

## EXPERIENCES OF REGISTERED MIDWIVES ASSISTING WITH TERMINATION OF PREGNANCIES AT A TERTIARY LEVEL HOSPITAL

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**NOTE:** The Amendment to the Choice on Termination of Pregnancy Act, Act No 1996, has changed the term "registered midwife" to "registered nurse". At the time of this study however, only registered midwives with the prescribed training were permitted to perform a termination of pregnancy up to and including 12 weeks of gestation.

**NOTE:** This research project was a course requirement in the final year of the B Nursing programme at the University of Cape Town.

## ABSTRACT

*The implementation of the Choice on Termination of Pregnancy Act, Act No. 92 of 1996 brought many challenges for the registered nurses/midwife assisting in the termination of pregnancy. In the gynaecological wards at a tertiary level hospital, registered nurses/midwives assist with the termination of pregnancies for women in the second trimester (13-20 weeks), using an oral medication, Misoprostol. A qualitative phenomenological study of the experiences of registered midwives who assist in termination of pregnancies was conducted. Registered nurses/midwives, each with at least six months experience in the assistance of terminations of pregnancies participated in this study. In-depth interviews were conducted with the participants. The audiotaped interviews were transcribed and analysed for themes and patterns within the transcriptions. Five theme categories emerged: obstacles experienced by the registered midwives, feelings evoked by the experiences, conflicts encountered, the coping mechanisms utilised and the need for support systems. Recommendations include the provision of support structures for registered midwives working in this setting.*

## OPSOMMING

*Die implementering van die Wet op die Beëindiging van Swangerskap, Wet Nr. 92 van 1996, het baie uitdagings meegebring vir die geregistreerde verpleegkundige wat met die beëindiging van swangerskap behulpsaam is. In die ginekologiese sale in 'n tersiêre hospitaal, is geregistreerde vroedvroue behulpsaam met die beëindiging van swangerskappe vir vroue in die tweede trimester (13-20 weke), deur van 'n mondelikse medikasie Misoprostol gebruik te maak. 'n Kwalitatiewe fenomenologiese navorsingstudie oor die belewenisse van geregistreerde vroedvroue wat behulpsaam is met die beëindiging van swangerskap is onderneem. Geregistreerde vroedvroue, wat elk ten minste ses maande ondervinding met die beëindiging van swangerskappe gehad het, het aan die studie deelgeneem. Indiepte onderhoude is met die deelnemers gevoer. Die analise van die onderhoude wat op band geneem is, is getranskribeer en geanaliseer. Patrone en temas is uit die transkripsies gelig. Vyf temas het uit die data tevoorskyn getree: struikelblokke wat deur die vroedvroue beleef is; gevoelens wat deur die ondervindinge opgeroep is; konflikte wat beleef is, die hanteringsmeganismes wat gebruik is en die noodsaaklikheid van ondersteuningstrukture. Aanbevelings sluit in die voorsiening van ondersteuningstrukture vir vroedvroue wat in hierdie kliniese omgewing werksaam is.*

## INTRODUCTION

Globally, 40% of women live in countries in which abortion is legal on request, and for a further 23% abortion is available on psychosocial grounds (Stewart & Fletcher, 2002:22). Stewart and Fletcher refer to Sir Dougal Baird, who in 1965 introduced the concept of the fifth freedom – that of freedom from unwanted fecundity, and state that “it is apparent that a freely available service for the therapeutic termination of pregnancy should be available as part of a strategy to reduce unplanned and unwanted maternities worldwide” (Stewart & Fletcher, 2002:22). Despite the ready availability of contraception, even in developed countries, termination of pregnancy continues to be a substantial health care need (Allsop, 2004:285).

In South Africa, the Choice on Termination of Pregnancy Act, Act No. 92 of 1996, gives women of all ages the right to have an abortion on request in the first twelve weeks of pregnancy. In the second trimester, from the thirteenth up to and including the twentieth week, an abortion can be obtained under specific circumstances (listed in the Act) when recommended by a medical practitioner.

Registered midwives, trained in the techniques relating to termination of pregnancies [TOPs], either perform these procedures themselves if the foetus is less than 12 weeks gestation, or assist the medical practitioner if the pregnancy is between 13 and 20 weeks gesta-

tion.

## OVERVIEW OF THE LITERATURE

In qualitative research the full literature review is done only after the data have been collected, to minimise the prejudging of the data. Thus a brief overview is presented.

Since the implementation of the Act in February 1997 there has been limited published research available describing the experiences of registered midwives who have provided the service or assisted in TOPs. Studies have been done in the following areas, among others: rights of the woman versus rights of the foetus, access to safe abortion services; barriers to implementation in South Africa; progress reports in implementation; nurses' accounts of their choice to be TOP providers and methodological issues (Potgieter & Andrews, 2004; Berer, 2002; Gmeiner, Van Wyk, Poggenpoel & Myburgh, 2001; Harrison, Montgomery, Lurie & Wilkinson, 2000; Varkey, 2000; Cook & Dickens, 1999; Guttmacher, Kapadia, Naude & De Pinho 1998; Schenker & Eisenberg, 1997; Long Queues for Freedom of Choice [Online] 1997).

With the implementation of the legislation, education of health care providers about their responsibilities under the new Act was a pressing issue. Values-clarification workshops were conducted in hospitals that provided abortion services (Guttmacher *et al.* 1998:191-

5). The main aim of these workshops was to facilitate the implementation of the services, and to gain an understanding of the providers' concerns. Marais (1997:7), who conducted abortion values-clarification workshops for doctors and midwives, identified concerns with respect to their involvement in the provision of TOP services - feelings of discomfort or uncertainty, particularly in respect of moral values and religious convictions, relating to pro-life or pro-choice.

DENOSA (Democratic Nursing Organisation of South Africa) states that midwives have a right to freedom of conscience, that they may not be denied employment, may not be victimised either for choosing to participate or choosing not to participate in TOPs. The nurse may not be coerced to participate in direct termination of pregnancy. DENOSA however, states that the nurses have a responsibility to make their viewpoints known in good time, so that substitute staff can be arranged if they do not wish to participate in direct termination of pregnancy (DENOSA Position Paper on Termination of Pregnancy, 1998).

At a tertiary level hospital in the Western Cape, registered midwives assist medical practitioners by administering an oral dose of Misoprostol to the woman in the second trimester (13-20 weeks gestation) undergoing a TOP. Misoprostol is a synthetic prostaglandin that induces cervical softening and myometrial contractions in the first and second trimesters of pregnancy, resulting in the labour process and evacuation of the foetus from the uterus (Gibbon, 2000:198). On admission, women are given an initial dose of 400mg oral Misoprostol, followed by 200mg orally every four hours. If the labour process does not begin, Misoprostol is administered vaginally.

## **PROBLEM STATEMENT AND AIM**

Abortion, or termination of pregnancy, is a complex issue, and the controversy surrounding is situated within the public arena and also in the health care professions. "It is the one area in which many nurses struggle with the conflict between their personal convictions and their professional duty" (Marek, 2004:472). Nursing students often have mixed feelings about TOPs when confronted with women who make the choice to terminate a pregnancy. Few research studies have examined the experiences of

nurses/midwives who participate in caring for the women undergoing abortion whether prior to, during or post-procedure.

The researchers, during the course of their undergraduate training, were challenged by their clinical experience and thus decided to explore the experience of registered nurses/midwives when assisting with TOPs.

The aim of the study was to explore the lived experience of midwives who assist with terminations of pregnancy in a tertiary level hospital.

## **RESEARCH DESIGN AND METHOD OF INQUIRY**

An exploratory qualitative study using a phenomenological approach was conducted with participants at a tertiary level hospital in the Western Cape. The primary focus of the phenomenological approach is gaining knowledge about the world in which we live by studying lived experiences (Bergum, 1991:56).

### **Sampling and selection criteria**

The sampling approach was that of purposive sampling, in which the study participants strategically selected are those who are best able to meet the informational needs of the study (Patton, 2002:230; Morse, 1991:27). The participants interviewed were selected because of their availability, knowledge and experience in the field of study, and their willingness to participate. The participant needed to be a registered nurse and midwife actively involved in assisting with termination of pregnancies. Further criteria were:

- Participants should have been working in the gynaecological ward assisting with TOPs for six months or longer. The period was selected as being the minimum that would be long enough for participants to have performed/assisted with sufficient TOPs on which they could reflect.
- Individuals who were fluent in the language of the interviewers (English).
- Individuals who expressed a willingness to share their experiences with the researchers.

Holloway and Wheeler (1996:164) state that it is difficult to decide on the specific number of participants

from whom data are collected, so interviewing of participants continues until there is repetition of information obtained or data saturation. As this study was an initial exploratory study, three participants were interviewed.

## **Ethical considerations**

Participation in the study was voluntary and informed written consent for the research was obtained (Munhall, 1988:156; Field & Morse, 1985:44). Confidentiality and anonymity were protected through identifying the participants only by code numbers. The right to withdraw from the study without prejudice was explained. The study was approved by the university research ethics committee.

When researching sensitive subjects, the right not to be harmed must be respected (Cowles, 1988:167). It is furthermore essential in researching sensitive topics to facilitate a relationship of trust between the researcher and the participant, and the participants were assured that their positions would not be compromised by their participation. Holloway and Wheeler (1996:47) further raise the consideration of the dual role and responsibility of being both a nurse and a researcher, and the difficulty of detaching oneself from the caring for participants in distress without compromising data collection. No pressure was put on the participants with respect to experiences that were difficult for them to speak about, and the researchers observed for signs of distress. Provision was made for support and referral if necessary.

## **Application of the phenomenological method**

The operations in this methodology are bracketing, intuiting, analysing and describing (Spiegelberg *in* Oiler, 1982:180). Abortion/termination of pregnancy is an ethical dilemma for many health professionals and a subject on which strong opinions are often held. In order to bracket out the researchers' own beliefs and knowledge about issue of termination of pregnancy, each researcher wrote down her beliefs and these were "unpacked", so that these could be laid aside to enable the interviews to be as open and unbiased as possible, and to analyse the data with "openness".

During the data analysis the researchers further attempted to "bracket" any preconceived notions and to analyse without prejudice. Hycner (1985:28) describes this process as "suspending as much as possible the researcher's meaning and interpretations and entering into the world of the unique individual who was interviewed...".

## **Data collection and analysis**

Interviews are an appropriate data collection instrument in qualitative research, as the purpose is to enter into another person's perspective, and the assumption is that the person's perspective is meaningful (Patton, 2002:341). The qualitative interview aims to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena (Kvale, 1983:174-9). The data in this study were collected using unstructured, in-depth interviews with the primary research question, "Describe your experience of assisting with terminations of pregnancies at a tertiary level hospital". Sub-questions and reflective statements, which aimed to clarify the participants' responses, encouraged the expression and exploration of their lived experience.

The recorded interviews were transcribed verbatim, and analysed according to Hycner's guidelines (1985:280-294). Careful reading and re-reading of the transcripts was done, with the aim of identifying manageable units of meaning as expressed by the participant. Natural meaning units and patterns were identified in the data, and then grouped into the emerging themes, described in the findings.

## **Trustworthiness**

In order to ensure that qualitative research is regarded as credible and trustworthy, the researchers are required to accurately describe the accessing of participants, the collection of data, the recording of information obtained and the analysis process, in order to document a "decision trail" (Koch, 1994:976).

Transcribed interviews were checked by the researchers and taken back to the participants for confirmation. During the analysis the researchers reflected on their own values and explored the impact of these on the analysis. Each interview was analysed by an individual

researcher and re-analysed independently by another researcher and then discussed with the supervisor. Thick descriptions of the participants' experiences, complementing direct quotes from the transcribed interviews, are presented in the findings.

## FINDINGS AND DISCUSSION

Five themes emerged from the data analysis:

- obstacles experienced by registered midwives
- feelings evoked by the experiences of assisting with a termination of pregnancy
- conflicts encountered
- coping mechanisms utilised
- need for support.

### Obstacles experienced by registered midwives

Participants experienced a number of obstacles when assisting with TOPs. These problems hindered them, not only when it came to giving quality care to the women, but also in their own coping with the situations they faced. They felt unprepared emotionally "*Nobody actually prepared you for this whole thing ... nobody actually tells you what is actually involved ...*". One participant had researched the topic in literature and by speaking to staff already working in the ward. She noted however that "*... it was more clinical, it had nothing to do with feelings ...*". She felt confident that she could handle any situation that might occur but that had she witnessed the birth of a live foetus she would have felt differently.

The participants felt that the women were not adequately prepared for the procedure, did not know what the procedure entailed or that the foetus would be fully developed when delivered, and thought that it was "*... just a blood clot coming down ...*". The midwives experienced this as a heavy burden, as they felt that they were expected to inform the women, as well as provide emotional support for them, yet they did not see this as part of their job "*... nobody counsels them ... it's not my job to go around and ask them how do you feel about this that you did and I think that is what they need, but I don't do it ...*". Patient counselling was seen as a necessity for women having a TOP in order to prepare them for the procedure and the psychological

effects, yet participants were unsure or unwilling to take on this added role. P1 felt that if the women were adequately prepared for the procedure, then they would not be as rude towards the staff, as this rudeness stems from fear of the unknown: "*... I'm sure their rudeness and obnoxiousness is just the fact that they are scared ...*". The women who were admitted for TOPs were isolated mentally, if not physically, in part because the midwives did not want to have to deal with their negative attitudes. P1 illustrated this in her comment "*... with someone who is rude and obnoxious we are just going to do what we are supposed to do and leave ...*".

Participants' expectations of their patient's behaviour were not met - expectations of sadness and loss were countered by the women's perceived lack of interest, and apathy: "*... you would expect her to cry or to feel something ...*". Instead it seemed as if women did not care about what they were doing and that it was "*... a normal day for them ...*". They were seen as "*... nonchalant ...*" and appeared uninterested in the TOP and its ramifications. The women were also viewed as being "*... demanding ...*" and "*... attention seeking ...*", and the participants found it difficult to cope with their attitudes. The participants' experience of the women was that they showed no regard for the feelings of the staff, expecting them to do the TOP regardless of the midwives' feelings on the subject because it was the woman's right to have an abortion "*She said ... it's part of our work ... we must just do it. Because they've got the right ...*". This perceived disregard was further reinforced by the women's lack of appreciation "*... none of them say thank you ...*".

The participants had difficulty with the apparent lack of responsibility shown by women undergoing a termination procedure. They expressed concern at the women's refusal to consider contraception, as it appeared to the midwives as if the women were choosing TOPs as a contraceptive method. This was difficult to accept "*... women not taking responsibility for contraception and they think that they can come back and terminate the baby anytime ...*". This left the midwives feeling that they were wasting their time: "*Why am I here if that is their attitude at the end of the day ...*".

According to Reproductive Rights Alliance (1997b:7), if women receive appropriate counselling prior to the TOP, there is a strong possibility that the interpersonal nurse-



patient relationship would be enhanced. The women would be more knowledgeable and prepared for a TOP, their behaviour would be more acceptable to the midwife, thereby potentially increasing the quality of care.

A study conducted at a Western Cape secondary hospital found that there was a general lack of information amongst women regarding the actual procedure and their personal legal rights, but when effective counselling was given to women having a TOP, they were more informed and prepared (Reproductive Rights Alliance, 1997a:7). High levels of distress and anxiety have been found amongst women undergoing TOP for whatever reason it is performed (Freeman, Cohen & Roth; Adler, in Marshall, Gould & Roberts, 1994:567). Not knowing what to expect from an experience such as TOP may leave the woman feeling vulnerable, with a decreased sense of control, and may have influenced the women's responses to the midwives, perceived by them as rudeness.

The participants in this study expressed concern that no formal counselling preparation or training had been given to them, to enable them to give adequate information and support to women undergoing a TOP.

### **Feelings evoked by the experiences of assisting with a TOP**

Assisting with TOPs evoked a variety of feelings, mostly negative, although despite some negative emotions, one participant said that for her assisting in TOPs was "... fine ...". The participants felt very alone as they assisted with the TOPs, particularly as they were left alone by the doctor to actually carry out the TOP. P3 commented: "... the doctor has nothing to do with you. You actually do everything on your own. The only thing that the doctor does: he prescribes it and you have to do everything actually ...". This left them feeling that they were responsible for the delivery of the foetus, a feeling they were trying to avoid. They often did not want to be alone with the woman and the foetus during delivery, and found comfort in the presence of someone else, even if that person did nothing other than provide moral support, "One of them always comes with me even if it's just for moral support ...". There was a real sense of aloneness: "... imagine you have to cut a cord of a foetus ... sometimes the foetus is still alive ... and you are alone ... at night ... not very

*pleasant ...*".

Anger was expressed. The participants were angry at the women admitted for TOPs because they were perceived as being irresponsible about using contraception, and used TOP as a contraceptive method, a practice unacceptable to the midwives "... makes me angry because of women not taking responsibility for contraception ...". This was evident particularly in respect of women who had had more than one termination. The apparent ease with which women terminated their pregnancies engendered feelings of anger and frustration. This was contrasted with the participants' personal experiences with infertility in their professional and personal lives. One participant said: "I felt angry because I've two friends who are trying to get pregnant – and they've got problems ... and here this sixteen-year-old comes and for her it was like nothing ...".

There was a sense of being trapped in their work. Although their midwife colleagues had refused to work in the TOP unit, they felt that they had to do the job because no one else was willing: "You just do it because you know that you have to do it. Because I was working here, and then I heard that I had to go and work in another ward. I wasn't even long in the ward and then I had to come back again because the sister that was supposed to work here ... it's against her religion. And they took her out of here and then I had to come back again to come and work here ...". It appears that once they have said "yes" there is no option but to continue working in the unit.

There was a sense of hopelessness felt in relation to their observations of the continuous cycle of no contraception, unwanted pregnancy, TOP and refusal of contraception. They perceived that their caring was being wasted as the women would be back again: "... they come back a year later and you treat them again ...". The women had refused other methods of family planning, leaving the participants with no option but to let the cycle continue. "She had a termination, she aborted, she refused family planning ...".

Although women were informed about the importance of not using toilet facilities at the point of delivery of the foetus, many women chose to use the toilets. The midwives had to retrieve aborted foetuses from the toilet bowl, and felt that they were being forced by the women

into dealing with this difficult aspect of the work. One participant had asked a woman to remove the foetus herself: *"I told these two ladies yesterday when they came in. And this morning, one had pain and everything, and she still went to the toilet. And the foetus and the placenta went down the toilet. And I didn't take it out. I thought, let her take it out ..."*.

There was a difference in attitudes towards women who were admitted for 'necessary' terminations. Most women were kept at a distance, but with rape survivors the midwives had a more empathic response *"... feel empathy towards that patient ..."*. Cignacco (2002) however, reported that even when terminations were done for foetal abnormalities, midwives experienced ethical conflict and suffered a heavy emotional burden. She found that midwives met the women for the first time when admitted for TOP, had had no role in the decisions taken, and were unhappy about having to implement a decision in which they had had no involvement. This raises issues of *how, when and by whom* women requesting termination should be counselled.

Walker (1995:819) found that Primary Health Care Nurses (PHCN) considered women who had TOPs to be irresponsible. TOP conflicted with their expectations of women as mothers, as TOPs were thought of as not only being the termination of life, but also the termination of motherhood, which was seen as irresponsible.

Allanach (*in* Moore, 1997:23) states that the emotions of the nurses and midwives assisting with TOPs must not be overlooked or forgotten. Marshall *et al.* (1994:567-9) cite a number of studies which indicate that nurses and midwives find involvement with TOP extremely stressful, and that the source of the stress has been attributed to contradictory value systems – that of the nurses/midwives' professional ethics and personal values. In their study of nurses' attitudes toward termination of pregnancy in Britain, Marshall *et al.* (1994:571-2) found that several factors were significantly associated with negative attitudes towards TOP: frequency of involvement in TOP, length of time spent working on a gynaecology ward, religious affiliation, and ethnicity. Some discrepancies in nurses' attitudes were found with respect to both the length of a woman's gestation and the circumstances for which the procedure was being performed.

Although all the midwives interviewed were pro-choice, they were still confronted with problems, conflicts and stressful emotions in the course of their work. Their support systems and coping mechanisms should have made this easier, but for the most part these were either absent or not functioning well. The major difficulty was the lack of preparation of the midwives to fulfil their duties and the need for well-functioning support systems.

The sense of isolation experienced by the study participants has been found in other studies. Cignacco, (2002:184) states: *"... in contrast to treating a woman who is admitted to hospital for a normal delivery, midwives dealing with a termination feel excluded from the procedure"*. This study, which focussed on termination when there was a recognised foetal abnormality, nevertheless highlights similar conflicts experienced by midwives in this study. Cignacco notes that all the midwives in her study supported the woman's right to self-determination, but were left with a sense of unease.

The culture and environment of the health care institution may also impact the provision of TOP services, and the willingness of midwives to participate in procedures. Kade, Kumar, Polis and Schaffer (2004:59-62) refer to the impact of nursing shortages on the provision of TOPs in Massachusetts hospitals. In this limited study nurse managers responded that it was increasingly difficult to schedule nurses for abortion procedures. The study further concluded that nurses' attitudes and their unwillingness to assist with procedures may hamper patient access to abortion services.

## Conflicts encountered

Assisting in TOPs has resulted in many conflicts arising for the midwives. Although their feelings were usually hidden, when confronted with an unusual situation, such as the delivery of a live foetus, they then reverted to ambivalent feelings experienced when they first started working with TOPs *"You go back towards feeling those same feelings ..."*.

The conflict between life and death surfaced, especially in situations when, after the foetus had been aborted, the midwife had to cut the umbilical cord of a foetus that was *"... still alive ..."*. There was the expectation that the foetus would not be alive at the time that it was

aborted. P3 recalled: "... *in midwifery your experience was actually different ...*".

Being confronted with life where death is anticipated and there is no hope of continued life places an enormous ethical burden on the midwife. P2 described how she and an enrolled nurse "... *covered the foetus with an incontinence sheet and put it in the sluice room and watched how this poor little thing was gasping for breath ...*". Another participant recalled: "... *the body still felt warm and you had to go and put it in the fridge ...*". There are ethical conflicts relating to a pledge to preserve life, yet confusion as to adherence to it when performing TOPs: "*It's part of the work even though with your oath ... But it never said anything about terminations ...*".

Moral and religious conflicts, despite supporting the woman's choice, remained an issue for the participants. Conflict presented itself in the actions of the midwives in assisting with TOPs and their religious tenets which regard terminations as murder. P2 stated that "... *it's against my principles and religion ...*". Moral conflicts left the participants feeling "... *uncomfortable with what you are doing ...*". This conflict was compounded by their perceptions and experience, that for the women it was just the easier answer to an unwanted pregnancy, and that they did not care about the life or death of the foetus "... *she just told me: 'just look there, it's still alive: the heart is beating' ... she was just so nonchalant, like nothing is happening ...*".

Participants experienced particular ambivalence when dealing with teenagers and were unsure whether to treat them as children or adults. They were perceived to be old enough to have sexual intercourse, conceive and make decisions on termination of pregnancy, yet informed the midwives that they could not take contraception without parental permission. "... *she must first get permission from her mother ...*".

Confidentiality, truth and avoidance became an issue for the midwives. In order to maintain confidentiality, questions from family members were referred to the patient: "... *must go to the patient and the patient will explain everything ...*". Yet they found themselves having to stand by while the women told their families that they had had "... *miscarriages ...*".

The ward also admitted patients for infertility treatment. This created a sense of confusion and anger: "... *it has affected some of the infertility patients lying right next to someone who has had a termination ...*". One participant expressed her difficulty, in that she had friends who wanted, but could not have children while "*these women*" did not want the ones they had.

Personal conflict may also result from the attitudes of fellow health care workers. Nurse participants in a California study reported that criticism was experienced by those who accepted assignments of caring for the patient undergoing a termination, and that those who refused to participate in TOPs had also experienced criticism (Marek, 2004:476).

### **Coping mechanisms utilised**

Participants used a wide variety of coping mechanisms in the course of their work, both external and internal. These coping mechanisms manifested in their interaction with patients, staff and family members.

They chose not to "... *become emotionally involved with the patients ...*". The emotional distancing that occurred between the midwife and the woman began at the point of admission into the gynaecological ward. P3 described how: "*You just admit them, you do whatever you have to do, but you won't talk to them still ...*". This contrasted with the ease of communication with other patients in the gynaecological wards: "... *but with the other patients you will pick up a conversation ...*".

The patients admitted for TOPs were purposely separated from the other patients and placed in a different cubicle. This was in part due to concern about the impact on the patient receiving treatment for infertility lying next to those awaiting termination, but this also served to minimise contact with the TOP patients during the course of the day: "*They like to put them in the one cubicle ... you just go every four hours to give the tablets ...*". "*But it's when you hear the bell go off in cubicle C and you are busy with another patient the first thing that goes through your mind is: is she busy aborting now ... and it's like you don't actually want to go there ...*".

Regarding TOPs as 'just part of the job' enabled the midwives to do the job mechanically and to distance



themselves emotionally from their patients. P3 described how she had to "... accept what you are doing is part of the work ...". She further described this job as "... it's like mechanical; like a robot now ...". The workload especially at night, contributed to this approach "... you are running between the two wards cutting cords all the time ...".

They coped with the situation by justifying their actions: "... carrying out the order ... given by the doctor; ... since it has been legalised ...", emphasising that it was the women's choice to have a TOP and therefore the midwife could not be held responsible "*I don't feel that I have a hand in the termination, I am just carrying out the order at their request ...*".

The participants found it easier to avoid conflict than to confront problems and were resigned to the job: "... you just do it because you know you have to do it ...". P2 said: "... it's against my principles as well but you have to do it ...".

Other coping mechanisms included being defensive about their actions, making a decision not to judge, using separation to get away from a difficult situation and taking another staff member with them when assisting with a TOP.

## **The need for support systems**

Sharing experiences with colleagues provided an outlet for some of the feelings that developed, particularly when there was no support at home. P2 said that "... with terminations we tend to share our experiences and just talk about it ...". It does, however, appear that as TOPs became more routine, there was less sharing of experiences: "... you actually don't talk about it anymore ...". P2 found that "... if you think about it too much and talk about it too much then it wears you down ...". Staff support was seen by one participant as making her vulnerable because "... you have to build a relationship again ...", if she changed wards. Despite these limitations "... talking ..." was still the way they coped. Support from colleagues, although considered important, did not always meet the real support needs.

Support from partners varied. One participant experienced significant support from her partner, but worried that it would be overloading him: "*I have a very support-*

*ive husband ... he has this amazing ability to understand ... if I need to I'll talk to him, but I just feel that it's too much for him ...*". The other participants did not receive support from their partners. One participant had not informed her husband that her work involved TOPs as for him "... abortion is almost like murder ....". The third participant had informed her husband of her role but "... he doesn't want me to be involved with it ...". She dismissed this as "... his problem ..." saying that "... he has to accept it, I've accepted it so he shouldn't have a problem with it ...". Participants hid their feelings to keep the peace at home: "*I tried to tell my parents and there was some objection. So I haven't told them ...*". Similar findings have been reported by Gmeiner, Van Wyk, Poggenpoel and Myburgh (2001:75).

Lack of support from managers in the work place was an issue: "... they never come round to ask how we are dealing with it ... my head nurse has never asked me how do you feel about doing it ...".

Working with a colleague provided moral support when delivering a foetus, and minimised some of the loneliness: "*But I won't do it alone ... one of them always comes with me .... just for moral support or just for help, just so you are not alone with the foetus ... or alone with her ...*".

## **LIMITATIONS**

This initial exploratory study, being of a qualitative nature, having a small sample size, cannot be considered representative of all midwives who assist with terminations of pregnancies. Rather, it serves to highlight that the stresses of working in this field are not linked to anti-abortion values held by health workers, but, for those committed to facilitating choices for the women, that the experiences of isolation, being the only person willing to be there for women in need, and lack of infrastructural and personal support play a key role.

## **CONCLUSION AND RECOMMENDATIONS**

Despite their support of a woman's right to make choices, the participants in this study found their work emotionally draining and stressful. This was in part due to their experiences with the women who terminated

their pregnancies and in part due to the structural difficulties experienced, for example, lack of support from colleagues and management.

From this study certain recommendations are made, which include suggestions made by the participants. There should be appropriate preparation for midwives who assist with TOPs. This should include information on the procedures and the techniques used for TOPs at the different gestational ages, preparation for the emotional aspects of assisting with TOPs and training in counselling. Values clarification workshops are seen to be useful, and should be held on a regular basis. This would facilitate clarity of values and beliefs and in doing so minimising the possibility of judgemental attitudes and actions towards women undergoing TOPs. This in turn would enhance the midwives' own coping abilities. Harrison *et al.* (2004:429) suggest that values clarification workshops could provide information regarding the legislation, the nurses' professional codes, and assist in resolving dilemmas in distinguishing professional responsibilities from personal beliefs. Potgieter and Andrews (2004:29), in a study on TOP providers at South African state hospitals, recommend a wider approach to training of nurses, which include human rights training with respect to women's choices in reproductive health.

Midwives already assisting with terminations of pregnancy may also benefit from values clarification workshops. Support however, is needed beyond this, and could take a number of forms. Support groups, providing an environment for debriefing and discussion should be offered on a regular basis for the registered midwives and other staff who assist with TOPs. Gmeiner *et al.* (2001:77) suggest that such support groups could provide a context in which midwives would feel cared for, and deal with issues of value conflict and utilisation of psychological defence mechanisms as a way of coping.

Midwives who assist with TOPs should regularly be offered the option of another rotation for a period. Increasing the professional staff complement, particularly on night duty, would reduce demands of multiple roles, and would provide for a shared workload and emotional support for colleagues. It is recognised, however, that there are currently many constraints in the allocation of staff.

Women require counselling prior to being referred to a hospital for a termination of pregnancy. Women opting for second trimester terminations require specific information and counselling on the issues they are facing, as well as on what the procedure entails. This task needs to be allocated to specific health/welfare professionals: doctors, midwives or social workers. Opportunities exist to offer counselling, information and support for women while they wait for the Misoprostol to take effect. Health professionals require training in appropriate counselling skills, and should be supported themselves. Ortayli, Bulut and Nalbant (2001:284) found that pre-abortion counselling combined with immediate post-abortal provision of contraceptives may significantly increase contraceptive use at a six months post-procedure. This may in turn reduce the emotional stress on the midwife who cares for women having repeated terminations.

There is a need to provide services which honour the rights and meet the needs of women who wish to terminate a pregnancy, while respecting individuals' rights of conscientious objection (Cook & Dickens, 1999:85). For those nurses and midwives who provide the service, there should be a supportive environment, recognition of the stresses which they face, and appropriate measures put in place to enable nurses and midwives to deliver an effective, empathic service. This includes an increased support network for both the midwives and the women. The Reproductive Rights Alliance (September 1997:1) states: "There are many lessons to be learnt from these hospitals such as the value of providing a participatory and supportive environment for the staff involved in termination of pregnancy, the increasing importance of reproductive health information to patients".

Insight has been gained into the problems, feelings, conflicts and coping mechanisms of midwives involved in second trimester TOPs. There is a need for further research in this area, particularly to identify, implement and evaluate interventions which provide infrastructural and emotional support for health professionals, and create a supportive environment for women undergoing termination of pregnancy.

## REFERENCES

- ALLSOP, J 2004: Termination of pregnancy. **Current Obstetrics and Gynaecology**, 14:285-290.
- BERER, M 2002: Making Abortion a Woman's Right Worldwide. Editorial. **Reproductive Health Matters**, 10(19):1-8.
- BERGUM, V 1991: Being a phenomenological researcher. (In: Morse, JM ed. 1991: *Qualitative nursing research: A contemporary dialogue*. Newbury Park: Sage, pp55-71.
- CIGNACCO, E 2002: Between professional duty and ethical confusion: Midwives and selective termination of pregnancy. **Nursing Ethics**, 9(2):179-191.
- COOK, RJ & DICKENS, BM 1999: Human rights and abortion laws. **International Journal of Gynaecology and Obstetrics**, 65:81-87.
- COWLES, K 1988: Issues in qualitative research on sensitive topics. **Western Journal of Nursing Research**, 10(2):163-179.
- DENOSA (Democratic Nursing Organisation of South Africa) 1998: Position Paper on Termination of Pregnancy. Pretoria: DENOSA.
- FIELD, P & MORSE, J 1985: *Nursing research: The application of qualitative approaches*. Aspen: Rockville.
- GIBBON, C 2000: *South African Medicines Formulary*; 5<sup>th</sup> edition. Pinelands: SAMA Health and Medical Publishing Group.
- GMEINER, A; VAN WYK, S; POGGENPOEL, M & MYBURGH, C 2001: Methodological issues involved in conducting qualitative research on support for nurses directly involved with women who chose to terminate their pregnancy. **Health SA Gesondheid**, 6(4):71-78.
- GUTTMACHER, S; KAPADIA, F; NAUDE, J Te Water & DE PINHO, H 1998: Abortion reform in South Africa: A case study of the 1996 Choice of Termination of Pregnancy Act. **International Family Planning Perspectives**, 24(4):191-194. On line. EBSCO Database.
- HARRISON, A; MONTGOMERY, E; LURIE, M & WILKINSON, D 2000: Barriers to implementing South Africa's Termination of Pregnancy Act in rural KwaZulu/Natal. **Health Policy and Planning**, 15(4):424-431.
- HOLLOWAY, I & WHEELER, S 1996: *Qualitative research for nurses*. Oxford: Blackwell Science.
- HYCNER, R 1985: Some guidelines for the phenomenological analysis of interview data. **Human Studies**, 8:279-303.
- KADE, K; KUMAR, D; POLIS, C; & SCHAFFER, K 2004: Effect of nurses' attitudes on hospital-based abortion procedures in Massachusetts. **Contraception**, 69:59-62.
- KOCH, T 1994: Establishing rigour in qualitative research: the decision trail. **Journal of Advanced Nursing**, 19:976-986.
- KVALE, S 1983: The qualitative research interview: A phenomenological and hermeneutical mode of understanding. **Journal of Phenomenological Psychology**, 14(2):171-196.
- Long Queues for Freedom of Choice [Online] 1997: November 14 [cited March 15 1999]. Available from: <http://wn.apc.org/wmail/issues/971114/NEWS9.html>
- MARAIS, D 1997: Abortion values clarification workshops for doctors and nurses. **HST Update**, 21(Jan):6-7.
- MAREK, MJ 2004: Nurses' attitudes toward pregnancy termination in the labor and delivery setting. **Journal of Obstetric, Gynecologic, and Neonatal Nursing**, 33(4):472-479.
- MARSHALL, SL; GOULD, D & ROBERTS, J 1994: Nurses' attitudes toward termination of pregnancy. **Journal of Advanced Nursing**, 20:567-576.
- MOORE, AA 1997: Change that is here to stay. **Nursing Standard**, 12(6):23.
- MORSE, JM (Ed.) 1991: *Qualitative nursing research: A contemporary dialogue*. Newbury Park: Sage.
- MUNHALL, P 1988: Ethical considerations in qualitative research. **Western Journal of Nursing Research**, 10(2):150-162.
- OILER, C 1982: The phenomenological approach in nursing research. **Nursing Research**, 31(3):178-181.
- ORTAYLI, N; BULUT, A & NALBANT, H 2001: The effectiveness of pre-abortion contraception counseling. **International Journal of Gynaecology and Obstetrics**, 74:81-285.
- PATTON, M 2002: *Qualitative research and evaluation methods*; 3rd ed. Thousand Oaks: Sage.
- POTGIETER, C & ANDREWS, G 2004: South African nurses' accounts for choosing to be termination of pregnancy providers. **Health SA Gesondheid**, 9(2):20-30.
- REPRODUCTIVE RIGHTS ALLIANCE 1997a: Provincial Access to TOP: Are all provinces equal? **Barometer**, 1(1):3.
- REPRODUCTIVE RIGHTS ALLIANCE 1997b: Editorial. **Barometer**, 1(2):1,7.
- SCHENKER, JG & EISENBERG, GH 1997: Ethical issues relating to reproduction control and women's health. **International Journal of Gynaecology and Obstetrics**, 58:167-176.
- STEWART, P & FLETCHER, J 2002: Therapeutic termination of pregnancy. **Current Obstetrics and Gynaecology**, 12:22-27.
- SOUTH AFRICA. 1996: *Choice on Termination of Pregnancy Act (Act No. 92 of 1996)*. Pretoria: Government Printers.
- VARKEY, SJ 2000: Abortion services in South Africa: Available yet not accessible to all. **International Family Planning Perspectives**, 26(2):87-89.
- WALKER, L 1995: The practice of primary health care: A case study. **Social Science and Medicine**, 40(6):819-821.