Sheffield Teaching Hospitals NHS
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Termination of pregnancy procedures: patient choice, emotional impact and satisfaction with care

Joanne Fletcher

Consultant Nurse Gynaecology

Sheffield Teaching Hospitals NHS Foundation Trust

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Background

- Context of abortion in England
- Stats – E&W
- Sheffield abortion service
- Methods of abortion

Aims of the study

- To investigate whether women felt that they were able to choose their abortion method of choice
- What factors influenced their choice
- What effect their choice had on emotional responses and satisfaction with care

Ethical approval, funding & PPI

- Ethical approval obtained by Yorkshire & Humber NHS Research ethics Committee (REC Ref:15/YH/0345)
- Funding – part funded by Jessop Wing Small Grants scheme & part by STHFT Psychology Dept
- PPI advice sought during development of the study

Methods, recruitment procedure, sample population

Methods 1

- Mixed methods prospective comparative study
- Semi-structured pre-abortion interview and questionnaire
- Post-abortion questionnaire four weeks after the procedure (telephone or via post)
- 8 month period (2016-2017)

Recruitment procedure

- Women identified by nursing staff as being eligible to participate
- Surgical abortion – recruited on day of procedure
- Medical abortion – recruited on day of admission for second visit
- Early medical abortion (EMA) – recruited on day of administration of misoprostol
- Informed consent obtained by research team

Methods 2

Quantitative data collected using:

- Patient Health Questionnaire (PHQ)
- Generalised Anxiety Disorder Scale (GADS)
- Positive and Negative Affect Scale (PANAS)
- Impact of Event Scale (revised) (IES-A, IES-I, IES total)
- Client Satisfaction Questionnaire

Statistical analysis carried out using SPSS

Qualitative information analysed using content analysis by second & third authors

Sample population

- Women between 5 and 18 weeks gestation requesting abortion under Ground C of the 1967 Abortion Act
- 16 years or above
- Exclusions: non English speaking

  pregnant as result of sexual assault

  TOP for fetal abnormality

Results

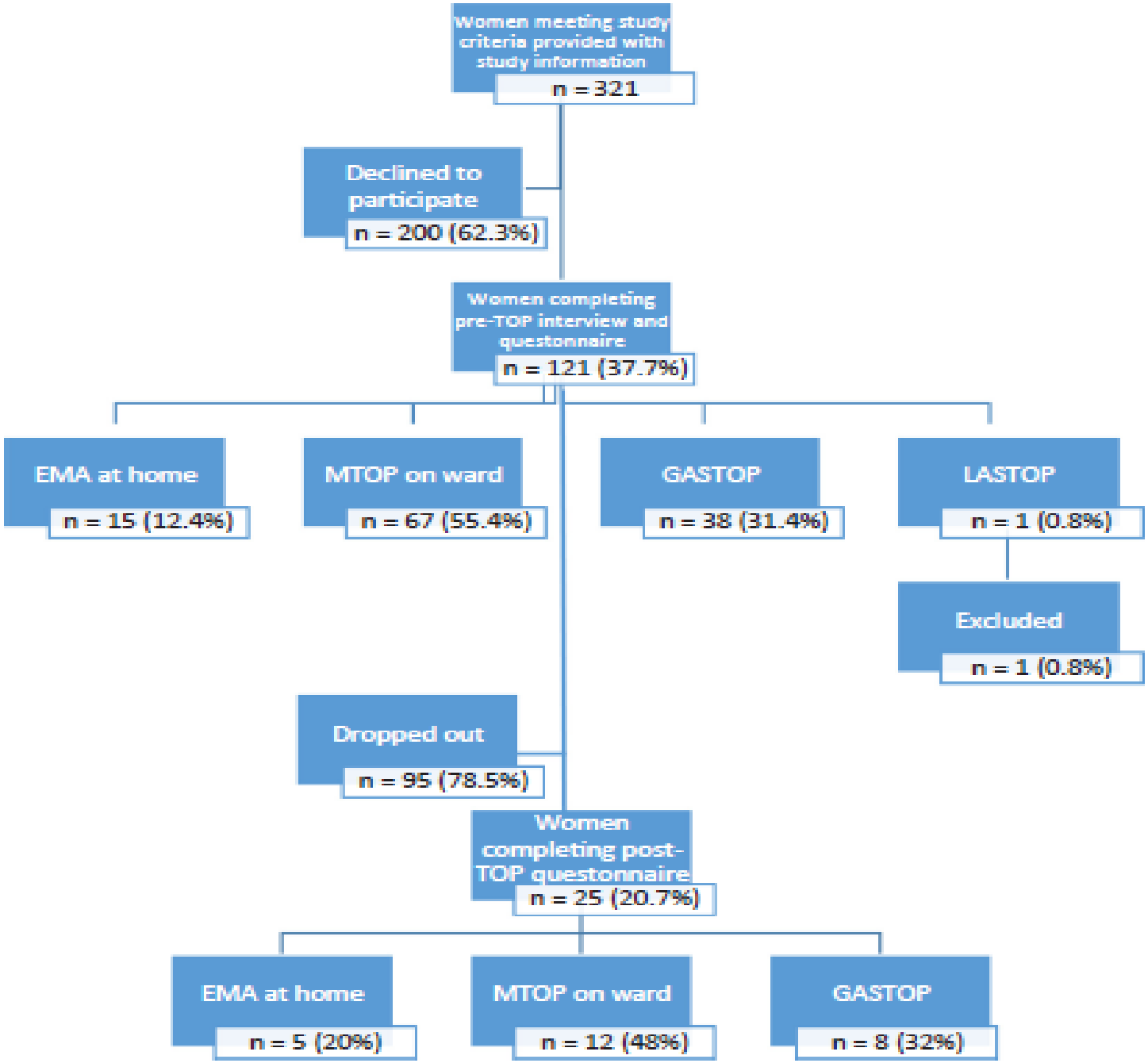

Fig. 1. Recruitment and attrition.

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Demographic pre-abortion results

- N=120 women aged 19-46 years, mean age 26
- EMA at home n=15, MTOP on ward n=67, GA STOP n=38
- Only one woman opted for LA STOP so excluded from analysis
- No statistically significant differences were found between groups for race, relationship status, educational level, employment status, health issues, level of support, waiting time for abortion

Demographics

	EMA at home (n=15)	MTOP (n=67)	GA STOP (n=38)
Ethnicity – highest group = White British	60%	**81%**	71%
Living with partner/ married	**87%**	44%	52.5%
Supportive parents/ family/ partner	**46%**	18%	35%
Employment (full time, part time or self employed)	46%	49%	**63%**
Educational level (mean) (1=no qualification, 7 = doctorate or higher)	**4.00** (SD = 1.31)	3.82 (SD=1.09)	3.97 (SD =0.94)

Pre-abortion emotion based measures

- Median pre-abortion scores were not significant for:

  PHQ

  GAD

  PANAS (positive or negative effect)

- Non- significant trend towards lower levels of depression in women opting for EMA at home

Factors influencing choice

- Multifaceted & varied, grouped into themes:

(1) procedure-related

(2) Life or social circumstances-related

(3) Emotional

(4) Based on any other factor

	EMA at home (n=15)	MTOP (n=67)	GA STOP (n=38)
Procedure related	57% More natural/ like a miscarriage Less invasive	66% Feeling safer in hospital Not wanting GA STOP	**68%** Want to be asleep Wanting IUD/IUS fitting at same time Perceived negative aspects of MTOP (seeing blood, pain, feeling unwell)
Life or social circumstances	**67%** Childcare	43% Quicker than waiting for a GA STOP	37% Convenience
Emotional	20%	43% Anxiety Lack of support Seeing fetus	**50%** GA STOP less traumatic Not seeing fetus Not having to witness or acknowledge being part of TOP procedure
Any other factor	7% Needle phobia	3% Needle phobia	

Comparison of post abortion emotion-based responses (4 weeks post abortion)

- N=25 (79.2% attrition rate) – no statistical analysis (EMA n=5, MTOP n=12, GA STOP n=8)
- Women in **GA STOP** group scored higher on **PHQ, GAD & PANAS negative affect, IES-A, IES-I, IES Total score** – indicating higher levels of depression, anxiety, negative effect, avoidance and intrusion than women in the other groups
- Women undergoing **MTOP** had lowest scores overall (except for PHQ – EMA at home)

Procedure related data

- EMA at home – rated procedure as more stressful, more painful, more distressing due to pain, most disruptive to daily activities
- MTOP – heavier bleeding
- STOP – bled for longer

- MTOP (50%) most likely to choose same procedure again – contrast to *Slade et al (1998)* where 77% would choose GA STOP

Patient choice

- 109 (90.8%) believed they had been able to choose their preferred method
- EMA at home (100%), however least likely to choose again
- MTOP – 57 (85%) indicated it was their choice. 10 (15%) women thought they had no choice (related to gestation, no GA STOP availability)
- GA STOP – 37 (97%) indicated it was their choice
- No choice = rated procedure more stressful

Patient satisfaction

- All groups highly satisfied with care (GA STOP → EMA at home→ MTOP)
- Women who felt they had a choice of procedure were generally more satisfied with their care

Discussion, limitations of study & implications for practice

Discussion

- Study design replicated earlier study of *Slade et al 1998*
- Introduction of EMA at home gives new method to analyse
- Trend towards lower level of pre & post abortion depression in EMA at home group
- No new evidence suggesting pre-abortion emotion based factors influenced procedure decision, however switch from GA STOP to MTOP to choose method again & GA STOP had least favourable outcomes overall

- All 3 groups had more favourable PHQ, GAD & PANAS scores post abortion →supports theory that women making complex decision to have an abortion do not suffer subsequent negative effects *(Kero etal 2004, Toffel et 2006)*
- EMA at home – lowest post abortion anxiety & depression despite reporting increased stress & pain during the procedure →? Due to social support at home, increased privacy, personal control & integrity

- Generally, if women are able to have method of choice, they rate satisfaction with care higher
- Service constraints/ lack of surgical availability impacted on patient choice
- Ability to access a method sooner may be greatest influencing factor of choice
- Procedure related factors play an important part in choice for all groups *(similar to findings by Cameron et al 1996, Slade et al 1998)*

Limitations of study

- Initial recruitment only 37.4%
- Attrition rate of 79.2% at follow up
- Only one woman was recruited from LA TOP group

- Low rate of participation and high rates of attrition possibly due to perceived burden of taking part in the study, unwillingness to be followed up or have contact post abortion (*replicates Slade et al 1998, Kero et al 2004*)
- Introducing choice of post abortion follow up (post or telephone) did not improve attrition rates

Implications for practice

- Improve access to all methods so women have full control of choice
- Allow nurses/ midwives to perform surgical abortions *(Sheldon & Fletcher 2017)* → improve waiting times and give more flexibility
- Future research should consider how attrition rates can be reduced – involvement of PPI group throughout research process

Conclusion

Conclusion

- No evidence to suggest that pre abortion emotional factors influence choice of abortion
- Post abortion it could be argued that women having GA STOP have least favourable outcomes
- Majority of women thought they had a choice of method and this related to increased satisfaction with care
- Better understanding of patient experience can inform service development

References

Cameron S, Glasier AF, Logan J, Benton L, Baird DT. Impact of introduction of new medical methods on therapeutic abortions at the Royal Infirmary of Edinburgh. BJOG: Int J Obstetr Gynaecol 1996.;03(12):1222-9

Slade P, Heke S, Fletcher J & Stewart P. A comparison of medical and surgical termination of pregnancy: choice, emotional impact and satisfaction with care. BJOG: Int J Obstetr Gynaecol 1998;105(12):1288-95

Kero A, Hogberg U, Lalos A. Wellbeing and mental growth – long term effects of legal abortion. Soc Sci Med 2004;58(12):2559-69

Toffel E, Pohjoranta E, Suhonen S, Hurskainen R, Partonen T, Mentula M, et al . Anxiety and quality of life after first trimester termination of pregnancy: a prospective study. Acta Obstetrica et gynaecologia Scandinavica. 2016;95(10):1171-80

Heath J , Mitchell N & Fletcher J. A Comparison of termination of pregnancy procedures: patient choice, emotional impact and satisfaction with care. Sexual and Reproductive Healthcare 19. 2019: 42-49