Referral to a National Health Service-funded abortion clinic

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Abstract

Objective To investigate the referral process from two Primary Care Trusts to a National Health Service-funded abortion clinic in the North West of England.

Methods The study comprised a survey of all clinic attendees from within the study area during a 6-month period. All attending women were asked to complete an anonymous questionnaire. A total of 202 questionnaires were given out and 143 were returned completed (a 71% response rate).

Results At least 90% of the women were referred directly from the first health professional they consulted to the abortion clinic. Five percent of the women were either referred to another health professional or not referred anywhere. Twelve percent of the women had to wait longer than the 3 weeks recommended by the Royal College of Obstetricians and Gynaecologists guideline. In a minority of cases this wait extended up to 7 weeks. However, most women were satisfied with the length of wait, the health professional they consulted with and, in particular, the care they received at the abortion clinic itself.

Conclusions In a minority of cases the referral system failed to meet the guidelines and recommendations made by professional bodies. Changes are necessary to ensure that all women receive a prompt and efficient referral to ensure that their procedure occurs at the earliest possible gestation.

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Key message points

- **Despite recommendations and guidelines to the contrary, there are still a minority of general practitioners who do not refer women, either directly to the abortion clinic, or on to another health professional for referral.**
- **Some women still have to wait longer than the recommended maximum of 3 weeks to have their abortion.**
- **Women are generally appreciative and grateful of the care they receive at an abortion clinic, particularly where staff are perceived to be non-judgmental.**

Background

Termination of pregnancy (TOP) is one of the most common female surgical procedures performed in England and Wales: some 176 400 abortions were carried out during 2002. Approximately one in three women aged between 16 and 45 years will have a termination.[1] In 2004 the Royal College of Obstetricians and Gynaecologists (RCOG)[2] published revised guidelines on TOP care. These guidelines focused upon the referral process and made recommendations with respect to waiting times.

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Whilst much research has been carried out around procedure, little has been undertaken around the referral process. Yet delay in referral can have serious consequences on the woman's mental health. Studies using psychometric measures have found that a high proportion of women show symptoms of anxiety and/or depression prior to having an abortion.[3–5] Bradshaw and Slade's review[6] concluded that "40–50% of women experience significant levels of anxiety and around 20% experience significant levels of depressive symptoms prior to the procedure being carried out".

Delay can also affect physical health, with rates of complications usually increasing with gestational age. The type of abortion that can be performed varies according to gestation. RCOG guidelines[2] recommend early medical aspiration up to 7 weeks' gestation (according to strict protocol), medical abortion using single-dose mifepristone and prostaglandin up to 9 weeks, and surgical termination under local or general anaesthetic from 7 to 12 weeks. From 9 to 24 weeks' gestation the recommendations are to carry out medical abortion using mifepristone and multiple doses of prostaglandin, with surgical abortion by dilatation and evacuation an option from 15 to 24 weeks.

Many factors influence how soon the TOP is performed. These include: the woman's willingness to consult a health professional, how quickly they get an appointment (if necessary), the health professional's willingness to refer on to the abortion clinic, and the clinic waiting time once referral has been made. With respect to the latter two stages, guidelines and recommendations have been made by health professional bodies in order to facilitate a quick and easy referral. These include doctors with a conscientious objection to abortion referring women promptly to another doctor.[7]

The RCOG's recommendations relating to the referral process include the following:

- Ideally, all women requesting abortion are offered an assessment appointment within 5 days of referral.
- As a minimum standard, all women requesting abortion are offered an assessment appointment within 2 weeks of referral.
- Ideally, all women can undergo the abortion within 7 days of the decision to proceed being agreed.
- As a minimum standard, all women can undergo the abortion within 2 weeks of the decision to proceed being agreed.
- As a minimum standard, no individual woman need wait longer than 3 weeks from her initial referral to the time of her abortion.

The local picture

In the two participating Primary Care Trusts (PCTs) TOP is not performed on request, although one local hospital provides TOP for reasons of fetal abnormality. Most women are referred to a clinic located in a neighbouring city hospital. Little is currently known about the referral process and anecdotal evidence suggests that some women are not being referred anywhere by their general practitioner (GP). At strategic health authority level, a survey by Cook *et al*.[8] found that 29% of GPs had a conscientious objection to abortion. It is thought that this might have important consequences for referrals in the area.

Study aim

The study aimed to examine the referral system to the TOP clinic for women from two PCTs in the North West of England, and to see if it met service users' needs. The objectives were to investigate:

- How long it takes to be referred to the clinic.
- How many health professionals are involved before a referral is made.
- Whether doctors provide alternative arrangements for referral if they do not refer themselves.
- Women's satisfaction with the staff they encounter during this process.

Methods

Ethical approval for the study was received from the local hospital and university research ethics committees.

All women from the PCTs referred to the clinic for a TOP during the 6-month study period were invited by letter to participate. A decision was made to exclude those aged under 16 years based on ethical concerns in relation to obtaining consent.

A questionnaire was devised and piloted specifically to collect the data. Piloting showed that many women were unable to remember the date they first visited a health professional to request a TOP. A second question was inserted in the questionnaire, which queried the approximate number of days/weeks it had taken from visiting a health professional to having the TOP.

Staff at the clinic provided women from the PCTs with a letter outlining the research project and inviting them to participate. The questionnaire was attached to the woman's medical notes together with a stamped addressed envelope. Once completed, the questionnaire was put in the envelope provided and handed to staff or to the reception desk. (Non-respondents were asked to do the same with the blank questionnaire so that staff members were unaware who had responded.)

Analysis

The data were analysed using the SPSS v.2 (SPSS Inc., Chicago, IL, USA) personal computer program in which frequencies and cross-tabulations were performed. The additional comments were analysed by putting each comment into a negative, positive or neutral category. Within each of these categories the comments were then assigned to one of the themes that emerged.

Results

In total, 202 questionnaires were given out, and nine blank and 143 completed questionnaires were returned, giving a response rate of 71%. Participants' ages were in the range 16–44 (mean, 23.4 and mode, 20) years (Table 1).

Analysis of the response by age group showed no significant differences in relation to factors such as length of wait, whether they were referred on to the clinic, satisfaction with the staff, or satisfaction with the length of wait. The responses were therefore combined for subsequent analysis.

Table 1 *Age of the study participants*

Age (years)	% (*n*)
16–19	22.8 (33)
20–24	35.2 (50)
25–29	19.8 (28)
30–34	12.3 (18)
35–39	6.2 (9)
40–44	1.9 (3)
None given	1.8 (2)

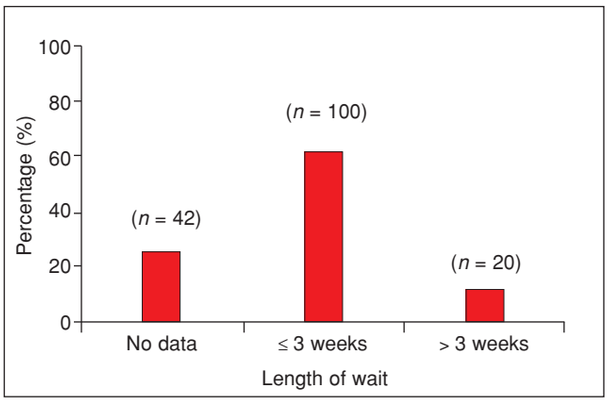

Figure 1 *Length of wait for termination of pregnancy*

The majority (62.3%) of women visited their GP for referral. Of the remainder, 18.5% went to a family planning clinic (FPC), 8.6% to Brook Advisory and 7.4% to either of two youth advice shops (YAS) in the district; just three (1.9%) women went to the British Pregnancy Advisory Service (BPAS) [information was missing in two (1.2%) cases]. Most women (90%) were referred immediately to the TOP clinic; 5% were not (information was missing in 5% of cases). No specific type of service provider was identified as deficient in onward referral. Of those women not initially referred to the clinic, 1.9% (three women) had been to see their GP, 1.9% (three women) to a YAS and 1.2% (two women) to an FPC.

Just one woman was referred elsewhere because there was not a doctor on duty. Four women did not know this information. In three cases the women had sought help from their GP who did not refer on. These women who had not been referred on then went to their GP (three women, 1.9%), an FPC (two women, 1.2%) and a different GP (two women, 1.2%) (information was missing in one case). All the women were referred straight to the TOP clinic at this point.

Referral took from 1 to 7 weeks (Figure 1). Altogether, 12% of referrals took more than the minimum standard of 3 weeks. However, these included women who elected to have a surgical abortion but presented too early in their pregnancy. This necessitated waiting until the procedure could be performed surgically. Unfortunately, it wasn't possible to ascertain what proportion this was, although clinic staff believed this would only be one or two individuals.

Most (86.4%) women were satisfied with the time it took to be referred, 10.5% were neutral, whilst 3.7% were dissatisfied. However, the relationship between the length of time and satisfaction was unexpected. Some women who were seen quickly were neutral about this, whilst others who waited a long time, up to 7 weeks, were satisfied (Table 2). (This might include the few women presenting early for a surgical termination.)

The majority (82.1%) of women felt that the health professional they initially saw was approachable and helpful, 3.1% disagreed, whilst 14.8% were neutral.

Additional comments made by the respondents

A key finding was the large proportion of women (45% of the sample) who chose to comment on the referral process, and aspects of the service they received. The majority (77.7%) of comments were positive, indicating a high level of satisfaction with the service, 6.9% were mixed (included both positive and negative comments), whilst 15.3% were negative.

The negative comments included GP and clinic staff attitudes ("*patronising*" and "*felt I was being judged*"), the

Table 2 *Study participants' satisfaction with the length of referral according to the number of weeks this process took*

Participants satisfied?	Referral time (weeks)						
	1	2	3	4	5	6	7
Yes [% (*n*)]	90.0 (9)	90.2 (46)	88.6 (31)	50.0 (2)	85.7 (6)	50.0 (1)	75.0 (3)
Neutral [% (*n*)]	10.0 (1)	9.8 (5)	5.7 (2)	50.0 (2)	0.0 (0)	0.0 (0)	25.0 (1)
No [% (*n*)]	0.0 (0)	0.0 (0)	5.7 (2)	0.0 (0)	14.3 (1)	50.0 (1)	0.0 (0)

length of time it took to be referred, and the need to chase up a GP before being referred. Other comments included:

"There wasn't much of a counselling service."

"I was lectured about contraception. It was the last thing I needed. I knew what I'd done!"

"I think girls who are having the termination should not be isolated from other women on the ward … You should not be made to feel like an outcast. You should not be made to feel like you are getting punished for simply making a choice in life."

Of the five women who wrote a mixed comment, three suggested that they should be allowed to have someone stay in the room with them. The other two women, whilst happy with the service generally, felt that it had taken too long to be referred (4 weeks).

The positive comments were as follows. The overall service was described as "*excellent*" (5), "*good*" (2), "*great*" (1) and "*brilliant*" (1). Five women wrote about the physical environment of the clinic. Others wrote about how quick the service was and how this helped them to deal with the situation. Nine women praised the quality of information they were given with respect to its clarity and depth. A number of women described how they were made to feel at the clinic: "*at ease*" (6) "*comfortable*" (5), "*relaxed*" (2) and "*safe*" (1). Finally, comments relating to staff at the clinic included how "*helpful*" they were. Nearly one-fifth of all participants (30 women) chose to describe the staff in this way. Other descriptions included "*friendly*" (8), "*nice*" (8) and "*understanding*" (6). Two women described the clinic staff as "*non-judgemental*", "*brilliant*", "*caring*", "*considerate*" and "*kind*". Other comments made were "*fantastic*", "*lovely*" and "*sensitive*". Typical comments included:

"Everyone has been kind and helpful and have not made me feel uneasy, they have been brilliant."

"At a not very happy time the ladies here were brilliant. They did not single anyone out and they were very friendly and explained everything clearly. I felt very relaxed here."

Discussion

The present study was undertaken to examine the referral procedure to an NHS-funded abortion clinic. The study showed that most women were satisfied with the referral procedure, particularly the care provided at the clinic. There were, however, some limitations to the study in terms of extrapolating the findings. The present study included only women aged 16 years and over; however, young girls might have a different experience of seeking a TOP, particularly as they are more likely to delay getting help.[9]

The information was only collected from women attending an NHS-funded clinic. Women who 'chose' to go privately might have done so because they experienced difficulties in being referred. Indeed, one survey[10] showed that almost half of women who paid for private treatment had been to an NHS doctor but help was either refused or unavailable.

Most women went to a GP for referral. In three instances the GP did not refer them on. Studies of GPs' attitudes have found that despite a large proportion supporting women's right to access safe legal abortion, a minority of doctors are anti-abortion.[11] Francome and Freeman[12] found that 18% of GP respondents said they were basically opposed to abortion. The Abortion Law Reform Association[13] are currently calling for GPs to be obliged to declare any conscientious objection to abortion, and for PCTs to provide guidelines pointing out their contractual duty to refer women promptly. As doctors do not advertise their stance on abortion, women will not know how their own GP will react until they actually request an abortion. One way forward might be to make women more familiar with alternatives, such as the BPAS or Marie Stopes clinics, which could be more user-friendly at this time.

Although many women were referred straight to the clinic, a small number were sent elsewhere to be referred on (or, as stated, not referred anywhere). It is possible that this figure was not a true reflection of the situation because young girls were not included in this survey nor women who went privately for their abortion. One study[14] of 16–24-year-olds found that they came up against professionals who acted as 'gatekeepers' to the TOP service. Kumar *et al*.[15] found instances when the GP asked clients to contemplate their decision (and return at a later date) before they would refer on, thus delaying referral.

Despite the RCOG recommendations,[2] 12% of women waited longer than 3 weeks, including a minority who waited up to 7 weeks for their TOP. However, although some women recorded exact dates when they first consulted a health professional, others couldn't remember and gave an approximate length of time. This might have inflated the 12% figure. However, it was considerably lower than the 26% found by Morrison[16] in her audit of induced abortions, carried out prior to the RCOG's published recommendations,[2] and it is possible that improvements have been made throughout the district (and also the country) since then. Further research, or audit, is necessary to assess whether the 3-week maximum limit is being met in other PCTs around the country, and to look at procedures that can be implemented in order to improve access to TOP services. For example, Lowy *et al*.[17] found that a specialist day care service, which included a dedicated telephone line taking referrals from GPs and family planning doctors, reduced waiting times.

Perhaps surprising was the finding that most (86.4%) women were satisfied with the wait from initial consultation to termination. This included women who had had to wait over 3 weeks, and even up to 7 weeks. Just 3.7% of women reported that they were dissatisfied with the waiting time. These findings conflict with a survey by Marie Stopes International[18] whereby 47% of respondents thought that women should be able to access procedures within 24 h, and 74% believed abortion should be completed within 72 h of the medical consultation. Just 12% of respondents were in favour of waiting 1 week, the recommended ideal maximum according to RCOG guidelines.[2] Differences between the two surveys might be due to sample variations. Marie Stopes International used a representative sample of women from the general population who were thus answering an abstract question.

The present study included women who had very recently undergone a TOP and the question was therefore more concrete. It is also possible that the more positive reaction in the present study was coloured by the general satisfaction women felt with the service they received, and relief that the TOP had been performed.

A high level of satisfaction with the service was evident, with many women choosing to comment on this. Whilst it is common practice for questionnaires to incorporate a 'catch-all' question, it is unusual for such a high proportion of respondents to provide feedback. Whilst there were some negative comments, the majority were positive, particularly regarding the care the women received from the clinic staff. It is possible that some women anticipated a negative reaction from the clinic staff, especially if they faced an unsympathetic or unco-operative health professional in the first instance. Other studies[5,14,19] have similarly reported that young women found staff at the TOP clinic to be very supportive.

Conclusions

To conclude, the present study showed that referral to a TOP clinic in a minority of cases took longer than recommended by the RCOG guidelines.[2] A few health professionals acted as 'gatekeepers': some women were not referred on anywhere, whilst others came up against GPs whom, they felt, acted in a judgmental way. Despite these individual cases, the majority of women were satisfied with the referral process, particularly with the care they received from clinic staff. Further research is recommended to consider the referral process for those aged under 16 years, those who attend a non-NHS abortion clinic, and to examine the current referral times across other PCTs in the UK.

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Competing interests. None identified.

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Book Reviews

Erectile Dysfunction: Current Investigation and Management (2nd edn). I Eardley and K Sethia. London, UK: Elsevier Limited, 2003. ISBN: 0 7234 3365 8. Price: £46.99. Pages: 152 (paperback)

The second edition of this book has been retitled *Erectile Dysfunction: Current Investigations and Management*, whereas the first edition was *Erectile Dysfunction: A Guide to Management in Primary Care*. This is a pity, as the management of erectile dysfunction has become much more a primary care issue in the intervening 6 years.

The illustrations remain excellent and the new edition is larger with major editions in the investigations and oral therapies section. Much more is included on colour duplex ultrasonography and cavernosography, with the same conclusion that such tests are almost exclusively research tools.

The section on new oral therapies is excellent, although unavoidably a little out of date in such a rapidly expanding area. Current issues on daily dosing and treating with testosterone to salvage failures in cases of borderline hypogonadism could have been included. A few case histories illustrating management problems would have been relevant for general practitioners.

The section on cardiovascular risk factors and associations is by no means as comprehensive as it might be, probably reflecting the urological background of the authors. Despite these criticisms, this edition is an excellent attempt to update a subject of considerable development in the last 6 years.

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Drugs for Pregnant and Lactating Women. CP Weiner and C Buhimschi. Philadelphia, PA: Churchill Livingstone, 2004. ISBN: 0 443 06607 8. Price: £62.99. Pages: 1049 (hardback)

This is a fantastic reference for any practitioner attempting to advise pregnant and breastfeeding women about the safety of medicines. Understandably, there is a scarcity of hard data in this area. Manufacturers often take the easy route of advising against use of a product in pregnant or lactating women. Yet we all know that in the real world, women may use a medicine before realising they are pregnant. In other situations, women (and their babies) can suffer adverse consequences from discontinuing a necessary medication; we need to help women balance the possible risks against the benefits of a given medication in these situations.

This text summarises and references the available data for over 700 drugs. The tables are easily accessed under generic or trade names and are succinct and easy to use. Where a safer alternative exists, this is recommended. Otherwise the practitioner is simply given the best available evidence to allow a useful discussion of the risks and benefits of a given drug for a particular woman. The text also covers changes in maternal physiology that may necessitate closer monitoring or dosing changes during pregnancy for women requiring long-term drug maintenance such as those using anti-epileptic drugs.

The weighty hardback book is complemented by a CD-ROM for easier reference. This will be updated regularly by downloads from the Internet, incorporating new evidence or guidance.

Although written for a North American audience, this book is surprisingly easy to use and highly relevant to practice in other developed countries. The vast majority of drugs can be found under familiar generic or trade names. The accent on information rather than guidance gives it a broad relevance beyond the USA.

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