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# INTRODUCTION

Tackling the issue of crisis pregnancy requires attention to a broad range of social, educational, legislative and medical areas. Crisis pregnancy is not the exclusive problem of one age group, nor is it the preserve of any one social group or geographical community. It is a reality for child-bearing women of every age group, of every walk of life and in every part of the country. The unique skills and expertise of the GP allows a doctor in general practice to play a crucial role in supporting the woman at the centre of a crisis pregnancy.

## The GP may be involved in:

- Prevention – education, contraception and emergency contraception
- Diagnosis of pregnancy and pregnancy counselling
- Support/referral/provision of information – depending on the woman's choice
- Ante-natal combined care
- Post-abortion care

91% of GPs provide emergency contraception; 95% provide pregnancy counselling and 88% provide medical care after abortion (1998 data). Yet, only slightly more than half the women who choose abortion receive formal counselling in Ireland. (Mahon, Conlon & Dillon report on Women and Crisis Pregnancy)

The objective of this publication is to improve the knowledge and skills of GPs when faced with the difficult human problem of crisis pregnancy and in the prevention of crisis pregnancy in the first instance.

## It draws together and updates a number of earlier ICGP publications, namely:

- Training Programme and Information for General Practitioners
- Clinical Factfile on Emergency Contraception
- Patient Information Leaflet on Emergency Contraception.

The authors would like to acknowledge the vision of the Task Group who compiled the Training Programme and Information in 1996, particularly Michael Boland, Mary Favier and Michael Coughlan. This publication builds on that foundation.

This work has been supported by a grant from the Crisis Pregnancy Agency. This publication is one of a series of resources being developed by the CPA under the banner of Key Contacts in the prevention and management of crisis pregnancy.

We include copies of the Patient Information Leaflet on Emergency Contraception and Patient Information Leaflet on Termination of Pregnancy as loose-leaf inclusions, to facilitate photocopying by members. This document, and the patient information leaflets may also be accessed in the members' section of the ICGP website [www.icgp.ie](http://www.icgp.ie)

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# 1

## PREVENTION OF CRISIS PREGNANCY

General practitioners are in a position to attempt to prevent unwanted and unplanned pregnancies as they provide ongoing medical care to their patients in an environment that allows doctor initiated issues to be discussed. Seventy per cent of women will attend their GPs in any year. Ninety five per cent will do so within five years. Thus GPs have repeated opportunities to address the issues that may contribute to a woman having a crisis pregnancy.

To improve prevention of crisis pregnancy, we need to consider the following:

- A APPROACH TO CONTRACEPTION
- B IDENTIFICATION OF HIGH RISK GROUPS
- C ATTITUDE TOWARDS SEX
- D MALE RESPONSIBILITY FOR CONTRACEPTION
- E AVAILABILITY OF EMERGENCY CONTRACEPTION

### A APPROACH TO CONTRACEPTION

We need to take a much more pro-active approach to the providing of contraceptive information and advice to our patients, both male and female.

In the past we have often discussed contraception only when the subject has been raised by the patient. General practitioners should consider introducing the subject of contraceptive needs when a patient attends for another reason. By creating opportunities for doctor-patient dialogue about contraception, we can avail of the window of opportunity a consultation provides and address any identified need. This can be done sensitively and unobtrusively. The GP will quickly pick up whether the patient does not need contraceptive advice, has an unmet need or is ambivalent about the area while being sexually active. The GP can then act on these issues as appropriate and explore them further at another time if necessary. Availability of emergency contraception should also be highlighted during family planning consultation. Patients will, in this way, be reassured that they can approach their doctor without the fear of being judged and they will not miss the opportunity to avail of this effective way of preventing pregnancy.

### B IDENTIFICATION OF HIGH RISK GROUPS

These will include:

- Women who think they are too young or too old to get pregnant
- Women with chronic ill-health
- Women with life-threatening illness
- Women of any age who are ignorant of the facts of fertility and conception
- Women who have disorganised lives or who suffer one life crisis after another
- Women who have an ambivalence to pregnancy and as a result to contraception
- Men and women who are sexually active and do not take precautions

## **C ATTITUDES TO SEX**

Ambivalence towards contraception often stems from ambivalence towards sexuality and the expression of this in the form of sexual activity. Sex education in our schools is vital and will go some way towards addressing this problem but GPs have a role in making the consultation a safe place to discuss sexuality and thus contraception. We must encourage our patients to be open about this aspect of their lives. To do this we must ourselves be seen to be comfortable dealing with any issues that may arise.

## **D MALE RESPONSIBILITY FOR CONTRACEPTION**

Any attempt to prevent crisis pregnancies must address the role men play in taking responsibility for contraception. By addressing only our female patients for contraceptive advice, we are confirming the stereotype that it is solely a woman's problem. It is a challenge for GPs to see their male patients as equal partners in sexual responsibility. Until we do so, we are forfeiting half the potential opportunities for prevention. This group may present with particularly ambivalent attitudes to contraception and this needs to be addressed.

## **E AVAILABILITY OF EMERGENCY CONTRACEPTION**

Emergency contraception (also called postcoital contraception) is widely accepted as a safe and highly effective way of preventing an accidental pregnancy after unprotected intercourse or a contraceptive accident. It is defined as any female method of contraception administered after intercourse and having its effect prior to the stage of implantation. There are two types of emergency contraception: hormonal methods or - the insertion of a copper-containing coil (IUCD). Both methods were introduced in the 1960s and their safety and efficacy have been well documented over the past 30 years. Many women are not aware that their GP provides emergency contraception. Some are afraid that their GP will disapprove of their behaviour. It is important that the GP reassures women who present for emergency contraception that this is a sensible action. In addition GPs should make it known to patients that emergency contraception is provided at their practice.

The term 'emergency contraception' is favored as 'morning-after pill' underestimates the time available to access it and 'postcoital contraception' is a technical term not generally understood by the public. It is appropriately called emergency contraception, as it is neither suitable nor effective as a regular method of contraception.

A detailed clinical guideline on the provision of emergency contraception is included in section 3, Information for General Practitioners.

A Patient Information Leaflet on Emergency Contraception is included at Appendix A and can also be downloaded from the ICGP website [www.icgp.ie](http://www.icgp.ie)

# 2

## THE ROLE OF GENERAL PRACTITIONERS IN CRISIS PREGNANCY

### A CONFIRMING THE PREGNANCY

Urine testing is reliable. Modern test kits detect HCG within a few days of conception. Negative tests should be repeated in 3 - 5 days. Confirmation of pregnancy as early as possible is important in management.

While doing the pregnancy test it is useful to establish what would the woman's attitude be to finding she was pregnant. Be careful not to assume that a married woman will be happy to be pregnant and an unmarried teenager necessarily unhappy.

Many women will attend after they have themselves confirmed the pregnancy by home testing.

### B HELPING THE WOMAN TO MAKE A DECISION

#### COUNSELLING FOR INFORMED CHOICE IN CRISIS PREGNANCY

##### Background

The three main goals of the counselling process are:

- To establish rapport and gain the trust of the woman in crisis
- To help her to formulate a clear definition of the problem
- To enable her to establish goals for its management and resolution

In many instances the GP is ideally positioned to comfort, advise and counsel a woman in crisis due to the unique knowledge and relationship which exists when providing her with an ongoing family health service. In other cases, the GP may be consulted by a woman (s)he has not previously met and in such circumstances different skills may be required.

In any case, counselling a woman with a crisis pregnancy can be challenging. It is highly probable that the patient does not share the doctor's reality or perception of the world. She may inhabit a totally different value system, may come from a totally different socio-economic background, and may represent a different ethnic or religious group. Therefore it will be very important to understand the situation as the woman in crisis sees it and to communicate with her in a way which is consonant with that view.

##### The GP then has two choices:

- Attempt to alter the reality of the situation itself
- Work towards changing the way the woman in crisis sees her situation

While the latter is perhaps more challenging, it may be the wiser course of action as it allows the woman to see alternative means of resolving her problem.

The GP should take care not to appear to be patronising or assume intimacy or friendship if (s)he does not know the woman well. Care should be taken not to address her in a demeaning or condescending manner. It is vital that the GP refrain from being, or appearing to be, judgemental.

Effective communication in crisis situations demands time, considerable patience and careful thought. The GP should avoid rushing into a particular course of action, avoid giving guarantees and should acknowledge difficulties and challenges. Removing the sense of urgency and reassuring the woman that there is time before decisions need to be made are key roles of the GP. It may be necessary to see a woman in crisis pregnancy more than once and to involve other family members if the woman wishes. A woman may be referred to other healthcare professionals for counselling. However, the doctor must keep in mind the medical necessity of avoiding undue delay, particularly where abortion is the likely eventual outcome.

Counselling is an acquired skill that is utilised daily in general practice. It is particularly important in crisis situations such as bereavement, life-threatening illness, breaking bad news, marital and family emergencies and in dealing with crisis pregnancy.

For further information on counselling in general practice, please refer to the ICGP publication, [Counselling in Practice: A Guide For General Practitioners](#) by Dr Austin O'Carroll, Dr Margaret O'Riordan

**Support for a woman in her decision making will usually require:**

- Space in which to make a reasoned decision
- Information about the alternatives available
- The opportunity to explore the implications of each option
- The opportunity to assess her own feeling, wishes and circumstances
- Information about further supports may be advisable

It is important to understand why the pregnancy is unwanted, if that is the case. In establishing this the GP will learn if the patient has unrealistic fears about pregnancy such as the pain of labour which once explained may allow her to continue with the pregnancy.

Financial implications should be discussed. If the woman is single and chooses to continue the pregnancy she may be advised to attend her Community Welfare Officer to determine what benefits she may be entitled to. The [Treoir Information Pack for Unmarried Parents](#) is a very useful information resource on legal rights, social welfare entitlements, support services etc

For many women who choose to have an abortion, finance may be a significant obstacle, particularly those from the lower socio-economic groups.

**The GP should aim to:**

- Enable the woman to reach an informed decision
- Minimise the risk of emotional disturbance, whatever decision is reached
- Lessen the risk of a further unwanted pregnancy

**To achieve these aims the GP must:**

- Be patient and careful
- Be willing to listen with interest
- Reassure the woman that help is available to her in making a decision
- Remove the sense of urgency and panic which may exist

The GP should be able to conduct the consultation without interruptions. Depending on how well one knows the woman, the GP may employ non-verbal expressions of support such as sitting beside rather than opposite the woman or placing a reassuring hand on her shoulder at an appropriate moment. All the choices and various options should be considered and their implications and possible outcomes discussed clearly and truthfully. It may be appropriate for the woman's boyfriend or partner, or family member or friend to be invited (with her permission) to take part in the discussion.

**SPECIAL SITUATIONS:**

**The teenager with a crisis pregnancy**

- May present late
- May cope by denial
- May be unrealistic and naive about her ability to cope with a baby
- Should always be interviewed alone even if accompanied by a parent. Her ideas should be sought and she should feel that any decisions made are hers
- May be reluctant to use contraception even if clearly at risk of further pregnancy
- Under the age of 16 parental consent is required for abortion (in addition to the patient's own consent which is always mandatory)
- Both abortion (particularly if late) and pregnancy/ childbirth involve greater risks in young teenagers

## C CARRYING OUT THE DECISION

The three possible outcomes after the counselling are:

1. The woman will continue the pregnancy and keep the baby
2. She will continue the pregnancy and have the baby adopted
3. She will seek an abortion

In all these instances the GP must offer information and support in an atmosphere that is free of pressure or constraints that may interfere with a woman's ability to think clearly and to decide for herself. A GP's personal opinions and beliefs should not interfere. It is not for the GP to attempt to influence a woman in her decision making, only to facilitate that process. If the doctor feels unable to explore the issue of abortion information with a patient, the woman should be informed of this as soon as is appropriate. She then should be advised as to where else she might go for such information.

### 1. KEEPING THE BABY

Any woman who has a crisis pregnancy and continues with the pregnancy will need considerable support both during the pregnancy and afterwards. The GP has a significant role to play here. Voluntary organisations provide a confidential counselling and telephone service (see section G page 14 on Information). Supportive combined ante-natal care will provide ongoing opportunities for advice and follow-up. Assistance with applications for financial benefits is useful. Ongoing support for the mother and baby is essential.

### 2. ADOPTION

Women can be referred to voluntary agencies who will give advice about arranging adoption. If it is not acceptable for the woman to stay at home, placement with a family can be arranged until she delivers. Local social workers may also be involved in arranging adoption through the statutory agencies (see section G page 14 on Information). Adoption in Ireland can only be organised through registered adoption agencies. Pregnant women who are considering adoption should be put in contact with a registered adoption agency (details of these may be obtained from the Adoption Board).

### 3. ABORTION

If the woman chooses to end the pregnancy it is important for the patient to obtain reliable information about abortion clinics that have a good reputation. Unscrupulous private clinics do exist and Irish women have suffered medically by attending them when they did not know of reputable alternatives. (see section G page 14 on Information). A doctor with a conscientious objection may decide not to supply the necessary information.

This right is provided for in the Termination of Pregnancy Information Act 1995. However, doctors are reminded of their duty of care to the patient, as outlined in the Medical Council's Guide to Ethical Conduct and Behaviour (6th Edition 2004), that they should never refuse treatment on the basis of moral disapproval of the patient's behaviour and that where they have a conscientious objection to providing care, they should make the names of other doctors available to the patient. The general practitioner should write a medical record summary note and give this to the patient to take with her to the clinic.

Under the 1995 Act, information on abortion can be provided within the context of pregnancy counselling on all options. The doctor cannot make an appointment with an abortion service on behalf of the woman but can provide medical records for the woman.

Having been properly counselled the woman may decide to travel abroad for an abortion. It then becomes the main concern of the GP to ensure that she does so safely, receives proper medical care, and returns for appropriate follow-up. It is now normal good medical practice to supplement verbal advice and explanation with a written handout. This is particularly important when advising patients in crisis because their ability to concentrate and to retain advice is impaired. A patient information leaflet is included at Appendix B and can be downloaded from the ICGP website [www.icgp.ie](http://www.icgp.ie)

## D PROVIDING FOLLOW-UP CARE

Irrespective of what decision a woman makes in the crisis pregnancy situation, follow-up care will be important. This may include antenatal care, counselling, future contraception or medical care after abortion. The GP's response to the initial consultation will have a profound influence on her willingness to attend for further care.

# 3

## INFORMATION FOR GENERAL PRACTITIONERS

### A EMERGENCY CONTRACEPTION – CLINICAL GUIDELINE

#### INDICATIONS FOR EMERGENCY CONTRACEPTION

- 1 Unprotected intercourse
- 2 Failure of contraception
  - Potential barrier method failures
  - Potential Pill failures
  - Potential IUCD failures
- 3 Sexual assault
- 4 Recent use of suspected teratogens

#### EMERGENCY HORMONAL CONTRACEPTION

This is the most widely used option and the current recommendation is to take two tablets each containing 750µg levonorgestrel (Levonelle ®) as soon as possible after unprotected sexual intercourse (UPSI).

Combined oestrogen-progestogen EC (Yuzpe regimen) was previously the method of choice. This is no longer recommended as a first choice after a large randomised controlled trial demonstrated better efficacy and acceptability of progestogen-only emergency contraception (POEC).<sup>1</sup> A large, well-conducted, multicentre trial was carried out by the World Health Organization (WHO) comparing single and divided doses of levonorgestrel taken with 120 hours of UPSI.<sup>2</sup> No difference in pregnancy rates between these regimens was identified. The licence has been modified as a consequence of this study and the single dose regime is currently recommended.

#### Mode of action

The emergency hormonal method works by postponing ovulation if given in the first half of the cycle, or by disrupting luteal function if used mid-cycle. It also makes the endometrium resistant to implantation. There is no evidence (either clinical or theoretical) that it is abortifacient, in that all its potential actions occur prior to the stage of implantation.

#### Efficacy

Reported failure rates of POEC range from 1% to 3%.<sup>3</sup> This is the percentage of women who get pregnant despite using EC and the higher rate applies to UPSI at mid-cycle. However, not every act of UPSI results in pregnancy, therefore many of the women treated would not have become pregnant in any case. For this reason the efficacy of POEC maybe more usefully expressed as the proportion of expected pregnancies prevented. POEC will prevent up to 86% expected pregnancies.<sup>1</sup>

#### Timing of treatment

Emergency contraception is most effective if commenced within 72 hours of unprotected intercourse and there is evidence from WHO that the failure rate is lower the earlier treatment is initiated.<sup>2</sup>

More flexibility on the cut off point is probably acceptable as there is evidence that emergency contraception still has some effect between 72 and 120 hours from unprotected intercourse.<sup>4</sup> However, it is important to advise a woman that the precise failure rate is unknown if giving emergency contraception within these time limits.

This is particularly important where access to IUCD fitting is limited.

#### Side effects

- POEC is a safe treatment and significant side effects are rare.
- Gastrointestinal side effects are much less of a problem than with the Yuzpe regimen. Since vomiting is very rare, anti-emetics are not routinely needed with POEC.
- 23% of women report nausea.<sup>1</sup>
- If vomiting occurs within two hours of taking the POEC a further dose should be taken as soon as possible.<sup>5</sup>

Research has demonstrated a range of disturbances in the timing of the next reported menses. Most women (57%) started their next period within three days of their expected date, some (15%) started early, some (15%) were up to seven days late, and the remainder (13%) were more than seven days late.<sup>1</sup>

A number of women will have a withdrawal bleed in the week after taking emergency contraception. This is of no consequence. However, the patient should be informed that this bleed is not a period and therefore does not exclude pregnancy.

#### Contraindications

Contraindications to emergency pills are very few and some women who cannot ordinarily take combined oestrogen progesterone contraception will be able to take emergency pills.

Despite the fact that the Summary of Products Characteristics lists a series of conditions (severe hypertension, diabetes mellitus with associated vascular complications, ischaemic heart disease, stroke, liver disease or past history of breast cancer) as relative contraindications<sup>6</sup>, the WHO Medical Eligibility Criteria For Contraceptive Use advise that there are no medical contraindications to POEC.<sup>7</sup> Caution should be used in women with acute porphyria, severe liver disease and allergy to LNG.<sup>7</sup>

A previous ectopic pregnancy is not a contraindication.<sup>6</sup> However if emergency contraception fails, the consequent pregnancy may be more likely to be ectopic. This is a

theoretical assumption based on the progesterone effect on tubal motility. Both clinicians and women should be aware of this possibility.

#### Drug interactions

There is very little evidence when using POEC in patients on liver enzyme inducers. Advice is that an additional tablet is taken 12 hours after the first dose of two tablets<sup>8</sup>. An IUD might be the preferred option in this case.

Caution is advised when prescribing POEC in women using warfarin because anticoagulant effect of warfarin can be decreased or increased following POEC use.

#### Repeated use

There is no medical cause for concern in repeated use of POEC<sup>9</sup>. However, repeated use of emergency contraception is likely to have a higher failure rate than established regular contraceptives. It is worthwhile exploring the reason why a woman needs to make repeated requests for emergency contraception.

#### Follow up

Ongoing contraception should be prescribed at the same visit as emergency contraception. This will reduce the number of pregnancies conceived while waiting for the next menstruation.

Women who have taken emergency hormonal contraception because of missed pills should discard any missed tablets and continue to take their pills as usual. They should also be warned that they will not be contraceptively covered until they have taken seven consecutive tablets. They should also be advised to do a pregnancy test at the end of the packet.

Women who wish to start using the combined pill or depo medroxyprogesterone acetate can be started at the next period without additional precautions.

The risk of sexually transmitted diseases should be discussed and testing should be arranged if appropriate.

#### THE EMERGENCY INTRAUTERINE CONTRACEPTIVE DEVICE

A copper-containing IUCD can be inserted in the usual way. The levonorgestrel-containing IUCD (Mirena) is not recommended for emergency use.

**Two copper devices are commonly used:** T-safe Cu 380 or FlexiT 300.

Despite the fact that both these devices have a European Registration (medical devices class 3), it is sometimes difficult to obtain them from Irish suppliers. It is always possible to obtain them from suppliers in the UK and because of the European registration no additional licensing is needed.

The IUCD is effective up to 5 days after unprotected intercourse. Where the earliest episode of unprotected sex was more than five days previously, an IUCD can be fitted up to five days after the calculated earliest day of ovulation.

This method is the most effective method for emergency contraception and it is important to inform women of this. However, it is not always a practical option as a doctor trained in fitting may not be available within the time limit or the woman may not wish to have an IUCD fitted.

#### **Mode of action**

The IUCD produces changes in the endometrium making it unsuitable for implantation. Copper ions inhibit enzymes necessary for fertilization and implantation. It is not abortifacient in that its actions occur prior to the stage of implantation.

#### **Eligibility**

The WHO consider that the same eligibility criteria that apply to IUCD insertion in routine circumstances should apply for insertion as emergency contraceptive.

#### **Side effects**

Side effects are similar to IUCDs in general. However, as the IUCD can be removed at the next menses, any side effects would be limited to the cycle of use.

The risk of post-insertion infection must be carefully considered and screening should be carried out where there is a risk of a sexually transmitted infection. If screening is unavailable or not practical, antibiotic cover with tetracycline or with a single dose of azithromycin is a reasonable option.

#### **Contraindications**

Suspected pregnancy is the only absolute contraindication. A past history of an ectopic pregnancy is a relative contraindication but may not prohibit use if the IUCD is removed at the next menses.

#### **References**

- 1 Task Force on Postovulatory Method of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the yuzpe regime of combined oral contraceptive for emergency contraception. *Lancet* 1998; 352:428-433.
- 2 Von Hertzen H, Piaggio G, Ding J, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised trial. *Lancet* 2002; 360:1803-1810.
- 3 World Health Organization (WHO). Emergency contraception: a guide to the provision of services. Geneva: WHO, 1998.
- 4 Rodrigues I, Grou F, Joly J. Effectiveness of emergency contraception pills between 72 and 120 hours after unprotected sexual intercourse. *Am J Obstet Gynecol* 2001; 184:531-7.
- 5 World Health Organization (WHO). Selected practice recommendations for contraceptive use. Geneva: WHO, 2002.
- 6 Levonelle: summary of product characteristics. [www.levonelle.co.uk](http://www.levonelle.co.uk).
- 7 WHO. Improving access to quality care in family planning, medical eligibility criteria for contraceptive use. Geneva: WHO, 2000.
- 8 PRODIGY Guidance: contraception – emergency. London: Department of Health, 2001.
- 9 Ellison J, Thomson AJ, Greer IA. Apparent interaction between warfarin and levonorgestrel used for emergency contraception. *BMJ* 2000; 321: 1382-1383.

## B UK LEGAL REQUIREMENTS FOR ABORTION

Under the 1967 UK Act, abortion performed by a registered medical practitioner is legal:

if two registered medical practitioners are of the opinion, formed in good faith -

- (a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman, or any existing children of her family, greater than if the pregnancy were terminated, or
- (b) that 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.

In determining the risk of injury to health "account may be taken of the pregnant woman's actual or reasonably foreseeable environment."

The law does not directly affect Irish GPs as they do not function as one of the two doctors who consent to the application for termination and fill out the official referral form. In the UK the woman must convince the two doctors that she will be adversely affected by continuing the pregnancy.

With Irish women attending clinics in the UK, it is generally accepted by the doctors in the clinics that if the woman is prepared to make the trip to the UK and considering the personal and financial cost that she must incur to do so, she will be very clear about her need for a termination and thus the request for abortion is normally granted.

## C IRISH LEGAL REQUIREMENTS ON PROVISION OF INFORMATION ON ABORTION TO PATIENTS

The requirements surrounding the provision of information on abortion to women are covered under the

**REGULATION OF INFORMATION (SERVICES OUTSIDE THE STATE FOR TERMINATION OF PREGNANCIES) ACT, 1995**

This act and a clear explanation are available on [www.oasis.gov.ie/health](http://www.oasis.gov.ie/health) (search 'abortion')

## D ABORTION TECHNIQUES

### (A) FIRST TRIMESTER

**MEDICAL ABORTION:** a combination of drugs is used to induce a miscarriage (usually oral mifepristone followed by vaginal prostaglandins 48hrs later). This method is usually not available for Irish women because it requires more than one visit to the clinic and a minimum stay of 3-4 days.

**SURGICAL TERMINATION:** The contents of the uterus can be emptied by suction up to 12-14 weeks of pregnancy. This procedure is well tolerated with local anaesthetic or conscious sedation up to 11 weeks. Local anaesthetic reduces the risk of the procedures and should be encouraged and explained to the patient.

Surgical termination in general is not advisable before 7 weeks gestation because there is a high risk of missing the gestational sac, which will make the procedure unsuccessful. Accurate gestation assessment is therefore necessary and the risk of failure should be explained to the patient who is generally anxious to travel as soon as possible.

Where there is any uncertainty about dates accurate assessment of gestation will require an ultrasound scan. If this is not readily accessible locally the Reproductive Choices Clinic (58 Blessington St, Dublin 7. Tel: 01 830 0630) will provide it as part of its overall termination of pregnancy care.

### (B) SECOND TRIMESTER

Dilatation and evacuation is the method most used in the clinics available to Irish women. As the procedure is a two-stage one, patients will need to be admitted overnight. Therefore it will not be carried out at centres that provide day-care services only.

This procedure is generally performed after cervical preparation, which reduces the risk of perforation and cervical trauma. A general anaesthetic is always required. Most clinics will have some exclusion criteria for a general anaesthetic, for example obesity. If the patient has risk factors for a general anaesthetic it is worthwhile discussing these with the patient because it might be impossible for her to have a termination in England.

## E MORBIDITY FOLLOWING ABORTION

There is an enormous literature on the risks of abortion, much of it difficult to interpret. Research into the long-term consequences of abortion is particularly fraught with difficulties. The risks of abortion depend above all on the gestation of the pregnancy when the abortion is performed and at any gestation the risks will also depend on the method used, the age, health and parity of the woman, and the experience, skill and attitude of the operator. Complications following abortion are relatively uncommon and are more likely to be minor than of major significance. **The most common complications, according to the Royal College of Obstetricians and Gynecologists (RCOG) 2000 guideline, are:**

- Haemorrhage (0.15%)
- Uterine perforation (0.1 – 0.4%)
- Cervical trauma (< 1%)
- Failed abortion/on-going pregnancy (0.2% for surgical, 0.6% for medical)
- Post-operative infection (up to 10%)

There is no proven association between induced abortion and subsequent infertility or pre-term delivery.

### Recommendations for reducing morbidity include:

- Terminations earlier in gestation period.
- Reduction in delay attending clinic and receiving an appointment.

**Note:** Particularly relevant to the Irish situation as there will be an inevitable delay for the patient who will have to make personal arrangements such as work, family and finance.

To minimise the risk of post-abortion infection, either screening for lower genital tract organisms or antibiotic prophylaxis is recommended using

- Metronidazole 1gm rectally at the time of abortion plus Doxycycline 100mg twice daily for 7 days, commencing post abortion or
- Azithromycin 1g stat pre-abortion (assures compliance)

## PHYSICAL EFFECTS OF ABORTION

Major physical complications are uncommon, particularly in first trimester abortions. The risk rises with increasing gestation and in teenage and older women. Complications may include perforation of the uterus, trauma to the cervix, haemorrhage, infection and retained products of conception requiring a D and C. Pelvic infection can occur if the woman has not been screened and treated for sexually transmitted diseases. Long-term risk may increase with recurrent abortions.

## PSYCHOLOGICAL EFFECTS OF ABORTION

Many women experience feelings of guilt and sadness immediately after an abortion. These are usually mild and short lived and include guilt, regret, sleep disturbance and self-reproach. Only a small minority of women experience long-term adverse psychological effects.

Attempts have been made to identify factors which might influence adverse psychological effects after an abortion. Ambivalence towards abortion, coercion, medical indications for abortion, a history of psychiatric illness, unsupportive attitudes of family and professionals have all been associated with unfavourable psychological sequelae.

Guilt has been found to be more common in women who request an abortion because of fetal abnormalities. These pregnancies may have been planned but become unwanted.

## F FOLLOW UP AFTER ABORTION

Ideally, a woman should have a post-abortion check-up three weeks after the procedure. The purpose of the check-up is:

- To establish the physical and psychological well-being of the patient.
- To establish that the termination has been successful and that the woman has no retained products of conception.
- To address the subject of prevention of further unwanted pregnancies through use of appropriate contraception.

### The non-judgmental approach

Many Irish women have in the past bypassed their GPs when arranging a termination. This may make the GP feel uncomfortable about follow-up. However, it is more a reflection on the attitudes of Irish society generally than on the GP personally. It is important for their clinical care that these women feel that they can attend their GPs for follow-up without fear of reproach. Successful follow-up therefore starts in the relationship established before the decision to choose abortion. The GP must convey a positive message that whatever decision a woman makes (s)he will want to see her again.

### PHYSICAL CONCERNS AT FOLLOW-UP

- Bleeding will usually reduce to brown staining within 2 weeks of the termination. Some slight blood loss may continue up to the next period. The normal menstrual cycle should return in 6-8 weeks.
- Bleeding that is bright red, with or without clots, more than one week after the termination, particularly if there is pain or fever suggests retained products of conception.
- Where abnormal bleeding is identified, it can be difficult to decide if referral to specialist services is required. GPs should have a low threshold for referral if there is uncertainty about the presence of retained products. An ultrasound is usually necessary to make this diagnosis.
  - If retained products are excluded and endometritis is diagnosed, the recommended treatment is ampicillin and metronidazole .
- The pregnancy test may remain positive for a few days but should always in the majority of cases be negative after three weeks.

### PSYCHOSOCIAL CONCERNS

It is to be remembered that the majority of women who terminate their pregnancies do not attend anyone for follow-up and a valuable opportunity is lost for discussion of the circumstances that led to the pregnancy. This area can only be discussed in detail after the termination as it will have little value in the crisis situation and might be interpreted by the patient as judgmental.

Given the general rejection of abortion in Irish society, feelings of regret, stigma, and remorse may not be uncommon. These reactions by the patient may be confusingly mixed with a strong sense of relief. The GP should tactfully establish whether these sorts of feelings exist – always ready to accept that they may not be present. Fear of discovery of a secretly arranged abortion may still be paramount. Anger towards others who contributed to the crisis – the father for his share of the blame (often with little responsibility for the consequences) and/or friends, family and society in general for their perceived attitudes of condemnation may need to be expressed.

### CONTRACEPTION

- From a purely medical point of view, abortion must be regarded as a serious failure of reliable contraception. It is important to establish whether conception resulted from mistaken beliefs about fertility or the need for precautions, unavailability of reliable means of contraception, method failure due to incorrect use, or simply impulsive or careless behaviour.
- Most women will be strongly motivated to accept contraceptive advice following an abortion. This is an opportunity to follow-up contraceptive issues explored in counselling before the termination.
- Some women may continue to be ambivalent about their need for contraception and this must be addressed. If this is so, a more profound exploration of their feelings and attitudes will be needed over a period of time.

## G INFORMATION ON SERVICES

The following state-funded agencies offer **confidential pregnancy support services**. These agencies offer free pregnancy counselling to women regardless of income, age, or geographical location.

### CURA

Tel: Callsave 1850 62 26 26

### Dublin Well Woman

Tel: (01) 872 8051,  
Lower Liffey Street;  
Tel: (01) 660 9860, Ballsbridge;  
Tel: (01) 848 4511, Coolock.

### Irish Family Planning Association

Tel: Callsave 1850 49 50 51

### LIFE

Tel: Callsave 1850 28 12 81

### Midland Health Board Crisis Pregnancy Counselling Service

Tel: Freephone 1800 20 08 57

### One Family (formerly Cherish)

Tel: Lo Call 1890 66 22 12; (01) 662 9212

### PACT

Tel: Callsave 1850 67 33 33

### Pregnancy Counselling and Support Service (Galway)

Portiuncuala Hospital Ballinasloe, Co Galway  
Tel: Locall 1850 20 06 00; (090) 964 8190

### Pregnancy Support Counselling Service (Mayo)

Mayo General Hospital, Castlebar, Co Mayo  
Tel: Locall 1890 20 00 22

For information on **single parenting, support services, social welfare entitlements and legal rights** the following listings may be particularly useful.

### CURA

Athlone  
Castlebar  
Cork City  
Derry City  
Dublin City  
Dundalk Ennis  
Galway City  
Kilkenny City  
Letterkenny  
Limerick City  
Monaghan Town  
Sligo Town  
Thurles  
Tralee  
Waterford  
Wexford Town  
Tel: Callsave 1850 62 26 26

### Life Pregnancy Care

Cork City  
Dublin City centre  
Thurles  
Tullamore  
Letterkenny  
Galway City  
Tel: Callsave 1850 28 12 81

### Midland Health Board Crisis Pregnancy Counselling Service

Tel: Freephone 1800 20 08 57

### One Family (formerly Cherish)

Cherish House, 2 Lower Pembroke Street, Dublin 2  
Tel: Lo Call 1890 66 22 12 or 01 662 9212

### PACT

15 Belgrave Road, Rathmines, Dublin 6  
Tel: Callsave 1850 67 33 33

### Pregnancy Counselling and Support Service (Galway)

Portiuncuala Hospital Ballinasloe, Co Galway  
Tel: Locall 1850 20 06 00; (090) 964 8190

### Pregnancy Support Counselling Service (Mayo)

Mayo General Hospital, Castlebar, Co Mayo  
Tel: Locall 1890 20 00 22

### Treoir

14 Gandon House, IFSC, Dublin 1,  
Tel: 01 670 0120 or [info@treoir.ie](mailto:info@treoir.ie)

The following organisations will give contact details for **abortion clinics**, if requested, in a pregnancy counselling session.

**Dublin Well Woman Centre**

Lower Liffey Street, Tel: 01 **872 8051**  
Ballsbridge, Tel: 01 **660 9860**  
Coolock, Tel: 01 **848 4511**

**Irish Family Planning Association (IFPA)**

Cork  
Limerick  
Galway  
Dublin  
Sligo  
Waterford  
Letterkenny  
Dundalk  
Tel: Callsave **1850 49 50 51**

**Midland Health Board Crisis Pregnancy Counselling Service**

Tel: Freephone **1800 20 08 57**

**One Family (formerly Cherish)**

Tel: Lo Call **1890 66 22 12**; (01) **662 9212**

**PACT**

15 Belgrave Road, Rathmines, Dublin 6  
Tel: Callsave **1850 67 33 33**

**Pregnancy Counselling and Support Service (Galway)**

Portiuncuala Hospital Ballinasloe, Co Galway  
Tel: Locall **1850 20 06 00**; (090) **964 8190**

**Pregnancy Support Counselling Service (Mayo)**

Mayo General Hospital, Castlebar, Co Mayo  
Tel: Locall **1890 20 00 22**

**Reproductive Choices**

58 Blessington Street, Dublin 7  
Tel: 01 **830 0630**

Under the “Regulation of Information (Services Outside State for Termination of Pregnancies)” Act 1995 it is lawful to give women information about UK agencies that carry out abortions in the context of non-directive counselling.

The following organisations have experience in dealing with Irish women who have opted for abortion.

**Marie Stopes International**

153-157 Cleveland Street  
London W1T 6QW  
Tel: (0044) **207 574 7400**  
[www.mariestopes.org.uk](http://www.mariestopes.org.uk)

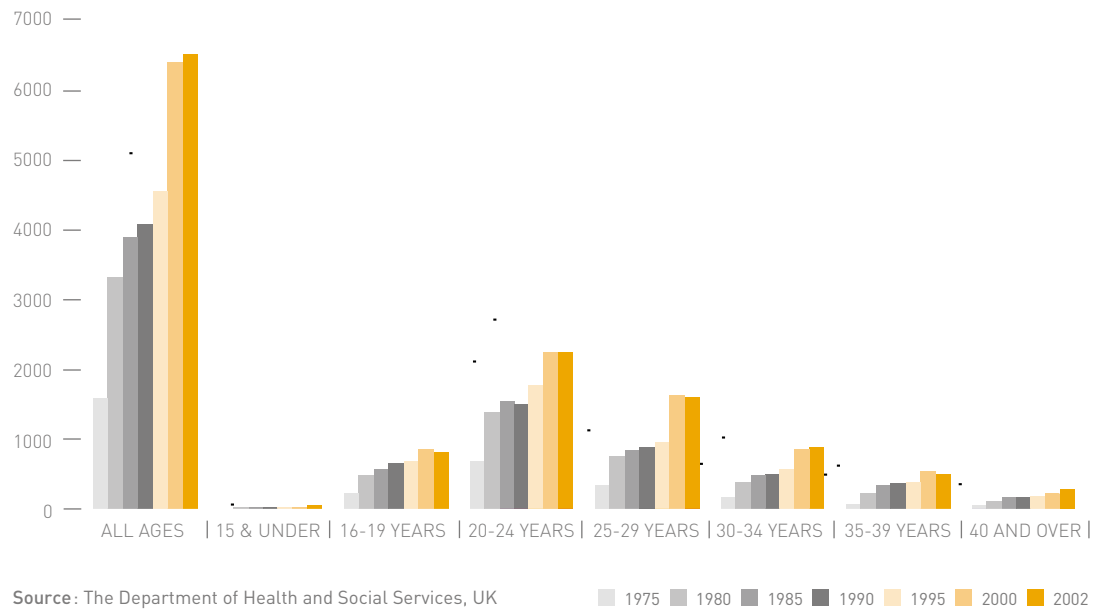
**British Pregnancy Advisory Service (BPAS)**

Austy Manor  
Wootton Waven  
Solihull  
West Midlands B95 6BX  
Tel: (0044) **121 450 7700**  
[www.bpas.org](http://www.bpas.org)

## H THE REALITY OF ABORTION IN IRELAND

Although absolute numbers are uncertain, the number of Irish women travelling to the UK to procure an abortion has been steadily rising over the last decades (Figure 1).

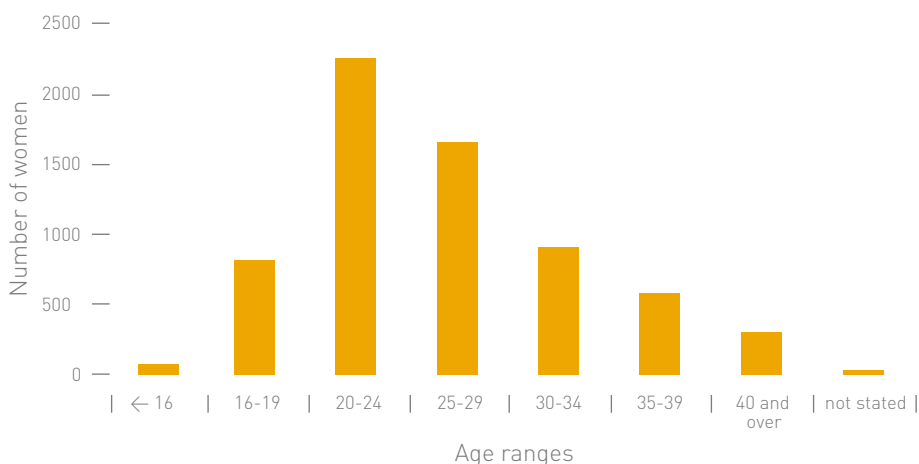
Figure 1: Numbers of abortions within the UK to Irish women, 1975 to 2002



It is thought that a significant number of Irish women attending UK clinics give UK addresses to maintain secrecy, so the national rate may be much higher. Overall, the number of abortions as a percentage of the overall level of conceptions has been calculated as 9.5% in 1994.

Although the perception is that the majority of Irish women having abortions are teenagers, this is not actually the case. Women in their twenties make up the majority.

Figure 2: Women giving Irish addresses at UK abortion clinics in 2002



## I CONFIDENTIALITY AND RELATED ISSUES

Confidentiality is a time-honoured principle of medical ethics. The normal rules of confidentiality apply to crisis pregnancy.

Issues which may arise:

### → Minors

A person under the age of 16 cannot consent to a medical or surgical procedure, thus parental involvement will be necessary if she is to have an abortion. This must be explained to the young woman and her agreement sought to involve her parents if she wishes to pursue the option of abortion.

However, if the parents of a minor present requesting termination of pregnancy for their daughter, the GP must establish that this is what the minor wishes. If she is not in agreement and the GP thinks she is mature enough to make an informed decision the GP must respect the right of the minor to refuse the procedure. Thus the consent of the person undergoing the procedure must be obtained, regardless of her age.

### → Spouses

The doctor-patient relationship between a woman seeking abortion and her GP supersedes marital relationships. Confidentiality must be maintained regardless of requests by spouses for information. This also applies to all areas of contraception such as the IUCD and emergency contraception.

### → Medical Records

Particular care must be taken by GPs when storing sensitive information in medical record systems. There should be limited access to such information by practice staff. Many women are highly sensitive to possible breaches of confidentiality in the area of abortion. The woman should be reassured by the doctor of his/her commitment to confidentiality and every effort made to uphold this.

## J GUIDELINES FOR GPs WITH A CONSCIENTIOUS OBJECTION

The rights of doctors who have a conscientious objection to abortion and therefore to any clinical action of theirs which they regard as assisting others to carry out an abortion, are provided for both in the Ethical Guidelines of the Medical Council and in the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995. The sixth edition of the Medical Council's Guidelines for Ethical Conduct and Behaviour (2004) states that "if a doctor has a conscientious objection to a course of action this should be explained and the names of other doctors made available to the patient."

When counselling a woman with a crisis pregnancy the GP may become aware that the woman is opting to travel for an abortion (her legal right). She will thus need information on abortion services which are available outside the state. In such circumstances the GP may exercise the legal right to inform the woman of his or her disagreement with or conscientious objection to abortion or the giving of information.

(S)he should be careful not to be judgmental and should endeavour to counsel the woman in a balanced and non-threatening manner. If not, the GP runs the risk of complicating the crisis or of contributing further to possible post-abortion physical or psychological problems. She may require further medical attention or counselling and must be in a position to receive this. In other words, the GP should remain mindful of his or her role in the **continuity of patient care** and should 'leave the door open'.

Within these broad parameters, individual doctors owe it to their patients and to themselves to clarify in a personal practice policy what they are and are not prepared to do.

It is unprofessional for any general practitioner to fail to be available and accessible to his/her patient (either personally or when off duty through a designated and suitably qualified locum) for whatever medical problems she may choose to present including the problem of a possible unplanned pregnancy.

**A conscientious objection to abortion does not absolve the doctor of the duty :**

- To care for a patient distressed by a personal crisis.
- To provide non-directive medical advice based on all available factual information regarding her options, possible adverse effects etc.
- To ensure that she is in possession of whatever personal medical records she needs were she to decide to seek an abortion.

- To sustain a professional relationship with the patient which will encourage her to return for post-abortion care or to make contact in the interim should she feel the need to do so.
- To provide post-abortion care including contraceptive advice.
- To preserve her right to confidentiality.
- To inform her of his/her conscientious objection to assisting abortion and offering her the opportunity to terminate the consultation at that point if she so wishes.

**A conscientious objection to abortion does not permit the doctor to discourage the patient from seeking an abortion, by unprofessional means:**

- By using the consultation to condemn abortion on moral grounds (unless asked directly by the patient to express a moral view).
- By creating delay which increases the medical risk to the patient.
- By withholding important medical records.
- By threatening to withhold further care, or make her circumstances known to family, employers, friends or others.
- By inducing fear by spurious information about services, methods, side effects, future fertility, psychiatric illness etc.

# Appendix A

## EMERGENCY CONTRACEPTION – PATIENT INFORMATION LEAFLET

If you have had sex without using contraception or if you think your method might have failed (e.g. burst condom or forgotten pill) you can use emergency contraception. This will usually prevent pregnancy.

Pills containing a progestogen hormone (levonorgestrel - Levonelle®) are most commonly used. The second option is to have a copper coil (IUCD) fitted.

### WHEN CAN YOU USE IT?

The pills can be taken up to 72 hours after unprotected sex. They come in a packet containing two pills. Both pills should be taken as soon as you get the packet.

The coil can be fitted up to five days after unprotected sex and it must be fitted by a trained doctor.

### HOW EFFECTIVE IS THE METHOD?

Emergency contraceptive pills are very effective. The failure rate is between 1 and 3%. They are more effective the sooner they are taken after unprotected sex.

The failure rate for the coil insertion is lower (less than 1%).

### HOW DO THE PILLS WORK?

The pills may stop or delay an egg being released (ovulation). Or they may stop a fertilised egg settling in your womb (implantation).

Emergency pills prevent pregnancy and do not cause abortion. Abortion can only take place after a fertilised egg has implanted in the womb. People who believe that life begins when the egg is fertilised may not wish to use this method.

### ARE THERE SIDE EFFECTS?

1. Some women may feel sick after taking the emergency pills but vomiting is extremely rare. If you vomit within 2 hours of taking the pills you should consult your doctor, as the dose may need to be repeated.
2. The tablets can also alter your menstrual cycle. You may have some irregular bleeding after taking emergency contraception. This is not harmful.
3. Your next period may arrive a little early or a little late. If your period is more than 10 days late, you should consult your doctor because of the risk that you might be pregnant. If the emergency pills fail and you find yourself pregnant, there is no proof that it causes any harm to the developing baby.

4. There are other potential complications in having a coil inserted and your doctor will discuss them with you.

### WHO IS SUITABLE?

Emergency pills are suitable for most women. If you have any medical condition or are on medications your doctor will be able to advise you.

### HOW OFTEN CAN IT BE TAKEN?

These pills should only be used in an emergency. They are not suitable for regular use as other methods are more reliable over time.

There are many forms of contraception you can use regularly and you should seek advice from your doctor on a safe method that would be suitable for you.

### WHAT DO YOU DO NEXT?

If you were already taking the contraceptive pill you can restart taking it the day after taking emergency contraception. You should also do a pregnancy test at the end of your packet.

You can still get pregnant after using emergency contraception if you have further episodes of unprotected sex before your next period.

### WHAT OTHER ISSUES SHOULD YOU CONSIDER?

Remember that having unprotected sex puts you at risk of contracting sexually transmitted infections. You can discuss the risks of infection and the need for tests with your doctor.

This is a good time to discuss your future contraception. There are many different options and your doctor can help you choose a method to suit you and your partner.

# Appendix B

## TERMINATION OF PREGNANCY – PATIENT INFORMATION LEAFLET

This leaflet is for use by women who have received pregnancy counselling and have decided to travel to the UK for a termination of pregnancy.

Ideally have someone accompany you to the clinic. The moral support is helpful. Inform at least one person that you are travelling and why.

### Before attending the clinic for the termination:

- Check that your appointment with the clinic has been confirmed.
- Check the location of the clinic- the clinic office and surgery may be in different places.
- Check transport to the clinic.
- Check the requirements of the clinic as to what you should bring with you- clothing, toiletries, sanitary protection.
- Check payment requirements. Will they accept a banker's cheque or do they want cash? Be careful carrying large amounts of cash about with you.
- Have you arranged accommodation? If not the clinic may be able to provide you with a list of bed & breakfasts and hostels for women.

Take the record summary your GP has provided with you. Check that you have your GP's telephone number. It is unlikely you will have any medical difficulties while in the UK but if you do your GP will be able to provide advice about what to do.

### Are you staying overnight in the clinic?

If not, you may need to have someone pick you up afterwards and accompany you to your accommodation.

### WHAT WILL HAPPEN AT THE CLINIC?

Procedures vary somewhat between clinics. In England you will have to be seen by two doctors. The purpose of this is to first confirm that you are pregnant and second to satisfy the British legal requirement that two doctors have agreed that you need to have a termination of pregnancy. British law requires the woman to state her reason for requesting a termination but not to explain or justify it. 'Psychological distress caused by continuing the pregnancy' is the most common reason given.

### YOU WILL BE ASKED TO SIGN A CONSENT FORM FOR THE OPERATION.

Some clinics will offer you screening for a sexually transmitted infection (chlamydia) before the operation. If this infection were present it could increase your risk of infertility after the operation. It is a good idea to accept the screening and to take the recommended antibiotics if an infection is present.

You will have either a general anaesthetic where you are put to sleep fully or a local anaesthetic where your lower body is numbed. There are even fewer complications with a local anaesthetic and the recovery time is quicker. The operation takes about ten minutes and you should not feel more than a little discomfort.

Afterwards you may feel some pain like a period pain. If it is uncomfortable you can request pain relief, such as paracetamol.

An overnight stay is usually not required if you are less than 14 weeks. In this case, you can travel back home the same day of your operation.

You will probably have a period for up to a week after the termination. You may use sanitary towels. It is probably best to avoid tampons for the first period after the procedure.

### ON RETURN TO IRELAND

**You should plan to visit your GP three weeks after the termination.**

**You should attend earlier if you have any of the following symptoms:**

- Prolonged or heavy bleeding
- Passing clots
- Abdominal pain
- Feeling unwell

### CONTRACEPTION

If you plan to resume sexual intercourse after the termination you may do so. Condoms are advised as protection against infection while you are still bleeding. Contraception is necessary immediately after a termination as ovulation may occur within a few days and as a result pregnancy can occur. If using 'the pill', it can be started on the day after the termination and continued as usual or started when your first period returns. A diaphragm can be used as before. An IUCD (coil) can be fitted immediately after termination. If you are considering having a coil like Mirena inserted at the time of the termination you should bring the coil with you. Your GP can give you a prescription for it.

### THE CHECK-UP WITH YOUR GP

This will allow your doctor to check that you have recovered from the procedure and do not have any complications. (S)he will discuss your contraceptive needs as appropriate. If you have any questions or concerns your GP will be happy to answer them.