Contraception

Contraception 92 (2015) 241–245

Original research article

Induction of fetal demise before pregnancy termination: practices of family planning providers☆,☆☆,★

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Received 7 November 2014; revised 7 May 2015; accepted 9 May 2015

Abstract

Objectives: Our survey aimed to characterize the practice of inducing fetal demise before pregnancy termination among abortion providers, including its technical aspects and why providers have chosen to adopt it.
Study design: We conducted a survey of Family Planning Fellowship-trained or Fellowship-affiliated Family Planning (FP) subspecialists about their practice of inducing fetal demise, including questions regarding the circumstances in which they would induce demise, techniques used and rationales for choosing whether to adopt this practice.
Results: Of the 169 FP subspecialists we surveyed, 105 (62%) responded. About half (52%) of respondents indicated that they routinely induced fetal demise before terminations in the second trimester. Providers' practices varied in the gestations at which they started inducing demise as well as the techniques used. Respondents provided legal, technical and psychological reasons for their decisions to induce demise.
Conclusion: Inducing fetal demise before second-trimester abortions is common among US FP specialists for multiple reasons. The absence of professional guidelines or robust data may contribute to the variance in the current practice patterns of inducing demise.
Implications: Our study documents the widespread practice of inducing fetal demise before second-trimester abortion and further describes wide variation in providers' methods and rationales for inducing demise. It is important for abortion providers as a professional group to come to a formal consensus on the appropriate use of these techniques and to determine whether such practices should be encouraged, tolerated or even permitted.

Keywords: Abortion; Second-trimester termination; Fetal demise; Dilation and evacuation

1. Introduction

Induced abortion is a common medical procedure for reproductive-aged women in the United States (US), with 1.06 million abortions reported in 2011 [1]. Of these, approximately 11% are performed after the first trimester [2]. These patients receive care from a smaller subset of physicians within the entire population of abortion providers; of all US abortion providers, only 64% offer procedures after 13 weeks' gestation, decreasing to 23% at 20 weeks and 11% at 24 weeks [3]. This decrease likely is due to both the greater technical skill and training needed for more advanced gestations, as well as increased political and legal hostility towards later abortions.

In recent years, debate has emerged over the practice of inducing fetal demise before terminations completed in the second trimester. Although the first case report of inducing fetal demise dates to the late 1970s [4], anecdotal reports suggest that such practices recently have become more common among abortion providers, especially since the 2003 passage of the Federal Abortion Ban and the subsequent 2007 Supreme Court decision upholding it [5–7]. The Ban, which mandates criminal penalties for any practitioner who "deliberately and intentionally vaginally delivers a living fetus," has led many providers and institutions to believe that

☆ Source: survey data from Family Planning subspecialists.
☆☆ Disclosures: The authors report that they have no conflicts of interest.
★ Funding: J.L.K. is funded by NIH/NICHD K23 Award no. 1K23HD067222.
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http://dx.doi.org/10.1016/j.contraception.2015.05.002
0010-7824/

inducing fetal demise before terminations could provide legal protection for abortion providers, although there has been no legal test so far [5]. Inducing fetal demise is not without controversy, as it involves risks to patients without associated medical benefit, making it difficult to justify from an ethical standpoint [6].

We sought to understand more about the practice of inducing fetal demise. Although small observational studies indicate an increase in inducing fetal demise before terminations since the Federal Abortion Ban [8], we know little about which abortion providers are inducing demise, what techniques they are using or for which patients. Furthermore, little is known about the reasons providers choose to induce demise. Our study aimed to better characterize the current state of inducing fetal demise in the US by gathering practice data from Family Planning (FP) subspecialists.

2. Material and methods

In 2010 and 2011, we anonymously surveyed both FP and Maternal Fetal Medicine (MFM) subspecialists across the country, including current fellows and faculty affiliated with the fellowships. We obtained names and emails of current and former FP fellows through the national Fellowship in Family Planning (FFP) office and also received names and emails of current affiliated FP faculty from the directors of each FFP site. With approval from the Society of Maternal Fetal Medicine (SMFM), we purchased list of names and postal addresses for SMFM members.

We invited all subjects via email to complete an online anonymous survey using KeySurvey software and subsequently sent two email reminders. We offered a $5 gift card to all participants that was not contingent upon survey completion and accessible through an anonymous link not connected to their survey answers. We asked participants to identify the region of the United States in which they practiced but not the state or institution. The study was approved by the University of California San Francisco Committee on Human Research.

The full survey included 65 questions on demographics, provision of second-trimester abortion and the practice of inducing fetal demise before abortions. "Elective" dilation and evacuation (D&E) or induction termination as a reason for abortion was not specifically defined but was distinguished from terminations for lethal or nonlethal fetal anomalies, severe maternal disease, inevitable abortion and preterm premature rupture of membranes. We asked participants to identify (a) whether their institution induced fetal demise as a step before abortion; (b) whether the individual him-/herself or others in that institution induced the fetal demise; (c) at what gestation fetal demise was routinely induced; (d) the main reason for inducing fetal demise before abortion (institutional policy, group/practice policy, physician preference or patient preference) and (e) the main method used [intraamniotic digoxin, intrafetal digoxin, intracardiac potassium chloride (KCl), umbilical cord division or other]. We asked providers to leave comments about their reasons for preferring to do abortions after inducing fetal demise.

We assessed personal abortion attitudes using a validated instrument with five questions using a five-point Likert scale. Scores ranged from 5 to 25, with higher scores representing more positive attitudes towards abortion [9]. We measured religiosity using three validated questions with true/false responses. Scores ranged from 0 to 3, with higher scores representing greater religious motivation [10].

Given a low response rate among MFM specialists, we limited our analyses here to the FP group. We report descriptive statistics using χ^2 tests, Fisher's Exact Tests, and *t* tests as appropriate, using Stata version 11.0 (Stata Corporation, College Station, TX, USA) to analyze the data.

3. Results

We identified 169 eligible respondents, including 34 current FP fellows (in 2010), 119 former FP fellows and 16 Fellowship faculty members who were not formally trained through the Fellowship but serve as Fellowship mentors, and sent online surveys to all identified providers. We received completed surveys from 105 FP specialists, for a 62% response rate. Of these, 26 were current fellows, 64 were former fellows, and 15 were Fellowship-associated faculty.

The majority of respondents were female and less than 40 years of age (Table 1). All regions of the country were represented, although respondents were less likely to work in

Table 1
Demographic characteristics of respondents (*N*=105).

Total	105 (100)
Age (years)	37 (30–69)
Female	91 (86.7)
Region	
West	32 (30.8)
Northeast	35 (33.7)
South/Southeast	10 (9.6)
Midwest	27 (26.0)
Works ≥50% of clinical time in an academic institution	93 (88.6)
Works with trainees	101 (96.2)
Abortion attitude [a]	22 (7–25)
Religiosity [b]	0 (0–3)
Number of D&Es performed per year	100 (2–2100)
Number of induction terminations performed per year	2 (0–500)
Institution allows elective induction termination	27 (25.7)
Institution allows elective D&E	88 (83.8)
Induce fetal demise before termination	55 (52.4)

Data are presented as *n* (%) or median (range).

[a] Abortion attitude was assessed using a validated instrument with five questions on a five-point Likert scale. Scores range from 5 to 25, with higher scores representing more positive attitudes towards abortion [9].

[b] Religiosity was measured using three validated questions with true/false responses. Scores range from 0 to 3, with higher scores representing greater religious motivation [10].