Termination of pregnancy

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Abstract

Unintended pregnancy is widespread in the United Kingdom. It affects women in all socioeconomic and demographic groups. Contraception in the UK is state-funded and is easily available; however, despite the easy availability of effective contraception, one in five pregnancies ends in termination of pregnancy (TOP). The UK has the second highest teenage pregnancy rate in the developed world, and the incidence of sexually transmitted infections is also increasing amongst 16–19-year-old girls. Women who choose TOP should have their choice respected and should have access to appropriate pregnancy-termination services. The right to have a TOP confidentially is the most controversial issue in the area of adolescent consent. Most pregnancies ending in termination arise from inconsistent and incorrect use of contraception. A consistently high rate of teenage pregnancy terminations has prompted the Department of Health to initiate and introduce youth clinics to help adolescents and advise them on sexuality, interpersonal relationships, contraception, and avoidance of sexually transmitted diseases.

Keywords consent relating minors; sexually transmitted infections; teenagers; termination of pregnancy; unwanted pregnancy

Introduction

The concept of pregnancy termination has been surrounded by controversy amongst various activists ever since the Abortion Act was introduced in the UK in 1967. A recent survey by The Royal College of Obstetricians and Gynaecologists (RCOG) revealed an astonishingly high number of young doctors opting out of training for termination of pregnancy (TOP). A survey conducted on 309 general practitioners (GPs) within the United Kingdom concluded that one in four GPs declined consenting for TOP, and nearly one in five GPs supported the view that TOP should be banned. This led to an outcry from the pro-abortion activists who supported women's choice for terminating pregnancies. They highlighted the fact that although the views of 309 GPs were taken into account, an opinion was not sought from 40 000 GPs in the UK who were not included in the survey. The women's health campaigners have called for an end to the anachronistic legislation which requires the consent of two medical practitioners to approve a termination of pregnancy. They reinforced the view that the Abortion Act of 1967 should be revisited and revised.

TOP is one of the commonest gynaecological procedures in the UK, with approximately 192 000 pregnancy terminations being performed each year. The UK also has the highest TOP rates among 15–19-year-old girls in Western Europe.

The White Paper 'Health of the Nation' has highlighted that the pregnancy rates of under-16-year-olds is an increasing health problem. Prevention of unintended pregnancies amongst teenagers has since then become a high priority for health-care providers and purchasers. There is no consensus within the UK at present on the best methods of tackling teenage pregnancies and sexually transmitted infections amongst 15–18-year-olds. This may be achieved, however, with a collective strategy incorporating effective school sex education, social learning theory, and provision of easily accessible contraceptive services.

Termination of pregnancy

TOP, a process of ending a pregnancy so that it does not result in the birth of a baby, is also referred to as 'abortion'. One third of all pregnancies are terminated worldwide. The UK Abortion Act of 1967 allows termination of pregnancy up to 24 weeks' gestation, with a few exceptions in which, on medical grounds, termination may be carried out after 24 weeks' gestation. The amendment to the Abortion Act in 1990 places no gestational limit for terminating pregnancies with fetal anomalies following prenatal diagnosis. All legal TOPs in England are governed by the provisions of the 1967 Abortion Act which sets out principal conditions under which TOP may be carried out. These are as follows:

1. the continuance of the pregnancy would involve risks to the life of the pregnant woman greater than those if the pregnancy were terminated;
2. the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;
3. the pregnancy has not exceeded its 24th week, and the continuance of the pregnancy would involve risk, greater than that if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;
4. the pregnancy has not exceeded its 24th week, and the continuance of the pregnancy would involve risk, greater than that if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman;
5. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

A pregnancy may only be terminated if two registered medical practitioners are of the opinion, formed in good faith, that TOP is justified within the terms of the Act. The Abortion Act has a conscientious objection clause which permits doctors to decline participating in pregnancy terminations. However, doctors are obliged to provide emergency treatment when a woman's life is at risk. In the UK, most pregnancy terminations are carried out before 13 weeks of pregnancy, and the commonest cause of TOP is under Clause C or D of the Abortion Act.

In the Confidential Enquiry into Maternal Deaths of 2002, there were five deaths following TOP. Two women, although referred

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promptly for TOP, were not given appointments for more than 5–6 weeks following a referral. A woman may seek termination of pregnancy through a GP, a family planning clinic, or a genitourinary medicine clinic. National guidelines state that, as a minimum standard, no woman should wait for more than 3 weeks from the initial referral to the time of her TOP. Pregnancy termination services should have local strategies in place for provision of information and access to TOP services. Appropriate written and verbal information of the choices available within the TOP service would provide a greater degree of support to women. TOP can only be carried out in a hospital or in a specialized licensed clinic in the UK, and the funding of NHS TOP services has regional variations. Women may contact a private TOP clinic without being referred by her doctor; however, the National Health Service (NHS) does not always fund self-referred women.

Late TOP at ≥22 weeks' gestation can be extremely traumatic, and parents must receive sympathetic supportive counselling prior to and after the procedure. For all late TOP, feticide by injection of intracardiac potassium chloride is recommended. It is essential to have an agreed multidisciplinary management plan with obstetricians, neonatologists, midwives, and medical and nursing staff prior to late TOP, particularly if it involves taking definitive action after the birth of the fetus whether it is born alive or dead.

The RCOG has implemented guidelines for women requesting induced abortion. A consultation with a sexual and reproductive health specialist provides the opportunity for women to discuss the possible reason for a TOP, and to give support in their decision-making and access to social services, appropriate counselling with the family planning and sexual health advisers, information about the different methods of pregnancy termination suitable for the stage of pregnancy, and the possible risks and complications of the procedures. In the absence of specific medical or social contraindications, most cases of TOP are managed on a day-case basis. The best method for TOP (medical or surgical) is usually dependent on the gestational age of pregnancy.

Management of women requesting TOP includes:

- a blood test to determine ABO and rhesus blood groups and screening for anaemia and haemoglobinopathies;
- a pelvic ultrasound to assess gestational age of the fetus and fetal viability, and to rule out an extrauterine pregnancy;
- a cervical smear test if indicated;
- screening for sexually transmitted infections such as chlamydia, HIV and hepatitis B;
- provision of information and advice about contraception after pregnancy termination;
- provision of support in the woman's decision-making to avoid untoward future implications of TOP.

Anti-D immunoglobulin is given to all non-sensitized rhesus-D-negative women, irrespective of the gestational age or mode of termination. TOP care should also include the prevention of infective complications. The use of prophylactic antibiotics after TOP is therefore justified. Women should be advised of the symptoms that may need urgent medical attention. Future contraception should be discussed and initiated following TOP. Women should be advised about a possible link between TOP and future fertility, risk of ectopic pregnancy, miscarriage, and complications in future pregnancy such as placenta praevia. A small proportion of women experience long-term adverse psychological sequel.

In 2005, 186 400 TOPs were performed in UK residents, which is a significant rise of 0.4% over the figures of 2004. This was equivalent to an age-standardized TOP rate of 17.8 per 1000 resident women aged 15–44 years. The highest age-standardized TOP rate was in 2005; this was 32 per 1000 women in the 20–24 age group; the TOP rate for under-16-year-olds was 3.7 and for under-18-year-olds was 17.8 per 1000 women, rates similar to those in 2004.

Eighty-nine per cent of the pregnancies were terminated at or under 13 weeks' gestation, with 67% of terminations under 10 weeks' gestation. A substantial increase in the number of terminations that were performed under 10 weeks was noted. Medical management of TOP accounted for 24% of the total terminations compared with 19% in 2004. Of late terminations, 1900 were on ground E (Abortion Act 1967): risk of severe mental or physical handicap in the child.

Sexual behaviour has changed over the decade, and a shift towards younger women requesting TOP has been observed. This has led to several debates on the best methods of dealing with teenage pregnancy. Teenage pregnancy is on the rise in the UK. Britain has the highest conception rate in Western Europe, which is twice as high as in Germany, three times as high as in France, and six times as high as in the Netherlands. There is clear evidence to show that having children at a young age can damage young women's health and well-being as well as limiting their education and career prospects. Of all teenagers who conceive, half of the under-16-year-olds and more than a third of 16–17-year-olds have a TOP.

In addition to the high conception rates in the UK, at least 10% of sexually active teenagers have a sexually transmitted infection. Chlamydia infection rates are high among 16–19-year-old girls. The cost of teenage pregnancy to the NHS alone was estimated to be £63 million last year. A key target of the Department of Health has been to halve the teenage conception rates amongst under-18-year-old girls by 2010. Since the introduction of the Termination of Pregnancy strategy in 1999, a steady reduction in conception rates in women both under 18 and under 16 have been noted. A recent survey by GPs in the UK on teenage pregnancy rates concluded that younger GPs are more likely to provide contraceptive advice and contraceptive services without parental consent, and are able to discuss sexual health issues with teenagers, compared with older GPs.

Girls below 16 years of age are able to consent or decline termination of pregnancy if they are able to reach an informed decision regarding the situation. However, it is recommended that a medical practitioner seeks medico-legal advice regarding TOP in girls less than 16 years of age if there is any uncertainty. It is of paramount importance to prevent unwanted pregnancies amongst schoolgirls/teenagers in order to protect their reproductive health. This may be achieved by improving access to relationships and sex education through either the national curriculum or intensive media campaign. Provision of easily accessible, confidential and well-publicized contraceptive services are the key factors contributing to the reduction of TOP.

Management of TOP is surrounded by clinical, legal, moral and ethical issues, and it is recommended that medical practitioners follow the guidelines laid down by the RCOG: 'The Care of Women requesting Abortion'.