Abortion Review

ISSUE 22 AUTUMN 2007 ISSN 02627299

WHY NOT DECRIMINALISE ABORTION ALTOGETHER?

By Ann Furedi, Chief Executive of BPAS

It's about time there was an inquiry into the English Abortion Act of 1967, and at last one is to be carried out: an influential group of British MPs will look into the scientific developments relating to the Act in the first dedicated inquiry into the 40-year-old law to be held in Parliament.

Since 1990, when the abortion law was last amended, governments and their civil servants have done their best to keep abortion out of Parliamentary politics. It's easy to understand why. Abortion is a complex and polarising topic, which confers political advantage on no party. Abortion is something that policymakers, like most people, accept but don't want to talk about. There have been other pressing political priorities, and the way in which the Abortion Act was drafted has allowed services to develop as society has needed them.

The way that abortion is provided has changed dramatically over the years, while the law has remained the same. In 1990, the last time that the law was subject to substantial Parliamentary scrutiny, the National Health Service (NHS) paid for less than half (48%) of abortions to women entitled to NHS care. Today the NHS funds 87% of a much greater number of abortions. Last year, almost 194,000 resident women obtained an abortion in England and Wales, 20,000 more than in 1990.

Today's social expectations create a climate where liberal access to abortion is a necessary part of healthcare. We expect to be able to plan our families. We regard sex as a celebration of love, comfort and intimacy - and even fun - and not necessarily a means of procreation. We know that contraception methods and their users are not infallible and so if we are to achieve planned parenthood, abortion is a necessary back-up to birth control.

Society regards parenthood as a significant responsibility to be undertaken with forethought and consideration. This view of parenthood does not easily sit alongside the idea that women with unwanted pregnancies should have no choice other than to broach unwanted motherhood. One woman in three will seek a termination of pregnancy before the age of 45. Although abortion is still stigmatised, it is now widely accepted as 'part of life'.

The ProLife Alliance recently told the UK Guardian that the increased number of abortions was evidence that Britain now had abortion on demand, 'which was never the intention of Parliament'. And this is a fair point. Britain does now have a situation where the law is interpreted to allow abortion when a pregnancy is unwanted. This may not have been the intention of Parliament in 1967, but it is regarded as acceptable today. The public seems comfortable with it. A poll carried out by Ipsos/MORI for BPAS in 2006 found that almost two thirds of respondents (63%) agreed that, 'If a woman wants an abortion, she should not have to continue with her pregnancy'.

And government ministers feel comfortable with this. Public health minister Caroline Flint was notably un-defensive in her comments on the release of official statistics showing that in 2006 abortion numbers had increased by four percent on the previous year. She used the opportunity to stress how government was improving the quality of services by facilitating earlier, easier access for women. While stressing that the NHS needed to work harder to reduce the need for abortion, she highlighted that 'we have invested £8 million to improve early access to [abortion] services and set a maximum waiting time of three weeks'. She also flagged up that the performance of Primary Care Trusts on abortion would continue to be measured as part of their performance ratings. In short: improving abortion services is officially a priority.

However, despite liberal interpretation and permissive practice, the Abortion Act 1967 (as amended by the Human Fertilisation & Embryology Act 1990) remains, on paper, one of the most restrictive in the developed world. Formally, the decision about whether a woman can end her pregnancy is placed in the hands of her doctors, with two doctors required to certify that certain medical conditions are met. In practice, most doctors accede to a woman's request for abortion, understanding that forcing a woman into unwilling motherhood is going to be damaging to her mental health; also abortion is less risky than childbirth. But other restrictions imposed by the Act are practical blocks on progress and cannot be circumvented.

The requirement that abortions may only be performed by doctors is ludicrous given the extended role of nurses. It may have seemed a sensible safeguard in the 1960s, when the procedure was regarded as complicated and potentially dangerous, but the modern vacuum aspiration used in early suction abortions could easily be carried out by nurses, as is the case in some US states and in South Africa. And the abortion pill can just as easily be issued by a nurse as by a doctor. Restrictions on where abortions can be performed limit the number of premises able to deliver services and leads to the pantomime where a doctor assessing a woman's suitability for abortion in a family-planning clinic has to make a separate appointment to see her at an approved clinic to give her the drugs (which she has to take on site).

And, of course, women and doctors in Northern Ireland are still excluded from the provisions of the Act.

Inside this issue:

Abortion Review, a quarterly update on issues relating to abortion is produced as an educational service by bpas. Editor: Jennie Bristow. Subscription enquiries to the marketing department - Email: abortionreview@bpas.org Published by bpas, 20 Timothy's Bridge Road, Stratford Enterprise Park, Stratford-Upon-Avon, Warwickshire CV34 4LZ, United Kingdom. www.bpas.org

It is time we created a law that reflects contemporary knowledge and social values

Now, with the fortieth anniversary of the Abortion Act approaching, it's about time we looked ahead and framed what a modern abortion law should look like; it's time we created a law that reflects contemporary knowledge and social values, ending the hypocrisy that pretends abortion is rare and the attempts to 'ghettoise' it. We should not have to work around an Act that stigmatises abortion, setting it aside from other procedures and privileging doctors' opinions about unwanted pregnancy above those of the women who experience them. Women deserve better: a flexible, fit-for-purpose law accepting that restrictions on abortion should be solely to protect health.

The new inquiry - which will be conducted by the Parliamentary Science and Technology Committee - is an opportunity to review the evidence around abortion and allow policymakers to separate the facts from the fantasy.

Paradoxically, the issue that has propelled the demand to carry out a review of the Act has been concern about fetal viability and the upper gestational limit. The great advantage of the current abortion legislation is that it draws no distinction between the grounds for abortion in the first or second trimester. Doctors are as free to refer women to end an unwanted pregnancy at 23 weeks' gestation as they are at six weeks. The inquiry will be a welcome opportunity to show there is no compelling scientific research to suggest we should reduce the upper time limit on abortion, while there is compelling social research that demonstrates why a 24-week limit should not be reduced.

It is excellent that the scope of the inquiry extends beyond consideration of fetal viability and the upper gestational limit to such issues as: the relative risks of early abortion versus pregnancy and delivery; the need for two doctors to confirm a woman meets the legal requirements; the practicalities and safety of allowing nurses or midwives to carry out abortions; regulations regarding where the 'abortion pill' can be used; and evidence of long-term or acute adverse health outcomes from abortion or from the restriction of access to abortion. It's interesting that the ProLife Alliance has objected already that 'the thrust of the inquiry appears to be geared towards gathering evidence in relation to measures that would further liberalise our current abortion law'. Another way of looking at it might be that the scope of the inquiry is comprehensive.

Women rely on termination of pregnancy as a back-up to their usual method of birth control. A third of women use an abortion service at some point in their life. They, and their elected representatives, should know that services are delivered to the highest clinical and ethical standards. An evidence-based inquiry is an opportunity to take the discussion forward towards a law that would explicitly allow abortion at the request of a woman because her pregnancy is unwanted; permit suitably qualified healthcare providers other than doctors to carry out abortions; remove 'class of place' restrictions; require the NHS to fund services to meet local demand; and remove the geographical anomaly that excludes Northern Ireland from the reach of the Abortion Act.

More simply, Britain could look simply at decriminalising abortion altogether.

Ann Furedi is Chief Executive of BPAS

Abortion Review **online**

www.abortionreview.org

For a regular update on abortion news and medical developments from around the world, visit Abortion Review online. Access is free, with a searchable archive and links to original news sources. Recent reports include:

- The barrister Barbara Hewson reflects on the 'bizarre dispute' over Ireland's 'Miss D': where a teenager, pregnant with a fetus with no head, was forced into a legal battle over travelling for an abortion.
- The US House of Representatives has voted to overturn a ban on aid to overseas groups practising abortion.
- A report by the UK Independent Advisory Group on Sexual Health and HIV claims teenagers are 'defining their lifestyle' through alcohol, drugs and risky sexual behaviour.
- A randomised controlled trial reported in the journal *Obstetrics and Gynecology* compares mifepristone and misoprostol administered simultaneously versus 24 hours apart.
- Mexico City legalises abortion in the first 12 weeks.
- A study in the *Journal of Family Planning and Reproductive Health Care* assesses compliance with RCOG Guidelines regarding screening for and treatment of Chlamydia trachomatis before vaginal termination of pregnancy and surgical evacuation of retained products of conception.
- The Romanian abortion film *4 Months, 3 Weeks and 2 Days* won the Palme d'Or at the 2007 Cannes Film Festival.

To receive regular updates straight to your inbox, JOIN OUR MAILING LIST. Simply visit http://www.abortionreview.org/index.php/site/subscribe/ and follow the instructions on screen.

Tory MPs have attempted to bring about a more restrictive law

1967 ABORTION ACT: THE DEBATE TO DATE
By Jennie Bristow

As the UK marks the fortieth anniversary of the 1967 Abortion Act, moves are underway to amend this law through the new Human Tissue and Embryos Bill, the draft of which was published in May 2007. (1) This provides a welcome opportunity for all those involved in abortion care and the pro-choice movement to re-examine the legal principles surrounding abortion in the UK, and to develop a law that best serves the interests of women today.

The Parliamentary debate also, of course, gives scope to the anti-abortion lobby to attempt to make the law on abortion more restrictive. To that end, we have seen three bills in eight months introduced in the House of Commons by Conservative backbench MPs, proposing further limits to the 1967 Abortion Act. These bills have all failed, yet they indicate that there is a continuing attempt to formulate new arguments against abortion, and that there is some constituency, in Parliament, the media, and the public, for such arguments. It is therefore worth assessing where things stand at the moment, in terms of the existing abortion law and the arguments for change being presented from both sides.

The law as it stands

The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, permits the termination of pregnancy up to 24 weeks' gestation where two doctors have formed the opinion, in good faith, that:

- 'The continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family.'

Furthermore, a pregnancy may be terminated up to birth where two doctors have formed the opinion, in good faith, that:

- 'The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
- 'The continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
- 'There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.'

The law further requires that abortion takes place on NHS or approved premises.

Currently a woman seeking a termination of pregnancy must find two doctors who believe she meets at least one of the four criteria outlined above. However, as the British Medical Association's (BMA) Medical Ethics Committee recently noted, 'In reality … it could be argued that a woman who is seeking an abortion in the first trimester will generally satisfy the first provision since an early termination is less risky to her health than pregnancy and childbirth.' (2)

The draft Human Tissue and Embryos Bill follows on from the policy proposals outlined in the white paper *Review of the Human Fertilisation and Embryology Act*, published in December 2006. The draft Human Tissue and Embryos Bill is intended to revise the law on assisted reproduction and embryology, and to establish the Regulatory Authority for Tissue and Embryos (RATE). Just as the Human Fertilisation and Embryology Act 1990 made some amendments to the 1967 Abortion Act, there is the possibility that the new Human Tissue and Embryos Bill will include amendments to the current abortion law. This is why both sides of the abortion debate are honing their arguments in relation to a) the kind of law they want and b) the legal changes they think Parliament may accept.

It is important to bear in mind the distinction between these two points. For example, many in the anti-abortion movement may *want* abortion to be outlawed completely, but they are aware that Parliament is not going to overturn the 1967 Act. Therefore, the arguments they employ are to do with restricting women's access to abortion in various different ways, rather than banning it completely.

A more restrictive law

The recent attempts by Tory backbench MPs to bring about a more restrictive abortion law have focused on three key arguments: a reduction of the 24-week 'time limit'; an end to confidentiality for under-16s; and compulsory counselling about the mental health 'risks' of abortion. Let's look at each of these in turn.

Reducing the time limit

On 31 October 2006, MPs voted 187 to 108 against a bill calling for the legal time limit for abortions to be cut from 24 weeks to 21 weeks. The bill was introduced by Conservative MP Nadine Dorries, who argued that a fetus may feel pain from 21 weeks. In previous times, the argument for reducing the time limit centred on viability, and there is still some sympathy with the view that a fetus should not be aborted at a gestation at which it would be able to survive outside the womb. However, there is clear evidence that the survival rate for babies born at under 24 weeks' gestation remains extremely low, and the prognosis for all 'pre-prematurity' survivors is extremely poor. (3) Perhaps for this reason, Ms Dorries centred her argument, not on viability but on 'the issue of fetal sentience - how fetuses respond to pain, sound etc.' Dorries claimed: 'The latest scientific research puts the case of sentience at around 21 weeks.'

In fact, the issue of fetal pain is a highly contested one, and claims about fetal responses often rely more on emotion than science. The introduction of 4-D ultrasound images of fetuses 'walking' and 'smiling' in the womb have done much to fuel the notion, popularised by the mainstream media, that a fetus is just like a born-at-term baby, with the same responses and reactions. Yet as Donald Peebles, of the Department of Obstetrics and Gynaecology at University College London, argued at a scientists' briefing in October 2006, there is 'a temptation to associate these movements - sucking a thumb, gasping as if talking - with adult movements, to think it is sucking its thumb because it is happy' and that feeling is 'extraordinarily dangerous'. (4) The scientific viewpoint is that it is a baby's contact with the social world that develops its consciousness, and therefore its ability to feel pain. But the anti-abortion lobby has gained some ground in exploiting the emotions aroused by hi-tech imagery and common-sense assumptions about fetal sentience, and we can expect versions of this argument to re-occur over the coming months.

Teenage confidentiality

On 14 March 2007, a bid by Conservative MP Angela Watkinson to force doctors offering abortion or contraception advice to under-16s to inform the child's parents was rejected by MPs, who voted 159 to 87 to retain the current guidelines guaranteeing confidential advice to under-16s. There have been attempts to undermine the right of under-16s to confidential sexual health advice since the infamous campaign by Victoria Gillick in the mid-1980s. The Department of Health (DH) reaffirmed the principle of confidentiality in its 2004 document *Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under Sixteen on Contraception, Sexual and Reproductive Health*, and a

The current debate has also generated some thoughtful, practical proposals

high-profile legal challenge to this guidance, brought by Sue Axon of Baguley, Manchester, failed in January 2006. (5)
With the government's commitment to reducing teenage pregnancy, and service providers' long understanding of the importance of confidentiality in being able to provide teenagers with an effective service, it is unlikely that such attempts to assert a 'parent's right to know' will be successful. However, the Watkinson bill is another example of the way in which the abortion law is rarely challenged head-on, but through targeting specific, emotionally-charged aspects of the law, such as the possibility of under-16s being able to have an abortion without their parents' consent.

Mental health 'risks' and a 'cooling off' period

On 5 June 2007, Conservative MP Ann Winterton's attempt to introduce compulsory abortion counselling and a week-long 'cooling off' period was defeated in the House of Commons by 182 votes to 107. Mrs Winterton said women should be made aware of the 'risks' of abortion, such as potential mental health problems. She said research showed that women with a history of psychiatric problems should not have abortions, and even those without were at risk of 'psychological ill effects'.

As Ellie Lee notes on page 5, there is no evidence that abortion directly causes mental health problems. Yet the argument that abortion is bad for women's mental health has become more widely used in recent years, by campaigners' cynical attempts to provide a 'woman-centred' argument against abortion.

A 'cooling off' period had also been proposed by Nadine Dorries, who proposed that women wait 10 days between a request for an abortion and it being performed, in order to receive information and counselling about the 'medical risk of termination' as well as of carrying a pregnancy to term 'as a condition of informed consent'. That this proposal is motivated by a desire to reduce abortion numbers rather than any genuinely woman-centred reason was shown by Ms Dorries' argument that providing (negative) information and counselling was based on experience in Western Australia, where abortions have dropped since it was introduced in 1998. Given that the policy context of abortion is one that emphasises women's early access and attempts to reduce waiting times, it is unlikely that demands to make women wait for the sake of it will garner much support. However, such arguments indicate the convoluted, insidious character reflected in many of the anti-abortion lobby's proposals.

A more flexible law

Fortunately, the current debate around the abortion law has also generated some thoughtful, practical proposals about how the needs of women could be better met. One example is the BMA Medical Ethics Committee's briefing paper *First Trimester Abortion*, which was produced for the BMA's Annual Representative Meeting in June 2007. The Medical Ethics Committee called for the revision of the Abortion Act 1967 so that, in the first trimester:

- Women are not required to meet medical criteria for abortion;
- The requirement for two doctors is removed;
- Suitably trained and experienced nurses and midwives may carry out both medical and surgical abortions;
- As long as safety is ensured, premises do not need to be approved to carry out first trimester abortions.

Furthermore, the committee has registered its belief that 'changes in relation to first trimester abortion should not adversely impact upon the availability of later abortions'.

These proposals are both positive and practical. The concept that women should be 'allowed to decide for themselves, on the basis of informed consent, whether to continue an unwanted pregnancy in the first trimester, rather than requiring women to demonstrate that they meet medical criteria', is, notes the committee, 'accepted as the norm in many countries' including Australia, Austria, Belgium, Canada, Denmark, France, Germany, Italy, Sweden and some parts of the USA.

The requirement that two doctors authorise a woman's abortion is unnecessary and time-consuming. The committee further notes the argument that such a requirement is 'out of step with the increasing emphasis on patient autonomy in all other areas of medicine': 'Women make other important decisions concerning both their own health and that of their fetus without the need to involve two doctors and they should be given the same decision-making authority in relation to this aspect of their pregnancy.'

The call to allow 'suitably trained and experienced nurses and midwives' to carry out abortions makes a great deal of sense in today's context, where the development of Early Medical Abortion allows for an easily-administered procedure, and the refinement of surgical abortion techniques has greatly reduced risk. As the committee argues, 'the level of training and experience a person has is the most important factor in determining which procedures should be undertaken by which professions'. Likewise, the committee's proposed relaxation of the rules governing the premises upon which an abortion may be carried out represents a welcome recognition of the extent to which abortion procedures in the first trimester are more straightforward than ever; and, in the case of Early Medical Abortion, the ability of women to carry out their abortion in the comfort and privacy of their homes would make a significant improvement to the service.

On 27 June, the BMA's Annual Representative Meeting passed the following policy motion by 67% in favour:

> 'That this Meeting calls for legislation to be amended so that first trimester abortion would be available on the same basis of informed consent as other treatment and therefore without the need for two doctors' signatures and that changes in relation to first trimester abortion should not adversely impact upon the availability of later abortions.' (6)

The meeting rejected, however, the proposal that nurses and midwives to carry out terminations.

Public, political and medical opinion suggests that calls for practical, positive reform to the abortion law are more convincing in the current times than the insidious attempts by the anti-abortion lobby to make access to abortion more restrictive. The challenge is to grasp this opportunity, and work to formulate the kind of law that will best meet the needs of women today.

Jennie Bristow is editor of *Abortion Review*

References

(1) *Human Tissues and Embryos (Draft) Bill.* Department of Health, 17 May 2007
(2) *First trimester abortion: A briefing paper by the BMA's medical ethics committee*. ARM 2007.
(3) 'Do 'pre-prematurity' survivors offer new evidence about fetal viability?' Laura Riley, *Abortion Review Issue 21*, Summer 2007
(4) 'New foetal scans "clouded debate on late abortion."' *The Times* (London), 3 October 2006
(5) 'Confidentiality guidance is lawful, confirms judge.' *Abortion Review Online*, 25 January 2006
(6) Annual Representative Meeting policies, British Medical Association.

Designing research that can make definitive statements about the psychological effects of abortion is complex

THE MENTAL HEALTH 'RISKS' OF ABORTION
By Ellie Lee

'Abortion exposes women to higher risk of depression', asserted a headline in the *Times* (London) on 27 October 2006. The story was provoked by a Letter to the Editor, signed by 15 doctors, which ran under the heading 'Risks of abortion'. The *Times* letter claimed that recently published research provides definitive evidence that abortion and the development of psychiatric conditions are causally linked. Those who signed the letter argue, on this basis, that the practice of abortion providers should be altered.

The claim that induced abortion can damage a woman's mental health is frequently made by anti-abortion campaigners, and has recently been used as the basis for Early Day Motions put to Parliament. But what does the evidence actually suggest? An examination of the study presented by signatories to the *Times* letter as definitive evidence that abortion causes mental health risks, and its wilful misinterpretation by the anti-abortion lobby, reveals the gap between what serious research tells us and the claims made by campaigners today.

The research to which the *Times* letter refers was published in the *Journal of Child Psychology and Psychiatry* in January 2006 and is titled 'Abortion in young women and subsequent mental health'. It concludes that: 'The findings suggest that abortion in young women may be associated with increased risks of mental health problems'. For those who take research seriously, this single line suggests very different conclusions to those presented in the *Times*.

The study was of *young women* - it considered the experience of women aged 15-25 who experienced a pregnancy. The researchers make no claims about women in general; indeed, their interest appears to be in the experience of adolescents and young adults. (It should also be noted that these young women grew up in a particular area of New Zealand, which may be significant for the relevance of the results for other societies).

The most important word in the study's conclusion, however, is *may*. Far from making strong assertions, the journal article is full of riders. These are:

- Confounding factors that this study may not have accounted for. The authors note that their findings may not have taken into account factors other than abortion that might account for the observed association between abortion and particular states of mind.
- Under-reporting of abortion in the sample. This is a well-known problem with research about abortion. For this study, the authors note there was a statistically significant difference between the rate of abortion in the sample and that in the general population.
- Contextual factors associated with abortion-seeking to which the study could not be sensitive. The authors note: 'It is clear the decision to seek (or not seek) an abortion following pregnancy is likely to involve a complex process' and that as a result, 'it could be proposed that our results reflect the effects of unwanted pregnancy on mental health rather than the effects of abortion per se on mental health'.

This last point, about the effects of unwanted pregnancy, is especially important. The comparator groups to participants in this study who had an abortion were those who stated they had not experienced a pregnancy, and those who continued a pregnancy to term. It was against this background that an association between abortion and poorer mental health emerged.

Yet this study was conducted in a context where abortion is legal, and relatively freely available. It should therefore be taken into account that it may be that the only group of women among these three groups compared who experienced a pregnancy that was truly and consistently unwanted were those who went on to terminate the pregnancy.
This point can be developed further. Since this study was conducted in a context where abortion is legal, and relatively freely available, it is likely that the pregnancies of those who continued to term and gave birth were in the majority self-defined as wanted. The importance of this point is that it raises questions about what experiences are being compared.

The most valid comparator group to women who have an abortion is women with an unwanted pregnancy who are denied abortion and then give birth. Where these groups are compared it can at least be assumed that the context of pregnancy in similar, and what is being compared is the effects of the resolution of the pregnancy (birth or abortion). Yet this study - for obvious reasons given the abortion law in New Zealand - did not include such a group of women.

Other research, however, has - most notably, that by Henry David, perhaps the most prolific researcher and writer on this subject. It shows that denied abortion and unwanted childbirth has stronger association with poor mental health than abortion.

On this basis, the authors of the *Journal of Child Psychology and Psychiatry* article are correct to be tentative in their conclusions. They are correct to make their strongest conclusion that 'the issue of whether or not abortion has harmful effects on mental health remains to be fully resolved', and call for more research into the area.

In taking this approach, they also reflect what seems to be something of a consensus about this area of abortion research. Academic research about the psychological effects of abortion is widely recognised to be a complicated enterprise. As Henry David has noted, designing research that can make definitive statements about the psychological effects of abortion (and other reproductive events) is complex. It is harder to make definitive statements than it is for physical health (where clear statements regarding the relative safety of abortion can be made).

It is for this reason that, very wisely, the British Royal College of Obstetricians and Gynaecologists (RCOG) takes stock, periodically, of the range of published studies on this issue, when drawing up its Evidence-based Guideline for abortion providers. In its leaflet for women considering abortion and their families, the RCOG states, on the basis of this evidence: 'How you react will depend on the circumstances of your abortion, the reasons for having it and on how comfortable you feel about your decision. You may feel relieved or sad, or a mixture of both'.

The RCOG also notes: 'Some studies suggest that women who have had an abortion may be more likely to have psychiatric illness or to self-harm than other women who give birth or are of a similar age. However, there is no evidence that these problems are actually caused by the abortion; they are often a continuation of problems a woman has experienced before'.

This reads like a balanced approach that takes careful account of available evidence. It tells women and their loved ones what published, peer-reviewed evidence suggests overall. This contrasts greatly with the line those associated with the *Times* letter called upon want medical authorities to take. On the basis of one study from New Zealand of women aged under 25 which actually makes only tentative claims, the letter's signatories claim: 'doctors have a duty to advise about the long-term psychological consequences of abortion'.

How could this conclusion be drawn? The emphasis on the 'risks of abortion' and their alleged implications for abortion practice clearly arises not from balanced consideration and debate about well-designed academic research. Rather its roots lie in the sociology of abortion. In the current context it is hard for those who are hostile to abortion to find support for arguments framed in moral terms. We live in an age where, for a range of reasons, few agree that abortion is simply 'wrong', so few agree with those

who moralise against abortion. In turn, the language of risk more and more provides a medicalised vocabulary in which anti-abortion argument is made. Those of us with training in social science can work to draw to public attention this 'medicalisation' of anti-abortion argument, and seek to provoke discussion of its consequences. It is to be hoped that those with scientific and medical expertise will respond by upholding the highest possible standards in relation to evidence-based abortion care.

Dr Ellie Lee is a lecturer in social policy at Kent University, and co-ordinator of Pro-Choice Forum www.prochoiceforum.org.uk She is also author of *Abortion, Motherhood and Mental Health: Medicalizing Reproduction in the US and Britain*, published by AldineTransaction.

References
The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7, RCOG September 2004
'Abortion in young women and subsequent mental health'. Fergusson DM, Horwood LJ, Ridder EM. *Journal of Child Psychology and Psychiatry*. 2006 Jan;47(1):16-24.

THE US PARTIAL BIRTH ABORTION BAN ACT: A BLOW FOR WOMEN'S AUTONOMY AND CLINICAL JUDGEMENT
By Stuart Derbyshire

On 18 April, America's Supreme Court decided to let the American Congress ban the procedure of intact dilation and extraction (intact D&E) known as 'partial birth abortion' by abortion opponents. The Court's decision reverses several earlier rulings and provides the first evidence that President Bush's replacement of more liberal Justices (especially the replacement of Sandra O'Connor by Samuel Alito) will yield the anti-abortion judgements long expected from a more conservative bench.

The 18 April decision is important for many reasons. Firstly it marks a willingness by the Supreme Court to rule on medical decision making, which it has previously been hesitant to do. Secondly it creates several practical difficulties for doctors performing abortions that could have negative health consequences for women seeking a late-term abortion or lead a doctor to break the law. Thirdly the ruling starkly illustrates the peril of relying upon the Supreme Court to uphold safe and legal access to abortion.

The Supreme Court's decision

The Partial Birth Abortion Ban Act (PBABA) was originally signed into law by President Bush in 2003 and was immediately challenged in the district courts of New York, Nebraska and California. All three courts ruled that the PBABA was unconstitutional because it failed to allow an exception to protect the health of the pregnant woman. Moreover, Judge Casey in New York correctly pointed out that a Nebraskan ban on 'partial birth abortion' had already been ruled unconstitutional in an earlier Supreme Court judgement (*Stenberg v. Carhart*). US district courts, and the circuit appeals courts, have a Constitutional duty to accept the rulings of the Supreme Court.

Subsequently, the Federal Government appealed the district court findings before the US Court of Appeals for the Eighth Circuit (one of 13 US Courts of appeals). Predictably, the Eighth Circuit judges also upheld the decision of the higher Supreme Court but this decision provided the opportunity to return the case for further judgement by the Supreme Court. Attorney General Gonzales petitioned the Supreme Court to review the Eighth Circuit decision on 25 September 2005 and oral arguments were heard by the court on 8 November 2006.

> The Supreme Court has set a worrying precedent for medical practice

Justice Anthony Kennedy delivered the opinion for the court and upheld the 2003 PBABA against a 'facial' challenge - that is, a challenge on the grounds of the ban being unconstitutional in all circumstances. Kennedy argued that although the ban does not provide an exception to protect the health of the mother it does provide an exception where the mother's life is at risk. Further, he argued that the possibility of a health risk to women in the absence of intact D&E was contestable, allowing the ban to survive a facial challenge:

> 'The Court's precedents instruct that the Act can survive facial attack when this medical uncertainty persists… Marginal safety considerations, including the balance of risks, are within the legislative competence where, as here, the regulation is rational and pursues legitimate ends, and standard, safe medical options are available.' (1)

Moreover, Kennedy argued that other abortive techniques could be used so that the ban will not provide an unconstitutional 'undue burden' on women seeking an abortion. In addition, Kennedy argued that the government has a legitimate interest in preserving and promoting fetal life, which would be compromised if the PBABA were overturned. Finally, Kennedy suggested that doctors who perform intact D&E do not describe the procedure sufficiently graphically for an informed choice. Consequently the government can act to prevent the negative consequences of a woman consenting to a procedure that is later revealed as particularly brutal and gruesome:

> 'The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.' (2)

Chief Justice John Roberts, along with Justices Samuel Alito, Clarence Thomas, and Antonin Scalia, agreed with the Court's judgement, and joined Kennedy's opinion. Justice Ruth Ginsburg dissented, joined by justices David Souter, John Stevens, and Stephen Breyer. Consequently the ruling was passed by a majority opinion of 5-4.

Medical ruling and consequences

In every relevant Supreme Court judgement on abortion since *Roe v. Wade*, the Court has upheld the need for any abortion law to include exceptions preventing a woman's health being placed at risk. Often for that reason, the Court has not previously upheld a ban on a particular method of abortion. The need for a health exception to allow an intact D&E was previously deemed necessary precisely because there is medical disagreement over the relative safety merits of an intact D&E and other methods of abortion. In *Stenberg v Carhart*, the Court accepted that clinicians should be free to judge that uncertainty and provide the procedure they perceive as in the best interests of their patient. (3) Clinicians were thus considered as being best placed to decide the precise medical procedures in any given set of circumstances. By allowing the ban on intact D&E to pass into law the Court is signalling that it is now prepared to pre-empt clinical decisions.

This introduction of the law into the operating theatre is very unwelcome. Rather than follow their clinical instincts, clinicians are now forced to look over their shoulder at Kennedy. Clinicians that are considering Kennedy might compromise patient safety to ensure compliance with the law or else put themselves at risk of criminal prosecution, loss of their licence to practice, a hefty fine and imprisonment.

Abortion providers must also ensure that their standard D&E procedures are 'Kennedy approved' D&E procedures. A normal D&E may violate the PBABA if too much of the fetus is revealed through the cervix. Even if this is not the case, excessive dilation of the cervix could conceivably be used as an indication of intent to violate the law, which can be construed as a crime.

This ruling infantilises women

Regardless of any views on the morality of abortion, anyone who cares about the autonomy of clinicians to make the judgements they have been trained to make should be appalled by the Court's decision. In seeking to define the kind of techniques doctors use, the Supreme Court has stepped onto new ground, setting a worrying precedent for medical practice in general. Doctors need to be able to decide freely the technique that best suits the interests of their patient - judges are not qualified to make such decisions, and in any other area of medical practice they are not empowered to do so. It is unfortunate that the medical organisations did not make more out of this argument in the debates over the PBABA.

Consequences for women's autonomy

Several commentators, and the dissenting opinion of Justice Ginsburg, have noted that Kennedy's opinion essentially removes women from abortion decisions (4-6). Kennedy upholds the PBABA on the dubious grounds that women will come to regret their decision later. Rather than viewing women as autonomous agents acting in their own interests, Kennedy views pregnant women as unable to make wise decisions regarding the course of their pregnancy. Kennedy describes all pregnant women as 'mothers' even though he is precisely addressing women who are electing or potentially electing to not become mothers. In Kennedy's opinion, women who are unwillingly pregnant nevertheless form a bond with their unborn fetus that will inevitably lead to regret should they allow an intact D&E. Furthermore, any woman who elects for an intact D&E is mentally suspect because her decision runs contrary to her innate maternal nature.

As others have noted (4), Kennedy's opinion harks back to laws that excused women from work and public service to protect their reproductive organs and enable their childrearing responsibilities. Such laws were believed to be in the dustbin of history; it is shocking to read a contemporary Supreme Court judgement so patronisingly dismissive of women's abilities and autonomy.

As well as being patronising, Kennedy's opinion also infantilises women. Although Kennedy exaggerates, it is undoubtedly the case that the decision to have an abortion can sometimes be very difficult and the decision might carry negative psychological consequences. That's life, many decisions can be tough and it is to be expected that sometimes tough decisions will be regretted. Everyone, however, needs the autonomy to make those tough decisions. Protecting women from the decision to abort because it will sometimes be difficult and sometimes regretted means denying women something that is fundamental to their personhood and humanity, namely their capacity for free will and agency and their ability to act as grown-up members of society.

Unfortunately it is not just conservative justices who infantilise women. In 1992, President Clinton articulated the goal that abortion should be 'safe, legal and rare'. Variations of this goal echo around a variety of groups supportive of abortion but it is a deeply problematic goal. Abortion should certainly be safe and legal but whether it is rare or common is not a decision that politicians, lawyers or clinicians can make. Women who have control over their fertility will decide for themselves how to achieve that aim, which means that abortion rates may go up or down depending upon the actual lives that women lead and the options and possibilities that are available to them. It is quite possible that if contraception becomes more readily available and women are encouraged and allowed to pursue control over their own reproduction abortion rates will increase alongside increasing expectation for control. In any case, abortion will always be required because contraceptive techniques can fail and lives and relationships can change quickly and unexpectedly. Avoiding the argument that abortion is a legitimate choice when seeking to control one's fertility undermines women's autonomy and questions their adult decision-making capacity when seeking an abortion.

Instead of women making the necessary decisions about abortion it has been the Supreme Court. Kennedy's opinion is simply a continuation of what the Supreme Court has been doing ever since *Roe v. Wade* in 1973. Justice Blackmun's majority opinion in *Roe* focused on abortion as a privacy right (the ability of patients and doctors to pursue clinical decisions without fear of interference from the State) and the right of clinicians to practice their profession. The rights of women to control their bodies and their destinies did not feature in the 1973 opinion and, more importantly, did not feature practically because true decision making was taken from women and given to the Supreme Court. Thus began more than 30 years of legal wrangling and posturing over abortion that has increasingly pushed women to the side.

In an important sense, the battle for autonomy over fertility was lost in 1973 rather than won because the battle was shifted away from a woman's autonomy to determine her life course, and to become an equal citizen, and into influencing nine Supreme Court judges. Without actually winning the battle for control over fertility, and by compromising political independence and autonomy for short-term gain, it was inevitable that one day half or more of those nine judges would turn against the precedent set in *Roe v. Wade*.

At the moment it is very unlikely that the Court will actually overturn *Roe*. Practically and politically it is not currently feasible to force over a million women into motherhood every year. But Kennedy's opinion demonstrates what we should have known all along; women's access to abortion in the USA is under constant threat of curtailment for as long as that access depends on the opinions of nine Supreme Court judges. Nobody who values women's autonomy as independent citizens should feel comfortable with the control the Supreme Court has over abortion.

Stuart WG Derbyshire is a senior lecturer in psychology at the University of Birmingham. His major research interest is understanding how the brain processes pain, and he has written extensively on abortion, especially in regards to the issue of fetal pain.

References

1) *Gonzales v. Carhart.* pp. 6-7. Available here: http://www.supremecourtus.gov/opinions/06pdf/05-380.pdf
2) Ibid., p. 29.
3) The docket on *Stenberg v Carhart* can be found here: http://www.law.cornell.edu/supct/html/99-830.ZS.html
4) Grossman J, McClain L. '*Gonzalez v. Carhart:* How the Supreme Court's Validation of the Federal Partial-Birth Abortion Ban Act Affects Women's Constitutional Liberty and Equality.' Available here: http://writ.news.findlaw.com/commentary/20070507_mcclain.html
5) Lazarus E. 'The Supreme Court's Split Decision to Uphold the Federal "Partial-Birth Abortion" Ban: Why, Despite the Court's Disclaimers, It Will Be Hugely Influential.' Available here: http://writ.news.findlaw.com/lazarus/20070426.html
6) Filipovic J. 'Terminating Women's Rights.' Available here: http://www.huffingtonpost.com/jill-filipovic/terminating-womens-right_b_46332.html

Information bulletin

EARLY MEDICAL ABORTION: A GUIDE FOR PRACTITIONERS

More than 40% of BPAS clients who request abortion in the early stages now opt for Early Medical Abortion (EMA), and report high levels of satisfaction with the service we provide. This new publication draws upon our experience to provide key information about EMA, and to offer a best practice guide to running an EMA service.

To request a copy of the Guide for Practitioners, please contact the Clinical Department, BPAS Head Office, 20 Timothy's Bridge Road, Stratford Enterprise Park, Stratford-upon-Avon, Warwickshire, CV37 9BF.

Tel: 01789 265018.
Email: susan.wyatt@bpas.org

BPAS 40th ANNIVERSARY CONFERENCE

25 and 26 June 2008,
Queen Elizabeth Conference Centre, London.

This two-day conference offers presentations from social, ethical and legal perspectives on the last 40 years of abortion and contraception provision in the UK and looking forwards (25 June), and clinical presentations and discussions on current and future abortion and contraception practice and service provision, aimed at a broad range of health care professionals (26 June). Speakers to be announced shortly.

For further information contact:

Laura Riley, BPAS Press and Public Policy Manager.
Tel: 020 7612 0206.
Email: laura.riley@bpas.org

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

Example of current campaign. Please contact marketing@bpas.org for more details.