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# A MORAL DEFENCE OF LATE ABORTION

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The blogosphere has been jangling in response to American writer Will Saletan's appeal for the pro-choice community to accept restrictions on later abortions. (1) Saletan argues that later abortions would be unnecessary if women behaved responsibly and society provided the means for them to do so. Contraception would, he argues, reduce the abortion rate by voluntary means.

We should, argues Saletan, see good contraceptive use as 'moral practice', abortion should be re-stigmatised and women requiring abortions repeatedly should be targeted for particular approbation: 'One intended pregnancy should be enough to warn you – and the doctor who vacuums out your uterus – not to risk another'. (2)

These arguments have been well-rehearsed by Saletan and others and are common in Britain as well as the USA. Two years ago, many British parliamentarians supporting a (failed) attempt to move the 24-week 'time limit' for abortion forward to 20 weeks' gestation of pregnancy believed that late abortion was unnecessary because it could be prevented. This thinking underpins the laws in most European countries, which allow abortion 'on request' in early pregnancy but impose stringent conditions at later gestations.

Saletan has written an intelligent book on abortion (3) and has a reputation for being a bit of a thinker, so his recent interventions have attracted support. In November 2010, in a conversation on Bloggingheads.TV, Frances Kissling, a former president of the US organisation Catholics for Choice, said that in view of the 'evolving potential of fetal life', she was willing to discuss rolling back the legal deadline for unrestricted abortion to 18, 16, or even 14 weeks. She stated her position this way: 'As long as women have an adequate amount of time to make a decision, and there are provisions for unusual circumstances that occur after that time, I would be satisfied. … Women have an obligation to make this decision as soon as they possibly can.' (4)

Kissling no longer speaks for Catholics For Choice, which has stressed its support for women's choice. (5) But as a visiting scholar at the University of Pennsylvania, Kissling's comments have carried some weight.

The heated character of the debate around 'late' abortion is curious, given that 'early' abortion is almost beyond controversy. Most developed countries now accept that women should be able to access abortions up to gestations of 10, or 12 weeks – the first trimester of pregnancy – with little debate or stigma around such procedures. But, paradoxically, as early abortion has become more accepted, later procedures have attracted increasing concern. And even some of those associated with the pro-choice movement have begun to express doubts openly about whether a woman should be able to choose to end her pregnancy once her fetus begins more closely to resemble a baby.

How do we account for this shifting approach to the parameters of choice?

## Early abortion

Society's difference in attitude to early and late abortion is simple to understand on a pragmatic level. Modern democratic societies tend towards a framework of values that are relative rather than absolute. So, abortion is often perceived as 'wrong' but, at the same time, it is accepted as the 'right' thing to do *in certain circumstances*. No one likes the idea of abortion, and everyone agrees it would be better if unwanted pregnancies were prevented. But when contraception fails, or people fail to use it effectively, abortion is usually seen as preferable to the alternative: an unwanted birth to an unwilling mother. In short, abortion is a 'lesser evil'.

It would be difficult for society to eschew support (at least, qualified support) for abortion and maintain other values it holds dear. For example, society attaches huge importance to the wantedness of children and the responsibility that their parents have for their care. It is seen as right and proper that people should plan their families. At the same time, sex is seen as a normal, healthy part of an adult relationship: most people accept sex is an expression of love, intimacy and pleasure; no longer is it, normally, associated with the intention to reproduce. It follows from this that preventing the *conception* of unplanned, unwanted children is seen as responsible and moral.

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Given that society believes that unwanted pregnancies should be prevented by contraception, it also follows that, when this fails, society accepts abortion may be used as a 'back-up' to prevent an unwanted birth.

Britain has based its law on the principle that abortion should be available to women who were 'unfit' to have children since its legislative defence against criminal abortion was codified in the Abortion Act 1967. Today, this view holds: abortion is a part of 'public health'. Almost all abortions are commissioned and funded by the state health care system, and access to early abortion has been part of official national strategies to improve sexual health.

But abortion still needs to be 'necessary': even at early gestations, two doctors must certify that legal grounds are met. An abortion is approved because it is the best outcome for the woman and her existing family. In essence: early abortion is justified pragmatically: it is socially necessary because, without it, the inevitable and unavoidable large numbers of unplanned pregnancies will result in the social cost of unwanted children born to unwilling mothers.

This relatively conservative rationale for abortion is accepted throughout most of society in the early weeks of pregnancy. But as the gestation advances, support for abortion declines for a combination of practical, ethical and aesthetic reasons, which are usually difficult to untangle.

## The problem of later abortion

There is little dispute that when abortion is necessary, there is a sound clinical case for abortion as early as possible. The risks of abortion increase with size and development of the fetus because later abortion techniques are more specialised and are associated with a greater risk of complications. Although any increased risks associated with later abortion is still lower than those of full term delivery, the procedure is more demanding physically and emotionally for patients and providers than in the early weeks of pregnancy. (6)

Public support for early abortion is far stronger than for late. The early abortion of an unrecognisable embryo is more acceptable to public opinion than a procedure that destroys an 'unborn baby' that is identifiably human. The ethical distinction between an abortion at six weeks and one at 16 is less clear (and we will return to this point), but many hold the view that early abortion is 'more right than wrong' whereas late abortion is 'more wrong than right' and requires a special justification.

The pro-choice movement has tended to side-step a moral, normative, discourse, preferring to concentrate on the truthful claims that later abortions are as necessary as early abortions and so can be justified on the same grounds.

We accept that abortions should be carried out 'as early as possible'. We, too, have advocate that it is better to prevent the need for later abortions, and promote contraception. Our defence of second trimester abortions has been based largely on the pragmatic acceptance that early abortion is not always a possible solution to a problem pregnancy and that later abortions are necessary, if regrettable. We believe that the delivery of an abortion procedure in the second (and even third trimester) is preferable to its denial, since the denial of abortion has consequences for a woman's life, for the lives that are touched by hers, and for the life of child that will be born.

## Why do women have later abortions?

We know that later abortions are necessary because we know why they are requested. The causes are well-documented in Europe and the US, and although national circumstances affect some aspects, the reasons women give are broadly the same. In the USA they tend more towards problems of access and cost, reflecting the difficulties with access and availability. (7) In Britain, the reasons for delays are more idiosyncratic and usually based on personal circumstances - but as research into why women have late abortions indicates, these reasons are no less compelling. (8)

In Britain, we know that the proportion of women requesting abortions after 20 weeks remains remarkably consistent (at around two per cent) regardless of changes to access in early services. This implies that better access to early abortion would not reduce the need for later procedures. Doctors explain that there are few later abortions because women rarely request them. Many women, who would have few qualms about opting for a pregnancy to be terminated in its early weeks, balk at the thought of ending a life they have felt move inside them. A late medical induction, or a surgical procedure, is no trivial matter.

In February 2008 BPAS, which provides most procedures in the UK between 20 and 24 weeks' gestation, audited the case notes of all women requesting abortion after 22 weeks' gestation. During this 28 day period, requests from 32 women aged between 14 years and 31 years were documented. A table of the case summaries is appended at the end of this article, with the comment BPAS issued at the time.

This data is interesting in the light of the comments made by Saletan and Kissling, which imply that women delay making 'their' decision *needlessly* and that an adequate amount of time for a woman to make up her mind might be 18 weeks or less (with special provision for those in 'exceptional circumstances'). It is striking that the circumstances of all of the women attending BPAS clinics could be seen as either 'exceptional' (as in exceptionally difficult and complicated) or 'unexceptional' (as in so similar in their causes).

It may seem *exceptionally* lax for a woman to 'not realise she is pregnant' for four or five months after she has conceived, until you consider how many of these women were not menstruating for various reasons, or didn't consider they could be pregnant – sometimes because they were had been using contraception 'responsibly'. When this is factored in, women's 'delay' seems *exceptionally* understandable. Every single case can be seen in this way – including the women whose circumstances change *'exceptionally'* during their pregnancy, because a relationship ended or a fetal anomaly was identified, and the young girls who are *'exceptionally'* driven to deny or conceal their pregnancy.

If our defence of later abortion is simply as a pragmatic response to the needs of a woman with a problem pregnancy, then there is no

reason to assume that any higher burden of justification is required than for earlier procedures.

If we think later abortions should only be an option in exceptional circumstances, we must ask: Who should decide what those circumstances should be? And what makes a circumstance 'exceptional'? Who do we think is better placed than the woman herself to understand and judge her situation? Why do we not trust women to make the decision about whether their own circumstances are 'exceptional' enough? Do we doubt that what individuals find exceptionally compelling about their own case, may be insufficiently compelling to *us*? Do we fear that others do not possess sufficient capacity to weigh the balance of 'right' and 'wrong' and precisely as we do?

This takes us into the realm of moral argument, and it is right that it should do so. We should scrutinise whether the decision to end a pregnancy is a matter for individual conscience or if it must be justified to others according to defined criteria. A discussion based on the pragmatic need for abortion does not, and cannot, address this.

## The ethics of later abortion

The ethical issue is straightforward for those who believe that abortion is absolutely wrong and should never be solely a matter of individual personal choice. Similarly, there is little ambiguity for those who believe that a woman has absolute autonomy to decide on the future of her pregnancy. The difficulty exists only for those who try to straddle the gap between these fundamental positions and argue that abortion should be a woman's choice, but it should be less of a choice in later pregnancy.

These 'ethical straddlers' represent a substantial section of the pro-choice community. Marge Berer, the editor of the journal *Reproductive Heath Matters*, wisely cautioned a recent pro-choice conference that: 'How late in pregnancy abortions should be permitted and carried out is a matter of great controversy among almost everyone – except the women who need them.' She might have added that even many of 'the women who need them' would claim that in general later abortion is wrong but their own case is 'exceptional'. (9)

To me, the argument for a gradualist approach to the ethical rightness or wrongness of abortion that depends on gestation of the fetus is weak, lacks intellectual consistency, and seems self-serving. It seems little more than a instrumental argument to justify women's access to abortion according to personal preference: to allow it when 'I approve' and to deny it 'when I don't'. Excepting those who think abortion is always wrong, most of us have personal preferences and subjective inclinations that cause us empathise with some women's requests but not others. For example, some of us will identify with the woman who requests abortion on grounds of fetal abnormality, some of us will be appalled by her thinking. Some of us will be sympathetic to a woman wants to end a pregnancy that happened because the condom stayed in the packet; some will think her undeserving. Some of us will personally feel that an abortion is acceptable in early pregnancy, but not when more time has passed.

If we are honest, we will probably admit that we all make judgements about which abortions that we think are right and wrong – just as women do for themselves. But there is a world of difference between making an individual judgement, and seeking to constrain others from making, *for themselves*, the decisions we would not. Our colleagues who argue that that should be greater justification for an abortion after *x* weeks, are really no different to those doctors who argue that, before they approve a woman's request, she should justify her failure to use contraception or why she is returning for a second procedure. In essence all they are saying is that abortion should be approved when *I* approve and not when *I* do not.

To the 'ethical straddlers' concerned about gestation we must ask: is there anything qualitatively different about a fetus at, say, 28 weeks that gives it a morally different status to a fetus at 18 weeks or even 8 weeks? It certainly looks different because its physical development has advanced. At 28 weeks we can see it is human – at eight weeks a human embryo looks much like that of a hamster. But are we really so shallow, so fickle, as to let our view on moral worth be determined by appearance? Even if at five weeks, we can only see an embryonic pole, we know that it is human. The heart that can be seen beating on an ultrasound scan at six weeks is as much a human heart as the one that beats five months later.

Claims that the fetus has 'evolving potential' make little sense. The potential of fetus does not evolve; it just is. A fetus may draw closer to fulfilling this potential as it develops and as its birth approaches, but the potential does not change. Indeed, from the time of conception, as soon as embryonic cells begin to divide, an entity with the potential to become a person is created. It is the product of a man and a woman, but distinct from them. It has a unique DNA and, unless its development is interrupted or fails it will be born as a child.

To accept that the blastocyst or embryo has the potential to evolve into a person is not to say it should be treated as a person or even that it must be accorded moral worth because of it's potentially. As the ethicist Professor John Harris argues, we are all potentially dead, but that does mean that we treat people as though they are already dead. (10)

The fact that a biological entity is potentially a person does not mean that we must treat it as a person – or, even, consider its moral status as special. We may wish to do this because we may feel something that has the potentiality to be a person has greater worth than something that not. We may feel that a human embryo has greater moral status than a cat (which for all its conscious abilities and sensory perception can never be a human person), or we may believe that a cat has greater moral claims than an embryo, which is potentially a person but not yet an independent living being. Both of these positions can be presented as consistent, rational, logical arguments.

But it is difficult to see how it can be argued that a fetus should be accorded a moral status that differs at different stages of its development on the grounds of 'evolving potential', since a fetus at 28 weeks is no more or less potentially a person than one at eight weeks.

If it is 'drawing closer' to the fulfilment of the fetus's potential that changes its moral status, then it seems that there is a difficult problem in finding a moral – as distinct from a pragmatic – justification as to at when is close enough for the status to change. Since a fetus draws closer to fulfilling its potential from the day it is conceived, and is constantly evolving as it grows, which day - or which developmental change - matters morally. Is it when there is evidence of a beating heart, or fetal movement, or a particular neurological or brain development? Who makes this decision? And why?

It seems to me that the attempt to accord a 'gradualist' moral significance to the development of the fetus is little more than an attempt to disguise a personal reaction as an ethical argument. It exemplifies thinking that starts from an *a priori* assumption that something is 'bad', and then tries to construct an argument to justify the badness. In this case, the assumption is that later abortions are 'bad' and the arguments about the significance of the evolving potential of the fetus is an intellectually elevated way of justifying an assumption that is, in fact, no more than prejudice.

## The case for permitting abortion 'as late as necessary'

To summarise: why should we assume later abortions are 'bad' – or at least, 'more wrong' than early ones? There is no clinical evidence that later abortions are harmful, and certainly not more harmful than coercing an unwilling woman to endure a full-term pregnancy and labour. Later abortions are undoubtedly gruelling for both the patient and provider, but we assume that both have made a conscious decision to undertake the procedure. The life that is destroyed is no more or less a potential person than it was in early pregnancy. Late abortions may cost more and use scare resources, but funding implications are a separate issue and distinct from the ethics of the procedure *per se*.

Ultimately, the distinction between early and late abortion seems reducible to the our response to the appearance of the fetus – which is why so much influence has been attributed to the development of high-resolution fetal imaging, which has enabled us to visual the fetus *in utero*. The argument seems reducible to this: it looks more like a child, so it should be treated more like a child.

Without doubt, it is much more difficult to countenance the destruction of a fetus once it looks like a miniature baby than before its body parts could be seen. It is even harder when an ultrasound scan shows movements that bring to mind familiar, endearing gestures – a 'yawn', thumb-sucking and grasping tiny fingers and when we can see whether it is a boy or a girl. This is a fair enough response when it is expressed as a personal, subjective observation. It seems illegitimate – either dishonest or shallow - however, to dress it as a moral philosophical principle.

The moral principle at stake in the debate on later abortions, the one that is genuinely matters, has been ignored completely in the recent discussions. This is the principle of moral autonomy in respect of reproductive decisions. To argue that a woman should longer be able to make a moral decision about the future of her pregnancy, because 20 or 18 or 16 weeks are now passed, assaults this and, in doing so, assaults the tradition of freedom of conscience that exists in modern pluralistic society.

The ethicist Ronald Dworkin explains it like this: 'The most important feature of [Western political culture] is belief in individual human dignity; that people have the moral right - and moral responsibility – to confront the most fundamental questions about the meaning and values of their own lives for themselves answering to their own consciences and convictions'. (11)

If we accept this it is clear that to deny a woman her capacity to make the moral decision about abortion is to strip away her humanity. It is to take away not just a right, but a responsibility, to come to a decision that accords with her values. This has profound consequences for how we see individuals and how they see themselves. Are they capable moral agents? Or must their agency be stripped away?

Dworkin's argument is interesting because, like most of us who participate in the current debates, he believes that it is 'irresponsible to waste human life without a justification of appropriate importance'. It is unclear whether he extends that principle to potential human life, but I am prepared to. Most of us think it is better to prevent a pregnancy than to end one. However, this is not the issue at stake: we can all have our own views on when life begins to matter. The crucial questions are: *who decides* what is 'a justification of appropriate importance', and *on what basis* should they decide this?

Saletan has previously argued for hospital panels to sit in judgement adjudicate on women's requests. Dworkin argues that 'the decision whether to end human life in early pregnancy should be left to the pregnant woman, the person whose conscience is most directly connected to the choice and who has the greatest stake in it'. Dworkin does not argue that this decision should be limited to early pregnancy - and in later pregnancy, too, I believe that the decision, and the responsibility that comes with it, should rest with pregnant woman.

Left to make their own moral judgements, some women will inevitably make decisions that we would not; perhaps even those we think are 'wrong'. And we must live with that: tolerance is the price we pay for our freedom of conscience in a world where women can exercise their human capacity through their moral expression. We either support women's moral agency or we do not. Part of our valuing of fetal life, is the value of what it means to be the humans they have the potential to become. Moral agency is part of that humanity.

The moral case for late abortion, and for preserving the right of women to exercise their moral agency in making their decision, is at least as strong as the pragmatic case. And our normative, moral case is more consistent and ploughs deeper than the instrumental attempts to find moral reasoning to restrict later abortion. Either we support women's right to make an abortion decision or we don't. We can make a judgement that their choice is wrong – but we must tolerate *their* right to decide. There is no middle ground to straddle.

## Appendix: 32 reasons not to lower the abortion time limit

British Pregnancy Advisory Service (BPAS) provides a specialist service for women requesting abortions near the current abortion time limit of 24 weeks. Most of these procedures are carried out on behalf of the NHS. To inform the debate about why women request abortions after 22 weeks gestation we audited, and have recorded below, all such requests during a 28 day period in 2008. To present this data as objectively as possible, the table below lists these clients in the order that they presented to our service.

We believe that these 32 cases provide compelling evidence for why the time limit on abortion should not be reduced – even by as a little as two weeks. They also illustrate the complex and difficult circumstances that these women face, and the hardship (often to their families) that would be caused if these women were not permitted to access abortion. Many of these women are already mothers, and are requesting an end to this pregnancy because they feel it is necessary to maintain their existing family life. Many others are women who feel unable to be 'good enough' mothers.

You will note that five of these 32 clients were found to be beyond the existing gestational time limit, and so could not be treated; a further woman could not be found an appointment for treatment despite her presentation before 24 weeks.

| Client | Age | Gestation | Circumstances |
|---|---|---|---|
| 1 | 23 | 23w | Has 2 children already and feels she just can't cope with a third. Delayed because she found the decision "really hard to make". |
| 2 | 21 | 23w 4d | Unplanned pregnancy but was going to keep the baby. However, she and her partner have just been served with an eviction notice and they have nowhere to live that would be suitable for a baby. |
| 3 | 18 | 22w 4d | Had an early medical abortion 14 weeks previously. Pregnancy test 4 weeks later was negative and she had a contraceptive implant fitted. She had no idea she could be pregnant. |
| 4 | 16 | 21w 2d | Not in a relationship and says she has only had sex once. Thought she may be pregnant but didn't tell anyone and "hoped it would go away". Told parents eventually who are supportive whatever her decision. Was still unsure and she and her parents thought she needed more time to come to the right decision. A provisional appointment for treatment was booked in case she decided to proceed with the abortion. |
| 5 | 14 | 23w 5d | Feels too young to have a baby. Started periods a year ago, but they have never been regular, so it didn't register with her that she could be pregnant. Had no idea where she could get help. Didn't feel able to tell her parents. Eventually "plucked up courage" to see the school nurse. |
| 6 | 28 | 22w | In longstanding relation. Has 3 children aged 9, 3 and 2. Middle child has Downs Syndrome. She has known about her pregnancy and felt that abortion was her best option for "some time", but as her son with Downs Syndrome was scheduled for heart surgery, she "pushed it to the back of [her] mind" until the surgery was over. |
| 7 | 31 | 25w 1d | Drug user on methadone programme. Her medication means that she has no periods so did not realize she was pregnant. Feels that having a baby at this time will "push her over the edge". Because she was over the current legal gestational limit there was no option but to refer her back to her GP to arrange future ante-natal care. |
| 8 | 27 | 22w 1d | Three existing children (aged 5, 6 and 10 months) are in foster care as mother is a drug user on methadone and was unable to cope. If she has another child now, she knows that it will also be taken away and placed in care. She is awaiting a place on a rehabilitation programme. She is sad about the abortion but feels it is the best decision as her priority is getting her existing children back. |
| 9 | 23 | 23w | Has 1 year old child with longstanding partner. Planned to continue this pregnancy but her relationship broke down and she feels unable to cope with two small children on her own. She feels she now needs to keep her job to support her existing child and that would not be possible with another baby. |
| 10 | 32 | 22w 4d | Has 3 existing children. Has been drinking heavily and using cocaine. Would have continued this pregnancy but read about the effects of alcohol and drug abuse on the fetus and no longer feels able to go ahead because of her perceived risk of the problems she may have caused. |
| 11 | 19 | 22w 1d | Has 9 month old baby that is still breast-feeding. Lives with parents and feels unable to cope emotionally or financially with a new baby. Says she suspected she was pregnant, but the two pregnancy tests she carried out were negative. |

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| 12 | 24 | 22w 1d | Has 2 daughters, under 5 years, from a previous marriage. This pregnancy was unplanned but her current partner persuaded her to continue. She then found out that he was abusing her daughters. When she contacted the police, he absconded. |
| 13 | 24 | 26w 2d | Had continued to have period-like bleeds until recently and so had no idea she could be pregnant. Because she was over the current legal gestational limit there was no option but to refer her back to her GP to arrange future ante-natal care. |
| 14 | 22 | 22w 5d | University student. Had continued to have monthly bleeds until recently and so had no idea she could be pregnant. Had complicated pre-existing medical condition that meant it would be unsafe to treat her anywhere other than an NHS hospital, however, none had available appointments. Referred back to her GP to arrange future ante-natal care and adoption. |
| 15 | 15 | 23w 4d | Had sex for the first time to see what it was like. Thought she may be pregnant but "buried [her] head in the sand hoping it would go away". Started to self-harm: punching herself in the stomach and making herself vomit. Mother took her to GP suspecting bulimia and pregnancy was detected. |
| 16 | 20 | 23w | Only found out she was pregnant at 19 weeks because her periods had always been very irregular. GP wrongly told her that an abortion would not be possible at this gestation and referred her into ante-natal care. She waited two weeks for an appointment, and was again told an abortion would be impossible. Heard about bpas from a friend. |
| 17 | 19 | 22w | Continued to have light monthly bleeds throughout pregnancy so it didn't occur to her that she could be pregnant. Is University student and feels unable to cope with a baby. |
| 18 | 22 | 22w 3d | Single mother with one child. At first had decided to continue the pregnancy, which was unplanned but now thinks she couldn't cope with two children on her own. |
| 19 | 29 | 25w | Couldn't remember when her last period was. Normally relied on the contraceptive pill, but says she knows she takes them erratically. Her husband tries to remember to use a condom but often forgets. She had suffered from nausea and vomiting but had put it down to the stress of losing her job. Because she was over the current legal gestational limit there was no option but to refer her back to her GP to arrange future ante-natal care. |
| 20 | 19 | 22w 3d | Her periods had always been irregular and she had never had sex without a condom so it took some time for her to suspect she was pregnant. She had carried out a home pregnancy test some weeks earlier and went to her GP the next day. It took 3 weeks to get an appointment with the local NHS hospital responsible for her local abortion service. They scanned her at 21w 1 day, which was above their own time-limit. She then found out about bpas. |
| 21 | 27 | 23w 2d | Already has 2 young children with her husband, and they don't think they can cope with a new baby. She realized she was pregnant early in the pregnancy and went to see GP, who said that as she was "fit and health, no doctor would give her an abortion". A family friend gave her details of a local NHS clinic, but she could not get an appointment for 3 weeks. She was then told she was over the (12 week) limit for the local service and so was referred on to bpas. It took her a further week to make an appointment because she was "terrified of being told off for being so far gone". |
| 22 | 25 | 23w 5d | Already has 4 young children. Had monthly bleeds throughout the pregnancy and so didn't realize she was pregnant. Went to GP when she started to feel fetal movement. GP told her, incorrectly, that she was 14 weeks pregnant and so she didn't realize the urgency of her situation. Unfortunately, no appointment could be found for her within bpas or any other NHS or independent provider so there was no alternative but to refer her back to her GP for ante-natal care. |
| 23 | 23 | 22w | Realised she had missed several periods and that, some months back, a condom had split during sex .Tried to "push it out of her mind" and concentrate on her University work. Eventually confided in student support officer who suggested she contact bpas. |
| 24 | 17 | 24w 2d | Relied on the contraceptive pill for birth control. Knew that she had missed some pills several months ago and took pregnancy test when she missed a period. Pregnancy test was negative and she stopped worrying because she had a period-like bleed. Took another two pregnancy tests when she missed subsequent period, both of which were negative. Lives with father and didn't feel able to confide in him. Eventually spoke with mother who took her to GP who referred her to bpas. Because she was over the current legal gestational limit there was no option but to refer her back to her GP to arrange future ante-natal care. |

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| 25 | 23 | 25w | Knew she had not had period "for months" but "stuck [her] head in the sand" for some time before going to GP. Was not aware that there was a legal time limit on abortion so didn't feel the need to act although she knew she could not cope with a new baby and keep up the payments on her house. Because she was over the current legal gestational limit there was no option but to refer her back to her GP to arrange future ante-natal care. |
| 26 | 20 | 23w 1d | University student being treated for depression. She thought her weight gain and nausea were side-effects of her medication, and went to GP to request a different prescription. GP diagnosed her pregnancy. |
| 27 | 22 | 23w 5d | Living at home with mother. Very ambivalent about whether to proceed with an abortion or not. Had been wrestling with the decision for some time. Partner would support her, whatever her decision. After counseling, decided she would continue the pregnancy and was glad she had not rushed into a hasty decision. |
| 28 | 18 | 30w | Thought she was about 18 weeks pregnant. Has an arranged marriage in the Indian sub-continent in the Summer with an expectation that she would be a virgin. She had told no one of situation because of fear, embarrassment and shame. An abortion was not possible because she was over the current gestational limit. Bpas counselors arranged for her to have help to mediate with her family and potential emergency accommodation, should she need it. |
| 29 | 23 | 22w | Already has two children under 7. This was a planned pregnancy. Severe facial abnormalities were detected during a routine ultrasound scan. The request for abortion was made following discussions with the care team attached to the local maternity unit. The plastic surgeon had that, if the baby were born, it would need to undergo repeated surgery and face a poor quality of life. The NHS unit was prepared to end the pregnancy but had been unable to give a date for this. The couple felt they "needed closure" and could not cope with the uncertainty. They paid privately to attend a bpas clinic. |
| 30 | 27 | 23w 2d | Already has 3 children, one of which is in care. First came to bpas when she was just under 7 weeks pregnant. Missed two appointments for treatment as she has difficulties traveling and finds child care impossible to arrange. Is a drug user. |
| 31 | 23 | 22w 3d | Came to Britain as a refugee from East Asia with her husband who has now left her. Is living in hostel accommodation. Speaks no English. Didn't know where to get help. Feels unable to cope with a baby in these circumstances. |
| 32 | 18 | 22w | Thought she was just 9 weeks pregnant. Feels she is not emotionally ready for motherhood and has no financial means to support a child. |

*March 2008*

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