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From the Patient's Perspective: Quality of Abortion Care

Prepared for the Kaiser Family Foundation by The Picker Institute

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Introduction

In the past decade, patient feedback has been increasingly acknowledged as a critical component in assessing the quality of health care. While much is being learned about what patients value and need beyond the clinical expertise for a wide range of health care services, relatively little is known about patient perceptions and preferences with regard to abortion care. That is not to say that quality has not been an important aspect of abortion care. In fact, abortions performed in the United States today are one of the safest medical procedures.[1] But, these measures have largely focused on the quality of care from a clinical versus patient perspective.

This study was conducted for the Kaiser Family Foundation, a national independent health care philanthropy (not associated with Kaiser Permanente), by The Picker Institute, a health care quality assessment and improvement research organization, provides the most comprehensive look at the quality of abortion care from the patient perspective. More than 2200 women who had abortions in 12 clinics nationwide were interviewed for the study between July and October 1998. Their views and perceptions about the quality of care they received from the first call to the clinic to follow up after the procedure were recorded and compiled to present an overall picture of abortion care today from the patient's vantage point.

The findings presented in this report are important to both health care providers and women. Abortion providers will find the results of this survey useful in making services more patient-centered. While many women have abortions, few talk about it with other women. This blanket of secrecy prevents providers from learning as much as they can from their patients that may continue to improve upon the quality of care women receive. *From the Patient's Perspective: The Quality of Abortion Care* helps make that connection clearer.

[1] *Council on Scientific Affairs, American Medical Association, Induced Termination of Pregnancy Before and After Roe v Wade,* ***JAMA****, 268: 3231-3239, 1992.*

Background

Before abortions were legalized with the Supreme Court's decision in Roe v. Wade, as many as 10 out of every million women 15-44 years old died from an illegal abortion every year and countless others suffered permanent damage to their fertility. Once abortion was legalized in 1973, abortion-related deaths and complications decreased rapidly and now are very rare. For example, between 1979 and 1985, there were 0.6 deaths per 100,000 abortion procedures, which is 10 times lower than the 9.1 maternal deaths per 100,000 live births for a comparable time period (1979-1986).[2]

Today abortions in the U.S. are one of the safest and most frequently performed surgical procedures. According to the Alan Guttmacher Institute, nearly half (43%) of all women in this country will have at least one abortion by the time they are 45.[3] Almost a million and a half abortions are performed each year for American women, most between the ages of 15-44,[4] Women in this age range undergo just under 6 million other types of ambulatory surgery procedures each year, making abortion the most common for women of childbearing age.[5]

Though many clinical studies have been conducted to document the safety and efficacy of abortion procedures, including more recently medical or non-surgical options such as methotrexate and mifepristone, no large-scale studies have examined the patients 'experience with abortion. There are a number of reasons that abortion patients have not been surveyed about their satisfaction and views on their care. The stigma associated with abortion causes many women to keep the procedure a secret and they do not wish to be contacted about their experience, and accordingly, are sometimes reluctant to participate in research studies about abortion.

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[2] Council on Scientific Affairs, American Medical Association, Induced Termination of Pregnancy Before and After Roe v Wade, ***JAMA****, 268: 3231-3239, 1992.*

[3] Henshaw, Stanley K., Unintended Pregnancy in the United States, ***Family Planning Perspectives****, 30 (1): 24-29&46, 1998.*

[4] Henshaw, SK, Abortion Incidence and Services in the United States 1995-1996, ***Family Planning Perspectives****, 30(6): 263-270&287, 1998.*

[5] Unpublished estimate by the National Survey on Ambulatory Surgery for ambulatory surgical procedures. Podiatry, dentistry and pain block practices are not included. The estimate does not include abortions performed in specialty clinics, but does include 130,000 abortions performed in hospitals and ambulatory surgery centers.

A Note About Access to Abortion Care

Access to abortion services has been, and remains, an important focus for researchers and the media. While the focus of this study is quality of and satisfaction with abortion care, without access to this service, a discussion about the quality of care becomes moot. It is important to note that the survey sample is drawn from women who successfully located a provider, could afford the procedure, and were able to get to the clinic. *Therefore, the access issues for this group are not representative of those facing the larger population of women of childbearing age*. The diminishing number of abortion physicians[7] and hospital providers,[8] increased restrictions,[9] and anti-abortion activity[10] remain very real concerns that are threatening to limit access to services for thousands of women. Between 1982 and 1996, the most recent year for which data is available, the number of abortion providers in the U.S. declined by 30 percent.[11]

In 1996, according to data collected by the Alan Guttmacher Institute, clinics that specialize in the provision of abortions ("abortion clinics") accounted for 452 of the 2,042 abortion providers in the United States. Although abortion clinics represent less than a quarter of all abortion providers, they performed 70 percent of all abortions. Four hundred seventeen other types of clinics such as surgical centers and family planning clinics perform another 21 percent of procedures. Hospitals and physicians' offices tend to have comparatively very small, and decreasing volumes. While the 703 hospitals accounted for nearly over one third of providers, they provided only 7 percent of abortions. Similarly, while 470 physicians' offices offered abortion services, they accounted for only 3 percent of abortions nationwide. Eighty-six percent of all counties in the United States did not have an abortion provider, and 32 percent of women ages 15 to 44 lived in these counties.[12]

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[6] *Henshaw, SK, The Accessibility of Abortion Services in the United States, **Family Planning Perspectives**, Vol. 23 (6):246-252&263, 1991.*

[7] *Darney, PD, Who Will Do the Abortions? **Women's Health Issues**, Vol 3 (3):158-161, 1993; and Westhoff, C, Abortion Training in Residency Programs, Journal of the American Medical Women's Association, Vol. 49 (5): 150-152&163, 1994.*

[8] *Henshaw, SK, Abortion Incidence and Services in the United States 1995-1996, **Family Planning Perspectives**, 30(6): 263-270&287, 1998.*

[9] *Joyce,T, Henshaw, S, Skatrud, JD, The Impact of Mississippi's Mandatory Delay Law on Abortions and Births, **JAMA**, Vol 278(8):653-658, 1997.*

[10] *Radford, B, Shaw, G, Antiabortion Violence: Causes and Effects, **Women's Health Issues**, Vol. 3(3):144-151, 1993, and Hern, W, Life on the Front Lines, **Women's Health Issues**, Vol. 3(3):138-143, 1993*

[11] *Henshaw, SK, Abortion Incidence and Services in the United States 1995-1996, **Family Planning Perspectives**, 30(6): 263-270&287, 1998.*

[12] *Henshaw, SK, Abortion Incidence and Services in the United States 1995-1996, **Family Planning Perspectives**, 30(6): 263-270&287, 1998.*

Patient Feedback

Many hospitals, health care insurance plans, and other types of institutional health care providers now routinely include customer feedback as part of quality improvement initiatives. National accreditation agencies like the Joint Committee for Accreditation of Health Care Organizations and National Committee on Quality Assurance have approved standardized instruments for use in accreditation and evaluation. However, none of these standards include measures specifically for abortion services. Abortion providers, because they are often freestanding specialty practices, have largely been left out of these efforts. Although many abortion clinics survey their own patients, standardized questionnaires and national comparative benchmarks have not been developed.

There are some aspects of health care that can only be evaluated by the consumer. For example, the patient is the best source of information about the effectiveness of pain control, the clarity of clinical information, or the coordination of care across settings. As health care providers have begun to understand the importance of patient evaluations of care, the distinction between technical quality of care and the values and preferences of patients is decreasing.

Clinical outcome measures are one type of quality of care measures, but they are of limited value because adverse clinical outcomes are extremely rare for routine abortions, and rates of infection and complication are very low.[13] The clinical quality of care is excellent for practically every abortion patient if we look at outcome measures alone. However, we know from surveys of patients that processes that affect both medical and emotional well-being are what really matter to patients.[14] While providers often assume they know best what patients want, patient reports are the only source of information describing what they need and want.

To our knowledge, there are no previous studies of quality of abortion care from the patient's perspective. Most surveys of abortion patients have focused on psychological issues related to the decision to have an abortion,[15] or on the demographic characteristics of women seeking abortion.[16] Several articles detail quality of care standards for abortion developed by providers, but little is available on what patients think is important.[17]

Anecdotally, there is variation among abortion clinics in amount and type of counseling offered, organization of clinics, visit process flow, and amount of support for patient.

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[13] *Council on Scientific Affairs, American Medical Association, Induced Termination of Pregnancy Before and After Roe v Wade,* ***JAMA****, 268: 3231-3239, 1992..*

[14] *Cleary, PD, Edgman-Levitan, S, Walker, J, et. al., Using patient reports to improve medical care: A preliminary report from 10 hospitals,* ***Quality Management in Health Care****, 1993, Vol. 2, 31-38.*

[15] *Adler, NE, David, HP, Major, BN, Roth, SH, Russo, NF, Wyatt, GE, Psychological Factors in Abortion: A Review,* ***American Psychologist****, 1992, Vol. 47 No 10: 1194-1204.*

[16] *Henshaw, Stanley K., Kost, Kathryn, Abortion Patients in 1994-5: Characteristics and Contraceptive Use,* ***Family Planning Perspectives****, Vol. 28, No 4 (July/August 1996): 140-147&158.*

[17] *National Abortion Federation, Standards for Abortion Care, Wash, DC: 1988: 1-19, and Hern, WM, The Concept Of Quality Care In Abortion Services,* ***Advances in Planned Parenthood****, Association of Planned Parenthood Physicians, Vol. 13 (1):63-74, 1979.*

Consequently, there is a need to systematically evaluate care from the patient's perspective. Comparative study of clinic performance using a standard patient-report tool with systematic samples of patients across large numbers of clinics is the best way to credibly measure the impact of practice variation on patients and to identify policies and practices that patients value. Differences among providers can help us identify best abortion care practices that other clinics might adopt to improve services.

Methodology

The survey was conducted among women 18 and over, English- or Spanish-speaking, competent to consent, who had an abortion at one of twelve clinics nationwide. Interviews were conducted between July and October 1998. Women were contacted by the telephone 3 to 4 weeks following their abortion. Of the 3601 women eligible for the study who agreed to be contacted, 2215 completed the survey. The Center for Survey Research carried out the telephone surveys for The Picker Institute and Kaiser Family Foundation.

The Picker Institute made site visits to abortion clinics around the country to map out the process of care and examine existing patient feedback mechanisms. Focus group research was conducted with patients and providers to identify which aspects of abortion care each thought are most important, including those which they thought are especially good or especially problematic. Different survey methods— hand-out, mail, and telephone surveys— were tested out to determine which methodology would achieve the best response rate with abortion patients. A national advisory committee helped design the survey instrument. (The advisory committee is listed in the Appendix.)

Sites

Twelve abortion clinics from different geographical regions in the U.S. (each was located in a different state) and representing a diverse set of characteristics were included in the study. Abortion clinics were selected to participate in the study with the assistance of the two major abortion provider associations, the National Abortion Federation and the National Coalition of Abortion Providers. The clinics participating in the study were chosen to reflect the characteristics of abortion clinics nationwide as characterized in the most current data available at the time the study was conducted from the Alan Guttmacher Institute.[vi] Annual procedure volume ranged from 1500 in one clinic to 8000 in the largest site. Four of the clinics were nonprofit and eight were for-profit. Six were freestanding, three were part of multi-clinic provider groups, and three were Planned Parenthood affiliates. Years in operation ranged from 3 to 26. Six of the twelve states represented did not allow Medicaid coverage of abortion, four required parental consent for minors, two had 24-hour waiting periods, and three restricted private and/or public employee insurance. The clinics had varying clinical protocols, and served diverse patient populations. Selected site characteristics are contained in the table below. (The order of the clinics does not correspond to tables later in the report that provide any clinic specific information.)

Profile of Clinics in Study

Clinic	Profit status	Years in operation	Affiliation*	Annual procedure volume	Procedures offered**	Procedures up to # weeks	Protesters	Restrictions***
A	FP	19	FS	3,300	S	22	Yes	F
B	FP	13	FS	2,000	S	19	Yes	
C	FP	25	FS	6,800	M,S,L	24	Yes	I,V
D	FP	4	PG	3,400	M, S,L	24	Rarely	V24
E	NFP	26	PPFA	5,000	M,S,E	20	Yes	F,V
F	FP	14	FS	3,100	M,S,E	17	Rarely	V
G	FP	3	PG	1,500	S,E	16	Yes	F1,C,W
H	FP	22	FS	2,000	S,E,L	21	Yes	F,C,I
I	NFP	12	PPFA	8,000	M,S,E	18	Yes	C,I,V24
J	NFP	25	FS	6,216	M,S,L	22	Yes	F,C,W,V
K	FP	5	PG	3,500	S,E,L	24	Rarely	V20
L	NFP	11	PPFA	1,800	S	19	Yes	F

Key:

** PG=Affiliated with Provider Group*
PPFA=Affiliated with Planned Parenthood Federation
FS=Free Standing
*** M=Medical, S=Surgical, E=Early (<8 wks), L=Later (>20 wks)*
**** F=Medicaid funding restricted to life, rape, incest*
F1=Medicaid funding restricted to life endangerment
C=Parental consent/notification for minors
W=24-hour waiting period
I=Restrict private and/or public employee insuance
V=Restrict in post-viability of pregnancy
V20=Restrict after 20 weeks gestation
V24=Restrict after 24 weeks gestation

Survey Enrollment Process

Survey enrollment comprised several steps. Demographic and clinical information was collected on ***every*** patient seen by the 12 clinics during the study period on a Patient Data Sheet. Women were considered eligible for the study if they were age 18 or older, mentally competent (meaning they did not have a clinical diagnosis of mental illness or retardation), spoke and read English or Spanish and completed the abortion procedure. Eligible women were asked during their counseling session if they were willing to be surveyed and were "enrolled" if they consented. They were interviewed by telephone about four weeks post-procedure.

The start-date for enrollment of patients was staggered through the summer of 1998. Four clinics began enrolling patients in July 1998, and the remaining eight clinics began enrollment activities in August and September 1998. Enrollment was completed in October 1998.

Survey Response Rates

During the study period the 12 sites cared for 8061 abortion patients, of whom 85 percent were eligible for the study. The 15 percent of patients who were not eligible were under age

18, had a clinical diagnosis of mental illness or retardation, spoke a language other than Spanish or English, or did not have the abortion procedure at the clinic. Of the women who were eligible to participate in the study, 52 percent consented to be surveyed. (The demographics of women who consented and refused to be surveyed were not statistically significantly different.) Consent rates varied by clinic, ranging from 43 to 74 percent.

Of the women who initially agreed to be surveyed, 62 percent or 2215 patients completed the telephone interview. Some women who were initially willing to be surveyed changed their minds, and others were not reached although multiple follow up calls were made to non-respondents who had agreed to be surveyed. A third (32%) of eligible women participated in the study.

Survey respondents were slightly older than non-respondents (average ages were 26.6 and 25.5 respectively) and more likely to have some college or graduate level education, (58% versus 49%) to be white, (51% versus 46%) and married (17% versus 13%). These differences are typical for surveys of patients.

Site	Percent of Eligible Women Who Consented to Be Interviewed n=3563	Percent Who Completed the Interview* n=2215	Number Who Completed the Interview*
1	51%	72%	208
2	54%	55%	240
3	65%	47%	115
4	55%	58%	248
5	43%	61%	237
6	43%	63%	242
7	44%	58%	144
8	66%	69%	46
9	51%	67%	252
10	63%	65%	169
11	74%	70%	180
12	56%	61%	134
Total	52%	62%	2215

** Among eligible women who consented to be interviewed*

Characteristics of Survey Respondents

The women who visited the clinics had similar characteristics to those found in a national survey of abortion patients conducted by the Alan Guttmacher Institute (AGI) in 1994-5, the most recent previous data available for comparison.[18] The table below compares the characteristics of the survey respondents with those of the clinic population overall and the AGI study population. Twenty-four women completed the interview in Spanish.

[18] *Henshaw, S K., Kost, Kathryn, Abortion Patients in 1994-5: Characteristics and Contraceptive Use,* ***Family Planning Perspectives****, Vol 28, No 4 (July/August 1996): 140-147&158.*

Clinic Patients Compared to National Sample of Abortion Patients

	AGI* Survey Respondents n=9985	Clinic Population n=8061	Survey Respondents n=2215
AGE			
Less than 20 years	22%	23%	12%**
Age 20-24	33%	30%	34%
Age 25-29	21%	23%	26%
Age 30-34	14%	13%	14%
Age 35-40	8%	9%	9%
Age 40+	2%	3%	4%
Age range (years)		13 to 48	18-45
Average age (years)		25	26
RACE			
African American	31%	31%	29%
White	61%	51%	51%
Other	8%	19%	16%
ETHNICITY			
Hispanic	20%	15%	15%
Non-Hispanic	80%	85%	84%
EDUCATION			
Less than High School	21%	18%	8%
HS Grad or GED	30%	34%	32%
Some College	35%	31%	38%
College Grad & Post-Grad	14%	17%	20%

**Alan Guttmacher Institute 1996*

*** Survey respondents were limited to those 18 and older.*

Note: Percentages may not add to 100% due to rounding.

Findings

Overall Satisfaction with Abortion Care

Abortion patients report high levels of satisfaction with their care: 60 percent of women say their care was "excellent" and another third (38%) say it was "very good" or "good." Two percent of women say their care was "fair" and less than one percent say it was "poor." Patient's overall rating of their care did not differ by a woman's age, race, insurance status or length of pregnancy.

Nearly all patients (97%) feel the information they received that day was excellent, very good, or good. Most (94%) thought the staff's overall attention to their privacy was similarly excellent, very good or good. All patients thought the clinic was clean (100%), including eight in ten who thought it was very clean (79%).

	Overall Information	Overall Attention To Privacy	Overall Care
Excellent	56%	55%	60%
Very Good	30%	25%	26%
Good	11%	14%	12%
Fair	2%	4%	2%
Poor	*	1%	*

**Less than 1%.*

Fifty-one percent reported back that their care was "better than expected." Almost all remaining patients (46%) say the care they received was "about what [they] expected." Only 3 percent of patients say the care was "worse than expected." Nearly all patients (96%) say they would recommend their abortion provider to a friend or family member.

Women's ratings on other general aspects of their care are almost as high, though there was more variation. About three quarters (78%) of patients say they had "a lot" of confidence and trust in the staff who treated them that day, compared to nearly one in five (18%) who say they had "some" confidence and trust. Almost nine in ten (88%) of patients say the staff treated them with "a lot" of dignity and respect, and 9 percent say they were treated with "some" dignity and respect. Patients did not feel inappropriately judged or treated with disrespect, either. Ninety-one percent say the staff treated them in a non-judgmental way.

	Overall Confidence and Trust in Staff	Overall Treated with Respect and Dignity by Staff
A lot	78%	88%
Some	18%	9%
Only a little	3%	2%
None at all	1%	*

**Less than 1%*

Perspectives on Quality of Abortion Care As Compared to Other Ambulatory Surgery Care

The Picker Institute has surveyed ambulatory surgery patients about their care for many years. From a national database of 21,750 adult ambulatory surgery patient surveys conducted by Picker, female ambulatory surgery patients ages 18 to 45 were selected as the group most similar to abortion patients, and their evaluations of care were compared. The comparison group of 5,509 female ambulatory surgery patients were seen in 71 medical practices nationwide (both in hospital outpatient clinics as well as medical offices, but not freestanding clinics) and were surveyed between July 1996 and September 1998. The types of procedures the comparison group underwent were: cataract removal, breast lumpectomy, excision of skin or tissue, release of carpal tunnel, and colonoscopy, among others.

The questions asked of the abortion patients were modified slightly for relevance from questions asked in studies conducted by Picker of other ambulatory surgery patients, including the ones used for the comparison data here. (Complete question wording appears below and in the toplines included in this report). The surveys of ambulatory surgery patients were conducted by mail, whereas this survey was conducted by telephone. A comparison of patients 'responses reveals that quality of care for abortion patients is roughly comparable to that for other ambulatory surgery patients, with two exceptions. Although the majority gave their care high scores, more abortion patients than ambulatory care patients felt their providers could have done more to help them with nausea after the procedure, and a higher percentage said that their providers did not help them make a follow-up appointment. However, the latter may be due to the fact that many abortion patients have follow-up appointments with their regular providers, or choose not to have a follow-up visit.

Abortion patients ages 18-45 (n=2215)		**Female ambulatory surgery patients ages 18-45 (n=5509)**	
QUESTION *(RESPONSE IN ITALICS)*		QUESTION *(RESPONSE IN ITALICS)*	
Did any staff member give you a chance to talk about any concerns or fears you had about the procedure? *(Yes)*	94%	If you had any anxieties or fears about your procedure, did a nurse discuss them with you? *(Yes)*	95%
How much pain or discomfort did you have during the procedure, was it severe, moderate, mild, or none? *(Severe)*	14%	If you had pain, was it severe, moderate, mild, or none? *(Severe)*	17%
Do you think the staff could have done more to control your pain, or did they do enough? *(Did Enough)*	91%	Do you think that the staff did everything they could to help control your pain? *(Yes)*	97%
When you were in the recovery area do you think the staff did could have done more to help you control your nausea or upset stomach or did they do enough? *(Did Enough)*	89%	Did the staff do everything they could do to help control your feelings of nausea or upset stomach? *(Yes)*	94%
Did a staff member tell you anything about problems to watch for after you left the clinic? *(Yes)*	96%	Did someone tell you what danger signals about your illness or operation to watch for after you went home? *(Yes)*	91%
Did a staff member tell you who to call if you needed help or had more questions after you left the clinic? *(Yes)*	97%	Did you know who to call if you needed help or had more questions after you left? *(Yes)*	92%
Did a staff member offer to make a follow-up appointment for you? *(Yes)*	86%	If you needed a follow-up visit in this department, did the staff do everything they could to make the necessary arrangements? *(Yes)*	96%
Would you recommend this clinic to your family and friends if they needed the same procedure? *(Yes)*	96%	Would you recommend this office or hospital to your family and friends? *(Yes)*	98%
Overall was the care that you received from the clinic staff excellent, very good, good, fair or poor?		Overall, how would you rate the care you received during your procedure?	
(Excellent)	60%	*(Excellent)*	53%
(Very Good)	26%	*(Very Good)*	33%
(Good)	12%	*(Good)*	11%
(Fair)	2%	*(Fair)*	3%
(Poor)	*	*(Poor)*	1%

**Less than 1%*

Satisfaction with Specific Aspects of Abortion Care

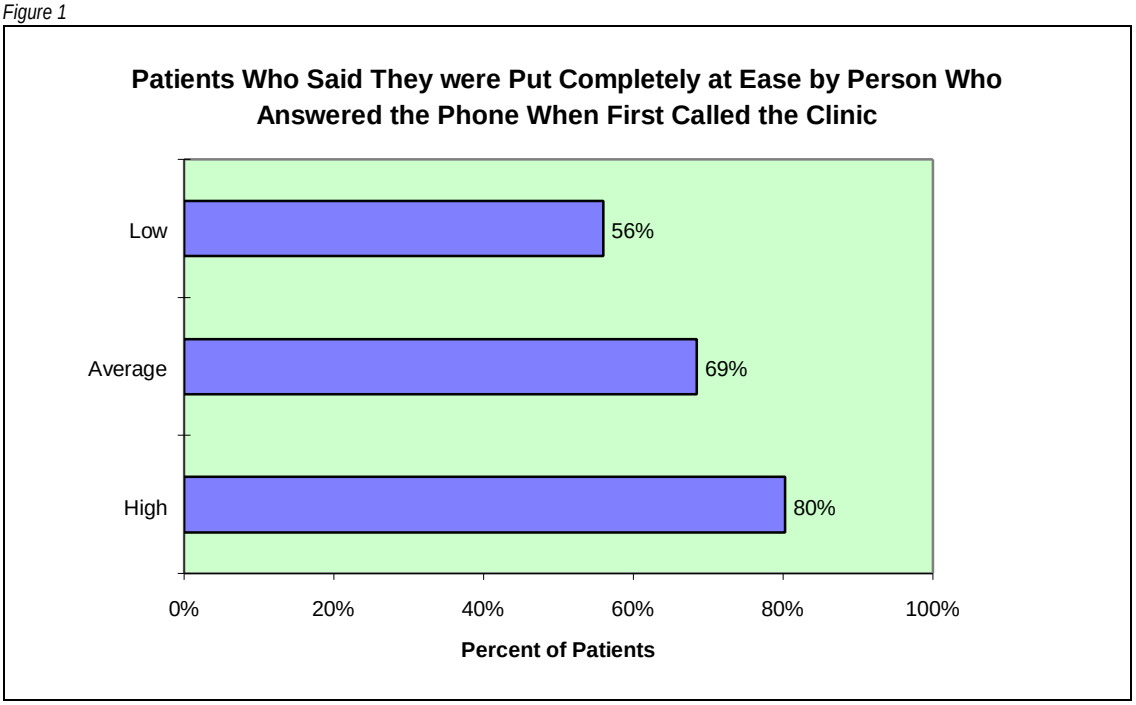
Overall, patients report that the clinics excel in providing all the information they want, counseling about the decision to abort and potential physical and emotional consequences, privacy during the procedure, and post-procedure information. Though still garnering high ratings from most patients, their responses indicate that clinics could improve their care by providing more privacy in the waiting area, more post-procedure telephone help, more information when patients call to make an appointment, more pain relief, and more intensive nursing care in the recovery time.

There were statistically significant differences in patient satisfaction with care among the twelve clinics participating in the study. (Unless otherwise noted, differences among clinics were statistically significant at the 99% confidence level.) This indicates that certain practices and protocols are preferred by patients, and that 'best practices' can be established by providers, which are discussed later in the report. There was not one clinic that consistently performed the best or the worst. Each site had its own strengths and weaknesses.

Making an Appointment

Telephone interactions were important in forming patients' first impressions of a clinic. Most patients made an appointment over the telephone before they visited the clinic for the procedure. Three quarters of women said they felt completely at ease after talking with the clinic staff member who answered the telephone. A quarter felt "somewhat at ease" (22%) or not at all at ease (3%). (Figure 1)

Figure 1



About half of the women spoke to a staff member about the "pros and cons of the procedure" ***before*** the day of the procedure, and of those, 97 percent said they got enough information. Of the women who did ***not*** speak to a staff member about the pros and cons of the abortion ***before*** the day of the procedure, 26 percent said it was something they would have liked to have done.

Thirty-five percent of women spoke with someone at the clinic about adoption and other alternatives to abortion before the day of the procedure. Women in later stages of pregnancy were more likely to have a discussion with a staff person about alternatives.

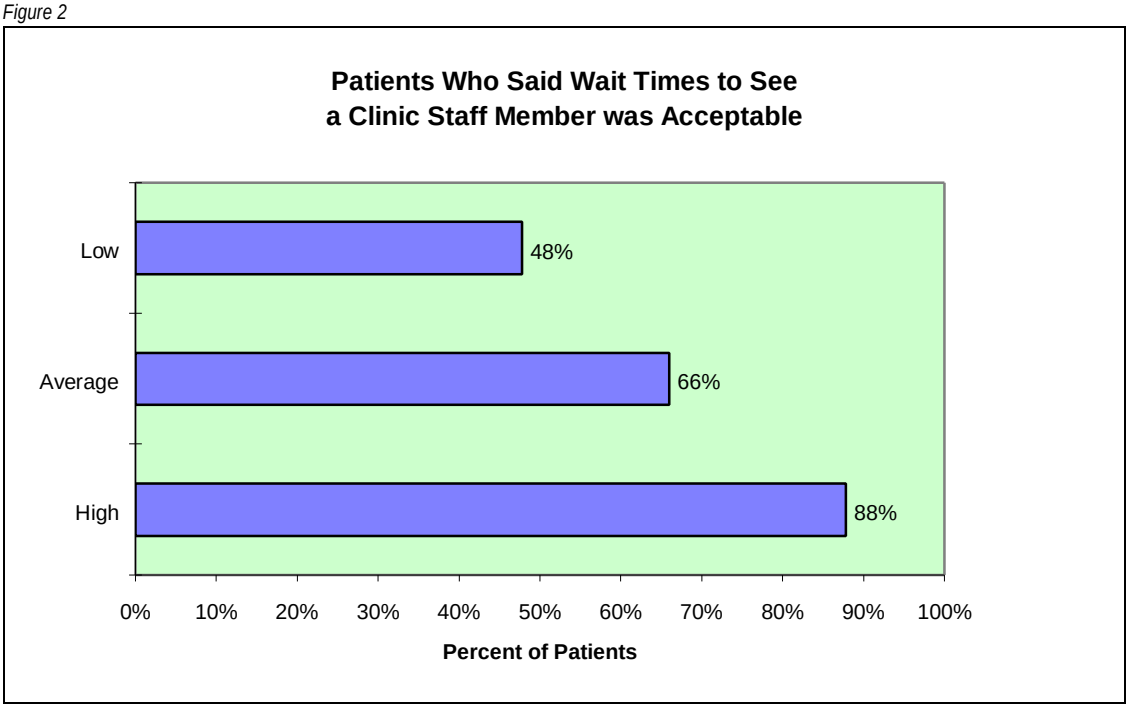
Ninety-three percent of women were told how long they could expect to be at the clinic on the day of their procedure and 93 percent discussed how they would get home after the procedure.

Care Prior to the Procedure

Waiting Time Before Being Seen

The average wait time before being seen by a staff member was 33 minutes. Two thirds (66%) of women felt that the wait time was acceptable. (Figure 2) One third of women (34%) felt that they waited too long. Women who reported waiting "too long" waited 60 minutes on average, or about twice as long as the norm.

Figure 2



Average Wait Times Before Being Seen

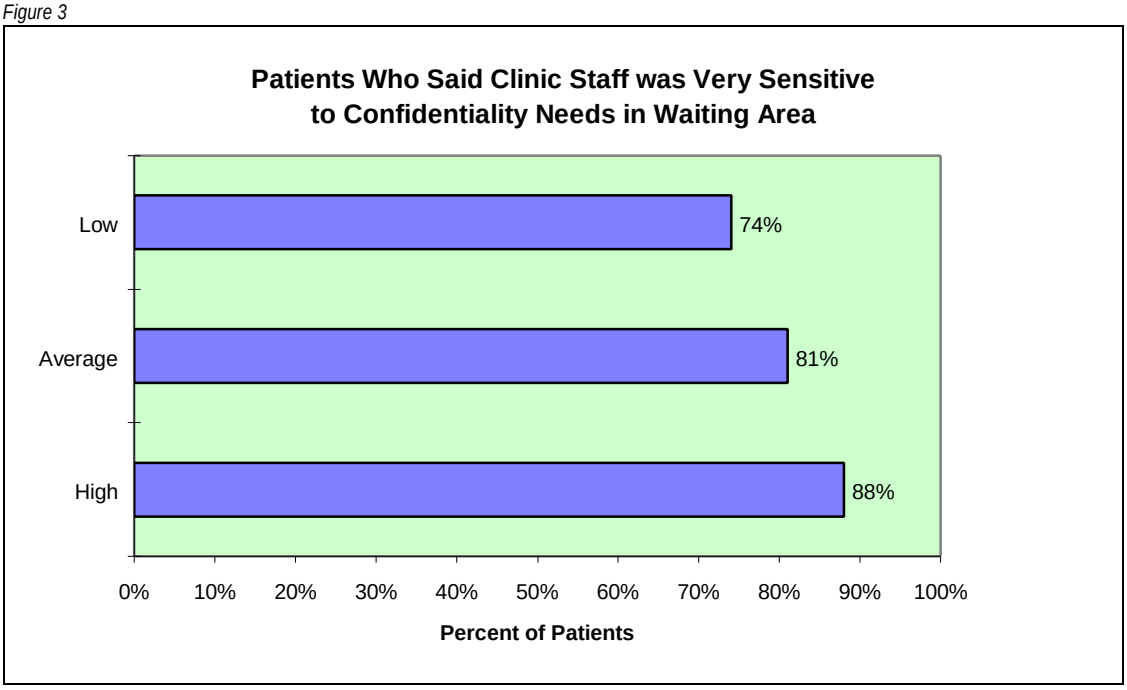
Site	Wait Time Before Being Seen	Wait Time for Women Who Say They Waited

	(minutes)	"Too Long" (minutes)
1	40	64
2	35	56
3	22	55
4	32	55
5	39	59
6	28	57
7	29	56
8	51	78
9	46	69
10	29	56
11	26	57
12	26	48
Total	**33**	**60**

Confidentiality

Nearly half of abortion patients (45%) say they were "very" or "somewhat" concerned about being seen or recognized in the waiting area. However, the vast majority (98%) thought that the staff was sensitive to their need for confidentiality, including 81 percent who thought they were "very sensitive." (Figure 3) The extent to which patients feel the staff was sensitive to confidentiality issues is highly correlated with their overall satisfaction with care.

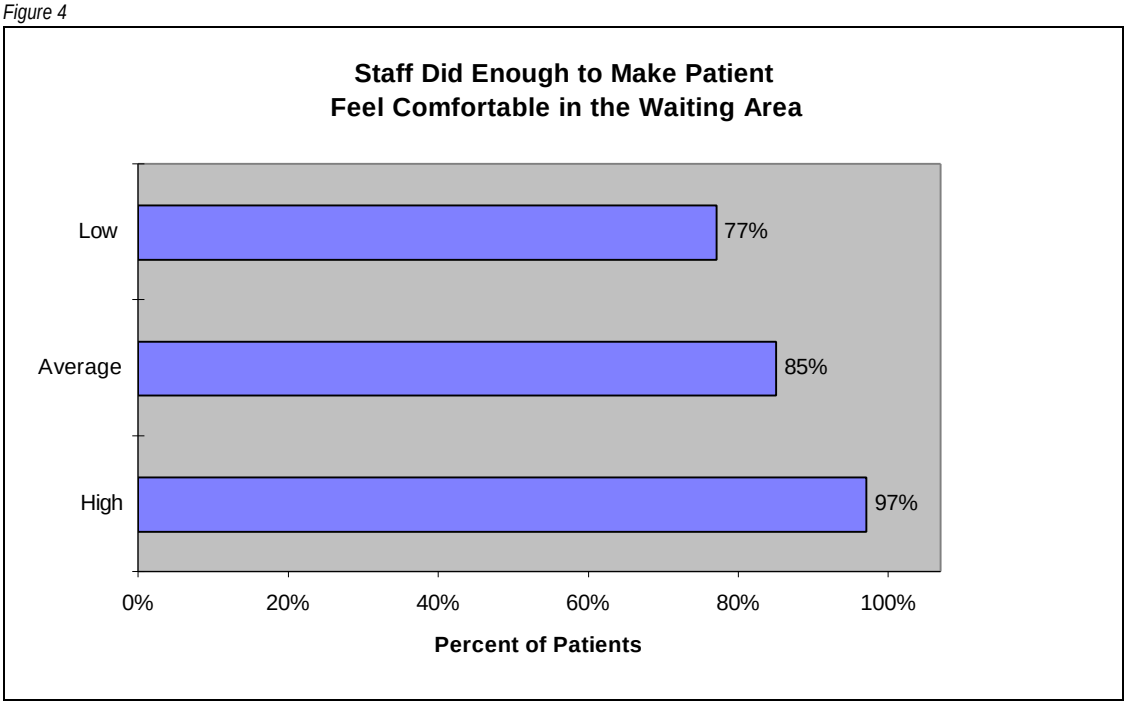
Figure 3



P = .03

Similarly, 85 percent of patients think the staff did enough to make them feel comfortable in the waiting area. (Figure 4) This item was also correlated with a patient's overall rating of care. If a woman felt that staff did as much as possible to make her comfortable while she was waiting, she was more likely to say her care was excellent.

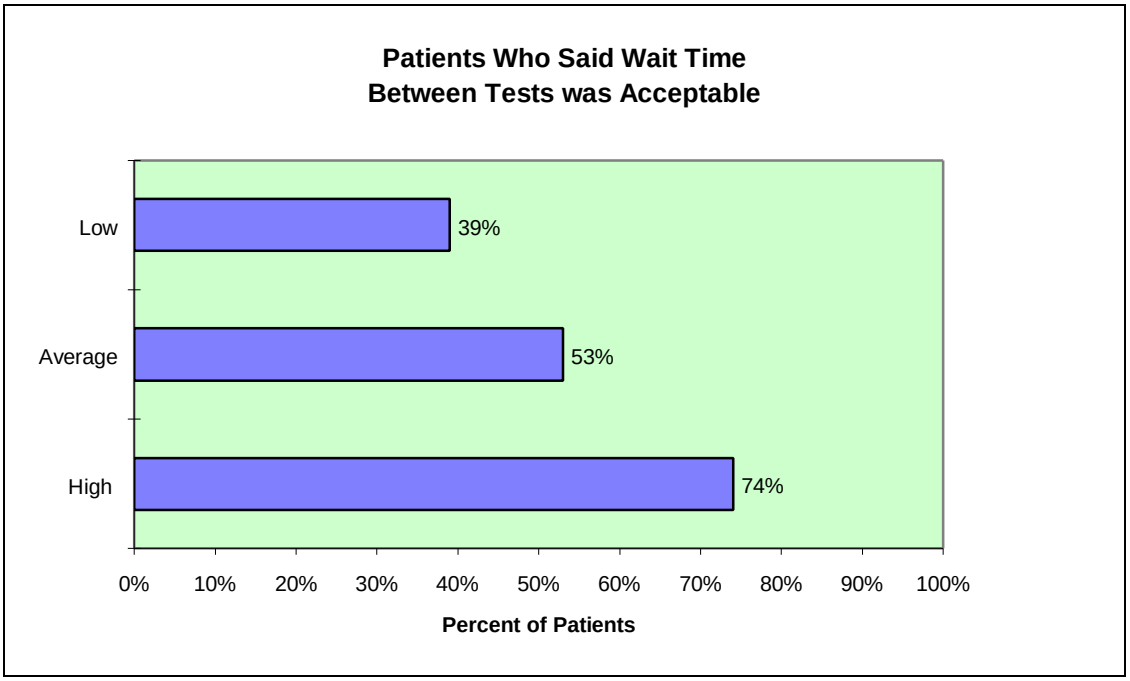
Figure 4



Waiting Time Between Tests, Counseling, and Procedure

About half (53%) of patients are not bothered by the time they waited between tests, counseling and the abortion procedure, and another third (31%) of women are bothered "a little" by the wait time. (Figure 5) However, some clinics did a better job of moving the process along or explaining the reasons for long waits. In one clinic, 74 percent of patients were not at all bothered by the amount of waiting, while in another 39 percent were not bothered. Seventy-two percent of women say they were told how long things would take when they arrived at the clinic, and 83 percent of them say the estimate was about right.

Figure 5



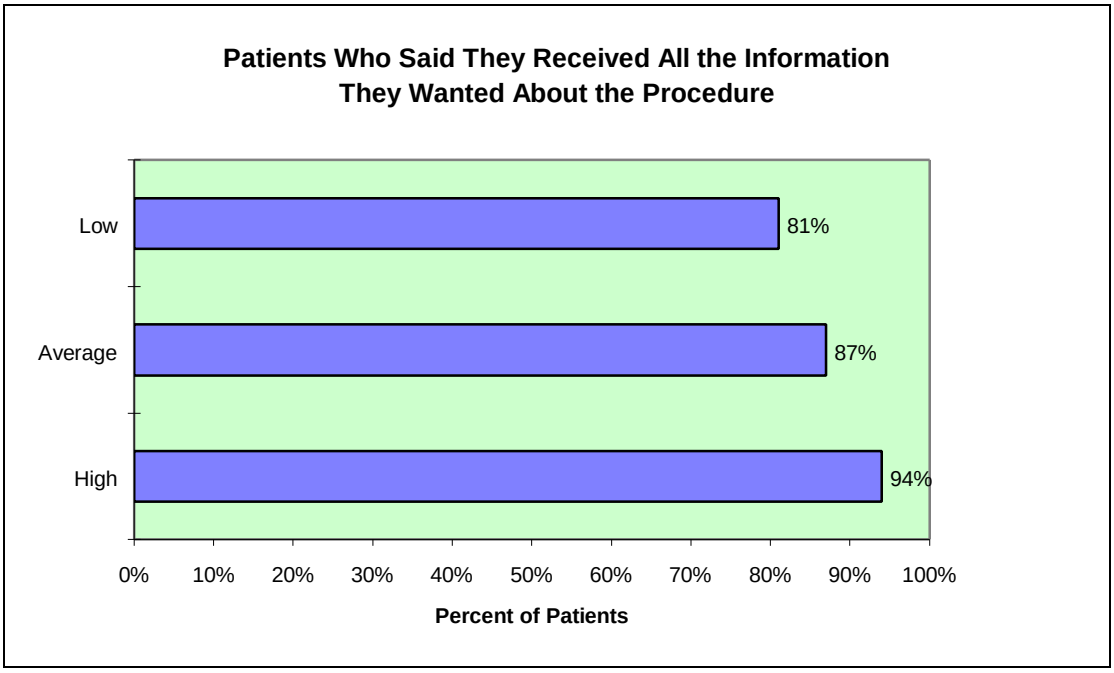
Information and Counseling

Scores on information and counseling were high. In nationwide studies of health care services conducted by The Picker Institute, patients consistently report problems with education and information, and at the same time, report considering it to be a very important aspect of care. Clearly, in this area abortion clinics are doing a good job of providing patient-centered care. Ninety-five percent of women say they were counseled on the day of the procedure. For most patients counseling was required (72% of respondents), for 22 percent it was optional and 6 percent were not sure. Of the 100 women (5%) who did ***not*** receive counseling (usually because they were counseled elsewhere), only 15 women said they would have liked it.

Ninety-eight percent of all women say the staff explained the procedure to them and ninety-nine percent of those women say the explanation was clear.

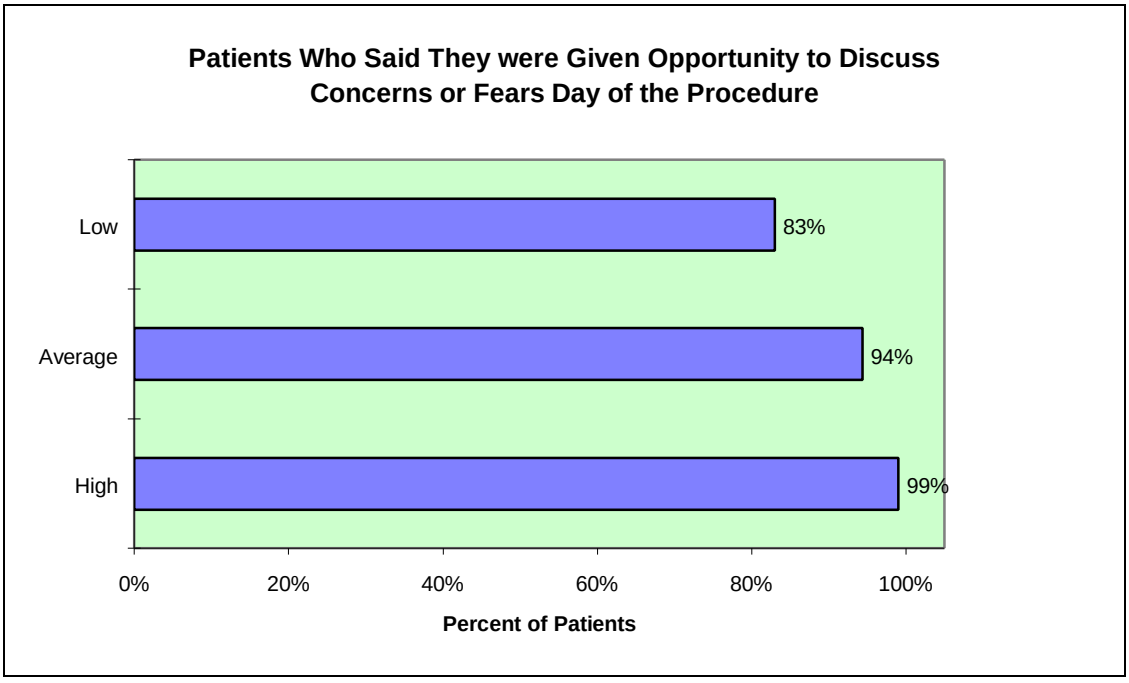
The majority of women say they received all of the information they wanted about what to expect during the procedure (87%). (Figure 6) Eleven percent received some of the information they wanted, and 2 percent received only a little, or none, of the information they desired.

Figure 6



Almost all women (94%) report that on the day of their procedure, they were given a chance to talk with staff about any concerns or fears they had about the procedure. (Figure 7) In several clinics the percentage was close to 100. However, in one clinic 14 percent of women say they were not offered a chance to discuss their concerns and fears.

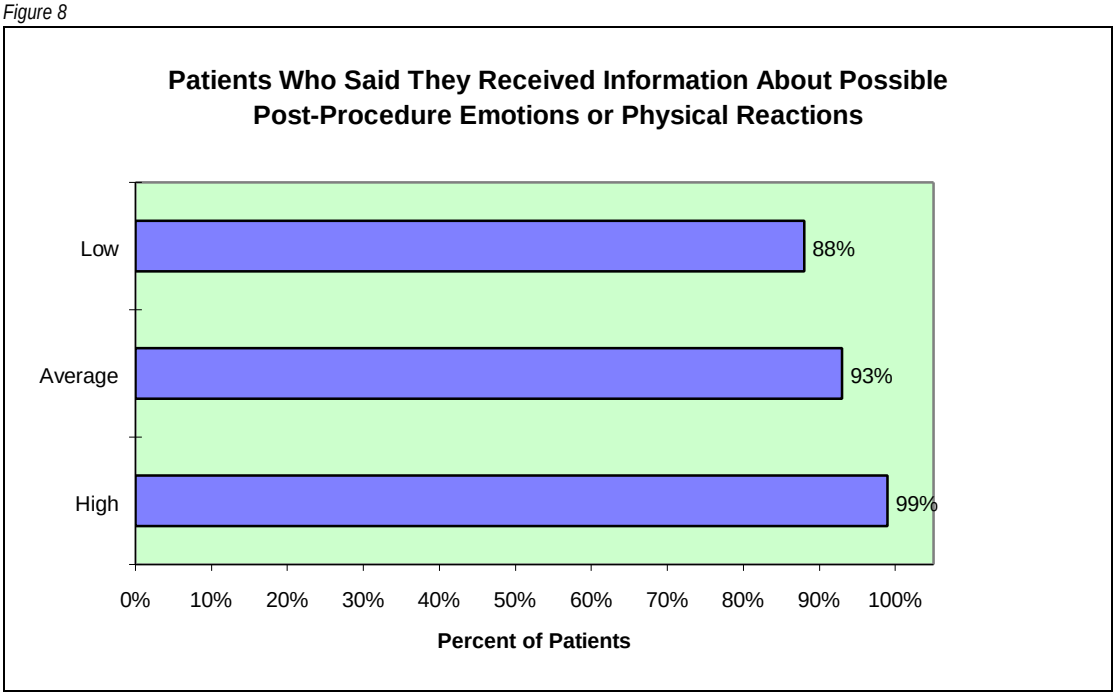
Figure 7



Again, when asked if the staff explained how they might feel physically and emotionally after the procedure, scores were high, with 93 percent of women responding yes. (Figure 8)

Ninety-one percent of women say they received as much information as they needed on this topic.

Figure 8



Nearly all women report being counseled by staff on their birth control options (97%), and 99 percent of them say the explanation was clear. (Figure 9) One in five (22%) women say they did need the clinic staff's help in deciding what kind of birth control to use after the procedure--these women ranged in age from 18 to 39 years old. Many fewer patients report being counseled on sexually transmitted diseases than birth control. Six in ten (60%) patients, on average, report receiving information on STDs, including HIV, with as few as 44 percent of women in one clinic and as many as 85 percent in another. (Figure 10) Almost every patient (99%) who received the STD counseling reports understanding the information.

Figure 9

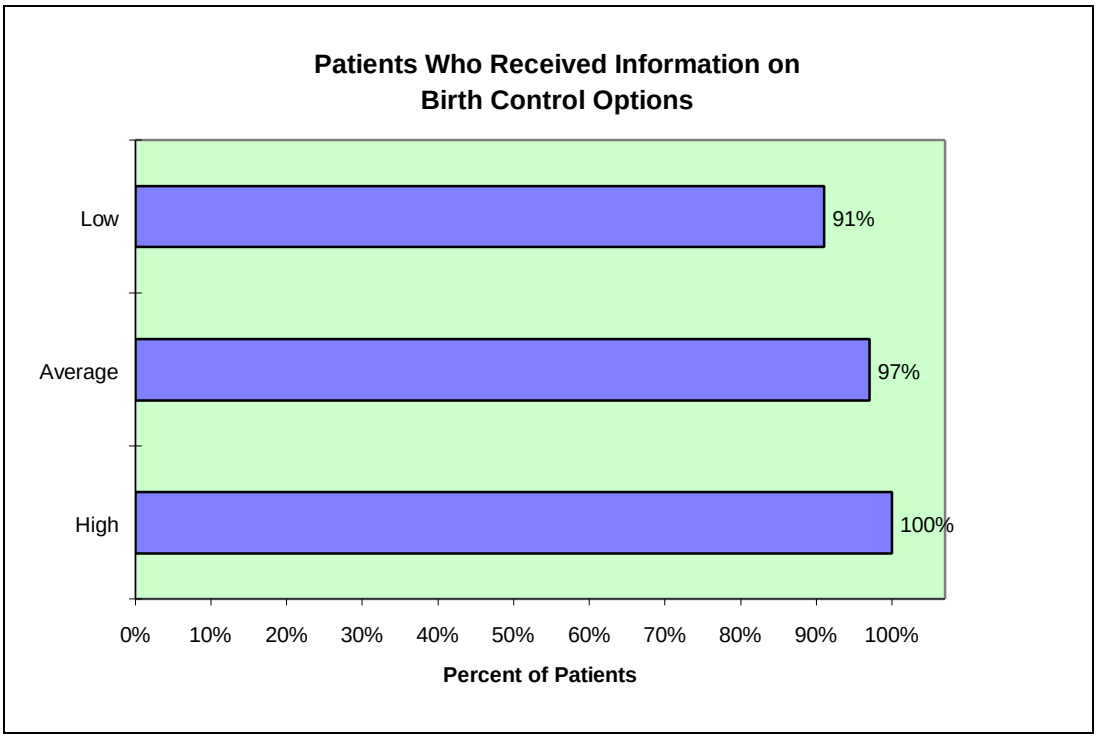
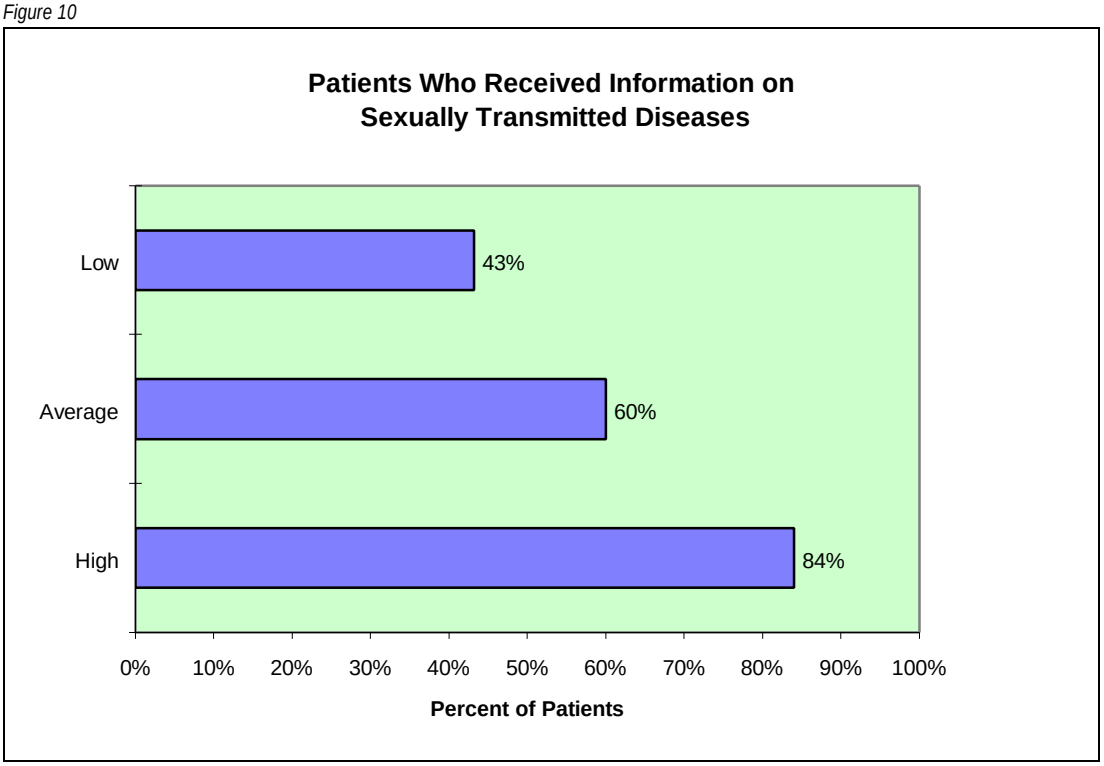
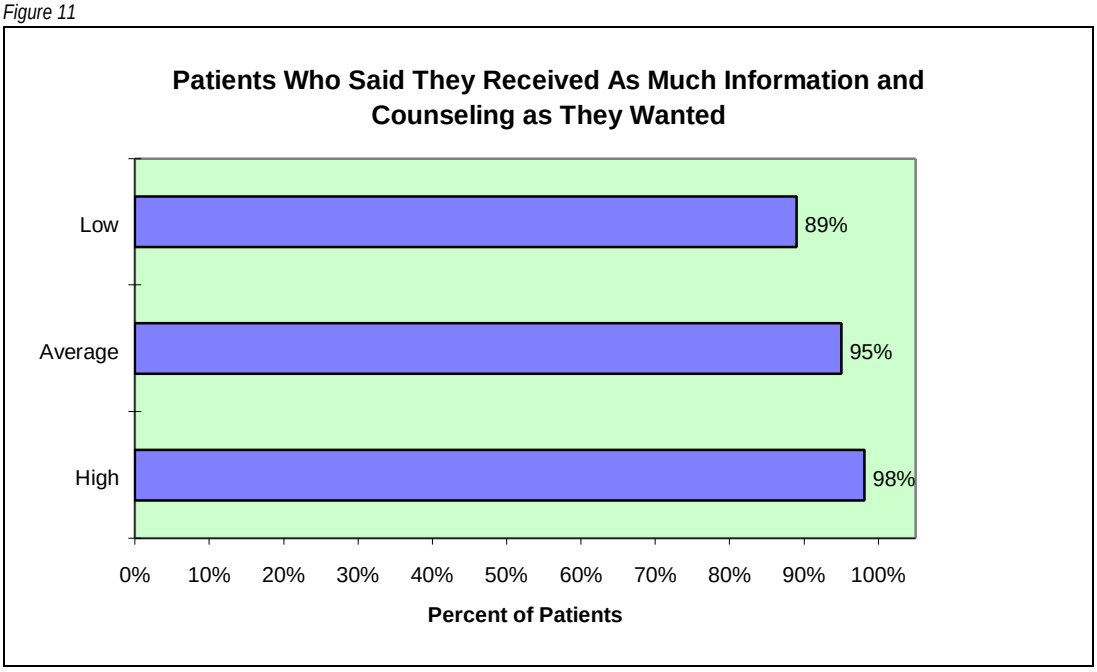


Figure 10



Overall, women rate the information and counseling they received highly, with nearly all saying they received as much information and counseling as they wanted (85%) or more (9%). (Figure 11) Just 5 percent of women say they received less information than they wanted.

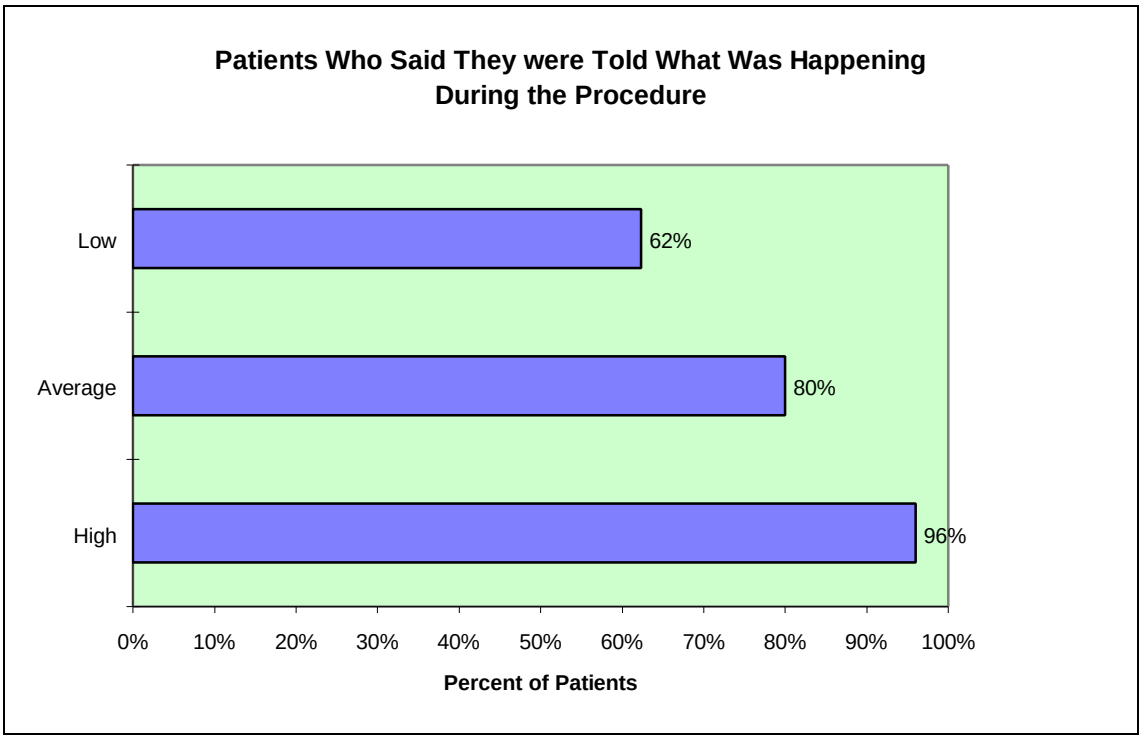
Figure 11



Care Given During the Procedure

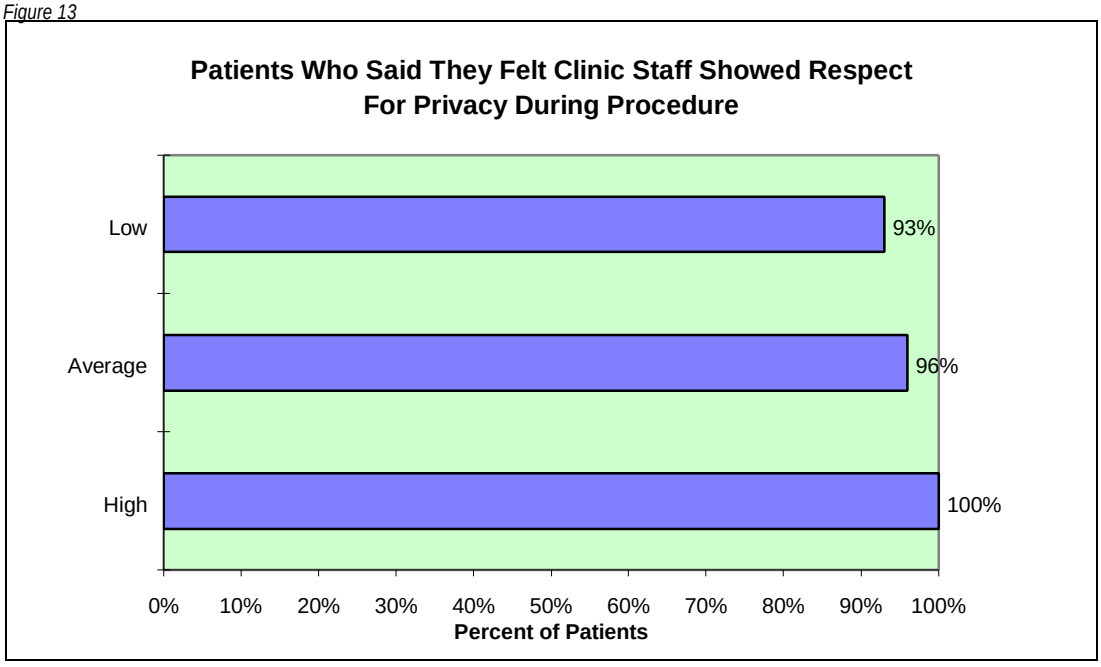
During the procedure, staff explained what was happening to 80 percent of patients, and 98 percent of them found the explanation clear. (Figure 12) Ninety-one percent of women report being comforted by a staff member during the procedure, and most patients (88%) say they wanted a staff member to comfort them then.

Figure 12



Patients say staff showed respect for their privacy during the procedure in 96 percent of cases. (Figure 13)

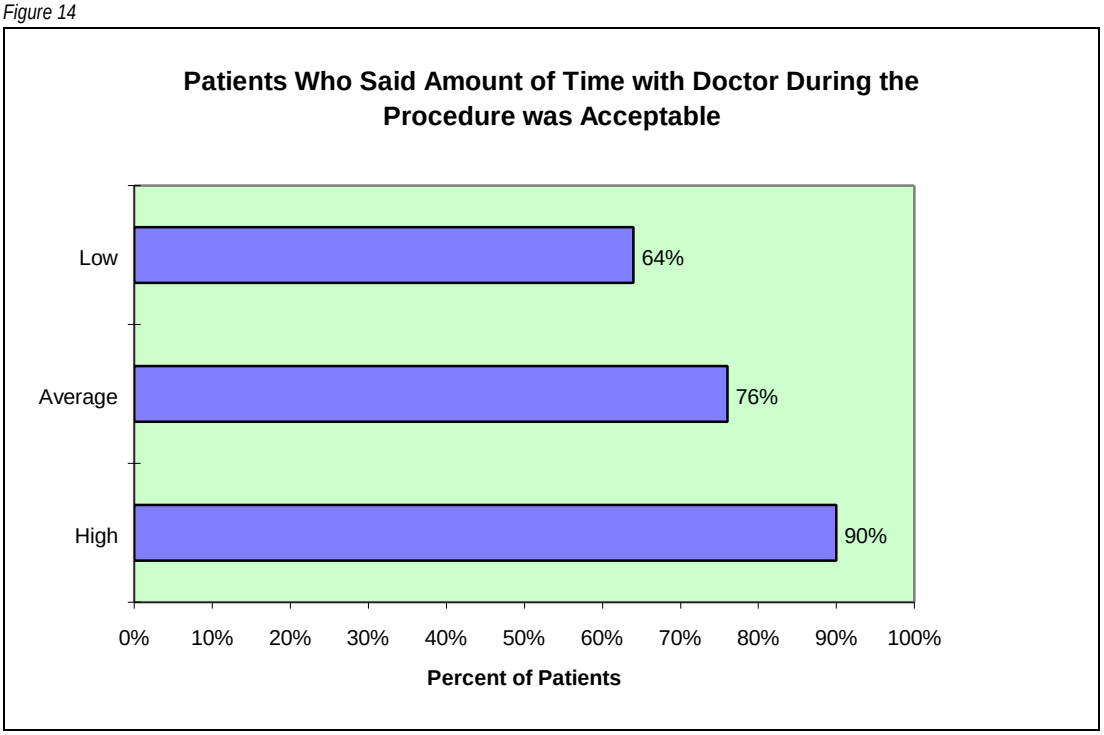
Figure 13



P = .03

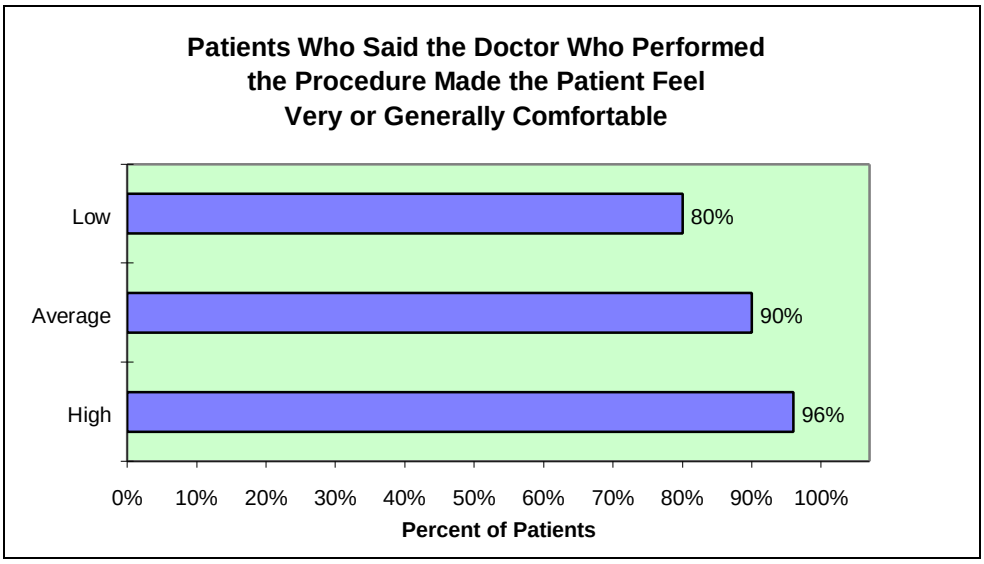
Three quarters (76%) of women report having as much time as they wanted with the doctor during the procedure, while one in five (19%) say they wanted more time, including 7 percent who wanted "a lot" more time. (Figure 14)

Figure 14



Nearly all (90%) women say the doctor who performed their abortion made them feel comfortable, including 51 percent who say he or she made them feel "very comfortable." (Figure 15) One in ten (9%), however, report he or she made them feel generally uncomfortable or very uncomfortable.

Figure 15



Pain Control

The clinics offered different anesthesia options depending on the type of abortion provided, weeks gestation, patient preference and insurance requirements. Some clinics used the same

protocol for all patients and some had several different protocols. Four clinics routinely offered general anesthesia, while others provide it in specific instances. Some insurers do not cover the cost of general anesthesia even if they cover abortion procedures. A few clinics offered general anesthesia for an additional charge to women who requested it when their insurer did not cover it. The table below shows the percent of patients receiving anesthesia by type, pain symptoms, nausea and readiness to go home, by site. Generally, women receive more than one type of anesthesia.

Although the abortion patients experienced somewhat less pain than the non-abortion comparison group of ambulatory patients described earlier in the report, they were more likely to say that their care providers could have done more to alleviate their pain and nausea. And regardless of degree of pain, one in five (20%) patients reported feeling more pain than they expected to during the procedure. It appears there is an opportunity to improve pain control as well as establish better expectations regarding pain. However, it is important to note that degree of pain was not strongly correlated with overall evaluations of care.

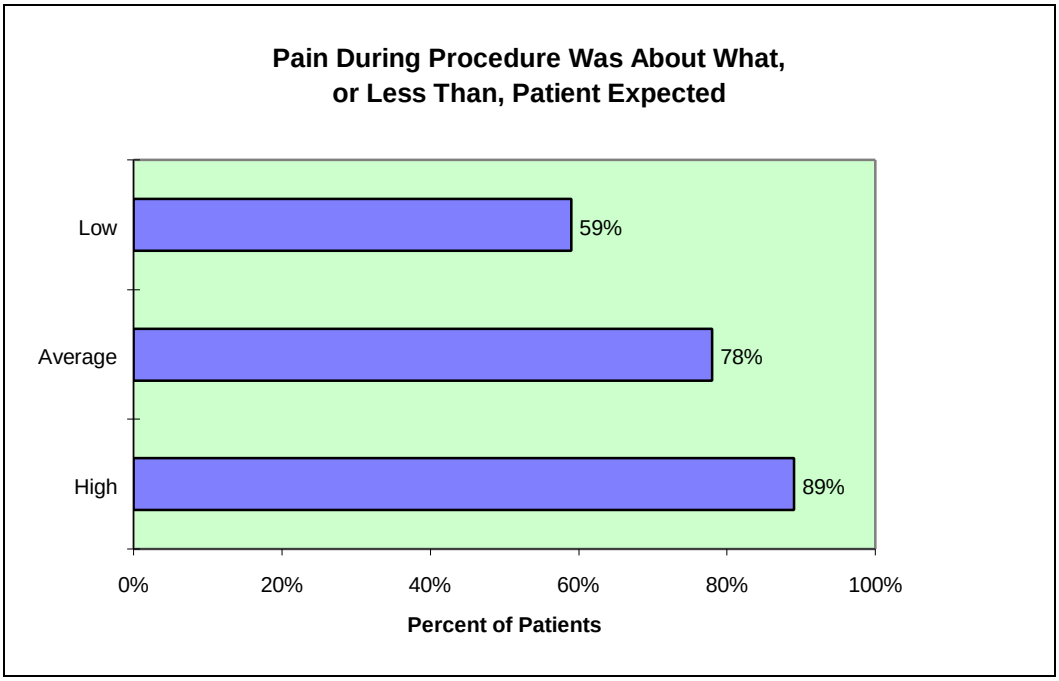
More research is needed on pain control using both clinical data and patient reports. There are obvious trade-offs between pain control, post-anesthesia nausea, and physical readiness to go home. Feedback from patients could provide clinics with an important source of information about the relative effectiveness of their various protocols.

Three-fourths (73%) of women reported being given a choice of the type of anesthesia they would receive.

Nearly a third (30%) of all patients report they felt no pain during the procedure. A little over half of women report feeling mild (25%) or moderate (29%) pain. One in seven (14%) patients, however, say they experienced severe pain.

Four in five patients say the pain they experienced during the procedure was about what they expected or less than they expected to experience. (Figure 16) Specifically, 43 percent say the pain during the procedure was less than expected and 35 percent say it was about what they expected. One in five (20%) say it was more than expected.

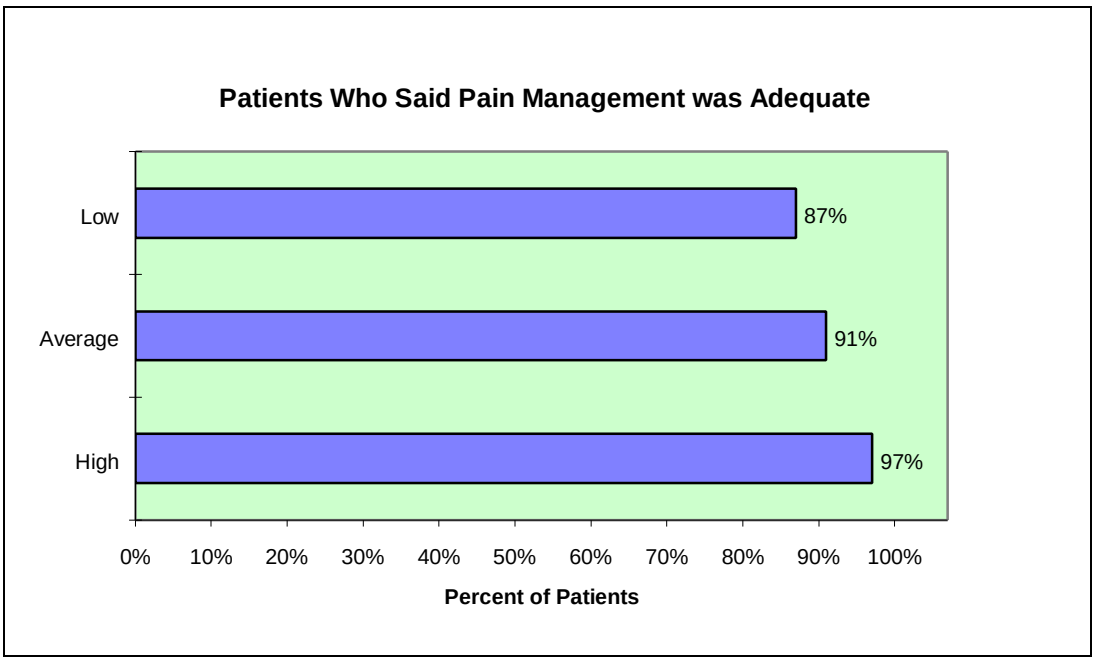
Figure 16



After the procedure, 18 percent say they had no pain, 37 percent reported mild pain, 34 percent reported moderate pain, and 11 percent of women say they had severe pain.

The vast majority of patients say the pain after the procedure was about what they expected or less. Thirty-eight percent of women say they experienced less pain than expected after the procedure and 44 percent say the pain was about what they expected. About one in five (18%) found the pain more than expected. Ninety-one percent of patients felt the staff did enough to control their pain. (Figure 17)

Figure 17

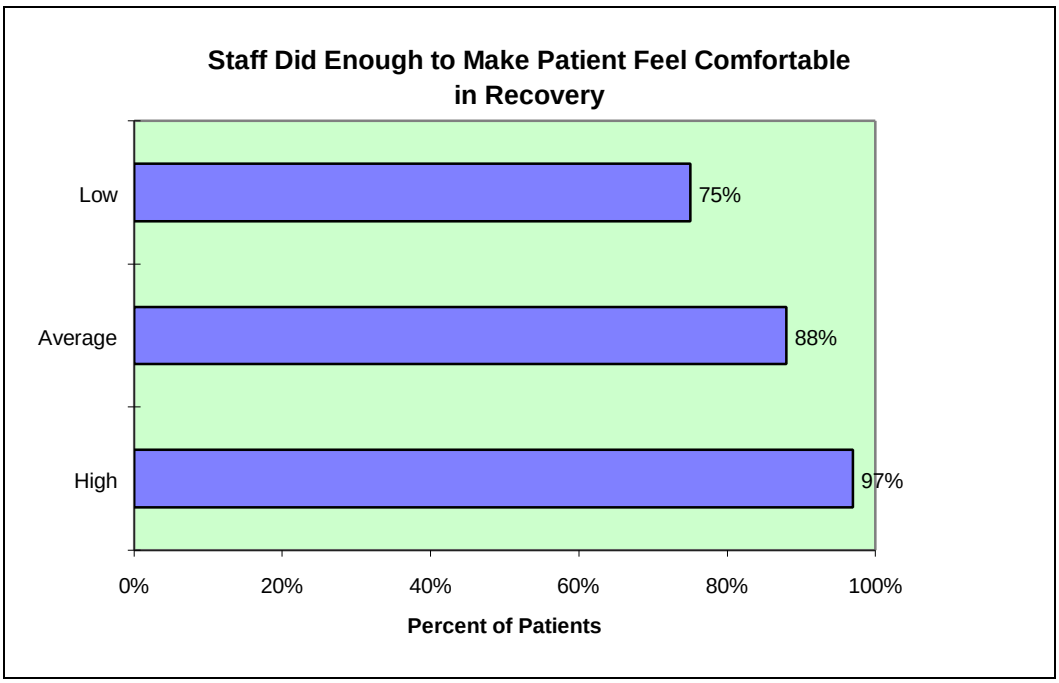


Care Given After the Procedure

Recovery

When women were in the recovery area, 88 percent say they felt the staff did enough to make them comfortable. (Figure 18) Clinics differed in the amount of recovery support provided, with 97 percent of patients in one clinic reporting that the staff did enough, while 75 percent of patients in another clinic say they felt that way.

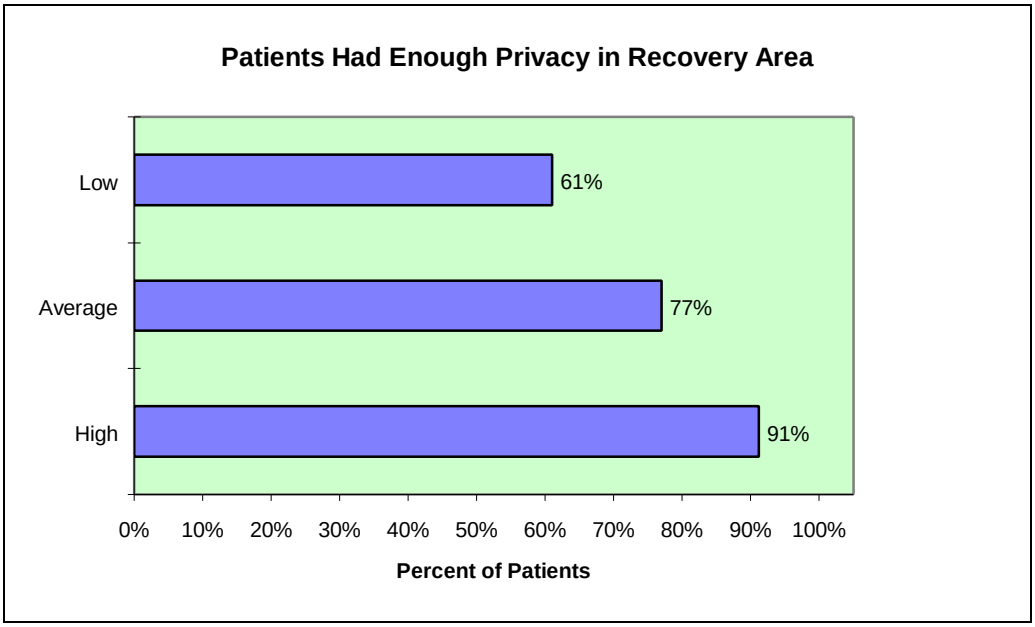
Figure 18



About one in three (36%) of women had an upset stomach or nausea while in recovery, and 89 percent of them thought that staff did enough to help them control the nausea.

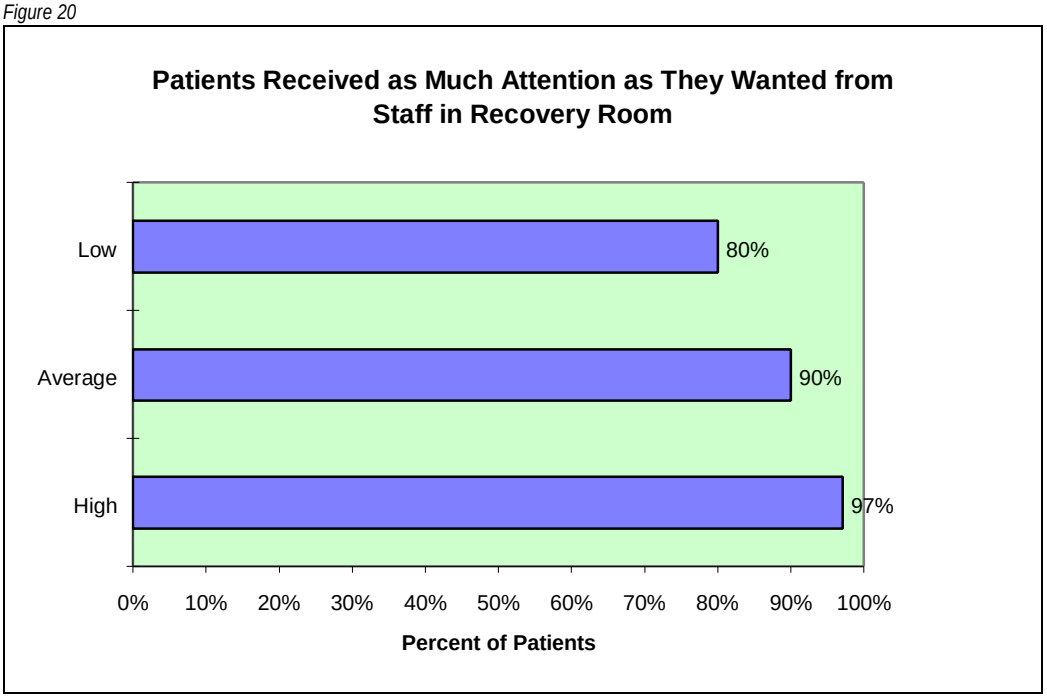
Privacy is a major concern of abortion patients, based on the weight women give to it in rating their overall abortion care. However, clinics scored well in providing women with sufficient privacy in the recovery area. The majority (77%) of patients say they had "enough" privacy in recovery, though it varied among clinics. (Figure 19) In one clinic, 91 percent of patients say they had enough privacy while at another site, 61 percent of patients say they had enough.

Figure 19



Ninety percent of patients say they got enough attention from staff in the recovery area. (Figure 20)

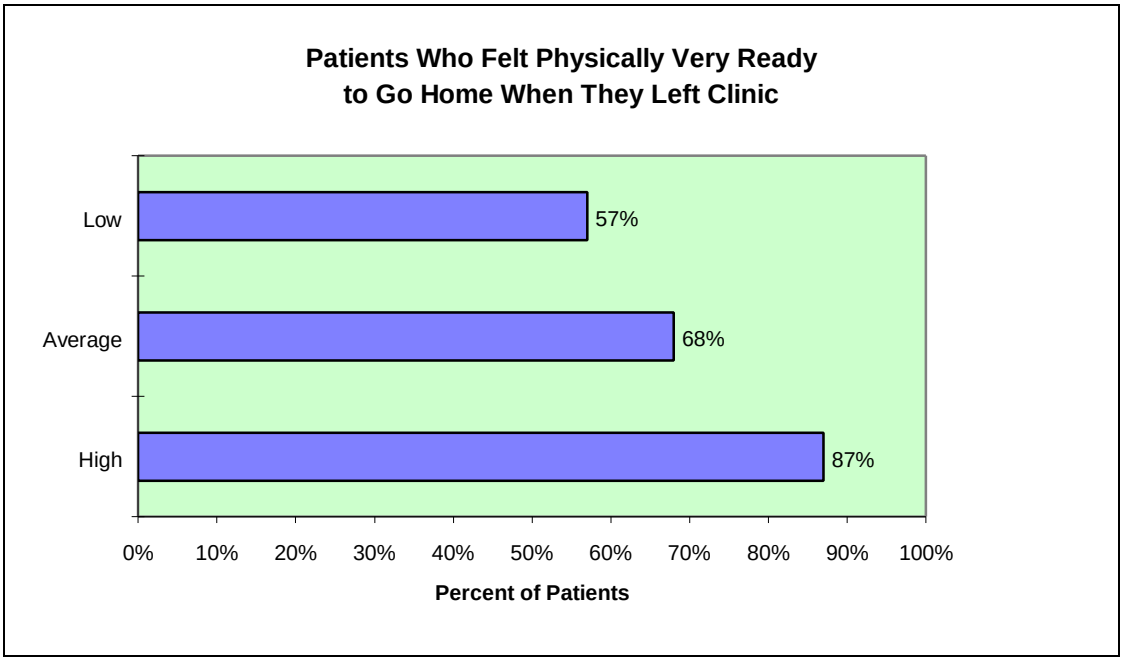
Figure 20



Preparation for Going Home

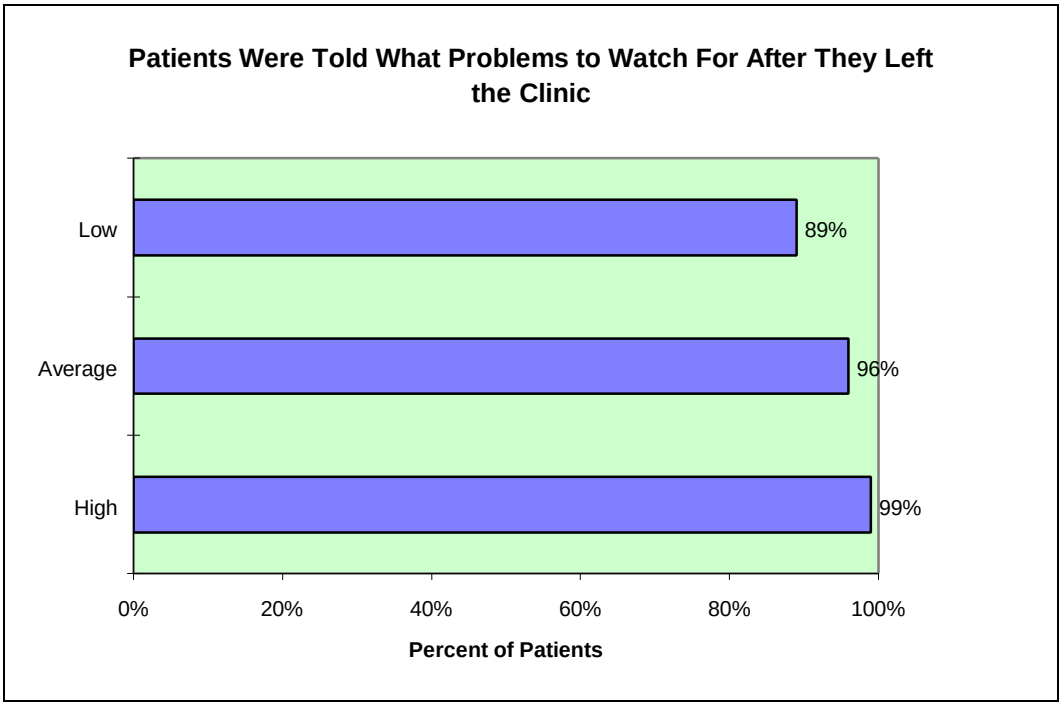
Women were asked about their physical and emotional readiness to leave the clinic. Women were almost universally ready to leave, with 68 percent saying they felt physically "very ready" to leave, and 28 percent "somewhat" ready. (Figure 21) Just 4 percent say they were physically not at all ready to leave when they did.

Figure 21



Similarly, almost all women report being emotionally ready to leave the clinic when they did. Three quarters (72%) say they were emotionally "very ready" to leave, and 22 percent say they were somewhat ready to leave. Five percent of all patients say were not at all emotionally ready to leave when they did. The differences between clinics were not statistically significant. Ninety-six percent of women were told what problem signs to watch for at home, such as bleeding or fever, and 95 percent say they received enough information on post-procedure problems. (Figure 22)

Figure 22



Most (86%) patients report that a staff member offered to make them an appointment for a follow-up visit. Nearly all (97%) women say they were told who to call if they needed more help or had questions after they left the clinic. One in five (21%) women followed through on this information and called the clinic with questions after their procedure. Of those women who called, three quarters (75%) report receiving all the help they needed, and 19 percent report receiving some of the help they needed. Six percent say they received none of the help they needed. Getting help through calling the clinic after the procedure was correlated with, and therefore an important factor in, women's overall satisfaction with their care.

By the time they were interviewed by telephone about four weeks after the procedure, three in ten (30%) women reported having a follow-up visit at the clinic where they had their abortion.

Specific Aspects of Abortion Care That are Most Important to Women

Patients' satisfaction with information and counseling provided by the clinic is the measure most closely correlated with their overall rating of abortion care. The second most important factor for patient satisfaction is the staff's attention to preserving the patient's privacy. Patients also highly valued being treated with dignity and respect by staff, getting help over the phone from staff post-procedure, and the cleanliness of the clinic. These factors are among the ten measures– out of all the questions asked– *most* closely correlated with patients' overall satisfaction with their care. The top ten measures most closely correlated with patients' rating of their care are indicated in the table below. The rankings show where improvements in care would be expected to have the greatest impact on overall patient satisfaction.

Measures Most Correlated with Patients' Overall Rating of Care

Survey Item	Rank[19]
Overall information	1
Overall clinic staff attention to privacy	2
Overall confidence and trust in staff	3
Overall how much the staff treated patient with respect and dignity	4
Patient got help from staff when she called post-procedure	5
Overall cleanliness of the clinic	6
How comfortable the doctor made the patient feel	7
Staff sensitivity to patient privacy in the waiting area	8
Staff made patient feel comfortable in waiting area	9
Staff made patient feel comfortable in recovery area	10

Information is an important dimension of care in other national Picker Institute surveys of ambulatory patients, so it is not surprising that it is for abortion patients, as well. Abortion patients need a great deal of information in a short amount of time, as well as time to discuss their feelings about the decision.

The importance of privacy and confidentiality corroborates what The Picker Institute observed in focus groups with abortion patients in preparation for the survey, in which patients expressed that these are paramount concerns for them. Many patients were concerned about being seen by people they knew in the waiting area. There are a variety of ways that providers can protect patient privacy, and these will pay off in terms of increased patient satisfaction.

The degree of confidence and trust inspired by staff members, and the degree to which patients are treated with respect and dignity are also significant factors in patient satisfaction.

[19] *Spearman Correlation Coefficients were used to determine ranking, all were significant at P < .01*

About one in five patients call the clinic with follow-up questions or problems, and the help they receive affects their evaluation of care. Physician interaction, although it may be brief, has a significant impact on patients' perceptions of care. The correlations also point to the importance of protocols and staff interactions in the waiting area. Finally, the way that staff treat patients in the recovery area also is significant in their overall satisfaction. Perceptions about quality of abortion care were not influenced by a patient's age, race/ethnicity, type or lack of insurance, or weeks pregnant.

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* The twelve clinics participating in the study also served on the advisory committee; the final survey instrument was determined by The Picker Institute and Kaiser Family Foundation.

Glossary

Hormone	A chemical produced by living cells that circulates in the blood or other body fluids and produces a specific effect on the activity of cells remote from its point of origin
Cannula	A hollow tube for insertion into a body cavity or into a duct or vessel.
Manual vacuum aspiration	Abortion in the very early stages of pregnancy by aspiration of the contents of the uterus through a narrow cannula (tube) using non-electric suction instruments. Withdrawing the plunger of a modified syringe creates the gentle vacuum (suction) required.
Methotrexate	Methotrexate interferes with synthesis of DNA, and thus blocks cell multiplication. Used during very early pregnancy, it stops growth of an embryo or fetus and leads to abortion.
Mifepristone	Mifepristone is a synthetic chemical similar in structure to natural progesterone. Mifepristone binds to receptors for progesterone in uterine lining cells, blocking the effects of progesterone. This action causes the uterine lining cells to separate from the walls of the uterus and shed like a menstrual period. An early embryo attached to the lining is shed at the same time.
Progesterone	Progesterone is a natural hormone produced in the ovary after ovulation, and thereafter by the placenta, to sustain the lining of the uterus. When progesterone is blocked, lining cells separate from the uterine wall, blood vessels in the uterine lining recede, and the lining is shed as menstrual flow.
Non-steroidal anti-inflammatory drugs (NSAID)	Oral non-narcotic analgesics such as ibuprofen or acetaminophen are preferred in first-trimester abortion because they generally provide adequate pain relief and are associated with few side effects.
Sedative	Sedatives depress the central nervous system and are used to reduce anxiety and relax muscles, but they do not reduce pain. Oral or parenteral sedatives are used to induce mild to moderate sedation. Versed is a commonly used oral sedative.
Analgesic	Analgesics are used for the control of pain, but they provide little relief for anxiety. Women undergoing mid-trimester abortion and those requesting stronger analgesia may receive quick-acting IV narcotics such as fentanyl.
Local anesthesia	A paracervical or intracervical block is typically done before an abortion to numb the cervical area. A syringe is used to inject the anesthetic (such as chloroprocaine or lidocaine) in several places around the cervix.
Conscious sedation	Conscious sedation refers to the use of analgesics and sedatives to induce a state of depressed consciousness in which the patient can respond to physical and verbal stimulator and the protective airway reflexes remain intact so intubation is not necessary.
General	General Anesthesia, or heavy sedation, involves the use of analgesic, sedative and

anesthesia	anesthetic agents to produce loss of consciousness and of protective airway reflexes. The patient must be intubated.
Manual cervical dilation	Starting with small sizes and increasing in diameter, cannula are inserted into the cervix until it is dilated to the appropriate size. Manual dilation is done in the first trimester.
Osmotic cervical dilation	Osmotic dilators expand like sponges. The most common osmotic dilators are laminaria, made from seaweed, although there are synthetic types as well. Dry laminaria are placed in the cervical canal where they slowly absorb fluid and expand up to three times their original size, dilating the cervix in the process.
Medical abortion	Medical methods of abortion have been developed in the past decade. Two common methods involve the use of Mifepristone in combination with a prostaglandin, or Methotrexate in combination with misoprostol. There are several different protocols for medical abortion, but success is highest in the first seven weeks of pregnancy. The administration of the drugs causes an abortion that is physically similar to a miscarriage.

Description of Organizations

The Picker Institute

The Picker Institute is the international leader in the field of healthcare quality assessment and improvement, focusing on the patient's experiences with care. The mission of The Picker Institute is to improve quality of care through the patient's eyes. Since 1987, the Institute has used its patient survey instruments to interview more than 300,000 patients and healthcare consumers in more than 500 health care organizations.

Research focuses on promoting health care quality assessment and improvement strategies that address patients' needs and concerns a defined by patients, and to help develop models of care that make the experience of illness and health care more humane. The Institute began by investigating discrepancies between routine assessments of patient satisfaction and patients' own accounts of their experiences, and found that while institutional ratings of patient satisfaction were usually high, patients' reported experiences often uncovered fundamental problems with the quality of care they received.

In 1994, with support from the Commonwealth Fund and Boston's Beth Israel Hospital, the program was formally incorporated as The Picker Institute, a nonprofit affiliate of CareGroup, Inc. (the Beth Israel Deaconess Medical Center Corporation).

In 1989 the Institute conducted a national survey of 6,455 recently discharged medical/surgical patients and 2,000 of their family members from 62 hospitals nationwide. The purpose of the study was to assess the status of patient-centered care nationally and to collect comparative data for benchmarking purposes in the future. In 1993 the Institute conducted a population-based national survey of recently discharged medical, surgical and childbirth patients to establish national norms for patient-centered care.

Among The Picker Institute's flagship research projects is a five-year grant from the Agency of Health Care Policy and Research (AHCPR) for the Consumer Assessment of Health Plans Study (CAHPS) project to develop a national standardized consumer satisfaction survey and report cards to present information to consumers and purchasers. The research team consists of representatives from the Harvard Medical School, The National Committee on Quality Assurance (NCQA) the American Institute for Research Document Design Center, the Center for Survey Research and the Lewin Group.

The Picker Institute has had considerable experience developing and implementing surveys to assess patient and customer satisfaction with and perception of delivery of health care services. Picker staff have collaborated with clinicians and survey researchers to adapt the Picker surveys for use in national comparative studies in Canada and Great Britain. Internationally, the surveys have been used in formal studies to monitor care in Canada, Great Britain, Germany, Australia and Israel. In 1998, the Institute launched Picker Europe, a joint venture with Bηre Management Company in Sweden, based in London. The company is now working in Switzerland, Sweden, and the United Kingdom.

The Center for Survey Research

The Center for Survey Research, established in 1971, is a facility of the University of Massachusetts Boston. The purpose of the Center is three-fold: to conduct basic and applied research that contributes to knowledge and understanding of important social issues; to assist academic scholars and community organizations with data collection and other aspects of survey research; and to encourage and facilitate the development of reliable population data which are relevant to policy making. The Center has carried out of 500 major studies and has also provided research services on a smaller scale to at least 200 groups and agencies.

As a university related facility, the Center's basic orientation is to augment knowledge. This orientation means that the research must be of good quality. We work with research groups to ensure that collected data reliably meet their research objectives to the extent that current social science techniques permit. The Center disseminates not only reports but also the tabulated data from projects for which it is totally responsible.

The Center's staff consists of carefully trained interviewers, coders, and technical and professional personnel who are experienced in all phases of survey research activities. In addition to the specific research interests of the professional staff, the main role of the Center is to help people with the actual administration and methodological aspects of the research process. In some cases we do only one part of the research, such as the interviewing or the coding; in other cases we carry out the entire research job from study design to analysis of the data, depending on the needs and capabilities of those with whom we are working.

Center projects have addressed problems in the areas of health, community organization, environment, employment, education, mental health, gerontology, law and criminal justice, public policy, social services needs and survey methodology.