INDUCED ABORTION – A RESPONSE TO THE DRAFT CONSULTATION FROM THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS DRAFT CONSULTATION – 'THE CARE OF WOMEN REQUESTING INDUCED ABORTION'

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Earlier this year the Royal College of Obstetricians and Gynaecologists issued a consultation document on good practice in induced abortion.[1] The initial period of consultation was very short but, remarkably, was subsequently increased after a Parliamentary challenge. There were many concerns about the consultation, but perhaps of greatest concern was that there appeared to be a minimisation of the harm done by abortion.

This document has understandably attracted much debate amongst healthcare professionals and concerned groups who question the extent to which the guidelines seek to act in the best interest of the patient. A few of the concerns will be discussed.

BACKGROUND

The number of abortions performed on residents in England and Wales reached 189,100 in 2009, representing a rate of 17.5 per 1,000 resident women aged 15-44.[2] Of the women having abortions in 2009, 34% had had at least one previous abortion which is an increase of 5% since 1998[2]. Currently a legally induced abortion must be justified on one of five grounds. [2] The majority of abortions (97%) in 2009 took place under Ground C of the Abortion Act 1967 which states that a woman can be referred for an abortion if 'the pregnancy has not exceeded its twenty-fourth week and [if] the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman'.[2] Currently, women can access abortions in two ways; via a referral from their GP, local NHS family planning clinic, or local genitourinary clinic; or directly from abortion providers such as the British Pregnancy Advisory Service or Marie Stopes International. UK law requires that two doctors' signatures are given before an abortion can be authorised. Medical abortions involve a woman taking abortifacient medication (mifepristone and a prostaglandin) on two separate occasions, whilst a surgical abortion involves a single procedure. All stages of an abortion must take place in a hospital or a specialised licensed clinic as with any medical or surgical procedure that carries significant risks to the patient.

PREGNANCY COUNSELLING

When a woman is faced with an unexpected pregnancy, there are many reasons why she may choose to seek an abortion. For example, when faced with the possibility of a foetal abnormality, a woman may feel confused, fearful of the unknown and initial shock. It is the role of the health care professional to try to understand the reason behind her seeking an abortion and to try and offer support and practical solutions to these problems. What may happen in reality is that a health care professional may offer a woman partial advice about her options or worse still may omit all information about alternatives to abortion and simply make a referral to an abortion provider. Without having all the options available to her, a woman's consent to abortion cannot be considered to be informed.

The RCOG recommend that "women should have access to objective information and, if required, decision-making support about their pregnancy options" (recommendation 14). However, they do not specify the need for health care professionals to make enquiries about the reasons for seeking abortion and the need to offer all alternatives following a detailed enquiry. Their use of the phrase 'if required' may suggest to some that discussion of alternative options is not always necessary in pregnancy counselling, which is of course not true. There are several pressures that can contribute to a woman seeking an abortion. If these are not coming from relatives or a partner (the latter is mentioned in line 2235), sometimes financial problems can lead to a woman feeling under pressure to abort her unborn child. A woman may also feel pressure from a healthcare professional who advises her to abort her unborn child because of a foetal abnormality. For consent to be valid, it cannot be given under coercion, so surely time should be taken to try to establish whether there is any evidence of doubt or pressure on the women, and if so appropriate measures taken. For example, steps can be taken to ensure a woman is seen alone, apart from a pressurising partner, for part of the consultation. A woman can be given details of charity organisations that are willing to offer financial and other practical assistance to help them look after their child, a service that women are not always made aware of (reference Good Counsel Network; LIFE; City Crisis pregnancy help). Although criteria have changed, the Sure Start Maternity Grant still offers women from low-income backgrounds some financial assistance. Although a difficult decision for some, adoption is also an option for mothers who feel unable to cope with an unexpected pregnancy. In the case of foetal abnormality, details of provision of care following the baby's birth should be presented to the woman, so that she knows that she will be supported.

Therefore, two additional recommendations should be included as follows:

- **Careful and tactful enquiry as to the reasons for wanting an abortion should be made with the opportunity for further discussion where women may suggest pressure to abort from others or doubts about the decision.**

- **Women should not be pressurised towards abortion by healthcare workers.**

With regards minors, the RCOG recommends that 'only in exceptional circumstances, where the health, safety or welfare of a minor, or other persons, is at risk should information be disclosed to a third party' (section 3.3). However, the law suggests that in the case of minors, "Doctors have an obligation to encourage a young person to involve her parent(s) or another adult (such as another family member or a specialist youth worker) but generally should not override the patient's views." (section 3.7). Therefore, to avoid confusion, the recommendation in section 3.3 could be omitted.

ACCESS TO ABORTION

As discussed already, the decision to abort a child is never an easy one and it is one that a woman should not be pressurised into making. The RCOG recommendation that "the total time from access to procedure should not exceed 10 working days" (recommendation 24) runs the risk of subjecting health care professionals to a pressure to meet targets, and in doing so may discourage them from giving a woman the time she needs to make a decision about her pregnancy. This is clearly not acting in the patient's best interest as a woman who changes her

mind may feel under pressure to go ahead with the abortion to avoid wasting an appointment. Furthermore, if the 10 day target is driven by a need to reduce health care costs, then this poses great ethical concern. A woman simply cannot be rushed into making such a difficult decision – she must have the freedom to be able to change her mind and choose to continue with the pregnancy without feeling that she has wasted NHS resources. The RCOG does attempt to counter this pressure by stating "women should be informed that they have a right to delay appointments and/or the procedure should they wish" (recommendation 25). However, a less judgemental recommendation can be used as follows:

- **Women should be informed that they will be supported by the abortion provider should they wish to delay appointments and/or the procedure for any reason.**

RISKS OF ABORTION

Whilst there are several concerns surrounding this aspect of the RCOG consultation, the statement "women should be advised that abortion is generally safer than continuing a pregnancy to term" (recommendation 31) is very concerning. This is a very bold statement to make and it is unclear where the evidence to support this recommendation comes from. The evidence presented is focused on surgical complications but does not include evidence on all-cause mortality or other potential adverse clinical outcomes. It would be very difficult to conduct a single study that could provide conclusive evidence on the overall risks of abortion compared with continuing a pregnancy to term. Without such evidence, one may argue that presenting this recommendation as evidence when counselling a woman about her pregnancy options may actually encourage her to have an abortion in a situation where she was uncertain, because she may believe that to continue the pregnancy will be a greater risk. This would be misleading. Secondly, pregnancy is a natural event and therefore to pathologize it may be considered inappropriate. Therefore, to avoid this error, the recommendation could be omitted. There are other recommendations that deal with the physical risks of abortion already in the consultation that make this recommendation unnecessary.

These recommendations however are not without concern. The RCOG recommend that "women should be informed that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility" (recommendation 41). However, it is well established that abortion carries a 10% risk of pelvic inflammatory disease (line 2488). Pelvic inflammatory disease is a known risk factor for infertility and ectopic pregnancy and therefore this recommendation is not accurate and therefore is misleading. Another inaccurate recommendation is "women should be informed that induced abortion is associated with a small increase in risk of subsequent preterm birth, which increases with the number of abortions" (recommendation 42). The RCOG report presents evidence which suggests that the increased risk of preterm delivery associated with abortion is 27-62%. This is not a small risk and in other fields of medicine and surgery would be considered significant enough to omit drugs. Therefore, the recommendation should be altered to state:

- **Women should be informed that induced abortion is associated with a significant risk of subsequent preterm birth.**

MENTAL HEALTH EFFECTS OF ABORTION

The mental health effects of abortion are contested. The Royal College of Psychiatrists are in the process of conducting an updated systematic review of the evidence which will be published later this year as the two literature reviews used in the RCOG consultation did not include several studies conducted after 2008 (Charles et al, and the APA). In the meantime, many studies have suggested that mental health problems exist after abortion. For example:

- Fergusson found increased rates of mental illness, self harm and substance misuse with persistent effects even after controlling for previous mental health and wantedness[3]
- Depression occurs in between 11 and 40% [4, 5, 6]
- Broen set out a substantial excess of depression in those who aborted compared to those who miscarried[6]
- Coleman and Taft found a 37% incidence of major depression[7, 8]
- Anxiety occurs in around 25%[6, 9, 10]
- Alcohol misuse 15-30%[11] and drug misuse 10-32%[11]

At 5 years post abortion, Broen et al found persistent mental disorder in excess of those who miscarry.[6] Broen et al found substantial differences in terms of 'impact of event' scores for avoidance, grief, loss, guilt and anger throughout the observation period with 5% of women post- termination retaining caseness at 5 years compared to less than 1% for women who miscarried.

A table is supplied in the RCOG document which summarises the risk of an adverse event by using a statement about how common the event is. Using the classification of Calman [12] they describe any complication that occurs between 1 and 10% of the time as "very common" (line 1866). If one was to apply this classification to the Broen study, then psychological sequelae should be defined as very common even at 5 years.

Therefore, in view of the above, to be more accurate, and consistent with the presentation of risk in the remainder of their consultation, this recommendation should be rephrased as follows:

- **Services should inform women about the range of emotional responses that may be experienced during and following an abortion and that these occur commonly.**

POST-ABORTION CARE

Given the adverse psychological effects of abortion experienced by women in the short or long term, the RCOG is right to recommend that "referral should be available for the small number of women who require additional emotional support" (recommendation 104). However, given that women may not actively seek help for a number of reasons including feelings of regret, guilt and shame, abortion providing services should ensure that they give women clear details of how to access emotional support should they require it. Independent advisors offer post-abortive helpline services, but these are not always free phone numbers which may act as a deterrent to women seeking help. There are several charities that also provide post-abortion psychological

support that may be appropriate for women of specific cultural and religious backgrounds, and women should be made aware of these (Rachel's vineyard, ARCH, Good Counsel Network and others). The recommendation should therefore state:

- **Women should be told how to access referral for and given clear details of sources of additional emotional support that are culturally sensitive in case they require it**

CONCLUSION

Whilst the RCOG has attempted to update their previous guidelines in order to create clarity to the issue of provision of care for women seeking induced abortion, there are several concerns with the proposed recommendations, only some of which have been outlined above. Perhaps what would help health care professionals act in the best interest of the patient is to assume that every woman presenting with an unexpected pregnancy wants to continue with the pregnancy. This may ensure that health care professionals actively try their best to consider and present all the alternative options to her, as well as provide counsel in an unpressurised environment. Failure to do so risks the consent procedure not being fully informed. The updated guidelines by the RCOG should seek to ensure these areas have been addressed.

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