Abortion Review

ISSUE 18 SUMMER 2006 ISSN 02627299

INCREASE IN EARLY MEDICAL ABORTION: A GOOD NEWS STORY

By Ann Furedi, Chief Executive, bpas

The British press always gets itself in a tangle over abortion, largely because it tries to follow public opinion and public opinion is muddled. Nobody likes the idea of abortion but most people think it is necessary - 'the least worse option' for a woman with an unwanted pregnancy. Most people want abortion to be provided safely and legally and preferably as early in pregnancy as possible.

Typical media muddle-headedness was expressed in the *Times* (London) on 29 May. News that the number of women using early medical abortion (EMA) was rising rapidly - the subject of discussion at a **bpas** medical conference on 30 May - was reported on the *Times* front page. Inside the paper, a leader column argued that 'the popularity of early medical abortion should prompt soul-searching….'

The fact that in 2005 the number of women using EMA, also known as the abortion pill, at **bpas** clinics had doubled to 10,000, and that the charity, which provides a quarter of all British abortions, was seeing 65 per cent of clients in the first nine weeks of pregnancy - up from 56 per cent the year before - could and should have been an unequivocally 'good news story'.

Early medical abortion is when a woman takes a pill that results in the ending of her pregnancy. It is recommended by medical organisations as the best way to end a pregnancy in its earliest weeks. It avoids any surgical intervention, which reduces the risk of complications, especially infection. It is also cost effective for the National Health Service because it doesn't involve the use of theatres, gynaecologists or anaesthetists. The woman attends her clinic to be provided with the necessary medication and then returns home where she loses the pregnancy, much as she would do if she were to have a spontaneous miscarriage.

The use of early medical abortion also allows women to access services more quickly. Doctors are sometimes reluctant to carry out surgical abortions at very early gestations, because it is more difficult for them to be sure they have completed the procedure - but with early medical abortion, earlier is always better. And this in itself makes it preferable for many women. Today's pregnancy tests can confirm a pregnancy even before a woman has missed her period, and most women wanting abortion care want it as soon as possible. Preferably yesterday.

Improving access to early abortion is central to the UK government's sexual health strategy. Local Primary Care Trusts (PCTs) have been given additional funding to help them achieve targets for the number of abortions that are carried out before 10 weeks of pregnancy, and access to the abortion pill is widely understood to be a means to achieve this*. The Department of Health has specifically advised PCTs that they should ensure women have the option of the abortion pill.

So why the soul searching? The *Times* leader said: 'The rise in EMA's popularity may be explicable; it is not necessarily to be welcomed. Parliament has repeatedly reaffirmed a woman's right to choose. Such a choice must never be easy.' Why not? The *Times* also said that the abortion pill has many critics who say that EMA 'could give rise to a false impression that an abortion even in the early stages of pregnancy is relatively simple without physical or psychological risk. This is not true.'

Well, actually it is - almost. Of course, no medical procedure is entirely risk-free, but the risks of early medical abortion are extremely small and considerably less than the risks of pregnancy. And studies have shown repeatedly that early abortion of an unwanted pregnancy does not put women at risk of psychological damage.

The 'many critics' who disturb journalists so much are not just concerned about the abortion pill but about abortion in principle. They are horrified by the existence of a drug that makes the experience of abortion easier for women. This agenda was challenged in a forthright column by *Times* science editor, Mark Henderson, on 3 June. Questioning the 'real motive' of the abortion pill's critics, Henderson argued that clinics 'are open about the fact that EMA causes painful cramps and heavy bleeding, and sometimes infection, and advise patients accordingly. If anything, the drugs increase a woman's personal responsibility for her abortion: she must actively take a pill and a pessary, instead of submitting herself to a procedure performed by a doctor. It is hard to see how this encourages cavalier decisions to terminate.'

Michaela Aston, a spokeswoman for the anti-abortion organisation LIFE, told the *Times* that 'RU486 is a powerful and dangerous cocktail of drugs.' She claimed it had been responsible for the death of at least ten women and that the US Food and Drug Administration was currently considering a ban because of safety concerns. Such assertions, wrote Henderson, are 'misleading to say the least.' While it is true, he said, that the FDA is reviewing the drug, and convened a scientific conference on EMA in May, such monitoring is 'common practice' for any drug; and while the conference called for more research into Clostridium sordellii, a rare bacterial infection implicated in all five US deaths, it did not come close to recommending a ban.

Continued overleaf

Inside this issue:

Abortion and breast cancer: Another study finds no increased risk
Structured training for abortion care
Comment: Why abortion clinics won't be building barricades

**Abortion Review, a quarterly update on issues relating to abortion is produced as an educational service by bpas.
Editor: Jennie Bristow. Subscription enquiries to the marketing department - Email: abortionreview@bpas.org
Published by bpas, 4th Floor, Amec House, Timothy's Bridge Road, Stratford-Upon-Avon CV37 9BF, United Kingdom.
www.bpas.org**

It is fair enough for critics to say the abortion pill is wrong; it is intolerable to claim it is unsafe

For Henderson, the most striking evidence about the safety of EMA comes from 'the vast number of women' who have used it since the early 1990s: 'In Europe, the drugs have been taken by over two million women and there have been only three confirmed deaths. In the US, over 500,000 have used them, and five have died'. He continues: 'The makers of many other medicines would be delighted for a safety profile like this: Viagra's associated death rate is at least five times higher, at 5 per 100,000 prescriptions.'

The critics of Early Medical Abortion are entitled to their views. It is understandable that if you believe the destruction of fetal life is evil, you will oppose the use of a pill that allows this to be achieved more easily. That is honest opposition. What is dishonest, however, is to brief journalists that women can't cope with the experience, or that women's health is harmed. It is fair enough to say the abortion pill is wrong, if you believe that; it is intolerable to claim that it is unsafe.

Medical abortion is not new. Women have tried to use herbs and medicines for abortion for as long as they have wanted to end pregnancies. Evidence that women used abortifacient herbs dates back to the Egyptians. In the past, though, the success of the methods were somewhat hit and miss; usually more miss. Beecham's remedies never have been an effective way to interrupt a pregnancy; other more traditional folk remedies, such as ergomot, may have achieved the desired result sometimes, for some women. Today, however, women can legally access a safe, reliable, effective method of medical abortion. The latest figures show that they are doing so in ever-growing numbers.

No woman ever wants to have an abortion. It is the solution to a problem they wish they didn't have. Most women struggle with their decision to end a pregnancy. The availability of the abortion pill does not make their decision easier. It may, however, make the process easier. And why should that be wrong?

**For details of the NHS funding to increase access to early abortion services see:* Resource and cash limit adjustment in respect of improvements in early access to abortion services 2005/06, *published 29 Sept 2005.* www.dh.gov.uk

'Abortion pill allows faster, earlier abortions' say bpas doctors, **bpas**, 29 May 2006; *Abortions at home for 10,000; Leader: Bedroom abortions; Treatment by tablet offers women the safer option*, all from *The Times*, 29 May 2006; *Junk medicine: early medical abortion, The Times*, 3 June 2006; *What's wrong with 'do-it-yourself' abortions? spiked,* 5 June 2006.

MEDICAL UPDATE

UK: Abortion and breast cancer: EPIC study finds no increased link

Cancer Research UK Epidemiology Unit, University of Oxford: The role of spontaneous and induced abortion on breast cancer risk is examined among 267,361 women recruited into the European Prospective Investigation into Cancer and nutrition between 1992 and 2000. The data were collected from 20 centres, across 9 countries, and included information on a total of 4,805 women with breast cancer, of whom 1,657 reported having ever had any type of abortion.

Overall, the relative risk of breast cancer in women who reported ever having had a spontaneous abortion was not significantly elevated when compared with women who reported never having had such an abortion (RR = 1.07, 95% CI = 0.99-1.14). However, there was some evidence of a slight increase in the risk of breast cancer among women who reported having had 2 or more spontaneous abortions (1.20, 1.07-1.35). The relative risk of breast cancer among women who reported ever having had an induced abortion when compared to women who reported never having had an induced abortion was 0.95 (0.87-1.03). Overall, the findings provide further unbiased evidence of the lack of an adverse effect of induced abortion on breast cancer risk. (c) 2006 Wiley-Liss, Inc.

Breast cancer risk in relation to abortion: Results from the EPIC study. Reeves GK, Kan SW, Key T, Tjonneland A, Olsen A, Overvad K, Peeters PH, Clavel-Chapelon F, Paoletti X, Berrino F, Krogh V, Palli D, Tumino R, Panico S, Vineis P, Gonzalez CA, Ardanaz E, Martinez C, Amiano P, Quiros JR, Tormo MR, Khaw KT, Trichopoulou A, Psaltopoulou T, Kalapothaki V, Nagel G, Chang-Claude J, Boeing H, Lahmann PH, Wirfalt E, Kaaks R, Riboli E. International Journal of Cancer. 2006 Apr 27

UK: Fetal pain: a review of the evidence

In a review of evidence for the existence of fetal pain for the *British Medical Journal* (BMJ), Dr Stuart Derbyshire argued that telling women who are considering abortions that fetuses could feel pain was inaccurate and exposed them to inappropriate medical treatment.

Dr Derbyshire found that while the necessary biological system required for pain is complete at 26 weeks' gestation, real sensations of pain depend on experiences outside the womb. He compared the pain response of an unborn baby to that of a fruit fly larva that reacts to a flame by bending and rolling away, describing it as merely an automatic biological mechanism designed to avoid harmful stimuli. Derbyshire wrote in the *BMJ*: 'The neural circuitry for pain in fetuses is immature. Pain becomes possible because of a psychological development that begins at birth when the baby is separated from the protected atmosphere of the womb and is stimulated into wakeful activity. It is something that comes from our experiences and develops due to stimulation and human interaction. Proposals to inform women seeking abortions of the potential for pain in fetuses are not supported by evidence. Legal or clinical mandates for interventions to prevent such pain are scientifically unsound and may expose women to inappropriate interventions, risks and distress.'

Can fetuses feel pain? Derbyshire SWG. British Medical Journal 2006 April; 332: 909-912

UK: Pregnancy intention and contraceptive use

NHS Lothian Family Planning and Well Woman Services, Edinburgh, Scotland: The authors assert that most pregnancies ending in therapeutic abortion are assumed to have been unintended. In the developed world, most arise from inconsistent or incorrect contraceptive use. Ambivalence about pregnancy might be associated with less effective contraceptive use.

Three hundred and sixteen women undergoing abortion in Scotland were interviewed about contraceptive use at the time of conception. A modified measure of pregnancy intendedness was used to determine

The authors concluded that varying the interval between mifepristone and misoprostol does not affect duration or quantity of bleeding

ambivalence. Pregnancy appeared to be clearly unintended for 92% of women. Sixteen percent were not using contraception and had higher intendedness scores than those using a method. Forty-four percent were using contraception inconsistently or incorrectly, almost always condoms or oral contraception, but method choice was not linked to pregnancy intendedness. The authors concluded that women who are ambivalent about the desire for pregnancy are less likely to use contraception. The challenge for reducing abortion rates lies in improving contraceptive use among the much larger group of women who do not intend to get pregnant but use contraception imperfectly.
Measuring pregnancy intention and its relationship with contraceptive use among women undergoing therapeutic abortion. Schunmann C, Glasier A. Contraception. 2006 May;73(5):520-4.

USA: Low dose mifepristone and misoprostol in medical abortion
Department of Obstetrics and Gynecology, Boston University School of Medicine, MA: This pilot study was designed to evaluate the outcome of medical abortion following simultaneous mifepristone (100 mg) and misoprostol (800 mug). Enrollees had gestational ages up to 56 days and desired a medical abortion. They received 100 mg of mifepristone orally and 800 mug of misoprostol vaginally. Follow-up examination occurred in 2-7 days. A phone call 3 weeks later assessed symptoms and acceptability.

Forty women were enrolled; 39 women had follow-up visits. Completed medical abortion was confirmed for 35 (90%) of 39 women. Four women had uterine aspiration. Two patients required repeat misoprostol. Median time from medication to abortion was 7 h. Most women (92%) strongly preferred taking all medications in the clinic. The authors concluded that the simultaneous administration of vaginal misoprostol with 100 mg of oral mifepristone had the outcome of completed abortion within the predicted confidence interval. In addition, simultaneous dosing was highly acceptable.
Simultaneous very low dose mifepristone and vaginal misoprostol for medical abortion. Kapp N, Borgatta L, Ellis SC, Stubblefield P. Contraception. 2006 May;73(5):525-7.

USA: Buccal misoprostol for cervical preparation in second-trimester abortion
Department of Obstetrics and Gynecology, John H. Stroger Jr. Hospital of Cook County, Chicago, IL: The objective of this retrospective, descriptive study was to assess the adequacy and safety of buccal misoprostol with and without laminaria for cervical preparation prior to second-trimester abortion. Researchers analysed Planned Parenthood Federation of America data from 2,218 elective dilation and evacuation (D&E) procedures conducted on women at 12 to 23 6/7 weeks of gestation from April 2002 to March 2003. Each woman received 400, 600 or 800 microg of buccal misoprostol with or without laminaria for preprocedural cervical preparation.

Of the patients, 62% received 400 mug, 32% received 600 microg and 6% received 800 microg of buccal misoprostol; 42.8% had laminaria inserted for phased cervical preparation. The adequacy of cervical dilation was 88.7%. The D&E procedure was completed during a single surgical procedure for 99.8%. The overall adverse event rate was 19.39 per 1,000 women, with a rate of 4.51 per 1,000 women for serious adverse events. The authors concluded that use of buccal misoprostol with or without laminaria is effective and safe. If buccal misoprostol eliminates or reduces the need for phased, multiday laminaria 1-3 days prior to the surgical procedure, then its use may offer service advantages such as reduced number of clinic visits and fewer pelvic examinations per woman.
Adequacy and safety of buccal misoprostol for cervical preparation prior to termination of second-trimester pregnancy. Patel A, Talmont E, Morfesis J, Pelta M, Gatter M, Momtaz MR, Piotrowski H, Cullins V; Planned Parenthood Federation of America Buccal Misoprostol Waiver Group. Contraception. 2006 Apr;73(4):420-30.

USA: Bleeding after medical abortion
Department of Obstetrics and Gynecology, Boston University School of Medicine, MA: This study examined bleeding pattern following medication-induced termination of pregnancy, comparing two different dosing schedules of mifepristone and misoprostol. Diary information was analysed from a randomised, multicentre trial in which women used vaginal misoprostol 800 mug either 6-8 or 24 h following 200 mg of oral mifepristone. One thousand and eighty women with pregnancies up to 63 days' gestation were recruited for the study; 540 were randomised to the 6- to 8-h dosing schedule, and 540 were randomized to the 24-h dosing schedule. Subjects recorded daily bleeding in a diary over 5 weeks.

Total duration of bleeding ranged from 1 to 54 days, with a median of 7 days. Duration of spotting ranged from 1 to 80 days, with a median of 5 and 6 days in each of the two groups. Neither duration of bleeding nor duration of spotting were related to interval between mifepristone and misoprostol. Bleeding and spotting durations were not correlated with maternal age or smoking. Increased gestational age was correlated with longer bleeding and spotting times. Nulliparity was associated with longer bleeding time. The authors concluded that varying the interval between mifepristone and misoprostol in medical abortion does not affect duration or quantity of bleeding.
Bleeding after medication-induced termination of pregnancy with two dosing schedules of mifepristone and misoprostol. Chen AY, Mottl-Santiago J, Vragovic O, Wasserman S, Borgatta L. Contraception. 2006 Apr;73(4):415-9.

Introducing...

Abortion Review **online**

www.abortionreview.org

A web version of Abortion Review is launched this summer, to complement the print edition. Updated weekly, the online edition provides more stories in greater depth, with links to the original news sources and a searchable archive. Access is free - simply visit http://www.abortionreview.org to keep up to date with the latest developments from around the world.

A structured training programme will improve the image of the important field of Sexual and Reproductive Health

Structured training for abortion care

By Dr V P Argent FIMC FRCA FRCOG
Medical Director, bpas

The Faculty of Family Planning and Reproductive Health Care (FFPRHC) of the Royal College of Obstetricians and Gynaecologists (RCOG) has published the Syllabus and Logbook for the Certificates in Abortion Care. This is now the standard training package for nurses and doctors involved in induced abortion practice.

Up to now, there has been little structured training in abortion care. Since 1999, the RCOG has been developing Special Skills Training in all aspects of women's health care. The FFPRHC has a multidisciplinary, multiagency working party to develop special skills. The RCOG Guideline on the Care of Women Requesting Induced Abortion has emphasised the need for training including ongoing education and maintenance of sufficient caseload.

There has been little interest in abortion practice among Specialist Registrars and Consultants. Sometimes this is due to conscientious objection to abortion but the main reason is that many colleagues prefer other areas of specialisation such as assisted conception, cancer or fetal medicine. A structured training programme will improve the image of the important field of Sexual and Reproductive Health, which is high on the current health care agenda. An example of the resurgence of interest in training in this area was seen in a recent high profile General Medical Council case, where criticism was made of a practitioner's lack of specific training in dilatation and evacuation. The new Standards also implement the recommendations of Med FASH (Medical Foundation for AIDS and Sexual Health) on 'Recommended standards for sexual health service' and the 'Centre for HIV and Sexual Health - Quality standards in sexual health training'.

There are eight Certificates of Abortion Care available in total.

For doctors and nurses these are:

- **Consultation Skills**
- **Medical Abortion < 49 days post conception**
- **Medical Abortion > 49 days post conception**

For doctors only:

- **Manual Vacuum Aspiration**
- **Surgical Abortion < 12 weeks**
- **Surgical Abortion 12-13+ weeks**
- **Surgical Abortion 14-19+ weeks**
- **Surgical Abortion 20-23+ weeks**

Such training is applicable to nurses, primary care specialists in general practice and family planning, and specialists and trainees in obstetrics and gynaecology and sexual health in both the NHS and the independent sector.

The Faculty of Family Planning and Reproductive Health Care suggests that under current law, discussed in the case of *RCN v DHSS* (1981), nurses and midwives are unable to perform abortion procedures but can provide the medication prescribes by a doctor for medical abortion and assist in the provision of surgical procedures.

This ruling has been much discussed and it has been argued that this practical reading may not be a true interpretation of the law. It could also be said that a nurse may perform any medical or surgical abortion procedure even if a medical practitioner is not present throughout the entirety of the procedure so long as the medical practitioner is in overall control.

The Training Objectives of the new Syllabus are an overview of the medical, social and legal aspects of practice. The trainee is required to understand his or her role in the service and the need to refer to other specialists, as well as the wider aspects of abortion care in the development of their local services.

The knowledge, skills, attitudes and competencies covered are: ethics and law, pre-assessment care, physical and psychological risk factors, clinical examination, methods of abortion, management of complications, early and late post procedure care, contraception and sexual health issues, understanding the patient's perspective, communication, the non-judgemental approach and service networking.

The Training Components are made up of entry criteria, training programmes, the role of the Principal Trainer and Training Centre, a logbook, assessments, completion of training and revalidation. Candidates will gain experience by case reviews, clinical activity, and observed consultations. There will be tutorials on practice and topics from books, journals and the web and the use of role play.

The new Syllabus defines Competence levels. For example, direct supervision of surgical procedures should involve a minimum of 5 cases, if experienced, but 20 if no previous experience. The trainer will then sign that the competency has been achieved and the practitioner may undertake independent practice. Objective clinical assessment makes use of the current trend to label training assessments - for example, CbD = case based discussion, OSATS = Objective Structured Assessment of training, Mini-CEX = Clinical evaluation exercises.

There will be recognised centres and networks for Subspecialty Specialist Registrar training in Sexual and Reproductive Health including Principal Trainers for Certificates in Abortion Care. This new Syllabus will also direct the need for a comprehensive induction and training package for new medical, nursing and other staff and will also aid ongoing Continuous Professional Development.

bpas fully supports the new Syllabus from the Faculty of Family Planning and Reproductive Health Care and looks forward to playing a major role as a training centre.

See: Syllabus and Logbook for the Certificate in Abortion Care of the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists. RCOG London (2006)
For further information visit **www.ffprhc.org.uk**

'This is about more than just South Dakota: it's about the country,' said Nancy Keenan, president of NARAL Pro-choice America

UK NEWS

Court hears compensation claim for failed termination

Hospital bosses in March attempted to have a damages bid from a woman who gave birth following an abortion thrown out. Stacy Dow launched the £250,000 civil claim against the NHS to pay for the twin who survived the procedure at Perth Royal Infirmary in 2001. Ms Dow said she needed to cover the 'financial burden' of raising her daughter Jayde, and is claiming Tayside University Hospitals NHS Trust failed properly to carry out the abortion, constituting a breach of contract. But Perth Sheriff Court heard the 21-year-old was given no guarantees the abortion would be successful.

Advocate David Stephenson, representing the hospital authority, said the case should not proceed. He said no contract had existed between Ms Dow and her consultant when she was told an abortion would be carried out, so her claim was not relevant. 'Nothing said to (Ms Dow) by the doctor could or did mention a warranty that her pregnancy would be terminated,' he said. 'NHS patients do not normally contract with their health trust or health boards for the provision of medical service. These services are delivered as part of a statutory obligation.' Mr Stephenson said no guarantee had been given to Ms Dow that the abortion would be successful. He added that only in 'truly extraordinary' circumstances would any sort of contract between a doctor and a patient be entered into.

Ms Dow is said to have suffered 'distress and anxiety' from the discovery of her continued pregnancy and 'pain and discomfort' when she had her daughter by Caesarean section. She also argued she had suffered economically through a loss of earnings because she was a single mother. Sheriff Michael Fletcher will decide how the case will proceed, following the legal discussions.
Hearing for abortion bid mother, BBC, 20 March 2006

bpas launches new information service

A ground-breaking pilot information and awareness campaign linked to a new faster abortion service referral scheme was launched on 8 May by **bpas**. The London-wide text message, website, poster, leaflet and postcard campaign 'Unplanned Pregnancy: Your choices' is aimed at women faced with an unplanned pregnancy. It gives impartial and practical advice on continuing the pregnancy, as well as on seeking abortion. The campaign seeks to raise women's awareness that time is of the essence when deciding about pregnancy or abortion care.

For the first time, information can be made discreetly available directly to the pregnant woman by a simple text message to her mobile phone. A confidential phone number for advice and even the location of her nearest abortion clinic can be given in this way. The new abortion service referral scheme will cut unnecessary waiting time by allowing women to refer themselves directly to see their local abortion professional via a priority booking number, rather than waiting for their doctor to refer them on.

Ann Furedi, Chief Executive of **bpas**, said: 'We are trialling new means of discreet information-giving because no woman anticipates needing an abortion - but vital information and help is not always easily or promptly available to her. Yet in other areas of healthcare or important domestic matters, most of us wouldn't think twice about keeping a number handy in case we needed to call a specialist in an emergency. We see around 50,000 women a year for abortion treatment and we know from them that a new system of balanced information provision about their options is vital. Sometimes the GP appointments system can not give women access to specialist services promptly enough. Women need this new service because appropriate treatment advice must be made available as soon as it is requested.'

The new priority bookings number is 0845 365 4545. The new website is at **http://www.pregnancychoice.co.uk** To access the discreet text message information service text 'CHOICE' to 60300.
Time for a new deal for women facing unplanned pregnancy, **bpas**, 12 May 2006

WORLD NEWS

USA: Campaigners fight South Dakota ban

South Dakota's governor, Mike Rounds, on 6 March signed a bill that will make it a crime for doctors to perform an abortion unless the procedure is necessary to save the woman's life. The legislation would make no exception for instances of rape or incest, though victims in such cases could get emergency contraception. Under the new law, doctors could get up to five years in prison for performing an illegal abortion.

The move is seen as one of several intentional challenges to *Roe v Wade*, the case that made abortion legal in the USA in 1973. Mississippi's governor, Haley Barbour, has said he will sign a bill to all but ban the procedure, and new anti-abortion legislation has been proposed in Ohio, Georgia, Missouri and Tennessee. 'The anti-choice folks across the country are feeling emboldened by the climate,' said Nancy Keenan, president of NARAL Pro-Choice America. 'You have an anti-choice president; you have an anti-choice US house and senate. We see that this is about more than just South Dakota: it's about the country.'

The abortion bill passed South Dakota's Republican-dominated legislature: the House voted by 50 to 18, the senate by 23 to 12. However, in the likely event of a legal challenge before the legislation is due to take effect, a judge would probably suspend the abortion ban, meaning that the bill would not change state policy unless the case got all the way to the US supreme court and the state won. About 800 abortions are performed each year in South Dakota.

Rob Regier, executive director of the South Dakota Family Policy Council, commended Mr Rounds' decision to sign the bill into law. 'His signature marks the beginning of a renewed effort to abolish abortion in our country,' he said. And the Republican senator Bill Napoli said on the US TV channel PBS that most abortions were being carried out for 'convenience'. He insisted, however, that exceptions could be made for rape or incest under a provision that protects the mother's life.

A US pro-choice group promptly launched a petition drive to overturn the ban. The South Dakota Campaign for Healthy Families aimed to collect 16,728 signatures needed to put the ban on hold and put it to a public vote. By 19 June, the campaign claimed to have gathered 38,000 signatures. Voters will now decide whether the law should be brought

UK LifeLeague's use of American resources demonstrates not a threatening alliance but its weakness

into force or rejected when the question is added to ballot papers in an election scheduled for 7 November 2006.

South Dakota outlaws abortion, Guardian Unlimited, 7 March 2006; *S Dakota abortion ban challenged,* BBC, 24 March 2006; *New S Dakota abortion ban on hold,* BBC, 19 June 2006

India: Sex selection controversy continues

A senior Indian doctor in March called on UK health officials to investigate what he says are rising numbers of British Asian women having abortions in India. According to gynaecologist Puneet Bedi, the women are travelling to India to have abortions if they find they are expecting girls. He said British GPs were referring women to clinics in India.

This claim follows a recent report in medical journal *The Lancet*, which estimated that as many as 10 million females may have been aborted in India in the last 20 years. However, the Indian Medical Association disputed the findings, saying gender selection had dropped since a court ruling in 2001 clamped down on the practice.

Also in March, it was reported that a doctor in India and his assistant have been sentenced to two years in jail for revealing the sex of a female fetus and then agreeing to abort it. This is the first time medical professionals have been jailed in such a case. Dr Anil Sabhani and Kartar Singh were caught in a sting operation in the northern state of Haryana. Government officials sent in three pregnant women as decoy patients to find out if the clinic would carry out abortions based on sex selection. Audio and video evidence showed the doctor telling one woman that tests had revealed that she was carrying a 'female fetus and it would be taken care of'.

In April, the state-controlled National Commission of Women (NCW) in India called for a more stringent implementation of a law banning sex selection. On the occasion of World Health Day on 7 April, the NCW says it has launched what it calls a 'fight-to-the-finish' against the misuse of sex selection tests and abortion of female fetuses.

In May, police in the Indian state of Rajasthan launched an investigation into 21 doctors who are alleged to have been involved in aborting female fetuses. The move came as women's groups marched in the state capital, Jaipur, in protest over the issue. The claims came to light when a private TV channel reported on female feticides across Rajasthan. Police have now filed cases under the Pre-Natal Diagnostic Techniques Act (PNDT), which makes selective abortions illegal, against 21 doctors from government-run and private hospitals. The state health minister said those found guilty of such practices would be severely punished.

Doctor queries Indian abortions, BBC, 8 March 2006; *India sex selection doctor jailed,* BBC, 29 March 2006; *India to tackle female foeticide,* BBC, 7 April 2006; *Inquiry into Rajasthan foeticides,* BBC, 15 May 2006; *Low male-to-female sex ratio of children born in India: national survey of 1.1 million households* Jha P, Kumar R, Vasa P, Dhingra N, Thiruchelvam D, Moineddin R. The Lancet - Vol. 367, Issue 9506, 21 January 2006, Pages 211-218; *India 'lost birth' study disputed,* BBC, 11 January 2006.

ANTI-ABORTION ROUND-UP

Comment: Why abortion clinics won't be building barricades

By Ann Furedi, Chief Executive of bpas

In April, a small group of anti-abortion extremists announced their intention to send a fleet of lorries around the country displaying anti-abortion material. Speaking on Sky News, the UK LifeLeague's spokesman, Reverend James Dowson, explained his plan to stop at abortion clinics along the way. However, Dowson has been big on talk and small on action.

Dowson's plans to make citizens' arrests on abortion doctors, to protest at the homes of abortion providers, and to organise mass protests to close down clinics, amounted to nothing despite media coverage. His newsletter reported that during advent, UK LifeLeague staged vigils 'outside abortion mills right across the UK'. This was news to us. **bpas** runs 18 clinics, more than 30 referral centres and performs a quarter of Britain's abortions but, if the protests took place at all, they passed us by.

Dowson's latest campaign, to 'name and shame' abortion providers by exposing us to the anger and disgust of the community, has failed because most of us are 'out and proud' about our work and know our communities support us. Following TV or radio appearances, I have faced a range of responses, from curiosity to support, but never hostility. My only physical assault has been a hug from a stranger in a supermarket, grateful to **bpas** for speaking out.

In today's news-hungry environment, what is reported by journalists rapidly acquires the status of truth, whether or not it actually happened. The activities and influence of abortion's opponents are particularly exaggerated because commentators look to the USA for trends that will appear in the UK. In the USA, elements of the anti-choice movement are a serious threat. Here, public policy and public opinion clearly supports legal abortion. The issue is less politicised, less polarised, and those fundamentally opposed to abortion have a tiny and marginal audience. UK LifeLeague's use of American resources demonstrates not a threatening alliance but its weakness and reliance on overseas resources.

Anti-choice activity is good copy for journalists. Anti-choice journalists like to write stories about the strength of the anti-choice movement because it allows them to promote their cause. Some pro-choice journalists like to write stories about the strength of the anti-choice movement because they believe it reminds people they should not take legal abortion for granted. But exaggerating the strength of the zealots like Dowson is more damaging than the stunts he pulls. It creates the impression that abortion services are controversial and under siege when, in reality, the opposite is true. Today, more women are able to get safe, legal NHS-funded abortions than ever before. Providers fret far more about how to make services more accessible than they do about anti-abortion activity. When they come to a **bpas** clinic they can be sure of being met by confident, caring staff and not a crowd of protesters.

Panics about small groups of fanatics take people's attention away from the real threats to abortion in Britain

Panics about small groups of fanatics take people's attention away from the real threats to abortion in Britain: the shortage of abortion doctors, new regulations that needlessly increase the cost of care with no discernable benefit, and political conservatism that blocks changes than could make abortion even easier.

If UK LifeLeague takes its trucks out, it may learn a few important lessons: how few people support it and how marginal its influence is. Hopefully, the media will get the same message.

Sunday Times 'scandal' of abortions for club foot
A front-page article by Lois Rogers in the *Sunday Times* on 28 May claimed that 'More than 20 babies have been aborted in advanced pregnancy because scans showed that they had club feet.' Citing 'figures from the Office for National Statistics covering the years from 1996 to 2004', the article also claimed that 'a further four babies were aborted because they had webbed fingers or extra digits, which are also corrected by simple surgery', and that all the abortions took place 'late in pregnancy, after 20 weeks'.

News of the terminations, claimed Rogers, has 'reignited the debate over how scanning and gene technology may enable the creation of "designer babies". She cited the 2002 controversy that took place over a fetus aborted at 28 weeks after scans found that it had a cleft palate, and said: 'Some parents, doctors and charities are increasingly worried by what they see as a tendency to widen the definition of "serious handicap". Club foot, says the article, is one of the most common birth defects in Britain, affecting about one in 1,000 babies - meaning that 600 to 700 infants are born with the condition every year.

Jane Fisher, director of the charity Antenatal Results and Choices, commented: 'The figures quoted by Lois Rogers represent a tiny minority of cases; cases we would not wish to comment on as we do not know the individual circumstances of the women involved. The suggestion that this is part of an increasing trend towards a quest for "designer babies" is at best erroneous and at worst insults those women who make the difficult decision to end a wanted pregnancy after a diagnosis. In our experience, it is not a decision undertaken lightly, on the contrary, women make their choice responsibly as they know they will live with the consequences.'
Babies with club feet aborted, Sunday Times, 28 May 2006. *Antenatal Results and Choices:* www.arc-uk.org

Anti-abortion campaigner denied hospital treatment
A 75-year-old man was denied hip treatment after health officials warned him about sending hospital staff pictures of aborted fetuses, it was reported in May. Anti-abortion supporter Edward Atkinson was jailed for 28 days for sending offensive photos to the Queen Elizabeth Hospital, King's Lynn, Norfolk. The hospital said Atkinson had been banned from treatment for anything other than life-threatening conditions.

Atkinson, of Ely Road, Hilgay, Norfolk, had been on a waiting list for an assessment for a hip operation when he started sending in pictures of aborted fetuses. The NHS Trust wrote to him asking him not to send such material to the hospital as it was distressing staff. When he continued, the trust said he had broken its 'zero tolerance' policy with regards to staff. On 8 May, Ruth May, chief executive of the Queen Elizabeth Hospital, said in a statement: 'The trust's view is that we have a duty of care to our staff. Our legal advisers were consulted and their opinion was that this man's actions contravened the NHS Zero Tolerance policy in cases of abuse or unacceptable behaviour towards our staff. We take such matters extremely seriously and because he continued to send extremely graphic material to us we exercised our right to decline treatment to him for anything other than life-threatening conditions.'

At Swaffham Magistrates Court, Atkinson was convicted of three counts of sending offensive literature or material to staff at the hospital between January and April this year. The literature, sent via the post, contained colour images of a dead fetus and the video, hand delivered, was of an abortion.
Hospital bars fetus photos man, BBC, 9 May 2006

Catholic leader admonishes church over contraceptive referrals
A Catholic hospital has been admonished by the leader of the church in England and Wales for referring patients for abortions and contraceptives, it was reported in March. Cardinal Cormac Murphy-O' Connor asked the St John and St Elizabeth Hospital in north London to tighten up its code of ethics. The private hospital said no abortions are undertaken or contraceptives prescribed on the premises, but it argued its doctors are obliged to refer people elsewhere for advice.

A spokeswoman for the hospital said: 'Under General Medical Council code of practice, which all UK doctors must observe, the doctors must provide information to patients who request abortions or contraceptives. So they will be referred to external services for advice and counselling.' Cardinal Murphy-O'Connor asked a Catholic peer to investigate complaints that Catholic teaching was not being upheld at the hospital.

A spokesman for the Archbishop of Westminster said the hospital's own code of ethics needed to be set out in a clearer way so that even doctors who were not Catholic knew what their obligations were at the institution. 'A Catholic hospital cannot refer people for abortions - they can't say you can't have it here but there's a place just round the corner,' the spokesman added. Equally it cannot carry out tests for fetal deformities if it knows the mother-to-be would have an abortion if the results were positive, he said. A General Medical Council spokeswoman said if doctors felt unable to offer a certain kind of treatment because of their beliefs they were obliged to inform the patient of this and inform them of their right to see another doctor.
Abortion row at Catholic hospital, BBC, 20 March 2006

Information bulletin

'Freedom and rights in reproductive health', the Seventh Congress of the International Federation of Professional Abortion and Contraception Associates (FIAPAC), will be held on 13/14 October 2006 in Rome, Italy.

Plenary discussions include:

- **Abortion in Europe**
- **Recent developments in abortion technique**
- **Pain management in abortion**
- **Fantasies and reality of abortion and contraception**
- **How to overcome the resistance against medical abortion**
- **Who is afraid of a woman's right to self-determination?**

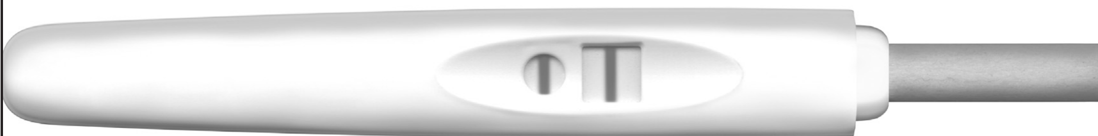
All participants are invited to bring teaching and information material like leaflets, posters and videos used in their country or institution. Please contact the organising committee if you have material to sell.

For further information visit www.fiapac.org

To contact the FIAPAC organising committee:
Tel: +43 699 178 178 03
Fax. + 43 1 89 22 581
Mariahilfergürtel 37
A-1150 Vienna
e-mail: fiapac@aon.at

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?



Your next patient is pregnant but doesn't want to be.

Where next? As a registered charity since 1968, **bpas** has offered affordable abortion care for women. We provide almost 50,000 abortions a year (including service agreements) and can offer all the professional help your patient needs.

bpas has a nationwide network of clinics and consultation centres. There are no long waits for appointments.
We can offer a choice of times, clinics and procedures. All it takes to arrange an appointment is one call to **bpas** on 08457 30 40 30.

08457 30 40 30

bpas positively the best service