SRH clinical consultations: abortion in non-specialist community-based clinics

Sam, aged 31, attends her local sexual health clinic requesting a pregnancy test after a split condom with her regular partner four weeks ago. She took oral emergency contraception (EC) the following morning. However, she has not had a period for six weeks and her breasts are more tender than usual. Her menstrual cycle is usually regular and monthly.

Before the pregnancy test, the healthcare provider (HCP) asks Sam how she would feel if the test were positive. Sam says she would be upset as she does not want to be pregnant.

The pregnancy test is positive. Sam is tearful and says she would like an abortion. The HCP explains how she can access an abortion and gives her the number to ring to arrange an appointment with the local abortion service.

The HCP asks Sam if she has any questions about the appointment or abortion in general. Sam asks what will happen at her appointment with the abortion service and says she would like to know more about the types of abortion available and which one the HCP would recommend. The HCP explains what the appointment will entail, gives a brief outline of what having a medical or surgical abortion would involve (see Table 1) and advises Sam to choose the method she thinks would be best for her.

The HCP asks Sam if she would like to talk about future contraception. Sam says she can't think about that now. The HCP says she understands and explains that it's possible to get pregnant within a week of having an abortion and offers to see Sam again before or after the abortion. She provides Sam with the appointment information, links to the provider's website and the Royal College of Obstetricians and Gynaecologists (RCOG) Outline of contraceptive methods infographic. [1]

Table 1: Outline of medical and surgical abortions < 12 weeks of pregnancy

Medical abortion	Surgical abortion
○ Can usually proceed on day of appointment.	○ No cuts/scars.
○ Usually at home with support of friends/family.	○ Medical/nursing staff present throughout.
○ Can feel more "natural".	○ Can have IUD fitted at the time of the procedure.
○ More pain and bleeding than surgical abortion.	○ Less pain and bleeding than medical abortion.

For more information on medical and surgical abortions see the RCOG's open access abortion care eResources. [2]

Background

45% of pregnancies and one third of births in the UK are unplanned. [3] Although abortion is still a criminal offence in Britain, the 1967 Abortion Act allows abortions to be legally provided if two doctors agree the grounds of the Act have been met and the abortion takes place in an NHS or licensed premise. [4] Whilst 99% of UK abortions are funded by the NHS, 77% in England and Wales are provided by independent providers. In Scotland and Northern Ireland, 99% are provided by the NHS.

Main aims when a patient requests an abortion in a non-specialist community-based clinic

1. Referring/signposting to the local abortion service.
2. Asking for and responding to patients' questions.
3. Creating a safe, respectful space.

Referring/signposting to the local abortion service.

For the majority of patients, this is the most important outcome of the consultation. It is important for HCPs to know how to do this and to be able to explain to patients what will happen during their appointments.

The first appointment will usually be on the telephone, although some services offer in-person initial appointments. An ultrasound scan may be performed prior to a surgical abortion. For those having a medical abortion, a scan is done if there is any uncertainty about the date of the last menstrual period, if there are any ectopic pregnancy symptoms or risk factors, or if the patient requests one. Medical abortion pills can be posted to patients' homes or collected by patients from their provider. Protocols around medication delivery vary among abortion services.

Asking for and responding to patients' questions.

It is also important for the HCP to allow time to respond to patients' questions, not least because this may dispel harmful myths about abortion, such as its effect on future fertility.

If there is time, HCPs can also consider STI screening, identify eligibility for different methods, check for coercion, explore feelings about the pregnancy, as well as ask sensitively about the need for future contraception, remembering these will all be addressed when the patient attends the abortion service.

Creating a safe, respectful space

This is particularly important when discussing feelings around pregnancy and abortion, as abortion stigma remains prevalent. [5] A few simple measures can help patients feel listened to and respected while counteracting abortion stigma.

Not making assumptions about whether patients are happy to be pregnant is particularly important.

Before doing a pregnancy test, ask:

- “What would you like the test to show?” or “How would you feel if the test was positive?”.

After giving a pregnancy test result, ask:

- “How do you feel about the result?”.
- Never say “Congratulations” until you know the patient wants to be pregnant.

Smiling, making eye contact, explaining how common abortion is and encouraging patients to talk to friends/family they trust can contribute to creating a safe respectful space and destigmatising abortion. Using value-neutral language around pregnancy and abortion also helps (See Table 2).

Table 2: Examples of stigmatising and value-neutral language

Potentially stigmatising language	Value-neutral option
Mother	Pregnant woman/person
Baby	Pregnancy/foetus
Father	Person you are pregnant with
Repeat abortion	More than one abortion
Crisis pregnancy	Unplanned pregnancy/unwanted pregnancy/a pregnancy you can’t continue

Not making assumptions about whether the patient is in a sexual relationship, sexuality and gender also demonstrates a non-judgemental and thoughtful approach. This can be achieved by asking, for example:

- “Are you in a sexual relationship at the moment?”
- “Is this the person you got pregnant with?”
- “Do they know about the pregnancy?”
- “How did they react when you told them?”

If the patient is not in a sexual relationship, the latter two questions can still be asked about the person they got pregnant with.

Bringing up contraception in a sensitive way, towards the end of the consultation when patients know you are helping them to access an abortion, is important. Avoid conveying an urgency to ‘sort out’ contraception and the presumption that all patients who request an abortion want or need future contraception. Instead, present contraception as something you can help with if needed, with no pressure to accept the most effective, or any other methods.

If a patient declines contraception, you can explain that it is possible to get pregnant within a week of an abortion and ensure they know where they can access contraception and emergency contraception, should they need it in the future.

Outcome

Sam takes the number of the local abortion service and leaves the clinic feeling grateful she hasn't been judged and that she understands what to expect. She calls her local abortion service later that day and is given an appointment for the next week. After checking the provider's website and the contraception infographic, she decides to have a medical abortion and an implant for future contraception.

Competing interests: JK is an Associate Editor for BMJ Sexual & Reproductive Health

Ethics approval: Not applicable

Funding information: There are no funders to report for this submission

Contributorship statement: CH drafted the first version of the article, based on JK's teaching resources on abortion consultations. JK improved the structure of the article and collated feedback. JK and CH finalised the article. PC critically reviewed and improved the article.

References

1. Royal College of Obstetricians and Gynaecologists. Best Practice in post-abortion contraception. Appendix 1: overview of contraceptive methods infographic. Available: https://www.rcog.org.uk/media/un4pxbiw/rcog-bpp-post-abortioncontraception-infographic-only-web_.pdf

2. RCOG's Making Abortion Safe open access abortion care eResources. https://elearning.rcog.org.uk/catalog?pagename=Abortion-Care-eResource [Accessed 18 July 2023]

3. Public Health England, Health matters: reproductive health and pregnancy planning, 2018 https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning

4. UK Abortion Law overview, Doctors for Choice UK. https://doctorsforchoiceuk.com/abortionlaw [Accessed 18 July 2023]

5. Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. Culture, Health & Sexuality, 11, 625–639