Is mandatory pre-procedure ultrasound viewing before termination of pregnancy ethical?

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Sally is a pregnant nineteen year old woman at eight weeks gestation. Sally is currently serving time in gaol and has arrived at the hospital gynaecology clinic with several members of Justice Health.

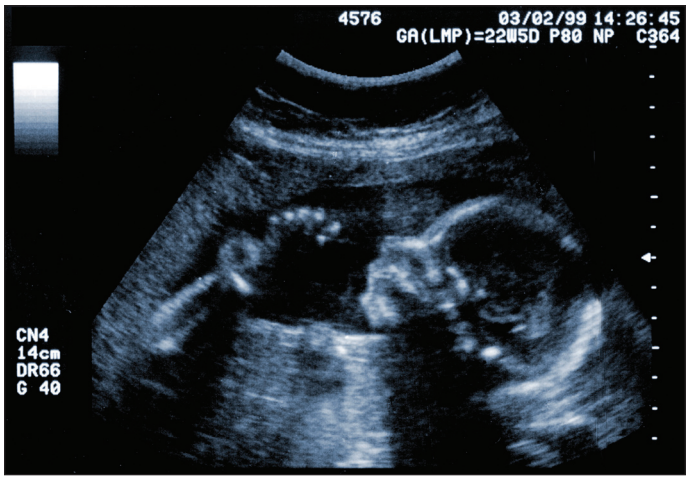
Sally is informed that the hospital can offer surgical termination of pregnancy and she is advised about the possible complications and risks of the procedure. Upon hearing these, Sally becomes tearful. The doctor advises Sally that she should not terminate the pregnancy if she has any uncertainties. Sally explains that she is concerned about the risks of the procedure, but still wants to go ahead with the termination.

As part of her initial assessment, the doctor performs an ultrasound. The consultant points out the fetal poles and heartbeat stating, "Here is the baby's heart beating." Upon hearing this, Sally begins crying and becomes withdrawn, not responding to any questions. The doctor concludes that Sally should be given more time to contemplate whether she wants to terminate this pregnancy and does not book her in for the procedure.

The above clinical example raises a number of ethical issues in regards to abortion. Can the woman make an informed choice without coercion when she is shown the ultrasound in this manner? Is the autonomy of the patient compromised when she is forced to listen or view information that is not necessary to her medical care? Is it in the patient's best interest to show her the ultrasound without first asking her preference? In this article I will focus on the medical ethical values of autonomy, informed consent and beneficence in regards to the use of pre-procedure ultrasound for abortion.

One in three Australian women will have an abortion during their lives, and most Australians do not support increasing restrictions on the availability of abortions. [1] Reasons for abortion are multi-factorial and relate to not wanting a child at the present time, maternal health, partner reasons as well as financial and housing limitations. [2] The majority of women who seek abortion were using contraception at the time they fell pregnant, highlighting the need for increased contraceptive education and options. [1] Abortion laws in New South Wales are relatively liberal, allowed on the grounds of preventing mental or physical harm to the mother, and in practice are freely available without restriction in the first trimester of pregnancy. [1] The abortion rate has changed little in Australia over the past twenty years and was 19.7 per 1,000 women in 2003, comparable to that in Sweden, New Zealand and the United States. Interestingly, countries with more liberal abortion laws such as Germany and Switzerland actually have lower abortion rates than Australia. [1]

The current Royal College of Obstetricians and Gynaecologists guidelines recommend ultrasound assessment before termination of pregnancy in order to confirm the gestational age, intrauterine location and viability of the fetus. [3] In New South Wales (NSW), the woman is not legally required to view the ultrasound during assessment, but changes are currently being proposed in parliament that would force women to view an ultrasound of their fetus before the procedure. [4] Several states in the United States, such as Oklahoma, have already established a similar law that requires every woman seeking an abortion, even if she is a victim of rape or incest, to view an image of the fetus prior to the procedure and listen to a detailed description of what can be seen. [5] Supporters claim that viewing the ultrasound is empowering, enabling the woman to make a fully informed decision.



However, it can also be argued that such government imposed restrictions are an invasion of patient autonomy, limiting a woman's access to abortions by placing limitations on how her decision can be made.

In the above clinical example, the health care team had a number of different options in managing this patient. They could have asked Sally whether or not she wished to view the ultrasound. Additionally, the doctor could have used less emotive language when describing the ultrasound or not described it at all in the presence of the patient. Since there is no current legislation in NSW requiring the woman to view the ultrasound, all of these options would have been legally sound. However, ethical issues of autonomy, informed consent and beneficence can be argued for each case.

Does the woman need to be shown the ultrasound in order to make an informed decision? Informed consent is defined as consent that is freely given without coercion from external influences such as hospital staff and family. It also requires that the patient is aware of the diagnosis, recommended treatment and significant risks associated with the procedure. [6] The woman is already well aware that she is pregnant, and therefore would satisfy the requirement that she is aware of the diagnosis without requiring to view the ultrasound. It seems unnecessary that she should require more detailed information about her pregnancy in order to make an informed choice. It can be argued that forcing the woman to view the ultrasound is a form of coercion, thereby making the patient's consent invalid. This is particularly true when the procedure is mandated by government legislation, as is the case with compulsory pre-procedure ultrasound viewing in Oklahoma, where it is unclear whether policy-makers' intentions are in the best interests of patient or in furthering political or religious agendas. Patient autonomy, the right of the patient to make informed decisions about personal matters, is clearly broached when legislation is introduced that places extraneous limitations on a woman's decision making process. Furthermore, the beneficence of such actions is questionable; whose interests are they really serving?

A Swedish study has shown that the majority of women describe feelings of relief in the short term after an abortion, a finding replicated by studies in other countries, [7,8] and two-thirds do not experience emotional distress in the long term. [9] Those who described feeling

no emotional distress had not experienced conflict of conscience or pressure during the decision making process. Those with the highest levels of post-abortion distress were more likely to have experienced coercion during the decision making process. [9] The core medical value of beneficence requires medical practitioners to take actions that serve in the best interests of their patient. If the best psychological outcome of abortion is achieved by limiting coercion, a woman's choice should be free from restrictions and she should be able to choose whether or not she wishes to view the ultrasound as part of her decision making process. What benefit does the patient gain by increasing distress related to the procedure by not providing her with this choice?

There are few studies available that have examined women's perceptions about pre-procedure ultrasound before abortion. A recent Canadian study analysed the experiences of 350 women attending an abortion clinic who were given a choice of viewing the ultrasound before abortion. Seventy three percent of women chose to view the ultrasound and of these, 86% found it to be a positive experience. None of the women in this study changed their mind about having an abortion after viewing the ultrasound. [10] A French study found the opposite to be true, with most women requesting not to see the ultrasound. [11] This highlights that all or nothing measures are not the best option, as women's preference for ultrasound is not always predictable. The current guidelines state that "When ultrasound scanning is undertaken, it should be in a setting and manner sensitive to the woman's situation," supporting the notion that a woman's wishes should be taken into account when the ultrasound is performed. [3]

Sally is clearly in a complex and difficult life situation, facing many social and psychological issues relating to her incarceration and unwanted pregnancy. Unfortunately, Sally was not given a choice in viewing the ultrasound during assessment, and became distressed upon seeing the fetus. This situation can be generalised to all women seeking abortion in NSW, where there is no legislation to force a woman to view the ultrasound, but it is not compulsory for women to be asked their preference on the matter either. From the viewpoint of medical ethics, the patient seeking an abortion should have the right to autonomy and to provide informed consent for the procedure. In light of the evidence, I believe that informed consent can only be valid if the woman has been given a choice before the ultrasound is shown. Some women may prefer to view the ultrasound as part of their decision making process while others do not want the added distress. If she is forced to view the ultrasound, this can be interpreted as a form of coercion, whether intentional or not. The beneficence of this act is also questionable, as it is certainly not in the best interests of the woman to place restrictions on how she can make her decision.

Clinical decisions are sound when based on current, good quality evidence and more research needs to be performed on the psychological impact of pre-procedure ultrasound before one can definitively argue whether viewing the ultrasound is beneficial for the patient. Based on current evidence, the option that best promotes patient autonomy and beneficence appears to be asking the woman before performing the ultrasound whether or not she would like to view it. Not viewing the ultrasound still fulfils the conditions of informed consent, as described above. It is not the viewing of the ultrasound which is unethical but the fact that the woman has no say in the matter. As such, policy directives in the future should be clearer about how ultrasound is used during the assessment of termination of pregnancy and aim to promote beneficence while respecting patient autonomy.

Conflict of interest

None declared.

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