

Violence and abortions: What's a doctor to do?

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Before 1989, in hospitals across Canada, groups of 3 physicians would meet once a week to read and consider stories of failure and remorse. No legal abortion could be performed in this country without such a committee's approval. For years I spent Friday mornings with a gynecologist and a psychiatrist in a small room at our downtown Toronto hospital, reviewing pleas for care from women whose histories were marked by sadness more than by irresponsibility.

In 1988 the Supreme Court of Canada struck down the existing abortion law (section 287 of the Criminal Code) as unconstitutional. A woman who wishes to terminate a pregnancy is no longer required to obtain a committee's opinion that continuing the pregnancy would endanger her health or life. A paradoxical effect of the decriminalization of abortion is that there is no requirement for anyone to bear witness, as William Fisher and colleagues do in a study published in this issue¹ (see page 637), to stories of lives disrupted by violence. Although their findings are neither new nor unique, they merit reiteration. Of 1127 women who completed a 65-item self-report questionnaire at a hospital abortion service in London, Ont., 68% were undergoing a first abortion, 23% a second, and 9% a third or subsequent abortion. Overall, 20% had experienced physical abuse by a male partner, and 27% had a history of sexual abuse. The vast majority (90%) had used contraception sometime in their lives, and, of note, at the time of the current conception 60% were using condoms and 40% were using an oral contraceptive. Compared with women seeking a first abortion, repeat abortion seekers were older, and were more likely to have given birth and to have had a sexually transmitted disease in the past. They had more limited personal and financial resources and were more likely to have been victimized at some time in their lives.

This study reinforces the consistent findings of 2 decades of international research. A recently published British survey found that among women seeking abortion, 35.1% had experienced intimate partner abuse at some time and 6.6% lived in fear. In the British sample, approximately 2% of therapeutic abortion requests may have followed forced intercourse.² US data show that 40% of women who seek abortions report abuse and that these women are likely to cite relationship problems as the reason for requesting pregnancy termination.³

What is the nature of the association between victimization and unplanned pregnancy? Do women with a history

of violence somehow become less responsible users of contraception, or do they become more likely to opt to protect future children from living in the disrupted or violent environments that they themselves face? Fisher and colleagues show that, in comparison with women seeking a first abortion, those requesting second or third procedures are more likely to be using contraception. They are not psychologically maladjusted and are not using therapeutic abortion as "birth control." However, many are from challenging and disrupted family circumstances. US research has shown that 31% of women seeking an abortion have experienced physical or sexual abuse at some time in their lives and, of these, more than half have witnessed domestic violence as children.⁴ The authors of this research suggest that a history of victimization should be considered a risk factor for being abused when pregnant and imply that previous abuse has a demoralizing effect that increases susceptibility to further violence. There may also be some truth to the idea that women "trapped" in more traditional, passive feminine roles are less able to assert control over themselves and their lives. The current study by Fisher and colleagues links repeated abortions to a tendency to miss taking daily birth control pills, and also to an inability to extricate oneself from harm. Perhaps, given this, we should understand both a mother's desire not to saddle her child with the risks she faces and the decisive behaviour that the act of seeking a termination implies.

Despite the comparatively greater history of victimization characteristic of women who request repeat terminations, the prevalence of violence against women is, in general, so great that differentiating rates of abuse among abortion seekers may be irrelevant. A British study found that the prevalence of abuse among women attending a family planning clinic was 33%.⁵ Women who were employed full time reported the highest rates, suggesting that victimization may be blind to income. In a general cross-sectional survey of American women, 55% had experienced some type of intimate partner violence and three-quarters of these reported physical or sexual abuse.⁶ An Australian study showed that 25% of women had been victims of physical or emotional abuse by their partners in the preceding year and that 28% had been sexually abused in childhood. Almost three-quarters had not disclosed their history to a physician, mostly because they had never been asked.⁷ A study of the prevalence of violence in the United Kingdom found that 41% of women surveyed had experienced

violence, while the incidence within the preceding year was 17%. The risk of violence more than doubled during pregnancy. Eighty percent of those surveyed believed that physicians should screen for exposure to violence.⁸

All of these findings have numerous implications for medical practice. Among these is the need to understand that women often seek abortions as a last resort, when personal circumstances preclude safe and positive parenting. We also need to appreciate that the *efficacy* and *effectiveness* of the birth control pill differ from one another rather dramatically. The data gathered by Fisher and colleagues preclude calculating an effectiveness rate for oral contraceptives, as we do not know how many women in the catchment area studied had no pill failures. It is striking, however, that almost half of those seeking therapeutic abortions were current birth control pill users who, for whatever reason, missed taking a pill or two before conceiving.

Finally, Fisher and colleagues recommend screening all women seeking abortions for a history of abuse. Given the prevalence of victimization among women in general, I would suggest that physicians, particularly those in family practice, emergency medicine and obstetrics and gynecology, screen *all* women for what could be defined as an epidemic. Whether such screening would change outcomes depends on the outcomes chosen. A study conducted in the UK found that women tended to favour screening, although most of their health care providers opposed it. Using outcome measures of decreased exposure to violence, improved quality of life and potential for harm, the authors concluded that, at present, screening for violence could not be justified.⁹ Although it may be true that trying to change a social problem and decrease exposure to violence by means of individual interventions in a physician's office is unrealistic, it is also true that the reluctance of caregivers to ask and hear about violence perpetuates its invisibility. Per-

haps a more appropriate outcome measure to use in assessing the merits of screening for violence against women would be a better understanding of the symptoms with which patients present.

Fisher and colleagues should be applauded for listening to the stories of women requesting abortions. Their careful research identifies an increased level of exposure to violence among women seeking repeat abortions and reminds us of the extent of victimization among our female patients.

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