Letters to the Editor

Mifepristone (RU486) and voluntary termination of pregnancy: enigmatic variations* or anecdotal religion-based attitudes?

Dear Sir,

Mifepristone (RU486), the first clinically efficient antiprogestrone (Herrmann et al., 1982; Baulieu, 1989), has made the concept of medical abortion a reality (Ulmann et al., 1992). Here we only refer to the voluntary termination of early pregnancy, which sustains so much controversy in the vast and evolving domain of women’s reproductive health (Van Look, 2000). Legally on the market for years in France, Britain and Sweden and massively produced and used in China, the compound has become available to women in need in Israel, Tunisia and Germany, where what might be called religion-based attitudes have been observed.

Of course the biology of pregnancy is quasi-identical for women all over the world, and its termination with an antagonist to the hormone of pregnancy, progesterone, should also be the same everywhere. But the use of this antagonist, mifepristone (RU486), does not mean the same thing to everybody everywhere.

In Israel, mifepristone was approved and has been sold to the public since September 1999. Remarkably, its reception by religious fundamentalist Jews was not hostile and even the opposite: on the grounds that under Jewish law, although the fetus is considered to be a potential person from the moment of conception, before 40 days of gestation it is ‘mayim b’alma’ (mere water) according to the Talmud (Eisenberg, 1998). Although disagreement does exist, many Jewish scholars believe that prior to 40 days one cannot ‘wound’ or ‘murder’ that which does not have the status of an existing person. Since fear of injury to the mother by abortion within these 40 days still remains an objection by Jewish law, a safe medical termination with mifepristone, which is easy to perform and efficient earlier than with an instrumental technique, may thus be preferable. This should be appreciated when attempting to avoid real or foreseen obstacles to the introduction of new forms of contraception or abortion. This argument of a spiritual nature may be important for confronting other objections: apparently some Israeli physicians are not over-enthusiastic about a method which is less financially rewarding than an instrumental intervention.

Clearly, the strong opposition from fundamentalist Christian groups should not automatically be extended to another (monotheist) religion. This can also be deduced from the Tunisian experience. In Tunisia, trials have been conducted by the Population Council and the Tunisian ‘Planning familial’ and confirm the Israeli case with respect to the opinion of religious Muslims. Tunisian trials have involved Muslim women practising the five daily prayers and regularly following Ramadan, sometimes even wearing a tchador during the consultations. They found the procedure more acceptable because it is early and ‘natural’ (non instrumental), and imams cite a ‘hadith’ also describing the first 40 days of embryogenesis as that preceding ‘unity’ (‘God’s breath’ being insufflated on ~120th day) (Banwell and Paxman, 1992). One unexpected favourable argument was provided by seven young single women (20–29 years old) who chose mifepristone which, not involving instrumental intrusion, would ‘protect their virginity’ in conformity with their fiancés’ indication that they had only had a ‘superficial’ sexual relationship, and, of course, this was eventually also approved by their family. The preservation of future fertility (unpublished observations in cases reported in Ulmann et al., 1992) is one more favourable reason for accepting mifepristone.

In Europe, mifepristone has recently been approved for use in a further eight countries, including Germany. In Germany, opposition came not directly from religious groups but from the German Society for Gynecology and Obstetrics (DGGG). This association reacted rapidly to the application for mifepristone, presented by the Bounder Institut für Arzneimittel und Medizin Products, and insisted on the ‘considerable mental duress for women, the (frequently life long) psychosomatic consequences’ caused by an abortion. The appointed DGGG committee recommended certain diagnosis of intact intrauterine pregnancy using vaginal sonographic proof of embryonic cardiac activity (German Society for Gynecology and Obstetrics, 1999), which is not possible before day 38–42 after the last menstrual period at the earliest. They tried to convince the Health Authorities and the public that mifepristone, which may be used to interrupt pregnancy very early—a physiologically and psychologically beneficial procedure— should be only used after the 42nd day because earlier intervention could constitute abortion ‘of an unfit object’ which would have been spontaneously eliminated anyway in up to 30% of cases (Blanch et al., 1998). The delay would avoid future remorse for these women, and thus it would be better to wait (and possibly suffer more from use of an instrumental method).

One of the rare cases when an appropriate medical treatment becomes improper because of its very early application! The story did end with the regular registration of mifepristone in Germany. At last.

The next ‘interesting’ case will be the USA, where the majority of religiously oriented professionals (pharmacists) supporting the right to refuse to dispense abortifacients, indicated abortion should remain a legal option including that using RU486 (Gianetti, 1996). The Food and Drug Administration has approved the drug (Time Magazine, 2000), a decision that generated debate between the candidates in the Presidential election (The New York Times, 2000).

*The play Enigmatic variations by Eric-Emmanuel Schmitt has been performed in several countries. It is based on the symphonic ‘Enigma variations’ by Edward Elgar.

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How interesting the diversity of confrontations of human beings with a drug. It is not unexpected that pregnancy interruption generates behavioural variations which are, after all, not so enigmatic...

References

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