Irish College of General Practitioners

ICGP Submission to the Citizen's Assembly

Experiences of Irish GPs supporting women with Crisis Pregnancy in Ireland, in the context of the 8th Amendment of the Irish Constitution

26th November 2016

1. Introduction

General Practitioners (GPs) are particularly familiar with reproductive healthcare challenges facing Irish women.

- Irish GPs provide antenatal care to Irish women during pregnancy. Before 20 weeks gestation (approximately 5 months), GPs provide most antenatal care and support to pregnant women in Ireland. After 20 weeks, GPs provide shared care with hospital colleagues, in obstetrics and midwifery.

- When a pregnancy is unwanted, GPs frequently support and care for women through this difficult experience. Evidence-based management of Crisis Pregnancy, provided by GPs, is set out in relevant ICGP publications, including ICGP Guidelines on Crisis Pregnancy 2004, and updated ICGP Reference Guide 2014.

- Further, Irish GPs provide high-quality contraception to Irish women.

Thus, the Irish College of General Practitioners (ICGP) is well placed to understand the concerns, fears and experiences of Irish women, regarding reproductive healthcare generally, and especially in relation to the area of early pregnancy, unplanned pregnancy and crisis pregnancy.

The implications of the 8th Amendment and associated legislative Acts are closely considered throughout this paper.

2. Crisis Pregnancy

Definition:

- A crisis pregnancy is a pregnancy "*which is neither planned nor desired by the woman concerned and which represents a personal crisis for her*" (ICGP Guidelines Crisis Pregnancy 2004). Crisis pregnancy can affect women at any age, of any social group or in any geographical community. Effective management requires attention to a broad range of clinical, social, emotional, educational and legislative issues. The response of the GP or other healthcare professional at the initial consultation is known to have a profound impact on her experience of this life crisis. The importance of the woman and her partner having a personal doctor available to her through this time is difficult to quantify, but greatly valued (McCormick 1996 Lancet)

Detail is already presented to the Assembly in relation to the incidence and outcomes in pregnancy, including the proportion of all pregnancies likely to end in Termination.

It is sufficient in this context to observe that irrespective of our legislation, and the Eighth Amendment, termination of pregnancy remains a mainstream aspect of medical care for many women resident in Ireland, their partners, and their General Practitioners.

3. Prevention of Crisis Pregnancy: Contraception, Emergency Contraception and Education Initiatives

- GPs are well placed to provide effective, accessible contraceptive care to Irish women. GPs are trusted professionals, knowing patients over time, with strong doctor-patient relationships. GPs promote and are proactive, in making available effective and accessible contraception for all women who are sexually active. The greater majority of GPs provide contraception, emergency contraception, crisis pregnancy counseling and post-abortion care, doing so as part of a highly accessible national network of points of readily accessible care, throughout Irish communities.

- Despite efforts of government, educational initiatives and healthcare practitioners, and despite widespread access to Emergency Contraception, ***crisis pregnancy cannot always be prevented***; 35% of all Irish women who have been pregnant describe having at least one crisis pregnancy (McBride ICGP 2010). It is usual for most GPs, as the first point of contact for individuals, to encounter women and sometimes their partners in an unplanned, unwanted pregnancy. It is a large scale issue in society.

- Abortion rates ***are lowest*** in health systems where contraceptive services are most readily available. There are definite barriers to contraceptive services in Ireland, chiefly relating to cost, and in instances involving adolescent women, their own concerns regarding confidentiality.

- The 8th Amendment does not typically impact upon the contraception and emergency contraception management for Irish women.

- It has made little or no difference to GPs, and most individuals, in their consulting around unplanned / crisis pregnancy.

4. Management of Crisis Pregnancy

To help outline the typical Crisis Pregnancy scenario, we outline a typical example.

Background to case

- Sandra, who is 38 years of age, attends her GP. She has three children, but recently separated from her husband three weeks previously, as he had become increasingly abusive towards her and her children. The GP has become more concerned about Sandra's isolation and lack of supports.

Crisis pregnancy

- Sandra says she missed her period two weeks ago. She thinks she may be pregnant, but she hasn't checked yet. She is concerned and anxious.

- Before the GP performs a pregnancy test, she explores Sandra's feelings, and asks if she would be happy if she found out that she was pregnant. Sandra bursts into tears. The GP listens to her many concerns, readily shared, and explains clearly that no matter what happens, the practice will be there to support Sandra.

- The GP proceeds to check a urine sample and it confirms Sandra is, in fact, pregnant. She looks despondent and devastated.

- She says she does not want to be pregnant.

Every Crisis Pregnancy is different. The reasons why a pregnancy is unwanted is both personal and unique to each individual woman (and her family). But the approach to managing Crisis Pregnancy is the same.

Managing Crisis Pregnancy in practice

a) Confirming the Pregnancy

- As the clinical vignette outlines, GPs do not assume all pregnancies are always wanted. GPs are well placed to sensitively enquire about the woman's feelings and to confirm a pregnancy (Ni Riain 2013 ICGP).

b) Non-directive counselling and discussion of options

- Next steps in management are to support the woman reach the best decision for her (ICGP 2014). Main consultation objectives involve establishing trust, helping the women formulate a clear definition of the problem and establishing the goals of management so that the crisis can be resolved. This involves non-directive, non-judgemental, compassionate, empathetic, listening. There is a legal obligation on those providing pregnancy counseling in Ireland to discuss all options in a non-directive manner, where a woman wants information on abortion. There are three options available to women, a) Continuing the pregnancy and b) Abortion and c) Adoption (although this is rarely chosen).

- A doctor has an ethical obligation not to allow his/ her own personal moral standards influence treatment of patients. Where the doctor has a conscientious objection to a course of action, they must explain this to the patient and make the names of other doctors available to them (ICGP 2014).

- Effective communication in crisis situations demands time, considerable patience and careful thought. The GP must enable a woman to reach an informed decision, to alleviate emotional disturbance whatever decision is made, and lessen the risk of further unwanted pregnancy. Pre existing long term relationships between GPs and people who attend them is critical in enabling this.

- In the familiarity of General Practice, we hope that women do find space, are listened to, and can share, explore and address their concerns with their own Doctor. Supporting this is a core value of the Irish College of General Practitioners, so that these consultations, and indeed any other consultations involving the woman, and the process of decision making, are all undertaken in a non directional and supportive process.

- Occassionally specialist counselling is required. For example, if a woman is younger, has poorer support structures or has a mental illness, they may benefit from specialist counselling services. In this case Irish GPs recommend specialist, accredited, counselling services, which offer accurate information. These are funded by HSE Crisis Pregnancy Programme, and locations and descriptions can be found on *www.positiveoptions.ie* (ICGP 2014)

c) Continuing the pregnancy

- If a woman chooses to continue her pregnancy, the GP will continue to provide compassionate support, antenatal and post partum care to the woman and child.

d) Choosing abortion

In the clinical vignette above, Sandra chooses to travel to the UK for an abortion.

- For women who choose an abortion, GPs cannot refer or make an appointment on behalf of the woman to a clinic in the UK, but would typically make a copy of the medical records. GPs would also encourage women to return to the practice after the abortion, if they have any concerns. GPs would also discuss post-abortion contraception. Irish GPs may need to consider arranging an urgent dating ultrasound, if the dates are uncertain.

- Any GP who has a conscientious objection **must** refer the women to another GP (ICGP 2014), either within or outside their own practice.

- Medically, abortion is regarded a safe procedure for the woman, and is carried out in large numbers in other jurisdictions.

- ICGP notes that some women (disabled, without financial means, asylum seekers) are unable to travel to access abortion services.

- ICGP understands that an increasing proportion of women will purchase **on-line hormonal abortifacient medication**. In these instances, it may or may not become known to their GP in subsequent consultations. There is clearly increased use of 'illegal abortifacients,' both from anecdotal evidence from GPs, and objective measures such as customs seziures, and a recent paper suggesting 5,560 women requested abortion pills between 1st January 2010 and 31st December 2015 (Aitken 2016 BJOG)

5. Issues pertaining to The Eighth Amendment and relevant Legislation

Cumbersome clinical guidelines

- The 8th Amendment and the Protection of Life During Pregnancy Act (PLDPA) 2013 allows for lawful abortion where there is a real, proven and substantial risk to life of the mother.

- There were 26 terminations of pregnancy performed in Ireland, under the Protection of Life During Pregnancy Act, in 2015 (Dept. of Health Notifications). Most terminations related to severe sepsis or haemorrhage, and were performed by our obstetric colleagues in Ireland.

- In terms of the Protection of Life During Pregnancy Act, GPs would only be involved in the setting of a risk of suicide, as a result of the pregnancy. To put it in context, in 2015 there were **three terminations** granted on the grounds of suicidal risk (Section 9 PLDPA) (Dept of Health Notifications). The clinical pathway in this context involves referral from the GP to general (non-perinatal) psychiatry services. Two psychiatrists and one obstetrician are required to agree that an abortion is lawful under that Act.

- In rare cases, under Section 9 of the Act, process is characterised by substantial delays (typically 4-6 weeks) in accessing termination of pregnancy. Further, evaluation by the second psychiatrist is frequently outside the woman's community, and the experience of travelling in such circumstances, in early pregnancy, adds another level of difficulty.

Abortion Information Act

- GPs can and do discuss all options pertaining to Crisis Pregnancy. However the 1995 Abortion Information Act does not permit GPs to either refer or advocate abortion services. This restriction on practice can be challenging when caring for women with complex medical histories or with high medical risk.

Inaccuate information from counselling agencies

- ICGP would like to point out that inaccurate information which is delivered by unaccredited counselling agencies is sometimes viewed by GPs as harmful and needs to be regulated.

Summary and Conclusions

The ICGP thanks the Citizen's Assembly for inviting us here today.

The work of the Assembly is important, complex and difficult; it has full support of the ICGP

Most GPs, and many individuals who attend them in the course of an unplanned pregnancy, do not experience the Eighth Amendment, or the process required for the operation of the current legislative framework to be satisfactory or helpful in the context of the self perceived needs of women experiencing unplanned and / or crisis pregnancy.

Crisis pregnancy continues to be a reality facing many women and their partners in Ireland on a daily basis. It is conspicuously evident in general practice, and a substantial proportion of these women choose to access means of termination of pregnancy.

The provisions of the PLDA are either ignored, or if considered, found to be cumbersome, intensely stressful and difficult by both GPs, and far more importantly, by the women concerned, and their partners.

From a practical perspective, and respecting cherished and sincere concerns regarding the right to life of the unborn child, the majority of GPs and indeed Irish Citizens will understand and acknowledge that in many instances of unplanned and especially crisis pregnancy, a substantial proportion of women in Ireland will continue to choose and undertake termination of pregnancy in neighbouring jurisdictions, or by means of chemical abortifacients.

From a purely 'whole of society' perspective, building on good work already done by many agencies, including our own College, in removing all remaining obstacles and barriers to contraception for all women almost certainly holds greater potential in terms of reducing the numbers of crisis pregnancies in Ireland, with consequent reduction in distress and suffering for the women concerned, and ultimately reducing the number of terminations in a truly meaningful way.

References

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Appendix Observations of GPs in relation to the Eight Amendment

It is our collective experience in general practice that in the majority of such instances of unplanned undesired pregnancy, the woman opts to follow through with the pregnancy.

This is felt to most likely occur among women from more deprived backgrounds or migrant backgrounds, and living under Direct Provision, where cost of termination and ability to travel are relatively more important as barriers to obtaining an abortion.

There is a tacit assumption among many GPs that reduced levels of enfranchisement result in increased levels of acceptance of continuing with the pregnancy. Women disadvantaged in these circumstances undertake to maintain the pregnancy, as they see it as the only option open to them.

It is evident to many GPs that the decision to continue with the pregnancy is frequently taken on the basis of financial considerations, and non standardised access to service. Poorer women accept pregnancy because they can't get together €1000 to fund a termination abroad. Women from less deprived backgrounds are more likely to undertake a termination, because they and their partners can afford it.

This reality in practice clearly adds to the sense of suffering for many women, their partners in some instances, and their GPs.

Inequality is writ large across most aspects of our health service, and this area of care is no exception

In keeping with current legislation, GPs do not provide formal referral letters to Abortion Clinics. Some GPs provide the women concerned with a copy of their medical records, particularly so in instances of high medical risk. In such instances, where the choice made is for termination of pregnancy, GPs in Ireland do remain engaged with their patients for the most part, and have felt it necessary to continue to reassure any undue concerns regarding substantial or increased levels of mental health or gynaecological complication arising among women following terminations carried out in adjacent jurisdictions. This is in keeping with international research. These women are unnecessarily afraid about complications and side effects of termination.

The prevalence of postpartum depression is a reality for those women who elect to continue with the unplanned pregnancy, and in general terms, is a real issue for GPs and their patients in this context, where unplanned pregnancy is a known risk factor for postpartum depression. Preoccupation around suicide around diagnosis of unplanned pregnancy is far less of a problem that post partum depression in the wake of continuing with an undesired unplanned pregnancy.