

What about us? Staff reactions to D & E*

WARREN M. HERN, M.D., M.P.H., and BILLIE CORRIGAN, R.N., M.S.

Boulder Abortion Clinic, Boulder, Colorado

Abstract

National statistics are beginning to suggest that dilatation and evacuation (D & E) may have important advantages for the patient experiencing a second-trimester abortion. However, significant emotional reactions of medical and counseling staff tend to accompany this procedure.

The present study used a self-administered questionnaire followed by an interview. The respondents were 15 present and former staff members of a small outpatient abortion clinic. All the respondents were asked to describe various reactions to the D & E procedures, which are performed up to the 23rd menstrual week of gestation. A follow-up study was conducted one year later.

There was clear agreement that D & E is qualitatively a different procedure, medically and emotionally, than early abortion. Many of the respondents reported serious emotional reactions that produced physiological symptoms, sleep disturbances, effects on interpersonal relationships, and moral anguish. This study attempts to evaluate these reactions in the context of the reports of the medical advantages of D & E.

Introduction

A major controversy has emerged in the last few years about the technical risks and acceptability of the "dilatation and evacuation" (D & E) abortion performed during the second trimester of pregnancy. Multi-center studies reported by the Center for Disease Control demonstrate a lower risk of major complications for D & E abortions than for abortions caused by instilling saline and prostaglandin into the amniotic sac.¹ There are wide differences of opinion about the use of laminaria for dilatation as opposed to manual dilatation and about the desirability or need for single or multiple laminaria treatment.

Several authors agree that D & E is emotionally easier for a patient because she does not have to deliver a fetus that may show signs of life.^{2,3} But though the emotional trauma of the experience is reduced for the patient, it is increased for those who per-

form the abortion. This problem, however, has received little attention.

The present study is the result of nearly five years of direct experience by staff members of a small, private, ambulatory abortion facility where D & E is performed up to the 23rd menstrual week of gestation. The senior author has performed more than 650 abortions by D & E.

Both authors have noted intense reactions in themselves and in other staff members to D & E. A study of these reactions is important because the feelings and attitudes of those providing abortion services have a profound effect on the quality of care the patients receive.⁴ These reactions may, in fact, determine whether the patient even receives the care she requests. It has been clear from the beginning, for example, that some staff members are unable to assist with late abortion because of their reaction

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to it or their belief that it is wrong to perform an abortion beyond a certain week of gestation.

Materials and methods

In the first part of this study, 23 present and former staff members of the clinic were surveyed by questionnaire to determine whether they had assisted with D & E and, if so, what their reactions to it had been. The questionnaire asked the respondents to specify the role in which they had assisted the patients, whether as physician, nurse, counselor, telephone contact, receptionist, or other, and to tell how many patients they had assisted in this capacity. Other information that the respondents were asked to provide was their thoughts about the moral, legal, and medical aspects of second-trimester abortions; their primary feelings about patients who have late abortions; D & E itself, the medical risks, the visual impact of the fetus, and the physician; and a list and explanation of the differences that existed for them in assisting with second-trimester abortions instead of first-trimester abortions. They were also asked to specify whether there was a limit to the length of gestation beyond which they would not assist with abortion, to give their reasons for their answer, and to describe uncertainties and changes in their feelings about this matter. Last, the questionnaire invited them to describe other reactions they had had from being involved with D & E, such as dreams or preoccupations about D & E while not at work.

The 15 present and former staff members who responded to the questionnaire were interviewed individually to follow up the answers they had written in response to the questionnaire. One year later, a follow up study was conducted with the same questionnaire and subsequent interview. The respondents that time were six staff members still assisting with D & E and one new staff member who had had considerable experience working elsewhere with abortion by amniocentesis.

Technically, D & E is performed after a serial multiple use of laminaria for cervical dilatation. The approach has been described previously.⁶ After a screening examination, patients receive a real-time

ultrasound examination for determining the length of gestation, individual counseling, and then three laminaria treatments over a period of 42 hours. After that, there is supplemental manual dilatation up to 2.5 to 2.8 cm under local anesthesia. Each counselor is assigned one patient to follow through each step, including the laminaria changes, the operation, and the recovery room.

The length in time of the operation has varied from an average of 15 to 20 minutes to now less than eight minutes, a change that reflects the growing experience and the improved technique of the physician. Operative complications such as hemorrhage have occurred more often with D & E than with the procedures used for first-trimester abortions, but in the first 650 patients, no truly major complication arising from D & E has occurred. The average amount of blood loss is between 100 and 250 ml depending on the length of gestation; the loss is often negligible, and it seldom exceeds 500 ml. Two of our patients have been hospitalized overnight for observation, one for a suspected perforation, and the other after treatment for operative hemorrhage due to uterine atony.

A change in the procedure of D & E that was introduced after our study began is the supplemental use of urea amniocentesis before D & E in patients who had had more than 20 menstrual weeks of gestation. The purpose of this amniocentesis is to obtain fetal demise, tissue maceration, and increased uterine irritability, making the D & E easier for the patient to endure and technically easier for the physician to perform.

Results

Of the 15 respondents in the first study, all approved of second-trimester abortion in principle, but eight mixed their approval with several reservations. Most of the respondents felt sympathetic or protective toward patients, but four had feelings of resentment, irritation, or anger toward patients who had waited so long before seeking an abortion.

There were few positive comments about D & E itself: only three respondents expressed the view that D & E was a better alternative for a patient. The rest thought

that D & E was more difficult, tedious, risky, and painful than other procedures for everyone involved, and some feared major complications. Nine of the respondents were concerned about the medical risks of D & E, while the other six either were not concerned or had no comment.

Reactions to the fetus ranged from purposely not looking at it to shock, dismay, amazement, disgust, fear, and sadness. Attitudes toward the physician were those of sympathy, wonder at how he could perform D & E at all, and a desire to protect him from the trauma. Two respondents felt that performing D & E must eventually damage the physician psychologically.

The respondents noted several differences between first-trimester abortions and second-trimester abortions done by D & E. For second-trimester abortions, there was an increased fear of complications, the visual impact of the fetus, and the violence of D & E. About one third of the respondents felt that D & E was longer and harder on the patients, and several thought it was more difficult to rationalize or intellectualize D & E.

Ten respondents thought that there was a limit to when a pregnancy should be interrupted, with opinions ranging from 12 weeks to 26 weeks of gestation.

Most respondents were considerably ambivalent about D & E, but their ambivalence depended to some extent on their familiarity and experience with amniocentesis and with D & E. About half of the respondents felt more positive toward D & E as their experience became greater, while the other half felt less positive toward it or "burnt out." One respondent increasingly resented the casual attitudes of some of the patients who have D & E abortions when she considered the emotional cost to those providing the service.

Two respondents described dreams they had had that related to D & E. Both described dreams of vomiting fetuses along with a sense of horror. Other dreams were about a need to protect others from viewing fetal parts. One respondent, a female, dreamed that she herself was pregnant and needed an abortion or was having a baby.

Six respondents denied any preoccupation with the D & E procedure outside the clinic. Several others felt that the emotion-

al strain affected their relationships significantly or resulted in other behavior, such as an obsessive need to talk about the experience. In this group, a common observation was that personal problems outside the clinic made it much more difficult to handle the stress of D & E. On the other hand, one respondent observed that the stress and intensity of D & E caused a search for outside personal relationships that were more honest, sincere, and mutually supportive.

The responses in the follow-up study were not much different from those in the first study. The technical innovation of amniocentesis before D & E, as well as the greater proportion of late abortions (over 20 menstrual weeks), introduced a new factor into the responses. There was greater anxiety than before about the safety of D & E and greater concern with the perplexing questions of how late in pregnancy abortions should be performed. However, the senior author has observed that anxiety consistently peaks with each new innovation in the procedure of D & E that permits abortions at a later stage of pregnancy. The new dimension in the urea D & E abortions is the issue of fetal viability. This issue could be more easily ignored in pregnancies ended before 20 weeks of gestation.

All seven respondents approved of the procedures in principle, but four had reservations similar to those expressed before. The positive feelings that were expressed arose from greater overall confidence in the basic midtrimester procedure. Also, counselors noted that the extensive amount of time they spent with patients experiencing D & E allowed them to develop much more understanding and empathy with them. It was more difficult for the respondents to fix a limit to the length of gestation at which an abortion should be done in patients with whom they had developed a relationship. Most now felt that D & E was the best available alternative for the patients seeking a second-trimester abortion.

The staff member who had participated in a hospital ward where abortions were done by amniocentesis observed that the patients undergoing D & E in our facility had significantly less physical pain, emotional trauma, and complications than

amnioinfusion patients whom she had observed. She felt that the D & E patients received far more emotional support. Her opinion was echoed by another part-time staff member, a psychology graduate student, who had worked as a nurse's aide in a similar hospital ward.

Three of the seven respondents reported preoccupation with D & E outside the clinic, and one still reports having occasional disturbing dreams.

A laboratory assistant not participating in the study began performing the postoperative tissue examination for the physician, allowing the physician a respite between procedures. This examination involved a time-consuming process of measuring fetal parts, weighing the fetus and placenta, and checking for completeness. After a time, the laboratory assistant asked to be relieved from examining the tissue obtained from urea D & E abortions because of the size and intactness of the fetuses. She found herself becoming nauseated during the tissue examination and having disturbing dreams at night.

Discussion

One of the questions that emerges from these studies is whether there is a relationship between the role played and the attitude toward D & E. In general, it appears that the more direct the physical and visual involvement with D & E, such as that experienced by nurses and physicians, the more stress is experienced. This is evident both in conscious stress and in unconscious manifestations such as dreams. Indeed, the two respondents of the first study who reported several significant dreams were directly involved with D & E. The experience of the laboratory assistant is also consistent with this observation.

Is there a relationship between the number of D & E's performed or participated in and the attitudes toward them? The evidence is equivocal, since some respondents reported more tension as they participated in more procedures and some reported less tension. All agreed that there was more psychological stress for themselves with D & E than with procedures for first-trimester abortions.

The physician's experience has been that

the confidence brought by greater skill has helped considerably in reducing stress. D & E remains a highly stressful operation to perform. However, knowing that technical problems are yielding to new approaches supports the physician's increased confidence. A clear example of a new approach is the amnioinfusion of urea several hours before D & E, which greatly facilitates the late D & E.

The physician has found that the relationships established with patients through repeated contacts during the ultrasound examination, the laminaria changes, and the D & E itself permitted him to develop a sense of the person whom he was helping and her special needs. This contact has proved to be important in maintaining the physician's commitment to performing D & E.

A common factor sometimes identified by the respondents and observed by the senior author is that staff stress from D & E is increased when the patient is uncomfortable and reduced when the patient feels relatively no pain. Increased operator experience and skill have contributed to rapid procedure times and greater patient comfort. The use of narcotic analgesia has helped to increase the patient's comfort, but only up to a point where increased dosages produce more physiologic depression than analgesia.

Although the overall experience of unplanned pregnancy and late abortion is stressful for the patient, it appears that the properly performed D & E may be less traumatic for the patient than other alternatives. An improperly performed D & E would be traumatic for the patient and would offer no reduction in risks. Nevertheless, it is technically possible to reduce the patient's discomfort and trauma to a minimum consistent with the medical objective of emptying the uterus with the least possible damage to the cervix and other pelvic structures.

The stress experienced by the staff is different from that experienced by the patient and is at its highest during the D & E itself. Failing to recognize the symptoms and signs of this stress may have important consequences for continuation of the service.

We discerned that the following psychological defenses were used by staff members

at various times to handle the traumatic impact of the destructive part of the operation: denial, sometimes shown by the distance a person keeps from viewing D & E; projection, as evidenced by excessive concern or anguish for other staff members assisting with or performing D & E; and rationalization. The last popularly took the form of discussing the pros and cons of performing D & E and its value. For the senior author, rationalization has been shown by his intensive involvement in professional meetings, where this matter is discussed, and by his seeking peer support from colleagues who have similar experiences.

Defense mechanisms, however, may be experienced or used by staff members but not expressed openly. In order to help staff members cope with the stresses of participating in D & E, we have adopted certain strategies. First, we try to give people ample opportunities to talk about the feelings and concerns they have. These opportunities take the form of informal meetings; this present study was another opportunity.

Second, we have made participation in D & E voluntary for all old staff members, although new staff members are informed during the employment application interview that assistance with it will be part of their job responsibilities.

Third, we have a highly flexible policy concerning time off, vacations, and mental health and personal days. This policy permits staff members under particular stress to get out of the office for a few days.

Fourth, the regular work week is four days, routinely allowing a three-day weekend. Travel and participation in professional conferences is liberally supported.

Last, we have consciously promoted the idea of team effort and the need for mutual support.

In summary, we have tended to support and reinforce the defense mechanisms that help staff members continue to assist patients in a supportive manner. These defense mechanisms are to be distinguished from those that withdraw support from the patients, such as scolding, hostility, indifference, or nonperformance.

Although this study is small and many of our observations the result of personal interpretation, it raises questions that should be explored in other settings.

Conclusion

The most important challenge in late abortion is not the technical problem of medical treatment. This yields to persistence, imagination, surgical skill, and commitment to standards of medical excellence. The most important challenge is how we feel about doing it.

We have produced an unusual dilemma. A procedure is rapidly becoming recognized as the procedure of choice in late abortion, but those capable of performing or assisting with it are having strong personal reservations about participating in an operation that they view as destructive and violent. The people who do not or cannot help with the procedure applaud its introduction because of its increased safety for the patient.

Some part of our cultural and perhaps even biological heritage recoils at a destructive operation on a form that is similar to our own, even though we know that the act has a positive effect for a living person. No one who has not performed D & E can know what it is like or what it means; but having performed it, we are bewildered by the possibilities of interpretation.

We have reached a point in this particular technology where there is no possibility of denying an act of destruction. It is before one's eyes. The sensations of dismemberment flow through the forceps like an electric current. It is the crucible of a raging controversy, the confrontation of a modern existential dilemma. The more we seem to solve the problem, the more intractable it becomes.

Note: Since this article entered the review process and went to press, 200 additional D & E abortions have been performed along with an increase in the gestational limit to 24 menstrual weeks. The latter occurred partly in response to a reduction in late abortions permitted in the local community hospital as a consequence of community pressure to stop the practice. The proportion of late abortion patients in the clinic practice has increased, and there has been one major operative complication, the first in the clinic's five-year history. All the problems described in the study have been exacerbated by these events.

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