

Early medical abortion at home: author's response

I would like to respond to the concerns of Mr Esen¹ as follows:

1. Mr Esen expresses concern that administering mifepristone on the same day as a hospital assessment may result in women being given mifepristone when they are not certain of their decision and thus consequent distress. However, women that received mifepristone in our study (and continue to do so) are those who are 'certain' of their decision, as indicated in our inclusion criteria.²

The two papers that Mr Esen alludes to actually show that a minority of women were ambivalent, that is, not certain of their decision.^{3,4} This is consistent with previous research from our abortion service using validated questionnaires that demonstrated that in the majority of cases (70%), the pregnancy was completely unintended.^{5,6}

2. Mr Esen uses the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations on maximum waiting times to support his proposal for a 'cooling off period'. However the RCOG recommendations are meant to shorten the existing lengthy waits rather than render waits justifiable.⁷

As the RCOG 2004 guideline points out, there may be some women who require more support in decision making (e.g. psychiatric history, poor social support or evidence of coercion). Clearly this latter group of women are not appropriate for treatment at an assessment visit. However, it is highly appropriate that those women who are 'certain' should not be made to suffer any further delays or additional visits.

3. Mr Esen believes that a mandatory 'cooling off' period away from the assessment environment may minimise psychological distress and infers that this is justifiable since it is not (usually) an emergency situation. However, several published studies have reported that measures of depression and anxiety are lower after the abortion procedure compared to just prior to the procedure.^{8,9} This would suggest that it is the state of being pregnant with an unwanted pregnancy itself that is stressful and that this is reduced once the decision to terminate has been agreed and the procedure has been completed. This 'cooling off' period proposed by Esen may actually result in greater psychological distress for women, by prolonging this unnecessary wait and stressful time for those women who are certain of their decision.

4. Mr Esen fears about the long-term 'psychological' morbidity of women treated with mifepristone at a clinic assessment visit. The better quality research studies conducted that examined psychological outcome after induced abortion have shown no increased risk of mental health problems in women having an abortion.^{10,11} Furthermore, studies have shown that only a minority of women experience any lasting sadness or regret.

5. There are good clinical reasons (in addition to 'psychological' reasons) as to why women who are 'certain' of their decision to proceed with an abortion should be able to have the procedure without delay (mifepristone the same day). The wait to get an appointment with the referring doctor, then for an assessment visit and then wait for the procedure can be significant. This can result in women (who are certain of their decision) and who would wish to have an early medical abortion being too late to avail themselves of this method. The earlier a medical abortion is performed the less pain, bleeding and higher success rate.⁷ Increasing gestation is also associated with increasing complications, regardless of method.⁷ Furthermore, a common reason that deters women from choosing a medical method, is the need for repeat visits.¹² Repeat visits mean more time off work, more travel costs, and for those with existing children, more child care to organise.

6. While the decision to have an abortion is not an easy one, the notion that women cannot really be certain of this decision, seems 'paternalistic' and could serve to increase stress for women who are certain of their decision.

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Competing interests None.

J Fam Plann Reprod Health Care 2011;**37**:124.
doi:10.1136/jfprhc.2011.0050

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