no association between choice of anaesthesia and deprivation category score (results not shown).

Discussion

This is the first study to determine women's views on four possible ways of managing miscarriage or induced abortion. This study showed that if women in Lothian having a medical abortion were offered all four options in the future, the hospital medical method would be the most popular future choice. Clearly the majority of respondents were women currently choosing a medical abortion, which is likely to influence the choice of method overall. Also, women choosing medical abortion had the highest response rate, which may reflect the duration of time that they remained in hospital and thus had available time to complete the questionnaire. Nevertheless, medical abortion at home was the preferred option for almost one in four women having a medical abortion. Although this cannot legally be initiated at home, our results suggest that allowing women to leave our medical abortion service soon after administration of misoprostol and to subsequently abort at home could be a welcome service development.[5,6] A recent evaluation of different sites for early medical abortion in England reported that the majority of women treated as outpatients were satisfied with this method.[6] Furthermore, one pilot of early medical abortion on this 'outpatient' basis reported that it was significantly cheaper for the NHS than providing an inpatient service.[5]

In our study, only a minority (6%) of those undergoing a surgical abortion stated that they would opt for this under LA. This may be because women in our population have tended to choose surgical abortion because they want to be asleep and unaware of the procedure.[7] Nevertheless, our study suggests that surgery under LA would be a welcome development for managing miscarriage, since almost one in three women in our miscarriage group stated that this would be their future method of choice. There was also good support for home medical management of miscarriage. Clearly, however, the limited numbers in this group mean that the precise extent of support cannot be accurately determined.

Conclusions

Our study suggests that one quarter of women undergoing an early medical abortion in our hospital service would choose to abort at home if this were possible. Allowing women to go home soon after they have received misoprostol may therefore offer a welcome service to women and be less costly to the NHS whilst remaining within the current legal framework. Women undergoing management of a miscarriage (although few in number) were also keen to opt for the new choices of home medical management and surgery under LA. By improving patient choice, these new services could help improve women's journeys through difficult life events such as abortion or miscarriage.

Acknowledgements

The authors would like to thank the nursing staff of Bruntsfield Suite, Day Case Gynaecology Surgery and Pregnancy Support, Royal Infirmary Edinburgh, for distributing and collecting questionnaires.

Statements on funding and competing interests

Funding None identified.
Competing interests None identified.

References

1 British Medical Association. *First Trimester Abortion. A Briefing Paper by the BMA's Medical Ethics Committee.* ARM 2007. http://www.bma.org.uk/images/Firsttrimesterabortion_tcm41-146722.pdf [Accessed 1 June 2009].
2 Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion* (Evidence-based Clinical Guideline No. 7.) September 2004. http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion [Accessed 1 June 2009].
3 Royal College of Obstetricians and Gynaecologists. *The Management of Early Pregnancy Loss* (Green-top Guideline No. 25). October 2006. http://www.rcog.org.uk/womens-health/clinical-guidance/management-early-pregnancy-loss-green-top-25 [Accessed 1 June 2009].
4 McLoone P. *Carstairs Scores for Scottish Postcode Sectors from the 2001 Census – Report.* March 2004. http://www.sphsu.mrc.ac.uk/sitepage.php?page=carstairs [Accessed 1 June 2009].
5 Tupper C, Andrews J. Setting up an outpatient service for early medical termination. *J Fam Plan Reprod Health Care* 2007; **33**: 199–202.
6 Department of Health. *Evaluation of Early Medical Abortion (EMA) Pilot Sites.* May 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084618 [Accessed 1 June 2009].
7 Cameron ST, Glasier A, Logan J, Benton L, Baird DT. Impact of the introduction of new medical methods on therapeutic abortions at the Royal Infirmary of Edinburgh. *Br J Obstet Gynaecol* 1996; **103**: 1222–1229.

The Complete Guide to IVF: An Inside View of Fertility Clinics and Treatment. Kate Brian. London, UK: Piatkus, 2009. ISBN-13: 978-0-7499-0970-3. Price: £12.99. Pages: 304 (paperback)

This is an excellent book, written by an ex-patient and an expert. The book is aimed at those couples that find themselves in the position of going for *in vitro* fertilisation (IVF) treatment. It is clearly written, systematic and balanced. In a field where there are often conflicting views and practices, this book provides a carefully researched, impartial guide for couples. I strongly recommend it to all patients who are contemplating IVF treatment.

As I am sure that this book will be updated and revised in the years to come, I take this opportunity to offer some suggestions for future editions. I think one of the most difficult situations that couples find themselves in is not so much when they don't get pregnant following treatment, but more so when things go wrong in the clinic. Most of us can cope with the ups and downs of life, but we all want to feel we have had the best treatment that can possibly be offered. I think, therefore, that it would be helpful to have a section entitled "When things go wrong" containing advice on to how to proceed specifically for those couples that attend for clinic appointments but who are unhappy with their experience. Another area that I think is worth exploring in a little more depth in this multicultural society in which we live are the pressures and challenges faced by couples from different ethnic and cultural backgrounds. Certainly couples from the Indian subcontinent face a number of challenges – be they cultural or religious – which many find difficult to overcome. Lastly, it might be helpful to expand the section on preparation before attending for fertility treatment to include topics such as being checked for rubella immunity, folic acid (this is mentioned but there are certain categories where the woman should be on a higher dose) and the woman being up to date with cervical smears. There is also a requirement for viral screening prior to treatment, and again it would be helpful to have this explained.

Whilst this book is aimed squarely at the patient population, there is one section describing the waiting room experience of patients that I think is an absolute 'must read' for all clinic staff. I am sure that we all recognise this particular experience.

Reviewed by **Masoud Afnan**, FRCOG
Consultant Obstetrician and Gynaecologist and Fertility Specialist, Birmingham Women's Hospital Foundation NHS Trust, Birmingham, UK