National Audit of Induced Abortion 2000

Report of England and Wales
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1 INTRODUCTION

The abortion audit is a national survey of clinical practice in England and Wales. It was undertaken as a baseline from which to evaluate change, prior to the publication of the RCOG Evidence-Based Guideline No. 7, The Care of Women Requesting Induced Abortion.¹ This is the first such national overview of the provision of abortion services.

The RCOG Guideline¹ was published in March 2000. Its aim is to ensure that all women considering induced abortion have access to a service of uniformly high quality. It is hoped that the Guideline will be implemented across all relevant healthcare sectors and will promote a consistent standard, regardless of the sector in which an individual woman is managed.

Clinical guidelines may be defined as systematically developed statements to assist practitioners and patients in decisions about appropriate health care for specific clinical circumstances. Clinical guidelines may address either conditions or procedures. Priority areas include major causes of morbidity and mortality, uncertainty about the appropriateness of healthcare processes or evidence that they are effective in improving patient outcomes. The guideline development process includes:

- multi-disciplinary working groups
- the development of focused questions
- systematic review of the research evidence
- link of the research evidence to the clinical practice recommendations
- explicit methodology
- external peer review prior to publication.

The national guideline can be used as the basis for the development of local protocols or guidelines, taking into account the needs and preferences of the local population. Such local adaptation should ideally take place in a similar multidisciplinary group.

Induced abortion is one of the most commonly performed gynaecological procedures in Great Britain. Around 180 000 terminations are performed annually in England and Wales.³ At least one-third of British women will have had an abortion by the time they reach the age of 45 years.¹ Over 98% of induced abortions in Britain are undertaken because the pregnancy threatens the mental or physical health of the woman or her children.²⁴

Unwanted pregnancies occur because women are unable to regulate their fertility by contraception alone. The complexities of managing sexual behaviour and the fallibility of contraception mean that some unwanted pregnancies are inevitable. The causes of unwanted pregnancies and the reasons why legal abortion remains a healthcare need have been clearly summarised by the Birth Control Trust in their document Abortion Provision in Britain¹ published to mark the 30th anniversary of the 1967 Abortion Act.
The Guideline Development Group viewed induced abortion as a healthcare need and supported the concept that abortion services should be an integral part of broader sexual health services.

Access to NHS abortion provision varies considerably. The clinical management of women requesting abortion spans a number of care sectors and involves a range of professionals. In England and Wales in 1998, of a total 170 145 abortions, 86 414 (51%) took place in NHS hospitals, 37 472 (22%) were funded by the NHS under agency arrangements with charitable sector providers and 46 259 (27%) were obtained privately. Access to NHS abortion provision varies considerably. The clinical management of women requesting abortion spans a number of care sectors and involves a range of professionals. In England and Wales in 1998, of a total 170 145 abortions, 86 414 (51%) took place in NHS hospitals, 37 472 (22%) were funded by the NHS under agency arrangements with charitable sector providers and 46 259 (27%) were obtained privately. There are large regional variations in funding arrangements. In 1997, only 19 of 105 English and Welsh health authorities funded 90% or more procedures, while 48 funded less than 75% and in the Thames Region, for example, only two of 26 health authorities funded more than 75%. By comparison, in Scotland in 1998, over 98% of terminations took place in NHS hospitals.

The aim of the audit is to improve the quality of care for women requesting induced abortion in England and Wales. The audit provides an evaluation of practice prior to release of the Guideline. This will help to inform the implementation of the Guideline by highlighting where current practice does not concord with the recommended practice and will provide a mechanism to monitor the impact of the Guideline on clinical practice. The data presented here represent current practice as reported by the lead clinician in each unit at the time. Calculations assume 100% compliance with the unit's policies, although this is likely to be an overestimate of actual practice. They also assume that all women are treated the same within a unit, regardless of their source of funding.

It should be noted that there is considerable variation in the number of procedures undertaken by different providers. The average size of unit is also different between the different sector providers. The specialised non-NHS providers have large units (in general performing thousands of procedures per year), the NHS has intermediate-size units (performing hundreds of procedures per year) and the private sector has small units that may perform less than ten procedures per year. The findings are presented within these categories to facilitate estimation of the likely number of women affected by a policy.
2 METHODOLOGY

A postal survey of all abortion-service providers in England and Wales was undertaken, using a questionnaire to describe what and how abortion services are provided and to evaluate the quality of these services against the clinical practice recommendations in the national evidence-based Guideline.

The questionnaire was based on draft criteria from the RCOG Evidence-based Guideline *The Care of Women Requesting Induced Abortion*. To facilitate completion, semi-structured and closed response questions were used. The questionnaire was piloted on Scottish consultants and the 14 members of the Induced Abortion Guideline Development Group.

Providers of abortion services were identified using data supplied by the Department of Health. The name of the clinical director for gynaecology or the lead clinician for each provider was verified directly with the provider. The questionnaire was sent out to this individual in November 1999.

Reminders and a copy of the questionnaire were sent to non-responders after six weeks. Larger centres, performing over 200 procedures, also received a telephone reminder. Central offices of the private hospitals were contacted to encourage these hospitals to return the questionnaires. The cut-off for responding was ten weeks after the initial mailing.

Data were entered manually with 100% verification for accuracy. All hospitals that informed us that they no longer performed abortions were excluded. A coding frame was developed for free-text answers. Quantitative and categorical data analysis was performed using STATA v6.0 (Stata for Windows; statistical software package, version 6.0. Stata Corporation).
3 RESULTS

3.1 RESPONSE RATES

Three hundred and forty one units from England and Wales were originally contacted. However, 17 units no longer performed abortions and were excluded, leaving a final sample of 324. Two hundred and thirty units responded to the survey, giving overall a 71% response rate (Table 3.1).

The units responding to the questionnaire tended to be the larger units and it is estimated that these units performed about 85% of the abortion procedures in England and Wales in 1998. One hundred and ninety one of the respondents (83%) provided an estimate of the number of procedures performed per year and the median number of procedures from this was 400. From these data, the units undertaking the largest number of terminations per year were the specialised non-NHS providers. The average number of procedures per year performed by the specialised non-NHS providers was 5598; 425 procedures per year in the NHS and ten procedures per year in the private sector units.

There was a statistically significant difference ($P < 0.05$) in response rates between the sector providers. Private units carrying out fewer procedures had a lower response rate. However, only the larger units had been contacted by telephone to encourage questionnaire response.

Table 3.1 Response rates

<table>
<thead>
<tr>
<th>Provider</th>
<th>Questionnaires sent ($n = 324$)</th>
<th>Respondents ($n = 230$)</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>247</td>
<td>176</td>
<td>71</td>
</tr>
<tr>
<td>Specialised non-NHS</td>
<td>19</td>
<td>17</td>
<td>89</td>
</tr>
<tr>
<td>Private</td>
<td>58</td>
<td>37</td>
<td>63</td>
</tr>
</tbody>
</table>

The audit data presented here are based on the service providers. Practice is described by unit, although units vary considerably in both size and the number of procedures performed per year and therefore the impact on the population by each unit is not equivalent. The unit size does vary between the sectors as described above and, where possible, the sector comparisons are given.

It has been assumed that the description of services given by each unit is representative of the service provided for all patients, irrespective of the origin of the funding for the procedure. Direct comparisons between the services provided to NHS patients compared with those provided to non-NHS patients is problematic, as the specialised non-NHS providers provide services to both NHS and private patients. In order to facilitate inter-sector comparison, the specialised non-NHS-provider sector is therefore identified separately.
3.2 ORGANISATION OF SERVICES

3.2.1 Choice of abortion method
For the purposes of the questionnaire, the cut-off date between early and late abortion was defined to be a gestational age of 13 weeks. This cut-off was used because statistics from the Office for National Statistics for 1998 show that 89% of all legal abortions were carried out at less than 13 weeks of gestation.

Where appropriate, women presenting in early pregnancy (at less than nine weeks of gestation) should have access to a choice of surgical or medical methods of abortion (Table 3.2). Early surgical abortion was the most commonly reported termination method available, offered by 176 units (77% of respondents).

Of the 194 units with facilities for abortion before 13 weeks, both medical and surgical termination was provided by 64 units (33%). Among the 130 units where only one method is available, surgical termination was the only option in 112 units (86%).

Of the 171 units with facilities for abortion after 13 weeks, both medical and surgical termination was provided by 42 units (25%). Among the 129 units where only one method was available, medical termination was the only option in 102 units (79%).

Table 3.2  Choice of method of induced abortion in different sectors

<table>
<thead>
<tr>
<th>Choice in different sectors</th>
<th>Total (n)</th>
<th>NHS</th>
<th>Specialised non-NHS</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Early</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>82</td>
<td>72</td>
<td>41</td>
<td>9</td>
</tr>
<tr>
<td>Surgical</td>
<td>176</td>
<td>131</td>
<td>74</td>
<td>11</td>
</tr>
<tr>
<td>Both methods (&lt; 13 weeks)</td>
<td>64</td>
<td>56</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td><strong>Late</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>144</td>
<td>139</td>
<td>79</td>
<td>5</td>
</tr>
<tr>
<td>Surgical</td>
<td>69</td>
<td>47</td>
<td>27</td>
<td>15</td>
</tr>
<tr>
<td>Both methods (&gt; 13 weeks)</td>
<td>42</td>
<td>37</td>
<td>21</td>
<td>5</td>
</tr>
</tbody>
</table>

3.2.2 Maximum gestation
One hundred and twenty-seven units reported a maximum gestation for medical abortion of over 13 weeks, 122 (96%) of these units being NHS providers. Thirty-eight units reported a maximum gestation for surgical abortion of over 13 weeks (Table 3.3).
3.2.3 Provision of management guidelines

One hundred and eighty-five units (80% of respondents) had written protocols for the management of induced abortion in their clinics. Of these units, 181 (98%) reported these protocols to be accessible to all health professionals involved in the service. There was not a significant difference between the providers with regard to having written protocols, or – among those who had them – the availability of the protocols.

The Royal College of Obstetricians and Gynaecologists’ internal guideline (known as ‘greentop’ guidelines) on induced abortion was published in July 1997. This guideline included the recommendation that women requesting abortion should be offered an appointment with a gynaecologist within five days of referral and should undergo the abortion procedure within seven days of the assessment appointment.

Clinicians in 206 units (90% of respondents) were aware of the existence of the greentop guideline. Of these units, 136 (66%) reported adherence to recommendations on referral and assessment times. Clinicians in NHS units were more likely to be aware of the greentop guideline than private or specialised non-NHS units. Specialised non-NHS units were the least likely to be aware of the greentop guideline (P = 0.03). Among units who were aware of the greentop guideline, private clinics were much more likely to report that they adhered to it than either NHS units or specialised non-NHS clinics.

3.2.4 Clinic facilities

Units were asked to define their services as either dedicated/specialist abortion clinics or general clinics that may see women requesting induced abortion alongside women attending for other gynaecological or antenatal care (Table 3.4). Units may run clinics of both types (i.e. the distinction is not mutually exclusive). One hundred and twenty nine units (56%) saw and assessed women in mixed or general gynaecology clinics, while 123 (54%) had dedicated hospital clinics or special abortion clinics. Six units did not answer this question.

Among the units covered by the specialised non-NHS sector, the availability of dedicated abortion clinics was greatest and the likelihood of women being seen in a mixed clinic was lowest. Among the private units, women stood a greater chance of being seen in a mixed gynaecological or antenatal clinic.

### Table 3.3 Units carrying out abortions after 13 weeks

| Type                  | Medical | | Surgical |
|-----------------------|---------|---------|
|                       | n       | %       | n         | %       |
| NHS                   | 122     | 96      | 21        | 55      |
| Specialised non-NHS   | 5       | 4       | 12        | 32      |
| Private               | 0       | 0       | 5         | 13      |
3.2.5 Inpatient services

It has been recognised that daycase management of abortion services can minimise disturbance for women and is a cost-effective model of service provision. Collection of data on the number of patients requiring inpatient beds is necessary to plan the likely staffing requirements and to audit the quality and consistency of care provided.

Only 100 units (43%) provided an estimate of bed occupancy rates (Table 3.5). Of those that reported inpatient figures, 15 units (15%) reported that no patients require inpatient services, while nine (9%) reported that 100% of patients required inpatient services. The median reported value was that 5% of patients required inpatient services. The private providers that gave figures had the lowest average proportion of women requiring inpatient stays.

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Median % of patients requiring inpatient services</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>5.0</td>
</tr>
<tr>
<td>Specialised non-NHS</td>
<td>7.5</td>
</tr>
<tr>
<td>Private</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Ninety nine (43%) out of the 230 respondents gave one or more reasons for a possible inpatient stay. A total of 227 reasons were given; there were conflated into the four categories shown in Table 3.6.

<table>
<thead>
<tr>
<th>Reason for inpatient stay</th>
<th>Units (n = 230)</th>
<th>Units (%)$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical indication</td>
<td>132</td>
<td>57</td>
</tr>
<tr>
<td>Hospital organisation problems</td>
<td>55</td>
<td>24</td>
</tr>
<tr>
<td>Social indication</td>
<td>53</td>
<td>23</td>
</tr>
<tr>
<td>Complications of abortion procedure</td>
<td>14</td>
<td>6</td>
</tr>
</tbody>
</table>

$^a$ percentage totals may exceed 100% since units could give more than one response.
3.2.6 Counselling and special needs
Counselling has been defined as ‘the process of enhancing a subject’s ability to assess and understand the index situation, evaluate options and make an informed choice or decision. This entails sensitive provision of comprehensive information in a non-directive or non-judgmental manner’.7 The provision of counselling is viewed as an essential element of fertility regulation services.7 Women requesting induced abortion may need support to understand the implications and consequences of their choice. The Guideline Development Group has recommended that services should have access to experienced counsellors and should be able to refer the minority of women who may require specialist help. Counselling provision is shown in Table 3.7.

Table 3.7 Provision of counselling

<table>
<thead>
<tr>
<th>Counselling Provision</th>
<th>Units (n = 230)</th>
<th>Units (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor only</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Nurse counsellor/social worker</td>
<td>83</td>
<td>36</td>
</tr>
<tr>
<td>Specialist referral</td>
<td>111</td>
<td>48</td>
</tr>
<tr>
<td>Did not answer question</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

Translators were available at 154 units (67%). Limited provision for visually impaired clients was available; 22 units (9%) reported having audiotape facilities available. One hundred and thirty-eight providers (60%) reported that a female doctor was available.

Other types of provision for special needs that were reported included:
- sign language
- wheelchair access
- language line
- typetalk.

3.3 INFORMATION FOR WOMEN

Both women seeking abortion and health professionals involved in the provision of this service need easy access to information on the provision of induced abortion services. It is important that all information shared in the initial consultation is backed up with good quality, accurate, impartial, written information that is easy to understand and well presented. Information on abortion services for health professionals was reported to be readily available by 138 (60%) of the survey respondents. There were no significant differences between the sectors. One hundred and eighty-nine units (82%) were able to name a place where information on abortion services was provided for women seeking an abortion. The most common places for such information are shown in Table 3.8. Forty-one units (32 NHS, two specialist non-NHS and seven private providers) were unable to name any such source of information.
Patients given written information are more likely to express satisfaction with the patient–health professional relationship.\(^8\) To be easily accessible to those who have limited understanding of English, have limited literacy or are visually impaired, the information may need to be available on an audiotape and in an appropriate range of languages to suit local racial representation.

One hundred and sixty units (70\%) reported that they provided ‘printed impartial information’ addressing issues related to the termination of pregnancy (Table 3.8). Information addressing issues of confidentiality was provided by 105 units (46\%). Information on possible complications and longer-term sequelae was also reported to be available in 142 units (62\%).

### 3.4 PRE-ABORTION MANAGEMENT

**3.4.1 Blood tests**

Three units did not answer the question about pre-abortion assessment. All other 227 units checked haemoglobin, rhesus status and blood group and/or saved serum.

The Guideline Development Group recommends that it is not cost-effective to carry out routine crossmatching for women undergoing abortion, since only 0.2\% of patients are estimated to require blood transfusion. In those rare instances where blood transfusion is required, the most cost-effective strategy is to initiate crossmatching on the basis of a newly submitted specimen of the woman’s blood.

The audit found that only 26 units (11\% of respondents) routinely carried out crossmatching. However, 11 private sector units (29\%) and five specialised non-NHS units (29\%) crossmatched routinely, compared with only ten (5\%) of the NHS units.

Rare conditions such as haemoglobinopathies and HIV should only be assessed when there is clinical reason to do so. The audit found that only four units (2\%) in England (one in London, three outside) carried out routine HIV screening. One hundred and three units (45\%) reported selective HIV screening, in line with the recommendation.
with the recommendations from the Guideline Development Group. Routine screening for haemoglobinopathies was carried out by 127 units (55%).

The maintenance of clear and adequate documentation is a necessary part of good clinical practice. Documentation of anti-D immunoglobulin G (IgG) should be recorded in the notes of non-sensitised rhesus D-negative women following abortion as part of quality assurance and this should be audited. In 141 units (61% of respondents) the documentation of anti-D was audited in the patients’ notes (Table 3.9).

Table 3.9 Audit documentation of anti-D

<table>
<thead>
<tr>
<th></th>
<th>NHS (n = 176)</th>
<th>Specialised non-NHS (n = 17)</th>
<th>Private (n = 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit documentation of anti-D</td>
<td>95 (54)</td>
<td>17 (100)</td>
<td>29 (78)</td>
</tr>
</tbody>
</table>

3.4.2 Cervical cytology
The audit found that 145 units (63%) took a cervical cytology history at initial assessment. Of these units, 112 (77%) provided a referral policy or co-ordinator to ensure that all abnormal results were managed and 133 (92%) contacted women with abnormal results.

3.4.3 Ultrasound scanning
During the three-year period 1994–96, one death as a direct consequence of a legal abortion was reported through the Confidential Enquiries into Maternal Deaths in the UK.11 On the basis of this one case, the CEMD report contains the recommendation that: ‘Ideally, all women should undergo ultrasound examination before termination of pregnancy to establish gestational age, viability and site’.

The Guideline Development Group was of the view that, while ultrasound scanning may be useful in pre-abortion assessment, its use was not mandatory in all cases. However, abortion services must have access to appropriate ultrasound facilities for those women for whom ultrasound scanning is clinically indicated.

The audit found that ultrasound facilities were available at the assessment clinic in 217 units (94%) (Table 3.10). Clinicians at 97% of NHS units had access to ultrasound services, compared with 81% and 94% at private and specialised non-NHS units, respectively.

Of the 194 units offering early abortion, 86 (44%) performed ultrasound scanning routinely. Among the 171 late-abortion providers, routine scanning was carried out by 126 (74%). There was no significant difference in the early or late routine scanning practices between providers.
Of the 217 units with an ultrasound service, 57 (26%) offered a service dedicated to women seeking an induced abortion.

Units providing ultrasound scanning selectively reported various clinical signs that would encourage a health practitioner to carry out a scan. The most commonly reported clinical signs were uncertain dates and borderline gestation.

Table 3.10 Clinical indications for ultrasound scanning

<table>
<thead>
<tr>
<th></th>
<th>Units (n = 140)</th>
<th>Units (%)^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertain dates</td>
<td>108</td>
<td>77</td>
</tr>
<tr>
<td>Borderline gestation</td>
<td>112</td>
<td>80</td>
</tr>
<tr>
<td>History of abnormalities</td>
<td>64</td>
<td>46</td>
</tr>
<tr>
<td>Other(^b)</td>
<td>30</td>
<td>21</td>
</tr>
</tbody>
</table>

^a percentage totals may exceed 100% since units could give more than one response; \(^b\) ‘other’ included: patient ambivalence regarding termination of pregnancy, pelvic pain, nuchal fold (13/40), bleeding, suspected ectopic pregnancy or twins

3.4.4 Prevention of infective complications

The Guideline Development Group was of the view that all abortion services should have in place some form of strategy for reducing the risk of post-abortion infective sequelae. Post-abortion infection may result in the long-term sequelae of tubal infertility or ectopic pregnancy,\(^12\) as well as causing morbidity in the immediate post-abortion period. Incidence rates among the control groups in trials of prophylactic antibiotics for abortion suggest that infective complications occur in up to 10% of cases.\(^{12-18}\)

A satisfactory policy is to provide all patients with prophylactic antibiotics or to take a genital swab from all patients and to provide antibiotics to all women or to those with a positive test. Overall, 76% of providers had an acceptable policy, with the NHS units more likely to have an acceptable policy than other sectors (Table 3.11).

Table 3.11 Units providing a policy of prophylactic antibiotics

<table>
<thead>
<tr>
<th>Policy</th>
<th>NHS (n = 176)</th>
<th>Specialised non-NHS (n = 17)</th>
<th>Private (n = 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n  %</td>
<td>n  %</td>
<td>n  %</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>28  16</td>
<td>5  29</td>
<td>13  35</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>146 83</td>
<td>12 70</td>
<td>17 46</td>
</tr>
</tbody>
</table>

Units were further questioned specifically about their screening policies for gonorrhoea (Table 3.12). It was found that 74 units (32%) had a policy to screen for both gonorrhoea and chlamydia. No units carried out screening for gonorrhoea without also providing chlamydia screening.
Table 3.12  Policy for genital tract infection precautions

<table>
<thead>
<tr>
<th></th>
<th>Units (n = 230)</th>
<th>Units (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not answer question</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Unsatisfactory policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No precautions</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Prophylactic antibiotics in selected patients</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Genital swabs in selected patients and antibiotics if needed</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td><strong>Satisfactory policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylactic antibiotics for all patients</td>
<td>69</td>
<td>30</td>
</tr>
<tr>
<td>Genital swabs for all patients and antibiotics if needed</td>
<td>64</td>
<td>28</td>
</tr>
<tr>
<td>Genital swabs for all patients and antibiotics for all patients</td>
<td>42</td>
<td>18</td>
</tr>
</tbody>
</table>

3.5 ABORTION PROCEDURES

3.5.1 Early medical abortions

First-trimester medical abortions are well established to be a safe and cost-effective method of termination of pregnancy. The Family Planning Association report, *Medical abortion – Meeting Women’s Needs* states that 32% of women actually present in time for early medical abortions.

The Guideline Development Group endorsed the following published regimens:

- mifepristone 600 milligrams orally followed 36–48 hours later by gemeprost 1 milligram vaginally (mifepristone data sheet).
- *mifepristone 200 milligrams orally followed 36–48 hours later by misoprostol 800 micrograms (4 × 200 microgram tablets) vaginally.
- *mifepristone 200 milligrams orally followed 36 hours later by gemeprost 0.5 milligrams vaginally.

* Regimens are unlicensed as described.

The manufacturer’s data sheet for mifepristone recommends a dose of 600 milligrams prior to prostaglandin administration for medical abortion up to a gestation limit of nine weeks. Evidence from randomised controlled trials\textsuperscript{19,20} indicates that a dose of 200 milligrams has similar efficacy when compared with 400 milligrams or 600 milligrams. As each 200-milligram dose of
mifepristone costs £13.94, there are cost-effectiveness implications for those units that use the higher doses. The Guideline Development Group recommends that a 200-milligram dose in combination with a prostaglandin is adequate.

The conventional prostaglandin E₁ (PGE₁) analogue used for abortion procedures is a gemeprost PGE₁ 1-milligram pessary, which costs approximately £20. The alternative E₁ analogue, misoprostol, costing around £1 per dose, is also effective in all three contexts. Misoprostol is more effective if administered vaginally rather than orally. Available data relating to the use of vaginal misoprostol for early medical abortion indicate that, at gestations up to seven weeks, gemeprost and misoprostol are equally effective. However, at gestations of seven to nine weeks, the continuing pregnancy rate may be higher when misoprostol is used (although a subsequent randomised controlled trial indicated that this was not the case).²¹

Eighty two units (36%) offered early medical abortion, with the maximum gestation varying between seven and nine weeks. Two units specified a maximum gestation of 12 weeks. The median maximum gestation was nine weeks, as recommended by the Guideline (Table 3.13).

Of these 82 units offering early medical abortion, 81 (99%) reported using mifepristone. The most commonly used dose of mifepristone was 200 milligrams, reported by 58 units (71%). Nineteen units (23%) reported using the manufacturer’s recommended dosage of 600 milligrams and three units (4%) had adopted a compromise strategy of 400 milligrams.

Twenty-nine early medical abortion providers (35%) reported the use of 1-milligram gemeprost. Misoprostol was used by 60 units (73%), administered most commonly in doses of 800 micrograms by 44 of these units (73%). Seventeen units (28%) used 400-microgram or 600-microgram doses of misoprostol. Eight units (10%) used both gemeprost and misoprostol.

### Table 3.13 Early medical abortion providers

<table>
<thead>
<tr>
<th></th>
<th>NHS (n = 72)</th>
<th>Specialised non-NHS (n = 9)</th>
<th>Private (n = 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers using gemeprost</td>
<td>27 38</td>
<td>2 22</td>
<td>0 0</td>
</tr>
<tr>
<td>Providers using misoprostol</td>
<td>52 72</td>
<td>8 89</td>
<td>0 0</td>
</tr>
</tbody>
</table>

Totals may exceed 100% as more than one response could be given.

### 3.5.2 Early surgical abortions

In current UK practice, suction termination of pregnancy is the standard method at gestations of 9–12 weeks. This is currently the only method recommended in the Guideline for this gestation band.
The method of choice at gestations of 12–15 weeks varies. Surgical abortion by conventional suction termination, without the need for specialised instruments, can be undertaken up to 15 completed weeks of gestation if local clinicians favour this method. Medical abortion is an appropriate alternative.

One hundred and seventy six units (76% of respondents) offered early surgical abortion, the most commonly available method of termination of pregnancy. The median maximum gestation was 12 weeks, varying between 10 and 13 weeks. Seventy two units (42%) specified a maximum gestation of 13 weeks (Table 3.14).

One hundred and seventy one units (97%) offered early surgical abortions under general anaesthesia. Local anaesthetic, as endorsed by the Guideline, is only provided by 24 units (14%). Twenty units (11%) offer a choice of either general or local anaesthetic for this procedure.

Anaesthetic provision appeared to vary with sectors. Specialised non-NHS providers were more likely to offer both local and general anaesthetic services.

The Guideline recommends that cervical preparation is beneficial prior to suction termination and should be routine if the woman is aged under 18 years or at a gestation of greater than ten weeks. Fifty one units (29%) used pre-operative cervical preparation for all patients, 102 (58%) used it in selected patients, nine units (5%) did not use pre-operative cervical preparation, while eight units did not respond to this question. The use of cervical preparation varied between sectors. Among units applying selection criteria for pre-operative cervical priming, patient selection was most commonly based on some combination of three factors: parity, age and gestational age.

The published regimen for the use of gemeprost 1 milligram is vaginally, three hours prior to surgery. Gemeprost was used for cervical preparation by 74 units (42%). In all but eight units, this was administered one to three hours pre-operatively.

<table>
<thead>
<tr>
<th>Using gemeprost</th>
<th>NHS (n = 131)</th>
<th>Specialised non-NHS (n = 11)</th>
<th>Private (n = 34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Using gemeprost</td>
<td>61</td>
<td>47</td>
<td>2</td>
</tr>
</tbody>
</table>

The recommended regimen for the dose of misoprostol is 400 micrograms (2 × 200 micrograms) vaginally, three hours prior to surgery. Misoprostol was used for cervical preparation by 68 units (44%). This was administered vaginally in 59 (87%), orally in seven (10%) and both vaginally and orally in one unit (1%). Sixty four units (94%) administered this medication one to three hours pre-operatively, a time when the prostaglandin is less effective.

The most commonly specified dose of misoprostol was 800 micrograms, used by 31 units (45%). Of the eight units that use oral misoprostol, four units used
a dose of 400 micrograms, one unit used 600 micrograms and three units used 800 micrograms.

Thirty units (17%) always sent products of conception for histopathology; 136 (80%) only did so when it was clinically indicated. However, only 70 units (39%) had a protocol to determine this management.

3.5.3 Late medical abortions
One hundred and forty four units (62%) offered late medical abortion (Table 3.15). The median maximum gestational age at which the units performed the procedure was 20 weeks.

The facilities provided were often varied but the majority of units provided a single room and a named nurse/midwife.

Table 3.15  Service provided

<table>
<thead>
<tr>
<th>Service provided</th>
<th>Units (n = 144)</th>
<th>Units (%)a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special unit</td>
<td>70</td>
<td>49</td>
</tr>
<tr>
<td>Single room</td>
<td>132</td>
<td>92</td>
</tr>
<tr>
<td>Named nurse</td>
<td>108</td>
<td>75</td>
</tr>
</tbody>
</table>

a Totals may exceed 100% as more than one response could be given

One hundred and fourteen units (79% of units carrying out late medical abortion) reported that it was their practice to use mifepristone prior to procedures (Table 3.16). The most commonly reported dose was 200 milligrams, used by 69 units (61%).

Sixty seven units (47%) used gemeprost. Eighty six units (60%) reported use of misoprostol, most commonly given as a 400-microgram dose. Prostaglandins were most commonly administered vaginally, in 85 units (59%). Doses were repeated three hourly up to a maximum dose by almost all respondents.

Twenty nine (20%) of the late medical abortion providers also continued to use intra-amniotic instillation of prostaglandin in late abortions.

If abortion did not occur, 105 units (73%) repeated the same regimen. Alternative policies are shown in Table 3.16.

Table 3.16  Unit policy if abortion does not occur

<table>
<thead>
<tr>
<th>Policy</th>
<th>Units (n = 144)</th>
<th>Units (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat regimen only</td>
<td>77</td>
<td>53</td>
</tr>
<tr>
<td>Another method only</td>
<td>29</td>
<td>20</td>
</tr>
<tr>
<td>Repeat regimen or use another method</td>
<td>28</td>
<td>19</td>
</tr>
<tr>
<td>Unsure/missing</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>
Surgical evacuation after late medical abortion was carried out routinely by seven units (5%). Of the 114 units estimating the percentage of women requiring evacuation of retained products of conception (ERPC), the median value was 20% (Table 3.17).

Table 3.17 Estimated percentage of women requiring evacuation of retained products of conception

<table>
<thead>
<tr>
<th>Units (n = 144)</th>
<th>Units (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–10</td>
<td>50</td>
</tr>
<tr>
<td>11–20</td>
<td>26</td>
</tr>
<tr>
<td>21–30</td>
<td>13</td>
</tr>
<tr>
<td>31–100</td>
<td>25</td>
</tr>
</tbody>
</table>

3.5.4 Late surgical abortions
The Guideline Development Group believes that dilatation and evacuation can be undertaken safely only by gynaecologists who have been trained in the technique, have the necessary instruments and have a caseload sufficient to maintain their skills. Where specialist expertise is not available, mid-trimester medical abortion may be an appropriate alternative. Contemporary methods of mid-trimester medical abortion have not been compared with dilatation and evacuation by means of a randomised trial.

Sixty nine units (30%) offered late surgical abortion. The median maximum gestational age for this procedure was 16 weeks. However, 38 units (55%) specified a maximum gestation for surgical abortion that was above 15 weeks. Facilities provided were again varied, with a single room and a named nurse commonly provided. Thirteen units offered this procedure as a daycase procedure, 20 units as an inpatient case and 36 did not answer the question. Thirty-nine units (56%) routinely carried out pre-operative cervical preparation, specifying at least one method. The most commonly reported method was misoprostol (25 units; 36%).

3.6 MANAGING COMPLICATIONS OF ABORTION

Professionals providing abortion services should possess accurate knowledge about possible complications and sequelae of abortion. In forty six units (67%) the response to suspected uterine perforation was laparoscopy.

Ninety seven units (42%) reported that they audited the complications of abortion and 92 (40%) of the 230 respondents mentioned one or more possible complications. The most commonly mentioned complications were retained products of conception/incomplete abortion, bleeding, infection, uterine perforation, cervical trauma and pain.
3.7 AFTERCARE

Following the termination procedure, 203 units (88%) provided patients with contraceptive advice and in 187 units (81%) this was given by a trained person and documented in the patient’s records. Only 170 units (74%) provided written information on possible post-abortion symptoms (127 NHS, 17 specialised non-NHS and 26 private units).

The Birth Control Trust\textsuperscript{22} advocates early follow up as a routine requirement for all women following abortion, usually within two weeks. This is the time period during which immediate complications of abortion will present and during which any problems with contraception should be resolved. Eighty units (35\%) reported that a follow-up appointment was available within two weeks of the procedure, in line with Guideline recommendations.

Other aftercare options provided were a letter concerning the procedure in case of emergencies (196 units; 85\%) and a 24-hour telephone help line (162 units; 70\%).
4 CONCLUSIONS

This national audit of the care provided to women undergoing induced abortion included responses from 71% of the 324 units currently providing abortion care in England and Wales. However, the authors would estimate that these units performed 85% of the abortions taking place. The major aim of the audit was to provide a baseline of current activity prior to publication of the RCOG Evidence-based Clinical Guideline, *The Care of Women Requesting Induced Abortion*,¹ in March 2000. It provides the first national overview of services carried out in England and Wales.

Overall, there appeared to be good awareness and anticipation of the likely recommendations to be included in the Guideline. It is encouraging that 66% of respondents were aware of existing guidelines and endeavoured to adhere to these recommendations. However, it was noticeable that this awareness was greater in the NHS than in the specialised non-NHS and private sectors. Overall, there were acceptable standards of care in many areas and it is clear that messages from earlier recommendations have been taken on board. For example, it has been widely recognised that daycase management of abortion services is a cost-effective model of service provision.

Early medical abortion was provided by 82 of the responding units; 41% of NHS units provided early medical abortion services and 53% of the specialist non-NHS providers now also provide these services. Early surgical abortion was still the most commonly provided form of induced abortion, especially in the private sector. Providing choice to women by offering both methods was still only available in 33% of units overall; 32% of NHS units were able to provide choice but 41% of the specialised non-NHS providers could do this; 71% of units provided facilities for abortion after 13 weeks of gestation. The majority of NHS units provided this in the form of late medical abortion. However, the majority of specialised non-NHS units provide late surgical abortion. Again, there were few units offering both methods, with only 21% of NHS units and 29% of specialist private providers offering choice.

However, there are areas where it is important to achieve change. Crossmatching of blood is still reported as being routinely undertaken by 29% of private-sector and specialised non-NHS providers. This practice is much diminished in the NHS and the Guideline Development Group recommendation is clear that it is not cost-effective to carry out routine crossmatching for women undergoing abortion. Only 0.2% of patients are estimated to require a blood transfusion and generally this can be initiated in cases where it is required.

It is disappointing that 24% of providers still do not have an acceptable policy of screening for infective complications. Again, the proportion of specialist non-NHS and private-sector providers not having an acceptable policy was higher than that within the NHS, although improvement could be achieved by all three sectors.
Compliance with the suggested early medical abortion protocols was good, with many units using mifepristone and gemeprost or misoprostol. However, the lower dose of mifepristone recommended as adequate in the Guideline was not always used. It is perhaps disappointing that not many units were actively auditing the quality of their services, specifically that only 61% of units actively audited the documentation of anti-D in patients’ notes. Few audited the number of women who required inpatient beds, the reasons for inpatient admission or any complications of the procedure.

For early surgical abortion, it is encouraging that the majority of units used cervical preparation prior to operation, if not in all patients then in selected patients. The alternative prostaglandin misoprostol was used in 68 (44%) of units, although many were using the higher dose (800 micrograms) and not the lower dose recommended in the Guideline. However, most units were administering the prostaglandin less than three hours prior to surgery, thus limiting its effectiveness.

For late medical abortion, it is encouraging that many units did not undertake routine evacuation of retained products of conception after a medical abortion, with only seven units (5% of providers) doing this. The majority of units said that they provided contraceptive advice and that generally this was given by a trained person and documented in the patient’s records. Only 74% of units provided written information and fewer were able to provide a follow-up appointment within two weeks.

The Guideline Development Group views induced abortion as a healthcare need, as unwanted pregnancies occur because women are unable to regulate their fertility via contraception alone. It is unlikely that this need will diminish in the near future but it is hoped that the RCOG Guideline and this audit will provide a mechanism from which providers can improve the quality of services they provide.
REFERENCES


10. Dixon M. Assertions about patient information are not supported [letter; comment]. *BMJ* 1995;311:946.


APPENDIX 1 AUDIT STANDARDS

Auditable standards were derived from the draft recommendations in the RCOG Evidence-based Clinical Guideline, The Care of Women Requesting Induced Abortion.¹

ORGANISATION OF SERVICES

- All services must be able to offer abortion by one of the recommended methods for each gestation band.

- Ideally, abortion services must be able to offer a choice of recommended methods for relevant gestation bands.

- Ideally, all women requesting an abortion should be offered an assessment appointment within five days of referral.

- Ideally, all women should be able to undergo the abortion within seven days of the decision to proceed being agreed.

- As a minimum standard, all women should be able to undergo the abortion within two weeks of the decision to proceed being agreed.

- The assessment appointment should be within clinic time dedicated to women requesting abortion.

- Women requesting abortion should be cared for independently from other gynaecological patients.

- In the absence of specific medical, social or geographical contraindications, induced abortion may be managed on a daycase basis.

- An adequate number of staffed inpatient beds must be available for those women who are unsuitable for daycase care.

- Access to services should be ensured for a woman with special needs, e.g. for non-English-speaking women, and a female doctor should be available.
INFORMATION FOR WOMEN

- Abortion services should have local strategies in place for providing information to both women and healthcare professionals on the choices available within the service and on routes of access to the service.

- Verbal advice must be supported by accurate, impartial printed information that the woman may take away and read before the procedure.

- Information for women and professionals should address the issue of confidentiality.

- Documentation of anti-D immunoglobulin G should be recorded in the notes of women who are non-sensitised rhesus D-negative following abortion.

- Pre-abortion assessment should include:
  - measurement of haemoglobin concentration
  - determination of ABO and rhesus blood groups with screening for red cell antibodies
  - screening for other conditions, such as haemoglobinopathies, HIV and hepatitis B (if indicated on clinical grounds).

- Women undergoing termination of pregnancy do not need to have blood crossmatched routinely.

- If a cervical smear is taken opportunistically within the abortion service, then mechanisms to ensure that the smear result is communicated to the woman, acted on appropriately and recorded within the local cervical cytology programme are essential.

- All units must have access to ultrasound scanning, as it can be a necessary part of pre-abortion assessment.

- When ultrasound scanning is undertaken, it should be done in a setting and manner that is sensitive to the woman’s situation.

- Abortion care should include a strategy for minimising the risk of post abortion infective morbidity.
ABORTION PROCEDURES

- For early medical abortion, a dose of 200 milligrams of mifepristone, in combination with a prostaglandin, is adequate.

- Misoprostol (a prostaglandin E\textsubscript{1} analogue) given vaginally is a cost-effective alternative for all abortion procedures for which the E\textsubscript{1} analogue would be used.

- Conventional suction termination is an appropriate method at gestations of 7–15 weeks, although individual practitioners may prefer to offer medical abortion at gestations above 12 weeks.

- Suction termination may be safer under local anaesthesia than under general anaesthesia.

- Cervical preparation is beneficial prior to suction termination and should be routine if the woman is aged under 18 years or at a gestation of greater than ten weeks.

- For mid-trimester medical abortion, a dose of 200 milligrams of mifepristone is adequate.

- Cervical preparation given at a minimum of three hours prior to surgery may reduce post-operative blood loss.

- Surgical evacuation of the uterus is not required routinely following mid-trimester medical abortion.

- Mid-trimester abortion by dilatation and evacuation, preceded by cervical preparation, is safe and effective when undertaken by specialist practitioners.

- An appropriately experienced midwife or nurse must care for women having second-trimester terminations by medical means. Ideally, the woman should have the privacy of a single room.

- Histology/pathology for products of conception should be performed when clinically indicated.
COMPLICATIONS AND AFTERCARE

- Professionals providing abortion services should possess accurate knowledge about possible complications and sequelae of abortion.

- In cases of suspected uterine perforation, laparoscopy is the investigation of choice.

- On discharge, each patient should be given a letter that gives sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications.

- After an abortion, the woman must be given a written account of the symptoms she may experience and a 24-hour helpline telephone number to use if she feels worried about pain, bleeding or high temperature.

- Before she is discharged following abortion, future contraception should have been discussed with each patient and contraceptive supplies should have been offered if required.

- A follow-up appointment (either within the abortion service or with the referring clinician) should be offered to each patient following abortion, within two weeks of the procedure.