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What is pregnancy tissue viewing and why is it client-centered care?

The Later Abortion Initiative acknowledges and thanks Lena R. Hann, PhD, MPH, CHES, Assistant Professor, Public Health Program, Augustana College, for her leadership of this work and her insightful review of and feedback on this fact sheet.

Summary

Patient-centered pregnancy tissue viewing (PCV) is a client-centered approach to reproductive health care that gives clients the option to view their products of conception after pregnancy termination. Historically, PCV has been offered inconsistently in the United States and therefore it has not been studied deeply; however, the studies that have explored PCV in the United States and Canada found that clients appreciate the option and largely do not feel that it makes their decision more difficult.[1,2] Providers report feeling mostly positive about the experience when the pregnancy is in the first trimester, though they report barriers to facilitation including concern and discomfort about showing the client recognizable fetal parts if the pregnancy is at a later gestation,[2,3] and a lack of accurate training materials.[3] PCV benefits the client, who may have their questions answered and obtain a sense of closure after their abortion, and the provider, who has the chance to practice evidence-based care and strengthen their commitment to providing abortion care.[3] Abortion providers who hope to enhance client-centered care in their practices should consider providing a PCV option to their clients.

What is PCV?

The result of every pregnancy termination is post-abortion tissue, which is either expelled from the uterus during a medication abortion or surgically removed. Post-abortion tissue is dealt with differently depending on the facility, the gestational age (GA) of the pregnancy, and the wishes of the client. PCV is an option that allows the client to look at and sometimes touch their products of conception after a pregnancy termination.

The importance of PCV as a facet of client-centered care

Patient-centered care, also called client-centered care, is an essential tenet of high-quality health care by which clients are actively involved in their own treatment and are respected, informed, and listened to.[4] PCV advances the principles of client-centered care by allowing abortion clients to remain involved in and informed about their care in an evidence-based manner.[5] Pro-choice discourse has long focused on the rights of the pregnant person in order to counter the anti-abortion rhetoric's singular focus on the fetus; however, pro-choice advocates have recently posed a framework for discussing abortion that acknowledges both the pregnant person's right to choose and the reality of the demise of the fetus that can cause feelings of guilt and sadness and sometimes represents the loss of a wanted pregnancy.[5] PCV honors this multifaceted approach to abortion care by normalizing the client's experience, providing them with evidence-based information, reducing feelings of guilt and shame, and creating space for grieving and closure.

PCV in the United States

In the United States, 61% of abortions are performed surgically, resulting in about 526,000 post-abortion tissues each year.[6] Despite the prevalence of surgical abortion, PCV is offered on an inconsistent basis in abortion facilities in the United States. A study by Hann and Becker surveyed 22 Abortion Care Network (ACN)-affiliated clinics and found that 73% provided fetal tissue viewing, 23% did not, and one performed only medication abortions and did not handle fetal tissue in-house.[3] Even among facilities that provided PCV, the practice itself varied by location, with most clinics (75%) allowing PCV by client request, and a smaller number providing the option verbally during pre-procedure counselling or in writing via intake paperwork.[3] PCV may also be facilitated differently depending on the constraints of the clinic space, the availability of staff, the gestational age of the pregnancy, and the type of abortion performed; viewing may occur in the procedure room or a private room, and may be facilitated immediately after the procedure of after some time has passed if the client was sedated.[3]

Key aspects of PCV facilitation

Clinical policies on PCV facilitation are similarly varied. In the Hann & Becker study, 56% of clinics did not have a specific policy in place for facilitating PCV even though it was available to clients if they requested it.[3] Sixty-three percent of these clinics were located in states that mandated fetal development education for the client but reported that most state-presented materials were inaccurate.[3] One-third of clinics provided additional education or counselling for clients regarding what to expect during the viewing, including verbal descriptions of fetal tissue or drawings or photographs of fetal development via the Fetal Development Guides for Abortion Providers.[7,8] The latter option is especially important as anti-abortion advocates often display developmentally-inaccurate photos of fetal tissue as a dissuasion tactic—the resources presented in the clinic may be the only evidence-based depiction of fetal tissue ever seen by the client.

The specifics of tissue display also vary between clinics—providers at some facilities present the tissue floating in water in a clear dish that is lit from underneath, while others show only the isolated pregnancy tissue to the client.[3] Some clinicians opt to stand back or step out of the room and allow the client to look at the tissue and ask questions as needed, while others are more involved and point out specific features of the tissue. For clients having second-trimester abortion, more education is often provided to prepare the client to see potentially recognizable fetal parts.[3]

PCV navigation for providers

Providers who facilitate PCV may have very different experiences and must consider the balance between client needs and their own comfort. In Hann and Becker's study, half of the clinic administrators expressed experiencing barriers to providing PCV, including concern about client reactions, a paucity of training resources, staff discomfort, and staff members not understanding clients' rationale for requesting to view their tissue.[3] To combat these challenges, the majority (63%) of clinics that offered PCV provided specific staff training on fetal development and how to discuss it with clients, and the vast majority of abortion facilities reported having support systems in place for staff who felt uncomfortable or ambivalent about PCV, including opting out of tissue work, discussing their qualms with management staff, or receiving additional training.[3] Encouragingly, most clinic administrators reported that their staff felt positive about providing PCV; in one Canadian study, all of the staff members who provided PCV reported feeling positive about the experience.[2] Further, almost one-third of clinic administrators indicated that offering PCV benefited staff by strengthening their commitment to abortion work and allowing them to further empathize with clients.[3]

Frequently asked questions

Is PCV handled differently for later-gestation pregnancies or in cases of fetal anomaly?

Generally, providers will spend more time and resources to prepare a client for PCV if their abortion is occurring at a later gestational age, as there is a higher likelihood of seeing recognizable fetal parts.[3] Further accommodations such as extended viewing time in a private room, swaddle for viewing, ink footprints, or memorial certificates may be made for clients with wanted pregnancies whose abortions involve fetal anomalies.[3,9] One provider reported that in these cases, she shows the client that she is willing to touch the fetus without gloves on and encourages them to do the same.[3] Studies estimate that roughly half of clients terminating for fetal anomaly choose to view the fetus when the option is offered, although this number varies greatly by the amount of clinical support offered to clients throughout the abortion and PCV processes.[1] Clients in one study that provided post-viewing counseling and support by a multidisciplinary obstetric team chose to view their fetus 97% of the time, indicating that the provision of additional support services may increase clients' comfort with PCV in cases of fetal anomaly.[1]

What are the common misconceptions about fetal tissue?

Much of the misinformation surrounding fetal tissue results from anti-abortion advocates showing medically inaccurate and heavily doctored fetal images to dissuade pregnant people from seeking abortions. In reality, the appearance of the fetal tissue resulting from an abortion depends greatly on the gestational age of the pregnancy, the type of abortion procedure used, and the presence or absence of fetal congenital anomalies; most post-abortion tissue will not look like the recognizable, intact fetus presented by abortion opponents.[3] PCV provides a unique opportunity for clients to correct their perception of the appearance of post-abortion fetal tissue and may help destigmatize the process for clients.[3]

What does PCV look like in other countries?

Abortion care differs greatly between countries. In India, unlike in the United States, abortion is considered a normal part of obstetric care, with almost 60% of OB/GYNs providing abortions routinely.[10] The majority (81%) of these abortions are performed using medication rather than surgery, meaning that clients often may informally view their products of conception without staff support; however, due to the overall large number of abortions performed in India (15.6 million) each year, there are still roughly 2.2 million samples of fetal tissue generated annually.[10] PCV is not regularly offered or requested, but requests made by the client are generally honored.[6] If the pregnancy is terminated after 20 weeks' GA, PCV occurs typically as the fetal tissue is handled and disposed of by the family in accordance with their religious practices.[10]

As of 2020, abortion before 20 weeks' GA is available without restriction in New Zealand.[11] Abortion rates in New Zealand are higher among the Māori people than their Asian, Pacific, and Caucasian counterparts; however, abortion remains a historically stigmatized and denounced practice among this group as reproduction is a revered and celebrated process.[12] Le Grice and Braun interviewed a diverse sample of Māori people in 2017 and found that alongside themes of protecting new life and bodily autonomy, many of the interviewees emphasized a break in spiritual connection to ancestral and family land as a deterrent to abortion. One Māori community health worker described expanding a Māori practice called *whenua ki te whenua*, whereby the placenta is buried on ancestral land, to include burying of aborted pregnancy tissue.[12] The Aotearoa New Zealand Standards of Care for those requesting abortion suggest providing information for Māori clients wishing to *whenua ki te whenua* and having procedures in place for conducting *whenua ki te whenua* for those who are unable to do so themselves.[13]

One study in the Netherlands interviewed 89 couples undergoing a second- or third-trimester termination of pregnancy (TOP) with fetal anomaly at a clinic that provided extensive practical and psychosocial support.[14] The authors found that the vast majority of parents opted to touch the fetus, and the majority also named and photographed the fetus.[14] A provider who worked at a different facility in the Netherlands reported that she regularly asked clients if they wanted to see the products of conception if she felt it would help soothe conflicting feelings, but that this created problems as she had to refuse clients who wanted to take the fetal tissue home for burial.[15] This same provider, who later worked in South Africa, reported that she had a client request PCV only once in her 20 years there and that after discussing the client's feelings and what she would see, the provider honored her request.[15] It is important to note that, given the understudied nature of this topic, there could be several reasons for the lack of requests to view. It could be due to lack of knowledge or comfort asking about PCV options, and may not necessarily be due only to a lack of desire from clients.

PCV is an essential tenet of client-centered abortion care that can destigmatize abortion, provide feelings of relief and closure for clients, and assist with the grieving process. Given the client-centered nature of PCV, providers should explore how PCV could be tailored to fit the needs of clinics, clients, and the broader cultural context.

We value your insight and feedback—if you are a provider who offers PCV and/or similar practices in your clinic, or if you would like to integrate PCV into your practice, please reach out to us at lai@ibisreproductivehealth.org. Some additional resources include the Patient-Centered Pregnancy Tissue Viewing Strategies and Best Practices: A Guide for Independent Abortion Providers (2020) and a Later Abortion Network presentation by author Lena R. Hann, PhD, MPH, CHES.

References

1. Sloan EP, Kirsh S, Mowbray M. Viewing the fetus following termination of pregnancy for fetal anomaly. *Journal of Obstetric, Gynecologic & Neonatal Nursing*. 2008;37(4):395-404. doi:10.1111/j.1552-6909.2008.00260.x
2. Wiebe ER, Adams LC. Women's experience of viewing the products of conception after an abortion. *Contraception*. 2009;80:575-577. doi:10.1016/j.contraception.2009.07.005
3. Hann LR, Becker A. The option to look: patient-centred pregnancy tissue viewing at independent abortion clinics in the United States. *Sexual and Reproductive Health Matters*. 2020;28(1):1730122. doi:10.1080/26410397.2020.1730122
4. Epstein RM, Street RLJr. The values and value of patient-centered care. *Annals of Family Medicine*. 2011;9(2).
5. Hassinger JA. Abortion providers help their clients and themselves when they talk about the fetus. *Sexual and Reproductive Health Matters*. 2020;28(1). doi:10.1080/26410397.2020.1735240
6. *Induced abortion in the United States*. Guttmacher Institute; 2019. Accessed January 7, 2021. https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf
7. Derenge JN. *A guide to fetal development for abortion providers: the first trimester. 5 to 14 weeks, LMP.*; 1993.
8. Derenge JN. *A guide to fetal development for abortion providers: the second trimester. 15 to 34 weeks, LMP*; 1993.
9. Mitchell LM. "Time with babe": seeing fetal remains after pregnancy termination for impairment. *Medical Anthropology Quarterly*. 2016;30(2):168-185. doi:https://doi.org/10.1111/maq.12173
10. Sheriar N. Induced abortion and patient centred pregnancy tissue viewing in the Indian context. *Sexual and Reproductive Health Matters*. 2020;28(1). doi:10.1080/26410397.2020.1737494
11. *Abortion Legislation Act 2020 No 6, Public Act Contents – New Zealand Legislation.*; 2020.
12. Le Grice JS, Braun V. Indigenous (Māori) perspectives on abortion in New Zealand. *Feminism and Psychology*. 2017;27(2):144-162. doi:10.1177/0959353517701491
13. Abortion Supervisory Committee. Standards of care for women requesting abortion in Aotearoa New Zealand. 2018;(January).
14. Geerinck-Vercammen CR, Kanhai HHH. Coping with termination of pregnancy for fetal abnormality in a supportive environment. *Prenatal Diagnosis*. 2003;23(7):543-548. doi:10.1002/pd.636
15. Alblas M. A practitioner's experiences from the Netherlands and South Africa. *Sexual and Reproductive Health Matters*. 2020;28(1). doi:10.1080/26410397.2020.1735241

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