Abortion

Informing and supporting the patient

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Around half of all pregnancies worldwide are unintended. GPs play an important role in providing sound information and support to women seeking an abortion, as well as aftercare and the management of any complications. A basic knowledge of medical and surgical abortion procedures and abortion laws are therefore essential for all Australian GPs.

Unintended pregnancy accounts for around 50% of pregnancies worldwide. Many women confronted with an unexpected positive pregnancy test will seek information online. However, the information provided by a woman's own GP can prove invaluable, particularly if she is considering an abortion and the decision is a difficult one. This article discusses some of the issues that women will face in seeking and experiencing abortion and provides information for GPs to help support these patients. It is important to acknowledge that not all GPs will feel comfortable in assisting or be willing to support patients who are considering an abortion. However, regardless of their own personal beliefs, GPs have a professional obligation to ensure ongoing care for their patients considering abortion, and this may involve referral to another practitioner who is willing to assist.

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In the past

Abortion has been practised as a way of limiting family size since antiquity, with both herbal and surgical means being used to deal with an unwanted pregnancy. However, by the 17th century the Catholic Church had taken the position that human life begins at conception, and prohibited abortion, even when performed to preserve the life of the mother. Today, although we live in an increasingly secular society, the ethics surrounding abortion continue to be a polarising issue. This is presently being played out in the United States, where there are moves in several states to significantly restrict women's access to the procedure and has also been evident in the debate over abortion law reform in Australia. There are no accurate figures on the rates of abortion in Australia, but a 2018 telephone survey found that around one in four women had experienced an unintended pregnancy in the past 10 years, with 30.4% of those unintended pregnancies ending in abortion.[1]

Medicolegal issues

Following the NSW Abortion Law Reform Act 2019, passed in October 2019, lawful abortion is now available in all Australian states and territories, although South Australia retains some restrictions on what constitutes a lawful abortion. However, specific provisions vary greatly from state to state. Lawful abortion for instance is permitted up to 14 weeks' gestation in the Northern Territory but up to 24 weeks in Victoria, with the remaining states ranging in between. Beyond those stated upper limits, abortion may still be lawful but there may be other requirements, such as the approval of two doctors or the requirement that one of these is a specialist. Western Australia requires that for abortions performed after 20 weeks of pregnancy, two medical practitioners from a panel of six appointed by the Minister agree that the woman or fetus has a severe medical condition. Western Australia also mandates that, for women under 16 years of age considering abortion, one of her parents must be notified, except where permission has been granted by the Children's Court or the woman does not live with her parents. The laws surrounding access to abortion in Australia are summarised in Table 1.

TABLE 1. CURRENT ABORTION LAWS IN AUSTRALIAN STATES AND TERRITORIES

State or territory	Outside criminal code?	Provisions
Australian Capital Territory	Yes	• All abortions must be performed by a medical professional, which includes a nurse practitioner • Medical abortion by telemedicine is permitted
New South Wales	Yes	• Lawful up to 22 weeks and with the approval of two doctors thereafter • Medical abortion by telemedicine is permitted
Northern Territory	Yes	• Lawful to 14 weeks' gestation with one doctor's approval, and at 14 to 23 weeks' gestation with the approval of two doctors • Unlawful after 23 weeks' gestation unless it is performed to save a pregnant woman's life • Medical abortion by telemedicine is permitted
Queensland	Yes	• Lawful to 22 weeks' gestation • Lawful after 22 weeks' gestation with the approval of two doctors • Medical abortion by telemedicine is permitted
South Australia	Yes, with restrictions: • unlawful abortion in SA remains a crime • penalties, including a possible prison sentence, apply for both the woman and the person who procures the abortion in the case of unlawful abortion	• Lawful if two doctors agree that a woman's physical and/or mental health are endangered by pregnancy, or for serious fetal abnormality • Abortion in SA must be performed in a hospital setting (precluding the option of medical abortion in a community setting) and the woman must have been resident in SA for a least 2 months prior • Medical abortion by telemedicine is presently not lawful
Tasmania	Yes	• Lawful to 16 weeks' gestation • Lawful after 16 weeks' gestation with the approval of two doctors • At the time of writing there were no clinics providing surgical abortion in Tasmania, although there is limited availability of medical abortion • Medical abortion by telemedicine is permitted
Victoria	Yes	• Lawful to 24 weeks' gestation • Lawful after 24 weeks' gestation with the approval of two doctors • Medical abortion by telemedicine is permitted
Western Australia	Yes, with restrictions: • where an abortion is unlawfully performed by a medical practitioner, they are liable to a fine of $50,000 • where an abortion is unlawfully performed by someone other than a medical practitioner, the penalty is a maximum of five years imprisonment • there are no penalties for the woman	• Lawful abortion is available to 20 weeks' gestation, with some restrictions particularly for those under 16 years of age • Very restricted after 20 weeks' gestation • Women in Western Australia requesting abortion require a referral from a GP

Counselling

The priority when counselling a woman who is considering abortion is supportive listening, coupled with a non-judgemental approach. Such counselling needs no predetermined outcome, but rather explores the personal issues as determined by each woman and is a facilitative and consensual process. If a GP is philosophically unable to provide such counselling they are professionally obliged to ensure that the woman has access to another

practitioner likely to assist and support her. In NSW this requirement can be satisfied by referral to an approved website.

Although ostensibly presenting for advice regarding abortion, some women may still wish to discuss other options or need more time to make their final decision. It is important to determine what social and support systems she has in place. Does her partner or parent agree with her decision to terminate the pregnancy, or are they opposed to her decision? A disclosure of sexual abuse, sexual assault, reproductive coercion or partner violence can sometimes occur during such a discussion. In these cases, it is important the GP ensures that the woman is safe before taking steps to expedite access to legal and psychological services as required. The woman should be reassured that the final decision regarding the outcome of the pregnancy is hers and that she will be supported in her decision. An excellent online training module in nondirective pregnancy counselling is available through the Royal Australian College of General Practitioners learning portal.[2]

There are times when counselling around abortion presents some more complex challenges. A woman who holds a general philosophical objection to abortion may experience significant ambivalence and guilt when considering it for her own unintended pregnancy. She may also feel isolated and unable to access support if those close to her hold similar views. In this situation it is important to give as much practical information as possible to assist her in making her decision. It may be useful to arrange a second counselling session with an experienced colleague.

Another difficult situation occurs when a woman with a planned or desired pregnancy finds herself having to consider termination because of a significant fetal abnormality. This may not be detected until the second trimester of pregnancy. A referral to a professional counselling service is an option. There are also a number of websites (unfortunately mostly US-based) that outline strategies for coping with the sadness and loss some women experience after abortion.[3,4]

Patient history

Accurate dating of the pregnancy is important in terms of access to both surgical or medical abortion and may have implications in some states, where gestation dictates whether the opinion of a second medical practitioner is required to access a lawful abortion (Table 1). The date of the last normal menstrual period should be established, along with the usual cycle length. Implantation bleeding and irregular light bleeding in the first few months of a pregnancy can result in an underestimation of the actual gestation. Current or recent use of hormonal contraception may also make dating a pregnancy more difficult. If a dating ultrasound is required, the referral should make it clear that abortion is being considered so that the sonographer does not assume the pregnancy is desired and therefore uses inappropriate language.

A disclosure of sexual abuse, sexual assault, reproductive coercion or partner violence can sometimes occur during such a discussion

It is also important to establish whether there has been any significant bleeding or pain since the last menstrual period, as this raises the possibility of ectopic pregnancy, miscarriage or trophoblastic disease. In such cases, the appropriate investigations should be undertaken as a matter of urgency. Any medical conditions should be carefully documented in the referral letter along with any known antibiotic or anaesthetic allergies. Should the woman experience significant morning sickness, an antinausea medication (such as metoclopramide, combination doxylamine and pyridoxine or ondansetron) can provide relief until she is able to arrange the abortion.

The experience of an unintended pregnancy presents an ideal opportunity to provide information about future contraceptive options. All methods of contraception can be initiated at the time of surgical abortion and this is an opportune time to insert an IUD or implant under sedation if that is the woman's choice. Women can start an oral or injectable contraception immediately after a surgical termination or when the first pill of a medical abortion regimen is taken.[5] Insertion of an IUD after medical abortion is usually delayed until it has been confirmed that the procedure was successful.

The abortion procedure

This article will restrict discussion to the procedures related to first and second trimester abortion, as these account for 98 to 99% of procedures in Australia.[6] Abortion is Medicare-funded, although there are usually additional out-of-pocket costs. It is performed in a mix of different settings from state to state including hospitals, freestanding private clinics and by private gynaecologists. GPs who have completed appropriate training may also offer medical abortion within their own practice. Some states also allow the provision of medical abortion via telemedicine (Table 1).

After taking a medical history, a blood test is done to determine Rhesus status, unless this is documented on a blood donor card or previous pathology report. Anti-Rh(D) immunoglobulin is offered to all Rh-negative women after the procedure to prevent Rhesus sensitisation.

Surgical abortion

Vacuum uterine aspiration allows for the evacuation of the uterus through a disposable cannula attached to either an electric or manual vacuum source. Most surgical abortions are performed from seven weeks' gestation onwards. This is

COMPLICATIONS AFTER FIRST TRIMESTER SURGICAL ABORTION

Although rare, complications after first trimester surgical abortion include:

- continuing pregnancy
- incomplete abortion
- postoperative bleeding
- cervical trauma
- intrauterine adhesions
- anaesthetic complications
- infection

because studies from the 1970s suggested that vacuum aspirations performed at less than seven weeks were three times more likely to miss the small gestational sac; the failure rate (i.e. incomplete abortion or ongoing pregnancy) beyond seven weeks was only 0.2%.[7] However, a subsequent study indicated that with modern ultrasonographic guidance, it should be possible to achieve comparable failure rates (0.13%) for very early surgical abortions provided strict protocols are followed.[8]

Surgical abortions beyond 15 weeks require a dilatation and evacuation procedure, in which a curettage procedure is performed after aspiration to ensure that all the products of pregnancy are completely removed. Later abortions require a high level of expertise from the operator and are associated with a higher rate of intraoperative and postoperative complications. Centres performing later abortions may request two visits and a more formal medical workup, such as an independent ultrasound and haematology, before a procedure is performed.

Surgical abortion takes between five and 15 minutes and is usually performed under intravenous sedation using a combination of midazolam and fentanyl citrate, and sometimes propofol. Women undergoing sedation are required to fast for several hours before the anaesthetic and are not allowed to drive for a further 24 hours. They also require a support person to accompany them home. Local anaesthetic is an alternative option for early terminations and negates the need for fasting. Complications (Box 1) are rare after first trimester surgical termination, but should be covered in any pretermination counselling.

Most practices that perform abortions supply or prescribe antibiotics at the time of termination to minimise the risk of infection, and many routinely screen for chlamydia before the procedure so that partners can also be treated if needed. Women are advised to abstain from intercourse for one week after the procedure to minimise the risk of infection. The cost for surgical abortion varies but starts at around A$450 in addition to the Medicare rebate. In most cases the entire cost needs to be paid upfront and the rebate claimed later.

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Medical abortion

Medical abortion in Australia is provided by stand-alone clinics (face-to-face and by telemedicine), gynaecologists and accredited general practitioners. Medical termination is a safe and effective option up to 9 weeks' (63 days) gestation. If the pregnancy occurred with an IUD in situ, the device must be removed before medical abortion.

Before initiating medical abortion, appropriate medical history is taken, the woman undergoes examination and counselling, and an ultrasound and a baseline serum beta-hCG test are done. To initiate a medical abortion, the woman first takes a mifepristone 200 mg tablet. She is also provided with 800 mcg of misoprostol (4 tablets), which she is instructed to take 36 to 48 hours after the mifepristone, ideally in the presence of a support person. The misoprostol tablets are placed between her cheek and gum for at least 30 minutes, with any undissolved residue to be swallowed with water. A number of randomised controlled trials have shown that this regimen achieves close to the effectiveness of surgical abortion up to 9 weeks' gestation, with an ongoing pregnancy rate of 0.5 to 0.7%.[9] If bleeding has not started within 24 hours of the misoprostol administration, a second 800 mcg dose is advised. The woman should be prepared to undergo a surgical abortion if the medical procedure is unsuccessful because of the risk of teratogenesis. Women are advised not to have intercourse or put anything into the vagina until vaginal bleeding stops.

In Australia, although the drugs themselves are relatively inexpensive, the cost of a medical abortion is comparable to a surgical abortion. The up-front costs of a telemedicine abortion are lower than face-to-face provision, but there may be additional costs for local medical consultations. In South Australia, the only Australian state to collect accurate data on abortion, the most recent figures suggested that around 60% of women had a surgical abortion and 40% opted for a medical procedure.[10]

After the abortion

Reputable abortion services provide a 24-hour emergency number in case of questions or concerns after an abortion, with the commonest problem being heavy or prolonged bleeding. After a medical abortion, cramping and heavy bleeding is to be expected initially but this should settle within one to two hours of passing the pregnancy sac. Cramping experienced after misoprostol administration can be quite severe and patients should be instructed to take minor analgesics or nonsteroidal anti-inflammatory drugs as required. However, ongoing abdominal pain or fever is concerning after either medical or surgical termination and may indicate more significant problems such as perforation or postabortion sepsis.

Regardless of the method of abortion, the need for more than two menstrual pads per hour for several hours and the passage of large clots are cause for concern. The only way to evaluate the significance of such symptoms is to have the woman return for clinical assessment. If a serious complication is suspected, it may be necessary to expedite review at the nearest hospital emergency centre or gynaecology unit.

After surgical abortion, some providers advise a follow-up appointment two to three weeks after the procedure to exclude complications; however, some women find it more convenient to see their GP for this. The aim of this appointment is to ensure that bleeding has largely settled and that there are no signs of infection. Pregnancy symptoms should resolve by this time, but a urine pregnancy test at two to three weeks after an abortion may still be slightly positive. A positive pregnancy test more than four weeks after the procedure suggests an incomplete abortion or persistent trophoblast. Women who have undergone a medical abortion must be reviewed by their provider two to three weeks after the misoprostol administration, at which time a quantitative beta-hCG test is usually able to confirm that the termination is complete.

Ongoing support

Perhaps the most important aspect of the postabortion visit is a review of the woman's emotional situation, and in particular how she feels about her decision to terminate the pregnancy and whether there are any unresolved issues or problems. Most women describe relief as their primary emotion and express comfort with their decision. Others may feel varying degrees of regret. A number of reviews on this topic indicate that, in the absence of coercion or complications, there are few differences in mental health sequelae between women who have had abortions and those who have not.[11-14] However, it is important to be alert to signs of extreme regret or sadness, as those women may require referral for more intensive support and counselling. This is also the time to check that the woman is happy with her choice of ongoing contraception or to discuss alternatives.

Conclusion

Abortion is a common medical procedure in Australia, with surgical and medical options available. A basic knowledge of Australia's abortion laws and abortion procedures can help GPs assist and support patients considering abortion. There are some doctors who may not feel comfortable in counselling or referring a woman for termination of pregnancy. Although all GPs have a right to their own personal beliefs, it is important to develop strategies and referral pathways that will ensure that any woman seeking such advice feels supported and respected rather than judged. MT

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

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