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ORIGINAL ARTICLE

From attempted abortion to pregnancy continuation: ethical and clinical challenges in comprehensive hospital-based gestational support

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Abstract

Argentine legislation on voluntary termination of pregnancy guarantees access to abortion within a framework that requires the provision of accurate, accessible, and non-coercive information while ensuring respect for the autonomy of the pregnant person. However, there is no evidence regarding the impact that comprehensive, non-directive counseling may have on reconsideration of an initial decision to terminate a pregnancy. In this context, the EVA Project (Supported Vulnerable Pregnancy) was developed at a university hospital in Buenos Aires with the objective of providing multidisciplinary support to women seeking pregnancy termination, prioritizing active listening, emotional support, and the delivery of comprehensive information. To illustrate the complexity of care in initiatives of this kind, we present the case of a woman who attempted to terminate her pregnancy at 11 weeks' gestation using misoprostol. When the expected therapeutic response did not occur, she presented to the hospital intending to continue the procedure she had initiated. After voluntarily receiving support from the EVA Project team, she freely chose to continue the pregnancy. Subsequent evaluation revealed amniotic band syndrome, for which fetoscopic release was performed with favorable results, allowing the pregnancy to progress without complications. Although based on a limited number of cases, this initial experience suggests that implementing a hospital-based, multidisciplinary support model that respects autonomy, promotes informed and non-directive decision-making, and provides emotional support for women experiencing vulnerable pregnancies, regardless of pregnancy outcome, is feasible. Further studies are needed to assess its long-term impact on decision-making processes and maternal-fetal outcomes.

Keywords: Termination of pregnancy, vulnerable pregnancy, abortion legislation, clinical case.

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Introduction

Legislation regulating the voluntary interruption of pregnancy has been progressively adopted in various Western countries [1-4]. Argentina recently joined this trend with the entry into force of its own regulatory framework [5]. Argentina's Law on Voluntary Interruption of Pregnancy (Spanish: Interrupción Voluntaria del Embarazo, IVE), Law No. 27,610, enacted on December 30, 2020, and promulgated on January 14, 2021, guarantees the right to abortion in two situations: (1) up to and including 14 weeks' gestation, based solely on the autonomous decision of the pregnant person, without the need to invoke specific grounds; and (2) without gestational limits, when the pregnancy poses a danger to the life or health of the pregnant person, or when it is the result of rape.

The national regulation also establishes that healthcare professionals must provide truthful, accessible, and non-coercive information while respecting the autonomy of the person seeking care. This includes the possibility of offering information about alternatives to pregnancy interruption, provided that doing so does not constitute undue persuasion or impede access to a legally recognized right. The law also allows for individual conscientious objection by healthcare professionals.

Whether providing pregnant women with complete and objective information, within a framework that respects their autonomy, fosters reconsideration of their initial decision and ultimately leads to continuation of the pregnancy remains largely unexplored.

In this context, the EVA Project (Supported Vulnerable Pregnancy) was launched in May 2024 at a university hospital in Buenos Aires, Argentina. This center has 257 beds, 2,240 annual births, a high-complexity neonatal unit, and a pediatric surgery service with experience in intrauterine procedures [6].
The EVA Project aims to offer comprehensive support to patients requesting pregnancy interruption by promoting active listening, complete information, and personalized guidance. The program includes support during pregnancy for those who choose to continue the pregnancy, as well as post-abortion support for those who decide to interrupt it.

The aim of this article is to analyze a complex clinical case, presented with the patient's consent, developed within the framework of the EVA Project in order to reflect on the comprehensive support provided to the pregnant person and the fetus in the context of an initial decision to interrupt the pregnancy.

Clinical case

Débora (a fictitious name), aged 22, attempted to interrupt her pregnancy at 11 weeks' gestation through the sublingual administration of misoprostol (four 200 µg tablets). Due to the lack of the expected therapeutic response to misoprostol [7,8], she attended a university hospital in Buenos Aires seeking to continue the process she had initiated. In addition to the initial assessment by the obstetric emergency team, she was voluntarily offered support from healthcare professionals trained in caring for women facing the dilemma of considering pregnancy interruption. Upon accepting this offer, she received counseling from the EVA Project's professional team. After several interviews, Débora decided to continue the pregnancy.

At that time, she was carrying a singleton spontaneous pregnancy at 14 weeks' gestation. She was a primigravida (G1P0), with no relevant personal or obstetric history. Combined screening for chromosomal abnormalities and preeclampsia indicated a low risk. During an ultrasound examination at 16.2 weeks' gestation, an image compatible with an amniotic band was identified at the level of the right ankle, in relation to the umbilical cord. The right foot presented mild edema, with preserved mobility and arterial perfusion. Follow-up imaging of the umbilical cord suggested partial compromise along the trajectory of the band, a finding confirmed by fetal MRI, which also demonstrated the viability of the anatomical structures. The condition was classified as Stage II according to Hüsler's classification [9].

The patient was informed that amniotic band syndrome is a congenital malformation in which constriction rings encircle fetal limbs, causing progressive compression that may lead to edema, deterioration of blood flow, and eventually partial or total amputation of the affected segment [10]. She was informed of the possibility of performing fetoscopic release of the amniotic band to restore distal perfusion. The patient and

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her partner provided informed consent, and at 20.2 weeks' gestation, the procedure was performed, with favorable fetal evolution and preservation of distal blood flow on subsequent ultrasound examinations. Thereafter, the pregnancy progressed without complications.

Discussion

Since abortion began to be legally regulated in various Western countries, several initiatives have been developed to optimize maternal health and perinatal outcomes within the current legal framework [11-13]. With the same purpose, and in the context of Argentina's recent legislation on voluntary termination of pregnancy, the EVA Project was developed in a high-complexity university hospital in Buenos Aires.

The EVA Project represents an innovative initiative of profound health, ethical, and social value. Its importance lies in offering an institutional model of comprehensive support to women experiencing a vulnerable pregnancy through active listening, emotional support, and the provision of truthful and up-to-date information that enables them to make free and fully informed decisions. Unlike other experiences promoted by civil organizations, the EVA Project is implemented within the care structure of a university hospital under validated health and ethical protocols, becoming the first program of its kind in Latin America. This institutional framework ensures transparency, public oversight, and high-quality care grounded in bioethical principles such as autonomy, beneficence, and respect for the dignity of pregnant persons.

The EVA Project fits coherently within the regulatory framework established by Law No. 27,610, as it promotes the full exercise of the rights recognized by this legislation: access to information, comprehensive care, and respect for each patient's free and informed decision (Arts. 2, 3, and 6). Its objective is not to influence the choice to continue or interrupt a pregnancy, but to accompany and support the process of personal deliberation, guaranteeing decisional autonomy and the protection of comprehensive health, in accordance with the law. Implemented within a hospital institution subject to ethics committee oversight, internal audits, and standards of good clinical practice, the program strengthens the effective fulfillment of reproductive rights recognized by national legislation and by international human rights treaties with constitutional status (Art. 75, para. 22, National Constitution).

From a psychological and humanistic perspective, the EVA Project offers a space for empathetic accompaniment and emotional support, where women can express doubts, fears, and experiences without being judged, facilitating conscious decision-making and subsequent emotional processing. This support — whether during pregnancy for those who continue it or during the post-abortion process for those who interrupt it — constitutes a form of comprehensive care that reduces anxiety, strengthens self-esteem, and promotes psychological well-being. Active listening and genuine respect for patients' self-determination embody the principle that truth and information foster autonomy, enabling fully informed decisions. In this sense, the EVA Project not only reflects the letter and spirit of Law No. 27,610, but also translates them into daily clinical practice, offering a respectful, constitutional, and humanized model of care that dignifies both women and the healthcare professionals who care for them.

The EVA Project was developed in several stages. The first consisted of training a group of hospital professionals. The training encompassed clinical, ethical, and legal aspects of maternal and fetal health, safe pregnancy management protocols, communication skills, and strategies for psychosocial support. This training was delivered through an in-person session with the participation of seven experts and nine hospital professionals who initiated the project, complemented by subsequent virtual guidance.

Once the protocol was approved by the Care Ethics Committee and the General Directorate, it was progressively disseminated throughout the hospital's various departments, beginning with those most directly involved (Obstetrics, Gynecology, Fetal Medicine, and Emergency Medicine).

Shortly thereafter, the first cases were presented. The very first, in May 2024, involved a patient who, after receiving guidance, did not change her decision and chose to interrupt her pregnancy. Since then and up to the present, 21 cases have been recorded. Among them was Débora, who sought to complete the interruption she had previously attempted with medication after not obtaining the expected result. In her case, comprehensive support — based on active listening, an empathetic and nonjudgmental approach, recog-

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nition of her distress, and a commitment to providing continuous support — created a context in which she could consider continuing the pregnancy. During her deliberative process, ultrasound constituted one of the elements that contributed to her reflection. Gradually, Débora consolidated her decision to continue the pregnancy.

Débora's process was not easy. As described in several international publications, feelings of guilt and the need to learn to forgive oneself emerged [14-17], while she began to establish an emotional bond with her baby. At this stage, support from the EVA team became a fundamental emotional anchor. The challenge lay not only in the decision to continue the pregnancy but also in facing possible complications resulting from the previous use of misoprostol to interrupt the pregnancy. Intrauterine surgery made it possible to overcome the medical complications that arose.

In a broader context, how might Débora's case be understood if it were to unfold within a different cultural and legal context? In several European countries, where respect for the autonomy of the pregnant woman is a central guiding principle, it is reasonable to assume that Débora, given her specific pregnancy and health circumstances, would have access to options comparable to those described here, allowing her to freely choose either to continue or to terminate the pregnancy.

By contrast, in more legally restrictive settings, such as those described by Arey et al. [18] in their analysis of the regulatory framework in the state of Texas, regulatory constraints have been shown to influence clinical practice and decision-making processes. Such contexts, in turn, invite broader reflection on the ways in which legal and cultural frameworks not only delineate available options but also shape the models of accompaniment, ethical deliberation, and comprehensive care that can be developed within institutional settings. From this perspective, the present case highlights the complexity of the relationship among legislation, autonomy, and clinical care, resisting overly simplistic interpretations.

Conclusion

Bautista was born at 37 weeks' gestation by elective cesarean delivery at maternal request, with a birth weight appropriate for gestational age (3,485 g) and Apgar scores of 8 and 9 at 1 and 5 minutes, respectively. Physical examination revealed findings consistent with sequelae of amniotic bands released in utero. He is currently undergoing routine medical follow-up as a healthy child.

Based on a limited number of cases, the initial experience of the EVA Project demonstrates the feasibility of implementing an institutional support model for women experiencing vulnerable pregnancies. The program is designed to support autonomous, informed, and non-directive decision-making, irrespective of the pregnancy outcome, and to provide structured emotional support throughout the deliberative process. Developed within a formal hospital setting and under validated clinical and ethical protocols, this experience contributes to the transparency and consistency of care and illustrates a novel hospital-based institutional approach within the Latin American context.

Similar situations to Débora's case may arise. Therefore, it is necessary to continue evaluating, over time, the impact of implementing this project — and any similar initiatives that may be developed — on decision-making processes within the current legal framework governing pregnancy interruption.

Conflict of interest

None declared.

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