

BRITAIN'S ABORTION LAW: APPLICATION AND MISINFORMATION



**By Jennie Bristow,
Editor, *Abortion Review***

Abortion providers over the past few months have been subject to intense scrutiny and suspicion, as a result of Health Secretary Andrew Lansley's decision, in March, to launch a series of unannounced inspections by the Care

Quality Commission (CQC). (1) The reason behind the 'Lansley raid' was purportedly evidence that doctors were 'pre-signing' the HSAI forms. Yet when the CQC reported its findings in July, its inspection of 249 clinics found just 14 instances of the 'pre-signing' of abortion forms in NHS clinics, no instances in BPAS clinics, and no evidence of substandard care across the abortion service. (2)

The pre-signing of HSAI forms is a regulatory not a clinical issue: it is not a practice which puts women at risk, as the CQC makes clear. The 'Lansley raid', which cost the taxpayer £1 million and diverted the CQC from more pressing concerns about clinical problems elsewhere in the health service, was a disproportionate response to reports of this practice. As Ann Furedi, chief executive of BPAS, told the *Today* programme back in March, the CQC inspections were being driven by political, rather than clinical, concerns.

In April, the CQC itself raised questions about the impact of the abortion clinic inspections on its core work; (3) and in May, the Royal College of Obstetricians and Gynaecologists had privately warned the NHS's medical director that these inspections could be used by politically motivated groups and 'recruited into an orchestrated approach to restrict abortion'. (4) When the CQC published its report in July, Diane Abbott MP, Labour's shadow public health minister, said: 'The CQC has blown Andrew Lansley's weak justifications out of the water by confirming that no women had poor outcomes of care at any of the clinics that he personally ordered raids on. What is beginning to emerge from this report looks like a dark, sordid and politically charged campaign against care providers, doctors and British women's right to choose.' (5)

Yet already, the CQC investigations and continual suggestions of criminal proceedings by the Department of Health have had a very negative impact on the small numbers of doctors working in this vital yet stigmatised area of women's healthcare, who are concerned they may be prosecuted over practices suddenly deemed unlawful. Doctors in some smaller services are struggling to find colleagues prepared to provide a second signature promptly, and the heightened scrutiny and uncertainty has made this even harder.

It seems that, on several occasions over the past few months, both the British abortion law and the practice of abortion providers have been wilfully misinterpreted to create the sense that a problem exists, about which 'something should be done'. From abortion counselling to 'sex selection' to the pre-signing of HSAI forms, individuals, groups and newspapers have attempted to create scandals around practices that, in reality, are both legal and well-managed within the abortion service. To their credit, pro-choice groups have fought back against the stream of misinformation, and made a number of important gains in defending their doctors and their practices.

But the past few months has also indicated a disturbing level of confusion among politicians, policymakers and journalists about what Britain's abortion law actually says; and this has trickled down to many of those in the abortion service, causing anxiety about current practices, and the scope of clinical judgement. For these reasons, in this edition of *Abortion Review* we publish a Q&A on the relevant aspects of the law, based on the knowledge of legal scholars and practising lawyers.

(1) *Health Secretary launches shock wave of inspections on abortion clinics. Abortion Review, 23 March 2012*

<http://www.abortionreview.org/index.php/site/article/1150/>

(2) *'Lansley raid' on abortion clinics finds high standard of compliance. Abortion Review, 13 July 2012*

<http://www.abortionreview.org/index.php/site/article/1200/>

(3) *Abortion clinic checks 'politically driven'. Abortion Review, 23 March 2012*

<http://www.abortionreview.org/index.php/site/article/1152/>

Health Secretary under fire over 'political' abortion clinic inspections. Abortion Review, 5 April 2012

<http://www.abortionreview.org/index.php/site/article/1156/>

(4) *Doctors warn of consequences of CQC inspections. Abortion Review, 31 May 2012*

<http://www.abortionreview.org/index.php/site/article/1190/>

(5) *'Lansley raid' on abortion clinics finds high standard of compliance. Abortion Review, 13 July 2012*

<http://www.abortionreview.org/index.php/site/article/1200/>

**Inside
this issue:**

*Clinical Update Q&A: Applying the Abortion Law
Understanding Abortion Statistics:
Key Questions and Relevant Commentary*

CLINICAL UPDATE

Q&A: APPLYING THE ABORTION LAW

1) What does the Abortion Act do?

The 1967 Abortion Act renders lawful activities that would otherwise constitute a crime under the Offences Against the Person Act 1861. The OAPA makes it a crime for a woman to 'procure a miscarriage', or for another person to help her do so. The Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) states that an abortion is legal if it is performed by a registered medical practitioner (a doctor), and that it is authorised by two doctors, acting in good faith, on one (or more) of the following grounds:

- (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
- (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
- (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
- (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

2) What does it mean for doctors to 'act in good faith'?

To show that an opinion has been formed 'in good faith' does not mean that authorising an abortion must be the 'right' course of action, simply that the doctor has not been dishonest or negligent in forming that opinion. What makes an abortion lawful is the doctor's opinion that there are lawful grounds for the procedure, rather than the fact that those grounds exist. So, for example, if two doctors *believe in good faith* that abortion carries less risk to a woman's physical or mental health than carrying the pregnancy to term, this makes the abortion legal – even if, in the eventuality, it would have been safer to carry the pregnancy to term (for example, if the abortion resulted in death or injury). Similarly, if a woman states that she cannot afford to continue the pregnancy, the doctor is not obliged to check that she really is lacking in funds.

3) What does 'risk to health' mean?

These circumstances under which doctors can authorise an abortion include risk to a woman's physical or mental health, which, under s.1(1)(a), is defined relative to the risk of giving birth. Prior to 1967, it was already established in law, by the 1938 Bourne decision, that an abortion was legal if the doctor was 'of the opinion on reasonable grounds and with adequate knowledge of the probable consequences' that continuing the pregnancy would 'make the woman a physical or mental wreck'. This was significant because it confirmed that the grounds for a lawful abortion extended not merely to from saving the woman from death but also to considering her mental and physical wellbeing.

The 1967 Abortion Act took the concept of wellbeing further, by indicating that an abortion was lawful if 'the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman' (emphasis added). In 2012, medical evidence is clear that, purely on a physical level, abortion carries less risk of maternal mortality and morbidity than does childbirth. In terms of mental health impacts, authoritative reviews of the evidence in the USA and Britain are clear that aborting an unwanted pregnancy has no adverse psychological sequelae, compared to carrying that pregnancy to term.

Thus it could be argued that any abortion carried out under Section 1(1)(a) (the ground on which 98 per cent of abortions are carried out) would always be lawful, provided the authorising doctors were acting on the basis of a good faith reliance on this medical evidence base.

4) Is it legal to terminate a pregnancy because of a woman's social or financial circumstances?

Yes. This is provided by Section 1(2) of the Abortion Act, which states that doctors may take account of the pregnant woman's actual or reasonably foreseeable environment when making a decision about the impact of the continuance of a pregnancy on a woman's health. Here again, the law bestows upon doctors a gatekeeping role in terms of deciding who may have an abortion, but within that role provides for a great deal of latitude in making their decision. The law does not state that doctors 'must' take account of a woman's environment, but that they 'may' do so. There is an implicit recognition that it is not always possible to separate the mental or physical health effects of abortion from a woman's wider social circumstances - such as her income, her housing situation, her support network. Doctors may take all this into account in determining whether to authorise an abortion.

Thus, it would be entirely reasonable for a doctor to decide that a woman who presents for an abortion saying that she cannot afford to continue the pregnancy can lawfully be provided with the abortion, as to refuse her might have relatively negative consequences for her health.

5) Is abortion for reasons of fetal sex illegal under the Abortion Act?

No. Fetal sex is not a specified ground for abortion within the Abortion Act, but nor are other reasons for abortion that are widely accepted as 'good' reasons – for example, if the woman has been raped. The scope of the doctor's discretion has been deliberately left very broad by the Act, meaning that what makes the abortion legal is the doctor's good faith opinion that authorising the abortion will be better for that woman's health, in her particular circumstances, than the alternative.

Part of the reason why official bodies, such as the General Medical Council and the Royal College of Obstetricians and Gynaecologists, initially claimed it is illegal to authorise an abortion for reason of fetal sex was because of a confusion with another piece of legislation. The Human Fertilisation and Embryology (HFE) Act 1990 (as amended, 2008), which regulates fertility treatment, prohibits pre-implantation genetic diagnosis (PGD) for the purpose of non-medical sex selection. However this provision does not apply to abortion.

6) Does the fact that there is such broad discretion for authorising abortions mean that British women have access to 'abortion on demand'?

No. The construction of the law around a doctor's good faith opinion was motivated firstly by a concern about the health consequences of unwanted pregnancy and backstreet abortion for women and their families, and secondly by an unwillingness to legislate for abortion on demand. Women in Britain cannot obtain abortions 'just because' they want them – doctors have to agree that this they are warranted.

That there is no right to abortion on demand is illustrated in three ways. First, the law makes very clear that the decision rests with two doctors, according to their own judgement about the impact of abortion versus childbirth on the woman's physical or mental health. Second, on the question of the woman's social circumstances, the law does not state that doctors 'must' take account of a woman's environment, but that they 'may' do so. This means that doctors are not compelled to take these broader factors into account.

Third, the Abortion Act allows doctors the right to conscientious objection to authorising or performing abortions, except where this is necessary to save the woman's life or to prevent grave, permanent injury to her health. This means that women do not have the right to

demand that any doctor performs an abortion for her. The fact that women do not in practice have access to 'abortion on demand' was well illustrated by the *Daily Telegraph* 'sting' operation, where most doctors refused to authorise the journalist's request for an abortion on the grounds of fetal sex, because they did not believe that it was right to do so.

7) Do doctors have to examine the woman in person before signing the HSAI form?

The Abortion Act legislates that two doctors must decide 'in good faith', that a woman meets the legal requirements for an abortion. It also requires the Government to make further provision regarding the certification of such decisions. These regulations regarding certification currently provide that two doctors must specify on what ground/s an abortion can be provided (with each needing to agree that at least one and the same ground is met) along with providing other prescribed information. Current regulations stipulate that they can do so through filling in a particular official document – the HSAI form; or by providing the same information on signed certificates.

It was established in the 1981 case *Royal College of Nursing of the United Kingdom v. Department of Health and Social Security* that abortion should be considered as a procedure that would be carried out by a medical team comprising doctors, nurses, midwives, and other qualified staff, acting in accordance with good medical practice; and that while a doctor should accept responsibility for 'all stages of the treatment for the termination of pregnancy', he/she did not personally have to conduct every stage of the procedure.

Therefore it has, for many years, been considered good practice for doctors to rely on the information gathered by other members of their team in determining whether a woman meets the criteria for an abortion, just as it is considered good practice for nurses to administer medications. There is no legal requirement for the doctor personally to examine the woman, or review her records in depth. That is why there is the option, on the HSAI form, for both doctors to certify that they have not seen or examined the woman.

8) Is pre-signing HSAI forms illegal?

While the Abortion Regulations provide that the form must be completed before treatment is provided, there is no specific legal prohibition of pre-signing and, indeed, it has been suggested that this practice is clearly legal when done to facilitate speedy treatment of a woman in some circumstances (eg where the doctor pre-signs forms knowing that s/he will be away from a clinic, with the intention of discussing the cases by telephone with a colleague, who can then complete other details with the doctor's approval).

The legality of pre-signing forms on the basis of a good faith reliance on the fact that early termination is statistically safer than continuing a pregnancy is less clear. The fact that the HSA form requires specific information regarding the individual patient might serve to suggest that the judgement must be an individualised one concerning the specific woman seeking an abortion. However, while pre-signing forms on this basis is not advisable, there appears to be nothing on the face of the statute to prohibit it.

Also read:

Event: The British abortion law: Challenging current myths and misconception

On 27 June 2012, a meeting of doctors, lawyers and academics was held in London to clarify the legal position of current clinical practice in Britain's abortion service. This article lays out the key arguments. A video of the introductions is available here:

<http://www.youtube.com/watch?v=O6AOjjk2EHk>
<http://www.abortionreview.org/index.php/site/article/1196/>

The public is being misled about pre-signed abortion certificates

Health secretary Andrew Lansley's attack on doctors pre-signing abortion certificates is both wrong in law and ignores the realities of medical life, writes Barbara Hewson in *Solicitors Journal*. 16/4/12
<http://www.abortionreview.org/index.php/site/article/1162/>

The Care of Women Requesting Induced Abortion - full guideline. Royal College of Obstetricians and Gynaecologists, November 2011.
http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf

Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses. Academy of Medical Royal Colleges (AoMRC), December 2011. http://aomrc.org.uk/publications/reports-a-guidance/doc_download/9432-induced-abortion-and-mental-health.html

ABORTION NEWS

JULY

UK: Tory MP to launch cross-party inquiry into unwanted pregnancy

The inquiry, led by Amber Rudd MP, aims to prevent the abortion issue from being hijacked by anti-abortion advocates in her own party, the *Guardian* reports. 'I am unequivocally pro-choice,' said the Tory MP for Hastings. 'Women who want abortions know what they're doing. They're grownups. The correct debate we should be having is how to improve contraception. It's about prevention.'

The inquiry, which is supported by Labour's Sandra Osborne MP and Liberal Democrat MP Lorely Burt, will take evidence from several sexual health experts on three main areas: the increase in unwanted pregnancy among 30-somethings, the continued high rate of teenage pregnancies in the UK, the highest in western Europe, and increasing women's access to contraception. It will take evidence from Marie Stopes and the British Pregnancy Advisory Service (BPAS), which provide abortions as part of a nationwide pregnancy counselling service. BPAS was dropped from the government's Independent Advisory Group on Sexual Health and HIV last year in favour of Life, an anti-abortion outfit which argues for an abstinence-based sex education. 'People think Nadine Dorries is the voice of the government because her voice is heard,' said Amber Rudd. 'If the outcome of this is to change people's perception and make it clear that we are pro-woman and pro-choice then that is a fantastic byproduct.' 12/7/12
<http://www.abortionreview.org/index.php/site/article/1201/>

UK: BPAS launches emergency contraception campaign, 'Just In Case'

The BPAS initiative sent out free supplies of the morning after pill to women in the Greater London area on request during the Olympic Games. Tracey Forsyth, BPAS lead contraceptive nurse, said: 'If you carry an umbrella in your bag or a spare tyre in your boot, no-one would suggest you are hoping for rain or planning a puncture. Having the morning-after pill is no different. It doesn't mean you're planning on taking chances, it means you're planning on protecting yourself when things don't go according to plan.'

A similar initiative launched by BPAS over the Christmas period attracted front-page headlines across the British press, and hundreds of requests from women. The Brook/fpa Sexual Health Awards awarded the scheme 'Adult sexual health service/project of the year'. In April, a new service provided by the internet medical practice DrEd.com was reported, which will allow women to order emergency contraception on the internet, so it arrives by courier within two hours. 3/7/12, 17/4/12
<http://www.abortionreview.org/index.php/site/article/1198/>
<http://www.abortionreview.org/index.php/site/article/1160/>

Family planning summit raises questions about domestic vs international commitments

At the London Summit on Family Planning in July, Melinda Gates pledged \$560 million as part of a campaign to expand access to contraception for women in some of the poorest countries in the world. The funding commitment was unveiled alongside pledges totalling \$4.3 billion from the British government and leaders from African nations, Reuters reports. The US government's Agency for International Development, the largest single donor in this area, has committed to \$640 million for family planning in the next year – up 40 percent under President Barack Obama compared to his predecessor George W. Bush.

<http://www.abortionreview.org/index.php/site/article/1204/>

IN BRIEF

• **UK: 'Lovewise' charity criticised for spreading abortion misinformation to children**

A controversial Christian charity has come under fire for teaching school children around England that abortion can lead to infection, holes in the womb and dramatically increase the risk of depression and suicide. 19/7/12 <http://www.abortionreview.org/index.php/site/article/1202/>

• **Commentary: Anti-abortion protesters must stop punishing women**

BPAS counsellor Cath Sutton writes on the *Huffington Post UK*. 30/7/12 <http://www.abortionreview.org/index.php/site/article/1217/>

• **Commentary: On abortion, beware the overshare**

American feminists want women to 'come out' about abortion. But the political needn't be personal, argues Hannah Betts in the *Guardian*. 17/7/12 <http://www.abortionreview.org/index.php/site/article/1203/>

MAY / JUNE

UK: Annual abortion statistics released

The national abortion statistics, published by the Department of Health, showed that for women resident in England and Wales, abortion rates remained stable in 2011, at 17.5 abortions per 1,000 women of reproductive age (15-44), for the third year in a row. This rate is lower than 2008 (18.2 per thousand) and is entirely in keeping with social changes in which women expect to play a full role in society and control the timing and size of their families - and indeed postpone motherhood until their circumstances are right.

The rates of abortion for women in all age categories under 25 have fallen since 2001, while the rates for women over 25 have increased. This on the one hand may reflect the emphasis there has been on reducing teenage pregnancy – with rates at their lowest since 1969. But there may also be issues specific to older women, including problem with accessing appropriate contraception with services geared towards younger women, public health messages about infertility which lead older women to believe they cannot get pregnant, and the dramatic decline in both male and female sterilisations in recent years. More than half of women having abortions are already mothers, an increase from 2010.

At 36%, the proportion of women undergoing abortion who report a previous procedure has increased slightly since 2010 (34%) but remains comparable with rates in France (35%) and lower than those in Sweden (40%) and the US (50%). Women have reproductive lifetimes of 30 years and may well be exposed during that period to unwanted pregnancy on more than one occasion, particularly as more women postpone motherhood. More women are able to access abortion at earlier gestations, with the proportion of abortions carried out at under 10 weeks climbing one percentage point from 2010 to 78% in 2011. Increasing numbers of women (60% in 2011 against 55% in 2010) now choose early medical abortion - the abortion 'pill'.

Ann Furedi, BPAS chief executive, said: 'Abortion is a fact of life, because contraception fails and sometimes we fail to use it properly. It is a service that one third of women will need in the course of their reproductive lifetimes so they can plan the timing and size of their families, and play a full role in society. There is no "right" number of abortions above and beyond ensuring that every woman who needs to end an unwanted pregnancy can do so, and that obstacles are not put in the way of her accessing supportive services as quickly as possible.

'What matters most is that all women can access the contraception that is most suited to them, and that services are able to accommodate all age groups. There has been much government focus on problematising abortion, while safeguarding robust contraception services appears low down the list of government priorities. We urge the government to publish as a matter of urgency its sexual health policy document, which is now more than a year overdue.' 29/5/12 <http://www.abortionreview.org/index.php/site/article/1189/>

Abortion Statistics: England and Wales, 2011. Department of Health, May 2012. <https://www.wp.dh.gov.uk/transparency/files/2012/05/Commentary1.pdf>

UNDERSTANDING ABORTION STATISTICS: KEY QUESTIONS AND RELEVANT COMMENTARY

A BPAS briefing produced by Abortion Review, May 2012.

Download it for free here:

<http://www.abortionreview.org/index.php/site/article/968/>

Contents

1) Introduction: About abortion statistics

Where do abortion statistics come from? What the statistics can tell us; What the statistics cannot tell us; Which statistics to treat with particular caution.

2) Number of abortions

How many abortions are there? What is the abortion rate? What is the birth rate? How many women come to Britain from overseas to have an abortion? How many women have 'repeat' abortions? What factors affect the abortion rate?

3) Grounds for abortion

How are the legal grounds applied in practice? How common is termination of pregnancy for fetal anomaly?

4) Age, marital status, previous children, and ethnicity

How does abortion relate to age? Abortion and fertility rates; Marital status, previous children, and ethnicity.

5) Gestation, method and complication rates

'Early' abortion; Later abortion; Methods of abortion; Which method is best? How safe is abortion?

6) Provision, funding and geographical location

Who provides abortions? What are the geographical variations in abortion provision? How is abortion regulated?

7) Further resources

USA: Gallup poll on abortion attitudes

According to a poll reported in the *Guardian*, four out of ten Americans identify themselves as 'pro-choice' on abortion, the lowest proportion in almost two decades; while 50% describe themselves as 'pro-life'. The decline in the proportion of people who identify themselves as 'pro-choice' is seen across the political spectrum, the research found. But it also revealed a disparity between what labels Americans choose

to identify with and their fundamental views about the morality and legality of abortion.

In a statement issued in response to the findings, Cecile Richards, president of Planned Parenthood of America, said: 'What this poll makes clear is that labels like "pro-choice" and "pro-life" simply don't reflect the complexity of how most people actually think and feel about abortion in this country. A majority of Americans still believe abortion should remain a safe and legal medical procedure for a woman to consider if and when she needs it, and these fundamental views have held steady for more than a decade. Instead of putting people in one category or another, we should respect the real-life decisions women and their families face every day.' 23/5/12
<http://www.abortionreview.org/index.php/site/article/1187/>

IN BRIEF

• **USA: Supreme Court upholds Affordable Care Act**

The US Supreme Court on 28 June voted by a 5-4 ruling that President Barack Obama's landmark healthcare reform act is constitutional. The ruling comes months before the US election, with Republicans vowing to push for a repeal of the bill.

<http://www.abortionreview.org/index.php/site/article/1197/>

• **Commentary: Abortion and the thirty-something woman**

Women in their early thirties are having both more babies and more abortions. How do we account for this shift? By Jennie Bristow. 14/6/12

<http://www.abortionreview.org/index.php/site/article/1195/>

• **Event: Debating the gap between policy and practice**

The BPAS conference 'Pills in Practice', held at London's Royal Society of Medicine on 11 May 2012, brought together renowned speakers from Britain, Europe and America to discuss how abortion and contraception policy can best meet the needs of women in the 21st century. Special editions of *Abortion Review*, based on transcripts of the sessions, will be produced in the autumn and available online.

<http://www.abortionreview.org/index.php/site/article/1185/>

• **Commentary: Why I'm proud to be an abortion doctor**

A BPAS doctor, working in a BPAS clinic in London, writes in the *Huffington Post UK*. 14/6/12

<http://www.abortionreview.org/index.php/site/article/1192/>

• **Commentary: Keep abortion out of adoption policy**

Jennie Bristow criticises the new official strategy that encourages women seeking abortion to give birth and do adoption instead. 13/6/12

<http://www.abortionreview.org/index.php/site/article/1193/>

MARCH / APRIL

UK: Contraceptive services not reaching all women, audit finds

An audit of the commissioning of contraceptive and abortion services in England carried out by the Advisory Group on Contraception revealed that a third of women of reproductive age are unable to choose from the full range of contraceptives or services in their local area. The report, *Sex, Lives, and Commissioning*, demonstrates that:

- As many as 3.2 million women of reproductive age (15-44) are living in areas where fully comprehensive contraceptive services, through community and/or primary care services, are not provided.
- Those PCTs restricting access to contraceptives or contraceptive services had a higher abortion rate than the national average.
- Over a quarter (28%) of PCTs responding to the audit did not have a strategy in place or under development to address

unintended pregnancy and the need for abortion or repeat abortion.

The audit also uncovered evidence of PCTs introducing access restrictions based on cost rather than choice or quality. Dr Connie Smith, Consultant in Sexual and Reproductive Healthcare, said: 'Contraception is a very personal issue. What is right for one woman may not be right for another. That is why the national NICE guidelines on contraception are built around the importance of choice. PCTs that are restricting choice are getting worse outcomes. For every £1 spent on contraception the NHS saves £12.50, so restricting access and choice is a complete false economy, harming women and the NHS.'

Also in April, a study by NHS South East London recommended that the contraceptive pill should be available at pharmacies without a GP prescription, including to some under-16s. 25/4/12

<http://www.abortionreview.org/index.php/site/article/1164/>

<http://www.abortionreview.org/index.php/site/article/1165/>

UK: 'Abortion: the case for change'

A *Guardian* editorial on 26 March responded to a wave of news stories about the increasing anti-abortion activity by protestors, and the hostile political climate. The editorial argues: 'A woman's right to choose is not best defended by legislation that on paper at least excludes her views. Nor is double-think that cherry-picks reasons for abortion any use. Women either have the right to choose – and that might include choosing to abort a foetus with a cleft palate, or one that is the "wrong" gender. Or they don't. The law should be based on one straightforward, rational principle – that women should be treated in law as the autonomous individuals they are.'

A letter to the *Guardian* on 29 March, signed by senior clinicians and academics involved in abortion care and research, argues that 'there appears to be determined effort by some politicians and sections of the media to present a profoundly misleading picture of how abortion provision works, the nature of the law as it stands, and the experiences of women.' 26/4/12, 29/4/12

<http://www.abortionreview.org/index.php/site/article/1154/>

<http://www.abortionreview.org/index.php/site/article/1155/>

IN BRIEF

• **UK: Abortion providers offer experience to a new generation of doctors**

A US group set up to help medical students get training in abortion services is to fund opportunities in the UK for the first time, amid fears that high-profile protest campaigns against terminations and an increasingly politicised climate will deter young doctors from working in the field. 6/4/12; 2/4/12

<http://www.abortionreview.org/index.php/site/article/1161/>

<http://www.abortionreview.org/index.php/site/article/1157/>

• **Commentary: Why 'choice' matters**

Writing in *Conscience* magazine, Ann Furedi challenges the argument that 'choice' does not do justice to women's abortion decisions.

<http://www.abortionreview.org/index.php/site/article/1163/>

• **UK: Judge sentences BPAS hacker**

An anti-abortion computer hacker who stole the personal details of 10,000 women from the BPAS website has been sentenced to almost three years in prison. James Jeffery, 27, was a member of the hacking collective Anonymous and had intended to publish the names, email addresses and telephone numbers of thousands of women, which he had taken from the BPAS website. Copying Anonymous's style, Jeffery boasted of his feat on Twitter soon after his crime. However, the former software engineer, described in court as an 'able' hacker and

'whiz-kid', was quickly tracked down by police to his home address after he failed to hide his computer's IP details. Police arrested him in the early hours of the morning of 9 March.

<http://www.abortionreview.org/index.php/site/article/1159/>

• **Commentary: Why anti-abortion activists should not intimidate women**

Ann Furedi, chief executive of BPAS, writes on CNN.

<http://www.abortionreview.org/index.php/site/article/1149/>

• **Event: The Americanisation of abortion politics in Britain**

The 2012 BPAS Public Lecture was given by Carol Sanger, Professor of Law at Columbia Law School, New York, on 7 March.

<http://www.abortionreview.org/index.php/site/article/1145/>

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MEDICAL UPDATE

USA: Expectant care versus surgical treatment for miscarriage.

Nanda K, Lopez LM, Grimes DA, Peloggia A, Nanda G. *Cochrane Database of Systematic Reviews*. 2012 Mar 14;3:CD003518.

The authors note that miscarriage is a common complication of early pregnancy that can have both medical and psychological consequences such as depression and anxiety. The need for routine surgical evacuation with miscarriage has been questioned because of potential complications such as cervical trauma, uterine perforation, haemorrhage, or infection. The study's objective was to compare the safety and effectiveness of expectant management versus surgical treatment for early pregnancy failure.

The authors concluded that expectant management led to a higher risk of incomplete miscarriage, need for unplanned (or additional) surgical emptying of the uterus, bleeding and need for transfusion. Risk of infection and psychological outcomes were similar for both groups. Costs were lower for expectant management. Given the lack of clear superiority of either approach, the woman's preference should be important in decision making. Pharmacological ('medical') management has added choices for women and their clinicians.

UK: Follow-up for improving psychological well being for women after a miscarriage.

Murphy FA, Lipp A, Powles DL. *Cochrane Database of Systematic Reviews*. 2012 Mar 14;3:CD008679.

The study's objectives were to ascertain whether follow-up affects the psychological well being of women following miscarriage. Six studies involving 1001 women were included. Three trials compared one counselling session with no counselling. There was no significant

difference in psychological well being including anxiety, grief, depression avoidance and self-blame. One trial compared three one-hour counselling sessions with no counselling at four and 12 months. Some subscales showed statistical significance in favour of counselling and some in favour of no counselling. The results for two trials were given in narrative form as data were unavailable for meta-analyses. One trial compared multiple interventions. The other trial compared two counselling sessions with no counselling. Neither study favoured counselling.

The authors concluded that evidence is insufficient to demonstrate that psychological support such as counselling is effective post-miscarriage. Further trials should be good quality, adequately-powered using standardised interventions and outcome measures at specific time points. The economic implications and women's satisfaction with psychological follow-up should also be explored in any future study. <http://www.abortionreview.org/index.php/site/article/1213/>

Switzerland: Perioperative antibiotics to prevent infection after first-trimester abortion.

Low N, Mueller M, Van Vliet HA, Kapp N. *Cochrane Database of Systematic Reviews*. 2012 Mar 14;3:CD005217.

The authors concluded that antibiotic prophylaxis at the time of first trimester surgical abortion is effective in preventing post-abort upper genital tract infection. Evidence of between trial heterogeneity suggests that the effect might not apply to all settings, population groups or interventions. This review did not determine the most effective antibiotic prophylaxis regimen. Antibiotic choice should take into account the local epidemiology of genital tract infections, including sexually transmitted infections. Further RCTs comparing different antibiotics or combinations of antibiotics with each other would be useful. Such trials could be done in low and middle income countries and where the prevalence of genital tract infections in women presenting for abortion is high.

<http://www.abortionreview.org/index.php/site/article/1214/>

USA: Unprotected intercourse among women wanting to avoid pregnancy: attitudes, behaviors, and beliefs.

Biggs MA, Karasek D, Foster DG. *Women's Health Issues*. 2012 May;22(3):e311-8.

The study set out better to understand the behaviours associated with unintended pregnancy, including the frequency and reasons why women engage in unprotected intercourse (UI), to help guide efforts to prevent unintended pregnancy. The authors surveyed 1,392 women with no history of abortion in 13 family planning clinics across the United States regarding the frequency with which they engaged in UI, the reasons for engaging in UI, attitudes toward UI, and their knowledge about the risks of conception.

Nearly half (46%) of respondents engaged in UI within the past 3 months, mostly owing to barriers accessing birth control (49%), not planning to have sex (45%), and the belief that they could not get pregnant (42%). The most prevalent attitudes about UI were that it 'feels better' (42%) or 'more natural' (41%). Factors associated with an increased odds of having engaged in UI, included holding the views that UI is okay at certain times, feels better, and is more natural, underestimating the risk of conception from 1 year of UI, experiencing difficulty getting birth control prescriptions, having less than a college education, being ages 20 to 24, and being African American/Black.

The authors concluded that, compared with their research on abortion clients, family planning clients report high, yet somewhat lower, rates of UI, similar reasons for having UI, and misconceptions about the risk of conception from repeated acts of UI. Long-acting, reversible contraception may offer some of the benefits of UI in terms of spontaneity and pleasure, while reducing women's pregnancy risk. <http://www.abortionreview.org/index.php/site/article/1181/>

France: Contraceptive paths of adolescent women undergoing an abortion.

Moreau C, Trussell J, Bajos N. *Journal of Adolescent Health*. 2012 Apr;50(4):389-94.

The authors note that although more than 30,000 teenagers had an induced abortion in France in 2007 (14.3% of all abortions), little is known about their abortion experience. In this study, a majority of French teens (82%) reported their pregnancy was unplanned and took on the responsibility of having an abortion: 45% made the decision alone, 46% shared the decision with their family or partner, and 9% reported the decision was made on their family's or partner's request alone. Sixty-nine percent of teenagers were eligible for both medical and surgical abortions, but only 43% thought they were given a choice of methods. Two-thirds of pregnancies were caused by contraceptive misuse or failure, mostly due to condom slippage or breakage (26%) or inconsistent pill use (20%). In 68% of cases, teenagers were prescribed a more effective method than the one they were using before, although only 11% received a prescription for a long-acting method. One in five teenagers reported not receiving a prescription for contraception.

The authors concluded that their results reveal varying degrees of young women's autonomy in the decisions regarding their abortion. Although most teens switch to more effective methods of contraception after an abortion, only a minority receives a prescription for a long-acting method.

USA: Prenatally diagnosed fetal conditions in the age of fetal care: does who counsels matter?

Brown SD, Ecker JL, Ward JR, Halpern EF, Sayeed SA, Buchmiller TL, Mitchell C, Donelan K. *American Journal of Obstetrics and Gynecology*. 2012 May;206(5):409.e1-11.

This study sought to characterise practices and attitudes of maternal-fetal medicine (MFM) and fetal care pediatric (FCP) specialists regarding fetal abnormalities. For Down syndrome (DS), congenital diaphragmatic hernia (CDH), spina bifida: MFMs were more likely than FCPs to support termination, and consider offering termination options as highly important. For DS only, MFMs were less likely than FCPs to think that pediatric specialist consultation should be offered prior to a decision regarding termination. MFMs reported higher termination rates among patients only for DS. The authors concluded that MFM and FCP specialists' counselling attitudes differ for fetal abnormalities.

<http://www.abortionreview.org/index.php/site/article/1218/>

USA: Autonomous abortions: the inhibiting of women's autonomy through legal ultrasound requirements.

Rocha J. *Kennedy Institute of Ethics Journal*. 2012 Mar;22(1):35-58.

Recently, the author argues, we have seen various proposed laws that would require that women considering abortions be given ultrasounds along with explanations of these ultrasounds. Proponents of these laws could argue that they are assisting with autonomous abortion choices by providing needed information, especially about the ontological status of the fetus. Arguing against these proposed laws, the author first claims that their supporters fail to appreciate how personalised an abortion choice must be. Second, the author argues that these laws would provide the pregnant woman no control over when and to what extent emotion is inserted into her deliberation. This unjustly inhibits her autonomy, making these ultrasound laws unjustified.

<http://www.abortionreview.org/index.php/site/article/1205/>

USA: Migration of intrauterine devices: radiologic findings and implications for patient care.

Boortz HE, Margolis DJ, Ragavendra N, Patel MK, Kadell BM. *Radiographics*. 2012 Mar-Apr;32(2):335-52

The authors note that intrauterine devices (IUDs) are a commonly used form of contraception worldwide. However, migration of the IUD from its normal position in the uterine fundus is a frequently

encountered complication, varying from uterine expulsion to displacement into the endometrial canal to uterine perforation. Different sites of IUD translocation vary in terms of their clinical significance and subsequent management, and the urgency of communicating IUD migration to the clinician is likewise variable. Expulsion or intrauterine displacement of the IUD leads to decreased contraceptive efficacy and should be clearly communicated, since it warrants IUD replacement to prevent unplanned pregnancy.

Embedment of the IUD into the myometrium can usually be managed in the outpatient clinical setting but occasionally requires hysteroscopic removal. Complete uterine perforation, in which the IUD is partially or completely within the peritoneal cavity, requires surgical management, and timely and direct communication with the clinician is essential in such cases. Careful evaluation for intraabdominal complications is also important, since they may warrant urgent or emergent surgical intervention. The radiologist plays an important role in the diagnosis of IUD migration and should be familiar with its appearance at multiple imaging modalities.

<http://www.abortionreview.org/index.php/site/article/1216/>

USA: Fighting 'personhood' initiatives in the United States.

Collins LR, Crockin SL. *Reproductive Biomedicine Online*. 2012 Apr 11.

The authors note that 'personhood' initiatives filed in many states within the United States threaten to impose potentially significant restrictions on infertility treatment, embryo disposition, pre-natal care, abortion, contraception, and stem-cell research, all through attempts to redefine a 'person' or 'human being' as existing from the moment of fertilisation or conception, and endowed with the full legal and Constitutional rights of personhood.

Virginia's recent, unsuccessful attempt to pass such legislation provides both a dramatic example of these efforts and valuable lessons in the fight against them by infertility advocates and others. Arguments over loss of infertility treatment seemed more persuasive to legislatures than did restrictions on abortion or stem cell research. Indeed, persuading legislators or voters that they could be 'pro-life' and still anti-personhood initiatives was a key strategy, and consumer efforts and media attention were instrumental. The most central lessons, however, may be the degree of intensity and coordinated strategy to shift public perception that lie behind these numerous state efforts, regardless of whether the actual initiatives are won or lost.

<http://www.abortionreview.org/index.php/site/article/1166/>

UK: The effect on use of making emergency contraception available free of charge.

Cameron ST, Gordon R, Glasier A. *Contraception*. 2012 Mar 28.

A questionnaire survey about knowledge of the availability of free EC from pharmacies, and its use to prevent the index pregnancy, was performed among 204 women requesting abortion in Edinburgh, Scotland. Seventy percent of 204 respondents (n=143) knew that EC was available free from pharmacies; 22 (11%) had used it in the cycle in which conception occurred. EC use was not influenced by knowledge of its availability free of charge. Women from affluent areas were significantly more likely to have used EC to try to prevent the pregnancy than counterparts from less affluent areas. The authors concluded that neither availability from the pharmacy nor removal of a charge for EC has increased its use among women having an abortion in Scotland.

<http://www.abortionreview.org/index.php/site/article/1179/>

IN BRIEF

• Netherlands: Anaesthesia for evacuation of incomplete miscarriage.

Calvache JA, Delgado-Noguera MF, Lesaffre E, Stolker RJ. *Cochrane Database of Systematic Reviews*. 2012 Apr 18;4:CD008681.

The study's objectives were to assess the effects of general anaesthesia, sedation or analgesia, regional or paracervical block

anaesthetic techniques, or differing regimens of these, for surgical evacuation of incomplete miscarriage. The authors concluded that particular considerations that influence the choice of anaesthesia for this procedure such as availability, effectiveness, safety, side effects, practitioner's choice, costs and woman's preferences of each technique should continue to be used until more evidence supporting the use of one technique or another.

<http://www.abortionreview.org/index.php/site/article/1212/>

• **USA: Antiabortion violence in the United States.**

Russo JA, Schumacher KL, Creinin MD. *Contraception*. 2012 Mar 28.

The authors concluded that harassment of abortion providers in the United States has an association with the restrictiveness of state abortion laws.

<http://www.abortionreview.org/index.php/site/article/1178/>

• **USA: Eliminating the routine postoperative surgical abortion visit.**

Gatter M, Roth N, Safarian C, Nucatola D. *Contraception*. 2012 May 2.

The authors concluded that elimination of the routine postoperative visit after a surgical abortion and the substitution of an 'as indicated' postoperative visit are not associated with an increase in either continuing pregnancies or repeat abortion.

<http://www.abortionreview.org/index.php/site/article/1182/>

• **USA: Midwives and abortion care: a model for achieving competency.**

Levi A, Angel James E, Taylor D. *Journal of Midwifery and Women's Health*. 2012 May-Jun;57(3):285-9.

The University of California, San Francisco, under the auspices of the Health Workforce Pilot Program, developed a competency-based training model to increase the number of certified nurse-midwives, nurse practitioners, and physician assistants who can provide uterine aspiration.

<http://www.abortionreview.org/index.php/site/article/1208/>

• **UK: Timing is everything: the demarcation of 'later' abortions in Scotland.**

Beynon-Jones SM. *Social Studies of Science*. 2012 Feb;42(1):53-74.

Drawing on semi-structured interviews with Scottish health professionals, the author explores the discursive practices through which they demarcate 'later' abortion as a problematic decision.

<http://www.abortionreview.org/index.php/site/article/1210/>

• **USA: Making abortion services accessible in the wake of legal reforms.**

Ashford L, Sedgh G, Singh S. *Issues Brief (Alan Guttmacher Institute)*. 2012 Apr;(1):1-4

A study of the process following legal reforms in six settings in Asia, Africa and Latin America confirms that the practical work of establishing safe abortion services can take years and requires resources and commitment. Where these efforts have been undertaken and information on trends in abortion-related illness and death is available, evidence is beginning to demonstrate that liberalised laws are followed by improved health outcomes for women.

<http://www.abortionreview.org/index.php/site/article/1207/>

• **WHO: Acceptability of misoprostol-only medical termination of pregnancy compared with vacuum aspiration: an international, multicentre trial.**

Rodriguez MI, Seuc A, Kapp N, von Hertzen H, Huong NT, Wojdyla D, Mittal S, Arustamyan K, Shah R; World Health Organization Research Group on Post-Ovulatory Methods of Fertility Regulation. *BJOG*. 2012 Jun;119(7):817-23.

The authors concluded that where medical TOP with mifepristone is

not available, misoprostol-only medical TOP is acceptable to women who have the choice between medical or surgical techniques.

<http://www.abortionreview.org/index.php/site/article/1211/>

• **USA: Paracervical block for pain control in first-trimester surgical abortion: a randomized controlled trial.**

Obstetrics and Gynecology. 2012 May;119(5):1030-7. Renner RM, Nichols MD, Jensen JT, Li H, Edelman AB.

The authors note that despite lack of efficacy data, the majority of first-trimester surgical abortions are performed with a paracervical block. The study's objective was to estimate the effect of a paracervical block and the effect of gestational age on patient pain perception. The authors concluded that although paracervical block is painful, it reduces first-trimester abortion pain regardless of gestational age, but the benefit on dilation pain was greater at earlier gestations.

<http://www.abortionreview.org/index.php/site/article/1169/>

• **Switzerland: Six years after deregulation of emergency contraception: Has free access induced changes in the profile of clients attending an emergency pharmacy in Zürich?**

Samartzis EP, Merki-Feld GS, Seifert B, Kut E, Imthurn B. *The European Journal of Contraception and Reproductive Health Care*. 2012 Apr 12.

The authors note that emergency contraception (EC) has been freely accessible in Swiss pharmacies since November 2002. Their study concludes that free access to EC has not resulted in less use of efficient contraceptive methods. This also applies to adolescents, who mainly used EC as a back-up method and seldom in the context of unprotected intercourse.

<http://www.abortionreview.org/index.php/site/article/1174/>

• **Turkey: Turkish pharmacists' counseling practices and attitudes regarding emergency contraceptive pills.**

Apikoglu-Rabus S, Clark PM, Izzettin FV. *International Journal of Clinical Pharmacy*. 2012 Apr 24.

The authors concluded that their results showed that the pharmacists served the clients in need of emergency contraception more frequently than the other health-care providers and in general had favourable attitudes towards ECP. Some aspects of their counselling practices need to be improved. <http://www.abortionreview.org/index.php/site/article/1168/>

Canada: Antibiotic prophylaxis in gynaecologic procedures.

Van Eyk N, van Schalkwyk J. *Journal of Obstetrics and Gynaecology Canada*. 2012 Apr;34(4):382-91.

The study's objective was to review the evidence and provide recommendations on antibiotic prophylaxis for gynaecologic procedures. Results were restricted to systematic reviews, randomised control trials/controlled clinical trials, and observational studies. The authors made 13 recommendations based on the findings.

<http://www.abortionreview.org/index.php/site/article/1177/>

• **Israel: Clinical, surgical, and histopathologic outcomes following failed medical abortion.**

Fuchs N, Maymon R, Ben-Ami I, Mendlovic S, Schneider D, Pansky M, Halperin R. *International Journal of Gynaecology and Obstetrics*. 2012 Apr 6.

The case group comprised 104 women who underwent surgical curettage following failed medical abortion; the control group included 104 women who underwent early surgically induced abortion. The authors concluded that curettage following failed medical abortion harbours particular difficulties, which may be attributed to an inflammatory response. The long-term consequences of curettage following failed medical abortion warrant further investigation.

<http://www.abortionreview.org/index.php/site/article/1175/>