GPs and the silence around abortion

It is time we lifted the silence around abortion so that we can explore evidence-based information, writes Mary Favier

IT IS JUST OVER 40 YEARS since abortion was decriminalised in England. In that time, about 130,000 Irish women have had abortions there. That's about one in 10 Irish women of childbearing age. So you're likely to know this woman – she'll be your sister, your friend, your wife, your daughter, your patient. But of course, you probably won't know she has had an abortion as she won't have told you. She is part of the silence around abortion in Ireland.

Abortion is the most common gynaecological procedure Irish women undergo. Yet we don't talk about it – both as a society and as doctors. Can you think of any other area of medicine that is not addressed in such a consistent way? Can you think of another subject where dialogue is actively discouraged; where instead disapproval and censure are promoted? We have debate and education programmes that address same sex relationships, domestic violence and minority health issues, yet one of the most common health issues facing us as a society is systematically avoided.

Another truism of abortion in Ireland, and one particularly pertinent to doctors, is the contradiction and hypocrisy of public condemnation but private acceptance. The public rejection position is promoted as a generic opinion for Irish society, while when the issue affects someone you know and care about, a pragmatic and accepting approach to abortion is taken.

Abortion is denounced as 'not for us' in Ireland, yet Irish women (and men with them as parties to the decision) are deciding to have abortions and travelling every day. Indeed, prominent politicians have publicly acknowledged that they would support a family member if she made a decision to have an abortion. They would respect her right to make that decision for herself – that it is her right to choose. Doctors often take the same position – public disapproval but private acceptance. Indeed, such is the social class gradient in Irish abortion figures that you are about 10 times more likely to have an abortion if you are well-off and well-educated than if you are not (...so you probably do know these women).

As GPs, an integral part of our work is listening to patients' stories. We hear the complex nuances of their lives, the myriad issues that impact on thoughts and behaviours. From a position of understanding context, we empathise and advocate, whether we agree or not with the patient's actions – except on the issue of abortion. Because of course, we rarely hear our patients' stories about abortion. We are ignorant of the many and complex reasons why patients choose abortion as an option when faced with an unwanted pregnancy. It is a truism of life that one generally becomes less judgemental with experience. However, our lack of 'doctor' experience of abortion means we can't learn from patient experience and inform our beliefs and attitudes (...and be less judgemental?).

Can you imagine working as a GP and never hearing about the experiences of someone with a disability or someone who has experienced adversity in life? Who has not had their attitudes challenged and changed by such patients? General practice would be a substantially less enriching experience if we did not see all sides of life and empathise with those in more challenging situations than our own.

However, more important than the loss to us as doctors is the significant disadvantage women (and men) suffer with the loss of a potentially powerful advocate on their behalf. Doctors will advocate for a patient whose experience has invoked empathy. Recent publicity around cases of foetal anomaly illustrates this point, as a majority of Irish people (and doctors) supported Miss D in travelling for an abortion because they heard her story and empathised.

Women don't tell us their stories because they don't trust us. They don't trust our response – fearing judgement and condemnation. They don't trust our confidentiality – fearing family and community may be told. They don't trust us to non-judgementally support them as we would if they were undertaking any other major life decision. Thus the majority of Irish women travelling for abortions (about 20 a day), avoid their otherwise trusted GP and at best seek help and support elsewhere, or more problematically, travel with little information and no support.

As GPs we are letting ourselves and our patients down. Our claims of holistic, patient-centred healthcare must ring a little hollow to the more than 130,000 Irish women whose

stories we've never heard. As GPs we need to find a way of addressing this gap in our care. To do this we must start to talk about the subject of abortion. We must talk to our patients who need to know who they can trust. They also need to know that only a minority of GPs will respond to their story in a judgemental fashion.

We must talk publicly about the subject, in society and in the medical community. In closed and open meetings. We need to explore our own attitudes and conflicts. We need information that's evidence-based and doesn't support any particular position. Talking about abortion is not easy. It requires courage and an acknowledgment of conflict and 'grey' areas, but sometimes being a doctor is not easy. This is the challenge and privilege patients bestow on us.

GPs are an important medical voice that must be heard in any discussion on abortion. By allowing masters of maternity hospitals be the only voice of Irish doctors in this area, we miss a vital opportunity to engage with women and the public and be the voice and advocates of all our patients, not just the rare ones that have a foetal abnormality or an uncommon medical condition.

We each have two to three patients a year who travel for an abortion. Who is their voice? Who will advocate for better provision of reproductive health services, better funding and support of non-directive counselling services or more research? If we don't acknowledge and discuss abortion we can't informatively discuss sexuality and contraception. Unless we accept the reality of Irish abortion we can't lobby for significantly improved sexuality education – something that is fundamentally needed to address our relatively high abortion rate.

When addressing the issue of abortion provision in Ireland the biggest disadvantage we face is the fact that England is so easily accessible and has acted as a safety valve for 40 years. It has allowed the 'Irish solution to an Irish problem', and the 'Irish silence'. Mary Harney stated as long ago as 1992 in an interview with the *Irish Times* that "if we were an island in the middle of the Atlantic we would have abortion provision in this country by now."

Because if you think about it – what is the realistic alternative? If abortion services were not legally available elsewhere, what would happen today in Ireland? Does anybody imagine that Irish women (6,000+ of them a year) would accept being forced to continue unwanted pregnancies? Forced to parent a child in a situation they currently think intolerable? No. What would happen is a desperate return to backstreet abortion with its associated maternal deaths and significant morbidity, *or* abortion would be quickly decriminalised.

Most Irish doctors will not remember Ireland pre-1967, when backstreet abortions were relatively common. Poor women attempted abortion at home with the potentially catastrophic consequences, while well-off women went to 'gynaecologists' and had 'cycle regulation' for 100 guineas, paid in cash.

The last Irish doctor to be prosecuted for assisting a woman with abortion – (he referred rather than provided) was Dr James Ashe. In 1944 he was imprisoned for 18 months for assisting a woman procure an abortion.

In Nicaragua, where abortion was made completely illegal for the first time in early 2007, over 80 women have already died following backstreet abortions, undertaken in desperation. Ireland, Poland, Cyprus and Malta are the only countries in the developed world that have abortion laws as restrictive as those of Nicaragua. Portugal legalised abortion in February 2007. There, maternal mortality from abortion has dropped from an average of 40 per year to nil in the year since.

As GPs we aspire to providing holistic care to our patients. At present we can't provide this to a substantial number of our female patients because we contribute to the silence in our society around abortion. Whatever your personal opinions on abortion, women must be supported in their right to decide for themselves what they will do if they have an unwanted pregnancy. This is a basic human right – the right to bodily integrity and self-determination.

The reality of Irish abortion must be recognised by doctors for what it is – a choice you may not yourself make but one we must respect other people will make, and indeed are making every day. The legalising of abortion in Ireland would mean we no longer export the problem.

Abortion provision needs to be regulated and fully funded through the general Irish health service. Doctors need to be trained and supported in abortion provision and it should be integrated into the mainstream health service. In England, close to 50% of abortions are now 'medical abortions' using mifeprostone (RU486) and misoprostol (Cytotec); 90% of abortions before nine weeks are carried out by this method.

This service is provided in general practice in many countries. Some Irish women are accessing this drug from the internet (about €70 by post compared to approximately €800 euro to travel to England or the Netherlands). The woman then has a miscarriage at home. She does this without important medical support. It is a marker of desperation.

Mifeprostone needs to be licensed by the Irish Medicines Board and provided on prescription in a primary care setting. In the US, nurses provide this care. In tandem with this, adequate contraceptive education and provision needs to be ensured for the entire population. This is the only activity for which there is robust evidence re a reduction in the abortion rate. Unfortunately, many of those who vocally oppose abortion provision in Ireland are also against the provision of comprehensive contraceptive and sexuality education and services.

Abortion is a reality that won't go away by not talking about it. As doctors we need to end our contribution to the Irish silence on abortion. Only then can we hear our patient stories and be able to provide holistic healthcare to the many, many Irish women who have had an abortion, only then can we advocate on their behalf with non-judgemental support and guidance.

In your next surgery, take a look at every tenth woman of reproductive age. Do you know if she has had an abortion? Can she tell you?

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Doctors For Choice in Ireland was formed in 2002 by a group of doctors, mainly GPs, who want to contribute to ending the silence around abortion in Ireland. We as doctors respect a woman's right to reproductive integrity. We support a woman's right to undergo abortion as a personal and individual choice. We reject the hypocrisy of exporting Irish abortions to England. We thus advocate the legalisation and regulation of abortion provision in Ireland. Our most important role is providing a public voice for the many doctors who privately support this position.