COMMENTARY

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Induced abortion and patient centred pregnancy tissue viewing in the Indian context

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Hann and Becker present an interesting documentation of the approach of abortion providers and independent abortion clinics to Patient-Centred Pregnancy Tissue Viewing (PCV) in the United States (US).[1] Most of the facilities reported providing PCV by patient request, in keeping with their patient centred mission, supporting choice, access to information and closure.

The situation in the US contrasts greatly with the situation in India and this has implications for abortion in general and PCV in particular, leading inevitably to a very different experience with abortion provision and practice. Firstly, while surgical abortions account for 70% of abortions in the US, medical abortions account for 81% of the 15.6 million abortions estimated to take place each year in India.[2] Nevertheless, substantial post-abortion tissue is generated by surgical abortion at clinics in both countries – 650,000 in the US and 2.2 million in India.[1,2] Secondly, unlike the US, India's Medical Termination of Pregnancy (MTP) is an Act of Parliament binding in all states, committing them to the provision of abortion and not allowing states to amend the MTP Act or Rules.[3] Although healthcare is otherwise a state matter, the Comprehensive Abortion Care Training and Service Delivery Guidelines prepared by the Ministry of Health and Family Welfare, Government of India, are applied nationally.[4] Thirdly, abortion provision is considered an integral part of obstetric practice, with 60.8% of Indian obstetrician gynaecologists providing abortion routinely and another 37.8% providing abortions, but not routinely.[5] Even so, India continues to be burdened with a high prevalence of unintended pregnancies and abortion, problems with access and social stigma. At the same time, the differences with the US outlined above, between techniques, uniform national legal and medical standardisation and abortion provision by most obstetricians and gynaecologists, have the effect of almost normalising abortion as part of women's healthcare, for both women and providers. PCV is not something that has been studied in India and does not seem to be a priority for patients or providers. This commentary on PCV is based on personal clinical experience of over three decades, anecdotal experience of colleagues in the public, private and NGO sectors and knowledge of the general practice of abortion provision in India.

In India, the handling and disposal of aborted tissue depends on and varies with gestational age, whether the abortion is medical or surgical, and whether the procedure is within or outside a facility approved under the MTP Act and Rules. Private and NGO facilities have to apply for and receive formal recognition to perform abortion, while all facilities in the public sector are deemed recognised. Mifepristone and misoprostol are approved for abortion up to 63 days (9 weeks) gestation. Of these early abortions, 11.5 million took place outside health facilities.[2] Some were provided by doctors in consulting room settings outside approved clinics, while the others were believed to be self-managed. The 1.2 million medical abortions performed in health facilities included first trimester abortions. For most

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abortions induced medically in the first trimester, there is little likelihood of PCV being put in place, though these women will probably see their abortus. First trimester medical abortion causes the woman to abort an ill-defined tissue mass, along with clots and bleeding. Where the medication is prescribed by a trained provider, the patient is generally prepared for the process and informed that the abortus will have no specific form or appearance. Where abortion is self-managed, as seems widely prevalent, there is no such preparation, yet, in general clinical experience, there seem to be no significant individual problems related to seeing the aborted tissue, as reported by women.

Most of the 2.2 million surgical abortions were performed in clinics in the first trimester.[2] Most were less than 12 weeks gestation, a few in the early second trimester up to 14 weeks, making surgical abortions in the second trimester a rarity. For surgical abortion, there is no accepted practice of offering PCV and requests for PCV by patients and their relatives are rare. When made, such requests are generally complied with and patients often express surprise since the tissue evacuated by vacuum aspiration bears no resemblance to what they picture early pregnancies to look like.

In India, second trimester abortions are permitted under the MTP Act up to 20 weeks gestation with terminations at later gestations permitted if the woman's life is at risk. There is a longstanding practice of inducing abortion after 20 weeks for major fetal anomalies incompatible with life, on obstetric indications, although this remains a grey legal area. Second trimester abortions are usually medical abortions using misoprostol, generally with mifepristone, performed by gynaecologists in clinics or hospitals. These result in the abortion of an intact fetus. It is uncommon for a patient or her family to request PCV in most of these cases. In the rare situation that PCV is requested, it is usually sought when a wanted pregnancy has to be terminated for medical or obstetric indications or major fetal anomalies. This seems to give the patient and her family the opportunity to grieve and for closure. The contrast with the predominant use of surgical abortion in the US is that medical abortion does not have the disadvantage of the fetus being delivered piecemeal and in parts which inevitably makes PCV a difficult and disturbing experience.

In most cases of late abortion, it is the disposal of the fetus which leads to PCV and the involvement of the patient's family and attendants. Prior to 20 weeks or a weight of 500 g, the pregnancy tissue is managed by the clinic or hospital in compliance with the Bio-Medical Waste Management Rules, which specifically address treatment and disposal of products of conception below the viability period as defined by the MTP Act, by incineration or deep burial.[6] After 20 weeks and over a weight of 500 g, when a pregnancy is terminated to save a woman's life under the MTP Act or for an obstetric indication outside the purview of the MTP Act, the responsibility for handling and disposal of the products of conception belongs to the patient's family as per their religious practices, either cremation or burial. In this situation, PCV seems the natural mode of expressing grief since these are wanted pregnancies. Where the patient does not opt for PCV, the partner and family usually do so and in rare situations may even give the fetus a name.

Interestingly, while PCV remains the exception in clinical practice of induced abortion, the patient and relatives frequently inquire about the gender of the fetus even in first trimester surgical terminations.

In conclusion, it is evident that the practice of induced abortion in India is very different from that in the US. PCV in India is not routine but is practiced selectively on a case by case basis. With abortion in India not being prominent in the public mind space, it is less contentious and controversial and treated as a routine medical procedure by patients and providers. This leads to a matter of fact approach to PCV and related issues.

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