

Opinion
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In Favor of Discussion on the Amendment of the “Abortion Prohibition Law” in Korea

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BACKGROUND

After ruling of a constitutional inconsistency with respect to the “Abortion Prohibition Law” by the Constitutional Court on April 11, 2019, there are pros and cons around the country including medical community. Legalization of induced abortion started in western countries in 1960s, spread out to the whole world, and many countries are proceeding with the relaxation of their restrictive abortion laws. In Korea, however, since enactment of the Criminal law in 1953 and “Mother and Child Health Law” in 1973, induced abortion has been permitted only when the legal conditions are met. If it is conducted out of that category, it has been defined as a crime subject to criminal punishment. In spite of several revision, there still has been constant demand of amendment for a permissible range. The United Nations (Convention on the Elimination of All Forms of Discrimination Against Women [CEDAW]) demanded Korean government a non-criminalization of induced abortion in 2018.

Recently Dr. Kim suggested medical concerns on legal artificial abortion in a neutral perspective.¹ This article presents clinical issues of induced abortion on women's health and my opinion on the reformation of the abortion laws from a medical point of view.

“INDUCED ABORTION” IS SAFER THAN CHILD-BIRTH

Induced abortion is defined as the termination of pregnancy before the time of fetal viability. It can be performed either medically or surgically. Medical indications are a fetal abnormality (e.g., anencephaly), serious maternal illness (e.g., cancer or pulmonary hypertension), and exposure to teratogens (e.g., rubella infection). Non-medical reasons, such as socio-economic grounds or maternal request account for major cause of procedures performed today.

Induced abortion managed by skilled professionals is a very safe procedure, especially in early gestation. Its associated mortality is low (< 1 death per 100,000 procedures)² and the risk of death is approximately 1/14 of that with childbirth.³ There has been an old belief that abortion may increase the future reproductive risk, but evidence demonstrated that induced abortion is not associated with subsequent increased risk of ectopic pregnancy, placenta previa, infertility, or miscarriage. For adverse effect on mental health, there was no evidence of excessive mental disorders after an induced abortion in the first trimester.⁴

MEDICAL ABORTION: A GLOBAL PHENOMENON

Medical abortion involves use of the progesterone antagonist (mifepristone) and/or prostaglandin E analogue (misoprostol). Mifepristone augments uterine contractility by reversing progesterone-induced myometrial quiescence. Misoprostol directly stimulates the myometrium. It is a very safe method frequently managed within area of telemedicine and rates of hospital admission due to any associated complications are extremely low, ranging from 0.04% to 0.3%.⁵ Long-term reproductive risk is comparable with surgical methods.

Induced abortion with medication has evolved considerably since mifepristone was first licensed in Europe in the early 1990s. It accounts for at least half of all abortions in the majority of high-income countries with liberal abortion law.⁶ This trend of preferred use as abortion induction has been spreading rapidly to developing nations with revision of restrictive abortion policy also. It reflects the women's perception of medical abortion as safe, being more natural and easily accessible method.

RISK OF “UNSAFE ABORTION”

According to the World Health Organization (WHO), every 8 minutes one woman in developing countries dies of an unsafe abortion.⁷ Unsafe abortion is defined as “a procedure for termination an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both”. Its methods include ingestion of toxic materials, direct injury to genital organs, blunt trauma to the abdomen, self-medication with a variety of drug or reliance on unqualified abortion provider. Unsafe abortion carries considerable risk and complications from it accounts for about 13% of all maternal deaths, nearly 50,000 annually. The main causes of death are hemorrhage, infection, sepsis, genital trauma, or necrotic bowel.⁸

Countries with restrictive abortion policies have much higher unsafe abortion rates and also higher maternal mortality. The average unsafe abortion rate was more than four times greater in countries with restrictive abortion policies in 2011 (26.7 per 1,000 women aged 15 to 44 years) than in countries with liberal policies (6.1 per 1,000 women). And the average maternal mortality ratio was also three times greater in countries with restrictive abortion policies in 2013 (223 maternal deaths per 100,000 live births) than in countries with liberal abortion policies (77 maternal deaths per 100,000 live births).⁹

NEED MORE DISCUSSION: PERMISSIBLE RANGE AND LIMIT OF GESTATION

In a view of permissible range, our law permitted induced abortion only in case of when physical or mental health of the mother was endangered, a pregnancy resulted from rape/incest or certain fetal abnormalities (achondroplasia, cystic fibrosis or other genetic disorders). About the limited range of “certain fetal abnormalities,” expansion is needed. Development of ultrasound resolution makes possible diagnosis of nonviable fetal abnormalities and most of them is out of permission. The mother and family who should continue pregnancy and give birth must suffer from physical, emotional and economic burden. Why should we maintain a pregnancy that ends in a death?

The other issue is about the gestational age limits for legal abortion. Pregnancy termination beyond survival limit does not meet the definition of induced abortion. With development of neonatal care, the survival limit of premature baby has been changed continuously. According to the Korean neonatal network from 2013 to 2016, the overall survival rate is 33% for 22 to 23 and 65% for 24 to 25 weeks of gestation, respectively.¹⁰ Therefore, current limit of gestation for legal abortion (within 24 weeks of gestation) should be considered for revision.

NEED MORE EDUCATION AND TRAINING FOR ABORTION

In an environment where induced abortion is prohibited as in Korea, medical education and training on this subject are usually limited. Most of the medical school curriculum did not include the formal abortion education and residents of Obstetrics and Gynecology (Ob-Gyn) could not have enough experience on abortion provision. On this issue, the American College of Obstetrician and Gynecologist supports the expansion of abortion education and recommends Ob-Gyn residency education must include access to experience with induced abortion; counseling around pregnancy options, early gestational ultrasonography, pain management for office procedures, cervical dilatation, the use of manual vacuum aspiration and out-patient medical abortion management.¹¹ With an effort to improve abortion education in medical schools and residency programs, we could prepare for future relaxation of abortion prohibition laws and provide women's reproductive health care properly.

CLOSING

Preventing unintended pregnancies mainly caused by lack of contraception remains the key strategy for reducing unsafe abortions and its associated maternal mortality. Therefore, the efforts to improve sex education and access to effective contraceptive method should come first. The relaxation of restrictive abortion law could be the next solution.

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