We need to talk about abortion

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One third of women in the UK will have an abortion before her 45th birthday. Yet the midwife's role in pregnancy choice counselling, abortion provision, and support of women's decisions remains a taboo. This opinion piece calls for an open conversation around termination of pregnancy and a better understanding among midwives of abortion as a medical procedure. Recognising the global impact of unsafe abortion, the author rallies the midwifery profession to take a clear pro-choice stance and demand the decriminalisation of abortion in the UK.

Introduction: The global picture

I never intended to become an abortionist. It happened when I was abroad, working in the humanitarian sector. As a former labour ward midwife, I arrogantly assumed I would have all the skills I needed to give excellent care and save lives anywhere in the world. I had cared for women in all situations, including families ending their pregnancies early due to fetal anomaly. While I knew abortion would be part of my role, I thought I had it covered.

I was completely unprepared for the number of patients I would see suffering from the aftereffects of unsafe abortion. Every day women would arrive at hospital with septic abortions, haemorrhages, perforations, lacerations - which would inevitably, for some, turn into life-long disabilities. I was unprepared for regularly seeing women die after desperately turning to an unsafe abortion by any means.

Unsafe abortion is the fifth leading cause of maternal death worldwide, and the only completely preventable cause. Worldwide, at least 22,000 women a year die from the complications of unsafe abortion, and a further 7 million are hospitalised. In some countries, unsafe abortion accounts for 33% of all maternal deaths [1]. I chose to help, to provide safe abortion to those who sought it.

Supporting choice "with woman"

Back in the UK, I took a job with one of the country's leading abortion providers. A lot of friends and colleagues asked whether I was still a midwife. The answer is a resounding yes! In fact, our unit is staffed almost entirely by midwives. A midwife is "with women" throughout her pregnancy (whenever and however it ends) and supports every pregnant person and their family through life-altering decisions, without judgement. My job ticks all those boxes, and yet I never see myself represented in discourse on midwifery. I am not the archetypal "good midwife" [3]. My work is discreet and unacknowledged. I work in the last area of taboo in our profession.

One in three women in the UK will have an abortion before her 45th birthday [4]. Every day I am grateful that our system prevents the deaths and complications I saw elsewhere. Yet one would think that nobody outside our clinic has ever had an abortion. Even as midwives, we don't talk about it. The majority of services are run by the charity sector and, in my experience, transfers to the NHS for complications can be met with suspicion and hostility. I have found that a lot of midwives lack understanding around the different methods of abortion and therefore struggle to support women completely. In many regions there is a two-tier medical system, with only women undergoing termination of pregnancy for fetal abnormality being given access to hospital labour wards and bereavement services. Anecdotally, this leads to harsher judgement by inexperienced staff towards women seeking abortion for any reason other than fetal anomaly. This could all be avoided if we just talked, if we acknowledged that this is a medical procedure that a significant minority of women will go through, and if we worked together to provide excellent, non-judgemental care.

Pregnant person or potential criminal?

We need to talk about our laws and legislation. In England, Scotland and Wales abortion is a criminal offence unless it is approved by two doctors [5]. The 1967 abortion act states that an abortion is justified if continuing the pregnancy would involve greater risk to the health of the woman than a termination of pregnancy [2]. The known and unavoidable risks of abortion before 24 weeks are largely the same as those of childbirth at term, with haemorrhage and infection being the most common complications [6]. However, the earlier in gestation a pregnancy ends, the smaller the relative risks become. For example, postpartum haemorrhage affects up to 10% of term births [7] but only 0.5% of abortions before 24 weeks [8]. In effect, therefore, the law allows abortion for every woman.

Practically, the law simply means that a handful of doctors are employed to spend their days remotely signing legal documents based on medical examinations carried out by nurses or midwives[9]. In my experience, requests are almost never turned down. The consequences are that charities spend money employing doctors in this role, and that women are inconvenienced while they wait for this process to be completed. It is simply a hangover of the paternalistic sentiment that pervades so much of maternity care, which views women as wayward children rather than as adults capable of making their own decisions [10].

Practically though, the law has other consequences. While great strides have been made recently (particularly during COVID-19) to widen access to home abortion, this is only legal up to 10 weeks' gestation [11]. Upwards of this, all abortion treatment must be undertaken on licensed premises. While this sounds sensible, in practice it means that women's choices are restricted. Women undergoing medical abortions at later gestations cannot be supported in the privacy of their own home by a midwife. Many women having an abortion experience it as a bereavement, whether their reasons are medical or 'social' [12] and arguably should be able to reduce any emotional impact by having control over place of delivery and choice of carer. Medically, for most women, there is no reason to be in a hospital setting, as long as they are cared for by an experienced practitioner. But women are denied the right to choose how and where they receive care simply because of the control that the health and legal systems have over their bodies and options.

Let's start a conversation

We need to talk about abortion. And we need to trust women. Putting aside our own personal feelings, we must recognise as a profession that abortions happen, and that they have a significant impact on the lives of the women we care for. The question of whether women should have abortions polarises views, but nevertheless women will always wish to end unwanted pregnancies. A more pragmatic debate would be on how we want this to happen, how we choose to education ourselves on the issue, and how we as a nation want to treat the one third of women who choose abortion at some point in their lives. Do we consider abortion to be a medical procedure or a potential criminal act? Should this be a hot political topic, or should it be a decision made between a family and a midwife, nurse, or doctor? I believe we, as a profession, need to have this conversation. Let's start talking about abortion.

References

1. Médecins Sans Frontières. Unsafe abortion: a forgotten emergency. http://safeabortioncare.msf.org/en/. Accessed August 22, 2020.

2. Government of the United Kingdom (1967). Abortion Act 1967. https://www.legislation.gov.uk/ukpga/1967/87/contents. Accessed August 22, 2020.

3. Carolan, Mary (2011). The good midwife: commencing students' views. *Midwifery,* **27**, 503-508. https://www.sciencedirect.com/science/article/abs/pii/S0266613810000550.

4. British Pregnancy Advisory Service (2015). Considering abortion? https://www.bpas.org/abortion-care/considering-abortion/ . Accessed September 28, 2020.

5. Government of the United Kingdom (2019). Offences Against the Person Act 1861. https://www.legislation.gov.uk/ukpga/Vict/24-25/100/crossheading/attempts-to-procure-abortion. Accessed September 28, 2020.

6. National Health Service (2020). Abortion: Risks. https://www.nhs.uk/conditions/abortion/risks/ Accessed September 28, 2020.

7. Fullerton, G; Danielian, PJ; Battercharya, S. (2013). Outcomes of pregnancy following postpartum haemorrhage. *British Journal of Obstetrics and Gynaecology,* **120** (5), 621-327.

8. British Pregnancy Advisory Service (2015). The abortion pill from 10 weeks to 24 weeks. https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-from-10-weeks-to-24-weeks/ . Accessed September 28, 2020.

9. British Pregnancy Advisory Service (2020). Job Requirements: Nurse/Midwife Practitioner. https://www.bpas.org/media/1444/nurse_midwife_practitioner__occ008a.pdf . Accessed September 28, 2020.

10. Goldbeck-Wood, Sandy et al. (2018). Criminalised abortion in the UK obstructs reflective choice and best care. *British Medical Journal,* **362**.

11. Royal College of Obstetricians and Gynaecologists (2020). Coronavirus (COVID-19) infection and abortion care. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-abortion/. Accessed September 28, 2020.

12. Whitney, Donna (2017). Emotional sequalae of elective abortion: the role of guilt and shame. *Journal of Pastoral Care and Counselling,* **71** (2). https://doi.org/10.1177/1542305017708159 . Accessed September 28, 2020.