

Abortion care in Britain: how can we enhance the patient journey?

Findings from a qualitative study.

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OBJECTIVE

Models of abortion care have changed significantly in the last decade, most markedly during the COVID-19 pandemic, when the home management of early medical abortion with the aid of telemedicine was approved. Our study aimed to examine women's levels of satisfaction with abortion care delivered in Britain, and their suggestions for improvements.

FUNDING

This research draws on data collected as part of the SACHA: Shaping Abortion for Change Study (www.lshtm.ac.uk/sacha), whose aim was to provide an evidence base to help shape health services and health systems in response to current changes in abortion provision in Britain. The study was funded by the National Institute of Health Research (Award ID: NIHR129529).

INTRODUCTION

Between 2017 and 2018 across England, Scotland, and Wales, the second medical abortion pill – misoprostol – was approved for home use, following clinic administration of the first abortion medication, mifepristone. In March 2020, in response to COVID-19, governments across Britain approved self-administration of the first abortion medication mifepristone at home, with telemedical support. This temporary measure was made permanent in 2022. Clinical guidance from RCOG further supported remote consultations to improve access and advised ultrasound before medical abortion at home only if gestation could not be assessed accurately using last menstrual period, or if there was concern regarding ectopic pregnancy (RCOG 2022). Quantitative studies comparing home administration of medical abortion with telemedical support have shown it to be as safe, effective, and acceptable to patients as in-person models of care, if not more so (Hyland et al, 2018; Reynolds-Wright et al, 2021; Gambir et al, 2020; Aiken et al, 2021; Aiken et al, 2022). Less is known of patients' perspectives on the current care delivered in Britain. The perspectives of patients are needed to enable benefits of those numerous rapid changes to be sustained and costs to be mitigated at all stages of the patient journey.

METHODOLOGY

- Qualitative, semi-structured, in-depth interviews with 48 women with recent (2-8 weeks) experience of abortion
- July 2021-August 2022
- Recruited from six sites in Britain: independent-sector services commissioned by the NHS & NHS hospitals and clinics
- Inclusion criteria: 16 and over, able to give consent, UK-resident, abortion for any reason other than fetal anomaly
- Purposive sampling in regards to demographic characteristics and clinical experiences
- Women asked about their experience of abortion and suggestions for improvements across the patient journey
- Data analysed using the Framework Method (Ritchie, 2003)
- Ethical approvals were obtained from BPAS REC (reference 2021/02/WEL), the LSHTM REC (reference 22761) and the NHS (reference 21/LO/0236).

RESULTS



Overall satisfaction with care: high for most
“Faultless”, “easy and simple”, “ideal for me”.



Help-seeking and accessing care

Information about abortion services was generally easily found online; any difficulties encountered stemmed from out-of-date information or incorrect contact details provided. Self-referral to an abortion provider was perceived as vitally beneficial, decreasing wait times and preventing women from having to disclose their unwanted pregnancy to their GP and consequently alleviating the concerns around judgment. Where there were delays, they caused major distress and discomfort. *“I didn't want to experience any of the side effects of pregnancy because I knew I wasn't keeping the baby, and I didn't want to go through it all for nothing.”*



Consultation and referral

Abortion clinic staff were universally commended for their “respectful”, “welcoming”, “supportive”, “non-judgmental” attitudes. Consultations that patients were most satisfied with were those featuring broad explanation of the upcoming procedure, e.g. leaflet sent via e-mail and talked through step-by-step; link to narrated videos describing the treatment. Almost all women had their initial consultation on the phone, and the convenience and privacy of telemedicine were appreciated, but the option to choose between remote and in-person consultation was held as important, just as the choice of abortion method, whereas some patients were not aware of their options. *“I don't think I really know enough about the surgical abortion really. [...] I didn't realise that was an option [...] even when you're early.”*



Treatment

Home medical abortion was welcomed for the convenience, comfort and sense of autonomy it provided. But the downsides of home management centred around lack of supervision, exacerbating the disparities between expectations and reality: for most, the pain was more severe than anticipated: *“I can't remember exactly but it I'm pretty sure it was like, 'it should ease the discomfort', [while] I remember thinking at the time, I'd rather be dead than feel this pain”*. For those who had a surgical abortion, the advantages included being able to take less active part in the procedure; the main issues centred around longer waiting times and overall worse access to the procedure.



After-care

Few women had medical concerns following their abortion, but they expressed the desire for pro-active follow-up call from the abortion providers. Some needed more emotional support. An important aspect was the provision of contraception – women generally preferred to receive it from the abortion clinic, but not all services were able to offer that option.

Characteristics of the sample (N=48)	n
Nation	
England	25
Scotland	20
Wales	3
Age group	
16-20	6
21-30	22
31-40	18
41+	2
Children	
Yes	14
No	34
Previous abortion(s)	
Yes	17
No	31
Abortion method	
Home MA	37
Hospital MA	8
Surgical	2
Home MA & surgical follow-up	1

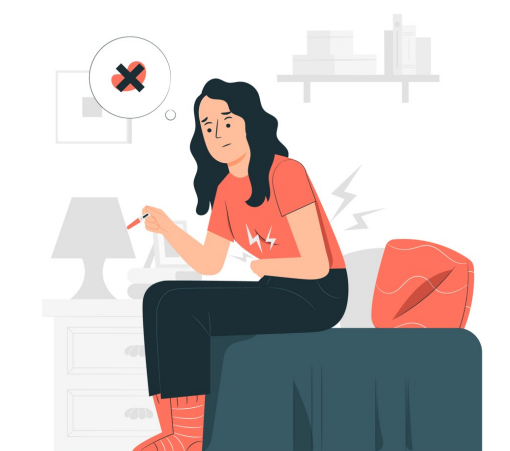
DISCUSSION

Patients' suggestions for improvements centred around four main themes:



Timely care

Timeliness was especially relevant to abortion care because of the legal framework and burden of remaining in an unwanted pregnancy longer than absolutely necessary. Patients' suggestions included widening and updating informational sources; raising awareness of the possibility of self-referral; ensuring that GPs have the necessary knowledge to signpost appropriately to avoid confusion over which services should be approached.



Management of expectations

A key area for improvement emerging from the study was the extent to which women were prepared for their abortion experience by the clinical providers, and the significance of this for the choices they made. As others have shown (LaRoche and Foster, 2020; Whitehouse et al, 2021), ensuring consistency between women's expectations and their actual experience is crucial to patient satisfaction.



Emotional and peer support

Explicit signposting to available support at all stages of the abortion experience is essential, but it also needs to be sufficiently prompt to benefit patients at the time of need. Calls by our participants for real-life accounts of experiences of abortion patients to be incorporated into the clinics' websites; for opportunities to connect to other abortion patients on supervised internet forums; and peer-support structures to help reduce feelings of isolation, all have appeal in the context of abortion, which is rarely talked about and still stigmatised.



Choice

The rationale for prioritising medical over surgical abortion where feasible was clear during the pandemic when personal contact had to be restricted. However, the suggestion in our data that medical abortion continues to be encouraged as the preferred, or default, option, is corroborated by other contemporary research (Footman, 2023). A possible unintended consequence of the high prevalence of medical abortion in Britain - accounting for 87% of all abortions carried out in England and Wales and 99% in Scotland in 2021 – is that it may lead to surgical abortion becoming unavailable in some settings even when it is clinically necessary.

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ACKNOWLEDGMENTS

Thank you to all the women who entrusted us with their experiences; and to the healthcare staff who supported us with recruitment. Thanks are due to the Advisory Group, and the stakeholders who helped us contextualise findings and prioritise areas for improvement.

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