how the ED nurses who participated construct their professional identities and relational care practices regarding threatened miscarriage, within the context of broader institutional and gendered discursive realms. Through this lens, the analysis depicts discursive realms as a distinct set of shared discourse, social interactions and relationships underpinned by the cultural, social and historical context they are set within (Riley & Paskova, 2022). As such, outlining the unique discursive patterns upheld by the ED nurses seeks to highlight the material impact of these taken-for-granted assumptions on how they understand, interpret and respond to women experiencing a threatened miscarriage in Aotearoa's acute clinical setting.

Phase one illuminated an overarching discursive realm: "*ED is a double-edged sword": Compromises in acute care*, with three unique discursive patterns set within this landscape:

1. *"We don't love pregnant women in ED": Systemic shortcomings;*
2. *"You've got to put a cap on it": Professionalism and emotional containment*; and
3. *"I'm going to take care of you": Situated agency and relational resistance*

Through this analysis, I explore the nuances, assumptions, and relational functions of these discursive patterns in what they mean for the participants, their patients, and emotional care practices in the ED. The wider literature was also consulted to make sense of these discursive patterns within their broader historical, social, cultural and ideological contexts (Arribas-Ayllon et al., 2017).

In phase two, I used voice-centred analysis to develop individual understandings and "I Poems" that express personal, politically informed accounts of how the participants negotiated and responded to the four discursive patterns. Lucy, Claire, Diana and Rebecca's "I poems" are integrated below, in providing a rich, emotive way of "illuminating the complex and multi-layered nature of the expression of human experience and the interplay between self and relationship, psyche and culture" (Gilligan et al., 2006, p.268). The remaining "I Poems" appear in Appendix 7. Through the identified voices of: *discord, humanity, professionalism, caution, tenderness, purpose, hostility*, and *apprehension*, the participants present a range of complicated and conflicting positionalities, within the context of their care work and the wider discursive assumptions at play.

Below, the findings from phase one (discursive patterns) and phase two (voices and I poems) are integrated, to provide a multi-layered exploration that considers both the broader discursive landscape and personally-situated accounts which seek to navigate and mediate these assumed constraints – that is, the personal *in relation to* the political (Thompson et al., 2018). The structure of this chapter considers each of the four discursive patterns in turn, and presents sub-patterns as necessary to detail complexity and distinct areas of insight that arose within the analysis.

4.2. "ED is a Double-Edged Sword": Compromises in Acute Care

Evident throughout the participants' distinct discourses and wider discursive patterns was an all-encompassing tension that depicted the provision of care in the ED for a threatened miscarriage as fundamentally *compromised*. This tension centred on the dominance of a biomedical discourse that privileges physical (bodily/physiological) care over a relational care discourse which openly accounts for a more holistic, patient-centred response. As such, the privileging of biomedical practice in the ED failed to reconcile emotional needs, introducing tension in how to adequately care for these women. For example:

> **Extract 1: Diana**
>
> That there's nothing that you can do, or it feels like there's nothing that you can do, you know? I think that's really challenging as a nurse. I like to help people get better. I like to do things. I like to be able to take blood tests, and do ECGs, and give medication. I like to do the things that help.

Diana's talk (Extract 1) depicts a tension when aligning with the established biomedical discourse that underpins her nursing practice. This tension is centred on the implication that a biomedical approach is *insufficient* ("there's nothing that you can do") in the case of a threatened miscarriage. The dominant biomedical discourse frames care through a reductionist lens that focuses on the physical body and associated clinical processes, reflecting wider assumptions of established healthcare institutions (Chamberlain, 2016). Diana draws on these assumptions when explaining an absence of care pathways to follow or "things that help" – limiting the role of "helping" to caring for the physical body. Here, her practical nursing identity is firmly tied to a medicalised model of "doing things" to provide care (i.e., blood tests, ECGs, medication). From this position, the core functions of the ED nurses' role places value in diagnostic processes and procedures, and in doing so, this system of care serves to *medicalise* the experience for women experiencing pregnancy complications and *minimise* the importance of wider emotional and psychosocial needs in the clinical setting (Andipatin et al., 2019).

Yet, Diana's adherence to this biomedical discourse was conflicted through a recognition that in these instances, this framework falls short of a women's wider needs – signalled by her inability to provide the appropriate type of care, that "helps people get better". Later, Diana's talk supports this opposing need for more holistic, emotional care and the compromising position it creates for her: "the miscarriages, you know, like the things that emotionally are traumatising for people like, I think it's hard for us as well". Therefore, having to avoid the more intangible aspects of emotional care through a biomedical focus maintained a troubled positionality for the participants when attending to threatened miscarriage in the ED.

This tension manifested in the participants' construction of a "double-edged sword" (see Lucy's "I Poem" below) in their practice, that set the *heart* of their care work (a sense of unique privilege, purpose and patient-centred care), against the boundaries, assumptions, and constraints of established biomedical practice in the ED setting. Within this discursive realm, they expressed what it means to be a "good nurse" who provides "good care" in different ways. Yet, the participants consciously depicted their role as involving compromises at every turn, in the context of threatened miscarriage.

Lucy's I Poem:
I don't think I can – I've tried, I've tried to work in other places.
You get brought back to the pace and the variety and the camaraderie,
I think everything in ED is a double-edged sword

You feel like you're not able to provide the care you would like to,
You can't, you can't say we're full.

I think nursing is a privilege.
You change as a human being. I think before I did ED, I was maybe a lot fluffier.
Because of the work I do and the things I've seen

I don't think it's the right place at all.
But there's no real other way I can do this…
I feel acutely aware, of the loss that that person is going through,
I think there's a bit of a disconnect sometimes,

Oh, I really want to be able to make you feel special and cared for in this moment.
I've gotta go, I can't, I've got 20 patients out there, all who needs things…
You end up having to try and code switch quite a lot

> I remember thinking, this is going to stay with her for a really, like forever. If I had a million dollars, and a way, not just a will, we could have done that differently
>
> You end up feeling like you're getting quite hardened to it, or quite flippant sometimes,
> I can't believe that I was just there for that moment, and now I'm here for this moment.
>
> You find yourself sort of signalling for them to stop, and that feels horrible.
> I'm not. I can’t. I'm here and I will look after you,
> I can't be here for the time that this deserves.
> I don't want to take away what it means to you
>
> I really don't know if that's the right thing to do
>
> So I’m just standing there like, Oh, my God. What am I doing? Where the fuck do I put this?
> Because I was a professional, I've been trained, and I've gone through that,
> I think I’ve got enough lived experience that I can project that successfully.
> I wish I didn't… but at the same time, I'm incredibly grateful

Above, Lucy’s “I poem” depicts a complex negotiation of the institutional assumptions and constraints within a biomedical discourse that complicate her role in caring for threatened miscarriage. Consistent with the discursive construction of acute care as inherently compromised, was an accompanying voice of *discord* within the participants’ individual accounts, that highlighted how they responded to the constraints of clinical scopes of practice, systemic assumptions and environmental barriers. For example, “I’m not”, “I can’t”, “I don’t want to”, alongside the reoccurrence of “but” i.e., “but there’s no real other way” and “(but) I’ve gotta go”. This voice reflects the dilemma of being caught between the necessity of biomedical care practices and an inclination to provide relational care. Ultimately, the dominant biomedical discourse overrules the relational care discourse, so that participants positioned themselves as having little choice or agency, as expressed in Lucy’s “I’ve gotta”.

The dominance of the biomedical discourse reflects the wider discursive context of the medical system, which is premised on the biomedical model (Stam, 2014). This was evident in the participants’ talk, which suggested that in medical settings, the biomedical discourse prevails, and is further justified in the ED context through a life-or-death understanding of acute care. In the *emergency* care setting, this considers how the provision of acute care in particular, maintains a biomedical model. For example, Sylvie’s depiction of how the ED prioritises care based on physical symptoms: “if they're not bleeding out actively in front of you, they can just be pushed to the side as a non-priority”. Likewise, Lucy explains the assumptions that underlie their decision-making at triage: “I wish that I didn't have to do this, but at the same time, triage is a clinical decision, not a psychosocial decision”. The participants therefore positioned themselves as *having t*o assume the established role of the clinician and adhere to a biomedical model of care – at a loss regarding how to comprehensively attend to potential pregnancy loss in the ED. As such, the prominence of a biomedical discourse in this setting spotlighted a fundamental difference between patient and provider perspectives, considering how easily it can be dismissed within an environment that triages and prioritises the most acute medical presentations (Saime et al., 2023).

As such, the possibility of resistance is highly constrained within a clinical landscape. Many participants described this setting as promoting both a desensitisation to miscarriage and a devaluing of its emotional significance from the patient’s perspective. For example:

> **Extract 2: Lucy**
> So I think there’s a bit of a disconnect sometimes between, what the patient is experiencing is something that’s incredibly important, and they never thought would happen to them, like this huge thing. And for us, we’re like, it’s sub 20 weeks, we’re not flippant about it, but it doesn’t, it’s not surprising. It doesn’t seem shocking to us.
>
> **Extract 3: Diana**
> Any presentation in ED like that is so, at that time that is incredibly serious for that person, whoever that is, they've presented to the ED for that and I think, we can get a bit jaded, because we see so many emergencies, and we've got that in our head, you know, we have to triage. We have to go off that. What's most critical to life or limb.

Above, Lucy and Diana’s talk presents a compromised position in the biomedical discourse as they describe how the ED context encourages a disconnect from the patient’s emotional experience, leading the participants to “get a bit jaded”. Again, this biomedical lens maintained a physical conception of miscarriage that downplayed the wider emotional and social aspects for women. For example: “it's so common, it happens all the time, that you kind of just do think about it as like another abdominal pain or another sprained ankle” (Sylvie). This construction amplifies the disconnect between patient and provider perspectives, considering how commonplace miscarriage is to ED staff (Dainty et al., 2021).

In response to these inherent compromises, Rebecca reframes the patient’s expectations of the ED to fit more comfortably within a biomedical response. For example: “They want a health professional to come and see them, to take them seriously, I suppose, and to be taken seriously they probably feel like the clinical stuff that we do is care, is the care that they need”. While this discursive work seeks to ease a compromised positionality, other aspects of her talk depict a sense of dishonesty in adopting a clinical approach. For instance: “It's also something to hide behind, because you can do your usual workup, you know, like as if it was something, something else completely”. This discomfort is centred on the binary that positions miscarriage as something different to the “usual” workup, that causes tension in the ED context. This awareness was reinforced by Christine, through a construction of threatened miscarriage as an *exception* to the “standard” cases in ED that fit more comfortably within a biomedical approach: “Other things you tend to fix, or, you know, you have some sort of pathway or plan”.

Such compromise was enacted against the discursive backdrop of the significance of each woman’s “emotional emergency” (Klein et al., 2012) when presenting to the ED with complications in early pregnancy. This is evident, for instance, in Yvette’s construction of threatened miscarriage as “life changing” for patients, regardless of the outcome. Such talk was common and indicates a shared acknowledgement among the participants – pointing towards an underlying resistance to the dominant biomedical discourse. Through their talk, the participants negotiate these opposing priorities, and seek to preserve a positive identity by accounting for this tension through their reference to miscarriage as something that is *“*incredibly important/serious” for their patients. Here, there is an effort to meaningfully acknowledge the moral and emotional significance of potential pregnancy loss (Parsons, 2010). As such, this discursive work alludes to a deeper understanding of what care in this context *should* be, and the kind of nurse they want to be, *if* the surrounding assumptions of the clinical setting allowed for a more holistic approach.

Therefore, the participants subtly challenged established biomedical assumptions through the adoption of a compromised positionality and nuanced critique of standard care practices. Their discursive work in negotiating these tensions surfaced through common expressions of frustration, confusion, and discomfort with *how* they as ED nurses, could adequately care for these women within the tenets of biomedical practice, as shown in Extract 1 and Lucy’s “I poem”. Rather than accepting these constraints as a necessary evil in acute care, the voice of discord indicated a resistance to the status quo, towards institutional change and improved resources that allowed the participants great agency in providing more comprehensive care in the ED. Likewise, Diana’s statement that: “I wouldn't say it's the best place. No.” speaks to an underlying dissonance with emergency care in this context, that links with Lucy’s voicing of an idealised system: “If I had a million dollars… we could have done that differently”. Through this voice, the participants position themselves against sociocultural ideals and established biomedical frameworks, that diminish and devalue the emotional aspects of care in this context (Budds, 2021; Dainty et al., 2021).

Further, there was also a distinct voice of *humanity* embedded within this discursive pattern, that spoke to the privilege of caring for women at such a critical juncture. Within this voice were mixed affects of pride, compassion and guilt that expressed an intent to purposefully account for the personal significance of experiencing a threatened miscarriage (Parsons, 2010). The shared voicing of “stay with her”, “this deserves” and “what it means to you” signal a relational understanding that is grounded in meaning and value (Wright, 2018), in resistance against societal assumptions that silence and stigmatise experiences of miscarriage in the ED.

4.3. “We Don’t Love Pregnant Women in ED”: Systemic Shortcomings

While the overarching discursive pattern highlighted the ways in which the ED simultaneously enables and constrains care through a dominant biomedical discourse, the next pattern shifts attention to specific institutional and gendered assumptions surrounding miscarriage and reproductive healthcare more broadly. In this discursive realm, pregnancy loss is constructed as out of place in the ED, and further, an inconvenience to the standard clinical systems and everyday assumptions of the acute care environment. Within this context, the participants position nurses as ambivalent agents within a systemic response not equipped for this kind of care.

Throughout the participants’ talk of negotiating the confines of their clinical practice, was an underlying discourse that was troubled by systemic assumptions and shortcomings in women’s reproductive healthcare in the ED setting. For example, Lucy expressed how: “ED deals with everything apart from, we don't love, we don't love pregnant women. We would much rather they were somewhere else”. Such assumptions were illuminated through the participants’ discursive work surrounding gaps in clinical guidelines and resources, alongside broader inequalities and accepted truths in women’s reproductive and sexual healthcare in Aotearoa.

4.3.1. Gaps in Clinical Guidelines and Resources

In areas of clinical practice specific to caring for a threatened miscarriage, the participants expressed how professional boundaries and protocols were inadequate or unclear. These shortcomings in existing biomedical practice impacted their ability to confidently and sensitively provide emotional care in relation to patient-provider conversations, dealing with “products of conception”, and ED discharge processes. Therefore, the participants explained an uncomfortable position in having to intuitively provide care work in these situations and learn through a process of trial and error. For example, “You basically just do it and then cringe through it the first few times, and then after that, you'll be like, oh, okay, yep, this is what I should do, this is what I shouldn't do" (Lianne). This points to institutional assumptions of care work, that alongside formal knowledge, there remains a complex negotiation and acquisition of more nuanced understandings of people and situations in the care setting (Davies, 1995). As such, there was an apprehension in having to blindly navigate and "cringe" through gaps in clinical guidance, in order to acquire more comprehensive care skills.

In particular, the absence of appropriate clinical guidelines was highlighted when participants were presented with the "products of conception" (i.e., blood, clots, early fetuses) that had been passed by patients experiencing a threatened or complete miscarriage. The complexity of how to respond to such an intimate event for their patients, and the enormity of what this signified was strongly expressed:

> **Extract 4: Yvette**
> She came out and she was screaming, and her partner came running out, and I came in there, and they handed me this bloody bundle. And I was mortified. It was just heartbreaking, because I'd never been handed anything like, so sad. And I was just like, what am I to do? What am I? Where am I? What am I doing now? What? No one's told me what to do. I was completely lost, and I just said to him, can you just get her on the bed and get some blankets around her and just, and just went away with it.

Yvette's talk exemplified an acute confusion of: "What am I doing now? …No one's told me what to do", alongside a "mortified" positionality that this situation represented something so inherently "sad" and "heartbreaking" from the patient's perspective. These clouded discourses that relate to a lack of training and guidelines in this context points to institutional assumptions that broadly devalue women's reproductive health, and further, fail to equip healthcare services with diverse Indigenous knowledge and reproductive practices that extend beyond a Western response to miscarriage in the ED (Hay et al., 2019; Le Grice & Braun, 2016). Yet, despite this confusion, the participants expressed an awareness to adapt and proactively care for different cultural needs in the ED, particularly around offering women the option to keep these products of spiritual and cultural significance. For example:

> **Extract 5: Rebecca**
> I try to normalise it. Almost like it's a standard protocol thing, which I guess it kind of is, there's always like, usually there's always a big enough box in the in the sluice room, SANDS boxes… I kind of approach it in that way, so that they don't feel like they should or shouldn't. Yeah, it's their choice.

Above, Rebecca depicts her efforts to normalise this option in her practice. Her discursive work to affirm this as a "standard" protocol was justified as means to reduce patient discomfort in requesting access to spiritual or culturally meaningful processes ("so that they don't feel like they should or shouldn't"). Yet, there was still some apprehension in how this practice was viewed within an overarching biomedical discourse – signalled through "almost like" and "I *guess* it kind of is" that speaks to an institutional resistance in responding to more diverse cultural needs in the acute setting.

Further, knowing what to call these products, and how to navigate other intimate conversations with patients highlighted the complexity of this interactional landscape. For example, Lucy reflected on the conversational dilemmas that surfaced: "But it's that toss-up between 'it' and 'baby' that is a real difficult one to balance sometimes". She expressed the inadequacy of having to deal with these situations objectively: "Sometimes, I'll call it 'it', but then probably apologise for, being like, I'm so sorry, there really isn't like, a very good word for this, but I don't want to take away what it means to you". This same complexity arose when the participants considered whether to use the word "miscarriage", in most cases deferring to an objective discussion of symptoms (bleeding/cramping) unless a miscarriage was confirmed, reasoning that: "You don't want to scare people more than what they already are. I think that's what it is. You just don't want to, like, be the one to cause that person more pain" (Diana). Together, this discursive work reflects the tendency to revert to biomedical discourses of pregnancy and reproduction. However, their underlying discomfort in assuming a biomedical explanation also indicated an active clash against the overarching medical discourses that marginalise wider cultural and psychosocial aspects of care (Layne, 1990).

A lack of specialised resources in the ED was also evident within the participants' talk, for example: "It would be ideal if you had some sort of, or even a midwife, or something that was an ED as well that could help those patients, or someone that you could call upon". However, this was less prominent for the two participants working within a hospital that included a 24-hour dedicated Women's Assessment Unit (WAU) for pregnancy and gynaecological complications. Below, Sylvie's talk depicted the benefits of a specialised service, through the construction of increased agency ("smooth transition", "quick handover") that provided satisfaction in being able to care for patients more efficiently when transitioning them to a dedicated clinical department:

> **Extract 6: Sylvie**
>
> I guess it's just knowing that I can be fast at doing that. And get them and call the Gynae reg quickly and just give a quick hand over brief and get them upstairs as quick as I can. So it always feels really satisfying when a patient comes in who does meet the criteria to go up to

> WAU, to women's assessment, when I can do that, that really quick handover, and just make that really smooth transition for them. So they can think, Oh, that was fast, and now they're upstairs in the place where they should be.

4.3.2. Systemic Shortfalls in Women's Healthcare

Within the ED's troubled discursive landscape to adequately prioritise and care for women's wider needs, the participants made inferences to an underlying assumption that women were more broadly devalued in the medical system. For example: "But it would be nice, nicer in general, if there was a lot more things for women's health. I feel like men have pain in their testicles and it's a, you know, medical emergency, whereas women really get left in the lurch" (Christine). To the participants, this was inherently linked to gendered systems of power at the institutional level, considering the systemic assumptions that dismiss gender inequalities in care and highlight a dominance of males as doctors and decision-makers (Hay et al., 2019). "I feel like, in New Zealand, we're still sitting in that, 'she'll be right' kind of brain. There's always so much harm" (Rebecca). Here, Rebecca also refers to a national identity in Aotearoa of laid-back and stoic attitudes, that have been linked to poor sexual health statistics (Braun, 2008). Rebecca's discourse below (Extract 7) interprets a need to counteract systemic inequalities and assumed negligence towards female patients, by adopting an advocacy role:

> **Extract 7: Rebecca**
>
> Yeah, advocating for women. I feel like, there's an inequality for women in this situation. I feel like I've come across some ED doctors – they're not female doctors, that's for sure, who are just kind of like, oh, you know, HP is normal. The bleeding is not worse. Just send them home. Just kind of, I don't know, they just don't seem to sort of have any, they don't have any kind of emotional connection at all.

The construction in Rebecca's talk that "they're *not* female doctors" considers gendered practices in the ED, inferring that male doctors lack a deeper level of emotional care and connection. Later, she expresses that despite a lack of specific training in women's reproductive health: "It's almost like you're expected, if you're a female nurse, it's like, you're expected to know how to do it". Therefore, caught within this discourse, was a construction that *women caring for women* made more intuitive sense in this context. This construction reflects wider assumptions of nursing in general, as women carrying out "women's work", that is heightened in the context of gynaecological care (Bolton, 2005).

Other participants reinforced this understanding from a gendered perspective, for example: "Maybe it's a gender thing, maybe we feel it a little bit more, oh gosh, you know, we're programmed as women to have babies aren't we? We don't want to go through that" (Claire). This also points to the ongoing influence of societal ideals that conflate womanhood with motherhood and embed reproduction as integral to women’s identity (Browne, 2025). Lucy’s talk upheld this intuitive, integral understanding of miscarriage as a female practitioner: “I think there's just a sense of, like, reverence for want of a better word, that you kind of you recognise… I'm sure men can practice really great empathy, but I do think there's something, there's maybe some sort of sense of having a level of understanding”.

> **Extract 8: Rebecca**
> If a woman wants to terminate then that is, yeah, that is 100% her choice, and the right thing for her to do. It's just not like it's just nine months, let's be honest. It’s a lifetime and you know, I mean, women see it that way

The above extract demonstrates how leaning into these gendered assumptions and adopting a positionality that upheld a shared womanhood allowed the participants to affirm reproductive choice and decision-making. This is indicated through Rebecca’s discursive work that “it’s 100% her choice”, “the right thing for *her* to do”, and an underlying affirmation that women understand (“women see it that way”). Her positionality links to deeper historical assumptions in the nursing profession that are rooted in maternity care, but also, through a purposeful social movement that aims to promote women’s empowerment and autonomy (Rabelo & Silva, 2016). Adopting this position also allowed the participants to enact a grounded approach to conversations around termination, and their relevance in the context of pregnancy complications: “Because one of the, I think really important questions is actually asking, is this something that you've wanted?” (Yvette).

However, despite their role as the frontline care provider in ED, overarching systemic shortfalls hindered the participants’ familiarity with these conversations and associated services, pointing to a lack of priority and understanding in women’s reproductive health. For example, Yvette’s reflection that: “emergency is not like, we're not specifically trained in, like being midwives or trained in, you know that I've never been on a course that is solely aimed at women who are pregnant?”. Through her experiences navigating pregnancy loss in the ED, Yvette also expressed these systemic shortcomings as they extend to spiritual and cultural processes:

> **Extract 9: Yvette**
> I did bring up years and years ago, there about loss and blessing areas, which got a few raised eyebrows. Because I, spiritually, I think there's been a loss. Sometimes the doctors and other nurses might look at it more of a sort of a clinical perspective, but there's a lot gone down in that little tiny spot. And then they were like, well, you can do it if you want to do it. And I just think that's a bit callous, to be honest.

Above, Yvette's talk grapples with a systemic inability of the dominant biomedical discourse ("a clinical perspective") to consider the spiritual and psychosocial significance of pregnancy loss. She adopted a more holistic understanding, that resisted the "callous" tendency to disregard these aspects of care in the ED. As such, the participants demonstrated cognisance and resistance to the systemic assumptions that produce disregard and densensitation to early pregnancy complications in the ED. This was evident through the adoption of wider care practices to validate and advocate for women, and further, an underlying dissonance against institutional gaps in women's reproductive healthcare in Aotearoa (Phillips et al., 2023). Together, their discursive understandings signalled a collective alignment *against* the broader shortcomings in women's rights and reproductive health, that have been linked to limited healthcare provision and repressed sexual, reproductive and bodily autonomy through Western systems of social and political power (Davis & Bryder, 2024).

Further, Lucy's talk (Extract 10) below also signalled an awareness of broader societal scripts, that continue to mute or suppress women's emotional response to miscarriage in the ED setting:

> **Extract 10: Lucy**
> Sometimes I wonder if the women would be acting differently had they not got someone that they maybe needed to show up for a little bit, or like, not be seen to be hysterical, or not to be seen to be overreacting, or like, wanting to be the, I don't know, it seems mad to me, but I think sometimes it does like, that idea of having to be like the chill girl who takes it in their stride, actually extends to miscarriage seems bonkers to me, but I do think it's something I've observed.

Lucy's construction of "the chill girl" who felt a need to "show up" and not be perceived as hysterical/overreacting in the ED setting, points to the wider stigma associated with miscarriage that not only complicates the provider response, but also, how women interpret their own experience (Saadi, 2020). This suggests an added complexity to the participants' care work, in navigating gendered assumptions of their own capacity, whilst deciphering societal cues that cloud how the women in their care can voice and account for emotional distress.

Finally, the participants' talk negotiated perceptions of a women's partner, support person or wider whānau, considering that: "Sometimes they're really angry at us, at the situation, at everything" (Christine). To account for this frustration, Claire justified this perception through the lens of institutional deficiencies: "Because people often have bad experiences within the emergency department or with their GPs or in healthcare, so they bring a person who feels that they need to protect them against you". This construction was common, considering the participants' shared perception of:

"That happens all the time. You bring a partner who is the kind of personality that makes most things difficult" (Mia). In the context of Aotearoa, this signals an awareness of a hostile healthcare environment for marginalised communities, and valid experiences of institutional racism that must be compensated for in the clinical encounter (Espiner et al., 2021).

Therefore, the participants' discursive work clearly demonstrated an awareness of wider systemic issues and societal assumptions that complicated their care work, in actively searching for a view of what more comprehensive care for threatened miscarriage *should* and *could* look like in the ED, within and beyond the current compromises (López-Deflory et al., 2023).

Rebecca's I Poem
I feel like it would be better if there could be some kind of capacity for, like gynae or maternity wards to have a service for women

I mean, they're ED docs, they're just a little bit different.
I feel like, there's an inequality for women in this situation,
I feel like I've come across some ED doctors – they're not female doctors, that's for sure

I remember one time I said something real stupid, and I regret it so much.
I feel like I'm not qualified because I haven't lived through it. I feel like if I'd had that life experience myself, I might be a better nurse for those people.

I couldn't even find a box big enough for everything.

I'd really like to do an IPV like, what's life like for this person? What do they need, do they need more help.
I'm absolutely 100% pro choice.
It's a lifetime and you know, I mean, women see it that way…
I think that women like historically, we're always on the back foot. We're always used and abused in some way.

I feel like that is a totally normal thing that you want to do as a woman going through anything like that, even like, before you have a baby, after you have a baby, miscarriage, like, whatever you know, we just we want to retreat to our safe place.

I feel unqualified to deal with that stuff because I haven't been through it and because, I don't remember having any training on like, I honestly can't recall having any specific training, like

> in nursing school or in my ED education… It's almost like you're expected, if you're a female
> nurse, you're expected to know how to do it.
>
> I feel like, in New Zealand, we're still sitting in that, she'll be right kind of brain. I feel like a
> lot of harm gets done to us.
> You know, you lose your dignity early on as a woman because of the like, because of
> procedures…
>
> I'm… a bit disappointed when there's a male O&G doctor, I'm kind of weird about that?
> I think it should be women.

Rebecca's "I poem" above conveyed a strong voice of *hostility*, in response to the shortcomings of women's reproductive healthcare that were tied to gendered assumptions ("they're not female doctors"), limiting the systemic response to patients in this context (Hay et al., 2019). For instance, her use of "inequality", "used and abused" and "harm" that conflicted against the possibilities of the right/better environment to comprehensively care for women.

This voice aligned with the participants' adaptive care processes that advocated for more time, privacy, information and emotional support in the ED. It also encouraged little acts of defiance, such as Yvette involving midwifery services without the support of senior doctors, and Rebecca freely sharing resources at discharge: "I'm happy to give away tons of pads. I don't care!". Further, a resistance to the inherent process of desensitisation was also present, through a sense that cases of threatened miscarriage broke through this barrier and maintained priority for the participants charged with their care: "and I want to do, I'll keep in mind, this patient, I need to go back to see her" (Mia).

Yet, a voice of *apprehension* remained, in response to evident gaps in clinical guidelines. For example, "I couldn't even find" appropriate products, alongside a lack of specific training and education. This apprehension was also caught within gendered assumptions of 'women's work' (Bolton, 2005), through the expectations of intuitive care as a female nurse, or the ability to be "better nurse" if Rebecca had her own lived experience of miscarriage. Further, her disappointment in a lack of female O&G doctors signalled the importance of a female-led workforce for pregnancy complications in the ED. Therefore, there was a complex balance between actively leaning into the traditionally gendered nursing ideals of warmth, compassion and connection (the voices of *humanity* and *tenderness;* Kirk et al., 2021) without more comprehensive training and support of this approach at a systemic level.

Thus, the participants constructed their clinical practice and capacity to expand their care repertoire towards cases of threatened miscarriage as compromised by institutional limitations. Here, their discursive work presented a discomfort with current constraints, in how they were able to respond to, prioritise, and interact with women in this context. The next discursive pattern explores their response to this discomfort, considering how the participants frame detachment as both protective and responsible, allowing them to position themselves positively as clinically competent and emotionally contained professionals.

4.4. "You've Got to Put a Cap on it": Professionalism and Emotional Containment

This discursive pattern encompasses talk of *emotional labour* or *emotion work:* the invisible management of emotion in order to align with expected standards and professional demands in a particular setting, in this case, the medicalised context of the ED (Bolton, 2001; Kirk et al., 2021; McCreight, 2005). In the ED, a privileging of "the 'medical-model' of caring [requires nurses] to remain detached from the patient" (Bolton, 2001, p. 91). Aligning with medical norms of emotional detachment, the necessity to contain emotions was commonly constructed as a response to the constraints of the ED environment, further emphasised within a discourse of professionalism. Participants drew on this discourse of professionalism to justify emotional regulation and the need to "put a cap on" their emotions when caring for cases of threatened miscarriage in this setting. This talk positions nurses as restrained by aspects of the ED context – specifically the acute nature of care in the ED and the need to maintain professional boundaries, as discussed below. Claire's "I poem" below highlights a voice of *professionalism* that was evident across many of the participants' accounts.

> **Claire's I Poem**
>
> You learn very quickly that you cannot… You've got to separate that because you, you can feel it inside, but you, you have got to put that aside, because it will change your practice.
> You have to keep it objective so that your practice, your clinical practice, comes first
>
> You have to do stuff. I'd love to be able to sit and hold her hand. But then I'd also like to hold the hand of somebody who has a stroke, or, you know, that's broken a knee, or, you know, because we care.
>
> I think you have to be a chameleon as a nurse.
> So you wear a mask, you know what I mean, because some things are very hard in ED, and some days will just get you like that.
> Ahhh, you probably get better as you go along.

What do I need? I need to get this and this and this.
So I'm dealing with the clinical side of things.
And of course, you add a softness to that. You don't motor in there. But you try and get as much clinical information as you can within the situation, without appearing cold.

Sometimes you can get it very wrong very quickly, and you have to change tactics, very quickly.
So then, they're gonna push that back onto you. So you just take it.
I know what to do clinically, but you know you feel really, oh my gosh!

And you can't say anything, because it's not your role as an RN.
I think they want to know.
Actually, I can't. I want to say it's okay, but I don't know, because you never, ever say it's going to be okay, ever.
I would absolutely use the right words,
I would not say you're going to, this is because you're going to lose your baby.

I think the worst part is, we don't have the time.
And sometimes in that rush of doing the clinical stuff, we cannot deal with the, we don't have time to deal with the - are you okay?
Because there's a lot of other patients to be seen to, and that's the sadness.
You're trying to give them a hundred percent in like 3 seconds

If you can't look after yourself emotionally, you're going to fall apart,
Because you can't sympathise. You've got to empathise.
You can feel it, don't act on it. And look after yourself.

This poem shows how a relational construction of miscarriage grounded in meaning and value (Wright, 2018), was difficult to account for in a professional capacity. Instead, the participants actively stepped into their clinical persona, by leaning into the objectivity of clinical processes and dealing with the patient's present symptoms as a priority. The voicing of "separate", "objective", and "mask" that speak to the more detached 'masculine' approach to nursing in the ED (Kirk et al., 2021), captures participants' talk of the need to present a professional identity. Further, Claire infers that allowing emotions to enter the care encounter will "change your practice", therefore, the construction of wearing a "mask" was used to morally legitimise this approach, as a necessary measure to uphold clinical standards and prioritise patient safety. As such, taking up the position of the emotionally contained professional offered a clear pathway for the participants to follow.

At the same time, however, assuming this position limited emotional care by privileging a biomedical construction of the maternal body – consistent with established medical practice in Aotearoa (Davis & Walker, 2010). As the "I Poem" above shows, the voice of the professional actively contrasts with a voice of *humanity* that was also evident in their accounts (Kirk et al., 2021). It also highlights how participants voiced discomfort with this positioning, signalling a pull toward more relational understandings of care. This echoes in Kirk et al.'s (2021, p. 1962) findings from their research with British ED nurses: "For many, adhering to this feeling rule [of emotional stoicism] prompts emotional labour – there is tension as they feel traditional (arguably female) nursing values should still be influential." Below explores how my participants justified taking up the expected self-contained professional position, in relation to the acute environment and professional boundaries, when building the skills and resilience to perform emotional labour, and in relation to the patient's bests interests.

4.4.1. The Acute Environment

The participants articulated a rushed and often chaotic clinical environment, describing how caring "too much" can be construed as problematic and overly time-consuming in the ED, potentially disrupting patient flow as in Kirk et al.'s (2021) study. The pressure of attending to an endless flow of patients was depicted as inhibiting the capacity to provide more comprehensive care, including wider relational care practices. This is captured in Lianne's comment that the acute care setting is not the ideal place to attend to threatened miscarriage: "I think, somewhere else would be better, quieter. So we have more, one-on-one staff, and time to…, because, you know, it's a busy place in ED, we don't always have time to support them emotionally". The emphasis on moving efficiently from one patient to the next echoes wider perceptions of the ED as an "assembly line" (Kirk, 2023, p. 183) and was described as stifling opportunities for interaction and extended relational care. For example:

> **Extract 11: Claire**
>
> I think the worst part is, we don't have the time. And sometimes in that rush of doing the clinical stuff, we cannot deal with the, we don't have time to deal with the "Are you okay?" Because then we rely on support people to do that. Because we're just trying to get the bloods done, we're trying to get her lure in, we're trying to see that she's okay. Because there's a lot of other patients to be seen to, and that's the sadness. But then we don't have that with any of the other patients, either. You don't have the time with anybody, so you've got to make it really quick.

In this extract, Claire's talk reinforces the emphasis on time and tasks-based work in the ED context, alongside the patient's *physical* wellbeing. She does not deny the need for relational care, as suggested by her reference to a reliance on support people to provide emotional care. Yet, her language ("cannot", "you've got to") highlights the limits of what is possible in the ED setting. Her desire for this to be different in the case of threatened miscarriage is suggested by describing this as "the worst part" and as prompting "sadness" – providing an assertion that maintains her moral integrity and attention to wider patient needs. Such discursive work rationalises a lack of emotional care due to resource and time constraints in a system that prioritises "doing the clinical stuff", that is, biomedical processes.

Further, adopting an acute clinical lens also highlighted how the participants constructed an institutional lack of adaptability towards cultural differences, considering the ED's assumptions to prioritise clinical needs and established processes. For instance:

> **Extract 12: Yvette**
> I suppose I should, yeah, I suppose that would be one of my poor areas, yeah, because I'm always looking at everybody as the same, as flesh and blood and rather than their culture, because I'm trained to manage clinically an emergency, and so that's what it's like with your brain trying to click in and out of things

Above, Yvette's talk presented the compromises of a biomedical discourse that focuses on the physical ("flesh and blood") and has trained her to perceive patients as medical beings, not cultural beings. Framing patients as a homogeneous group through this lens, by "looking at everybody the same" points to a systemic inability to respond to diverse cultural needs and understandings of miscarriage in the acute settings. Further, this suggests a lack of agreed-upon frameworks, clarity and consistency in how patient-centred care is implemented in the ED setting (Walsh et al., 2022). For instance, Christine explains that: "but there's not really much difference that I've noticed in the way of culture… There probably are cultural things that I'm unaware of". Yvette seeks to justify these shortcomings by prioritising the impetus within the emergency response to "click in and out of things", yet, aspects of her care remain unresolved in the reflection that she *should* attend to cultural needs more purposefully. Likewise, Lucy explains that you: "end up having to try and code switch quite a lot", in constantly shifting roles and tasks within the ED landscape, that points to a limited capacity to prioritise more holistic and culturally nuanced approaches within the context of acute care.

Yet, ambivalence is evident in this talk. The participants' inferences that "somewhere else would be better" for patient's experiencing miscarriage (Lianne) and "the sadness" (Claire) of the current status quo, suggests an underlying ideal of a different approach to care in this context. This is captured in

Lucy's explanation of why she has to limit emotional conversations, reasoning that: "it would be psychologically irresponsible to be like, tell me how you're feeling, but *I've gotta go in a minute*. So like, sometimes you find yourself sort of signalling for them to stop, and that feels horrible". While the mismatch between her workload and the patient's emotional needs serves to justify her lack of engagement, Lucy's statement also conveys discomfort with this approach. Her assertion that it feels "horrible", allows a moral statement that aligns with a recognition of women's wider needs. These expressions of dis-ease point to the presence of *moral injury* (Dean et al., 2024), considering the participants' lack of agency and capacity to attend to women's emotional needs due to environmental pressures and systemic assumptions of the ED setting.

4.4.2. Professional Boundaries

The presence of professional boundaries and scopes of practice outlined a distinct set of discourses for the participants, that emphasised an emotional distancing from their patients in this context. Specifically, there was tension surrounding the fact that participants had access to diagnostic information (i.e., urine samples, blood results) associated with pregnancy viability, but had to defer these conversations to the assigned doctor to remain within their professional scope. For instance: "It's not my role to say the diagnosis, actually it's out of my scope" (Mia). As such, there was a voice of *caution* within the participant's accounts, that frames emotional containment as a precautionary measure to stay safely within the boundaries of their prescribed role, without overstepping more senior clinicians who hold greater clinical power specific to diagnosis and further intervention. This caution reflected an alignment with their clinical education and the established hierarchy of professional scopes of practice, as nurses with less agency and power in the ED setting (Essex et al., 2023).

From the patient perspective, these critical discussions of viability represent the underlying reason for their emergency presentation (Strommen et al., 2017). However, the scope of the ED nurse created an invisible barrier between emotional connection and relational care. These limitations indicate frustration and unease for both sides of the patient-provider relationship – relying on doctors to review and deliver critical information, despite the majority of patient care and interactions remaining with registered nurses (Freeman et al., 2020).

> **Extract 13: Lucy**
>
> So you feel like you know something they don't. You know that they're having a miscarriage and they're still holding on to a glimmer of hope that it's normal pregnancy bleeding, and that's the thing that really gives me, for the want of a better term, the ick, like I really don't, that makes me probably feel the most uncomfortable, because you don't feel like you can talk to

> them candidly. I feel really, really sorry for them, and I feel really uncomfortable in that situation, because you kind of feel like you know what's happening, but you're not really sure if they know what's happening.

Above, Lucy’s talk depicts an acute discomfort (“the ick”) with the enforced boundaries of her professional scope, alongside a sense of deceit in holding information at arm’s lengths from her patients. Lucy explains: “it feels like you're keeping a secret”. Here, the participants reflected on a unique relational dilemma, that demonstrated their awareness of the power imbalances embedded within prescribed clinician-patient roles (Buetow, 2016) through a desire to maintain an authentic relationship (to speak more candidly) with the women in their care. Lucy’s articulation of feeling “really, really sorry” for her patients and “really uncomfortable” within these interactions allowed for a moral position that asserts her awareness of the troubling power dynamics, as well as the emotional significance of potential pregnancy loss (“a glimmer of hope”). Yet, this remains unresolved within the enforced boundaries of her current practice.

Lianne chose to manage this discomfort by aligning herself more closely with the patient and *not* looking at the diagnostic results, yet, she grappled with this decision through a conflict with her discursive construction of a “good nurse”: “I know, good nurses, we check blood results and, you know, so that we could action things, if it's a result that we're waiting for”. Diana reflected on how this clinical boundary could inhibit more comprehensive support: “I do feel like we kind of have to withhold information. And I wonder if that prevents us from maybe, really getting in and providing support as much as what we could be”. Again, this references an ideal of what relational care *could* be, without these clinical constraints.

For the most part, the participants expressed how they navigated this uncomfortable bind internally, while being mindful of care responsibilities that extend beyond the doctor’s diagnostic conversation:

> **Extract 14: Yvette**
> Sometimes you become a very good actress, which sounds horrible, but I'm always somebody that tries to retain as much hope for that person as I can, and then also have to be there when it's not that great, because you're always the last person to say goodbye to that person. It's not, it's usually not a doctor.

Yvette expresses the “horrible” nature of having to ‘mask’ clinical knowledge and understandings from the patient through the construction of becoming “a very good actress”. This aligns with Claire’s talk around concealment and constant adaptation: “you have to be a chameleon as a nurse… so you wear a mask”. Here, Yvette maintains a positive identity and alignment with the patient’s emotional needs, in retaining hope on their behalf. Yet, her discursive work also highlights a tension between the role of nurses and doctors in fronting this emotional landscape. This points to the division of emotional labour in the ED, whereby doctors/consultants are tasked with ‘breaking the bad news’, however, nurses are tasked with caring for a patient’s subsequent emotional distress (McCreight, 2005).

Later, Yvette describes how she offers her patients the opportunity to hear the fetal heartbeat… “and I know the doctors hate me doing this, because I've been told not to do it”. She argues that: “I've got no qualms in getting more specialist teams in, because they're nurses as well, yeah? And that's, you know, that's what they’re amazing at doing”. Asserting that she’s “got no qualms” about causing disruption in the department and accessing multidisciplinary support from other nurses (who are “amazing” at what they do) spoke to a tension between the assigned roles in the ED. Through this positionality, Yvette constructs nurses as being more patient-centred despite systemic constraints, by actively searching for ways to validate and account for the emotional emergency at hand (Dainty et al., 2021).

4.4.3. Developing a Backbone in Performing Emotional Labour

On top of these complex tensions in managing clinical systems and professional scopes of practice within the ED, the participants’ talk considered how they negotiated the heavy emotional load that was associated with caring for a threatened miscarriage. Through this discourse, the participants positively constructed their own emotional resilience as a learnt and necessary *skill* to negotiate their role, the ED environment and the messiness of miscarriage. This construction aligns with Kirk’s et al.’s (2021) “feeling rules” of navigating emotional labour in the ED, highlighting an expectation of suppression and stoicism that is often actively encouraged by senior leadership. Therefore, articulating a strong sense of resilience and skills at emotional distancing allowed the participants to demonstrate moral legitimacy, through the construction that being a “good nurse” also means not being “too involved”. For instance: “But I chose, and I've trained myself that, walk out the door and that's it” (Yvette). Below, Sylvie’s talk (Extract 15) explores this emotionally loaded landscape, and the need to build resilience by “putting a cap on” emotionally charged thoughts and reflections.

> **Extract 15: Sylvie**
> …because you can't help save everybody. So I just kind of put a cap on it and have my nursing hat on when I come home, and like I do, think about things sometimes, but that's where I just don't let my mind go there. And there's nothing I can, thinking about it's not going to change anything for that situation. So I look after myself and my mental health, to just end it there.

Through this talk, Sylvie traverses the tension between a tendency to reflect on situations and having to purposefully distance herself from her clinical work ("to just end it there") – to assume the "feeling rules" of the ED. Her "nursing hat" allows her to extend these assumptions across other contexts (including her personal life), embedding the above construction of a "good nurse" as measured and emotionally contained. She performs discursive work to justify this approach, through the assertion that she "can't help save everybody" or change the outcomes of her clinical work, alongside the importance of her own mental health. As such, the participants' talk reflected on their ability to build resilience (to develop a 'backbone'; Kirk et al., 2021, p.1960) against their emotionally complex care work, signalling an institutional expectation in the emergency setting to build maturity and coping skills within their nursing practice. Diana depicted that: "Maybe my cup's just a bit deeper, so it doesn't empty out as fast, and I'm a bit more resilient" after years of experience in the ED. Likewise, Claire expressed the importance of adopting the *right* personality and understanding of boundaries to combat against compassion fatigue, through learned experience in an acute caring role. For example: "I think it's personality and knowing your boundaries. Ahhh, you probably get better as you go along. Not necessarily, but your experience as a nurse, rather than your age".

Yet, having to suppress their own emotional responses, created an inevitable sense of *holding* that felt heavy and unfinished for many of the participants, despite their discursive work to leave "emotional things at the door" (Rebecca). For instance: "Definitely, yeah, those, these miscarriage cases, they do stay with me" (Lianne). Here, the presence of unresolved emotions and experiences alludes to a difficult dichotomy that is unique to the ED context, as observed by Kirk et al. (2021). That is, in a traditionally gendered role that leans into "feminine" values of warmth, compassion and connection, the ED setting demands more "masculine" expectations of toughness and task-based care that enforces emotional disconnection. As such, the expectations of clinical practice in this context were associated with ongoing internal compromises and residual tension. For example:

> **Extract 16: Lucy**
> But what it does mean is that you end up holding a lot of it and it just sits there and never really goes anywhere, and you feel like you were just witnessing that. Yeah, you're just sort of there, just for someone else's, someone else's story, and even though you were a part of it, you kind of weren't. It's odd.

Lucy's talk above points to wider understandings of the silent and cumulative emotional burden ("holding a lot of it", "never really goes anywhere") associated with emergency nursing despite the assigned 'feeling rules" to cope with these demands (Nasr, 2025). Here, Lucy presented a complex construction of the importance of miscarriage from the patient perspective in witnessing an intimate aspect of their story. However, framing this as occurring to *someone else*, and her evaluation of the situation as "odd", signifies an unresolved positionality, in how to integrate this experience into her own life and knowledge. Such moments highlight the ambivalence that marked these accounts of self-contained professionalism.

4.4.4. In the Patient's Best Interests

Despite being affected by or feeling for their participants, the participants described containing their emotions and consciously tempering how they communicated with their patients for the patients' own good. This talk further justifies adopting the position of an emotionally contained professional and a "good nurse", through a privileging of patient's best interests. For instance:

> **Extract 17: Claire**
>
> You do absolutely have that little feeling of, oh gosh, you know… they always tell you their story … But you can't. You can't show that too much, because you have to be the strength in the room" …You have to keep it objective so that your practice, your clinical practice, comes first, because your clinical practice is what will save her, not your feeling bad about her situation.

This extract depicts concealing "feeling bad" for a patient underneath the mask of her clinical detachment as in the patient's best interests. Maintaining objectivity allows a nurse to be strong for the patient. Alongside this, appealing to the life-or-death nature of ED care, emotional care is depicted as less useful than clinical care ("your clinical practice comes first… is what will save her"). A miscarriage is thus implicitly constructed as the *same* as any other serious physical condition in which empathy ("feeling bad for her situation") is not needed. Adopting this understanding of miscarriage points back to the overarching discursive tension – the "double-edged sword" – considering the participant's underlying awareness that miscarriage also represents an *exception* to the everyday cases in ED and that wider patient needs remain unresolved within standard biomedical practice. In this context, such talk points to a conscious negotiation of emotional engagement, that places limits on relational care and connection.

Discursive work surrounding the patient's best interests was also infused with the voice of *caution*. This voice negotiates perceived emotional distress associated with a threatened miscarriage, as a reminder to tread carefully in an effort to protect the patient's wider wellbeing (i.e., "You can feel it, *don't* act on it"). This trepidation indicated the participant's underlying acknowledgement of an *unspoken motherhood* present within the clinical encounter, by subtly responding to the moral and emotional significance of potential pregnancy loss (Parsons, 2010). For example, recounting a patients' emotional response to her, Diana commented that, "I think I definitely just touched a sore spot" and the need for caution as her choice of words or approach could cause further distress. This voice supports the construction of emotional containment as beneficial for the patients' emotional wellbeing, even reframing such care as indirectly attending to the emotional and relational dimensions.

These descriptions of the process of suppressing emotional experiences and reactions in order to remain focused on clinical processes aligns with Kirk's (2023) depiction of the 'A&E swan': appearing calm on the surface, despite frantic internal responses to the cases at hand. They position themselves as emotionally contained – without being unfeeling or dismissive of the situation – and as doing what is best for the patient, thus securing a positive identity.

4.5. "I'm Going to Take Care of You": Situated Agency and Relational Resistance

Despite the tensions the participants articulated within opposing discourses of acute care, systemic constraints and expected rules of engagement and emotional containment throughout the previous discursive patterns, their talk also presented strong accounts of conditional or situated agency. In this final discursive pattern, *situated agency* considers the capacity to act within, and in partial resistance to, the constraints of dominant institutional and discursive norms (Madhok, 2013). This surfaced through their discursive redefinition of "good care". Rather than openly challenging the dominant biomedical discourse of the ED, the participants develop nuanced discourses that promoted adaptive care practices, patient-centred care, and efforts to "stay soft" in attending to the construction of the unique privilege associated with their care work in this context.

4.5.1. Adaptive Care Practices

By leaning into their professionalism and established clinical protocols embedded within a biomedical discourse, the participants depicted an active positionality in caring for women with a threatened miscarriage, which was reinforced by a shared construction of the calming, reassuring benefits of this approach for the patient. For example, Sylvie reflects that: "I'll stay pretty consistent and calm and just always, just kind of reassuring and keeping them up to date with what's happening with their investigations and what we're waiting for, and just making sure that they're well informed". Further, the participants developed accountability through their role as clinicians, to assume ownership and responsibility for their patient's safety while in the ED: "That's what I say. I'm just like, I'm going to take care of you, I'm going to keep you safe… it literally, is just that sentence, like, we're going to take really good care of you" (Lucy). This demonstrates a relational resistance against institutional norms that encourage emotional distancing and a detachment from clinical outcomes (i.e., Sylvie's prior statement that you "can't help save everybody"). Mia also expressed the importance of *another* anticipated life from the patient's perspective, while still within the confines of a medical lens:

> **Extract 18: Mia**
>
> Oh, you have to be very, very, very careful, more careful. We're already careful when we're dealing with other patients, but for this one, because they are high risk, there's two lives. We have to very careful each step, you know, and I'm always more anxious.

Above, the elements of Mia's talk (Extract 18) that highlight extra care in attending to both the patient's safety and the presence of extra life within their pregnancy demonstrated an intuitive understanding of *unspoken motherhood*. Even within a biomedical discourse (that centres life or death), the anxiety that accompanied her understanding points to an acknowledgement of the moral and emotional disruption a potential pregnancy loss represents for her patients (Parsons, 2010). Therefore, Mia re-works what it means to care for threatened miscarriage *within* the constraints of the ED environment, using a biomedical framework to emphasise the importance of these cases in the clinical setting. This demonstrates situated agency, through Mia's ability to stretch the norms of a biomedical discourse towards hidden moral, emotional and relational implications. She indicates that each women's emotional needs were implicitly held present under the surface by the participants in their clinical work ("I need to go back to see her"), in recognising and adapting to the gravity of the situation.

> **Extract 19: Claire**
>
> You do as a nurse, hear those, "Oh, I really wanted this baby," and, you know, how this is going to be really expensive, or "I'm going to take time off work," and she's way in the future. And she needs to be pulled back to say, "actually, let's deal with it today." We'll do the bloods, sort out this, go to the next thing, then just keep her present, because the future will burn a hole, you know, for her? And "We'll do that tomorrow. That's the future you." So then you can't answer all of those things, but you can make them see what's in the present.

Yet, rather than opening conversations around an anticipated life (or loss) with their patients, Claire's talk (Extract 19) depicted how the participants responded through a purposeful approach to the present symptoms and diagnostic processes. Here, Claire developed situated agency in taking ownership of the patient's troubled future thinking through the dominant biomedical response, asserting that: "she needs to be pulled back". This positionality allowed the participants to attend to their perception of patients in this context as predominantly "distressed" and "anxious" through a pragmatic approach to care – to ease anxiety and bring patient's back to the present moment ("let's deal with it today"). Through this lens, the biomedical discourse behind clinical protocols and processes offered the participants agency in attending the patient's distress within their presentation. However, this also developed a clear cut-off between what was possible in the acute response, considering how other elements were left unanswered i.e., "We'll do that tomorrow… that's the future you".

Nonetheless, the participants' discursive work explored adaptive care practices that softened and shaped how they cared for women and their support people in this context, subtly resisting systemic assumptions of objective, task-based practice (Kirk et al., 2021). In doing so, this allowed the participants to express a calm and sombre approach, which suggested attempts to validate the "emotional emergency" and attend more comprehensively to each women's distress. For example, Diana's talk below (Extract 20) against "bursting" or "barging in", and instead, prioritising privacy and a gentler approach that sought to convey their understanding of the "seriousness" of their patient's situation. This was proactively chosen and reinforced miscarriage as an exception to other admissions, for example: "So usually you'd be like, you know, more jovial" (Lianne), but: "for these women, I think it's more sensitive in the manner you present to them" (Mia). A slower, more present style also actively accounted for wider perceptions of care in the ED: "Because that's one thing that's huge in ED is that people feel like they're not being listened to, because we're like, bang, bang, bang, bang, bang. You know, you've got to listen to that. What's going on behind this?" (Claire).

> **Extract 20: Diana**
> You know, you're not going to burst into the room and be like, Hi! You're probably a lot more gentle, I guess, and kind of just letting that person know that you're there if they need anything. But you probably, like, I don't know, I tend to give them a bit more privacy, and I think as well, you know, you're sort of just waiting for that conversation. You're just letting them know you're there, but you're not really, like, barging in to do things. I think, just being a bit more gentle. I don't mean as in, like, physically. I just mean, acknowledging the seriousness of it for them.

4.5.2. Patient-Centred Care

Despite the overarching binary between biomedical and relational care discourses that troubled their clinical response, the participants' talk demonstrated a resolute capacity to overcome these barriers and keep each woman's wellbeing and integrity at the forefront when in their care. In doing so, their discursive work referenced a move towards patient-centred care in fostering trusting patient-provider relationships and a holistic approach that centres communication, patient autonomy and accounts for physical, psychosocial and cultural needs (The Health Foundation, 2014). For example, Sylvie expressed the importance of offering validation at triage, to actively voice to women that: "you've done the right thing to come in". This positionality provided the participants with ways to regain power and purpose within their care practices, that suggested situated agency against the wider challenges and assumptions of acute care in the ED. For example, signalling an affirmation of women's emotional needs in an environment that prioritises biomedical (physical) care demonstrates how Sylvie negotiates the systemic assumptions that inherently devalue a threatened miscarriage: "So I just make sure, like, *no*, you know, this is important" (Sylvie).

Further, when women presented on their own, or with a support person that the participants depicted as unhelpful or uninvolved, their discourse underlined a protective instinct to deepen their care and attention. For example, the exasperation of "could you not help her?" (Extract 21) within Lianne's perception of a young women who was highly distressed and ended up passing her fetus in the ED:

> **Extract 21: Lianne**
>
> We weren't, I guess no one was really expecting that to happen right there and then, but also, her mum was there. And I don't, I don't know if it's like, you know, like what - surely a mum could tell her what was going on and help keep her calm. It's just, like, just watching that mother, I don't know, just watching that mother-daughter relationship. I'm just like, could you not help her, tell her what's going on? She thinks she was dying.
>
> **Extract 22: Lucy**
>
> You get the feeling you're putting them in, like, a really uncomfortable situation, that they really don't want to be talking about. You're like, *sorry* bro, but like, and then, you know the answer is, like, five sentences long, and he's like, No. You're like, I'm gonna need more, because I know that there was more!

Likewise, Lucy expressed frustration (Extract 22) when presented with cultural barriers that required translation and conversations via male partners, hindering the ability to speak to and care directly for the woman. The construction of an uncomfortable interpersonal situation for the patient's partner elicited a response of "*sorry* bro", signalling that the women was her priority, and that she deserved a more thorough handover, at the expense of his discomfort and inability to provide further detail. Therefore, when partners or support people inhibited their role or fell short of expectations, the participants expressed a powerful intent to act as an ally or advocate, that demonstrated a priority to protect and empower the women in their care. This positionality indicated an overarching need that is evidenced in female nursing practice, to humanise and democratise the relationship – ensuring that patients have the appropriate power and knowledge within the ED setting (Rabelo & Silva, 2016).

As such, when a women presented on her own, many of the participants depicted an ability to demonstrate this ethos and "really take charge of a caring role" (Lucy). Being granted the relational capacity to care for women *without* a support person suggested opportunities for more comprehensive care, such as: "if they're alone, then it kind of kind of opens up the opportunities to talk to them more about their social situation. And it's a good opportunity for like, IPV [Intimate Partner Violence] screening" (Rebecca). While leaning into the voice of professionalism that implies comprehensive processes (i.e., Lucy capturing patient information and Rebecca attending to IPV screening) and therefore, securing clinical legitimacy, the participants develop situated agency by using the tasks and tools of their biomedical practice to stretch and deepen relational care in this context. Further, the participants constructed a capacity to assume the role of an emotional support person, by making themselves available for a deeper connection outside of their clinical work: "I would probably linger in the room a little bit longer just to see if she wants to talk or open up" (Christine).

In striving towards a patient-centred approach to care, the participants also constructed a discursive understanding that their own emotional involvement must be tempered and carefully managed. This decision-making expressed an effort to protect professional boundaries (i.e., Claire's talk to keep clinical practice *objective*), but also, included a more nuanced attempt to maintain the patient's integrity in having autonomy over the emotional response:

> **Extract 23: Sylvie**
> I feel like I'm like, empathetic with all my patients, but I guess maybe I try not to make it look like I feel sorry for them, because I don't want them to pick up on that at all. So I wouldn't kind of go overboard with any of my interactions, but I think I would just probably keep that to myself and treat them all, everyone the same.

> **Extract 24: Rebecca**
> But it's just there's such a, there's such a variation of reactions and situations that come through ED That like, I'm just like, everyone's so different, and I don't and like, yeah, I just, I don't want to upset people. I don't want to over sympathise or make them feel like, uncomfortable. Yeah, like so I suppose I just assume the role of the clinician who tries to offer everything that I can, but probably not, but not emotionally, I guess.

For example, Sylvie and Rebecca's talk above presented discursive work against over sympathising, to avoid the patient feeling upset/uncomfortable ("like I feel sorry for them"). Through this work, there was an understanding that it was *their* experience and not the nurses' place to react to or reciprocate the patient's associated distress. Here, the participants referenced the "professional face" of established nursing practice, through a situated contradiction of care *at a distance*, that sought to actively manage power dynamics between patients and providers (Bolton, 2001). Christine reinforced this: “I think I cut off quite a lot when I'm at work… they haven't come in here to hear my point of view or my, you know, my life, or anything about me” – underlining a construction of patient’s expectations that clinicians must maintain their professional persona and allow the patient to *own* the emotional landscape in the ED. Likewise, when Claire felt moved by a women’s experience in the ED, this needed to be contained internally, otherwise: “The patient will feel very ah, they understand your, what you are, but then you’re making it about you, not about them. So that's a very big thing. You can feel it, don't act on it”. Therefore, within the bounds of biomedical discourse, the participants found a means to reinterpret these boundaries through a patient-centric approach to emotional care.

4.5.3. Privilege, Purpose and Staying Soft

In the emotionally intense context of threatened miscarriage, the participants discursively constructed a sense of professional pride and moral identity. While their talk affirms the difficulty and emotional toll of their care work in this context, it also revealed a situated or conditional form of resistance through an intentional refusal to become emotionally hardened or detached (by “staying soft”, being “seen”, and “making space”). Through this re-interpretation of their role, the participants stretch dominant understandings of what counts as competent care in the ED. These accounts do not reject professionalism; rather, they rework it, asserting relational and affective commitments as a legitimate source of clinical authority and moral purpose. In doing so, these commitments provide the participants with greater agency to respond to threatened miscarriage more intuitively and comprehensively within the constraints of the acute care setting.

Collectively, the participants framed caring for threatened miscarriage as meaningful but heavy work – as both a privilege and a burden – that spotlighted an intricate balance between the privilege of supporting women in such a vulnerable situation, and the complexity of attending to an invisible emotional load. In response to this tension, the participants talk’ suggested a prioritisation of the privilege, that pointed to their construction of an ED nursing identity and a measure of satisfaction in the workplace. Lucy refers to the privilege of emergency nursing as “a front row seat to the circus of life” that has stretched and shaped her perspective “because of the work I do and the things I've seen”. Studies on resilience in nursing in Aotearoa have pointed to “a badge of honour” that facilitates a reclamation of pride and purpose against adversity in the workplace and frames survival as an *individualised* personal strength (Conolly et al., 2022). In contrast, my participants tended to construct professional pride through a shared vulnerability, rather than heroic endurance or “toughing it out”.

They also express ambivalence through moments of discomfort and moral negotiation, particularly when an institutionalised sense of detachment conflicted with relational expressions of care.

> **Extract 25: Yvette**
>
> I tend not to like ruminate too much on certain things, but in my own head, I know what I've done. And you know, in a way, it's a gratifying experience being sort of privy to so much and so much vulnerability, but I do think that if you can manage it well, it makes you stronger.

Above, Yvette's talk (Extract 25) justifies the gratification associated with heavy emotional labour, in being "privy" to so much vulnerability that plays up the unique position the ED nurses are placed within to witness such raw and intimate aspects of humanity. However, there are elements of the double-edged complexity of the ED nurses' work in this context that remain. For example, the implication of "*if* you can manage it well" and the construction of "in a way" – suggesting that not all elements of this emotionally taxing care work are resolved. Within this discourse, was an assumption that you have to go *through* the associated messiness and reality of mortality in acute care ("to so much and so much vulnerability") in order to achieve career fulfilment and a more insightful outlook on life. This talk aligned with Kirk's (2023) depiction of ED as a 'warzone', whereby participants were shaped by their 'battle' like experiences in a volatile and unpredictable setting. In response, the participants discursively constructed a sense of pride and accomplishment, in feeling exposed and emotionally altered by the enormity of emergency care, without becoming hardened to it:

> **Extract 26: Diana**
>
> Um, I think you just can't, like, you can't let it get to you, like you can't let it drain you, but also, I don't want to be bitter, and I don't want to build up like a hard shell, because I know that's like, the way a lot of people go as well. But yeah, it definitely it teaches you a lot.

Diana's talk (Extract 26) expressed an underlying pride – in actively resisting the "drain" of emotional work, against the "bitter" or "hard shell" that many nurses succumb to (i.e., "the way a lot of people go"). In doing so, Diana rejects the idea that a stoic, hardened identity is inevitable in the ED setting, and instead, constructs emotional sensitivity and "staying soft" not as weakness, but as a deliberate professional stance. This active voice of *tenderness* comes to life in Diana's "I poem" below, in developing a discursive resistance to institutional norms surrounding emotional labour and established nursing identities in the ED.

Diana's I Poem

I just found I have a real love for it,
I really feel like it's my calling, and the emergency department was just where I always wanted to be. I feel really seen in it as well.

You want to provide comfort, but you also don't want to give any false hope.
You really only know someone's story if you've had the chance to actually engage with them,
I guess you probably try and lean into it a little bit more to be their support person.

You definitely feel empathy for that person, and you're definitely not going to joke about it,
You're not going to burst into the room and be like, “Hi!”. You're probably a lot more gentle… I tend to give them a bit more privacy,
You're sort of just waiting for that conversation

I think they're absolutely devastated.
I just reassure them, we haven't forgotten you.
You sort of, you’re gauging, you gauging what's needed.

You can just imagine, what people are going through,
I guess the main, like, everyone's scared they're going to lose the baby.
I think, just, getting them out of the wait room and getting them into a private room somewhere where they can have their grief,
You just don't want to, like, be the one to cause that person more pain.

I don’t like saying something, unless it comes across sincere,
I would probably say we’re here, if you need us, we’re open. We're here. 24/7, you know?
You know, sitting down early with them and making space and making time,

Because, like, I think they need that.
I might have a little word with one of the doctors

You don't want to have something interpreted the wrong way.
I think everything is always very like, gently, gently,

And I think when I first started, that was something that I found really challenging, you know, and all those things were built up… I need to have a few days off, my cup is empty.
But I think the more experience you have, and I'm finding over the years, the more nursing experience I have, the less, I don't know… I’m a bit more resilient

> I think it makes me appreciate my life more as well.
> I don't want to be bitter, and I don't want to build up like a hard shell,
> It definitely, it teaches you a lot.
>
> You get a bit jaded. And then I think something like that comes in, and it just reconnects you to that more therapeutic part of yourself, where you're, you have to be more caring,
> You have to access that, it reminds you to keep in touch with that.

In Diana's "I poem", the voice of *tenderness* is developed through the presence of adaptive care practices that foster "comfort", "reassurance", and a "gently, gently" approach that closely aligns with the voice of *humanity* within the overarching discursive realm. Instead of associating the references to "grief", "pain" and devastation with the ED as a "warzone" (Kirk, 2023), this voice of tenderness responded through a return to the traditional nursing ideals of comfort and compassion (Kirk et al., 2021). This ability to translate the emotionally volatile nature of their work into moments of situated agency underlined a capacity to purposefully adapt in their role, despite the confines and assumptions of the clinical context (Madhok, 2013). As such, within these tender acts of situated agency, was also a resistance to the dominant biomedical discourse, in resolutely attending to emotional aspects of the experience that exist beyond a physical understanding of miscarriage. For example, Diana's talk: "I don't mean as in, like, physically. I just mean, acknowledging the seriousness of it for them" that centres women's emotional realities and builds space for meaning-making in care.

In addition, there was a voice of *purpose*, developed through Diana's talk of having "a calling", feeling "seen", being "sincere", and "in touch" with the therapeutic parts of herself. In doing so, the participants construct emotional openness and relational care as legitimate, even necessary, components of "good" nursing. Through this construction, their purpose was brought to life through acts of availability, reassurance and validation that further developed situated agency in the ED setting and stretched the boundaries of what counts as legitimate practice. For example, "we're here, if you need us, we're open", "we haven't forgotten you" and "making space and making time" that disrupt the ED's dominant discourse of speed and detachment. Despite the tension that exists within this assumption of heavy emotional labour and stretching above and beyond for patients, Diana justified the importance of this purpose-led approach for "something like *that*". Therefore, this active voice resists a biomedical discourse, through the understanding of threatened miscarriage as an *exception* to everyday cases. As such, the participant's acts of relational care in this context aren't just affective, they discursively challenge institutional norms by redefining what professional success looks like, by subtly extending the limits of existing systems and clinical processes.

In redefining these norms, the participants reframe their role and resist the cynicism associated with emotional labour in the ED, by reclaiming emotional labour not as a cost, but as a source of growth and motivation. As such, despite uncomfortable learnings and assumed emotional load, the participants demonstrated an openness to this messy and taxing process of acquiring resilience – positioning themselves as purposeful moral agents. Lucy reflects how: "I think I probably, like maybe my first five years of practice, there were probably a lot of women who are like, she was a bit flustered, wasn't she?". Yet, she constructed a sense of gratitude in having accumulated the lived experience to overcome this perception and acquire competence: "even if all I'm able to do is project a sense of like having something under control that's better than nothing". This aligned with Claire's construction of acquiring learned experience over time, in getting "better as you go along". Likewise, Mia affirms that: "learning is always a part of my, it gives me the motivation and the energy to carry on".

Within this mindset, the participants constructed meaning in their developing experience, considering how these learnings could improve their practice and assume a purposeful identity. For example: "I've been here in ED for about three and a half years now, and I feel like it's just who I am, like who I am as a nurse" (Rebecca). These moments express how the participants resist burnout and detachment discursively – not through heroic individuation, but through a narrative, relational construction of meaning that is inherently linked to their developing nursing identity and ability to deepen care encounters (Conolly et al., 2022). As such, they construct a professional identity that affirms emotional engagement as a strength, not a liability. Their talk reflects a relational ethics of care grounded in empathy, presence, and quiet resistance to dominant discourses of detachment and containment. In this way, situated agency is enacted by stretching the limits of the roles available to them – not rejecting biomedical norms outright, but reworking what it means to be a "good nurse" within them.

4.6. Conclusion

This chapter explored rich qualitative insights obtained within the FRDA (Thompson et al., 2018), specific to the discursive patterns and individual voices that were emphasised by the participants within their reflective interviews. Overwhelmingly, this pointed to a pervasive sense of *compromise* that troubled and challenged the participants' intentions and ability to provide more comprehensive care for women presenting with symptoms of a threatened miscarriage in local EDs across Aotearoa. This was detailed within the overarching discursive realm: "*ED is a double-edged sword": Compromises in acute care*, that considered how the dominance of a biomedical discourse stifled opportunities for wider emotional and psychosocial care. "*We don't love pregnant women in ED": Systemic shortcomings* detailed gaps in clinical guidelines that dismiss and devalue women's experiences of threatened miscarriage and reproductive health more broadly, alongside gendered assumptions of nursing practice. Here, the participants position nurses as ambivalent agents restricted by systemic assumptions that fall short of women's wider needs in this context. "*You've got to put a cap on it": Professionalism and emotional containment* explored the more acute constraints of the ED setting, specific to professional boundaries and emotional labour that troubled the nurses' capacity to deepen their care. In response, the participants emphasised a discourse of professionalism to justify emotional containment and secure a positive identity within their practice. Finally, "*I'm going to take care of you": Situated agency and relational resistance* explored how the participants renegotiated these constraints into adaptive and patient-centred care practices, and the ability to "stay soft" despite assumed norms of coping and clinical practice. In redefining these norms, the participants demonstrated their capacity to reframe their role and resist the cynicism associated with emotional labour in the ED – upholding vulnerability, openness and relational care.

Within these discursive patterns, the identified voices of: *discord, humanity, professionalism, caution, tenderness, purpose, hostility*, and *apprehension* expressed a complex set of conflicting positionalities, that highlighted how wider social, political and institutional assumptions complicated their care work in this context. The next chapter will provide a discussion of these findings in relation to the wider literature, considering their implications and recommendations for further critical exploration.

Chapter Five

Conclusions

5.1. Introduction

The aim of this study was to critically explore ED *nurses' accounts* of their care encounters with women experiencing a threatened miscarriage in a local ED in Aotearoa, considering how the participants drew on cultural understandings as they made sense of their role and constructed personal/professional boundaries in their accounts of caring for women with pregnancy complications. My research contributes to this under researched area by attending to the healthcare provider perspective (Jensen et al., 2018; Freeman et al., 2024). I adopted a relational prospective of care, spotlighting emotional and relational practices and interactions within particular contexts and in relation to wider social norms and discourses. In doing so, I understand these as shaping women's experiences of acute care in ED, alongside their outcomes and future expectations of healthcare services (Due et al., 2018; Trostian et al., 2022).

In line with this view, I undertook a Feminist Relational Discourse Analysis (Thompson et al., 2018), which allowed me to foreground how the participants negotiated institutional pressures, gendered expectations, and the moral weight of pregnancy loss. This approach to data analysis illuminated forms of emotional labour and situated agency that are not captured in existing research on miscarriage care or emergency nursing, specific to clinical settings across Aotearoa. The findings contribute new insights into the emotional, relational, and structural dimensions of healthcare in a context that has received little scholarly attention.

Within this relational perspective, my own experiences of multiple miscarriages reinforced a conceptualisation of miscarriage as *more than a medical event,* that speaks to the intimate ties between miscarriage and motherhood and the wider emotional and moral significance of a potential pregnancy loss (Layne, 1990; Parsons, 2010). As such, I included an attention to the established societal structures and assumptions that collectively silence an *unspoken motherhood* – that is, the importance of women's wider emotional and psychosocial needs in the experience of a threatened miscarriage (MacWilliams et al., 2016; Zucker, 2021). Further, a critical feminist epistemology supported complex and diverse understandings of the political, social and cultural relationships and responsibilities that shape women's stories, and a research endeavour *with* women and *for* women through affirmative and evolving accounts of embodied experiences (Braidotti, 2008; Fine, 2017; Oakley, 2016). This approach actively made space for my unique positionality within the research – both personally and professionally – through a relational co-construction of knowledge that challenges dominant schools of thought by upholding a partial, embedded perspective and deep appreciation of the care encounters that inform this context (Greenberg et al., 2021; Haraway, 1988).

My analysis was guided by the following questions: (1) What *discourses* do the ED nurses draw on in their accounts, including gender and cultural discourses? (2) How do they *position* themselves, patients, and others in these accounts? (3) What are the implications of *power relations* in the professional relationship/encounter and beyond? FRDA (Thompson et al., 2018) explored these questions in depth, highlighting the overarching discursive patterns that inherently shape clinical care practices and power dynamics in the acute setting, alongside an understanding of how the ED nurses responded to social, cultural and gendered assumptions and environmental constraints. As such, the analysis illuminated an overarching discursive realm: "*ED is a double-edged sword: Compromises in acute care*. This realm highlighted an ongoing tension in emergency nursing practice specific to threatened miscarriage, through a constant renegotiation of a dominant biomedical discourse that implicated systemic assumptions in prioritising and responding to women's reproductive health, clinical scopes of practice, and emotional labour in the ED. Within this, were three marked discursive patterns that demonstrated how the participants paid attention to wider systemic inequalities in the ED's response to pregnancy complications, navigated and understood their clinical practice, and constructed situated agency in their care work: "*We don't love pregnant women in ED": Systemic shortcomings*; "*You've got to put a cap on it": Professionalism and emotional containment*; and "*I'm going to take care of you": Situated agency and relational resistance.*

Together, these discursive patterns shed light on the research questions – underlining the social, cultural and gender discourses that informed the participants' care encounters, alongside the complex ways these encouraged a constant renegotiation of power dynamics in the clinical setting. This discursive work also considered how the ED nurses positioned themselves – through their clinical persona, in light of systemic shortfalls, and as women, mothers and frontline care workers who responded in emotive ways to the patient's wider needs. Further, the individual "I poems" and voices identified in phase two of FRDA (Thompson et al., 2018) explored these more deeply. The shared voices of: *discord; humanity; professionalism; caution; tenderness; purpose; hostility*; and *apprehension* storied the inherent conflicts and relational complexity of their care encounters with women experiencing a threatened miscarriage in the ED setting. In doing so, this multi-layered relational analysis was able to reveal complex tensions and situated accounts that have not been previously articulated in the literature.

Collectively, the research findings point to the presence of emotional and relational understandings of threatened miscarriage that extend *beyond* established biomedical assumptions and systems of care, and necessarily complicate the ED nurses' own understandings, responses, and resistance to the established institutional, social and cultural frameworks that structure their care work. The participants shared a pervasive acknowledgement of the moral and emotional signifiance of potential pregnancy loss for their patients, in recognition of the *emotional* emergency it represents for many women that challenged the existing societal assumptions that tend to silence and invalidate women's wider needs when accessing acute care (MacWilliams et al., 2016; Parsons, 2010; Zucker, 2021). Despite this recognition, the findings show the structural constraints on open acknowledgement and their ability to respond accordingly, as well as how they navigate and sometimes resist these limitations.

Across the four discursive patterns I discussed in the previous chapter, I noted overarching themes, including insights on: *The boundaries of biomedical discourse; The extremes of the ED; Gendered assumptions in nursing practice;* and *Systemic shortfalls in women's reproductive healthcare*. In what follows, I discuss each of these in turn in and explore the importance of the research findings in relation to the existing literature, alongside the research limitations, implications and recommendations for future critical exploration in this context.

5.2. The Boundaries of Biomedical Discourse

The overarching discursive pattern: "*ED is a double-edged sword": Compromises in acute care* pointed to the persistence of biomedical constructions of miscarriage and the maternal body in the participants' workplaces, as in Aotearoa's medical settings more broadly (Davis & Walker, 2010). In doing so, the capacity to respond to the emotional and psychosocial aspects of perinatal mortality was limited, considering the overarching institutional and societal frameworks that marginalise a more comprehensive response (Layne, 1990). Therefore, the participants were left to navigate the tension between biomedical and emotional care discourses, in how to interact with and adequately care for women experiencing threatened miscarriage in the ED. The tension itself, that was expressed by the participants through their discord, frustration, confusion and hostility towards current systems and assumptions, was the critical thread that maintained an underlying (albeit compromised) *relational* understanding of potential pregnancy loss (Browne, 2025).

As such, despite the constraints of everyday biomedical practice in the ED setting, the participants were actively aware of the unique meaning and value embedded in miscarriage and the wider "emotional emergency" (Klein et al., 2012) it presented for their patients (Wright, 2018). While Edwards et al. (2018) illustrated that women and their partners were "hyper-aware" of provider attitudes and a willingness to support both emotional and physical needs related to pregnancy complications, the insights from my study suggest a *shared* awareness from the provider perspective. Illuminating the discursive tension and participants' sense of compromise to meet these wider needs offers a powerful counterpoint and a multi-layered understanding, in response to current literature that highlights patient's largely negative experiences of accessing emergency care (Freeman et al., 2020).

Together, the participants' depicted threatened miscarriage as an *exception* to the "standard" cases in ED, associated with increased conflict to a typical biomedical response. Here, the constraints of overarching biomedical systems and established procedures and responses in the ED limited the ability to adapt to unique care needs, detailed within the discursive pattern: "*You've got to put a cap on it": Professionalism and emotional containment*. For example, the boundaries of their professional scope of practice created a sense of deceit and discomfort for the participants in deferring crucial conversation to doctors – despite their role as the frontline care provider (Freeman et al., 2020). These compromises from the provider perspective align with wider reflections from patient's experiences that detail a lack of transparency, confusion, uncertainty, and delayed or disjointed care within the ED (Emond et al., 2019; Freeman et al., 2020; MacWilliams et al., 2016). In considering established provider understandings of emotional support practices, the boundaries of clinical practice appeared to reduce the participants' capacity to access their psychosocial skills and resources, in listening, counselling, validating, and addressing and mitigating guilt due to the interactional limitations that were enforced within a biomedical perspective (Freeman et al., 2024; Griffin et al., 2021).

The individual voices of *professionalism* and *caution* the participants associated with the boundaries and assumptions of clinical practice pointed to the prevalence of a biomedical perspective, that maintained uneven power dynamics in the ED setting. That is, by leaning into a medicalised response to early pregnancy complications, the patient's wider emotional and psychosocial needs were minimised – reinforcing a constrained understanding of women's reproductive bodies through problematic biomedical discourses of preconception, pregnancy, and motherhood (Andipatin et al., 2019; Budds, 2021; Marshall & Woollett, 2000). For instance, the reliance on clinical systems and processes in the acute response signalled an alignment with a neoliberal "managing risk" repertoire that continues to position blame on women for "abnormal" pregnancy complications which fall outside of normative ideals of a healthy, successful pregnancy (Bommaraju et al., 2016: Budds, 2021). This approach indicates a continuation of patient experiences of feeling silenced, sidelined and invalidated in Aotearoa's EDs, when nurses are caught within the dismissive aspects of established biomedical discourse (MacWilliams et al., 2016; Meaney et al., 2017).

Further, even when attempting to actively care for the distress associated with the loss of an anticipated life (the would-be baby) and maternal identity, the pragmatic, present-day focus of a biomedical discourse did not allow for this (Parsons, 2010). This was presented as outside of the participants' scope of practice as nurses, for instance: "We'll do that tomorrow… that's the future you" (Claire). Yet, the participants demonstrated awareness of this compromise, through the construction of threatened miscarriage as "life changing" (Yvette) thereby acknowledging the gravity of this experience for their patients, irrespective of the diagnostic outcome. This construction of miscarriage as a more holistic and personally pivotal experience was troubled by the dominance of a biomedical lens within the context of an acute care setting. For instance, the neccessity to triage and prioritise clinical resources based on physical symptoms within the assumption that triage is "not a psychosocial decision" (Lucy). This biomedical stance was problematic for the participants, pointing to a shared understanding that general emergency providers do not respond with an appropriate sense of urgency (Wong et al., 2003).

Yet, on the other hand, the constant exposure to threatened miscarriage as a common ED presentation was described as encouraging a desensitisation that favoured physical conceptions of the event, reinforcing the biomedical framing. For example: "you kind of just do think about it as like another abdominal pain or another sprained ankle" (Sylvie). This finding aligns with Dainty et al.'s (2021) depiction of miscarriage as commonplace to healthcare professionals in contrast to a uniquely significant experience for women faced with potential pregnancy loss – highlighting a fundamental mismatch between patient and provider perspectives that is maintained by a biomedical discourse.

The expectation that healthcare providers perceive patients primarily as "flesh and blood" (Yvette) in response to physiological needs, indicates a systemic inability to consider and respond to diverse emotional, social, and cultural needs in the ED. Considered in relation to Aotearoa's bicultural context, this finding echoes Currie and Barber's (2016) insight that nurses are frequently viewed as overly rational/technical and that women lack access to specialised cultural support (Benner et al., 2009). Further, the dominance of biomedical framing focused on physical care helped sustain a lack of adaptation to Indigenous knowledge and cultural needs within reproductive healthcare, perpetuating Māori perceptions of hospitals as compromising spaces when their spiritual and cultural beliefs are overlooked (Espiner et al., 2021; Le Grice & Braun, 2016; Wilson & Barton, 2012).

5.3. The Extremes of the ED

The participants described the rushed, chaotic clinical environment in the ED, that compromised their capacity to provide emotional care. This description aligns with patient's perceptions of the ED as busy, overwhelming and lacking the privacy and amenities to comprehensively attend to their emotional distress (Freeman et al., 2020; See et al., 2020). Patients participating in research have previously expressed their agitation at the "absolutely horrendous" (Meaney et al., 2017, p.4) conditions the ED presents in the experience of threatened miscarriage. My findings indicate that these conditions are deemed similarly "horrible" (Lucy) for the participants themselves, preventing them from offering, and sometimes having to signal their lack of availability for, extended relational care. The participants shared a collective construction of the sadness related to the limited time to prioritise these patients, and supported a view of somewhere "better, quieter" (Lianne) and with more capacity for emotional support than the ED for these women.

As such, the participants' discursive work depicted a set of adaptive care practices to subtly soften their care and counteract the chaos of the emergency setting. Such accounts imply that current approaches are insufficient. They also recognise the personal implications of pregnancy loss and admit the importance of an *unspoken motherhood* for their patients (Wright, 2018). For example, expressing validation at triage that: "you've done the right thing to come in" (Sylvie). This purposeful approach resists biomedical constructions of care and further, offers a positive counter to research that cites the uncertainty women experience surrounding the ED's role in their obstetric care, as well as shaming or dismissive behaviour from ED staff (Baird et al., 2016; Rojas-Luengas et al., 2019).

Yet, the heavy emotional landscape of the ED, particularly considering the acute distress associated with potential pregnancy loss, aligned with a complex set of "feeling rules" (Kirk et al., 2021) in how the participants' expressed their response to emotional labour. They depicted a conscious distancing between their professional and personal selves, by "putting a cap on it" (Sylvie). As such, the construction of these self-protective processes in response to an under-resourced, outcomes-based environment in this context reflected an understandable, yet complex barrier to the provision of more comprehensive emotional and psychosocial care (Jensen et al., 2018).

However, the discursive pattern: "*I'm Going to Take Care of You": Situated agency and relational resistance* explored how the participants discursively transformed aspects of "emotional labour" into empowered "emotion work" (Griffin et al., 2021) by upholding the rewards and unique privilege of caring for women at such a such a critical juncture – shouldering an invisible load and "gifting" their own emotional resilience in the nursing labour process (Bolton, 2000). Here, the associated voice of *purpose* in the participants' accounts of situated agency develops a nuanced understanding of how they attended to the compromises of their care work, considering how the ED setting's priorities, functions and environment is at odds with women's wider needs in this context (Freeman et al., 2020).

5.4. Gendered Assumptions in Nursing Practice

The findings point to underlying political assumptions, that maintain miscarriage as a deeply gendered phenomenon in the clinical setting (Browne, 2025). Throughout, my research offers a detailed understanding of how the participants navigated gendered assumptions of nursing practice and attended to heavy emotional labour in the ED, specific to the context of pregnancy complications (Dean et al., 2024; Kirk et al., 2021). For instance, the participants constructed an intuitive understanding of *women caring for women* in this context, reflecting wider assumptions in nursing practice of a female-led workforce carrying out "women's work", that is further emphasised in gynaecological care (Bolton, 2005). Therefore, the identified voices and embodiment of *humanity* and *tenderness* aligned with traditionally gendered nursing ideals of compassion, connection and warmth (Kirk et al., 2021). Further, the adoption of gendered assumptions and a shared womanhood was depicted by the participants through their affirmation of reproductive choice and decision-making through the inference that "women see it that way" (Rebecca). With the nursing profession's deep roots in maternity care, this positionality echoed a purposeful social movement in promoting women's empowerment and autonomy when accessing clinical care (Rabelo & Silva, 2016). Through this lens, the participants accounted for more diverse familial and socioeconomic backgrounds and different meanings of pregnancy loss, that actively made space for unwanted pregnancies and demonstrated an attention to reproductive justice in the ED that challenges the portrayal of women as a homogenous group (Morison, 2023; Price, 2019). As such, this discursive work provides a promising counter to the mismatch between provider assumptions and women's psychosocial needs that was observed by Corbet-Owen and Kruger (2001) in a South African setting.

However, the acute context of the ED introduced a unique conflict between gendered assumptions of nursing practice, through the depiction of more "masculine" expectations of task-based care, toughness and stoicism (Kirk et al., 2021). This approach was highlighted in the participants' discourses around emotional labour, in developing resilience and the ability to emotionally disconnect: "I've trained myself that, walk out the door and that's it" (Yvette). In maintaining a professional face and conducting care work at a distance, this troubles the existing literature that women feel silenced, sidelined and invalidated in their accessing care for pregnancy complications (Bolton, 2001; MacWilliams et al., 2016; Meaney et al., 2017). Yet, these insights make sense through underlying institutional expectations to develop maturity and coping skills within their care work in the ED, that aligns with an aversion to the psychological impacts associated with moral injury (Dean et al., 2024).

Further, the participants expressed perceptions of their patients' own inclination to act "chill" and "show up" (Lucy) in the clinical setting that reinforces wider accounts of women containing and restricting their emotional response to pregnancy complications in Aotearoa (Currie & Barber, 2016). This signals the prevalence of societal scripts of shame and silence surrouding miscarriage, that implicate the patient's capacity to interpret their own experiences, alongside the gendered assumptions that complicate the provider's emotional response (Saadi, 2020).

5.5. Systemic Shortfalls in Women's Reproductive Healthcare

Sitting alongside the participants' depiction of the tension and inherent compromises associated with a dominant biomedical discourse, was an underlying voice of *discord* and *hostility* against the system's inability to adequately prioritise and respond to women's reproductive healthcare needs in the ED. This construction was centred on a belief that women's unique reproductive healthcare needs were broadly devalued, in that "women really get left in the lurch" (Christine). The participants' speculation that "they're *not* female doctors" (Rebecca) who diminish wider emotional and psychosocial care in the ED pointed to a dominance of males as doctors and decision-makers, in maintaining gender inequalities in clinical resourcing and established care practices (Hay et al., 2019). These inferences consider historical and political structures of Western patriarchal power that perpetuate ingrained ideals of womanhood with motherhood, and in doing so, sideline the need to comprehensively acknowledge and support "abnormal" pregnancy complications and wider reproductive care (Bartky, 1998; Browne, 2025; Ulrich & Weatherall, 2000). The participants also depicted a "she'll be right" (Rebecca) response to women in the ED, that aligns a stoic, laid-back national identity already linked with poor sexual health statistics (Braun, 2008). As such, these systemic assumptions translate to patient perceptions of seeking acute care for pregnancy complications as helpless and fearful, in a system innately geared towards "normal" pregnancies (Currie & Barber, 2016).

The systemic discrepancies in caring for pregnancy complications also surfaced more acutely in the participants' discursive work around the inadequacy of clinical guidelines. Exploring how these embedded structures of Western patriarchal power continue to dismiss and devalue everyday experiences of threatened miscarriage in Aotearoa, offers a critical lens to account for the current gaps in clinical guidelines, resourcing and established care practices in this setting. For example, the participants depicted an uncomfortable positionality in blindly navigating the more intimate aspects of their care work and learning through a process of trial and error. These insights align with international findings that emergency healthcare providers feel under-equipped in attending to the social and psychological needs of miscarriage, that maintains a lack of clinical guidance and specialised training within EDs in Aotearoa (Edwards et al., 2018; Engel & Rempel, 2016; Freeman et al., 2020). Yet, this discomfort was expressed less acutely by the participants who had institutional access to the support of 24-hour dedicated Women's Assessment Unit (WAU), reinforcing the perceived benefits of a specialised approach to early pregnancy complications beyond the ED setting (Wendt et al., 2012). The remaining participants depicted an idealised view of somewhere *other* than the ED, with the skills and resources to offer more emotional support. This demonstrated that the participants were acutely aware of the need for sensitive and community-specific care in response to early pregnancy complications, through specialised services that appropriately cater to women's psychosocial needs (Edwards et al., 2016; Meaney et al., 2017).

As such, a current lack of specialised care and resources was amplified in the ED, considering the participants' intimate conversations around "plannedness" of pregnancies, viability, and dealing with pregnancy products. For instance, the participants' confused and "mortified" positionality in response to the absence of clinical guidelines when attending to patient's products of conception spotlighted critical systemic shortfalls in relation to Indigenous reproductive practices in the ED (Le Grice & Braun, 2016). These insights align with evidence of limited cultural knowledge and confidence in initiating tikanga for wāhine Māori within wider nursing practice, alongside a growing reliance on international nurses who may have insufficient cultural training (McLean et al., 2024; NCNZ, 2024).

Likewise, training and familiarity around pregnancy viability and termination presented treacherous interactional ground for the participants, through the voices of *caution* and *apprehension*. These shortcomings appear to reflect the continuation of taken-for-granted cultural standards and normative ideals of "successful pregnancy" through a lack of institutional focus into more diverse personal meanings and significance assigned to pregnancy (Bommaraju et al., 2016). As such, a surface-level understanding of "intentionality" was depicted within Aotearoa's public reproductive health conceptions of pregnancy, in lacking a more nuanced response to individual emotions and cognitions that constrained women's reproductive rights and decision-making in the ED, as highlighted in Reproductive Justice scholarship (Macleod, 2016; Morison & Mavuso, 2022). This is an important step forward, in offering research that promotes a systemic critique from a reproductive justice perspective, unique to Aotearoa's diverse sociocultural context.

5.6. Reflections

As I have indicated, this research is shaped by my perspective as a woman and mother who has personally experienced miscarriage; this positionality traverses my overall approach, reading of the literature, interactions with the participants as practitioners in this context and, ultimately, how I interpreted and presented the qualitative insights (Haraway, 1988). As a woman who desperately *wanted* to achieve healthy pregnancies, I may also represent a limited viewpoint that focused my attention in a particular direction. A reproductive justice lens may require making space for *unwanted* pregnancies within the research and more actively exploring this possibility to resist the assumption that all pregnancies should be responded to in a particular way and inadvertently reinforcing the portrayal of women as a homogenous group (Morison, 2023; Price, 2019). Yet, within this situated feminist methodology, it is recognised that all researcher perspectives come with advantages and limitations. There is also a possibility that a research agenda born from my own experiences can help generate unique knowledge, producing deep insights and appreciation of the underlying perspectives that inform the participant's care encounters (Greenberg et al., 2021).

Reflecting on the composition of the participant group, the mean age of 42.4 years old within the present sample is broadly indicative of the wider nursing population in Aotearoa (mean age of 50.3 years; NCNZ, 2023). Further, their relevant experience within six different EDs across the country allowed for diverse insights in relation to resources, ED settings and services, and the local communities they serve. However, the absence of wāhine Māori participants is important, considering Aotearoa's bicultural context and my commitment to affirming research for Māori within the tenets of Te Tiriti o Waitangi – to develop and elevate distinct Māori knowledge in relation to reproductive health, and cultural safety in Aotearoa (Hudson et al., 2010). While I took time to explore cultural and spiritual understandings of *whakatahe* (miscarriage) from a *mātauranga Māori* perspective, these insights were compromised by the dominance of Western perspectives and understandings favoured by the NZ European participants and me, as a Pākehā researcher. This was particularly evident in how the participants vocalised their lack of cultural knowledge in this context. Upon reflection, I could have probed more deeply to link these reflections to existing understandings that Māori perceive hospitals as often confronting and compromising spaces in relation to their unique spiritual and cultural needs (Espiner et al., 2021; Wilson & Barton, 2012). The research offers limited insights specific to wāhine Māori and their whānau accessing acute care for a threatened miscarriage, and this is a critical consideration for future research on this topic in Aotearoa.

Another pertinent consideration in relation to the participant characteristics and how this shaped the data that were generated is the career stage of the participants. All the nurses who participated in my research were relatively senior, with at least ten years of nursing experience. It's possible that at this career stage they may be more adept at handling emotionally sensitive cases and have developed assumptions and reflections in relation to caring for cases of threatened miscarriage (for instance, Rebecca's views on gendered inequalities and negligence towards female patients). Relatedly, the participants of course were volunteers with an interest in research on women's reproductive healthcare – perhaps, with personally situated experiences surrounding miscarriage and/or an awareness of the insufficiencies of the care they are able to offer. Research with nurses newer to their practice and the ED setting would highlight different issues, for instance, interactional learnings and adjustments to care in this context that considers how graduate nurses adapt and respond to established systems and processes, alongside shifts in their foundational training, such as cultural awareness.

Finally, another aspect that is important to reflect on is my positionality as a potential (or actual) colleague to my participants in my role as a Peer Support Worker in Whakatū (Nelson) ED. This undoubtedly shaped how I approached the research through the lens of an insider within the same clinical environment. Through my professional work in this capacity, I have witnessed the dedication and determination of ED nurses operating in a stressful and often severely understaffed context. As such, I have built an admiration for their *mahi* (work) that motivated my desire to avoid a deficit-based or critical (as in evaluative) approach to the study as a whole. This shared professional identity shaped both our interactions in the interviews and my own interpretations. While this connection may have helped to develop richer insights and reflections from the participants through our collective understanding of the ED setting, it is necessary to also highlight how this alignment impacted the research findings. For example, considering how I may have perceived their care work and storied this differently if I only had my own personal experiences as a patient accessing care in the ED as my primary point of reference.

5.7. Implications

My research responded to a lack of literature from the provider perspective by purposefully attending to the complexity of assumptions, perspectives, and emotional and relational care practices associated with threatened miscarriages in the acute setting (Jensen et al., 2018; Freeman et al., 2024). By adopting a relational perspective and critical feminist epistemology as a counter to the pervasive biomedical focus in existing research, my findings offer a deeper, more nuanced exploration of how miscarriage is interpreted and responded to within intimate care encounters (Freeman et al., 2020). Further, this approach actively considers how provider expectations and assumptions inevitably shape patient understandings, experiences and outcomes (Lyons & Chamberlain, 2006).

FRDA (Thompson et al., 2018) allowed a rich exploration of the ED nurses' unique perspectives, that highlighted power-laden discursive systems within the healthcare landscape. For example, a depiction of the overarching institutional and societal frameworks that privilege a biomedical discourse in the ED setting, and in doing so, curtail the participants' capacity to respond to the emotional and psychosocial aspects of perinatal mortality in complex ways (Layne, 1990). Detailing the participants' discursive tension and compromise within these implied constraints provides a crucial counterpoint to the established literature on patient's largely negative experiences of accessing emergency care

(Freeman et al., 2020). Based on these experiences, and in the absence of healthcare provider perspectives, it may be possible for patients, and others, to infer that nurses are uncaring or unaware of their emotional distress. My findings suggest that this is not necessarily the case and highlights the importance of a contextual and relational perspective that attends to surrounding power relations (Morison et al., 2025; Urry et al., 2021). Further, these insights offer detailed understandings of how the participants navigated gendered assumptions of nursing practices and attended to heavy emotional labour in the ED, specific to the context of pregnancy complications (Dean et al., 2024; Kirk et al., 2021). Finally, embedded historical, political and sociocultural structures of Western patriarchal power were illuminated through systemic assumptions that dismiss and devalue experiences of threatened miscarriage and women's reproductive healthcare more broadly, offering a critical lens to account for the current gaps in clinical guidelines, resourcing and established care practices in this setting.

5.8. Recommendations

As such, the findings substantiate a crucial need for increased clinical resources, guidelines and training to support emergency care providers in attending to pregnancy complications in the ED more comprehensively. This attends not only to more detailed scripts and support surrounding triage, discharge, treatment and diagnostic conversations, but also an investment in specialised workforces and tailored reproductive healthcare services that are better equipped to adaptive emotional and psychosocial care in this context. Further, wider institutional frameworks are implicated in the current dominance of biomedical systems and approaches, whereby the adoption of a more holistic understanding of patient's diverse needs produces opportunities for relational care practices, cultural responsiveness, and increased reproductive justice and decision-making in the acute setting. Together, these changes also seek to reduce to the invisible emotional load that ED nurses in Aotearoa currently shoulder, in navigating a deeply compromised response to threatened miscarriage.

In expanding the present findings, further critical, feminist and relationally orientated research endeavours are encouraged in Aotearoa, to develop a collective body of knowledge unique to our national and local healthcare landscape. It is also necessary to explore Kaupapa Māori and narrative methodologies to meaningfully incorporate Indigenous perspectives specific to threatened miscarriage in the ED, that build on existing knowledge and highlight critical aspects of culturally adaptive clinical practice (Le Grice and Braun, 2016; McLean et al., 2024). Further, there is scope to consider other provider perspectives – such as those of emergency doctors, junior registered nurses, and multidisciplinary teams within established early pregnancy clinics/assessment units to explore a more diverse set of provider assumptions and experiences in this context.

5.9. Conclusion

In this thesis I examined how ED nurses in Aotearoa construct care for women experiencing threatened miscarriage, how they position themselves and their patients, and how institutional and sociocultural discourses shape these interactions. Through FRDA (Thompson et al., 2018), the study demonstrates the dynamic interplay between emotional labour, systemic constraints, and professional identity in acute care. Further, these findings provide a voice to ED nurses, in how they navigate, resist and transform existing constraints towards affirmative and empowering accounts of the provision of acute healthcare in Aotearoa. In doing so, it contributes to scholarship on reproductive loss, emergency nursing, and feminist healthcare research, and highlights opportunities for enhancing culturally responsive, relational care. Ultimately, this research underscores the structural impact of established cultural, social and gender discourses in Aotearoa's ED setting when caring for threatened miscarriage, highlighting the complex ways these constrain and enable clinical care encounters, from the perspective of registered nurses who frontline the acute healthcare response.

Above, a concluding discussion was provided to situate the discursive findings within the broader body of existing literature. The underlying themes of *The boundaries of biomedical discourse; The extremes of the ED; gendered assumptions in nursing practice;* and *Systemic shortfalls in women's reproductive healthcare* were used to detail how this responded to existing provider and patient perspectives of caring for threatened miscarriage in the ED. Across these aspects, the findings depict an alignment between negative patient experiences and the participants' own discomfort with current systemic constraints and clinical practices, that highlights similarities between international settings and EDs in Aotearoa. In doing so, the research's critical, relational approach also adds depth to current knowledge, by offering a more nuanced view of provider identities and assumptions as they relate to historical, political and sociocultural structures of power in the acute healthcare landscape. However, this research was complicated to my own partial perspective – inherently shaped by my personal experience of miscarriage and professional experience working in the ED setting, alongside limitations specific to an absence of Māori participants and the age, experience and vested interests of the registered nurses who were involved. Nonetheless, my findings offer important recommendations for the revision and expansion of existing services, systems and supports for emergency care providers tasked with attending to pregnancy complications. These insights point to a purposeful investment in clinical resources, education and specialised services that necessarily challenges the predominance of a biomedical response and facilitates more holistic, adaptive capabilities in the ED. Further research is recommended, in broadening critical, feminist and relational understandings that also encompass Māori-led metholodogies and wider healthcare provider perspectives.

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Appendices

Appendix 1: Recruitment Poster

Masters Research: Interview study on the relational space between healthcare providers and patients presenting to a local ED with a threatened miscarriage in Aotearoa New Zealand

Call for interview participants

Kia ora, I'm Bella and I'm completing my Masters in Health Psychology through Massey University. I've had my own experiences of multiple miscarriages in an ED setting… and I've also been on the other side, working as a Peer Support Worker at Whakatū Nelson ED. I'm deeply interested in your amazing mahi, and I'd love your help to understand more about your experiences and interactions supporting women experiencing a threatened miscarriage in a local ED here in Aotearoa.

Please contact me if you're interested, and:

- *You're currently employed as a registered nurse within a local Hospital Emergency Department in Aotearoa*
- *Have worked regular shifts for at least six months,*
- *Have cared for at least one presentation of a threatened miscarriage*

**For your own wellbeing, this study excludes anyone with their own personal experience of a threatened or confirmed miscarriage.*

We'll either share a cuppa in person or do this online via Zoom, and you'll receive a **koha of a $40 Woolworths voucher** *for your time.*

Contact: Bella van Hattum [redacted]
Bella.VanHattum.1@uni.massey.ac.nz)

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
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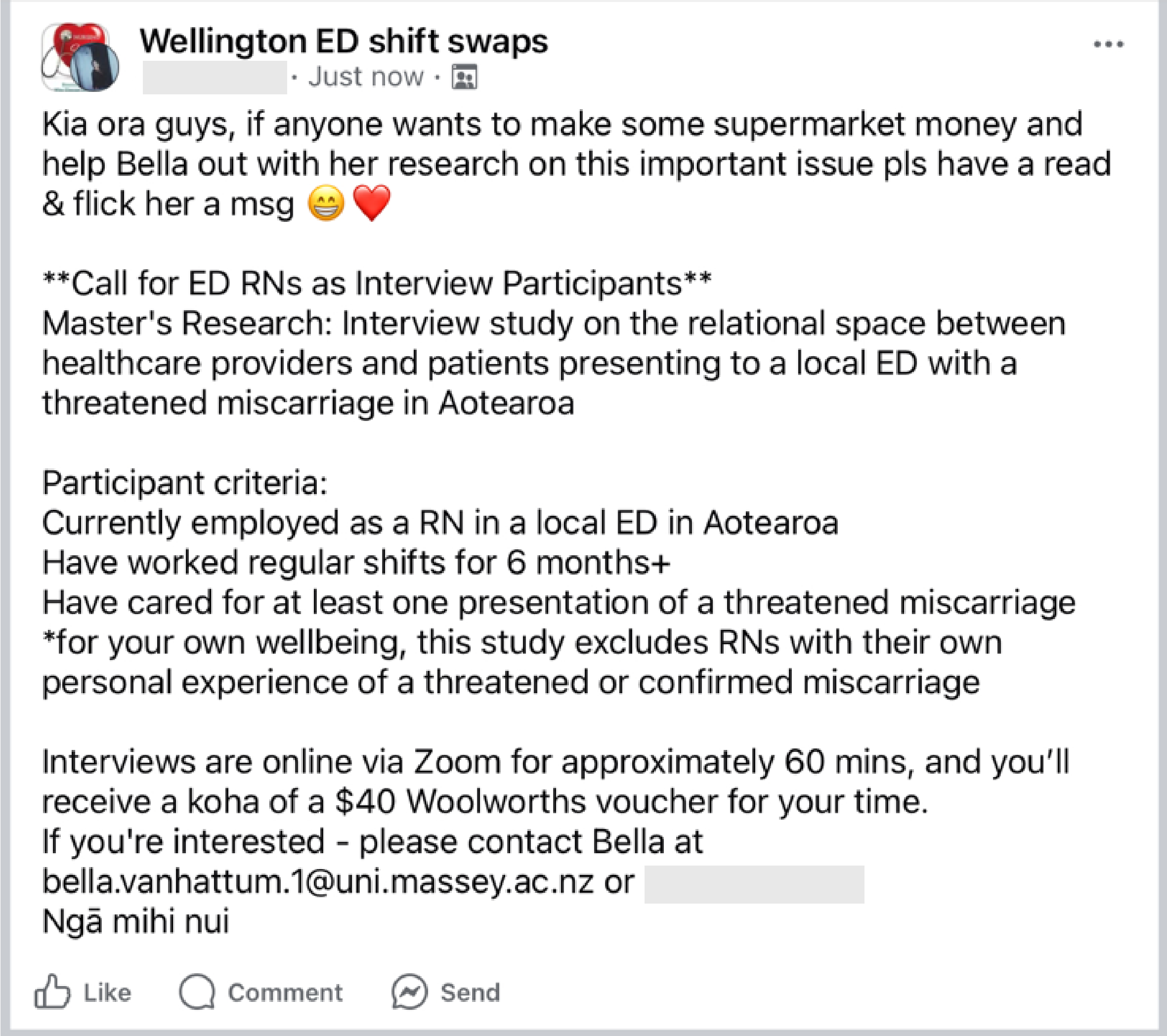
MUHEC Ethics Application: 4000030424
Approved 03/04/2025 (low risk)
humanethics@massey.ac.nz

Appendix 2: Facebook Post (Midcentral Nurse Shift-Swap Community)



Wellington ED shift swaps

[redacted] · Just now ·

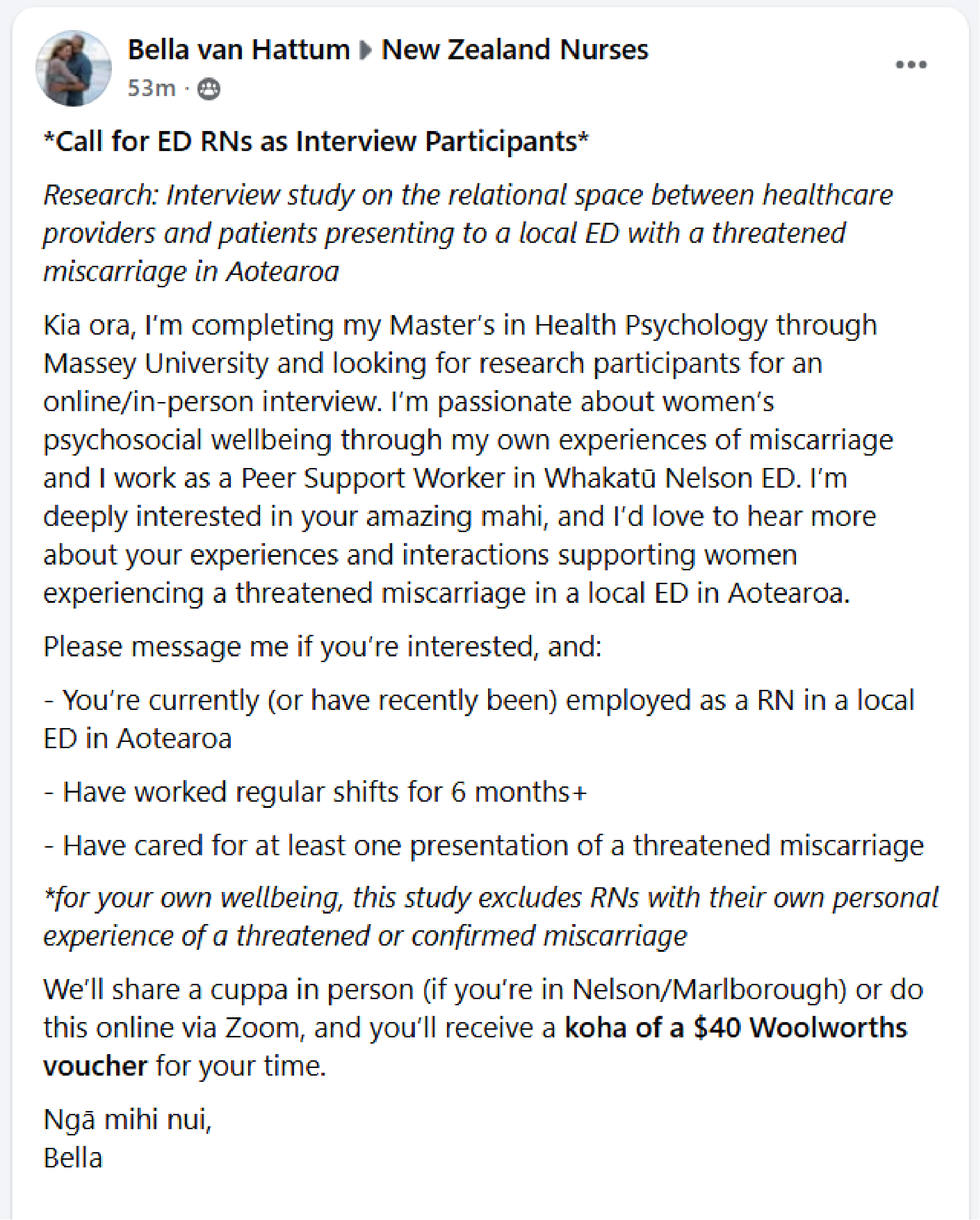
Kia ora guys, if anyone wants to make some supermarket money and help Bella out with her research on this important issue pls have a read & flick her a msg 😁❤️

Call for ED RNs as Interview Participants
Master's Research: Interview study on the relational space between healthcare providers and patients presenting to a local ED with a threatened miscarriage in Aotearoa

Participant criteria:
Currently employed as a RN in a local ED in Aotearoa
Have worked regular shifts for 6 months+
Have cared for at least one presentation of a threatened miscarriage
*for your own wellbeing, this study excludes RNs with their own personal experience of a threatened or confirmed miscarriage

Interviews are online via Zoom for approximately 60 mins, and you'll receive a koha of a $40 Woolworths voucher for your time.
If you're interested - please contact Bella at bella.vanhattum.1@uni.massey.ac.nz or [redacted]
Ngā mihi nui

Appendix 3: Facebook Post (New Zealand Nurses Community)



Call for ED RNs as Interview Participants

Research: Interview study on the relational space between healthcare providers and patients presenting to a local ED with a threatened miscarriage in Aotearoa

Kia ora, I'm completing my Master's in Health Psychology through Massey University and looking for research participants for an online/in-person interview. I'm passionate about women's psychosocial wellbeing through my own experiences of miscarriage and I work as a Peer Support Worker in Whakatū Nelson ED. I'm deeply interested in your amazing mahi, and I'd love to hear more about your experiences and interactions supporting women experiencing a threatened miscarriage in a local ED in Aotearoa.

Please message me if you're interested, and:

- You're currently (or have recently been) employed as a RN in a local ED in Aotearoa

- Have worked regular shifts for 6 months+

- Have cared for at least one presentation of a threatened miscarriage

**for your own wellbeing, this study excludes RNs with their own personal experience of a threatened or confirmed miscarriage*

We'll share a cuppa in person (if you're in Nelson/Marlborough) or do this online via Zoom, and you'll receive a **koha of a $40 Woolworths voucher** for your time.

Ngā mihi nui,
Bella

Appendix 4: Participant Information Form

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PARTICIPANT INFORMATION FORM

Interview study on the relational space between healthcare providers and patients presenting to a local Emergency Department with a threatened miscarriage in Aotearoa New Zealand

Thank you for your interest in this study. Before you decide, it is important for you to understand why the research is being done and what it will involve if you choose to participate. Please take time to read the following information carefully and ask me if anything is unclear or if you would like more detail.

About the Researcher

Kia ora, my name is Bella van Hattum, and this research project forms the final stage of a Master of Science – Health Psychology at Massey University. I grew up in sunny Whakatū and have returned to raise my family after time in Melbourne and Te Whanganui-a-Tara (Wellington). I'm deeply passionate about women's psychosocial wellbeing, specifically, through understandings of motherhood and reproductive health challenges such as infertility, miscarriage and birth trauma. I've experienced multiple miscarriages and pregnancy complications during my journey to motherhood – I now have three busy tamariki (10, 7, 6). If you participate in this study locally, you may also recognise my face from previously working alongside you in the COMPASS Peer Support team, focused on Mental Health and Addictions admissions. Therefore, I have enormous respect for your mahi and the challenging ED environment you work within.

Eligibility Criteria

- Currently (or recently) employed as a registered nurse at a local Hospital Emergency Department in Aotearoa
- Have worked regular shifts for at least six months,
- Have cared for at least one presentation of a **threatened miscarriage**

Exclusion Criteria: For your own safety and wellbeing, please do not participate in this study if you have personally experienced a threatened or confirmed miscarriage.

Project Details

This research is interested in ED nurses' accounts of your interactions with women experiencing a threatened miscarriage, thinking about how you make sense of your role, your personal/professional boundaries and culturally understandings of miscarriage and motherhood. It aims to uncover insights surrounding the unique patient-provider relationship, and what these mean for healthcare encounters, patient/provider experiences and outcomes.

What's Involved?

Taking part in this research is entirely voluntary. If you choose to participate, you will be invited to either a face-to-face interview in a convenient, quiet space, or an online interview via Zoom - depending on your location. This will last approximately 60-90 minutes. If needed, we will do a shorter (30 minute) follow-up interview to clarify themes or complete the interview guide. Before the first interview, you'll need to complete a signed Consent Form, and we'll have time to cover any questions/concerns. During the interview, we'll have a conversation around your understandings, experiences and interactions when caring for women admitted for a threatened miscarriage. You don't need to answer any questions that make you feel uncomfortable and you're welcome to withdraw from the study at any time, without giving a reason. Once I have transcribed and anonymised your interview recording, I will request your approval to ensure you're comfortable for it to be included in my study findings.

What Happens to the Information?

During the interview (and only with your consent), I will record our discussion using Zoom. I'll also be using an AI assistant to transcribe our conversation, and once this has been reviewed and approved by you, the recording will be deleted. All identifying information within the transcript, including your name, others' names, places and other identifying features, will be changed or omitted to protect your anonymity. The final transcribed interviews and your completed consent forms will be password protected and securely stored on Massey University's network, OneDrive – where only myself and my supervisor, Tracy Morison, will have access to the information. Your personal information (e.g., email address, mobile phone number) will also be kept confidential, and deleted at the completion of the research project. In accordance with Massey University policy, the consent forms and transcribed interviews will be held for five years by the research supervisor and then destroyed. The final research findings will be shared with you for your interest, and may be further disseminated through academic publications, forums and conferences.

Participant Rights

You are under no obligation to participate in this research. If you decide to take part, you have the right to:

- Decline to answer any particular question
- Withdraw from the study (at any time, up until your interview transcript has been finalised or analysis of the transcript has commenced)
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used
- Be given access to a summary of the project findings when it is concluded
- Ask for the recorder to be turned off at any time during the interview

Risks/Discomfort

Given the research subject (threatened miscarriage) occurs within your everyday practice and clinical environment, there is no expected harm/risk associated with taking part. However, sometimes talking about more intimate subjects can bring up discomfort and emotional distress. If any question/topic of conversation makes you feel uncomfortable or distressed, you do not have to answer or talk about it, and you are welcome to stop the interview at any stage. Contact details for myself, my supervisor, and information about relevant support services will be made available to you below, so that you can further discuss any concerns that may arise during the interview.

Benefits

You may find it beneficial to reflect and explore your experiences and interactions when caring for women with a threatened miscarriage in the workplace, and further, to contribute to a research project that will deepen understandings of patient-provider relationships and clinical practice in Aotearoa. As a token of appreciation for your time and effort, you will receive a koha of a $50 Woolworths voucher.

Support Services

Free phone or text 1737 – counselling/peer support
Free phone 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)
Free phone 0800 611 116 – Healthline

Sign Up

If you would like to take part in this study, please contact Bella using the contact details below.

Thank you for your time!
Ngā mihi

Contact Details

Researcher
Bella van Hattum
Email: Bella.VanHattum.1@uni.massey.ac.nz
Phone: [redacted]

Supervisor
Prof Tracy Morison
School of Psychology, Massey University
Email: T.Morison@massey.ac.nz
Phone: [redacted]

MUHEC Ethics Application: 4000030424
Approved 03/04/2025 (low risk)
humanethics@massey.ac.nz

Appendix 5: Interview Guide

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INTERVIEW GUIDE

Kia ora, welcome to our interview together!

<Unscripted rapport-building to establish comfort and connection in the interview setting i.e. How has your morning/afternoon been? What shifts/units are you currently working within?>

Are you feeling ready to get underway?

Tēnā koe (greetings)
E mihi ana ki ngā mana whenua (I acknowledge the mana whenua)
Ko Ingarangi te whakapaparanga mai
(engari)
No Whakatū ahau (I am from Nelson)
E mahi ana au hei Kaitautoko ki COMPASS, a ka ako ahau i te hinengaro i whare wananga o Massey
Ko Bella toku ingoa (My name is Bella)
No reira, tēnā koe

As you'll be aware from the participation information and consent forms, this research is focused on the patient-provider relationship within an ED in the occurrence of a threatened miscarriage in Aotearoa local hospital settings.
I am deeply interested in reproductive health and maternal wellbeing, through my own challenges with having a family – I have experienced four miscarriages and a medical termination for a severe birth abnormality all ranging from 4-14 weeks gestation (I also now have three beautiful, healthy tamariki) and I have received care within EDs and surrounding health services in Melbourne. So, I appreciate this a difficult, intimate area to study, and I aim to hold space and sensitivity for your own experiences caring for women in this situation. I am approaching this from a postfeminist perspective that aims to celebrate the diversity and potential of unique understandings and knowledge of miscarriage. Professionally, I am trained in an intentional peer support framework, that centres hope, human connection and mutually led relationships, so I hope to bring some of these qualities to our interview.

The research has been informed by Te Ara Tika and the Massey Code of Ethics to protect us both, in ensuring the integrity of my conduct throughout the project and to avoid any possible harms. You don't have to answer any questions that make you feel uncomfortable and have the right to withdraw at any time – and for any reason, during the interview or before your final interview transcript has been approved by you. I will anonymise and transcribe the interview and share this with you for your review, prior to analysis. I'll also take care to protect your personal data within Massey's secure online platform and delete all records and communication once I submit my final research proposal. Your consent form and transcribed interview will be stored securely by my supervisor for five years and then deleted.

Are you feeling comfortable to proceed? Do you have any questions or concerns?

Fantastic, I will start the recording now, and open the interview with a karakia:

Ma te rongo, ka mohio;
Ma te mohio, ka marama;
Ma te marama, ka matau;
Ma te matau, ka ora.

Through listening comes awareness; through awareness comes understanding; through understanding comes knowledge; through knowledge comes life and well-being.

Questions

1. Background and identity (warm up)

Can you start by telling me a little about yourself and your role as a nurse in the emergency department? *Use probes to* *<u>capture demographics</u>:*

- Age brackets, 18-24, 25-30, 30-40, 40-50, 50+
- Ethnicity
- Anything else you'd to add around how you identify, any disabilities?

Explore length of time in role, passion and pathways into nursing, and any aspects of personal identity the participant feels are relevant.

2. ED Work and Challenges

What are some of the challenges or rewards of working as an RN in the ED generally?

As you know, I'm interested in pregnancy complications specifically. Can we start with the bigger health system picture. Are these patients supported in the system at present?

- Probe: reasons, changes/improvements
- Do you think the ED is the best place for this sort of care?
- What happens at discharge? i.e. referrals/resources/social services

What about when women present with pregnancy complications — how do you approach these cases?

- What do you see your role as in these cases?
- What do you find challenging?
- How do you prepare to care for a woman with a threatened miscarriage, *before* you meet the patient? (probe: what thoughts/feelings does it bring up?) **personal experience of noting this emotional shift in shift handover*
    - What is your mindset, considerations, what relevant medical information impacts this?
- What tools/strategies do you use to create connection or adapt your care? What sort of things do you say?

Other probes, as necessary:

- How do think these women are feeling, in that situation? And how does this impact how you speak and interact with them, and provide their care?
- What makes it different to caring for other presentations in the ED?
- What about their partners or support people with them? How do you create a relationship with them?
    - Is this different if they don't have a support person present?
    - Does a women's age/family status/ethnicity impact your care?

3. Experiences with Threatened Miscarriage

Can you walk me through a time you cared for a woman experiencing a threatened miscarriage?

- What stands out to you about this experience? **clarify if complete/threatened miscarriage*
- How did you interact with her and any support people?
- How did you talk about miscarriage with the patient and her support people? What kinds of language or approaches did you use?

Other probes, as necessary:

- How did you use your body language/touch?
- How did you describe/talk about 'miscarriage' with them?
- How did you end the encounter with them?
- How do you feel reflecting on this? Do these experiences stay with you?

4. Emotions / communicating / connecting

[If not already covered/to probe deeper:]

A threatened miscarriage is obviously very distressing for patients (+ their partners and support people), can you tell me a bit about that aspect and how you negotiate that?

- Do you need to adapt your approach to care in these moments? How so?
- Probe for connection or other approaches (distancing, boundaries)

What kinds of thoughts or feelings come up for *you* in these situations?

- How do you negotiate these emotional aspects of care in these cases?
- Are there ever times you feel a tension between your feelings/responses and the job you have to do? *(i.e. searching for the conflicts/overlap between clinical scope and emotional care/personal beliefs)*
- Do you feel supported to deal with the emotional burden, and to adapt your care?

I'm interested in how cultural views (of pregnancy/pregnancy loss) play a role—can you tell me a bit more about that?

- Are there any examples that stand out to you? *(privacy, permission, communication, bodily products)*
- How do you understand and respond to these? **especially when different to your own culture*
- How does this affect your care or your sense of your role?

5. Closing reflection

What have you learned — about your role or yourself — from these experiences?
Is there anything else you think it's important for me to understand?

Thank you so much for your time today – I truly appreciate it. I'll now close our interview with a karakia and stop the recording so we can discuss next steps.

Kia whakairia te tapu
Kia wātea ai te ara
Kia turuki whakataha ai
Kia turuki whakataha ai
Haumi e. Hui e. Tāiki e!

Restrictions are moved aside, so *the pathway is clear to return to everyday activities. Enriched, unified and blessed.*

<End with reminder of right to withdraw, and follow-up to review and approve transcript. Prompt to take care and access support services in participant information sheet if needed. Reach out for any further thoughts, questions, or concerns>

Appendix 6: Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

CONSENT FORM

Principal Investigator: Bella van Hattum

Interview study on the relational space between healthcare providers and patients presenting to a local Emergency Department with a threatened miscarriage in Aotearoa New Zealand

Thank you for your interest in this study. The data you provide will be used only for research purposes. As a participant, you will never be individually identified in any outputs (e.g., reports, research articles) that arise from this project and your data will never be identifiable to anyone outside the research team.

	Initial Showing Consent
I confirm that I have read and understand the information sheet for this study	
I have had the details of the study explained to me	
I have had opportunities to ask questions, and my questions have been answered to my satisfaction. I understand that I may ask further questions at any time	
I understand that my participation is voluntary and that I am free to withdraw at any time, without providing any reason	
I have received enough information about the study	
I agree that the de-identified transcript and extracts from this may be used in reports and publications arising from the research	
I agree to take part in this study under the conditions set out in the information sheet	

I volunteer to participate in the above-named study.

Printed Name ....

Date……. ....

Signature..

I have explained the study to the above participant, and they have agreed to take part.

Printed Name ....

Date……. ....

Signature..

Appendix 7: Participant I Poems

“*We don’t love pregnant women in ED”: Systemic shortcomings*

Claire

Maybe as a woman, you feel a little, a little bit a tinge if you know what I mean
But you do just, you do absolutely have that little feeling of, oh gosh, you know,
I look at where I was for that age, I think, you know. Um. Gosh! It’s sad.

So you do say, I'm sorry that you're feeling like this today.

I think that every single woman that goes into ED with PV bleeding when they're pregnant, think that they're going to lose their baby.

But then, if somebody came in, say, for instance, with a bowel cancer as a woman, I would also feel bad… I'd also like to hold the hand of somebody who has a stroke, or, you know, that's broken a knee, or, you know, because we care

Lianne

I wouldn't say it's the best place. No. The right place? It depends,
I think it would be nice if they could get assessed initially, perhaps somewhere else

You just feel like, oh, did I do something wrong? Should I have done something more?
I wish we could do more, but I just don't know what to do as well.

I think, when they see that also, they just try to be more quiet in the department, just in respect and being mindful of a person who's possibly, quite possibly grieving, or in the process of grieving,
I don't think that one differs to many other patients

Because I'm a woman myself, and I mean, I haven't had any children or any miscarriages, but you can just, you know, I can put myself in their shoes

And I was just like, Oh, crap. What are we going put this in?
And I would most likely not want to come to the ED for that, just, just because it's, well, yeah, I mean, it's also because it's where, it's where I work, you know

I suppose I am scared that one day I would be going through a miscarriage myself,
Yeah, I'm scared
Because all I know is at this moment, like you know is, is being a nurse to them, I don't, I don't have experience as a mother,
I don't think any amount of experience can really prepare you for going through it yourself

Diana

I'd be the one who initially sees them, and I might put them in a clinic room for some privacy

But I think it's something that, like, I don't know - pregnant women are, like, shielded a little bit from, before it happens.
You know, I've never had a miscarriage, and I can't, you know, imagine what that feeling is like, but I, I do know that I would be devastated if that had happened in my pregnancy.

You can just imagine, what people are going through. What I do when someone's had a miscarriage or a potential miscarriage, is that I'll talk to them first, and then I'll be like, right.
And I think that's like the hard part, is that is that we can't (fix this)

I feel like, maybe our hospitals are less caring than some of those…
I feel like maybe they have a lot more care, as in, like, how kind of nurses used to be, you know, mopping brows

You might not even see that person slip out, depending on what, how busy the emergency department is… I would love to say you get to go say goodbye to that person
You might be in a room with someone else who needs a bag of blood, and you might not even see that person leave.

I think it would just be great if there was more training
I think it's hard for us as well.
I think they do stay with you

Sylvie

There's nothing I can do except, monitor them, make sure they're stable,
Then when there's a bed, I get them upstairs

I do think that ED is probably the right place for them to come.
I think, unfortunately, I do feel that that's the way.

I looked and I could see puddle of blood sitting underneath of her,
I really wanted to get her into the department, because, being out there wasn't alright for her,
I felt like I had to sell her to the charge nurse and the ED consultant to get her a bed inside,
So I just felt, feel like they're always kind of pushed to the side a little bit unless it's something extreme.
Because I felt bad that I had triaged her to the wait room to begin with

I guess it feels good, in a way, knowing that they're going to the place where they should be,
I guess it's just knowing that I can be fast at doing that

I think, and it goes back to, unfortunately, feeling a little bit desensitized to it as well, is that it is part of working in emergency,
I see so much of it that it's just almost, you know, how many abdominals that I see, that it's hard to…
I think I do probably focus on other patients with higher needs,
So I think sometimes we will put that back on the patient's responsibility

Should I give them the statistics?
I think maybe, the education has gotten better out there

Mia

I think if they're pregnant woman and they have any symptoms the first place, they have to come to is ED,
I'm sorry I'm making you wait for so long.
You always think, I never have enough time,
I need to make sure my patient is safe

I spend time and maybe listen to them, but it won't happen all the time.
I'll be anxious too because I don't know what's going now when they rush into the ED, I have to find

out what's going on,
I will work quicker – coordinator, come!
I have to talk, but I will keep away from my patient, I will hide in a corner

And I want to do, I'II keep in mind, this patient, I need to go back to see her,
I will always make a time to make sure

Christine

I mean, it would be ideal if you had some sort of, or even a midwife, or something…
But I think with our initial ED, because it's so small we can't.
I don't think people know that there's actually nothing you can do if they're going to miscarry

I almost feel like she feels, she must hate it when she sees me on shift,
I feel like men have pain in their testicles and it's a, you know, medical emergency, whereas women really get left in the lurch.

I guess maybe they just hide it well, how they're feeling, because I don't know how you could not have those feelings or, you know?

I probably should be more culturally aware and ask them if there's anything else that they need on that side of it,
I still feel a little bit awkward in those situations

Yvette

I suppose it's a starting point.
I have seen this firsthand… is that they are happy, yep, yep, off you go, hurry, hurry, like next one in, kind of thing.
And I've seen doctors do it as well

I think a really important question is actually asking, Is this something that you've wanted?
I think it makes a big difference in an emergency department if there's that knowledge,
It feels different to me personally, because it's not just that person.

I think women caring for women in that regard, is a little bit more, there's more knowledge,
I suppose women in themselves are very strong in not, in suppressing loss like that.

I was like, mortified… what am I to do? What am I? Where am I? What am I doing now?
I'm not a big guru.
One thing I do like to offer is, and I know the doctors hate me doing this, because I've been told not to do it,
I've got no qualms in getting more specialist teams in,
I think also women's, you know, just in general, like, women's sexual health is, in emergency, it's not managed that great

Because I, you know, spiritually, I think there's been a loss,
And I just think that's a bit callous, to be honest.
I know in Australia, they have a lot of courses aimed at just women's health.
I think there's a lot of gaps with women health

Emergency departments in general, I feel, are very poor at debriefing

I think we are becoming a little bit more frank in being honest about how we feel
I think we're becoming a lot more multicultural in New Zealand… But now I think it's gone into a whole different spectrum
So culturally, for me, it's not just about the race of person

I haven't been shown any other way, and I've been told no differently, that I'm doing something wrong. So I'm hoping I'm doing it the right way!

Lucy

And I think that there's a lot, some people use, most people probably do use the emergency department very, very like, appropriately
I think all nursing and medicine is very kind of patient facing, public facing.

I don't think it's the right place at all.
And I think that's kind of inappropriate.
I think ED deals with everything apart from, like, we don't love, we don't love pregnant women.

Like I can't, I can't get every lady who's got PV bleeding and is early pregnancy. I can't take every single person into a little side room and have a proper chat, because I'd never get through my triage.

I would always strive to, to support that decision.
I wouldn't say politics comes into it, but I am very much like I want to support the woman in the choices that they've made,
I think we, all pregnant women or people who've recently been pregnant, we lump into sort of one category

I wonder if the women would be acting differently…
It seems mad to me, but I think sometimes it does like, that idea of having to be like the chill girl who takes it in their stride, actually extends to miscarriage seems bonkers to me, but I do think it's something I've observed.

"*You've got to put a cap on it": Professionalism and emotional containment*

Lianne

I'm not a doctor,
I guess no one was really expecting that to happen right there and then

I don't think I change. Uh maybe I do,
I'll try and help you, keep you comfortable if any way I can.
So oftentimes you don't actually have to actively do anything like medically,

I would say it's a lot of just talking face to face time.
I guess task wise, it's easier, but I wouldn't say that it's not as time consuming

And then I was like, honestly, that question caught me off guard. No one's ever asked me that.
I can't just come right out and say…
But I try to understand, I try to explain to them a little bit,
And you know that they still have that hope, right?

I'm not allowed to talk to you about, that like the doctor will do that.
I would definitely grab them a tissue like, sit with them for a little bit.

So I would say things like, most likely or like, probably like, so try to reassure without getting, without giving definite answers.

I've always kept that in mind, like it's dangerous to think that

You're allowed to be sad, you're allowed to show you care, and that's good for the patients.
You wouldn't, you know, have a full-on breakdown with them,
If you just be respectful all the time, then there's like, no chance of, you know, always, like, ever overstepping the boundary.

Diana

I don't think that there's much to be done so, and I think that's the part that that is hard for us to deal with.
I just think we all struggle with that side more, because it's not as obvious

I think the hard part as a nurse is that you almost don't want to say too much before the doctor sees them,
I don't want to tell someone that they're having a miscarriage before the doctor assesses them
you've got a good idea, you know, you see a lot of it

I do feel like we kind of have to withhold information.
And I wonder if that prevents us from maybe, really getting in and providing support as much as what we could be.
I feel like that, like, I just, yeah, you don't want to put your foot in it.

I think just reassuring them with symptoms,
I guess, bring them back to the present moment.
I know I do when I'm when I'm anxious about something, I can think about all the possible outcomes… I guess I don't say too much

I would never, ever say to someone - you know, like the things, the dumb things that people say,
And I think people take things in different ways.

You're not, you can't diagnose as a nurse, even if you know, you're not meant to diagnose,
You've got to hold back, yeah, that’s the hard part.
I'm asking them, like I'm not, not just doing it, and kind of explaining what we're doing

I think you just, it's messed up that you see so much trauma, badness, have to go to that extreme, to like… because we do go through quite a lot. I think, like you do learn to, ways to deal with that,
I think most of the time, it's incredibly sad, but I know how to not take that sadness on myself anymore.
I'm a bit more resilient.

Sylvie

I just make sure that they're comfortable and just making sure they've got pain relief,
I'm always attentive and just go in and try and answer questions and do as much as I can with the information that I have.
I immediately think it's probably a miscarriage, but obviously it's not confirmed,
So I would never say that to the person

You kind of just do think about it as like another abdominal pain or another sprained ankle,
You start to kind of get in that mindset,
So I definitely feel like, okay, this is tick, tick, tick. It's all sorted

I'm glad I'm not the one that's going to tell them,
I have a pessimistic view of that.
I feel like women that have had previous miscarriages or previous pregnancies, they kind of have an idea, and they know what's going on,
I think some people are just, they also just kind of give you nothing as well.

I guess it's just always just keeping them informed and asking them,
Because you don't want to give false hope
And I can't answer that now, yeah, like I don't,
I absolutely don't say no, no, it's fine. But I also don't say, hmm it's probably a miscarriage

I hope this doesn't make me sound like a bad nurse or anything like that,
I am an empath, like I consider myself an empath, but there also is, I've learned so much you can take on as that, because you can't help save everybody,
So I just kind of put a cap on it and have my nursing hat on when I come home,
I just don't let my mind go there

So I do to look after myself and my mental health, to just end it there,
I know what my like, my scope is, and what my role is for what they've come in for, and there's like a cap on that,
I know what I need to do for this person now. So that's kind of where it ends

Mia

The first thing I do, the vital signs, check and see if there's bleeding,
And then I will ask more questions.
I won't take anything lightly.

I don't want to cause tension and cause more anxiety for the patient, I will remain calm,
It's not my role to say the diagnosis, actually it's out of my scope

And if you need anything, just tell me anytime. No problem.
And I'll explain to her, I'm going to do vital signs, blood test everything, and we're waiting for results

But I was surprised, the boyfriend wasn't there, but the mother was there!
I can see the mother gave me a lot of support when I say something,
I will not mention anything that I think. I will ask them – what do you think?
And I won't give a conclusion. No, that is not my role

So when I see a different ethnicity patient walk in, I will try to detect what's their background
And if you want to touch with them, of course, I think this applies to any patient, if are you okay, I do this for you?
I will say to her, I will be with you, I know this is uncomfortable,
Because what you say and you know the attitude and the way you say to them causes different reactions,
I'm sorry, it doesn't mean…

Rebecca

I just have quite high expectations.
I'm not trying to impress people, but just trying to show them the nurse that I am, or the nurse that I want to be.
I suppose I just try to be myself.
And then I'll sort of move on to, like, the more clinical stuff

And I just thought, oh, far out like,
I suppose I was just seeing it through a different lens.
Why did you say that?

I think I definitely just touched a sore spot and yeah, I just read it, yeah, I just read it wrong.
I kind of feel like honesty is always, honesty is always the best policy,
I've kind of got like a dialog,
So I just kind of like talk to them, without making it seem too, I try not to make it seem too scary

I guess there's a feeling that I can hide behind the clinical stuff, as a way to protect myself.

I feel like, me telling them what I see, what I think could be the problem, and that I'm going to do something about it, is less stressful?
I remember, and I'm just like, I don't know. I'm sorry. I don't.
I never. I never want to be like, I never say oh yeah, you know, you probably are

I try really hard not to say that,
You can't really do too much, you can't say anything, that's for sure, like there's really nothing you can say.
I go in and I speak to the patient directly… I feel like I'm just really, I'm just really there for, really there for the patient,
I guess most of the specific talk is about blood loss and pain,
I just try and keep it open.
I try not to get into the emotional stuff at all.
I just probably feel like I'm going to say the wrong thing

Christine

I just see how the patient is, to be honest.
I kind of just leave them to it…. I feel like I have to take a step back and just leave them to it.

I don't know if that's a English thing or not, but we're quite private about stuff like that, so, I don't really want to feel like I'm sticking my nose in even though, yeah

I've kind of detached a little bit,
I just kind of carry on as normal, to be honest, because I don't, like I said, I don't really want to get too involved emotionally with what they're going through.

I think for the patient, the most reassuring thing can probably come from the doctor
I kind of just leave it literally to the person and the support person to, you know, and if they were to turn around and say something, then I would honour it, but I don't offer it

Yvette

I always pre-warn, like, if I'm triaging, I'll always let them know,
And you have to just keep putting on a brave face until it's delivered by somebody who's either one

of the more senior doctors, because it's not our role to diagnose and it's not our role to be telling people this is, you know,

I try not to have any preconceived ideas about the person.
Sometimes I just, I have to personally dull my personality down,
I just try to be myself, it’s the easiest way

I always gather as much historical information as I can,
I always get them involved [the support person], even if it's saying, go get a glass of water

Because I don't want to, you know, I wouldn't say to them, I don't want to give you the wrong information,
So it's very important to me that I'm not sort of overstepping boundaries

I said, I don't remember that. I did, but I chose, and I've trained myself that, walk out the door and that's it.
I'm usually pretty honest, but it's also about learning about how your priorities,
I suppose there's only so much time that you're able to give somebody
Yeah, it's not something I like to talk about, not just with this topic, but in a context of a lot of different scenarios, just because it's a way of protecting myself as well.

I'm always looking at everybody as the same, as flesh and blood and rather than their culture, because I'm trained to manage clinically an emergency

I just kept going over and over and over. How would you not know? I was like, How can you do that to me?
I like to actually speak face to face with a person,
I'm not a huge touchy-feely person…
I tend to stand at the head of the bed, not at the foot of the bed

I often don't even ask them. I just say, oh, there's some here if you need it,
And I often use a sense of humour

I think you've sometimes you have to allow people to express as well,
There’s not a lot more you can often say.
I'm a big fan giving out literature to people

Lucy

You feel like you really have to be doing things,
I can see like we're asking these questions because they're important to us
And I get that and I'm like, oh, but there's no real other way I can do this.
I think it's kind of that two-pronged thing.

I think primarily I'm worried about them from a clinical standpoint,
It's a clinical thought process for me.
I find myself being guided by the woman

So you feel like you know something they don't.
You don't feel like you can talk to them candidly… I feel really, really sorry for them, and I feel really uncomfortable in that situation, because you kind of feel like you know what's happening, but you're not really sure if they know what's happening.
It feels like you're keeping a secret.
I think we all have an instinct to want to keep our patients well informed, but it's not your place

And I never feel great about that. That's always that's something that I'm almost a bit like, wish that I didn't have to do this…
I'd like to think that I try and do it for everyone, but maybe I do it slightly more,
Sometimes I can feel like it's a little bit, inappropriate maybe isn't the right word

I can remember being like, go away!
You do feel like you can kind of crack on and, like, really do your job,
So you only can do that supportiveness in that time that you are spending with the patient

"*I'm going to take care of you*"*: Situated agency and relational resistance*

Claire

But you can't. You can't show that too much, because you have to be the strength in the room

You learn so much.
You're there in the critical times of people's lives.
So you learn ah one, about how you can cope things.
Because you don't sympathise you empathise – first thing.

I love it, absolutely.

And so you kind of have to either step out, or just take a couple of deep breaths.
Don't go home. Change your clothes as soon as you get home and shower,
So you wear a mask, you know what I mean

And you do get better at pushing off things as you get older.
I don't know if it's a maturity thing, because I've seen a lot of the young nurses be able to do it.
I think it's personality and knowing your boundaries.
You really do, because it's a long learning process.

You do feel proud as a nurse that you can do the things that you can do,
I think the one thing I have learned very early in my nursing career is to look after myself emotionally, because if you can't look after yourself emotionally, you're going to fall apart at every.

You can feel it, don't act on it.

And I always say if I do something that upsets you or you feel I've crossed a border please tell me immediately, because I need to learn from that.
So you've got to feel aware of your therapeutic self is there, because she doesn't want to know that you lost a child last year, or that you haven't had a baby,
You know, I don't go on about this is my journey.

Lianne

So I try to keep them as comfortable as possible until that happens,
I would say that we have a pretty good team

You kind of have a gauge, I guess, about the seriousness it is.
You know, you can, like, almost, sort of, put aside, compartmentalize it maybe a little bit

I think probably the first few times caring for patients like that, I was probably a bit awkward.
Why did I do this? Why did I do that?
I've learned how to, you know, be softer, quieter, just be more mindful what I say or do, and also, I

think, pick up on the cues
I would definitely spend more time with the one that is quite distressed and has no one there with them,
I would prioritise them

You basically just do it and then cringe through it the first few times, and then after that, you be like, oh, okay, yep, this is what I should do, this is what I shouldn't do.

Sylvie

I mean, working in ED can be tiring, and you definitely feel that burnout,
I just felt like it was my time, and just needed to drop back,
So it's been, for me, it's been life changing, dropping down hours

If I can make somebody feel better while they're there, that's a huge benefit about my work.
That's kind of where I get my job satisfaction from

I feel like those pull on my heartstrings a little bit more than other ones,
Those are the ones that I can feel my heart feeling heavy for.
Because, yeah, you can see it,
And I just say that you've done the right thing to come in

I feel like I'm empathetic with all my patients, but I guess maybe I try not to make it look like I feel sorry for them, because I don't want them to pick up on that at all,
But I think I would just probably keep that to myself and treat them all, everyone the same to the care.

I think it's kind of debriefing on the day early on, so that if I've got any kind of feelings or emotions about it, I can talk about it

I'll stay pretty consistent and calm,
I will just make sure that everybody is included in that,
I'll feel like, actually, you’re a team here, and this is all of you

I remember even when I got pregnant, I was like, Oh, I'm probably gonna have a miscarriage, because so many people do,
I was actually, it’s probably not going to stick.
I guess it's just for me. It's just realizing how common it can be.
I can feel for them, you know… and especially people who have been doing and trying and trying this like, my heart feels for them,
Before I had her I might not have thought about it in that way

Mia

So this is why I stick with them for eight years, even though I don't like the city and the people,
But during covid, I think it is enough,
I have very positive feedback from the patients.
But I also get some people that don't like my Asian culture

I will turn my role to like a mother role actually, not really just a nurse,
I will be beside you,
Of course, I need to stay

Oh, you have to be very, very, very careful, more careful,
And I will be more anxious for that

I always tell myself as long as I have done my best,
Then I just give them my blessing.
And I will look back - anything I can do to help, to relieve the stress or to preserve a bit the longer for that patient’s life, I can't, if I can't

If I could, I will think about, OK, I'll keep me in mind next time,
I think that learning is life long.
I have a better resolution, and I will feel better – I’ve learnt something.
You’re expecting that these things happen, but you feel sad at any time, but I know that's life.

Rebecca

I feel like it's just who I am, like who I am as a nurse,
I just feel like in ED I'm like my best self.
And I like the fact that you, you're supported to do all the extra education, and you can really kind of take ownership, ownership of your practice

For me personally, the pressure I put on myself, not to make mistakes,
I find, for me, it puts things into perspective, like just with life as well.
I feel like if I'd had that life experience myself, I might, I might be a better nurse for those people.

I'm usually quite good at leaving, leaving emotional things at the door. Yeah, there’s other things I can't. I can leave the emotional stuff behind.

I feel like I want to see them a bit more, if they're by themselves,
I wouldn't mean to, but I probably would be thinking differently, like I'd be thinking more around, like the do we need social worker?
I don't know how people survive that (IVF)

I feel like I, I'm not as good because I haven't lived that experience,
I can only, like, guess or assume what people go through…
I could not survive that if one of my children died, I could not survive it. And I don't know how people do. I don't know how people live. I don't know how I would live if I lost a child

I don't want to over sympathize or make them feel like, uncomfortable,
I suppose I just assume the role of the clinician who tries to offer everything that I can, but probably not, but not emotionally, I guess.
I'm just there to do a job sort of thing.

Christine

I like ED. That's kind of where I wanted to be.
I actually like the minors more than the resusses and stuff in ED. I like it that, you know, someone comes in with a broken bone, you can fix them and send them on.
You actually feel like you've helped them and treated them

I think it's sad, no matter what you kind of feel the sadness for whoever's going for it, no matter of age or things, even if the person seems completely fine, you still feel sad for them

I think I cut off quite a lot when I'm at work, like I'm really in my own head, they haven't come in here to hear my point of view or my, you know, my life, or anything about me

I guess you could just start by saying, I'm really sorry about your loss.
I would probably linger in the room a little longer just to see if she wants to talk or open up,
I guess it's quite a nice healing way, and a way to say goodbye

I obviously don't want to be laughing and joking and super happy and bubbly.
I think we were more concerned and upset for her,
So I guess it's having, kind of more of a resilience to that emotion

I would like to learn more about how to - I'm not very good at being emotional anyway [laughs] I think that's an English trait,
I guess the more people that you look after, the more times you see it, the more difference you can expect…
And the more that you see, the more that you can explain

Yvette

I found my passion was trying to organize chaos.
It's not something you can just walk into and expect to know in the first year.
I've learned a lot, and I still learn a lot,
You need to be open to learning all the time, and you're always dealing with, yeah, weird and wonderful characters…
Unfortunately, I've had to manage people I know

I'm always somebody that tries to retain as much hope for that person as I can,
I'm usually genuinely apologetic, and will be honest about why, you know this is, that I've just got this, I have to go,
I find that really sad because it's, it's almost defeat, like they've hit defeat

And I think that's the least you can do for somebody.
And I felt very selfish, but then quite happy that everything went well…
I do hope that that person has you know, has gone ahead in life and had a better outcome with, you know

I feel like I’ve got better at it. I'm no guru, but definitely better.
I think that's just comes with my own age and being able to, I suppose there's a better engagement than, say, if I was like 25 and looking after an 18 year old,
I tend not to like ruminate too much on certain things, but in my own head, I know what I've done

But I do think that if you can manage it well, it makes you stronger.
I'm not as scared as I used to be,
I think, it’s just a matter of learning over time, and just more and more exposure to stuff like this

Lucy

You get brought back to the pace and the variety and the camaraderie and it's something very uniquely stressful and challenging place to work, but it's also got some really unique privileges as well,
You do get to experience how like people can be really, really stupid, but people can also be really, really brave and really funny and really caring

I think everything in ED is a double-edged sword, and the challenges are sort of the same as the privileges in many ways,
You feel like you're not able to provide the care you would like to provide

I think that's something very unique about having been witness to a lot of those situations.
I think I do have perspective that I don't know if many of my peers outside of nursing medicine have, because of the work I do and the things I've seen,
I think there's just a sense of, like, reverence for want of a better word, that you kind of you recognise…
I definitely do think it shifts the energy we maybe try to take a little, a little more care

I don't want to take your job [of the support person].
I'm going to take, I'm going to take care of you, I'm going to keep you safe
I'm taking responsibility for this situation now

And you're not concerned or like it's, it's maybe not got the same punch for you anymore. You do think it's really like, it's hard, it's a concerted effort to check yourself in your emotional reaction to those women