Termination of Pregnancy

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.

Doctors may have strongly held personal beliefs concerning TOP. Current General Medical Council (GMC) guidance states: 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 2014, according to Department of Health statistics, for women resident in England and Wales:

- The total number of abortions was 184,571. This is 0.6% less than in the 2004 statistics 10 years before.
- The age-standardised abortion rate was 15.9 per 1,000 resident women aged 15-44.
- The abortion rate was highest at 28 per 1,000, for women aged 22.
- The under-16 abortion rate was 2.5 and the under-18 rate was 11.1 per 1,000 women.
- 98% of abortions were funded by the NHS; of these, over 67% were in the independent sector under NHS contract.
- 92% of abortions were carried out at under 13 weeks of gestation; 80% were at under 10 weeks.
- Medical abortions accounted for 51% of the total.
- 3,099 abortions (2%) were under ground E (risk that the child would be born handicapped).

In Scotland in 2014, there were 11,475 abortions, representing 11 per 1,000 women aged 15-44. In Northern Ireland, the abortion law is different (see below). There were 23 terminations in the year 2013/2014.

Legal requirements

The 1967 Abortion Act allows TOP in England, Scotland and Wales 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. Currently, the British Medical Association (BMA) does not favour a reduction in the gestational age limit for terminations. 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.

In Northern Ireland, the law is different. The 1967 Abortion Act does not apply. Abortion is unlawful other than in restricted circumstances.

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 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

- 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.

Royal College of Obstetricians and Gynaecologists guidelines

The RCOG further advises that:

- All women should have access to a clinical assessment.
- There should be a pathway to tertiary medical care for women with significant medical conditions.
- There should be arrangements to minimise delay - eg, direct access from referral sources other than GPs. Referrals should be made within two working days.
- All women should be offered an assessment appointment within five working days of referral.
- All women should undergo an abortion within five working days of the decision to proceed.
- No woman should wait longer than three weeks from initial referral to the time of her abortion.
- Services ensure that written, objective, evidence-guided information to take away before the procedure is available for women considering abortion. Information should be available in a variety of languages and formats
- Women who decide to continue their pregnancy should be referred for antenatal care immediately.

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 extraterine 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

Antibiotic prophylaxis
Antibiotic prophylaxis and/or infection screening with treatment should be offered. This is recommended because 10% of women develop genital tract infection (including pelvic inflammatory disease) after induced abortion. Regimens include:

- Metronidazole 1 g rectally or 800 mg orally, prior to or at the time of abortion, plus doxycycline 100 mg bd for seven days starting on the day of abortion; or
- Metronidazole 1 g rectally or 800 mg orally, prior to or at the time of abortion plus azithromycin 1 g orally on the day of abortion; or
- Metronidazole 1 g rectally or 800 mg orally prior to or at the time of abortion for women who have tested negative to chlamydial infection.

Method of abortion
Abortion may be:

- **Surgical.** This may be by vacuum aspiration or by dilatation and evacuation. Cervical preparation should be considered in all cases. In cases of less than 14 weeks of gestation, vaginal or sublingual misoprostol 400 micrograms is administered three hours before surgery:
  - Vacuum aspiration is suitable up to 14 weeks of gestation. Before seven weeks, strict protocols should be followed to ensure the gestation sac has been fully removed (examination of aspirate, and follow-up blood tests for human chorionic gonadotrophin (hCG) levels.) Between 14 and 16 weeks vacuum aspiration may be appropriate but a large bore cannula may be required.
  - Dilatation and evacuation may be used between 14 and 24 weeks of gestation. Ultrasound guidance is recommended.

- **Medical.** Regimens using 200 mg oral mifepristone followed by misoprostol are effective and may be used at any gestation. The regime is dependent on gestation:
  - ≤63 days of gestation: mifepristone 200 mg orally followed 24-48 hours later by misoprostol 800 micrograms (vaginal, buccal or sublingual).
  - ≤49 days of gestation: mifepristone 200 mg orally followed 24-48 hours later by 400 micrograms of oral misoprostol.
  - Between 50 and 63 days of gestation, if abortion has not occurred four hours after the first misoprostol, a second dose of 400 micrograms may be used.
  - At 9-13 weeks of gestation: mifepristone 200 mg orally followed 36-48 hours later by misoprostol 400 micrograms vaginally. A maximum of four further doses of misoprostol 400 micrograms may be needed at three-hourly intervals (vaginally or orally).
  - At 13-24 weeks of gestation: mifepristone 200 mg orally followed 36-48 hours later by misoprostol 800 micrograms vaginally, then further doses of 400 micrograms orally or vaginally at three-hourly intervals up to a maximum of four doses. If abortion has not occurred, the mifepristone can then be repeated three hours after the last misoprostol, followed by misoprostol 12 hours after that.
  - Feticide should be performed before medical abortion after 21 weeks and 6 days of gestation.

Ideally, services should offer a choice of methods and, where possible, women should be given a choice.

Analgesia and anaesthesia
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 (1st 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 wellbeing of women and their families, and research is ongoing in this area.[9]

Further reading & references
- Facts on Induced Abortion Worldwide; Guttmacher Institute, 2012
- Personal beliefs and medical practice - guidance for doctors; General Medical Council
- Termination of pregnancy statistics, year ending 31 December 2014; Publication date May 2015; Information services division (ISD) Scotland
- Northern Ireland Termination of Pregnancy Statistics 2013/2014; Northern Ireland Executive, January 2015
- The Law and Ethics of Abortion; British Medical Association (2014)
- Good Medical Practice, 0-18 years; General Medical Council (GMC), 2013
- The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7; Royal College of Obstetricians and Gynaecologists (November 2011)

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