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CONFIDENTIALITY AND CHILD PROTECTION

By Jennie Bristow, editor, *Abortion Review*

The issue of young people, sexual health and confidentiality has become a challenging one in the past few years. On one hand, the government's desire to reduce teenage pregnancy and a recognition that young people need access to contraception, abortion and sexual health services has resulted in a reaffirmation of young people's right to confidentiality, along with an explicit demand that:

'All services providing contraceptive advice and treatment to young people should:

- Produce an explicit confidentiality policy making clear that under-16s have the same right to confidentiality as adults.
- Prominently advertise services as confidential for young people under 16, within the service and in community settings where young people meet.' (1)

On the other hand, the introduction of more stringent legislation and guidance aimed at preventing the abuse of children has raised some questions about how far young people (particularly those under the age of 13) should expect confidentiality from professionals working in the field of sexual health. The revised government guidance *Working Together to Safeguard Children*, published by the Department for Education and Skills in April 2006, with its emphasis on 'information sharing' between agencies about young people who may be at risk, has fuelled further discussion of the tension between confidentiality and child protection.

So where do professionals working in contraception, abortion and sexual health services stand according to the new guidance? The bottom line is that the duty of confidentiality owed to a person under 16 in any setting is the same as that owed to any other person. As regards contraception, the law continues to follow the Fraser Guidelines laid down in 1985, which broadly state that girls under 16 may receive contraceptive advice and treatment without parental consent providing she can understand the advice, and that the doctor considers such advice and treatment to be in her best interests.

A similar approach is taken to abortion. As the Royal College of Obstetricians and Gynaecologists (RCOG) stated in 2004:

'Any young person, regardless of age, can give valid consent to medical treatment providing she is considered to be legally competent - that is, able to understand a health professional's advice and the risks and benefits of what is being offered.

'All very young women are encouraged to involve their parents or another supportive adult. If you choose not to do this, doctors can offer you an abortion if they are confident that you can give valid consent and that it is in your best interests.

'You have a right to confidentiality like everyone else. However, if staff in NHS hospitals suspect you are at risk of sexual abuse or harm, they are obliged, with your knowledge, to involve social services.' (2)

So far as information sharing goes, the revised *Working Together* guidance does not require that professionals automatically pass on information about sexually

active young people. It requires that confidentiality should be breached only where a young person is considered at risk of significant harm and cannot be persuaded to agree to a referral being made to social services (3).

However, despite the reaffirmation of young people's right to confidentiality, some important things have changed as a consequence of the new government guidance. Organisations providing sexual health services are seen to have a responsibility for identifying and reporting cases of suspected child abuse, and will have to develop clear protocols about how they deal with referrals by young people. Furthermore, the government guidance states that, in cases involving under-13s: 'There should be a presumption that the case will be reported to children's social care'. While this does not amount to an automatic breaching of the young person's confidentiality, it does demand that the organisation in question fully documents any such case, 'including detailed reasons where a decision is taken not to share information' (4).

While abortion providers and other organisations working in the field of sexual health will continue to work according to what they believe is in the best interest of their clients, they will have to be aware of the need to account for their decision-making in such cases to the wider bodies responsible for child protection, and to liaise much more closely with other agencies working in child protection. To ensure that the key agencies work effectively together, Local Safeguarding Children Boards (LSCBs) have been established on a new statutory footing. Local Authorities convene these inter-agency fora, which have responsibility for agreeing how the different services and professional groups should cooperate to safeguard children in each particular area, and for making sure that arrangements work effectively (5).

Another consequence of the new guidance, and the discussion it has generated, may be that young people become confused about their right to confidentiality. In September 2006, research by the Office of the Children's Commissioner found that teenagers were suspicious of the new Children's Index, which by 2008 will bring all records about children held by doctors, schools and so on together into one gigantic database. Many of the teenagers polled said that they might stop using contraception and abortion services because of fears that their confidentiality could be breached (6). Young people are highly sensitive about their privacy, and easily put off using sexual health services. It would be unfortunate if the government's desire to protect children were to discourage young people from using the services they need.

(1) *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*. Department of Health, July 2004

(2) *About abortion care: what you need to know*. RCOG 2004

(3) *Under 16: the law and public policy on sex, contraception and abortion in the UK*. Brook. Updated May 2006

(4) Para 5.25 *Working Together to Safeguard Children*. DfES April 2006

(5) For more information on the role of LSCBs, please see <http://www.everychildmatters.gov.uk/lscb>

(6) *Teenagers do not trust database to keep details confidential*. Daily Telegraph, 7 September 2006

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Ultrasound does not definitely diagnose or exclude ectopic pregnancy

The detection and management of ectopic pregnancy and induced abortion

By Dr Vincent P Argent FIMC FRCA FRCOG

Concern about ectopic pregnancy

Induced medical and surgical abortions are now performed at earlier gestations, which is welcomed from the point of view of responsive patient care as abortion is always safer and more straightforward for the woman when performed earlier. However, undiagnosed ectopic pregnancy has become more common as a result, because of the very early stages of pregnancy at which these terminations are carried out.

This causes concern to practitioners, who may wish to defer treatment until a definite diagnosis of intra-uterine pregnancy is made. However, clients understandably ask for early procedures and improved early access is now Department of Health policy. Nevertheless, clients usually think that an ectopic pregnancy should not have been missed by the abortion provider and complaints and legal action may result.

In response to this situation **bpas** has produced new guidelines on ectopic pregnancy. These guidelines are available from **bpas**.

Because of our emphasis on woman-centred care and the distress that women report when asked to wait for a procedure they urgently want to have done, it is not **bpas** policy to defer the client's treatment until cardiac activity is seen or a gestational or yolk sac is identifiable.

Important messages for our clients

The most important messages we need to emphasise to women are:

- To promote an awareness of the signs and symptoms to look out for. When women present at the early stages of pregnancy for consultation, symptoms and signs of ectopic pregnancy are often completely absent. Where a pregnancy is ectopic and the woman has felt the symptoms of this, suspicious ultrasound findings are far more common. In the earlier asymptomatic stages of early ectopic pregnancy, these are usually absent.
- Clients must be informed that ultrasound does not definitely diagnose or exclude ectopic pregnancy. The client must always be informed of the small risk of ectopic pregnancy whenever intrauterine pregnancy has not been confirmed.
- Any suspicions before the procedure must be clearly documented and the treatment doctor must be informed.
- Appropriate action must be taken whenever an ectopic is suspected. In case of doubt, clients must be followed up by **bpas** after the abortion has taken place and referred into the NHS for advice.

Risk factors

Clients should also be aware that some women have a higher risk of ectopic pregnancy. Risk factors are:

- Previous ectopic pregnancy;
- Tubal disease;
- Tubal surgery, including failed sterilisation;
- Sexually transmitted infections, including chlamydia;
- Intrauterine contraceptive device in-situ.

Signs and symptoms

Although absent at earlier gestations, key factors are:

- Pain, especially unilateral;
- Dark vaginal bleeding;
- Feeling faint;
- Abdominal tenderness;
- Tenderness on vaginal examination.

Ultrasound findings

There is no research work on ultrasound findings in early asymptomatic ectopic pregnancy. In our experience women presenting to early pregnancy clinics usually have symptoms. Many of the ultrasound features are associated with swelling of the fallopian tube and bleeding associated with the onset of symptoms from the ectopic.

The following findings on abdominal scanning (as routinely used in **bpas** consultation centres prior to a termination) may suggest an ectopic:

- Round or irregular sac only seen;
- No fetus seen;
- Findings do not correspond with gestational age based on last menstrual period;
- Dark echoes (blood) behind the uterus;
- Swellings or sac-like structures next to the uterus.

In cases of doubt, a second opinion from a colleague or a more experienced ultrasonographer is crucial. There is no doubt that transvaginal views give a better picture than transabdominal views and we will aim to move towards this becoming standard for early pregnancy work. Transvaginal scanning (TVS) requires training, skill and experience.

The new *St George's Criteria* (2005) are more specific. This is not mandatory guidance, but at **bpas** we aim to capitalise on our research-led ethos by adopting these as aids to best practice. The criteria state that:

Women are diagnosed with an ectopic pregnancy using TVS if any of the following were noted in the adnexal region:

- An inhomogeneous mass or blob sign adjacent to the ovary and moving separately from the ovary;
- A mass with a hyper-echoic ring around the gestational sac or bagel sign;
- A gestational sac with a fetal pole with or without cardiac activity.

Other reasons for unexpected ultrasound findings

If no fetus is seen, other possible reasons are:

- Incorrect gestational age - the pregnancy is less advanced than expected;
- Missed miscarriage - pregnancy failure (the woman is not pregnant any more);
- Molar pregnancy.

During the abortion procedure

Little is known about variations in symptoms and signs of ectopic pregnancy during attempted early medical abortion. It is reasonable to assume that warning signs would include unexpected pain, lack of bleeding, fainting and feeling unwell.

It is generally agreed that the practice of early medical and surgical abortion is acceptable

At early surgical abortion, ectopic may be suspected if the uterus is smaller than expected for gestational age and if the products of the pregnancy do not seem to be sufficient for the age. An adnexal mass may arouse suspicion but there is a risk of rupture if the mass is manipulated.

Closed systems and histopathology

Closed collection systems are commonly used, but the surgeon can note the products as they pass through the suction curette. In case of doubt, the surgeon should open the closed system and inspect the products.

Products may be sent for histopathology. The Arias Stella reaction - a particular histopathological appearance of the tissue - is common in ectopic pregnancy. There must be good communication between the clinic and the laboratory so that suspicious pathology results lead to immediate action.

Early follow-up

The risk of severe internal haemorrhage from an ectopic pregnancy is probably more common after examination of the pelvis, because manipulation may burst the ectopic. The condition must be considered as a life-threatening emergency. If ectopic pregnancy is suspected, the woman must be transferred urgently to the local gynaecology/early pregnancy service for further consultation, ultrasound examination and beta HCG testing.

Later follow-up

Robust follow-up for early abortion is essential. **bpas** practitioners giving advice and **bpas** 'Actionline' telephone enquiry personnel must be fully trained and aware of the possibility of ectopic pregnancy, and on guard for warning signs such as:

- Severe pain, especially if unilateral;
- Fainting;
- Still feeling pregnant after the early medical abortion.

In case of doubt, prompt consultation with a gynaecologist with access to high quality scanning and beta HCG testing must be arranged for the woman.

Risk management

With the awareness of the risks of undiagnosed ectopic pregnancy, is it acceptable to perform early abortions?

Ectopic pregnancy is difficult to diagnose in early pregnancy at the time of early medical abortion (EMA), the manual vacuum aspiration procedure (MVA), or other surgical methods. This begs the most important risk management question: Is the practice of early abortion acceptable or will clients complain or take legal action on the basis that early abortion is associated with unacceptable risks of missing an ectopic pregnancy? A plaintiff may allege that the practice is unsafe and should not be done, that she did not receive adequate warnings about the risk, that she was not given the chance to postpone the procedure until confirmation of intra-uterine pregnancy, that the ectopic in her own case should have been diagnosed earlier, or that the management of her case was inadequate.

There are no published law reports of successful actions based on the premise that early abortion is unsafe because of the ectopic risk. Quite a large number of actions based on late diagnosis of an ectopic have been settled out of court, for a variety of reasons - for example, failure to act on histology results, and failure to recognise ongoing pain as a warning sign.

The Royal College of Obstetricians and Gynaecologists' (RCOG) Guideline on *The Care of Women Requesting Induced Abortion* (2004) does not deal with the problem of missed ectopic pregnancy with early

surgical or medical abortion. It only recommends that early suction aspiration before 7 weeks should be carried out according to a strict protocol, as they are three times more likely to fail to remove a gestational sac. The Guideline suggests that practitioners' confidence that the gestational sac has been removed can be increased by safeguards such as magnification of aspirate and follow-up serum beta HCG. Since the Guideline was published, there has been a huge increase in client demand for EMA and MVA, and this trend seems set to continue, with patients, NHS funders, regulators and policymakers in support of the general principle of removing unnecessary delays from access to abortion.

Practical risk management

It is therefore generally agreed that the practice of early medical and surgical abortion is quite acceptable, but it is reasonable to allow the client to wait until intrauterine pregnancy is confirmed at a later date, if she so wishes.

All cases of delayed diagnosis of ectopic pregnancy should be reported as Patient Safety (Clinical) Incidents and analysed in audits of practice. Complaints and litigation can be reduced by the provision of comprehensive information about the risk of undiagnosed ectopic in early pregnancy. **bpas** provides this for doctors in the form of the ectopic pregnancy guidelines and for clients in the client information sheet *Caring for yourself after an abortion*. In suspected and doubtful cases, appropriate action must be taken. Consulting with colleagues to gain further advice and robust follow-up are essential. In combination these activities will reduce risk and lead to a better outcome for the woman.

Conclusion

The new **bpas** guidelines will raise awareness of the risk of ectopic pregnancy both with staff and clients. Ectopic pregnancy is a dangerous, painful condition and accordingly clients will feel aggrieved by any delayed diagnosis of it. Awareness of the problem will improve early detection and reduce morbidity from the condition.

References

The accuracy of transvaginal ultrasonography for the diagnosis of ectopic pregnancy prior to surgery. Condous G et al., Human Reproduction. 2005 May; 20(5): 1404-9.

The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7. Royal College of Obstetricians and Gynaecologists. 2004

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Specialist contraceptive advice and enhanced provision did not appear to reduce repeat abortions

MEDICAL UPDATE

UK: Aiding women's abortion decisions

Fertility Control Unit, St James University Hospital, Leeds: This study set out to evaluate the effectiveness of a decision aid to help women choose between surgical and medical methods of pregnancy termination. It was a randomised controlled trial comparing a decision-aid leaflet about termination methods with a control leaflet about contraception, set in an NHS regional centre for pregnancy termination. The sample comprised all women less than 9 weeks of gestation referred for termination of pregnancy over a period of 7 months in 2002.

Participants were given an envelope containing either the decision aid or the control leaflet prior to choosing between medical and surgical termination methods and completed two questionnaires, one immediately after this consultation and another after the termination procedure. The main outcome measures were: choice of termination method; measures of effective decision making including risk perception, attitudes and knowledge of both the medical and surgical methods; decisional conflict; anxiety and usefulness of the leaflet.

Three hundred and twenty-eight women participated. There was no difference in the method chosen between the groups (60/162 women in the decision-aided group chose a medical method versus 54/164 women in the control group). Women in the decision-aided group had higher knowledge and lower risk-perception scores about both methods, more positive attitudes about the medical method, lower decisional conflict, more stable evaluations of the decision information over time and higher perceived usefulness of information ratings. Anxiety was high but unrelated to leaflet type.

The authors concluded that women made more informed decisions when provided with an evidence-based decision-aid leaflet preceding a routine consultation about choices of termination method.

A randomised controlled trial of a decision-aid leaflet to facilitate women's choice between pregnancy termination methods. Wong SS, Thornton JG, Gbolade B, Bekker HL. *BJOG.* 2006 Jun;113(6):688-94.

USA: Use of online information about early abortion

Ibis Reproductive Health, 2 Brattle Square, Cambridge, MA: This study analysed the use patterns of an English-, Spanish-, Arabic- and French-language website dedicated to three methods of early pregnancy termination: mifepristone/misoprostol, methotrexate/misoprostol and misoprostol alone. It examined both the overall and language-specific use patterns of the website from October 1, 2004, through September 30, 2005.

Over the 12-month study period, the website received more than 78,000 visits and nearly 240,000 page requests. The English version is the most popular version of the website (accessed in 46.1% of all visits), followed by the Spanish (35.0%), Arabic (10.4%) and French (8.8%) versions. Spanish-language visits are nearly three times as likely to access the misoprostol-only section of the website when compared with the other language versions.

The authors concluded that this study confirms that multilingual, medically accurate online resources have the potential to expand information about medication abortion to both providers and women considering the option of abortion in diverse communities. Analysis of the language-specific use patterns highlights the different priorities of various types of website visitors and suggests future priorities for educational outreach, collaboration and research.

Providing medication abortion information to diverse communities: use patterns of a multilingual web site. Foster AM, Wynn L, Rouhana A, Diaz-Olavarrieta C, Schaffer K, Trussell J. *Contraception.* 2006 Sep;74(3):264-71. Epub 2006 Jun 6.

UK: Contraceptive methods and repeat abortions following termination of pregnancy

Lothian NHS Family Planning and Well Woman Services: One in four abortions in the UK is undertaken for women who have had one before. Women undergoing abortion in Edinburgh were targeted for improved contraceptive advice and provision in this randomised trial. Between November 2001 and May 2002, women recruited at assessment for abortion were randomised at admission to receive specialist contraceptive advice and enhanced provision (316 women) or standard care (297 women). Randomisation was based on the week of admission. Contraceptive use 16 weeks after abortion was assessed by questionnaire and subsequent abortions by review of the hospital records 2 years later.

Women receiving specialist advice and enhanced provision were more likely to leave the hospital with contraception (271 versus 115), which was more likely to be a long-acting method (141 versus 78) than women receiving standard care. Four months later, there was no significant difference in contraceptive prevalence or continuation, but women in the intervention group were more likely to be using contraceptive implants (32 versus 6). Two years later, 14.6% of women in the intervention group (44/302) and 10% of controls (27/268) had undergone another abortion in the same hospital.

The authors concluded that specialist contraceptive advice and enhanced provision had a short-lived effect on contraceptive uptake and increased the use of long-acting methods but did not appear to reduce repeat abortions.

Specialist contraceptive counselling and provision after termination of pregnancy improves uptake of long-acting methods but does not prevent repeat abortion: a randomized trial. Schunmann C, Glasier A. *Human Reproduction.* 2006 Sep;21(9):2296-303.

UK NEWS

Abortion statistics released

The Department of Health in July issued its annual bulletin. The key facts are as follows.

In 2005, for women resident in England and Wales:

- The total number of abortions was 186,400, compared with 185,700 in 2004, a rise of 0.4%;
- The age-standardised abortion rate was 17.8 per 1,000 resident women aged 15-44, the same as in 2004;
- The abortion rate was highest, at 32.0 per 1,000, for women in the 20-24 age group;
- The under-16 abortion rate was 3.7 and the under-18 rate was 17.8 per 1,000 women, both the same as in 2004;
- 84% of abortions were funded by the NHS; of these, just over half (52%) took place in the independent sector under NHS contract;
- 89% of abortions were carried out at under 13 weeks' gestation; 67% were at under 10 weeks;
- Medical abortions accounted for 24% of the total compared with 19% in 2004;
- 1,900 abortions (1%) were under ground E, risk that the child would be born handicapped.

Non-residents:

- In 2005 there were 7,900 abortions for non-residents carried out in hospitals and clinics in England and Wales (8,800 in 2004)

Abortion statistics, England and Wales: 2005. Department of Health, 4 July 2006.

In the USA in August, the Food and Drug Administration approved over-the-counter sales of the emergency contraceptive pill

bpas welcomes new Chair

After six very active years of sterling service to **bpas**, Joan Greenwood has handed on her chairmanship of the Board of Trustees to board member Ian Hammond. Ian brings a breadth of experience to the **bpas** Chair, including five years as Chief Executive of an NHS Trust and two years' interim management experience in the NHS. He spent 13 years as a civil servant in the Department of Health working in a number of high-level policy areas. One of his first tasks will be to work with the **bpas** senior management team on a Corporate Plan to take **bpas** to 2010.

Ann Furedi, Chief Executive of **bpas**, said: 'We thank Joan for her energy and expertise over the years, and she is handing over the Chair with **bpas** on a high. We are very much looking forward to working with Ian, who comes with a fantastic track record in senior health service management.'

Failed termination claim thrown out of court

A mother seeking compensation after giving birth following an abortion lost her damages bid in September. Stacy Dow claimed she had been told that both of her unborn twins would be terminated during an operation at Perth Royal Infirmary. She raised the legal action to force a health authority to pay £250,000 for the upbringing of her surviving twin. But her damages bid, launched at Perth Sheriff Court against NHS Tayside, was rejected.

Miss Dow, from Perth, claimed the hospital 'breached a warranty' after her daughter Jayde, now a healthy five-year-old, was born. In his ruling on the case, Sheriff Michael Fletcher said patients being treated within the NHS could not normally be said to have a 'contract' with their doctor. He stated that simply because a doctor had used the word 'termination' during a conversation with Miss Dow, it did not guarantee success, adding: 'In my opinion the action is irrelevant and should be dismissed.'

Abortion bid mother case rejected, BBC News, 11 September 2006

Sexual health funding used to pay off debts

The Independent Advisory Group on Sexual Health and HIV claimed in August that a substantial part of the £300 million set aside for improving sexual health services had been diverted into paying off primary care trusts' (PCTs) debts. A survey for the group found that cash set out in the *Choosing Health* White Paper is reaching frontline services in only 30 of the 191 PCTs questioned. Fifty-one said that they had absorbed their entire allocation into the general budget, and 33 had withheld some or most of the sexual health funding. A further 40 said that funding had not reached contraceptive services. The Department of Health said that trusts were responsible for sexual health services: 'We have provided . . . more sexual health funding than ever before.'

Sexual health funds used to cut trust debts, Times, 2 August 2006

WORLD NEWS

USA: ECP to be sold over the counter

After three years of controversy, the US Food and Drug Administration (FDA) in August approved over-the-counter sales of the emergency contraceptive pill (ECP). The drug, Plan B, will be sold only to women over the age of 18. Younger people will still need a prescription. The pills will be kept behind pharmacy counters and the drug manufacturers will send anonymous shoppers to check whether pharmacists are enforcing the age restriction.

The makers, Barr Pharmaceuticals, say Plan B will be sold at pharmacies but not at corner shops or petrol stations. Barr has said it hopes to begin non-prescription sales of Plan B by the end of the year. 'While we

still feel that Plan B should be available to a broader age group without a prescription, we are pleased that the agency has determined that Plan B is safe and effective for use by those 18 years of age and older as an over-the-counter product,' said company chief executive Bruce Downey.

'This is a historic event in the struggle for women's reproductive health and rights, and a long-overdue victory for science over ideology,' says Sharon L. Camp, president and CEO of the US Guttmacher Institute. 'For the first time we're trusting women to make good reproductive health care decisions by letting them buy their own hormonal birth control, without a prescription.'

Emergency contraceptive pills may prevent pregnancy if a woman takes them within 72 hours of having sexual intercourse. They work by stopping or delaying ovulation, or by stopping an egg settling in the womb. Research from the Guttmacher Institute suggests that in the USA in 2000, use of emergency contraceptives prevented more than 100,000 unintended pregnancies, 51,000 of which would have ended in abortion.

A news release from the Guttmacher Institute challenges the age restriction, claiming that this is 'contrary to the recommendations of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and other medical groups'. This restriction, says the Institute, is 'likely to delay or even prevent use within the window of time in which the pills are most effective. A number of studies support the safety of the drug for young teens and show that easier access does not lead to greater risk taking by teens.' Pharmacists in the UK have been allowed to sell ECPs without a prescription since 2001. **bpas** doctors can prescribe ECPs in advance, so that women will have a supply handy at home in case of emergency need.

US backs morning-after pill sales, BBC News, 24 August 2006; Plan B Decision by FDA a Victory for Common Sense, Guttmacher Institute, 24 August 2006

USA: Senate passes new anti-abortion legislation

The US Senate in July passed legislation making it a crime for adults to help minors travel to another state to get an abortion without the consent of their parents. The Bill imposes fines and up to a year in prison for an adult, apart from a parent or guardian, who helps a pregnant girl go to another state to get an abortion. There is an exception for when the pregnancy threatens the mother's life. Senator Hillary Clinton opposed the Bill, which, she said, would 'put any family member - a sister, an aunt, a grandmother - in jail, for helping a teenager deal with one of the most difficult decisions that any person has to make.'

New abortion rules will cost girls' lives, says Hillary Clinton, Daily Telegraph, 27 July 2006

Row over abortion case in Colombia

The first legal abortion was performed in Colombia in August since the deeply-Catholic nation legalised the procedure in May. Abortion is only permitted in three cases - if the mother's life is in danger, if the fetus is badly deformed or if the pregnancy results from rape. This case involved an 11-year-old girl who was raped by her stepfather. Despite the change in the law, the girl's case had to go all the way to the constitutional court before an abortion was authorised. The tale of the abuse the girl had endured at the hands of her stepfather filled the Colombian papers and news broadcasts for weeks. The Catholic Church nonetheless condemned the abortion and protesters gathered outside the hospital to oppose the procedure.

First legal abortion in Colombia, BBC News, 25 August 2006

'It can never be in the best interests of girls and women to force childbearing upon them,' said Ann Furedi, Chief Executive of **bpas**

ANTI-ABORTION ROUND-UP

More than 60 MPs have signed a Commons motion backing a review of abortion time limits, it was reported in July.

House of Commons science and technology committee chair Phil Willis said the issue should be looked at again, warning it was unwise to ignore changing circumstances. Lib Dem science spokesman Evan Harris said there should be a full Parliamentary debate, although he was sceptical whether advances had brought fetal 'viability' to under 24 weeks. 'I don't know the answer and I think Parliament should have the opportunity to see the science before advancing,' he added. Shadow health secretary Andrew Lansley agreed that abortion limits must be debated. He called for a free vote on all sides in the event of any legislative reform.

In June, Cardinal Cormac Murphy-O'Connor, head of the Catholic Church in England and Wales, called for ministers to lower the 24-week abortion limit. The Archbishop of Westminster made his recommendation at a private meeting at the Department of Health. He wants a joint committee of both houses of parliament to review the 1967 Abortion Act, and argues that technological advances meant the abortion laws are outdated.

In a press statement responding to the Archbishop of Westminster's proposals, Ann Furedi, Chief Executive of **bpas**, said: 'We know that the views of the Archbishop of Westminster are not representative of the UK public at large, the majority of which supports access to safe, legal abortion - or indeed, of the many Catholics who make a private choice to regulate their own fertility.'

'We see a small number of women coming forward for termination of pregnancy between 20-24 weeks' gestation. This group is particularly vulnerable. These are very young girls who have been simply too frightened to tell their parents about their pregnancy, or women undergoing the menopause, which can mask the symptoms of pregnancy; or women who have experienced a catastrophic family event during a wanted pregnancy. These devastating changes in circumstances typically involve the serious illness of an existing child who will need long-term care, or sudden desertion by their husband or partner.'

'These women have made an incredibly hard decision to end their pregnancy and they need support, not condemnation. It can never be in the best interests of girls and women to force childbearing upon them.'

Downing Street has said the prime minister believes the abortion laws are a matter for individual MPs rather than the government. Health Minister Caroline Flint said the issue was unlikely to be revisited. In July, it was reported that Austen Ivereigh, Cardinal Cormac Murphy-O'Connor's director for public affairs, resigned after admitting he had had an affair that led to an abortion.

Abortion time limit rethink urged, BBC News, 3 July 2006; *Cardinal's aide quits after admitting 'abortion' affair*, Daily Telegraph, 19 July 2007; *Women in difficult circumstances need support, not condemnation*, **bpas** press statement, 21 June 2006

COMMENT: Antenatal diagnosis and human rights

Barbara Hewson, counsel for D, reflects on the implications of D v Ireland.

According to evidence given to the All-Party Oireachtas Committee in 2000, Ireland has the second highest risk of neural tube defects in the world. This is not a record of which any country can be proud. But the European Court of Human Rights' recent ruling in *D v Ireland* suggests that Ireland may now have to provide termination of pregnancy to women diagnosed with lethal fetal anomaly. The 41-page decision, published on 5 July, has major implications for pregnant women and maternity hospitals, as well as for the media.

The tragic background to this case is well known. D was expecting twins when she had a routine scan at 14 weeks, early in 2002. She was informed that one twin had died. At 17 weeks, her other twin was diagnosed with a lethal chromosomal anomaly: Trisomy 18, also known as Edwards' syndrome. Her doctors indicated that they appreciated she was not eligible for an abortion in Ireland. Their view was understandable, in the light of the X case (the 1992 Irish Supreme Court case which established the right of Irish women to an abortion if their life was at risk because of pregnancy).

So D travelled to the United Kingdom for a termination. Later that year, whilst still in the throes of bereavement, she complained to the European Court of Human Rights. This was a brave step, which no Irishwoman had taken before. The European Court's rules allowed D to be granted confidentiality.

The Fourth Section of the Court held an oral hearing last September. There were seven judges, six of whom are men. Their nationalities are Irish, British, Maltese, Spanish, Finnish, Bosnian, and Albanian. By a majority, the size of which was not disclosed, the Court declared the case inadmissible. The majority reasoned that because D had not tested the legal waters in Ireland before she went abroad for her operation, she failed to exhaust her domestic remedies. At a minimum, the Court said, she should have sought counsel's opinion on her situation, and issued a Plenary Summons with a view to 'an urgent, preliminary and in camera hearing to obtain the High Court's response to her timing and publicity concerns.'

Nevertheless, the Court's decision is groundbreaking in a number of respects. Clearly it felt that the Irish courts should grapple with the difficult issues raised by D's case, first. This will come as a relief to politicians, who can now leave this topic to the judges. But the European Court also indicated that if D had started a constitutional action in Ireland, she could have succeeded. The government took the same approach, arguing that such an action had reasonable prospects of success. This may cause surprise in some quarters.

The European Court said: 'there is, in the Court's view, a feasible argument to be made that the constitutionally enshrined balance between the right to life of the mother and of the fetus could have shifted in favour of the mother when the "unborn" suffered from an abnormality incompatible with life.'

This is a green light for those who would like to see a development of the law in the X case. The government's stance fortifies this conclusion: whilst accepting that Article 40.3.3 of the Constitution prohibits a liberal abortion regime, it told the European Court that Irish judges would be unlikely to apply 'remorseless logic' when interpreting this Article, especially when the facts were exceptional.

Many will find it reassuring that the government takes such a pragmatic stance. But how can a pregnant woman contemplate a constitutional

How can a pregnant woman contemplate a constitutional action when coming to terms with a terrible diagnosis?

action, at such a vulnerable time, when coming to terms with a terrible diagnosis? Many would think this unrealistic. But the European Court disagreed. It accepted that the time frame for the Irish courts to decide such a case was extremely limited: a few weeks, at most. It also accepted that it was 'essential' for the woman's identity to be kept confidential in any litigation.

Other common law jurisdictions have shown that they can provide a speedy response in cases of controversy over proposed medical treatment. In England, for example, hospital lawyers and the Family Division of the High Court are used to urgent applications in medical cases. These cover a wide range of scenarios, from the mental patient who refuses medical treatment, to a hunger-striking prisoner, to cases where a patient lacks capacity and there is disagreement about what treatment is in his 'best interests.'

These cases are handled in a non-adversarial fashion: the court's role is to declare whether a particular procedure is lawful or not. They are almost always heard in private, and judges routinely order that no identifying details be published. I can see no reason why a pregnant woman seeking an urgent court ruling, following a diagnosis of Trisomy 18 or some other fatal condition, should not have her case handled with the utmost care and expedition by the Irish courts.

The government suggested to the European Court that it would be most unlikely that such a woman would be liable for legal costs, if she lost. And it argued that court pleadings would not be made available to a third party, without consent of the parties. So the way is clear for a hallmark case, provided that a woman unlucky enough to find herself in a situation similar to D's case has access to prompt legal advice and representation.

In future, women attending Irish maternity hospitals who receive a diagnosis of lethal fetal anomaly should be informed that they could apply to the High Court, should they want a termination in Ireland. Both the hospital and the State should cooperate, given the need for speed. The hospital might wish to apply with the woman as a co-plaintiff, because her doctors might also want preliminary directions from the court prohibiting their identification, and for the case to be heard *in camera* (in private).

The court would need to ensure that no details were published in any judgment or report of the case, which might identify the woman or her doctors. The present practice, whereby courts 'request' the media not to identify parties, will not do. It does not provide sufficient safeguards to a litigant whose constitutional rights to medical privacy and effective access to the courts are at stake.

The case of D has also helped to clarify aspects of the law relating to abortion information. For example, the law permits a hospital to give a woman her medical notes, if she wants to travel abroad for a termination. According to the government, there is no prohibition on Irish consultants making a formal referral to another hospital abroad, provided they do not make the actual appointment for an abortion.

So when a consultant is caring for a woman with an adverse antenatal diagnosis, who wishes to travel abroad for a termination, he can pick up the phone in the patient's presence to make contact with a foreign provider and explain his patient's situation. He can do a handover of care there and then, to ensure that continuity of care is not unduly interrupted.

A diagnosis of fetal anomaly is a tragedy for all concerned. It is sad that there is no guidance on the specific problems faced by pregnant women like D in Ireland. But the charity Antenatal Results and Choices (ARC) provides non-directive help and support to parents during and after the antenatal testing process (see www.arc-uk.org). It also produces a

useful handbook for parents when an abnormality is diagnosed in their unborn baby. Until some form of official guidance is available, this remains a helpful resource for those involved in maternity care, and their patients.

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Information bulletin

Education For Choice provides one-day training on discussing abortion with young people, for professionals working in health, education and youth work. For more information about the training and details of how to commission a training day in your area or attend a training day in London please email:

training@efc.org.uk

or

visit <http://www.efc.org.uk/Forprofessionals/Training>

Abortion Review is circulated to over 1000 subscribers consisting of health care professionals and advice agencies. If you would like to tell them about a key point of interest relating to abortion and sexual health or would like to promote a training event or seminar within the publication, please contact the marketing department on 01789 265009 or email abortionreview@bpas.org

But is she positive?



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