

# ABORTION IN THE COMMUNITY?

## A new ethical challenge

Gareth Hughes

*Recent events in Parliament have been reported as if the discussion over abortion is simply about gestational age and the prospect of survival at 20 weeks, but the perennial debate, which may well require regular parliamentary revisiting in future, is only one of a number of ethical issues surrounding the current state of abortion law. Gareth Hughes, a medical student on the Lancaster campus of Liverpool University, reviews the current issues. Are we about to see the introduction of 'home abortions'?*

Abortion is a word which provokes many ethical, moral, political and religious opinions in our society. The aim of this report is to look at the current scientific evidence regarding abortion and to try and apply ethical principles to the proposed changes in relation to abortion in UK law.

The basis of this report is the recent publication by the House of Commons Science and Technology Committee.<sup>(1)</sup> Amongst other items, the report suggested the place where abortion could be carried out should not be confined to hospitals and could be extended to non-medical settings. This prompted the Department of Health to set up a trial at two non-traditional settings in the UK. One site is in a community hospital, and the other in a stand-alone unit within an acute hospital.<sup>(1)</sup> The location of the two hospitals was kept secret to avoid disruption by anti-abortion activists. This again highlights how emotive the subject of abortion is. The two hospitals are running early medical abortion services in non-traditional settings to evaluate the effectiveness and safety of provision in these settings.<sup>(2)</sup>

It is useful to discuss the difference in terminology of the words 'abortion' and 'miscarriage'. In medical terms, abortion can be divided into spontaneous abortion (known as miscarriage in the lay community) and therapeutic abortion. The latter of the two referring to the process by where abortion is artificially induced before the 24th completed week of gestation.<sup>(3)</sup> This is what this report will be focussing on.

In 2006, for women resident in England and Wales, the total number of abortions was 193,700, compared with 186,400 in 2005 – a rise of 3.9%.<sup>(4)</sup> If we look at abortion figures for the last three years, it is clear that there has been a steady rise in the number of women undergoing abortions. Clearly, any potential change in the law on abortion is important as it will affect a large number of people. The majority of abortions are carried out before 13 weeks of gestation (89%).

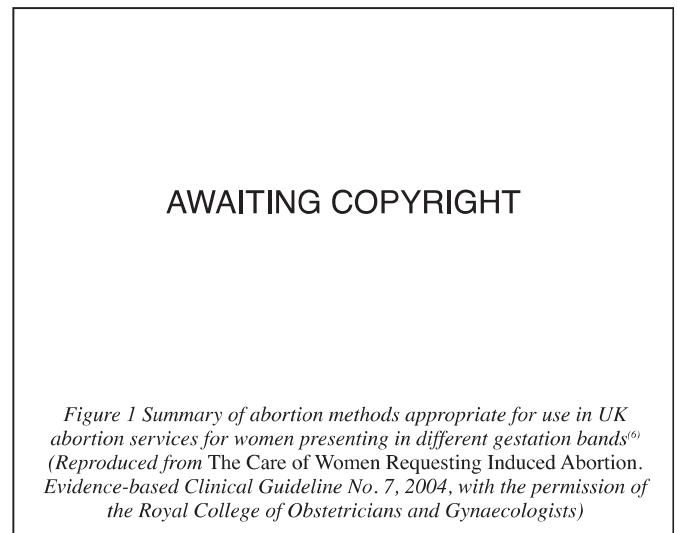
The current law on abortion is governed by The Abortion Act of 1967. This states that a medical termination of pregnancy is only allowed under the following criteria:

- to save the woman's life
- to prevent grave permanent injury to the woman's physical or mental health

- under 24 weeks to avoid injury to the physical or mental health of the woman
- under 24 weeks to avoid injury to the physical or mental health of the existing child(ren)
- if the child is likely to be severely physically or mentally handicapped

The vast majority of abortions in the UK are carried out under the third of these five criteria.<sup>(5)</sup> Changes to the 1967 Act were made in 1990 through the Human Fertilisation and Embryology Act. Part of this Act decided that due to improved medical technology, the upper limit of gestation should be reduced from 28 weeks to 24.

The Royal College of Obstetricians and Gynaecologists (RCOG) recommends differing methods of induced abortion for women depending on the gestational age of the fetus.<sup>(6)</sup>



Abortion can now be managed either surgically or medically. At the time of the 1967 Act, abortion was mainly a surgical procedure. For this reason it was decided that places where abortions could take place needed to be tightly governed. However, with the increase in medical abortions the requirements from a medical perspective have changed. Currently in the UK, a woman having a medical abortion must attend hospital for the administration of both the mifepristone and the misoprostol. However, in other western countries, notably the USA, France, Sweden and Norway, the misoprostol can be taken at home by the woman.<sup>(7)</sup> She is then required to attend a follow-up appointment. The evidence suggests administration of misoprostol outside a clinical environment has minimal risk attached to it.<sup>(8,9)</sup> However, a randomised controlled trial is needed to confirm these findings. Most studies have suggested that although the side effects reported from medical abortions (cramping, headache, prolonged bleeding and nausea) are higher than for surgical, none of them

present serious medical risks. The government's own report on abortion suggests that the case fatality from medical abortion (0.8 per 100,000) is virtually the same as for miscarriage (0.7 per 100,000).<sup>(1)</sup> The incidence of complications from medical abortion was 145 per 1,000 in 2006.<sup>(10)</sup>

The Department of Health's (DoH) proposed plans are only looking to allow *early* abortion outside hospitals. It would not be appropriate for general practitioners (GP) to be performing surgical abortions. The RCOG guidelines on medical abortion up to nine weeks consist of a licensed and an unlicensed regime:<sup>(6)</sup>

- *The unlicensed states:* mifepristone 200mg given orally followed one to three days later by misoprostol 800mg vaginally. If abortion has not occurred four hours after administration of misoprostol a second dose of 400mg may be given providing the woman is 49-63 days into the pregnancy.
- *The licensed states:* mifepristone 600mg to be given orally followed 36-48 hours later by gemeprost 1mg vaginally.

The guidelines state that the misoprostol may be administered either by a clinician or the woman herself.

The physiology behind the two drugs is that mifepristone, being an anti-progestogenic steroid, will sensitise the myometrium to prostaglandins; it will also soften and dilate the cervix. Misoprostol or gemeprost, being prostaglandins, are used to induce uterine contractions and hence complete the abortion.

Section 1(3a) of the 1967 Abortion Act states that the Health Secretary has the powers to approve another type of place for medical abortions to be carried out, ie, a non-traditional setting. As of yet these powers have not been exercised.

The arguments against allowing medical abortions outside of hospitals are varied. Some would argue that medical abortions carry ten times the mortality of surgical abortions, although the numbers involved in each of these is very low.

The following figures give an idea of how the mortality from therapeutic abortion compares with that of miscarriage and delivery:

- 1/1,000,000 with surgical abortion through 63 days gestation<sup>(11)</sup>
- 1/100,000 with medical abortion through 63 days gestation<sup>(12)</sup>
- 1/100,000 with miscarriage<sup>(13)</sup>
- 1/10,000 with a term delivery<sup>(14)</sup>

Approximately 5-8% of women require surgical intervention following medical abortion.<sup>(1)</sup> With this in mind, would GPs be adequately equipped to deal with such complications? Obviously they would not be dealing directly with complications, particularly any surgical intervention, but are they prepared to invest the time and money into this service and how big a task would it be to put the infrastructure in place into an already overstretched Primary Health Care team?

It would be appropriate to mention the four principles of ethics as described by Beauchamp and Childress when

talking about the ethical considerations surrounding a topic. They include autonomy, beneficence, non-maleficence and justice.<sup>(5)</sup>

## AUTONOMY

Theoretically, abortion is not available 'on demand' in the UK; for it to be legal it has to fall into one of the five categories mentioned above. However, avoiding injury to the physical or mental health of the woman is often seen as a grey area which allows women to have an abortion on social grounds. The autonomy of the pregnant woman is threatened to some extent by the law. For example, women at 25 weeks' gestation would be unable to ask for an abortion unless any of the three categories referring to post 24 weeks' gestation were satisfied. However, this upper limit is in place to protect the limited autonomy of the fetus. The report by the Science and Technology Committee<sup>(1)</sup> recommended a number of changes which may increase women's autonomy with regard to abortion.

The committee looked at the current requirement for two doctors to conclude that an abortion can take place legally and for them to both sign the relevant health forms. If, as a society, we accept that women should have the right to have an abortion at least in principle, then should we not be making every effort to avoid any sort of delay in that abortion taking place? That is the argument of the so-called 'Pro-Choice' lobby. There is no other medical or surgical procedure that requires the signatures of two doctors before being carried out. It would be fair to argue that any delay, from a woman's request to an actual abortion taking place, could be an infringement of her autonomy.

Obviously, continuing with the requirement for two doctors' signatures takes into account the autonomy of the unborn fetus. It ensures legislation is observed correctly. The 1967 Abortion Act did not make abortion legal; rather it gave defence to doctors against illegality. The clause was designed so that each doctor could police the other. Allowing this clause to remain also demonstrates the seriousness of the decision to terminate. Those against the principle of abortion would argue that being able to abort a fetus is extending patient autonomy too far. Therapeutic abortion is a medical procedure, yet it often takes place on non-medical grounds. This is unusual in that it does not happen in many other areas of medicine.

Another interesting point raised by the Science and Technology Committee's report is the anti-abortion views expressed by many doctors. The General Medical Council (GMC) clearly states that one of the duties of a doctor is to:

*'Make sure that your personal beliefs do not prejudice your patients' care.'*<sup>(15)</sup>

However, section 4, paragraph 1 of the 1967 Act clearly states that a doctor may refuse to participate in a termination but they must provide necessary treatment in an emergency situation, eg, if the woman's life is jeopardised. This conscientious objection clause allows doctors who don't personally agree with abortion to refer their patients to a colleague. There is clearly a large spectrum of doctors' views in relation to abortion. Many who disagree with abortion may only disagree on the principle of 'social' reasons for an abortion. This may present something of a problem to

potential government plans as the majority of medical abortions take place before 13 weeks, as mentioned above. The medical abortions the government are proposing GPs become involved in will take place even earlier. At this point the reason for the woman wanting an abortion is likely to be for 'social' reasons.

The GMC has recently updated existing guidelines meaning that GPs now have to reveal their personal beliefs to patients in addition to referring them to another colleague if they do not want to be involved. This will seem unfair to many and it could be argued that this infringes on the GPs own human right to respect for privacy and family life.

Various studies have shown doctors' opinions to be divided in regards to abortion. A study carried out by Marie Stopes International (the leading provider of abortion services outside the NHS) asked 690 GPs nationwide about their attitudes to abortion.<sup>(16)</sup> They found that almost 20% considered themselves anti-abortion. Further to this, when asked about government proposals to allow medical abortions to take place in GP practices, nearly 70% disagreed that GPs should be licensed to dispense the medical abortion pill.

These above points suggest that even if the government was to change the law on abortion, there are many potential barriers to overcome.

## BENEFICENCE

When looking at the current requirements for an abortion to take place in the UK, three out of five of them appear to be in place to safeguard the health of the mother:

- to save the woman's life
- to prevent grave permanent injury to the woman's physical or mental health
- under 24 weeks to avoid injury to the physical or mental health of the woman

There is some overlap between beneficence and non-maleficence on this subject, so the majority of the debate will be dealt with below.

## NON-MALEFICENCE

The largest review of the evidence on health risks to women associated with abortion was produced by RCOG.<sup>(6)</sup> It looked at the mental and physical risks associated with abortion. They concluded that most studies looking at the mental health risks associated with abortion were flawed for a number of reasons, ranging from failure to control for confounding factors (such as previous psychiatric history) to small sample sizes. The difficulty in coming to any firm conclusions about abortion and its ability to influence mental health can be summed up by two recent studies.<sup>(17,18)</sup> One of them found those that had had an abortion had elevated levels of depression, anxiety, suicidal behaviours and substance misuse disorders.<sup>(17)</sup> However, the other found better outcomes amongst young women who aborted their pregnancies compared to controls who continued the pregnancy.<sup>(18)</sup>

There has been some concern about the associations between induced abortion and future complications such as ectopic pregnancy, placenta praevia and infertility. However,

RCOG guidelines<sup>(6)</sup> state that there is no proven evidence for this. They do, though, state that abortion could be linked with a small increase in the risk of future miscarriage or pre-term delivery. The proposed hypothesis behind this is that during abortion the cervix may become injured, therefore making it less competent in future pregnancies.<sup>(1)</sup> Although damage to the cervix may occur with surgical abortions, it is unlikely to occur in medical abortions. With this in mind, should we be advising medical abortion?

The requirement for two doctors' signatures could be putting mothers at increased risk of harm. It has been reported that early abortions result in less harm to the mother.<sup>(1)</sup> The delay in getting two doctors' signatures could be delaying early abortions from taking place. As noted, if the time taken to have the abortion increases so do the risks of complications.

As mentioned above, the complications from medical abortions are relatively minor. However, the conversion rate from medical to surgical abortion may prove a stumbling block in any potential plans to relocate medical abortions to the community. GPs and district nurses would probably be appropriately skilled in managing the minor complications from a medical abortion, though identifying those who need surgical intervention may require more experience. It may become necessary for those involved with community abortions to attend a course to gain this experience.

Some would argue that because of all the factors mentioned above, abortion (whether surgical or medical) should remain in a hospital where staff are experienced in caring for women in these situations, which would therefore minimise any potential harm coming to the woman.

There is the potential for a dark vacuum to evolve out of the proposed government plans. At present, abortion in this country is tightly regulated and one would hope this would continue if abortions became prevalent in general practice. However, would this change in the law be interpreted by patients as a downgrading of the serious nature of a medical abortion? Would we see a market appear for internet purchases of the abortion medication, ie, the return of illegal abortions? This is a point which needs to be addressed before any change in permitted locations for an abortion takes place.

At present the principle of non-maleficence as applied to the fetus is exercised by the requirement for an upper gestational limit for an abortion to take place. Following the recent debate in the House of Commons, where, as is the custom for debates of this nature, the members were given freedom to vote according to their own beliefs, this limit will remain at 24 weeks. This upper limit gives the fetus a limited right to life. Limited, because whilst a mother cannot abort her pregnancy beyond 24 weeks for 'social' reasons, she may still abort if the fetus is likely to be mentally or severely handicapped or if indeed there is a risk to her own life. This upper limit was governed by the fact that below 24 weeks the fetus was unlikely to survive. However, as neonatal care advances this may change.

## JUSTICE

The ethical principle of justice relates to the fact that resources (eg, time and money) are limited and they must be distributed fairly. This principle is highly relevant to abortion because as stated above, most women choose to have an

abortion on socio-economic grounds. Some would argue that if this is the case then abortion should not remain free on the NHS and patients should contribute an amount towards it. In France and Sweden patients contribute a set amount towards the total cost of the abortion. In the UK these costs are met via taxation in the form of National Insurance. However, many medical treatments exist in the UK which are only available in the private sector and costs must be funded by the patient without state contribution.

One of the main advantages of expanding medical abortions into the community would be to alleviate the pressure on current abortion services. Medical abortions should in theory be more economically viable than surgical ones as less staff and other resources are involved. A medical abortion is essentially the induction of a natural procedure, so unless the patient develops complications costs can be kept to a minimum. Allowing this second pill to be dispensed outside a hospital may reduce resources spent in receptionist time, doctors' time, nurses' time and most of all patients' time, as many will live a fair distance from the hospital.

Currently, women have to attend hospital on at least two occasions if they opt for a medical abortion. Firstly, to receive the mifepristone and then secondly, 48-72 hours later to receive the misoprostol or gemeprost. For the patient this can be decidedly inconvenient; many patients have to travel a fair distance to their nearest abortion centre. From this point of view, allowing patients to receive the second pill (misoprostol) outside a hospital, eg, in their GP surgery, would reduce the time and money spent by the patient on travelling to these centres.

If GPs were licensed to prescribe 'the abortion pill' would they also be expected to monitor and follow the patient up? If not, then the patient would still need a follow-up appointment at the hospital, which would still take up limited resources. A follow-up appointment is more important for medical abortions than surgical abortions as it is imperative to check that all products of conception have been passed.

In France, the safety of home administration of prostaglandins is recognised by the French National Agency for Accreditation and Evaluation in Healthcare (ANAES). ANEAS guidelines<sup>(19)</sup> state that a medical abortion can take place either in the home or in a hospital, providing that the pregnancy has not exceeded seven weeks from the last menstrual period. After this date, they recommend that medical abortions should take place in a hospital. They list a number of criteria that must be met if the patient is to have a medical abortion outside a hospital, including:

- the patient's home should be within reach of the hospital (less than an hour away) and it should be possible to contact and/or be admitted to the hospital 24 hours a day
- the patient should be allowed to choose where the abortion should take place, in hospital or at home, and she should have a close friend or relative with her at home
- particular attention should be paid to providing the patient with information, particularly concerning what to do in the event of bleeding
- patients eligible for this type of procedure should undergo a medical and psychosocial assessment
- it is important to emphasise the need to attend a follow-up appointment 14 to 21 days after the abortion. This should include at least a clinical examination and there should be

easy access to ultrasound equipment to verify that the uterus is empty

- if the patient is Rhesus negative, anti D IgG will be given when they attend hospital for the mifepristone administration

## CONCLUSION

It is clear from the above literature that the issue of changing the number of places where abortion can take place is not an easy one. Using the four ethical principles to guide the debate we can attempt to draw some conclusions. The autonomy of the woman would be improved to some extent if the proposed change took place. Being able to take the second abortion pill at home would require less travelling to hospital and make it easier for the woman in general. Although, if she did develop complications which usually occur with the prostaglandin as opposed to the misoprostone, she would be better managed if she was in a hospital. This brings us on to the topics of beneficence and non-maleficence. As mentioned above, the mortality of medical abortions is higher than that for surgical. However, we are still talking about relatively small numbers of people. In addition to this, the potential complications from surgical abortions such as future miscarriage and pre-term delivery are obviously more serious than the more minor side effects of headache and nausea commonly associated with medical abortions.

What will any change mean to patients and doctors at a local level? Having spoken to some of the local GPs it is clear that in theory the proposed changes could work. If GPs were offered enough money to make it cost efficient to their individual practice, then there would be support for the idea. GPs are already carrying out minor surgery lists which are saving the Health Service money. The set up may work by which one GP per practice who feels more comfortable with abortion goes on a course to become qualified in medical abortions. Each GP in that practice would then refer their patients requesting medical abortion to this doctor. There still runs the problem of personal objection to abortion. In a small practice it is likely that many of the partners will object to carrying out abortions themselves. What would happen if the one GP who carries out the abortions goes on annual leave or is ill? Perhaps the GPs could organise a pregnancy test before and after the abortion. If the result is still positive at follow up then the patient could then be referred back to hospital.

Whatever the outcome of the DoH study, a few fundamental questions still remain:

- How much benefit would abortions in the community, as opposed to hospital, bring to women?
- If the law did change, would GPs be agreeable to a higher degree of involvement in the management of abortions?
- Would women's safety be compromised by having a medical abortion outside a hospital environment?

The answers to these questions still remain to be seen.

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## Letter to the Editor

### Dear Editor

My follow up patients are having their appointments moved. There is no clinical input into this decision which has led to potentially dangerous actions. I have broached this with my immediate managers and requested to be involved with the decision to move patients. This was first in February. Nothing has happened.

The problem with follow up patients, unlike new patients, is that there is no national target time-frame within which they need to be seen. The pressure of the 18 week target and the greater tariff price for new patients places follow ups at a disadvantage. Since this central target was introduced the problems have arisen. I am sure that it wasn't intended to have this perverse effect. It is obvious that for clinical reasons it needs to be revised to allow equality of patient care. I implore the Trust to take this issue seriously.

**Name and address supplied**