Patient

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Termination of pregnancy

Synonyms: induced/therapeutic abortion; abortion is a widely used synonym amongst the general public

Termination of pregnancy (TOP) is a medically directed miscarriage prior to independent viability, using pharmacological or surgical means. It is also referred to as abortion and termination throughout this article.

Important information
Doctors may have strongly held personal beliefs concerning TOP. Current General Medical Council (GMC) guidance states [1]: **"You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.** **You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress."**

Epidemiology

Incidence

In 2018, according to Department of Health statistics, for women in England and Wales [2]:

- There were 200,608 abortions for women resident in England and Wales in 2018, and 205,295 abortions including non-residents. 17.4 per 1,000 resident women had an abortion. The figure for women resident in England and Wales is an increase of 4% since 2017.

- Over the last 10 years abortion rates have decreased year on year for women aged under 18. Abortion rates have been increasing for women aged over 35.
- 9 out of 10 abortions were carried out under 13 weeks.
- 3,269 abortions were due to the risk that the child would be born seriously handicapped.
- 71% of abortions were medically induced.
- Almost all abortions in England and Wales were funded by the NHS in 2018, with most of these abortions taking place in the independent sector.

In 2017 in Scotland, terminations were at a five-year high of 12,212 (11.8 per 1,000 women aged 15-44) [3].

In Northern Ireland, the abortion law was different until recently. There were 12 terminations in the year 2017/2018 [4]. However, abortion in Northern Ireland has now been decriminalised and abortion services in Northern Ireland are now in line with the rest of the UK.

Legal requirements

The 1967 Abortion Act allows TOP throughout the UK (Northern Ireland in line with the rest of UK from 2020) before 24 weeks of gestation:

- If it reduces the risk to a woman's life; **or**
- If it reduces the risk to her physical or mental health; **or**
- If it reduces the risk to physical or mental health of her existing children; **or**
- If the baby is at substantial risk of being seriously mentally or physically handicapped.

Two medical practitioners must certify in good faith by signing form HSA1 (Certificate A in Scotland) that at least one of these criteria applies. Most terminations are performed under the second of these criteria. There is a general debate in political and public circles every so often that the upper gestational age limit ought to be reduced from 24 weeks to 22 or 20. This is due to the recognition of advances in neonatal care and improving the survival rates of some premature infants born around this time, setting up an environment of moral concern that babies who could survive are having their lives ended. 4-dimensional ultrasound also appears to show 20-week gestation fetuses displaying complex behaviours, prompting a call for a shift from viability as the main criterion, towards sentience[5]. Currently, the British Medical Association (BMA) does not favour a reduction in the gestational age limit for terminations[6]. This is based on the fact that there is no significant improvement in survival statistics for babies born under the age of 24 weeks. The BMA also supports the position that the need for two doctors to certify should be removed in the first trimester.

There is no upper limit on gestational time if there is:

- Risk to the mother's life.
- Risk of grave, permanent injury to the mother's physical/mental health (allowing for reasonably foreseeable circumstances).
- Substantial risk that, if the child were born, it would have such physical or mental abnormalities as to be seriously handicapped. Such terminations must be conducted in an NHS hospital.

A minority of terminations are performed after 20 weeks. This is usually following amniocentesis, or in very young girls who have concealed or not recognised the pregnancy.

Termination of pregnancy in girls under 16 years[7]

GMC guidelines state that girls under the age of 16 may be able to make an informed decision without parental consent if they are deemed to have capacity to do so. The guidance states that abortion can be provided without parental knowledge or consent if:

- The girl understands all aspects of the advice and its implications.

- You cannot persuade her to tell her parents or to allow you to tell them.
- Their physical or mental health is likely to suffer unless they receive such advice or treatment.
- It is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent.

The GMC further advises you should keep consultations confidential even if you decide not to provide advice or treatment (for example, if your patient does not understand your advice or the implications of treatment), other than in the exceptional circumstances.

The consent of a competent young person overrides parental refusal to allow treatment[6]. If a young person lacks capacity, someone with parental responsibility can consent on their behalf. The young person's views must be heard and taken into consideration. Consider the possibility of sexual abuse; if the young person does not have the capacity to consent to abortion, do they have the capacity to consent to sexual intercourse?

See the separate Consent to Treatment in Children (Mental Capacity and Mental Health Legislation) article.

It is strongly recommended that you seek medico-legal advice from your medical indemnity organisation regarding your statutory and ethical duties, and the rights of patients and/or their parents, regarding terminations in girls aged <16 if you have any uncertainty.

Before termination of pregnancy[8]

- Confirm the patient is pregnant.
- Counsel to help her reach the decision she will least regret.
- Most clinics provide optional counselling. Encourage the woman to utilise this if she would find it helpful; however, the Royal College of Obstetricians and Gynaecologists (RCOG) and the BMA state this should not be mandatory. (There have been political calls for it to be so in the past.)
- Discuss the methods of abortion and choices available.

- Ask her to consider the alternatives (eg, adoption); ask about her partner (but note that the partner cannot consent to, or refuse, TOP).
- Ideally, allow time for her to consider and bring her decision to a further consultation. However, remember that the RCOG guidelines state that: 'The earlier in pregnancy an abortion is performed, the lower the risk of complications. Services should therefore offer arrangements that minimise delay.'

If she chooses TOP, the RCOG recommends the following:

- Screen for chlamydia (10-13% of women attending abortion services screen positive for chlamydia. 25% of these would get postoperative salpingitis if untreated).
- A risk assessment for other sexually transmitted infections (STIs) should be made and a screen done for these if indicated.
- Discuss future contraceptive needs - start the pill next day or insert an intrauterine contraceptive device (IUCD).
- Check rhesus (Rh) status in all women - if negative, anti-D is needed. FBC, blood group and haemoglobinopathy screen should be checked where clinically indicated.
- Assess the risk of venous thromboembolism (VTE).
- Establish whether her smear is due. If it has not been done within the recommended time period, it should be offered within the abortion service, or she should be given information about when and where to get it done.

Ultrasound scanning

All services must have access to scanning, as it can be a necessary part of pre-abortion assessment, particularly where gestation is in doubt or where extrauterine pregnancy is suspected. When ultrasound scanning is undertaken, it should be in a setting and manner sensitive to the woman's situation. It is inappropriate for pre-abortion scanning to be undertaken in an antenatal department alongside women with wanted pregnancies.

However, ultrasound scanning is no longer considered to be an essential prerequisite of abortion in all cases. This is because medical TOP is now used at all gestations, so accurate dating of the pregnancy within the first trimester is no longer essential. Small differences in gestation are unlikely to affect management.

The termination of pregnancy procedures

The National Institute for Health and Care Excellence (NICE) guideline for abortion care states[9]:

- Offer a choice between medical or surgical abortion up to and including 23+6 weeks of gestation.
- Offer anti-D prophylaxis to women who are rhesus D negative and are having an abortion after 10+0 weeks of gestation. Do not offer anti-D prophylaxis to women who are having a medical abortion up to and including 10+0 weeks of gestation. Consider anti-D prophylaxis for women who are rhesus D negative and are having a surgical abortion up to and including 10+0 weeks of gestation.
- Do not routinely offer antibiotic prophylaxis to women who are having a medical abortion. Offer antibiotic prophylaxis to women who are having surgical abortion.
- For women who need pharmacological thromboprophylaxis, consider low-molecular-weight heparin for at least seven days after the abortion. For women who are at high risk of thrombosis, consider starting low-molecular-weight heparin before the abortion and giving it for longer afterwards.
- Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy. There is a small chance of an ectopic pregnancy. Follow-up appointments to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy may be needed.
- Anaesthesia and sedation for surgical abortion: for women who are having surgical abortion, consider local anaesthesia alone, conscious sedation with local anaesthesia, deep sedation, or general anaesthesia.

The guideline provides detailed recommendations for medical and surgical abortions at different gestations - see the guideline for details.

Editor's note

Dr Sarah Jarvis, 3rd February 2021

NICE Quality Standard

NICE has issued a quality standard on abortion care[10]. It recommends that:

Women requesting abortion up to and including 23+6 weeks of gestation should be offered a choice between medical and surgical abortion.

Up to 9+6 weeks, women having a medical abortion are given the option to take misoprostol at home.

Women deciding to proceed with abortion should have the option to have the procedure within a week of assessment.

Women wanting contraception should receive their chosen method before discharge following the abortion procedure.

Women are advised how to access care and support following an abortion.

Analgesia and anaesthesia[8]

For medical abortions, the RCOG recommends an analgesic such as a non-steroidal anti-inflammatory drug (NSAID) be offered (but not paracetamol which has been shown to be ineffective for this indication). Stronger analgesia may be required in some cases.

Ideally there should be the option of local anaesthesia, general anaesthesia or conscious sedation for surgical abortions. An NSAID should be routinely offered for pain relief.

Aftercare[8]

Medical

Anti-D IgG to all non-sensitised RhD-negative women. Discuss contraception and supply if accepted. Abortion services should be able to supply contraception immediately after the procedure. Intrauterine contraceptives can be inserted immediately after an abortion as long as successful abortion has been confirmed.

Written

Provide a list of possible symptoms, highlighting those that need urgent medical attention, with a 24-hour number where it can be obtained. Also, a letter with enough details to allow another doctor to be able to deal with any complications. If abortion has been confirmed at the time of the procedure there is no need for routine follow-up. Arrange further counselling for women who experience long-term distress.

Complications[8]

TOP is considered a safe procedure and major complications are rare. The most common complications are:

- Infection: up to 10% of terminations. Reduced by prophylactic antibiotics or pre-procedure screening for infection.
- Cervical trauma: 1%, lower when TOP is performed early. A risk of surgical abortion only.
- Failed TOP - less than 1 in 100.

Uncommon complications are:

- Haemorrhage (severe, requiring transfusion) - 1/1,000 (first trimester) - 4/1,000 (beyond 20 weeks).
- Perforation of uterus - 1 to 4 in 1,000. Usually at late gestations. A risk of surgical abortion only.

There is no clear evidence to link abortion and breast cancer, preterm delivery or subsequent infertility.

Psychological effects

Only a small proportion of women experience long-term adverse psychological sequelae. Although early distress is common, it is usually a continuation of the symptoms present before the abortion. Evidence suggests termination of pregnancy is no more likely to be associated with poor mental health outcomes than if the pregnancy is continued[8]. Denial of or lack of legal abortion services may have serious consequences for the physical and mental health and well-being of women and their families, and research is ongoing in this area[11].

Further reading

- Kulier R, Kapp N, Gulmezoglu AM, et al; Medical methods for first trimester abortion. Cochrane Database Syst Rev. 2011 Nov 9;(11):CD002855. doi: 10.1002/14651858.CD002855.pub4.
- Wildschut H, Both MI, Medema S, et al; Medical methods for mid-trimester termination of pregnancy. Cochrane Database Syst Rev. 2011 Jan 19; (1):CD005216. doi: 10.1002/14651858.CD005216.pub2.
- Induced Abortion Worldwide; Guttmacher Institute, 2022

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