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Contraception 78 (2008) 492–499

Contraception

Original research article

Second-trimester surgical abortion practices: a survey of National Abortion Federation members☆

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Received 5 March 2008; revised 22 July 2008; accepted 22 July 2008

Abstract

Background: The objective of this analysis was to assess the second-trimester surgical abortion practices of National Abortion Federation (NAF) members in North America and Australia.
Study Design: In 2002, questionnaires were mailed to 364 active member clinics of NAF for completion by their clinic administrators and individual providers.
Results: Two hundred eighty-nine (79%) clinics responded. Most NAF clinics (72%) offer second-trimester abortion services. The majority of second-trimester providers are obstetrician/gynecologists (63%), male (62%) and at least 50 years old (63%). We describe second-trimester surgical abortion practices in terms of patient eligibility, cervical ripening, ultrasound use, anesthesia and postoperative care.
Conclusions: Surgical techniques and postoperative practices for second-trimester abortions are similar among these respondents, suggesting that NAF's efforts to promulgate best practices using evidence-based guidelines are succeeding. The aging of skilled practitioners raises concerns about the future availability of second-trimester abortion.

Keywords: Abortion; Second-trimester surgical abortion; Dilation and evacuation; United States; Canada

1. Introduction

Pregnancy termination is one of the most common surgical procedures performed in the United States, with most occurring in the first trimester. The Guttmacher Institute estimated that 1.31 million abortions were performed in the United States in 2000, with no estimate by gestational age [1]. However, the Centers for Disease Control and Prevention (CDC) estimates that about 12% of abortions are performed at gestation ages of 13 weeks or more, resulting in 157,200 second-trimester abortions performed in 2000 [2]. Abortion in the second trimester is technically more difficult than that in the first trimester, and fewer trained clinicians perform the procedure. To date, no published study has examined the clinical practice patterns of these abortion providers.

The National Abortion Federation (NAF), the professional organization of abortion providers in North America, conducted a survey of first-trimester and second-trimester surgical abortion practices among member clinics in 2002. This survey expanded on a first-trimester surgical practices survey conducted in 1997 [3]. The purpose of this analysis was to document current second-trimester surgical abortion techniques and perioperative practices to guide future efforts in medical education, research and quality assurance.

2. Materials and methods

In 2002, NAF mailed self-administered questionnaires about both first-trimester and second-trimester abortion practices, including surgical and medical abortion, to their complete membership list of clinics consisting of 364 clinics in the United States, Canada and Australia. Awards were

☆ Financial support was provided by an anonymous foundation.
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doi:10.1016/j.contraception.2008.07.011

offered to increase response rates: two clinics, randomly selected from the respondent list, would receive a waiver of NAF membership dues for the following year. Telephone follow-up of nonrespondents occurred 1 month after the initial mailing and led to second mailing of the questionnaires.

Each mailed package consisted of two questionnaires: one for the clinic administrator and five copies of the second questionnaire for individual clinicians. The first (administrative) questionnaire elicited information about services and procedures offered at the surgical site; instructions to the administrator requested consultation with the medical director or other relevant personnel as needed for completion. The second (clinician) questionnaire inquired about individual surgeons' practices, preferences and opinions; administrators distributed this questionnaire to providers. Both instruments covered five major topics: facility and staff demographics; laboratory tests for abortion service patients; cervical preparation; anesthesia; and practices and instruments. The clinician instrument also included a section on second-trimester surgical abortion practices. Questions had precoded responses, although respondents were encouraged to write additional remarks if necessary. All questions asked about practices during the year 2001. The study was approved by the Northwestern University Institutional Review Board.

2.1. Statistical analysis

This work presents results only regarding surgical abortions performed past the 12th week of gestation. Tables and figures include combined data from the United States, Canada and Australia focusing on four categories: clinician characteristics, patient eligibility criteria, cervical preparation and other clinical practices. Results from the administrative survey are presented with *clinics* as the unit of analysis, whereas results from the clinician survey use *clinicians* as the unit of analysis; both are clearly delineated in the text.

Respondents reported the annual number of second-trimester abortions performed via dilation and evacuation (D&E) within predefined ranges (categories: *none*, *1–49*, *50–100*, *101–250*, *251–400*, *401–750*, *751–1000* and *>1000*). We calculated estimates of the total number of surgical abortions performed using the midpoints of these ranges. For the largest range, we estimated totals using 1000 procedures. We classified clinics by size: small clinics — those that perform less than 250 second-trimester surgical abortions per year; medium clinics — those that perform between 250 and 1000 second-trimester surgical abortions per year; and large clinics — those that perform more than 1000 second-trimester surgical abortions per year.

We explored differences in clinical practices by clinic size and clinician demographics using Student's *t* test and chi-square test to assess differences in continuous and categorical outcomes. Analysis of clinician characteristics included age, gender, years of abortion provision since training and years of D&E provision since training. We examined associations between these characteristics and clinical practices; all significant associations, as well as noteworthy nonsignificant findings, are presented.

3. Results

The response rates to the surveys are detailed in Fig. 1. Seventy-nine percent (289 of 364) of NAF member clinics responded with either the administrative survey, the clinician survey or both. Two hundred seventy-three clinics returned the administrative survey, including 258 clinics in the United States, 13 clinics in Canada and 2 clinics in Australia. One hundred eighty facilities returned clinician surveys from 293 total abortion providers.

Two hundred fifty-three US clinics reported an estimated total of 68,900 D&Es and 3643 medical inductions in 2001 (five US surveys had missing data regarding the number of cases). Thirteen Canadian clinics reported an estimated total of 1850 D&Es and no medical inductions. Two Australian clinics reported 550 D&Es and no medical inductions. We did not collect information on the gestational age distribution of these cases.

Seventy-two percent of responding clinics (192 of 268) provide second-trimester abortion services. Most of these clinics were small (60%), although 17% of clinics (n=33) performed more than 1000 second-trimester cases annually. Twenty-four percent of clinics also offer medical induction abortions. Most facilities self-identified as clinics (68%); fewer facilities self-identified as private offices (15%), surgical centers (15%) or hospital-based sites (2%). Sixty percent of facilities were for-profit entities (including private practices).

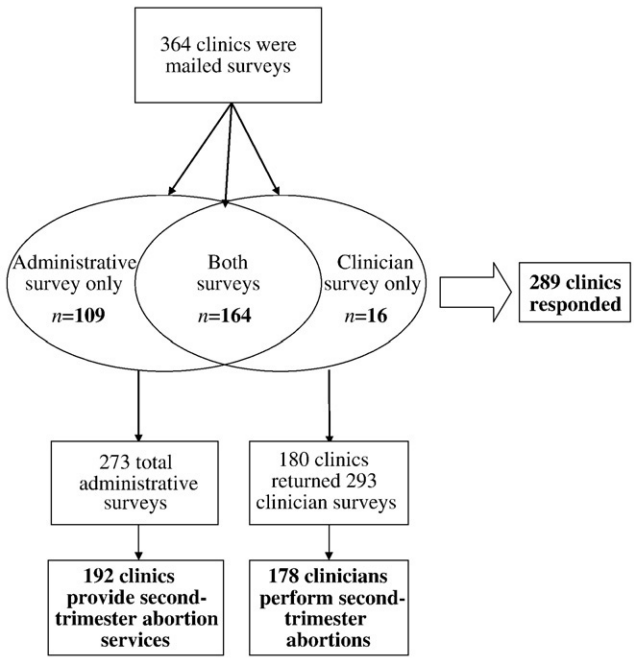

Fig. 1. Response rates to mailed surveys.