

ABORTION IN EUROPE: ARE THE LAWS AND PRACTICES PATIENT CENTRED?

By Christian Fiala

The diagnosis of an unwanted pregnancy is a crisis situation for most women, even if the extent of the crisis varies greatly.

For most women the diagnosis of an unwanted pregnancy is unexpected. The women are therefore unprepared and may not fully comprehend the matter or know where to go to get counselling, be it for carrying the pregnancy to term or having an abortion. In effect, the diagnosis of an unwanted pregnancy places the women concerned in an informational state of emergency. She needs a great deal of information within a very short space of time. This search for information is made significantly more complicated by a number of factors:

- The information concerns one of the most intimate areas of life;
- This area is particularly taboo in many societies;
- The pregnancy is sometimes not the result of an existing, socially accepted relationship, which is why the fact of pregnancy itself must not become public;
- The woman's own social circles, and also professionals in the social-services field, often react with moral condemnation, refusal of assistance or even misleading information;
- The information required is extensive and complex. It affects both physical and psychological processes. There are fundamental questions about the abortion as well as specific ones, such as addresses;
- The impending decision has major effects on the woman's social environment, on her future life, and is irreversible;
- With a partner, a second person is immediately and directly concerned and more or less involved in the decision;
- Not least, the information requirements are very different for each individual, and sometimes vary widely, as a result of which it is not always easy to provide the necessary information.

Societies react differently to these requirements, although the last 200 years were dominated by a rigid paternalism. Coupled with religious beliefs in some countries, this was often the expression

of a male-dominated conviction among the dominant social strata that pregnant women could not responsibly make decisions regarding their own pregnancy. Society therefore "had" to intervene in order to ensure that the "right" decision was taken. This paternalism led, among other things, to a ban on abortions, which again was one of the reasons for the very high level of maternal mortality. This is still the case in many low-income countries, because abortions are illegal there owing to the laws imposed by former colonial powers.

With the improvements in technology, especially during the second half of the twentieth century, and a recognition of women's rights, the situation has slowly changed over recent decades and women or couples now have a high degree of autonomy over their fertility. As a result of this autonomy, Dutch women, for example, have the lowest rate of abortions worldwide (1). On the other hand, some countries still have regulations that reflect outdated procedures and thinking and do not adhere to medical and social service standards that have been established in the meantime. One example is a compulsory counselling session before an abortion. Even though this has been abolished in some countries, such as France two years ago, it still exists with varying guidelines in some other countries. For example, in the Netherlands and Austria all doctors can provide this counselling and there is no regulation as to its content, while in Germany it is more rigidly prescribed and impedes access to abortion. It remains unclear why it is so difficult to offer counselling voluntarily, as this is the usual practice for other medical procedures.

Obligatory waiting periods

Another example is an obligatory waiting period for reflection between counselling and the abortion. The very idea of a legally required waiting period between counselling and medical treatment is, for good reason, unusual in medicine. Rather, the law has given a special status to the doctor-patient relationship and it is particularly protected. It is incumbent

alone upon the two parties involved to find the best procedure for a particular situation. If there is now a legally binding period for consideration before terminating a pregnancy, it seems to be based on three basic misunderstandings:

- pregnant women have to be protected from themselves so that they do not hastily decide against having a child;
- women with an unwanted pregnancy would only enter into the actual decision-making process after counselling with someone they do not know;
- a reflection period (usually of an arbitrary length) could reduce the number of abortions.

In countries that do not have such an obligatory waiting period, women with an unwanted pregnancy and professionals working in the field, see no need to introduce one (2). As shown in Table 1, this obligatory waiting period varies greatly from country to country regarding the length, how it is calculated and possible exceptions. It can be assumed that the needs of the women in these

countries do not essentially differ, so that for most women the waiting period must seem arbitrary and not corresponding to their needs.

Above and beyond this, in some countries there are special regulations, such as those stipulating that the woman may not be treated or cared for by the same specialists who are counselling her. Such a regulation is unique in medicine. On the contrary, it is self-evident that the specialists with whom one has established trust in the course of preliminary consultation and examination should also carry out any procedure and are also responsible for care during the process. The continuity of care is particularly important in a crisis situation such as an abortion, so that the women do not have to repeat their whole story every time they come to the service. Only in this way can a certain trust develop which acts as a positive influence on the course of treatment. It is hard to comprehend why this important quality standard should not be applied in particular in the crisis situation of an unwanted pregnancy. In other branches of medicine such an

approach would be regarded as unethical or even as mental cruelty.

In Switzerland, even after the recently liberalised law, a woman still has to declare in writing that she is in distress before she can have a legal abortion. Here, too, this kind of procedure, unusual in medicine, accords no recognizable advantage for the woman concerned. Rather, it seems to be something which will provide legitimacy to the action, whereas it probably serves only to make the woman concerned feel she has to justify herself to society for what she is doing.

Positive developments

There are nevertheless some important positive developments. One of them is the increasing spread of the internet. This brings many advantages to women with an unwanted pregnancy. Without a great deal of effort, they have unhindered access to a large amount of information from varying perspectives. Most importantly, their private sphere is secure; they do not have to explain anything about themselves nor do they have to justify themselves to anybody. We found that visiting websites on abortion had a positive influence on counselling and treatment, provided that these sites had no religious background. There are two main disadvantages to the internet in this regard: on the one hand, not all women have access to it. On the other hand, it is often hard to distinguish between factual evidence and emotional propaganda and misinformation.

Multiple methods for abortion

There is a great difference in abortion procedures between countries. Whereas, for example, in the Netherlands most surgical abortions in the first trimester are carried out under local anaesthetic, in other regions general anaesthesia is the standard. Also, a surgical abortion in the fifth or sixth week is a matter of course in the Netherlands and even exempt from the legal waiting period. But in other countries, surgical abortion as this early stage in pregnancy is not offered and is even considered to be medical malprac-

Table 1. Overview of obligatory waiting periods in selected European countries

Country	Waiting Period	Details
Belgium	six days	from first contact with any counselling body
Germany	three days	three full days, certified by confirmation from an approved counselling centre
France	seven days	from first contact with a specialist, doctor/counsellor/midwife/nurse; can be shortened near the end of the term of legal abortion
The Netherlands	five days (applicable only after the 44th day since last menstrual period)	five full days after the first contact with a specialist, with many exceptions: can be shortened near the end of the term
Italy	Seven days	from first contact with a doctor (certification required)

No waiting period in Austria, Denmark, Finland, Norway, Spain, Sweden, Switzerland

tice by some doctors.

Whereas in France, Scotland and Sweden in some institutions more than 50% of women choose a medical abortion, in Germany, the Netherlands and Austria this is only a very small percentage.

It cannot be assumed that women's needs in the above-mentioned countries are so different as to explain the so widely varying frequency of the various methods. It must instead be assumed that the difference in frequency of methods is the expression of different organizational, legal or financial circumstances, or just a continuation of traditions that have not been called into question.

In summary, one can say that in most countries the general conditions in the run-up to an abortion, as well as in carrying it out, are hardly or not at all oriented to the requirements of the women concerned and often leave little room for individual needs. Rather, the professionally inexperienced and those not personally involved manifest themselves in an apparently arbitrary way depending on the country. Unfortunately, the restrictive conditions lead to precisely the opposite of what they are intended to achieve.

If one compares the frequency of abortions in various countries, it is clear that the countries with the lowest rate of abortions are those where the general conditions are most oriented to the needs and where women have the greatest possible autonomy in access to sex education, contraception and abortion, e.g. the Netherlands.

There is no evidence that restricting access by e.g. obligatory counselling or waiting periods is of any benefit. They do, however, lead to a delay in the provision of abortion and have negative effects on the physical and psychological experience of those affected. Consequently, all guidelines underline the advantages of early abortion (3-5). These aspects should be highlighted in the public discussion and in the formulation of new general conditions.

Developments in recent decades have been encouraging inasmuch as the regulations in many countries have been

changed and are now less restrictive. The example of Canada is particularly worth mentioning. There, the long established view is that the abortion of an unwanted pregnancy is a medical treatment and requires no legal interference. Therefore, after long legal arguments, in 1988 the Supreme Court declared the law on abortion to be unconstitutional and abolished it. It will be interesting to see how long it will take for this solution-oriented approach to replace the existing ideologically motivated regulations in other countries, especially those in the European Region.

Finally, I would like to introduce another gender aspect. As men, it is well-known that we cannot get pregnant, let alone have an abortion ourselves. Maintaining the reproductive health of women, however, is also in our interests. We are directly affected by and dependent on it. We should therefore argue for conditions which permit women, who have after all become pregnant through our actions, to end an unwanted pregnancy in the best possible way and without unnecessary suffering.

Christian Fiala

[christian.fiala@aon.at]

Gynmed Clinic for Abortion and Family Planning
Vienna, Austria
President of the International Federation of Professional Abortion and Contraception Associates (FIAPAC)

The information on the legal situation and the practice in different countries is from national sources. Links to national institutions of different countries are available at the Link section of the FIAPAC website: www.fiapac.org/e/Links1.html

References

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