

ABORTION, ETHICS, CONSCIENCE AND CHOICE

Papers from the **bpas conference,
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INTRODUCTION

By Jennie Bristow, Editor, *Abortion Review*

The **bpas** conference *The Future of Abortion: Controversies and Care* was a groundbreaking event. It took place in Westminster in the midst of a battle over the UK's abortion law, as amendments to the Human Fertilisation and Embryology Bill from the anti-abortion side attempted to impose further restrictions on the gestational age at which women can access abortions, and those from the pro-choice side sought to modernise the law, bringing the legal framework more into line with social and clinical developments. With this critical Parliamentary debate as a backdrop, a discussion of the future of abortion could not have been more timely.

The conference brought together clinicians, academics, policymakers and advocates from the UK, Europe and the USA. The high level of international input, and the calibre of speakers, ensured that this two-day event was as well-rounded as it was intense. The conference also brought together several different issues surrounding abortion – issues which, as Ann Furedi notes in her contribution to this special issue of *Abortion Review* – tend to be compartmentalised, to no good effect. So at *The Future of Abortion*, the ethics of abortion and the moral questions it raises were discussed alongside clinical developments in abortion research and practice, legal and policy developments, and the context of women's lives. For the audience and speakers alike, this connected issues of direct relevance to their work with issues of all-round interest and importance, and levels of engagement in the discussion remained at top levels throughout the event.

In order to maximise the strides made by *The Future of Abortion* conference in taking forward an international, inter-disciplinary discussion, *Abortion Review* is producing a series of special editions in which we have published edited transcripts of the presentations. In this first edition, *Abortion, Ethics, Conscience and Choice*, the presentations go to the heart of the moral and ethical debates about abortion.

Stuart Derbyshire's discussion of fetal pain examines both anatomical and psychological explanations, concluding that pain lies in the development of subjective human experience, and life as it is lived in relation to others. **John Harris'** presentation compels us to interrogate assumptions about what makes life valuable, and what makes us human.

In putting 'the case for conscience', **Jon O'Brien** discusses the way in which conscientious objection has been heavily politicised in the USA through the rise of refusal clauses. Also from the USA, **Kirsten Moore** suggests new ways in which 'the case for choice' might be presented: ones which move from making judgements about abortion towards empathising with women's decision.

Lisa H. Harris examines the conflicts and pressures experienced by providers of second trimester abortions in the USA, and suggests that these conflicts should be better engaged with in order to have a more honest discussion about abortion within the pro-choice movement. In reflecting on the themes of the conference, **Ann Furedi** suggests that pro-choice advocates can be too defensive: abortion providers are doing a profoundly moral job, and the levels of political and public support for abortion in the UK suggest that their work is more widely accepted than the pro-choice movement tends to assume.

Subsequent special editions of *Abortion Review* will examine the themes 'Abortion and Women's Lives', 'Abortion and Clinical Practice', and 'Abortion, Policy, and Law'. For further information about the 2008 'Future of Abortion' conference, including the programme and full speakers' biographies, please visit: <http://www.futureofabortion.org>

THE PROBLEM WITH PAIN:WHAT THE FETUS FEELS

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Why do we care about whether a fetus feels pain? In summary, there are three reasons:

- **Fetal Surgery.** Over the past 20 years there have been some dramatic improvements in fetal surgical techniques. Surgeons can do some amazing things now *in utero*, and those who perform these procedures are obviously interested in whether they should be using an anaesthetic when they do so.
- **Abortion.** The reason why most people have heard about the fetal pain question is because of abortion. I find the fetal pain and abortion question rather annoying because it gets in the way of understanding pain, and doesn't help us to understand abortion. To put it bluntly: whether or not a fetus feels pain isn't going to change anyone's opinion on abortion, the law on abortion, or the way in which we approach abortion.
- **Because it is interesting.** The reason that why I am interested in fetal pain is because it is an interesting question. It tests everything that we know, or that we think we know, about pain in a very peculiar and very precise way.

So how do we address the question of whether or not the fetus feels pain? I suggest that there are two ways: the 'easy' way and the 'hard' way.

The 'easy' way focuses on looking at things like the neural structures that are there, the physiological responses of the fetus, and the behavioural responses of the fetus. When I say this is an 'easy' way of addressing the subject of fetal pain I don't mean to imply that these studies are somehow trivial or that they are not difficult: these are very difficult studies that require a lot of patience and training to do well. I mean that they are 'easy' because you can, in general, measure these things; and when you measure these things you will get an answer. You can get numbers associated with these things and that makes it conceptually quite easy.

The 'hard' way is to look at the nature or the content of pain, the psychology of the fetus and in what sense the fetus might be considered 'conscious'. When I say that this is 'hard', that is not to say that psychology and philosophy are somehow superior to basic science and that we should get more accolades for this: it's very easy to be trivial about psychology and philosophy in the same way that it's easy to be trivial about basic studies. Most of my opponents tell me that 'of course the fetus feels pain, don't be absurd', which demonstrates how easy it is to be trivial about the psychology and the philosophy of what the fetus feels.

What I mean when I say that psychology and philosophy are 'hard' is that you can only argue about these things: it's difficult to find numbers to attach to them. There will never be a fetal-ometer or a conscious-ometer that we can somehow wave over the womb and

which will tell us whether the fetus is conscious or unconscious inside. My view is that the only way of understanding whether the fetus feels pain is by concentrating on the 'hard' side. The 'easy' studies, valuable as they are, will never give you the answer that you are looking for.

However, let us first take a look at the 'easy' side of the equation – at the neurophysiology of pain and how it matches up in the fetus.

Development of the neural apparatus

In order to answer the question of whether the fetus feels pain, one approach is to look at the pain system in conscious mature adults and ask, 'When is the system available for use in the fetus?'

Figure 1 is a cartoon of the pain system. From this you can see that there are fibres in the periphery. Those fibres pass information to neurons in the dorsal horn in the spinal cord, which passes information to the thalamus. From there information is passed out to the cortex. This can be known as an 'alarm system' for pain.

Figure 1



By asking when this 'alarm system' is available for use by the fetus, you could hope to get a marker for when the fetus feels pain.

7 weeks' gestation

The earliest that anyone has ever suggested that this system is available for the fetus is 7 weeks, and that is based on the assertion that by 7 weeks the free nerve endings are available for use, and there are projections from the spinal cord to the thalamus. However, there are very few people who take seriously the idea of the fetus feeling pain at 7 weeks. That is in part because the thalamus at 7 weeks is immensely immature. Scientists have 'stained' the thalamus to study its structure. At 22 weeks the thalamus is basically a homogenous mass of grey. By 27 weeks, however, clear and separate divisions are visible within the thalamus. We do not exactly know what the relationship between structure

An anatomical answer to fetal pain is problematic

and function is, but we do think that there is some relationship between structure and function, and that if you want mature function, generally speaking you're going to look for mature structure. The brain at 27 weeks is mature structure that can presumably support some mature functions; the brain at 22 weeks is an immature structure that presumably cannot support mature functions.

So the immaturity of the thalamus blocks any arguments that the fetus may feel pain at 7 weeks. In addition, the lack of projections to the cortex blocks any arguments that the fetus can feel pain at 7 weeks. There is a large amount of data now suggesting that the cortex is necessary for an experience of pain. Furthermore, if you look at the brains of people who are in a coma or a persistent vegetative state, who are asleep or are under general anaesthesia, you will observe a profound decrease of activity in the cortex. In such cases – while under general anaesthesia, for example - we don't believe that people can experience pain. This is not to say that they can't respond physically to a noxious stimulus – they certainly can, and can respond in ways that look quite dramatically human and as though there is experience behind them. But we don't actually think there is experience behind these reactions.

That interpretation has been challenged – most notably by Sunny Anand (1) and also by Bjorn Merker in a paper published in 2007 (2), which argued that children born with dreadful conditions such as anencephaly and hydranencephaly, where the cortex is completely absent or almost completely nearly absent, do have some conscious awareness. I think this argument is a bit of a reach. I'm certainly not arguing that these patients are asleep – they are not, because they obviously do have waking consciousness, and some sort of emotional reaction. But what they seem to be missing is a phenomenal consciousness – the *what it is like to experience things* is absent in the absence of the cortex.

12-18 weeks

So if the cortex is important for phenomenal experience, when does the cortex become available for use? The earliest the cortex is available for use in any kind of form is between 12 and 18 weeks. In the fetal brain from about 12 weeks you can observe the development of a transient structure called the subplate, which develops underneath the cortical plate proper. The subplate can be viewed as a waiting compartment, where neurons sit and wait until they are moved into their correct place in the cortex. To avoid making this debate overly technical, it helps to think of the subplate as being like the wings of a stage, where people wait before they come on and act out their part. They are in position, ready to enter the stage, but they are not yet on the stage. It is on the stage where things happen, not in the wings. And most developmental psychologists and most developmental neuroscientists believe that the subplate is a transitory part of the brain that is necessary for development, it's not a part of the brain that is necessary for function. If it could carry out functions, then why would the cortical plate ever be needed?

Another stage of advancing neural development takes place at 18 weeks, when it has been demonstrated that the fetus will launch a hormonal stress response to direct noxious stimulation.

A paper published in 1994 by Giannakoulopoulos *et al* (3) caused a tremendous amount of excitement in the UK. Investigators demonstrated that if you put a needle directly into the fetus, which is innervated with free nerve endings, instead of placing the needle in the placenta, which is not innervated, there is an increase in cortisol and beta endorphin.

The authors commented that the hormonal stress response of the fetus raises the possibility that the human fetus feels pain *in utero*. They also added that a hormonal stress response cannot be equated with a perception of pain, and that is very true. You get exactly the same hormonal stress response in patients who are under general anaesthesia, among patients who are in a coma or in a vegetative state, where we don't think they are actually experiencing any pain.

23-26 weeks

At around 23-26 weeks there is a further important development. At this point projections arrive in the cortical plate proper, there is final maturation of the free nerve endings, there is maturation of the thalamus and the cortical plate, and probably most important of all, there have been demonstrated functional cortical responses to noxious events. This latter finding was reported in a paper by Maria Fitzgerald and her colleagues published in 2006, where they placed electrodes onto the surface of newborns' brains. In the UK all newborns must undergo a heel-lance test, and while that heel-lance was performed the researchers recorded blood flow in the brain. This showed a bump in activity in the primary sensory cortex on the contra-lateral side of the head, indicating a response to that noxious event. What is important about this is it indicates a response from the periphery through the spinal cord through the thalamus and into the cortex, so that alarm system for pain is clearly complete and available for use by around 25-26 weeks.

It is worth noting that Maria Fitzgerald wrote a summary of fetal development for the Department of Health over 10 years ago examining the question of fetal pain: and her conclusions still hold true today. She said that prior to 26 weeks' gestation the cortex is not a functioning unit, and therefore any discussion of perception of conscious reaction to stimuli is inappropriate. What was particularly interesting about that paper is that Fitzgerald didn't stop at this point, and say that the lack of a functional unit resolves the question of pain. She went on to say that true pain experience develops postnatally along with memory, anxiety and other cognitive brain functions. In other words, pain is not just a reflex response to noxious events: there is something that it is like to experience pain, and we need to account for that if we're going to have a true understanding of pain.

What is pain?

That is where I really come in to the question. We are never going to solve the question of pain based on studies of anatomy, as interesting and important as those studies are. In fact, I would say that an anatomical answer to fetal pain is very problematic. It is problematic in the first instance because it gives rise to a bogus politics: there is an expectation, a hope, that the question of abortion can somehow be solved by the indisputable facts of

There is a distinction between sensing a noxious event and the recognition, 'I'm in pain'

science, without recourse to arguments about bodily sovereignty and individual rights. I think that is essentially incorrect. There will never be a machine or a scientific development that will tell you whether or not it is right or wrong to take the life of a fetus. That is a moral and political decision that has to be made on moral and political grounds.

But even more annoying than bogus politics is the bogus science to which an anatomical explanation gives rise. There is a similar expectation that the question of subjectivity can be solved by the indisputable facts of brain development without recourse to arguments about consciousness and qualia. There is a belief that there is going to be some sort of development in the brain that answers all those difficult questions about what it is to be human, what it is to experience, without our having to examine the contents of experience, the contents of psychology, the philosophy of being, and so on.

The philosophy of being

So now let us now start again, and look more critically at this alarm system for pain. The alarm system basically tells us that there is a noxious event that creates activity in a nerve fibre, and that passes information to a dedicated centre in the brain that is responsible for pain experience. The problem with this model is that it mystifies what pain is. Is pain in the needle, is it in the nerve fibre, is it in the brain? No, it is not in those places. Pain is your experience, it is what you experience. It's not something that is located within a needle. To give a better idea about why this is problematic: we start to say things like 'the pain is in the hand' but it's not, it's in your mind. We start to say things like 'the pain is in the needle' but of course it's not. We start to say that pain is caused by a painful event, which reduces you to saying pain is caused by pain, and becomes tautological.

Descartes was well aware of this problem. When he proposed his idea of how to understand human bodies, he notoriously placed God as the person or thing that creates the mind, and he also placed reason and intuition at the centre of human experience. What he basically said was that reason and order are not things that exist out there, they are things that exist in here; and when you have a sensory experience, it doesn't just wash through you: you exercise judgement in the face of that sensory information.

By way of example: if you listen to a sentence played in sine wave, the first time it sounds like goobledgook. If you listen to the sentence in clear sound, and then play the sine wave again, the sentence makes sense. This illustrates that physical information doesn't just force itself onto your awareness. The moral of this is that the physical information that is arriving at your eyes and ears is not changing, because that's just physics. That's out there, and it's invariant. But what you experience – what you hear and what you see – is changing and it is changing because you change: it's the judgement that you exercise in the face of those physical pieces of information that has changed. This is what Descartes was getting at with his idea of being self-located. You are somehow self-located within the experience: experience isn't just washing through you, you aren't just being dazzled or drowned by sensation: you remain you within that sensory experience. Sensory experience, if you like,

meets resistance within us, and that resistance is caused by the self who it is that is experiencing.

Representational memory

The fetus is not self-located within experience. For the fetus sensory information really does wash straight through, to produce an automatic reaction. The fetus doesn't have any choice about how it's going to respond. It is the same for adults who have their knee ligament hit with a hammer – you don't have any choice about moving your leg, your leg is just going to move; and in that sense the fetus is responding reflexively. One way of putting this is that the fetus can't choose to bear the pain. It cannot launch a protest against what is happening to it; the fetus just has to respond in the way that fetuses respond. The reactions of the fetus are simply reflexive, they are not conscious. Things happen, but they are not felt to happen.

So the question then is how do we become self-located, how we attain these conscious experiences? I would say that continued brain development is certainly important in that. There is no doubt that the development of the frontal cortex, for example, is necessary for certain types of responses such as memory, and stranger anxiety. One of the things that I have latched onto, and other developmental psychologists have looked at as being of particular importance, is the development of representational memory, which occurs at around four months of age.

Representational memory is basically the ability to hold in memory a thing for a period of time; and in the classic experimental demonstration of this, an experimenter will cruelly hide a sweet under one of two cups, and then will hide the cups, distract the infant, and then a few seconds later reveal the two cups again and ask the infant to go and get the sweet. Infants under four months of age have forgotten about the sweet and may do nothing; knock both cups over; or respond randomly. Infants at four months plus can find the sweet very quickly, indicating that they now have an ability to hold things in memory for a period of time. That to some extent is just a raw biological cognitive development, but it doesn't just appear in a vacuum. It appears within a context of a searching interaction between the infant and other conscious beings, and that search is a search for themselves. There are discoveries that are now made in action, patterns of mutual adjustment, and interaction between the infant and the caregiver.

Subjective experience

What this means for subjective experience is that even though you experience pain, say, as something that is entirely personal and private, that is not the way it evolved initially. It was only through engagement with others that you came to have this experience. So the content of our minds becomes meaningful to us only insofar as it is meaningful to others. And it is the consequence of a developmental process that is social as well as natural. Conscious experience, including pain, becomes possible as objects, events and emotions become a focus between the infant and caregiver or other, conscious being. We make a connection to the world, we find meaning in the world, through another person's meaning. It is not something that is innate and automatic, but something that requires

an active interaction with other conscious beings in order to arrive at experience.

I realise that this is not entirely unproblematic. Taken to its extreme my position does threaten the link between feelings, thinking and reality, and I am not arguing, for example, that injury and pain are arbitrarily stacked together. When someone sticks a pin in you chances are it's going to hurt, and you don't have much choice about whether or not that's going to hurt. I am also aware that there may be a reasonable distinction between sensing a noxious event and the recognition, 'I'm in pain'. It's the difference between being cold, for example, and knowing *that* you are cold. But I do think that distinction is important, and I do think that we routinely, effortlessly and continuously make that distinction.

Conclusion

I would say that fetal pain is a moral blunder, because it draws a false equivalence between the observer and the observed, and it misses the process of development beyond the womb entirely. Distinguishing sensations from thoughts, emotions or each other requires a conceptual basis upon which that distinction is drawn. And it's easy to forget that this conceptual basis is required when we view the system as basically about hooking alarms up to buttons. We must remember that what we are really doing is creating subjective experience.

References

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THE VALUE OF LIFE: WHEN DOES IT BEGIN, WHEN DOES IT MATTER?*

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I want to try to answer a fundamental question here, but if I fail to answer it no matter, because you will have already worked out an answer. If you have not, you could not conceivably have a view about the ethics of abortion. If my answer does not agree with yours, that is fine with me. I have no interest in whether or not you agree with me; what I am interested in is an answer to the question of what it is that makes life valuable.

To have a view about the ethics of abortion, indeed to have a view about most issues in healthcare, is to have an answer to this question. By 'valuable' I don't mean anything very special, simply what it is that makes it right to save a life if we can, wrong to end a life if we can, what makes a life worth saving, worth preserving, worth prolonging. That is the fundamental question.

The value of life

To get a handle on this question, consider a very large teaching hospital. It's on fire. And because it's a very slow-burning fire and we are the management of the hospital, we have to work out how to prioritise the contents of the hospital for rescue. How are we going to do that? First we have to know what we're dealing with. The hospital contains patients of all ages, including pregnant women; but there are other life forms as well. There are doctors, for example, and nurses, and midwives, and cleaners, and cooks, and a whole range of other human staff. This hospital has a very large assisted reproduction facility, so there are also embryos, sperm and eggs aplenty, thousands of them frozen in fridge drawers. It's a teaching hospital with a lot of science going on, so there is also an animal house with many laboratory animals, there are pot plants on the shelves, and there are of course bacteria and viruses and many other living things.

So we are going to do some prioritising. I'm assuming that you would think that we ought to rescue the patients before the viruses, and you may make all sorts of other distinctions. Now to do this, even to think about it, is to take a view about the value of life: about which lives are more important, morally speaking. This is unavoidable. It doesn't just arise in relation to abortion, though many people seem to think that it does – it is a perennial problem about how we respond to all of the other living things in the world.

Let us here concentrate on prioritising between various life forms that might be thought of in one way or another as human, and ask whether it is reasonable to make distinctions between them from the perspective of the importance of their lives and hence the importance of rescue. So for example, to go back to our burning hospital and the pregnant women in the maternity wards: do they count for two? If they are pregnant with sextuplets, do they count for seven? Do we rescue them first or give them equal priority? Do the young get equal priority with the old, does it matter how much life expectancy they have left? If it's a matter of life expectancy you might expect that newborns count the most, because other things

Potentiality is not a very good argument for moral value

being equal they have the longest life expectancy, and the terminal patients in the cancer ward have much less. So perhaps the old age pensioners also count for less because they have less un-elapsed time. There are all sorts of familiar but acute problems.

Being alive

If we think just about humans, and the sort of humans that are called in to question in abortion, many people think that the problem just is to answer the question, 'When does life begin?' Once we know the answer to that question it is assumed that we know to whom we have moral responsibilities, who we should save. But that question is unhelpful. The sperm and egg are alive before conception, and they are human if they are anything; and conception can result in many things. It can, for example, result in a hydatidiform mole, a cancerous multiplication of cells that will not form anything. But worse than that – the human zygote, the human embryo, the newly-alive human individual, is less complex and interesting in every way save one or two than a hamster or a parrot, a cat or a canary, or the Sunday roast. The human embryo is a very simple creature. So what does it have going for it that the Sunday roast does not or did not before it became a roast?

Species membership

There are two possibilities. The first is simply its species membership: simply the fact that it is human, it is one of us. But the fact that something is 'one of us' does not in itself accord us the reason to prioritise it. History is notoriously full of generally vicious appeals to the idea of 'one of us'. We should not prioritise individuals because they are 'one of us', whether 'us' is defined as white like me, male like me, female like some of you, or British or black or whatever. That is not a good reason: unless you can supplement it with some account of why being white or British or female gives you an edge, makes you more important than those who are not like 'us'. It is disreputable to prioritise our species simply because they are our species.

We are all descended from a female ape in Africa about 5-7 million years ago, and at sometime in that evolutionary process we changed species: if human individuals survive it is inevitable that we will change again, that we will further evolve, and that eventually human beings will no longer exist. That itself is not an important fact so long as creatures that matter morally in the ways that we do, that are valuable in the ways that we are valuable, continue to exist. So I have a perfectly easy mind about the human race dying out so long as creatures that are comparable in moral importance and value continue to exist. But that again raises the question of what it is that makes creatures of any sort morally important.

Potentiality

Species membership isn't enough, and being alive isn't enough. There is one other thing that the human embryo and the human fetus has going for it that cats and canaries and the Sunday roast do not, and that is its potential: its potential to become a glorious, thinking, feeling individual like all of us. Unfortunately, potentiality is not a very good argument for moral value either, for two very different but mutually reinforcing sets of reasons.

The first is a logical problem. Acorns are not oak trees. The fact that something has the potential to become something else does not give us a reason to treat it now, before it has acquired that potential, as if it has acquired that potential. Most of us share one very important piece of potential: we are potentially dead meat. But that does not afford any of you to treat any others of you as if you were already dead meat. The fact that something has potential does not give a good reason to treat it, before it has achieved that potential, as if it *had* achieved that potential.

The non-logical argument is simply that it is not only the human zygote that has the potential to become a wonderful creature like you and me. Lots of other things do. The first is the unfertilised egg and the sperm before they get together. It is alleged that the zygote is morally important, valuable, because of its potential to become something else. The something else that it has the potential to become is a glorious adult creature. So the potentiality argument says: 'This is important if and only if it has the potential to become that.' But consider – something has the potential to become a zygote. Whatever does, shares the importance that the potentiality argument conveys; because whatever has the potential to become a zygote has the potential that the zygote has. And the unfertilised egg and the sperm have the potential to become a zygote.

The potentiality argument says that we ought to protect certain things because of their potential in order that they may achieve their potential. And if we're going to protect the zygote, the embryo, then we have to protect not only the egg and the sperm, wherever they are to be found, but all the other things that can form a zygote: and that is the nucleus of every cell in your body and mine, thanks to the neat little bit of trickery that Professor Ian Wilmut first used in animals a few years ago. And indeed, now we can manufacture eggs and sperm out of stem cells as well. So potentiality won't do the trick.

The problem that we are left with is the problem: how do we account for the moral importance - if it has one - of the embryo or the fetus? It's not the fact that it's human, it's not the fact that it has potential, so what if anything is it?

And that is the same question as why we should prioritise the normal adult patients and children in the hospital over the hospital cat and the bacteria and the viruses and the pot plants and all the other living things in the hospital that we think are of lesser importance. What is it that gives the embryo importance - if you think it has moral importance such that it ought to be protected? And if you, like me, don't think that the embryo and the fetus has that moral importance that requires that it be protected, what gives it to you and me?

The meaning of life

Consider now a different question: not, 'What is the value of life?', but 'What is the meaning of life?' One very eloquent answer to the question of what is the meaning of life was delivered by a contemporary philosopher: the late, genuinely great, Douglas Adams, in his five-part trilogy *The Hitchhiker's Guide to the Galaxy*. In that marvellous book of philosophy – and I do think Adams is a substantial, powerful and important philosopher – a race of hyper-intelligent, pan-dimensional beings set out to answer the question

Fetal viability is not a moral consideration but a practical consideration

of the meaning of life, the universe and everything. And to that end they build a super-computer called Deep Thought which they programme to solve the problem. Having done so they go up to Deep Thought and they say, 'Can you answer the question?' And he (or she) says, 'Tricky'. They say, 'But can you do it?' She says, 'Yes, but it will take me seven million years to run the programme.' So seven million years later they go back and repose the question and get the immortal, the famous answer to the meaning of life, the universe and everything: '42'.

Clearly, '42' is an unsatisfactory answer to such a profound question. But the problem is that we lack the perspective from which to criticise that answer, because we don't know what a good answer to any such question would look like. Because we don't know what a good answer to the question would be, we lack a perspective from which to criticise what we instinctively feel is a bad one. That is why I think that this is a genuinely profound piece of philosophy.

What is a person?

Now let us return to our question, the value of life, by doing a little thought experiment. Consider this question: are there persons on other planets? We don't know the answer to this question definitely, but - unlike the hyper-intelligent pan-dimensional beings in Douglas Adams' book - we know what we are looking for. We are not looking for animals on other planets, or plants, or bacteria, or just any old life form. We are looking for a particular type of life form - a particularly morally important, valuable type of life form. Unless we lack imagination totally, we don't expect it to be human necessarily, but we know roughly what it would have to be like to qualify as a person. Science fiction - and more than science fiction, religion - is teeming with non-human persons: gods, demi-gods, and so on. They are all examples of non-human persons.

Now suppose that, instead of us finding them, they turn out to have the superior technology and they find us. After a long exhausting journey they arrive tired and hungry - what would we say to them about ourselves? Remember that they have the superior technology. What could we say about ourselves that could (or should) convince them that they had found persons on other planets, rather than animals or plants or bacteria; and that given that their food supplies are running very short, it would be more appropriate to have us for lunch in the social sense rather than in the culinary sense?

I hope that we would have something to say, because our lives might depend on it. And of course that is precisely the issue. Just as in the issue of abortion, or the case of the hospital fire, creatures' lives depend upon the answer to this question, so this is a very important question and we have to find the answer.

There is a long tradition of looking for such an answer in philosophy. The most eloquent answer was given by the great John Locke around 1690 in his essay concerning human understanding. He deliberately chose to use the term 'person' rather than 'human': he called it a forensic term, and wanted to say that he was not just trying to describe individuals like him.

This is how Locke put the point:

We must consider what person stands for; which I think is a thinking intelligent being, that has reason and reflection, and can consider itself the same thinking thing, in different times and places; which it does only by that consciousness which is inseparable from thinking and seems to me essential to it; it being impossible for anyone to perceive without perceiving that he does perceive.

So what Locke suggests is a combination of consciousness and self-consciousness: self-awareness. Not just perception, which is simple awareness, but self-perception: self-awareness.

Self-awareness

There is one other way of arriving at an answer to the question of the value of life, and this involves another thought experiment. What makes life valuable to you? What makes life worth living? What makes it important to you to go on living? Write down the 20 things that make life worth living in rank order of importance! The answers that you would give would interest me greatly and I hope might even appeal to my prurient interest, but they are not of theoretical interest - what is of theoretical interest is that you are the types of being for whom that is a meaningful question. You are the types of being who do have valuable lives, and who could compile such a list - if you got over the sense of embarrassment about the exercise.

So if you ask the question 'what sorts of beings are valuable?' my answer is: those sorts of beings that are capable of having valuable lives. That is to say, those sorts of beings that are capable of having lives that they themselves value, that they themselves want to continue. If you ask what sorts of creatures they are, you get John Locke's answer: because in order to have a valuable life you have to know that you've got a life. So to get a life, you have to know that you've got one, you have to be an independent centre of consciousness, existing over time, with enough intelligence to know that you're such a being, and enough self-awareness to be able to take up an attitude, to form a view, about whether you want life to continue or not. So to be capable of valuing life is to have a view one way or the other as to whether you want it to continue. And to have such a view you have to know that you do have a life and that it might be possible for it to continue.

This is what it takes to be a valuable being. And on this account, the wrong done when you end the life of such a being, or fail to sustain it when you have the opportunity to do so, is the wrong of depriving that being of something that they don't want to be deprived of - their life. This answer yields an account, not only of the value of life, but of the wrongness of ending life. It follows from this that it is not a wrong to the individual whose life is ended *if* it is ended when they are not capable of wanting it not to end, when they are not a person.

This provides an account of what persons are, which can be applied to persons on other planets, to human creatures, to dolphins and chimpanzees - and that can be applied to the developing human individual. This account enables you to draw distinctions between that individual and its mother, and between that individual and

I see no indication that we have got the wrong policies on abortion in the UK

creatures like you and me. This same account enables us to make sense of conundrums at the other end of life, dealing for example with individuals in permanent vegetative state – as the House of Lords had to do in the Tony Bland case. It also allows us to make sense of cases such as that of the Manchester conjoined twins, when the courts had to decide whether it was reasonable to separate conjoined twins knowing that that would kill an identifiable one of the two twins. Those cases would be impossible to decide without taking a view about the moral importance of the sort of lives concerned.

The ethics of the UK abortion law

One further point. Consider the present law, which allows for termination of pregnancy right up to term for serious fetal handicap. We know that disability of whatever sort does not affect the value of human life, and does not affect the value of the individual who is disabled. We also know that disability is not the sort of thing that could diminish, by one scruple, the value of a life. So if it is legitimate to end the life of a disabled fetus or embryo, this has nothing to do with the fact that they have a disability. It has to do with the fact that they are not an individual of a moral status that allows their life to be protected *whether they have a disability or not*.

That is also why gestational age has nothing to do with the ethics of abortion. Why Parliament has worried recently about the issue of whether the abortion age should be changed from 24 weeks to 22 weeks, and has turned to science for an answer, is completely perplexing to me, because science is incapable of giving the answer. Fetal viability, the ability to survive independently of the mother, is not a moral consideration but a practical consideration. As it happens it is a consideration to which the law attaches importance, but it cannot conceivably explain why some individuals have protected lives and others do not. Many adult humans are not independent in the relevant sense, but are dependent on machines to keep them going. Independence, whether from a mother or from a piece of technology, does not plausibly carry with it moral status.

In conclusion: I see no indication that we have got the wrong policies on abortion in the United Kingdom, as they are broadly conceived. We permit abortions over the whole range of gestational age and I think that this accords with the moral considerations, which are that it is not possible to think that the developing human embryo or fetus has anything about it which relevantly distinguishes it, morally speaking, from other life forms that we don't protect: except those characteristics which we have discredited already, its species membership and its potential. But for what it is, the fetus is not the sort of being that has a valuable life: at least on any argument that I have considered.

Now if you do not like my conclusion, fine. I am not an evangelist, and I don't want to manoeuvre the law in any particular direction. I am democrat, and these things are not ultimately up to me or to you, but to society. But society must have reasons for what it does and I see no reason to tighten the abortion law that we currently have. It's important to err on the safe side when there are cloudy issues, whether it's about fetal pain or about fetal rights to life or the value of fetal life, but I am pretty confident that the safe side is development over the first three trimesters of human development.

If you disagree, answer this – what would justify, what would show the moral importance of the fetus, how would it relevantly differ from cats, canaries, chickens, and other life forms?

*** I first developed the ideas expressed here in John Harris (1985) *The Value of Life* London: Routledge**

PRESENTING THE CASE FOR CONSCIENCE

Jon O'Brien

President, Catholics for Choice

Catholics for Choice is an organisation that gives voice to Catholicism as it is lived by Catholic people on sexual and reproductive rights issues - as opposed to Catholicism as it is sometimes imagined from the lofty heights of the Vatican. Based in Washington, DC, we have 11 sister organisations in Latin America, and we are accredited and active at the United Nations, and in the European Parliament. I believe that the Catholic hierarchy has every right to speak out and share its views, but when the bishops attempt to say that they speak for all Catholic people, especially to politicians, it is my job to remind politicians that Catholics don't necessarily agree with the Catholic hierarchy. That is the mission of my organisation: to give voice to Catholics, whether they be from Poland, Portugal, the Philippines or Perth; to allow those voices to be heard at a public policy level.

Here I want to present the case for conscience. When discussing conscience and the provision of reproductive healthcare, the question quickly becomes that of 'Whose conscience are we talking about?' Are we talking about the conscience of the woman who is seeking the procedure or the medicine; of the doctor who will provide the service; or of the institution in which it occurs? The question of just whose conscience we are talking about is critical to understanding the case for conscience.

It is also important to understand that conscience is not solely a religious matter. Everyone has a conscience, and everyone is compelled to follow it. Some of my comments here are addressed to the case for conscience from a Catholic perspective, because that's my area of interest, and because the Catholic hierarchy and its conservative allies play an outsized role in framing the debate about the morality of reproductive healthcare. But people of all faiths, as well as those who are non-religious, need to be concerned about the role of conscience regarding access to reproductive health services.

What should be especially troubling to those of us who work to ensure access to care is the myriad ways that conscience is being used these days to *limit* access to care. This raises the question of the legitimate use of conscience, especially the attempts to manipulate conscience protections to foist religious ideology on the general public. In the United States, this has resulted in a woman being told that a pharmacist would not only *not* fill her prescription for birth control, but would not even transfer it to another pharmacist. It has resulted in a lesbian woman being denied artificial insemination by a medical practice that disagreed with her lifestyle, and it has resulted in Catholic hospitals' failure to provide emergency contraception to women who have been raped.

Because of the leading role that the Catholic church plays in framing the debate about the role of conscience in access to reproductive healthcare, it is important to understand the true Catholic teaching about conscience. It is also helpful to understand the limits of the church's current teaching on the sanctity of life, because this drives much of how it constructs its arguments about the role of abortion

and emergency contraception. The Catholic bishops have become the public face of opposition to abortion in many countries. They have worked very hard to lay down the line that a good Catholic may not dissent from the church's teaching that abortion is always morally wrong and forbidden because it is the taking of human life. But the reality is that the picture is much more complicated than the bishops would have Catholics, and non-Catholics, believe.

Catholicism and the sanctity of life

Officially the Catholic church today teaches that abortion is wrong because it is the taking of human life: life, in this case, defined as beginning at the moment of conception. However, as Daniel Maguire, a leading Catholic moral theologian, has noted, there has been a diversity of views on when human life begins and on the morality of abortion throughout the history of the church. As a result, Maguire says, there is no one Catholic view on abortion. In the early centuries of the church, Saint Augustine held that early abortion was wrong, not because it involved the taking of human life, but because it separated sex from procreation, which he believed was the only justification for intercourse, even between married couples.

In the thirteenth century, St Thomas Aquinas postulated there was no life present in an early fetus, and that ensoulment occurred only after quickening, in the fourth or fifth month, when the woman first felt the signs of fetal life. So early abortion was not murder. The view that early the early fetus was not a person, and that the fetus gained human value as a pregnancy progressed, was widely held in science and law throughout history. Most opposition to abortion centred on the fact that it was a way for people to cover up illicit sex, not in the belief that it was murder. In the seventeenth century, believing that early magnifying instruments had detected the human form in fetal tissue, the church moved towards the belief that life begins at conception. It wasn't until late in the nineteenth century, however, that the church officially banned abortion; and until the twentieth century that it became a cornerstone of church teaching, based on the belief that life begins at conception.

The Catholic teaching about conscience

Not only has church teaching on when human life begins varied, but the bishops have worked very hard to suppress the primacy that Catholic teaching gives to the well-formed conscience when it comes to individual decision-making regarding weighty moral issues. From listening to the bishops' rhetoric, especially from people like Cardinal O'Brien in Scotland, you would think that all Catholics are obligated to follow the Vatican's pronouncements. But nothing could be further from the truth. Catholic thinkers from St Paul through Thomas Aquinas through to the Vatican's own 1965 declaration on religious freedom have consistently held that Catholics have a duty to follow their conscience, and that no-one should be forced to act contrary to their consciences. In his widely-respected book on Catholicism, the theologian Father Richard McBrien sums it up: 'If, however, after appropriate study, reflection and prayer, a person is convinced that his or her conscience is correct, in spite of a conflict with the moral teachings of the Church, the person not only may but must follow the dictates of conscience rather than the teachings of the Church.' [*Emphasis in the original*]

Women seeking abortion are operating according to their consciences

For the most part, Catholics do actually follow their consciences, when teachings of the church are in conflict with the lived reality of their lives, and their own sense of wisdom and compassion. As is well known, in the United States 97% of Catholic women over the age of 18 have used a method of contraception banned by the Catholic hierarchy. Use of modern contraceptive methods is high in many predominantly Catholic countries: 67% of married women of reproductive age in Spain use modern contraceptive methods, as do 69% of married women in France, and 60% of Catholic married women in Mexico and 70% of Catholic women in Brazil. Clearly these women are following their consciences, which tell them that modern birth control methods are moral, and that they contribute to their health and the health of their families.

Similarly Catholics are more than willing to disagree with church teaching on abortion. Less than one quarter, 22%, of Catholics in the US agree with the bishops' position that abortion should be illegal. And 58% of Catholics believe that you can be a good Catholic without following the bishops' teaching on abortion. In the US, Catholic women have abortions at the same rate as women in the population as a whole, so clearly they have decided to follow the dictates of their consciences, rather than the pronouncements of the church.

It is also important to note that while the Catholic bishops often try to give the impression that Vatican teachings on abortion are infallible, they are not. It's a popular misconception that whatever the Pope says on a serious topic is infallible and must be followed. It is not. Infallible statements are only made in very limited and narrow circumstances in the Catholic church. The teaching on abortion has never been proclaimed infallible. Even John Paul II, who was renowned for his opposition to abortion, tried to find ways to pronounce his teaching on abortion infallible. He was unable to do so.

The politicisation of conscience

While Catholics the world over clearly follow their consciences on the matter of abortion, the bishops do have an impact on women's ability to access abortion and other reproductive health services. Especially in the United States, the Catholic hierarchy works through the political process to try and get their minority views enshrined into law. This is clearly a violation of the consciences of many Catholics and non-Catholics alike, whose views are not in keeping with the teachings of the Catholic Church. Catholic tradition demands that Catholics respect the views of other faith groups, and that the church accept the principle of church-state separation. According to one pastoral letter, Catholics should recognise the legitimacy of different points of view about the organisation of worldly affairs, and show respect for their fellow citizens. The documents that came out of Vatican II, an influential church-wide conference that took place in Rome during the 1960s, clearly recognise that the political community and the Church are independent of one another.

But as a result of the bishops' involvement in the political process, the very issue of conscience has become highly politicised in the United States, as well as in some European countries. In the name of conscience, opponents of contraception and abortion have aggressively tried to use the political process to allow healthcare

professionals, including emergency room doctors, nurses, and even pharmacists to opt out of providing essential reproductive healthcare services and medications. These refusal clauses, which are called 'conscience clauses' by their backers, draw on claims of religious freedom to make the case that healthcare professionals should be allowed to refuse to provide services with which they have a moral disagreement in order to protect their consciences.

The rise of refusal clauses

The right of individual healthcare providers to refuse to participate in a controversial service such as abortion is well established in most countries. In the United States, such protections were signed into law shortly after the historic *Roe v Wade* decision that made abortion legal in the early 1970s. What is different about the conscience protections that anti-choice forces are seeking and winning today is that they will dramatically expand the basis of such objections to virtually any healthcare service to which a provider objects, even birth control, often without adequate protection for the rights of patients; and that they will extend conscience protections to institutions, as well as individuals. These refusal clauses manipulate the concept of conscience to raise the anti-choice and anti-contraceptive beliefs of a small minority of healthcare providers over the right of the majority of patients to receive standard medical procedures and prescriptions at their local institutions in a timely manner.

Nowhere is this clearer than in the case of exemptions in the provision of emergency contraception, which the Catholic hierarchy has pushed very hard for in Catholic hospitals. Many states in the US require hospital emergency rooms to inform rape victims about emergency contraception and to provide the medication to women who request it. Catholic hospitals have sought exemptions from these rules, because of the church's insistence - not substantiated by science or medicine, but based on the church's modern view that human life begins at the moment of conception - that emergency contraception causes an abortion. These exemptions would allow Catholic hospitals to withhold information about emergency contraception from women who have been raped, whether or not they are Catholic, even in the form of not providing a referral.

Similarly some conservative Catholic and Christian pharmacists have sought exemptions from providing emergency contraception to pharmacy patients. Like refusing to treat rape victims, this is problematic because of the 72-hour window in which emergency contraception is effective. In some rural areas of the United States, where the only pharmacist on duty at the drug store in town refuses to fill a prescription for emergency contraception, women have nowhere to turn. Similarly, a woman seeking emergency contraception late on a Saturday night or a Sunday may have limited options and may give up trying to access the medication if she is humiliated by being refused a prescription. This is clearly an instance of religious ideology being allowed to trump the rights and the needs of patients.

In the United States 46 states have passed some form of refusal clause for medical professionals and institutions. Of those, 13 allow providers to refuse to perform contraception-related services, and 17 protect healthcare providers who refuse to perform

The question is how to formulate policies that meet the needs of patients while protecting the beliefs of providers

sterilisations. Four states allow pharmacists to refuse to provide contraception, including emergency contraception. In a more balanced approach, California allows pharmacists to refuse to dispense contraceptives only if their employer approves and the woman can get access to the contraceptive in a timely manner.

The United States Conference of Catholic Bishops and the Catholic Health Association have been major backers of the refusal clauses in legislative assemblies across the United States. But major medical societies and public health groups have become increasingly alarmed by the proliferation of refusal clauses and their ability to hamper women's access to reproductive healthcare. The American Medical Association and the American Public Health Association deem refusal clauses appropriate only if a plan is in place to provide adequate referral, and the refusal does not disrupt a patient's access to care. The American College of Obstetricians and Gynecologists recognises a physician's right to refuse to provide a service but says it must be balanced against their other values and duties, including the degree to which the refusal imposes the provider's beliefs on the patient's autonomy, effects on patients' health and wellbeing, whether the refusal is based on a proper understanding of scientific evidence, and whether it results, intentionally or not, in discrimination and inequality.

Meeting patients' needs

The question is not whether the conscience of healthcare providers should be protected. The question is how to formulate policies that meet the needs of patients while protecting the beliefs of providers. The goal of any reasonable conscience clause must be to strike the right balance between the right of the healthcare professional to provide care that is in line with their moral and religious beliefs, and the right of patients to have access to the medical care that they need. In the case of pharmacists who refuse to fill prescriptions for emergency contraceptives, this means having another pharmacist on duty with them to dispense the medication; or, if that's not possible, transferring the prescription in a professional and timely manner to a nearby pharmacy that will fill the prescription.

Too often, however, the goal of some providers seems not to be to strike this balance, but to strike a blow for their own radical anti-contraceptive beliefs: such as in the case of a pharmacist who refused to transfer a prescription for oral contraceptives to another pharmacy, or the pharmacist who worked for a large retail chain in the US, who began refusing to fill prescriptions for oral contraceptives without even informing her employer who could have created a seamless back-up for pharmacy clients seeking contraceptives. She was subsequently fired and became a major voice of the refusal clause movement.

Do institutions have consciences?

Healthcare providers who wish to exercise a conscience objection have a moral obligation to do so in a transparent manner. In the US, a handful of doctors and pharmacists who object to the provision of contraceptives have started practices that cater to patients who share their views, clearly stating to potential patients the limits of their service. In the field of medical ethics, the accepted resolution to a conflict of values is to allow the individual to act on his or her

conscience, and the institution, be it a hospital, clinic or pharmacy, to serve as a facilitator of all consciences. Many backers of refusal clauses are turning the arrangement on its head by claiming a conscience exemption for the actual institutions themselves, as if a hospital or an insurance company can be said in any meaningful way to have a conscience.

As previously noted, Catholic hospitals have sought refusal clauses that allow them not only to withhold emergency contraception from rape victims coming into their emergency rooms, but even to exempt them from the obligation to refer women to another hospital that can provide the medication. Catholic insurance groups have sought exemption from state laws that require insurers to provide coverage for contraceptives, even if the majority of those they insure are not Catholic. Both Catholic hospitals and insurers have sought exemptions from providing family planning services to women insured by the US government-funded Medicaid programme: again, even if the patient is not Catholic.

In these instances these healthcare institutions have clearly gone beyond the bounds of exercising a reasonable conscience objection. Instead they are using the rhetoric of conscience to impose their morality on individuals, Catholic and non-Catholic alike, and depriving them of their right to conscience, as well as their right to a timely and complete medical service. When an institution rejects its role as a facilitator of conscience for individuals, and instead turns its own conscience-based refusal to provide services, it violates the right of patients and healthcare providers to make their own conscience-based decisions. It is the obligation of healthcare institutions to provide professionals who will provide services that patients deem moral and that are legal, while allowing those medical professionals who choose to opt out to do so.

In unavoidable situations, where the conscience of an individual doctor or nurse or pharmacist conflicts with the needs or wishes of a patient, it is up to the institution to make seamless care available to the patient from medical professionals who are committed to providing such care. When it is not possible to do so, a reasonable fallback is for the institution to provide a meaningful referral, which means a referral that ensures that the patient receives continuity of care without facing undue burdens such as having to travel a long distance, having her desire to access reproductive health services questioned or ridiculed in any way, or encountering additional burdens to obtaining the desired service. It goes too far to grant blanket conscience exemptions to institutions such as Catholic hospitals, which should not be allowed to impose the hierarchy's ideology on patients seeking care.

Conclusion

The discussion about conscience would not be complete without making the point that the controversy over abortion can easily obscure that women seeking abortion are operating according to their consciences. Many women wrestle with the abortion decision, whether it is concern over their ability to be a good mother at the present time or in the present circumstances, concern for their existing family, or worries about their health or financial security. Women bring their own consciences into the decisions about abortion. Good women have decided for, and against, abortion. No

one decision can be right for every woman. Many theologians and lay people believe that abortion can sometimes be a moral decision, and that conscience is the final arbiter of any abortion decision. The consciences of women choosing abortion must be respected by law, medical professionals and healthcare institutions. It's only by respecting conscience in the abortion decision that everyone can be said to be truly exercising free choice.

Catholics for Choice (CFC) is a leading prochoice organisation that addresses sexual and reproductive rights from a standpoint of culture, faith, and morality.
<http://www.catholicsforchoice.org/>

PRESENTING THE CASE FOR CHOICE: MOVING FROM JUDGEMENT TO EMPATHY

Kirsten Moore

President & CEO, Reproductive Health Technologies Project

The Reproductive Health Technologies Project began in the late 1980s and early 1990s as an informal network, and then as an independent nonprofit organisation to develop a political strategy that would bring new options to women and men in the US for preventing unwanted pregnancy, terminating an unwanted pregnancy, and preventing sexually transmitted disease. We are focused on technology – the options that are available to women and men – and recognise that how those options get developed and made available happens in a very political context. We engage with that politics and policy.

It feels a little awkward for me to be telling you about the research I am presenting here, given the victory that you in the UK have recently had in terms of maintaining the status quo on the abortion law. Somebody said to me, 'all we did was maintain the status quo, that's not a real achievement': but where I come from, maintaining the status quo looks pretty good. And from the press coverage that I read, it seemed like a rational debate. There was a legitimate question on the table: 'Has the viability of a fetus lowered in gestational age, and if so do we need to update our abortion law accordingly? Let's look at what the science has to tell us about that question. Oh, the science tells us that no, it hasn't, so we're going to vote to maintain the status quo.' I'm sure there was a lot more drama and emotion to that debate, but from an outsider perspective, it looks very sensible; and levels of support in the UK for a woman being able to end an unwanted pregnancy is something we in the United States simply do not have.

As the title of this presentation, 'Moving from judgement to empathy', indicates, we are really in a different universe than the one in which pro-choice advocates in the UK are operating; and as pro-choice advocates in the US, we are trying to tackle the question of how we radically change the nature of this very polarised debate. How do we get people to a place from where they are right now, which is judging abortion, judging the woman who have abortions, judging the people who provide abortion services; and get them to a place where they say: 'You know what? It's really difficult decision and I can't make that decision for someone else. And maybe I can start thinking about how I can support somebody who is having to make that decision, or providing those services.' We are trying to move from a very legal debate to a more holistic debate, and that's the overarching premise of the research I will be discussing here.

Our odyssey started with a *Newsweek* cover story that came out in 2004, which asked: 'Should a fetus have rights?' The article made the claim that in the US, science is changing the debate; and while it is creating some unlikely allies, such as those people who believe that a fertilised embryo in a petri dish is different from a fertilised embryo in the womb, and therefore can support stem cell research, for a lot of other people things like sonograms, that window into the womb, is changing the way that people feel about the issue of abortion – and not in the pro-choice direction. What occurred to me looking at that *Newsweek* article was not just that science was

We need to be engaging with people in the middle

the problem, but that our response to what was going on was the problem. Because we have been holding our hands up and saying, 'Don't worry about the technology, that's not really the issue.' And in the meantime, people are looking at that picture and they're having an intense emotional and physiological reaction to it. So how do we engage with that?

In an early survey that we did, when we weren't even talking to people who believe that abortion should be illegal in all circumstances, we found that 4 in 10 respondents, including 1 in 5 who described themselves as solidly pro-choice, said: 'Yes, when I see a picture of a sonogram I feel more sympathy with restrictions on abortion'. So that was our original hypothesis in doing our current research. But what became clear as the work has evolved is that it's not just things like sonograms that are changing the debate. A lot has changed in the 35 years since *Roe* legalised abortion in the US. Women's status in society has dramatically changed, as have our expectations of women being able to participate fully outside of the home. The stigma around being an unwed mother has very much lessened, even if the economic hardships of that have not. Birth control is much more widely available, much safer, and much more effective. Technology is not just sonograms: the technology of how we relate to each other and interact with each other has changed, so that a new generation of people have a radically different concept of privacy than their predecessors. Demographics have changed in the US, so like a lot of other countries we're getting younger, we're becoming more mobile, and we're becoming a lot more diverse. When all that has changed, why wouldn't we think our messages need to change too?

Support for abortion in the USA

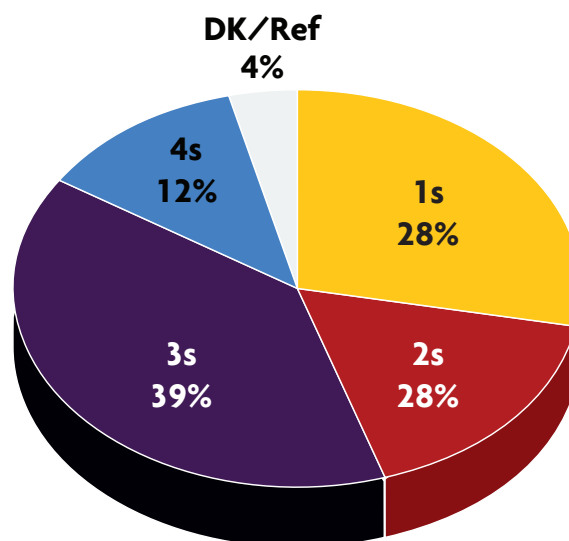
Focusing on the demographics, consider the kind of question that is typical of abortion polling in the US, again falling within the legal framework. Respondents are asked which of four responses comes closer to their view. You are a 1 if you believe abortion should always be legal; you're a 2 if you believe abortion should be legal but you don't mind a few restrictions; you're a 3 if you believe abortion should be legal but only in certain circumstances - rape, incest, health of the mother - and you're a 4 if you believe abortion should be illegal in all circumstances.

Figure 1

Which comes closest to your view on abortion?

- 1) Abortion should always be legal
- 2) Abortion should be legal most of the time
- 3) Abortion should be made illegal except in cases of rape, incest and to save the mother's life
- 4) Abortion should be made illegal without any exceptions

TOTAL POPULATION



The trend data that I have seen over time indicates that we're a country that believes that abortion should be legal. What is changing is that the number of people who describe themselves as 1 or 4 is going down, and the numbers of people who describe themselves as 2 or 3 is increasing. There are a lot of people in the middle: there are a lot of people who are conflicted in this debate. Those in the Latino population are more likely to be 3s; young women and young men are more likely to be 2s than their mothers and fathers.

We need to be engaging with the people in the middle. For a long time, the overarching principle of our message was this very simple, very basic proposition: 'Who decides?' Who decides, you or the government? You or policymakers? The answer to that question is pretty simple: 'I decide'. I know what's best for me, I know what's best for my family - and it's a very powerful frame. We've seen it over the years, and we have seen in our research today that it is still a very powerful frame. But there are some potential limitations to that frame. Stating that 'I believe that I have the best information to make that decision' is different from saying, 'And I

Talking about a woman and her decision-making process is important

believe you should be able to make your own decision too'. You see this in focus groups all the time: women who talk about their own decisions can validate and rationalise their own decision, but *their* circumstances were different. That other woman? You know, not so sure about her, I think she's trying to get away with something.

'Who decides' keeps the conversation isolated and limited. It's isolated because it's 'out there' – somebody else's issue, somebody else's problem. So what we're trying to do is change the frame into something that brings the listener in, that creates a role for the listener: 'I can accept someone's decision to end the pregnancy, even if I couldn't make that decision myself'. So it's not just a case of 'Abortion is someone else's problem, because I'm never going to have one, and even if I've had three already I'm not going to have another one'; it's about 'me', it's about 'How am I going to interact with this issue, how am I going to interact with the woman who is seeking an abortion?'

Another recent trend analysis shows a slightly different picture; that things haven't changed that much in the US. I'm sure that this, too, is accurate; and what that probably says to me is that the opinion polling, the research that we have, only gets us so far in understanding what people really think and feel about this issue, and how those thoughts and feelings actually motivate their political action. Even if the trends are staying basically the same, there is no denying that in the US, there is a perception that the pro-choice movement is really losing ground. So something is not quite connecting here.

Owning the grey

In our research, we wanted to bring a lot of different statistical tools and analyses to bear. In addition to the prominent pollster Celinda Lake, who used a lot of advanced statistical techniques, we worked closely with a psychologist and a cognitive linguist. The psychologist continually reminds us that we're a culture now that really expects to be validated. People expect to have their personal life experiences, their own world view, their emotions, validated by somebody external. And even if they agree with you, they're not listening to you unless you are saying, 'I understand who you are, I understand where you're coming from'. So this is a key way in which we are trying to change where we enter this debate.

The cognitive linguist looks at language, and language as a way of understanding how people are reasoning their positions and their point of arrival. So one of the first assignments that we gave was to ask Alyssa Wulf, who is with the group Real Reason, to look at the language on pro-choice websites and to look at the language on our opposition's website, and give us a sense of how we are each framing the issue. She made a couple of important observations, one of which was that the opposition does a very good job of engaging its audience, through using such language as: 'We can all agree'. 'We can all agree abortion late in pregnancy is wrong'. 'We can all agree that children should talk to their parents before making an important decision'. The language of the pro-choice movement, because it's rooted in the legal construct of privacy, is keeping listeners out: 'Personal, private, medical decision'. 'My body, my choice'. The listener doesn't have a way to get into that conversation.

Some of the first things that we are trying to do are acknowledge these deeply-held beliefs that people have about the issue of abortion;

to use words like 'we' and 'us', rather than they and them; to use active verbs that include the audience; and to try to avoid polarising or setting up a conflict in the message, by avoiding language that assumes a right/wrong, or a black/white. From my perspective what we need to do, to quote one of my colleagues, is to 'own the grey'. This is a really difficult issue, it's usually difficult for an individual woman, it's difficult for us as a society to come to grips with. We have to own the grey here, it's not going to be easy black or white. So the first rule of thumb is making a connection with the listener.

Another thing we are trying to do is to focus attention on the decision to become a parent. This message came out of one of our focus groups: 'It has nothing to do with ultrasounds and science, I'm not thinking about that. I'm thinking about me, my life, and what I can give to this'. And this was such an Aha! moment. We went into these focus groups asking women, 'Do sonograms change the debate; are you worried, is it a life or isn't it?', and they were responding, 'I know it's a life. If it isn't today it will be tomorrow. That's not the only question I'm really worried about though. I'm worried about, is he going to stick around? I'm worried about the fact that I already have three kids and I feel like I'm at my limit. I'm worried about the fact that my mother just was diagnosed with breast cancer'. So the point is not to let our opposition keep that debate in its narrow context of 'Is it a life or isn't it?', because that's just one of the many dimensions with which the woman who is making the abortion decision is grappling.

A woman's decision-making

I want to make two personal editorial notes here. In thinking about the decision to end the pregnancy, I think in the US in particular our decision has tended to hide behind this as a private medical issue, a decision between a woman and her doctor. And the fact of the matter is that there's a lot more that goes into this decision than just medical procedure. So it goes back to the discussion about what really are the reasons why a woman is deciding to end a pregnancy, and that we need to be more honest about that. When we are engaging with people, we'll be engaging them in the way they think about this issue, instead of trying to make them think about the issue in a different way than they already are.

The second point is that we thought that, through this research, we could make abortion a more aspirational issue: in the sense that no woman wants to have an abortion, but to try to put it back in an aspirational context by linking it to parenting and the decision to become a parent. We have not yet been able to show how this could be persuasive in a messaging context. In the US there is a worldview that is pretty broadly shared, which is that God has a plan for you, and if you got pregnant, there's a reason for it, and you're just supposed to go along with that, you're not supposed to second-guess that plan. There's a lot more aspiration about being a parent and there's a lot more wrapped up in that than I think we know how to tap into yet. But still, focusing attention on the decision is key.

Talking about a woman and her decision-making process is another important strategy for us. So to take another quote from the focus groups: 'I think that *Newsweek* cover is hilarious, that they put this baby floating against a black background like it's the only thing that exists'. Our job, as advocates, is to draw that lens out: to remind the

'I don't like abortion, but it's not my place to tell someone they should or should not have one' is the way that a lot of people think about this issue

listener or viewer that the fetus exists inside the woman. That woman has a set of circumstances, a set of relationships, a set of beliefs, and it's impossible for us to know all of those things for every woman, which is why we can't make the decision for someone else about whether or not they're ready to continue the pregnancy.

There are a couple of other subtleties going on about the woman and the decision-making process. The cognitive linguist has advised us to try to use woman (singular) instead of women (plural), because when we talk about women as a class, we trigger stereotypes in people's minds, and the stereotypes around women, sex and abortion are pretty harsh. Focusing on a woman breaks that down a little bit. Also, talking about 'decision' rather than 'choice'. 'Choice' is the operative political word in the US, and it is something that people use in their everyday language, but 'decision' just captures the more weighty nature of this political issue. And then, we should try to evoke empathy for that decision. Everyone has strong feelings about pregnancy, abortion and the decision to become a parent, which is why we can't make that decision for someone else. So: 'I'm acknowledging that you have strong feelings about this issue, I get that. And precisely because you do, that's why we can't make this decision for others.'

Framing the message

These were the hypotheses that we generated in our original research, and then we had to test it out more rigorously. Much of our opinion research took the form of the '1,2,3,4' pie chart described above, and then mapped demographic information, like race, ethnicity, class, educational status, income, on top of that, in order to understand who our target audience is. In a later national survey, we used a slightly more sophisticated cluster technique, which tries to group people according to attitudes or patterns of attitudes. In this survey, the 'Absolute Adversaries' group makes up 17% of the population: these are people who believe abortion is killing, that's wrong, end of discussion; it's important to do what God intends you to do. Those are not people that we're ever going to connect with.

'Staunch Supporters' are people who believe that abortion is a 'woman's decision', and there's some evidence in our survey that their beliefs are so firmly entrenched that part of what motivates them these days is their reaction to the opposition. It's not just their own beliefs that are driving them, it's worry and concern about what the opposition is trying to do. What gets lost sometimes in the middle, because our political strategy has been about trying to out-mobilise our base compared with our opponents' base, and then we lose all these people in the middle. So how do we connect with them?

About 3% of Absolute Adversaries believe abortion should be legal all the time or most of the time. But then you look at what happens if you ask them: 'I can accept someone's decision even if I cannot make the same decision myself'. This is what we measured on the survey, and you see some real movement. It's a different way of thinking about the issue, a different way of engaging people on this issue. So we looked at who moved, and we looked at which statements were most strongly correlated with movement, or predicted movement. The one that resonates most strongly across the board, and the one that we have seen validated, as other organisational partners have used some of this language and are testing it themselves, is this:

- *'Women have abortions for many different reasons. Some of those reasons may not seem right to us, but even if we disagree, it is better that each person be able to make her own decision.'*

What of the other statements?

- *'I believe abortion is a life or a potential life, but I still feel I can't make that decision for someone else.'* That works for the 'Exceptions Only' group, and 'Conflicted and Concerned': these are people who tend to be more pro-life.
- *'I don't like abortion, but it's not my place to tell someone they should or should not have one.'* This works with 'Conflicted and Concerned' and with 'Mainstream Choice' – 'Mainstream Choice' meaning people who are more likely to describe themselves as 2s, so they are open to restrictions on abortion, but who look a lot like our base – they are well educated, usually post-high-school; middle income; slightly more likely to be women than men.
- *'There's just something about pregnancy and everybody has feelings about it, but each circumstance is different, so we must respect and support women and families who must make life altering decisions about whether or not to have a child.'*
- *'A woman has a right to make her own personal decision about abortion without the government interfering.'* Not surprisingly, that works very well with our base.
- *'We should be focused on making abortion less necessary, not more dangerous and difficult.'* That statement works with 'Exceptions Only' and 'Conflicted and Concerned'. The one caveat that I want to offer there is that this is a very explicit policy statement, while the rest are not; and we think that we were able to attract 'Exceptions Only' and 'Conflicted and Concerned' because they were hearing so many of these other messages like 'I don't like abortion but', or 'I believe abortion ends a life but'.

Let's go back to the statement: 'I don't like abortion but it's not my place to tell someone'. As we have been sharing this research with our colleagues in the US, in the pro-choice community, there has been some concerns about this. One of the biggest questions is, 'Could a politician really use that kind of language? Is it appropriate for a politician to use that kind of language?' So we ran a test in which we did a mock town hall debate, and we had four elected officials talking about abortion for 35 minutes. And they had slightly different points of view. So one of the elected officials used this kind of language, and what was surprising was the way in which our base – the women who described themselves as strongly pro-choice – zeroed in on that statement: how they liked that, how he gets it, how he understands it. It is a controversial statement and I think that we would need to think about whether we would want to use it, but 'I don't like abortion but it's not my place...' is really the way that a lot of people think about this issue.

We broke the model out and to see what was working for young women; for African Americans; and for Latinos.

Conclusion

Our baseline statement was: 'I can accept someone's decision to end a pregnancy even if I could not make the decision myself.' And we were able to show in this survey that we moved 12% of the population in a pro-choice direction with that statement and with these kind of frames, so we are excited about the potential for this kind of language. We think it opens a different conversation with our audience: it's not just about telling people 'this is the way you should think about it', it's starting where people are at, and helping them move in a different direction.

For more information about the Reproductive Health Technologies Project's research, please visit www.rhtp.org/empathy.

HOW LATE IS TOO LATE FOR PROVIDERS?

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How do abortion providers figure out the limit of their abortion provision services? The short answer is that we don't know, because there isn't a literature on this subject to which to turn. And while there is growing interest in some unpublished data on barriers to second trimester care in various regions of the world, at this moment we have very little informational provider perspectives on second trimester abortion. We also don't know the contribution of provider perspectives to the overall success of safe second trimester abortion services worldwide. So I'm left with opinions and reflections and with calling on ideas from a broad variety of disciplines that may bear fruitfully on the question: 'how late is too late?'

We do know why doctors do abortions in general. Patient need, receiving adequate training and personal beliefs top the list, according to US data. We certainly don't know why or how doctors make the leap to providing second trimester abortions, and how they set their gestational age limit once they do provide that service. We don't know how individual providers balance the rewards of providing second trimester abortion with the unique burdens of it.

The rewards are the ability to provide life-altering clinical care to those women who often pull at our heart strings the most; and since unsafe second trimester abortion accounts for 60-80% of worldwide maternal mortality from unsafe abortion, the rewards may also be making real progress in reducing death from unsafe abortion. However, caring for women who most break our hearts is also one of the great burdens, as are the higher risk of complications, and the fact that providers are practising in the face of public opinion that views second trimester abortion as uniquely gruesome and morally challenging. We don't know why nurses and counsellors, clinic managers, choose to be involved in second trimester abortion services; and we don't know very much about the organisational issues involved in launching or expanding a second trimester abortion service.

Now we also, in truth, don't know the reasons, be they technical or psychological, why any medical specialist chooses her/his practice limits, and in this way abortion care may not be different from other medical care. But the argument I want to make here is that it is different. Providing second trimester abortions is different, say, from incorporating robotic surgery techniques or other kind of clinical or technical boundary-pushing. Abortion care is technical and clinical care provided around the boundary between life and death, and in the context of political or social controversy and commitment. So what I would like to do here is to begin to outline the considerations for providers as they, or we, consider the gestational age-stopping point for abortion. In the US where I practice there is a chronic shortage of abortion providers in some regions of the country. To compound that shortage, only 20% of providers offer services at 20 weeks' gestation, and only 8% provide services at 24

I want to focus on issues that don't have a space in current abortion discourse

weeks. I will discuss surgical termination of pregnancy or Dilation and Evacuation (D&E) primarily, because around the world it is less available, when second trimester abortion is available at all, than is second trimester medical or induction termination.

In the UK, although 75% of abortions at over 13 weeks are accomplished by D&E, D&E itself is provided by only a handful of providers and agencies. And when you consider abortion providing units themselves in the UK, less than half provide surgical termination of pregnancy in the second trimester. This is despite support for its provision by the Royal College in 2004, and in the face of a Cochrane review written by **bpas'** Medical Director Dr Patricia Lohr, which found superior safety of D&E. Lohr's review included data from a small 2004 randomised control trial showing six times the rate of complications of medical induction compared to second trimester surgical abortion.

Part of my goal here is to interrogate the reasons why surgical termination of pregnancy is not more widely practised in the second trimester, how physicians set their gestational age limit, how they might increase it, and how to manage the organisational and institutional issues around abortion at increasing gestational ages. Ultimately I will be making the argument for a new kind of abortion and pro-choice discourse: one which is honest about the nature of abortion procedures, and which uses this honesty to strengthen abortion clinical services, move public opinion, and which will better support the women and men who work as doctors and nurses and counsellors and fill many other roles in abortion clinics.

Legal considerations

So what are some of the considerations? Clearly law is one, and the UK has faced that recently in a particularly acute way, with the Parliamentary debate around the Abortion Act. Where the law provides the upper limit of abortion, providers need not sort it out for themselves. However, there is not a direct correlation between abortion law and abortion practice. To take Ghana, for example – this is a country to which my OBGYN department has a strong relationship. In 1985, the Ghanaian law on abortion changed from what has been called its preoccupation with prohibition and punishment, towards liberalisation. Ghana's law explicitly allows abortion on medical, social and psychological grounds. However there has not yet been a translation of this new law into wide availability of services. Neither first- nor second trimester abortion is practised to the extent that the law allows, and as a result unsafe abortion remains a major cause of maternal mortality in Ghana, responsible for as much as one third of maternal deaths. Ghanaian legal analysis and logic makes us conclude that the legal status of abortion is not the most important factor in determining the availability of abortion services.

Training

Training is another factor. While first trimester abortion can be accomplished by electrical or manual vacuum aspiration, and is not significantly different from a dilation and curettage performed in other contexts, such as for miscarriage or post-menopausal bleeding, a second trimester abortion involves a different set of instruments and skills. The cervix needs to be adequately prepared

and opened, large forceps with grasping destructive teeth are used to remove the fetus, usually in parts, and often ultrasound is an adjunctive measure that is useful where it is available. In addition, the stakes are higher. Complications, when they happen, can be worse, more dramatic and more devastating. In the US, of 68 abortion-related deaths in a recent 10 year period, 49 of them were in the second trimester.

Second trimester abortion is a different skill, and we might expect training to predict provision of late abortion services. So it does, to some extent. Unpublished US data tells us that providers would go to later gestational ages if they could get trained. And we also know from US data that the greater number of abortions done in residency training, in particular second trimester abortions, does predict later provision of abortion overall. But we also know that over half of residents, whose training programmes routinely include abortion care, ultimately do not provide abortion services. So training is not the only issue, though it is central and we do need more research on second trimester abortion training.

Other factors

There are obviously other factors at play as well, among them national policy, socio-cultural norms, practice group restrictions, malpractice considerations, insurance reimbursement considerations (although those probably play a much bigger role in the US than in the UK), and personal beliefs and attitudes of health professionals. Here I want to begin a discussion about some of those other, less tangible factors: provider factors that might have a role in the decision to provide second trimester care or increase gestational age limits. We should also consider whether, when legal and insurance reimbursement reasons are given by doctors as reasons for not providing second trimester abortions, these could in fact be surrogates for a less tangible distaste for the procedure. If more training was widely available, would clinicians actually take advantage of it?

I want to focus here on the things that we don't normally talk about; issues that don't have a space or a place in current abortion discourse - in particular, ironically, in pro-choice discourse. Many of the things that I address here are frankly too dangerous to talk about in organisations that support abortion. And those things are:

- 1) Personal and psychological aspects of abortion provision;
- 2) Visual and visceral dimensions of late abortion care;
- 3) The issue of violence inherent in abortion;
- 4) Legitimate ethical and moral issues that physicians may have with second trimester abortion in particular.

Ultimately I will argue that there has been a noticeable silence on some of these more difficult aspects of abortion service provision. I'll explore what I think are some of those reasons for it, and ultimately make an argument that this silence is harmful to individual providers, to the abortion rights movement itself, and, most importantly, to the women who need our services. It doesn't matter how many randomised controlled trials say that D&E is safer and more acceptable for patients if there are no providers to provide the services. So we need to understand what motivates doctors who perform abortions and the teams that they work with.

Abortion providers see things that most people don't

Personal and psychological aspects of abortion provision

There are no studies focused on how cohorts of providers determine gestational age limit, so we have to look at other types of evidence. This consists primarily of personal accounts in memoirs, and some anthropological and sociological investigations of abortion workers. There are a handful of memoirs, mostly by US providers, and these are stories of activism and commitment: stories of the personal rewards that come from caring for memorable patients, and from providers' own personal experiences of abortion. Often they are 'life on the front line' stories, tales of the personal and family sacrifices made to support women's right to choose abortion, including harassment and death threats.

These are also stories of conflict, but the conflicts in their narratives are generally limited to conflicts with abortion opponents. Difficulties and conflicts that abortion presents for the providers themselves do not appear in these narratives. Those memoirs of providers who gave care at a time of illegal abortion describe how they were motivated by the drama and necessity, by the unnecessary suffering and death, of women who had unsafe self-induced or illegal abortions. For the most part the need for providing a service was made apparent by the lives and life stories of these patients, and the decisions of these doctors was self-evident. It was a public health issue and it was a matter of understanding women in the context of their lives. The issue of providing first- versus second trimester abortions was not prominent in these narratives: providers were motivated by what women needed, not their own discomfort or comfort with procedures.

More recent narratives, after legalisation of abortion, feature slightly more the distinction between first- and second trimester abortions. They reveal a rather black-and-white way of managing the decision to do second trimester abortion. For example, in dealing with the decision to provide second trimester services, the representative range of opinion is – as one Canadian provider has articulated it – 'Once a physician is committed to freedom of choice, the question of whether to provide first or second trimester abortion should no longer be an issue.' In contrast, a US physician, upon observing her first second trimester procedure at 21 weeks, wrote: 'Seeing an arm being pulled through the vaginal canal was shocking. One of the nurses in the room escorted me out when the colour left my face. Not only was it a visceral shock, this was something I had to think about deeply. Confronting a 21-week fetus is very different. It cannot feel pain, or think, or have any sense of being. But the reality is, this cannot be called tissue. It was not something I could be comfortable with. From that moment, I chose to limit my abortion practice to the first trimester: 14 weeks or less.'

I disagree with the first statement and argue instead that there can be legitimate feelings that first- and second trimester abortions are different. However, I also take issue with the second stance, and argue against the idea that this difference means categorically avoiding abortion practice in the second trimester. I am looking for a different kind of space; a kind of middle ground in which we can acknowledge that there may be a profound difference between a first- and second trimester abortion, but that this does not require choosing to limit abortion practice to the first trimester.

Visual and visceral dimensions of late abortion care

The second issue I want to consider is the way that first- and second trimester are different in visual and visceral terms. And since we don't have a lot of literature, again you'll have to permit me an anecdote. This is my own anecdote from when I was pregnant: a little over 18 weeks pregnant with my now 4-year-old child. I was busy at work in one of the offices in which I practice, and I was about to do a second trimester abortion for a patient who was also a little over 18 weeks pregnant. And I was thinking to myself as I read the chart that this fetus was exactly the same size as my fetus; and I was interested in what these fetal parts would look like because I knew it would give me a window into my own pregnancy at that time.

So I was going about the procedure as usual: I removed the laminaria I had placed the day before, I confirmed I had adequate dilation, I used electrical suction to remove amniotic fluid. And then I picked up my forceps and began to remove the fetus in parts as I always do. I felt lucky that this fetus was already in the breech position: it would make it easier to grasp the small parts. With the first pass of my forceps I grasped an extremity and began to pull it down; and I could see a small foot hanging from the distal part of my forceps. With a quick tug I separated the leg, and precisely at that moment I felt a kick, a fluttery thump-thump in my own uterus, and it was one of the first times that I had felt fetal movement. There was a leg in my forceps and a thump-thump inside me and instantaneously tears were streaming down my face. It was as if I wasn't even cognitively aware of what had happened; it was a pure visceral response: like my hands and my eyes and my uterus were somehow directly connected to my tear ducts. This was an overwhelming feeling, a brutally visceral response, heartfelt and completely unmediated by my training and by my pro-choice feminist politics. It was one of the most raw moments in my life. And the point is that, visually and viscerally, doing an 18-week abortion is different from an 8-week abortion. Removing a microscopic fetus and gestational sac is visually and viscerally different from removing what looks like a fully-formed, but small, baby.

So what do you do with experiences like that? Abortion providers see things that most people don't. I wonder what kind of dissociative processes in me allow me to do this kind of work, and I ask myself what kind of normal person does this?

Violence

This brings me to the third issue – violence. There is a violence in abortion, and that is particularly apparent in doing a second trimester abortion. And certain moments make that more obvious than others. I will illustrate this with one final anecdote. One day as a third year resident I spent the day in our hospital abortion clinic, and the last patient of the day was about 23 weeks pregnant, and I performed an uncomplicated D&E procedure. I dutifully went through the task of reassembling the fetus in the tray to ensure that I had removed everything. It's an odd ritual filled with both respect for the fetus, a kind of awe at seeing fingers and fingernails, miniature organs and heart, intestines, kidneys, adrenal glands; but obviously it is filled with complete disregard for the fetus at the same time. Then I rushed upstairs to take call on labour and delivery. And one of the first patients that came in was delivering a

There is a case for honesty about abortion work as the basis for a stronger movement

23-and-a-half week fetus. Her dates were not exactly clear, and the neonatal intensive care team resuscitated the premature newborn and brought it to the intensive care unit. And as I watched it on the ventilator I thought to myself that I could have legally aborted this fetus if it were inside its mother's uterus; but that same kind of violence against it now would be illegal and unspeakable.

Of course I understand that the difference between the fetus I aborted and the one in the NICU was its location inside or outside a woman's body, and most importantly, the woman's hopes or wishes for that fetus or baby. I get that. But that doesn't change the fact that there is a kind of violence involved in second trimester abortion that is always present, but that can become particularly acute at certain moments like this one.

Let me add that, in my estimation, declining a woman's request for abortion is also an act of violence. So when I talk about violence, I am not proposing that abortion options be limited. Rather I am making an attempt to be honest about what's involved in abortion. Currently the violence and, frankly, gruesomeness of second trimester abortion is owned only by those who would like to see abortion at any gestational age disappear; by those who stand on street corners and in front of sports arenas holding enlarged signs of fetal parts or partially-dismembered fetal bodies.

The pro-choice movement has not owned or owned up to the reality of the fetus or the reality of fetal parts. The anti-abortion stance is that the fetus has a right to life; and in efforts to deny that a fetus has a right to life, those who support abortion rights have neglected the fetus and made it unimportant. When we see those signs and placards we may reflexively say that abortions don't really look like that. However, to a doctor and a clinic team, they may. And of course, if we were to acknowledge the violence of abortion we would risk admitting that the stereotypes anti-abortion forces hold of us are true: that we are monsters, butchers and murderers.

It is worth considering at this moment the relation of feminism to violence. In general, feminism is a peaceful movement, does not condone violent problem solving, opposes war and capital punishment. So what do we do with the version of violence in abortion? How do we incorporate this into what we are as a movement; in particular a feminist movement? In feminist sociological and anthropological literature the acceptability of acknowledging this tension is in dispute. Some scholars consider the possibility that understanding the anti-abortion side of things is all right, and in fact may lead the way to finding a common ground with those who oppose abortion. Others argue that there is no room for compromise or finding a middle ground - that there is no ground to give up.

But where does that leave the abortion provider and team? What does one do when caught between pro-choice discourse that, while it reflects my values, does not accurately reflect the full extent of my experience of abortion and in fact contradicts an enormous part of it; and the anti-abortion discourse and imagery that is actually more closely aligned to my experience but holds values that do not align with my own? Where do we go to talk about that? It is one of the more notable gaps and silences in the provision of abortion care – and I would argue that this is to the detriment of the pro-choice movement, and in particular to the availability of second trimester abortion.

Reasons for our silence

Why does this silence exist? First, obviously speaking about these things is threatening to abortion rights movement. While some of us involved in teaching abortion may routinely speak to our trainees about this aspect of care, we don't make a habit of speaking about it publicly. Discussions like this, which may be accessed by media representatives or opponents of abortion, bring the risk that comments will be distorted or taken out of context, and obviously I fear that happening. Second, speaking frankly about abortion may precipitate a schism with feminism, and there already is a history of an uneasy, often contradictory, relationship between feminist activists and abortion providers. For example, the feminist view of abortion is that it is a woman-centred service, with a limited 'technical' role for physicians. However, the abortion-providing physician desires to further medicalise and professionalise abortion services, in part as a response to the long history of stigmatisation of abortion providers. So frank talk on the part of physicians could do damage to feminist abortion rights agendas.

Third, abortion is already stigmatised as 'dirty work', and to raise the ideas I am would further entrench this idea. Sociologist Everett Hughes coined the term 'dirty work' in 1951 to describe work that is perceived as disgusting and degrading, that has physical, social or moral taint: for example, the work of grave diggers and garbage collectors. Hughes says that society delegates certain people to do dirty work and then stigmatises them, effectively disowning and disavowing the very work it has delegated to them. There has been a lot of research work on dirty work, a limited amount of it about abortion itself, that shows that doing dirty work can threaten the self-esteem of a worker's identity. So to focus on the challenges of second trimester abortion could stimulate further disavowal and stigmatisation. Even within the ranks of obstetricians and gynaecologists, there is stigmatisation and marginalisation of those who do abortions. Ongoing work in South Africa on the expansion of D&E services shows that among some OBGYNs abortion is perceived as not just dangerous, which actually goes against the evidence, but also as a procedure that is 'below them', akin to lowering one's class position.

The final point I want to make on the issue of silence is that I see a hint that this silence may be breaking. The US Fellowship in Family Planning, the post-residency abortion and family planning sub-specialty training programme, has initiated an annual psychosocial workshop for its fellows, aimed at giving light and voice to these issues.

There are probably a couple of reasons why this breaking silence might be happening now. Perhaps one is that OBGYN doctors in general are increasingly women, and as we increasingly face the issue of doing abortions while pregnant or while caring for small infants, which means you are dealing with little baby parts in real life and little fetal parts at work. Gender may be playing a role, but that's something that needs further investigation. I also wonder if demographic shifts in the cohort of abortion providers, at least in the US, may have something to do with breaking this silence. As the generation of doctors who provided abortions prior to *Roe v. Wade* retires, the cadre of doctors who now provide abortions are no longer personal witnesses to the horrific consequences of unsafe illegal abortion. This younger generation of providers may

We need research focused on provider perspectives on second trimester abortion

go through a different kind of soul-searching in deciding to provide abortion. They may demand new kinds of discussion meaning and nature of abortion provision.

Ethical and moral positions that allow grey areas

Now it is possible to say at this point that an abortion provider who feels that abortion is violent is simply ambivalent, conflicted, just should not be doing this work, or is perhaps not really committed to women's rights. There are also 'pro-life' supporters who hear the kind of stories I am telling today and argue that feelings like this may spell the end of abortion - that honesty from abortion workers about what abortion work entails will weaken the pro-choice movement to the where it cannot sustain itself any longer. I disagree. In the light of this I want to make the case for honesty about abortion work as the basis for a stronger movement, one that makes it easier for providers and the teams they work with to do all abortions, especially second trimester abortions.

There are ethical and moral positions that make complete sense of the position that women should have full access to abortion but that simultaneously allows for the feeling of loss or discomfort, and respect for the fetus; but these are not the positions that dominate pro-choice feminism. In general the terms of the debate have focused on the intrinsic moral status of the fetus, and the main anti-abortion stance is a natural law position the inviolability of the fetus from the moment of conception, in contrast to a liberal feminist position that moral status comes sentience or birth, and that focus only on the location of the fetus, in or outside of a woman's body.

But there is a third position, a gradualist one, which states that the respect owed to the fetus increases as gestation progresses or as it becomes more like a born person. There is no bright line here that distinguishes what is morally acceptable or prohibited or not. That is, even as we accept that abortion is morally permissible, we are permitted increasing discomfort, grief or loss with later abortions. With the gradualist position, we need not be afraid to acknowledge the value early human life - which I would argue has been missing from mainstream abortion rhetoric, to the detriment of the movement and, more importantly, to the women we serve. Women's lives and decisions are complex and richly textured, and in particular this may be true for the lives of women who seek second trimester abortions. Centring abortion rights on a gradualist position may help us do an even better job of being woman-centred and patient-centred. In other words strength may come from being honest about this.

The organisational challenges of providing a second trimester abortion service

The final issue that I will briefly discuss is challenges that may come when attempting to increase gestational age limits or start a second trimester abortion service. How do you grow provider and staff comfort with later procedures? How do you expand second trimester services? In the late 1970s and 80s, the time of David Grimes' work showing the safety of D&E, there was a brief interest in the effects of second trimester abortion, especially D&E, on staff, and what could be done to mitigate those effects.

There were two studies: one was a psychological analysis of providers providing D&E and induction termination; and the other was primarily a study of patients, but they also looked at provider perspectives and found that nurses experienced abandonment by medical staff, in the cases of medical induction terminations, and nurses found the deliveries too reminiscent of delivering premature babies. In contrast, in the D&E operating rooms nurses had more support from physicians and more choice about being present or not for D&E cases. Physicians, interestingly, welcomed the non-involvement that induction termination permitted. Some doctors had disquieting dreams and strong emotional reactions to surgical termination in the second trimester. One other US investigator looked at 15 former staff members and concluded that there was clear agreement that D&E was qualitatively a different procedure, medically and emotionally, than early abortion. Respondents reported serious emotional reactions that produced physical symptoms, sleep disturbances including disturbing dreams, and effects on interpersonal relationships. This clinic began a policy of giving people the opportunity to talk about their feelings, making D&E participation voluntary, having flexible and liberal vacation and mental health and personal days, and consciously promoted the idea of a team effort and need for mutual support. In other words they promoted coping and defence mechanisms that allowed staff to continue to assist patients in a supportive manner.

The challenges of providing a second trimester abortion service, therefore, include the emotional impact on providers and staff, largely due to the visceral and violent aspects of the procedures. To that we need to add the stigmatisation of abortion, and pro-choice rhetoric that is different in important ways from the reality of doing abortion.

We have no other research to guide us on the provider and organisational issues relevant to expanding gestational age at which services are provided. I am involved in such research now, and will report on my findings in the future.

Conclusion

The bottom line is that we need research focused on provider perspectives on second trimester abortion, in particular D&E, for which there is evidence of superiority over induction termination. This literature should consider both the unique burdens and the unique rewards in providing this care. Along with this, we need legitimate, formal and informal spaces and places for me varying perspectives of different team members to come to light. Abortion rights discourse itself needs to take these perspectives seriously. All of this would, I hope, both improve second trimester abortion and improve the care of women we provide with this service.

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The public and politicians are broadly with us

WHO IS ETHICAL, WHO IS MORAL?

Ann Furedi
Chief Executive, *bpas*

bpas decided to hold this conference on 'The Future of Abortion: Controversies and Care' because we thought it was important to bring together some of the discussions on the ethics and morality and policy around abortion and some of the discussions around service delivery. When we first put together the programme, some of the feedback was quite negative – people said that we were bringing together two things that really don't sit together; that there was an audience who would be interested in the ethics and morality aspects, and then there were the doctors to do the service delivery.

I think that is very wrong. It is important that those of us who aren't clinical and are advocates who try and influence policy understand the way that abortion services are provided, because until we do we will never get the policy right that shapes abortion services. And those who provide abortion services, the doctors and nurses, are not somehow divorced from the ethical and moral issues involved in it.

This was brought home to me on the second day of the conference, when I was called into the press office to have a discussion with the media about a breaking news story over here: one that really made me think about the link between ethics and morals, and service provision. This case, from Romania, involved a 10-year-old girl who was raped by her 19-year-old uncle, who then absconded, leaving her pregnant. The girl was now 11 and her parents had been trying to organise an abortion for her, which involved her going through a number of panels, which in turn involve the Catholic church – which has systematically opposed her right to have an abortion, driving her to the point where she was 11 years old and 20 weeks pregnant, and she was travelling to the UK to have her abortion here.

The comment that I gave to the press was that I am proud to be living in a country that can still provide abortions up to 24 weeks; and that those people who have recently been trying to lower the time limit here need to think about the refuge that would be lost if they had succeeded, not just for women in this country who need access to those late abortions, but for women in the rest of Europe. People talk about 'abortion tourism' as though this is something shameful and wrong about it, but I think that it is good to be a safe haven and that this is a moral and a right thing to do. And when we talk about the ethics and the morality of all this, and we ask 'Who is ethical and who is moral?', and we look at the representatives of the Catholic church who have tried to make this 11-year-old child have a baby – how moral do we think that is? And when we think about the doctors who will be carrying out the termination on this child, how moral do we think they are? I know where I stand when I think about weighing up the ethics and the morality of this situation, and there is a pulling together of ethical action between the doctors and the nurses who are involved in that child's care.

So it's very important that we bring together ethics, and morals, and law, and service delivery. Over the course of the conference, we have heard several persuasive arguments that support changes to the UK law. We have heard that there is certainly no need for two

doctors to approve grounds for an abortion: abortions are taking place for unwanted pregnancy, and we should be upfront and honest about that and have a law that reflects that practice. We have heard that nurses are more than able to provide abortions. We've heard that Early Medical Abortion is wildly over-regulated, and we need to make sure that this procedure and all abortion procedures are regulated according to clinical necessity and not according to the backward attitudes of some Parliamentarians. We have heard that there's every reason for women in Northern Ireland to have the same access to abortion as women in the rest of the Britain. The example given by Duarte Vilar about the legalisation of abortion in Portugal was an uplifting demonstration of how an organisation like the Portuguese family planning association can change their law. I think we can take great inspiration from that in the UK.

As the pro-choice movement, we have been on the defensive for so long. We have always felt that we were the people who were apologising and that public opinion was not in our favour. I remember lots of discussions recently about the upper time limit for abortion, in which people were saying that the anti-choice movement had got the support of public opinion on this issue, and there was a great deal of nervousness about whether we could win that vote in Parliament. But we did, by a bigger majority than we won it by in 1990. So sometimes we talk ourselves down by assuming that what we're doing is more controversial than it actually is in modern society. The public and politicians are broadly with us. The public might not like the idea of abortion and they don't really want to talk about it, but they know that it needs to be provided and they want a service - because they like the idea of denying women access to abortion and compelling them to continue unwanted pregnancies even less than they like the idea of abortion.

In a funny way, the organisation and high profile of this *bpas* conference demonstrates this. In the run-up to the event, we had some amusing discussions with the excellent conference organisers about contingency arrangements in the case of huge protests and disruption: it was even explained to me that the speakers' lounge was a bunker that is bomb-proof, and should there be any serious problems that is where we put the minister. (And, I would say, our late-abortion-providing doctors!) We had a discussion about the banner outside the venue, which read '*bpas*: The Future of Abortion' in letters that were two feet high. Was this going to cause protests? I have seen a lot of people lying on the grass outside in the sun, and fleetingly wondered if this might be mistaken for some kind of protest die-in – but no, it was people sunbathing: they were so not disconcerted by the banner that it passed almost without a remark.

We in the pro-choice movement should stop thinking of ourselves as outsiders. We have huge potential to influence how abortion is provided in this country. We have the attention of politicians right now, and we have the attention of policymakers: they are looking to us to discuss what a good abortion service looks like and how it should be regulated. We have the attention of NHS commissioners who want to provide and purchase good services and want to know what those services look like. We are the future of abortion care, and we should face up to that and get on with it.