Experiences of working with induced abortion: focus group discussions with gynaecologists and midwives/nurses

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Background: While there exists an extensive amount of research regarding the medical aspects of abortion, there is a great lack of studies investigating staff’s views and experiences of working in abortion services.

Aims: To elucidate gynaecologists’ and midwives'/nurses’ experiences, perceptions and interactions working in abortion services, their experiences of medical abortions and abortions performed at the woman’s home. An additional aim was to illustrate gynaecologists’, midwives’ and nurses’ visions of their future professional roles within the abortion services.

Method: Three focus group discussions within each profession were carried out in 1-hour sessions with a total of 25 gynaecologists and 15 midwives/nurses from three different hospitals.

Results: The content analysis reflected that gynaecologists and midwives/nurses had no doubts about participating in abortions despite the fact that they had experienced complex and difficult situations, such as repeat and late-term abortions. They experienced their work as paradoxical and frustrating but also as challenging and rewarding. However, they were rarely offered ongoing guidance and continuously professional development education. For gynaecologists, as well as midwives/nurses, their experiences and perceptions were strongly linked to the concurrent development of abortion methods. The interaction between the professions was found to be based on great trust in each other’s skills.

Conclusions: In order to promote women’s health, gynaecologists’ and midwives'/nurses’ need for a forum for reflection and ongoing guidance should be acted on. With a higher number of abortions done medically and a higher proportion of home abortions, midwives/nurses will get increased responsibilities in the abortion services in the future.

Keywords: abortion care, ethical considerations, experience, gynaecologist, focus group discussion, home abortion, interaction, midwife, nurse.

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Introduction

There are many international studies on abortion, which elucidate attitudes for and against abortion, and the willingness among healthcare staff and those who intend to become gynaecologists or nurses to work with induced abortions (1–3). However, there is a lack of wider and deeper knowledge of staff’s experiences and the informal interaction that prevails in abortion services.

The Swedish Abortion Law has remained unchanged since 1975 with some fewer adjustments (4). Women in Sweden decide for themselves if they want to have an abortion up to 18 weeks of gestation with no obligation to state their reasons. They should always be offered the opportunity to see a counsellor (5). After 18 weeks of gestation the woman must apply to the National Board of Health and Welfare and indicate that she has extraordinary reasons for having an abortion. Such reasons may be malformation of the fetus, severe disease in the woman or psychosocial and social circumstances. Late-term terminations are few in number and in the last 15 years they have been 0.5 to 1.0% of a total of approximately 33 000 abortions yearly (6). The viability of the fetus is decisive in determining whether or not a termination can be performed, thus, today the limit in Sweden is 22 gestational
weeks. In Sweden, in 2009, the yearly rate of abortions before 9 gestational weeks was 77.7% and was before 12 weeks 93.3% of all abortions. In 2009, for 60.7% it was the woman’s first abortion and for 39.3%, it was her second or more (6).

At the beginning of the 1990’s medical methods using tablets of mifepristone followed by misoprostol for expulsion of the fetus before 9 weeks were introduced and also much improved as a method. In 2009, 85.6% of all terminations before 9 weeks were performed medically and 73.3% before 12 weeks (6). The supplement to the Abortion Law from 2004 has made it possible for women in Sweden to have their medical abortions at home on certain conditions stated by the gynaecologists (5).

In 1973 a Swedish questionnaire study was published making known the views of healthcare staff regarding induced abortion (7). After 8 years of free abortion, in 1983, the researchers in a further study concluded that compared with 1973, the views on legal abortion among healthcare staff had become less restrictive but that they still perceived the work as frustrating (8). Another study was performed by the research group after almost three decades of free abortion, this time among a representative national sample of gynaecologists and midwives with a response rate of 85% (9). At this period of time gynaecologists and midwives were the professions that at the most met the abortion-seeking women. However, women who had abortions performed at the inpatient wards were taken care of by nurses. Comparing over time, from 1973 to 1983 to 2005, staff had become increasingly less restrictive in their attitudes and agreed overwhelmingly that women should have the right to have an abortion.

The more, and the more recently in time, the gynaecologists had the main medical responsibility. However, there were a few differences in the structure of the teamwork, for instance; at one of the hospitals all gynaecologists participated in abortion care, at the other hospitals the responsibility for this care was assigned to certain specialists the responsibility for this care was assigned to certain gynaecologists only. Among the nurses some worked only with surgical and some only with medically induced abortions.

Data collection procedure

In mixed groups of disciplines there is a tendency to have a tense atmosphere (12). This may impede speaking freely and may raise possible underlying conflicts between the gynaecologists and MNs. Therefore, the decision was made to compose homogenous focus groups.

The recruitment resulted in a total of six groups: 25 gynaecologists and 15 MNs. There were three groups of gynaecologists; one with nine participants and two with eight participants. Two groups of MNs consisted of two midwives and three nurses, and the third included three midwives and two nurses. Concerning five of the groups, the participants comprised of those who were at work on the actual day of the session. The sixth group consisted of all gynaecologists at that clinic since the focus group discussion (FGD) took place on their regular conference day.

Each FGD was tape recorded and held in a conference or staff room at the participants’ own working place. With the
permission from the heads of the clinics, four FGDs were interviewed during working hours and two were interviewed during the lunch hour.

The participants in the FGDs should be free to build a conversation within a particular subject area, to word questions spontaneously, and to establish a conversation style themselves but with the focus on the particular subjects in the interview guideline. The overall themes in this guideline were: experiences and perceptions working with abortions; experiences and perceptions working with medical and home abortions; visions of the future role in abortion care among gynaecologists and MNs, respectively. The moderator, a senior social worker familiar with FGD (the first author), was aware of listening for subjects the participants were most keen to talk about and to give space for reflections. After the FGD, the participants were asked to answer a questionnaire on some basic background data similar to questions asked in earlier national studies published in 2005, 2006 and 2007 (9–11) (Table 1).

The empirical material discussed was mainly obtained by reading the transcriptions of the FGDs. In addition, the research group read the moderator’s memos, written after every FGD, and listened to the original tape recordings.

Analysis

Content analysis was used for exploring the FGDs since this method analyses the manifest and latent content of communicated material (13–15). The verbatim transcripts were analysed in order to find broad categories of repeated themes as well as rare ones, generating summaries of content patterns for the gynaecologist and MN groups separately (15). The analysis was made on the two professional groups (gynaecologists and MNs) with no intention to compare them either within each city area or separate groups, but simply in order to gain multifaceted descriptions of gynaecologists’ and MNs’ experiences.

The moderator and the other three researchers made their transcript analyses separately and then compared and discussed the results. The senior research group consisted of a medical sociologist, a gynaecologist and two social workers, who altogether represented both theoretical and clinical skills as regard FGDs and content analysis. In order to strengthen the reliability of the analyses the transcripts were once again analysed but with the focus on repeated and unusual words. The contexts in which these words occurred were observed and summarised in tables that were then compared with the themes of contents from the first analysis (13–15). All quotations, presented in the Results are quotations from the FGDs transcriptions either in full sentences or in shorter phrases or just words. Current study findings can only be valid for the respondents who took part in these focus group interviews.

The Medical Ethics Research Committee of Umeå University, Umeå approved the study.

Results

Experiences and perceptions of work with induced abortion

Gynaecologists. Initially, the gynaecologists were asked for their experiences and perceptions of working with induced abortion. Many of them answered spontaneously, with one word; ‘of use’, ‘positive’, ‘grateful’. In the years after 1975, with regard to the administration of the abortion care, it was not always possible for the gynaecologists to meet the women before the surgical procedure, making them feel that they were sitting at ‘a conveyor belt in a factory’ performing abortion. The treatment at that time comprised dilation and vacuum expiration. When pharmacological substances for maturing cervix became available the gynaecologists felt that the abortion care improved.

As the gynaecologists became used to performing surgical abortions their focus moved successively from technical skills to reflection on what they were participating in:

... then maybe you are a little more conscious of what you are doing in the operating ward ..., ... I try to shield myself, repress what I am doing, .... ... More strong feelings have emerged ....

The gynaecologists believed that there were many dimensions and depths to be understood during the consultations with the abortion-seeking women compared to

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<th>Background data of the gynaecologists and the midwives/nurses</th>
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<td>Gynaecologists</td>
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a Numbers of gynaecologists’ and midwives/nurses’ estimated years with work in abortion services.

b Percentage of working time in abortion services related to full time work.

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those with other patients. In addition, they also believed: ‘But there are few patients who are so grateful, in fact’.

The gynaecologists expressed a concern about the nurses working in the surgical and recovering wards since this group of staff did not have any information about the women’s situations but were simply involved in the surgery.

There was a feeling of frustration among the gynaecologists with the occasions of repeated abortions. It could be hard to maintain a professional approach, but at the same time, they emphasised, they had not been ambivalent about performing the abortions:

Ten years ago women felt forced to argue a bit to get an abortion … then they came here and you had to help them and speak up for them a little, you noticed that they were a bit aggressive in their approach.

Currently, the gynaecologists described that:

Women who have decided to have it at home, you perceive as strong and mature in making their decision themselves, and taking a lot of responsibility … They have to insert the tablets into the vagina themselves, they do things themselves … contribute.

When the partner accompanied his woman or accompanied her at home with her during the performance of the abortion, the gynaecologists thought that it was as if ‘the pair had the abortion together’.

The gynaecologists conveyed that it was never easy for the women to have an abortion and that they took their time, thereby showing that they wanted to listen to the woman and learn about her situation.

Midwives/nurses. Initially, the MNs were asked what they had experienced and what their perceptions were of working with abortion:

If I think about the 1960s, I remember firstly the pain … pain-relief was almost non-existent. They got very little analgesic and … it was very difficult to make diagnostics because there was no ultra-sound … so the fetus could be very big … so you felt very sorry for them …

MN reported that they always tried to make sure that the women would not suffer or have any pains:

We changed the regime for pain-relief. The pain-relief treatment has to be characterised by professionalism, you must not show your feelings although you go to the bathroom sometimes and cry.

At medical abortions the MNs stayed in contact with the woman the whole day and helped her to confirm that the termination was completed. With the late-term abortions, where the whole procedure was protracted, they said: ‘You are more aware of your feelings’.

If the fetus was malformed there was another aspect:

Then it is not about help it is something else … it is both about caring and coping with the sorrow.

Youngsters, they meant, were best at using contraceptives considering their age and the circumstances. However, it was difficult to understand the mature women:

It’s as if … I do not think it’s lack of information but of their own self-discipline.

At the same time they felt sorry for them, and felt powerless. About terminations after 18 gestational weeks, they said:

Emotionally it is very hard … you save lives at 22–23 gestational weeks and … So, there is so short time between.

Experiences and perceptions of medical and home abortion

Gynaecologists. The gynaecologists were convinced that the other staffs were knowledgeable of the routines for the medical methods but they had doubts about their attitudes to abortions:

Well, there may be consensus on what we should do but what about staff attitudes and the consequences of them … ?

The counsellors’ work within the abortion services was seen as providing good support not only for the women seeking abortion but also for the gynaecologists themselves. They were not in favour of an abortion service that excluded this professional category.

When the woman herself requested the abortion at home, when she expressed ‘a sort of desire’, the gynaecologists agreed to home abortion. However, they wanted more criteria to be fulfilled, such as that the woman was ‘secure’, had had ‘a spontaneous abortion or, had had a medical abortion earlier’, as well as that her ‘mental health was stable’ and that she had ‘a certain social stability’.

Midwives/nurses. When the patient was under the age of 18 the MNs wanted to be sure that she had an adult to talk to; her parents or someone she had confidence in.

In the case of medical abortions the MNs themselves took care of the women on the day the abortions took place. The MNs were asked whether they believed that the gynaecologists were well aware of their specific duties:

No, I don’t believe so. The fact that we examine the bleeding, try to find the gestational sack or the fetus, so we know that the abortion is completed, I do not think that they reflect on us doing these things. I don’t think that they always know how … that the women may have very serious pain.

Regarding the MNs work with home abortions a typical procedure was that they called the woman in the morning the day of the expulsion, then after lunch, and once again when they thought the abortion was completed in order to ‘make sure everything is alright with her’. When calling the women, the MNs believed that:
The optimal situation is when you have met the woman previously ... It is always easier when you know the person and have a picture of a face in front of you. The chain of care in the abortion services was very good, the MNs thought; ‘the best of all’.

**Vision of their future role in abortion services**

**Gynaecologists.** The gynaecologists’ discussions elucidated thoughts as:

The focus should be on supporting the women to manage home abortion, thus, we would certainly have 40–50% at home.

Some stated how important it was, both for themselves as professionals and for the women, to know that the women had made a well-thought-out decision, regardless of the gestational week or abortion method. If the MNs could become educated sufficiently well in the future, they also foresaw that it could function but, as one of them pointed out, there is the risk of complications:

We must maintain it, that future gynecologists get the same training and acquire the skills to treat complications.

However, they did not want to become just ‘a consultant verifying gestation length’.

The gynaecologists did not think it was a good idea for the future solution of medical abortions to be managed by primary healthcare.

**Midwives/nurses.** Regarding future roles in abortion services MNs elucidated visions as:

Do not know. ... the abortions must be organized in one way or another and I think that the MNs will do that even in the future. ... home abortions will certainly increase ... I can imagine that we will give the responsibility over to the women more. But ... we have to protect woman’s right to get support and help ...

They predicted that the late-term abortion would continue to exist but they wished they would be fewer and fewer. The MNs expressed a desire that, in the future, the professions would be able to diagnose more fetal malformations without examining amniotic fluid. They also wished that the medical abortions performed in hospitals would be carried out in congenial environments.

**Discussion**

To our knowledge, this study is the first interview study on experiences and perceptions on gynaecologists’ and MNs’ work with induced abortion. The advantage of using FGDs is that the method provides the possibility of range, specificity, depth and to take the personal context into account on the gynaecologists and MNs work in abortion services.

The groups of gynaecologists contented six to eight persons, which is the very best number to obtain high-quality data (15). Among the MNs there is, however, a weakness in the fact that they were five in each group. The abortion service on its own implies uncovered factors of complex thinking and behaviour in individuals. Within the FGDs such factors were uncovered. One impediment is that the results will only be valid for the participating groups. However, comparing sex, age and numbers of working extent in abortion services in the participants within the three first population-based questionnaire studies with the present FGD study no differences were found (Table 1) (9–11).

**Experiences and perceptions**

The contradictable approach gynaecologists and MNs showed towards work with induced abortion, and that they still did not hesitate to support the women, can be understood knowing that they were convinced that it was right for Sweden to have free, legal abortions and that abortions should be safely performed (9, 10). The range and specificity in findings in this study are very much linked with gynaecologists’ and MNs’ experiences and perceptions over time. In the 1970s, the gynaecologists felt that the work with induced abortions was dehumanizing and made them feel like sitting at ‘a conveyor belt in a factory’. Primarily, they focused on being well trained and good at performing the surgery, thereafter they began to reflect on the meaning of what they participated in. The MNs’ discussions concerned analgesics, they discussed about the women’s pain, pain that was really hard to accept in the shadow of a very restrictive approach to pain-relief.

The phenomenon of *repeat abortion* was experienced by both professions as hard to understand. In one way, it was easy to regard it as a failure not having been able to help the woman with the contraceptive and in another way it raised mixed feelings of frustration and sorrow towards her. When it came to *late-term* abortions, the MNs, more clearly than the gynaecologists, expressed that these were even harder to cope with. This could probably be explained by the MNs being more close to the woman during the whole process. When it came to *medical abortion* the gynaecologists highlighted that this method had radically changed their role from being an active surgeon to having a more passive role. Despite the challenges described above, the gynaecologists and the MNs were rarely offered ongoing guidance and continuous professional development education. However, from earlier studies we know that staffs in abortion services have a wish for this to 100%
(9–11). Such support could have made both the individual and the team more progressive and open to insights (16, 17).

When people meet, wherever, privately or at workplaces they have a tendency to project feelings on each other without being aware of it (18, 19). For instance, in the examination room, the gynaecologist or the MN, without really recognizing it, may take over the woman's frustration which then becomes her/his own and vice versa. In a Swedish study on women and men who had experienced an abortion it was shown that, within the actual performing of the abortion there are contradictory feelings in the pair, although they have made a well-founded decision and want to have the abortion (19). The authors claimed that in the field of clinical work as well as research there has to be openness to contradictory feelings and paradoxical thinking in women and men facing abortion (19).

**Interactions**

At work places there are rules, which are well known to everybody. Side by side with these formal rules are informal rules existing which are not overtly communicated or known, but which are very important for the efficiency of the organisation. For example, Giddens states that these abstract ideas (or values) give meaning and guidance to people when they interact with and in the social reality (18). Theoretically, the concept interaction can be used to point out the informal rules in abortion services as well as in all multidisciplinary teamwork (18).

The gynaecologists described a modified interaction between the women and themselves. Currently, the women are well informed, have enough self-confidence and come to the consultations to get the medical help. As the gynaecologists obtained increased knowledge and insights into how home abortions were experienced by women and how they themselves could support and develop the medical responsibility for such abortions, the more positive they became about offering the women this option. The MNs were more doubtful, they were very concerned for the women's right to receive good care and believed that their own working routines might be jeopardised. Furthermore, MNs stressed that they wanted to be convinced by the woman that she had made her final decision about her pregnancy before the day of abortion. We also found that if the woman was very young the MNs wanted to make sure that she had someone to talk to.

Focusing on the interaction between gynaecologists and MNs the FGDs gave the impression that the gynaecologists left a lot of responsibility to the MNs regarding medically induced abortions. This did not seem to have been discussed among the professionals, it occurred without any objections. However, the MNs had great trust in that the gynaecologists would always support them and the staff members knew the routines, thus, everybody felt secure. In general, conversation and reflection in group offers not only important insights about oneself but even clarifies interaction patterns within the team, which in turn brings certainty in one's work (17, 18, 20). When it comes to talking about teamwork, all FGDs spontaneously mentioned the counsellors as an important and much needed team member.

**Visions of future professional roles**

Visions of future professional roles in abortion services did not seem to be much discussed among staff at abortion services. However, when home abortions will become more common, the expectations of the gynaecologists' roles will change into a less active one. Consequently, gynaecologists expressed anxiety about losing medical skills since they had to maintain their competence in order to deal with the complicated cases. In parallel, with a higher number of abortions done medically and a higher proportion of home abortions, MNs will get increased responsibilities and a more active role in the abortion services in the future.

To summarize, this study is of clinical relevance for providers in abortion services and has shown that the gynaecologists and the MNs had no doubts about participating in abortions. Their work was experienced as paradoxical and frustrating but also as challenging and rewarding. For gynaecologists, as well as for MNs their experiences and perceptions were strongly linked to the concurrent development of abortion methods. In order to promote women's health and to improve the work environment for the staff the gynaecologists' and midwives'/nurses' need for a forum for reflection and ongoing guidance should be acted on. With a higher number of abortions done medically and a higher proportion of home abortions midwives/nurses will get increased responsibilities in the abortion services in the future.

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**Author contribution**

Meta Lindström: design, interviewing, analyses, manuscript writing. Marianne Wulff: design, analyses, manuscript writing, supervision. Lars Dahlgren: design, interviewing, manuscript writing, supervision. Ann Lalos: design, analyses, manuscript writing, supervision.
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