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Who should be in a position to provide pregnancy terminations?

EDITORIAL

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These days, most pregnancy terminations do not involve surgical treatment; they tend to be medically induced. Who should be able to offer this type of treatment?

In 2009, the Norwegian Society for Gynecology and Obstetrics approached the Ministry of Health and Care Services with a request for the legalisation of pregnancy terminations performed by specialist gynaecologists and obstetricians who have a reimbursement agreement with the public health sector, so-called specialists in private practice. The Norwegian Directorate of Health was asked to evaluate a pilot project. The study conducted by Devold Pay et al., now published in the Journal of the Norwegian Medical Association, forms a part of this evaluation (1).

The study shows that most of the women who had a medically induced pregnancy termination provided by a specialist in private practice were satisfied with the treatment they received. They felt safe, and they would recommend pregnancy termination provided by a specialist in private practice to others. The study included a small proportion (n = 476) of the approximately 26 000 women who had an abortion in Norway during the study period. The study participants were probably not representative of all those who had an

abortion, but there is no reason to doubt the findings. Most patients will be satisfied when they receive the treatment they want from a doctor they have chosen themselves.

Today, more than 80 % of all pregnancy terminations are performed by medical treatment rather than surgical procedure, which used to be the most common (2). Furthermore, the medical abortion is now commonly initiated in the hospital, after which the patient goes home. The termination is then completed at home.

In 2006 Ullevål Hospital's Division of Gynaecology and Obstetrics initiated a study on at-home abortions (3). This showed similar results to those presented by Devold Pay et al. Women therefore appear to be satisfied with their pregnancies being terminated at home irrespective of whether the treatment was initiated in hospital or in the surgery of a specialist in private practice.

Wherever the abortion is initiated, the hospitals are responsible for the treatment of women who experience significant complications following a pregnancy termination. Hospitals must also respond to patient needs outside normal working hours, in which case it may be beneficial to have the patient records easily available. This is not always possible if the patient has been treated outside of hospital.

Devold Pay et al. give little attention to important economic, medical and legal considerations that have a bearing on the issue of whether abortion provided by specialists in private practice should become a treatment offered by the Norwegian health care sector on a permanent basis. The fact that the patient is satisfied with the treatment is obviously important, but it is not the most important argument for expanding the existing abortion treatment offer. Abortion rates are dropping and, as far as I know, hospitals have ample capacity to provide such treatment (2).

Insufficient treatment capacity in hospitals is therefore not an argument for allowing specialists in private practice to perform medical abortions. In Norway, all costs associated with pregnancy are covered by the public purse, including the cost of abortion. If specialists in private practice are to offer abortion treatment, this may increase the cost to the public purse unless the hospital costs associated with such treatment are reduced.

An abortion is not only a termination procedure; the treatment includes examination for venereal diseases and rhesus antibodies, immunisation with anti-D immunoglobulin and pregnancy prevention guidance, in addition to offers of contraception. Women who seek an abortion are also entitled to information about the alternatives to termination (4). Abortions must be reported to the Norwegian Registry of Pregnancy Termination (5), and compliance with the Abortion Act must be safeguarded (4).

Centralisation of patient treatment often makes it easier to establish procedures and to secure a high quality of treatment. In England, where specialists in private practice have taken over large parts of the abortion services, the medical responsibility for ensuring that all women receive good

and up-to-date abortion treatment has become pulverised (professor Lesley Regan, President of the Royal College of Obstetricians and Gynaecologists (RCOG), lecture at the RCOG's Word Congress, Singapore 2018).

The Norwegian Biotechnology Act's provisions for first-trimester foetal ultrasound scans are interpreted by obstetricians and gynaecologists in different ways (6). It can be difficult to distinguish between ultrasound as a part of normal pregnancy care procedures and ultrasound as a foetal diagnostic test (7). Prenatal findings that cause suspicion can give rise to anxiety in pregnant women. Is it possible that the route is too short between ultrasound findings that cause suspicion, and abortion on demand, if the pregnant woman's doctor can provide both ultrasound scans and abortion pills?

The need for discretion and greater freedom of choice has been put forward as an argument for allowing specialists in private practice to offer abortion treatment. Women who live in places where everyone knows everyone else may well have a greater need for discretion than women who live in urban areas. The geographic distribution of gynaecologists and obstetricians in private practice is uneven across Norway. Should women from sparsely populated areas be able to choose to have abortion treatments provided by urban specialists in private practice, and should they have their travel and accommodation costs covered as well? And furthermore, should specialists who have no contract with the health authorities be allowed to offer abortions? If so, should they be allowed to charge the patient? Norway has very liberal abortion legislation compared to many other countries. Should foreigners be offered abortion treatment by specialists in private practice in Norway if they pay for it themselves?

Under the current abortion legislation, all pregnancy terminations must take place in a hospital (4). The Ministry of Health and Care Services granted special permission for the pilot project with abortion treatments provided by specialists in private practice. The Abortion Act will presumably need to be reviewed to allow for pregnancy terminations by specialists in private practice in the future. An amendment to the Act may well be required. The study conducted by Devold Pay et al. gives us grounds to believe that patients will be satisfied with abortion treatments provided by specialists in private practice, and that they will not experience a greater number of complications than if they had been treated in hospital. However, several important questions need to be discussed before we can make a good decision on who should be in a position to provide pregnancy terminations in the future.

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