Abortion Review

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ABORTION IN BRITAIN: THE DEBATE MUST GO ON

In the run-up to a major international conference on 'The Future of Abortion' (London, 25-26 June 2008), Ann Furedi, chief executive of BPAS, welcomes MPs' defence of the 24-week time limit but says much more can be done to free up abortion services.

The vote in the UK parliament on 20 May to retain the 24-week upper gestational limit for most abortions was important for two reasons.

Firstly, because it retained the precedent that has existed since abortion was legalised in England and Wales in 1967 that the time limit is set by medical and scientific consensus on viability. Secondly, because MPs acknowledged why women need access to abortion services in the later weeks of the second trimester, and indicated that this would not change even if access to earlier abortion was improved.

There was much discussion on the floor of the House of Commons about 'evidence': evidence from august medical bodies about when severely premature infants can be kept alive, and evidence from abortion providers about the circumstances of their clients. There was little discussion about 'principles': whether abortion is 'right' or 'wrong', whether it is a 'social good' or a 'social evil'.

For those of us who have watched the debates evolve over the decades, it was interesting to see how the limits of the discussion have shifted. In 1990, the best of the pro-choice placards and posters demanded that abortion should be available 'as early as possible, as late as necessary', suggesting that women's need for abortion should be met irrespective of fetal viability (a principle that was adopted for women whose pregnancies were affected by a serious risk of severe abnormality). At the other end of the spectrum, the anti-abortion lobby argued that abortion was murder and should not be tolerated by civilised society.

During the Parliamentary debate in 2008, there was no consideration about whether a time limit is necessary and no argument about the need to outlaw abortions entirely. How curious to hear the most vociferous opponents of abortion accepting that abortion should be available to 12 weeks, and arguing that a reduction to 12 weeks would still allow the majority of procedures to take place. Did we really see that veteran anti-choice war-horse, Ann Widdecombe MP, walk into a division lobby in support of abortion in the first trimester? Tactics, tactics; it was all about tactics; it was all about what could be won.

Abortion politics in Parliament today is about pragmatism more than principle. The anti-choice movement accepts that it cannot win support for an outright ban on abortion. The pro-choice movement accepts that politicians will set restrictions. Everything is about where the boundaries of provision are set. The discussion as the Human Fertilisation and Embryology Bill moves towards its Report stage and final vote will be focused on the 'politics of the possible'. And there is much that should be possible.

The 'progressive' or 'modernising' amendments that have been discussed by the pro-choice movement are so moderate that they were recommended by a recent House of Commons Science and Technology Committee. The possible amendments that will receive serious consideration will not 'liberalise' the abortion law, in the sense of making it easier for women to have abortions in circumstances which would now be restricted. They are modest measures that would make the provision of services more straightforward and less bound by out-of-date bureaucracy.

The current requirement for two doctors to certify that a woman meets the legal grounds for abortion has been questioned even by many parliamentarians who wished for a lower gestational limit. The 'two doctors' rule is not a clinical assessment and not linked to obtaining consent, which happens later during a medical consultation. The requirement was seen as essential in the 1960s to underline the gravity of the abortion decision, and to provide reassurance to doctors who were concerned that abortion referrals might be challenged and who thus drew confidence from a colleague's 'second signature'.

But today, when abortion referral is so common and it is accepted by officials that the law can be interpreted to provide abortion when a pregnancy is unwanted – because it is accepted that an unwanted pregnancy is a threat to mental health – the certification requirements have become nothing more than a tick-box exercise. The doctors are not even required to see the woman – both can sign 'unseen' – making their assessment on the basis of recommendations made by a nurse or counsellor. Currently, it is difficult to sustain an argument for why two doctors need to certify rather than one. It is even difficult to argue that it should be a doctor that signs rather than a nurse or other trained professional. An amendment to get rid of the 'two doctors' requirement would eliminate some unnecessary bureaucracy that can sometimes delay treatment and which wastes clinicians' valuable time.

Inside this issue:

bpas

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Currently the law insists that only doctors registered with the General Medical Council can perform abortions. This requirement means that nurses can only assist and not take responsibility for carrying out procedures. This is frustrating for nurses denied the possibility of developing and practicing skills that are seen as a normal part of nursing care in other countries.

Early aspiration abortion procedures are less complicated than many procedures routinely undertaken by nurses, and nurses already lead many early medical abortion services – doing everything except prescribe the drugs. The Royal College of Nurses is solidly behind a reform that would allow nurses to take responsibility for abortion care – a move that would make it possible to increase access to early abortion by increasing the number of appointments, and improve the quality of care.

Forty years ago, when the Abortion Act was passed, abortions were a more complicated medical procedure, usually requiring an overnight stay in hospital, and legislators were concerned to ensure that women received appropriate clinical care in properly equipped clinics. Memories of 'backstreet' abortions were recent, and the legislation was designed to ensure they were eliminated.

But today, an increasing number of pregnancies are terminated by medication: the abortion pill. This is a procedure that does not fit easily into a clinical environment, and it would be best if the medication used to bring on the woman's 'miscarriage' were taken in the comfort and privacy of her own home, as happens in the US and many European countries. Yet the law, as it stands, means that women must receive the drugs at a licensed clinic and then travel home. In effect this undermines the quality of care that clinics can provide, as it means that women are at risk of starting to cramp and bleed while they are travelling. The current requirement for places using the abortion pill to be licensed by the secretary of state for health excludes facilities that could meet the technical requirements for early medical abortion provision, and consequently denies women more local, easily accessible services.

And then there is the issue of Northern Ireland, which was excluded from the provisions of the Abortion Act in 1967, meaning that a woman in Newcastle, County Down, is denied a procedure that is available to a woman in Newcastle-upon-Tyne, unless she meets the cost and emotional burden of travelling to a clinic in England.

The Report stage of the Human Fertilisation and Embryology Bill provides an opportunity for these modernisation measures to be considered in the context of the previous House of Commons vote that endorsed the current time limit. The House of Commons has clearly endorsed legal abortion up to 24 weeks' gestation. When abortion is legal, it should be provided to the highest standards, by appropriately qualified staff, in an appropriately equipped environment. The law should surely ensure this and not frustrate it, as it does currently.

There is a longer and more complex debate to be had about the place of abortion in modern society. Right now, the HFE Bill provides an opportunity to deliver a quick fix on areas of the law that are clearly broken.

'The Future of Abortion' conference takes place in central London, June 2008. Please see back page for details.

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- Links to the key news stories and incisive commentary surrounding the Human Fertilisation and Embryology Bill, including:
  - A reduction in the legal limit for abortion from 24 weeks would give false hope to the parents of severely premature infants, Dawn Primarolo, the Health Minister, says.
  - *Guardian* columnist Polly Toynbee launches a blistering attack on the 'mendacious, emotive and unscientific campaign to cut the time limit from 24 to 20 weeks'.
  - As Tory MP Nadine Dorries launches her campaign '20 reasons for 20 weeks', Jennie Bristow, editor of *Abortion Review*, gives 24 reasons why the time limit should stay as it is.
- Abortion news from around the world, including:
  - As an evaluation of widening the provision of Early Medical Abortion (EMA) in England finds this to be safe and effective, ministers say they will launch a consultation over whether to relax rules on the settings where EMA can be carried out.
  - The Council of Europe on 16 April passed a resolution calling for all of its member states to decriminalise abortion.
  - Following a long campaign by the fpa, guidelines regarding the provision of termination of pregnancy services in Northern Ireland are due to be published in Autumn 2008.
- Updates from the medical press, including:
  - Research published in the *British Medical Journal* shows that survival rates for babies born before 24 weeks are extremely low and getting no better in spite of medical advances; while the major Epicure 2 study has found no significant improvement in the survival rate for very premature babies over the last 10 years.
  - A summary of US research finds no support for the contention that use of emergency contraception leads to sexual risk behaviour among female minors or is associated with lower use of effective contraception.
  - An article in *Reproductive Biomedicine Online* surveys the causes, consequences and social adjustments of gender-imbalanced populations.

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Abortion is not a scientific issue

FETAL PAIN AND THE POLITICISATION OF SCIENCE

By Dr Stuart Derbyshire

Over a decade ago a friend called me and alerted me to a forthcoming article in the *Lancet* arguing that a fetus might feel pain in utero. (1) She asked what I thought, and I replied the idea seemed, at best, to be a little strange. Subsequently I wrote a letter of response arguing, in essence, that pain is too complex a sensation and emotion to be experienced by a fetus. (2)

In the months that followed I was invited to give evidence before the Rawlinson Committee, a pro-life parliamentary grouping headed by Lord Rawlinson and including Sir David Alton, and to speak at a conference in Queen Charlotte's Hospital and at a further conference at the Novartis Foundation. The conference at Queen Charlotte's was cancelled because of concerns about negative publicity and the mix of science and politics. Although the conference at the Novartis Foundation went ahead, the organisers cancelled their planned press conference.

The question of whether the fetus feels pain is an interesting academic question that tests much of what we believe about pain but it is also much more than that. The question was quickly bound up into abortion politics and has become a central argument for those who oppose abortion. I think this is highly problematic because fetal pain cannot resolve the question of whether abortion is right or wrong.

If it is accepted that the fetus does not feel pain that will not mean that it is acceptable to dismiss the life of the fetus out of hand. There will remain very good reasons to defend fetal life and to protect the welfare of the fetus. Similarly, if it is accepted that the fetus can feel pain that will not mean that it is acceptable to force pregnant women to become mothers against their will. There will remain very good reasons to defend the rights of women to control their own fertility and protect their bodily sovereignty.

In October 2007, the House of Commons Science and Technology Committee (STC) published a report gathering the most recent science regarding viability, fetal development and fetal pain. (3) I gave evidence to the committee and I believe the report is very good. It is pleasing that Parliament had a document with the science right, but it is important to understand that abortion is not a scientific issue, and science cannot dictate when an abortion should be allowed and when it should not. Abortion is a moral and political issue that should be resolved by moral and political debate. In other words it should be resolved democratically and to do otherwise is bad for democracy.

Allowing the question of fetal pain, and other scientific issues, to dominate the question of abortion can have negative consequences for the political understanding of abortion. The reverse is also true: politicising fetal pain can have negative consequences for the scientific understanding of fetal pain.

Immediately before the Science and Technology Committee published its report, Channel 4 aired an episode of its documentary series *Dispatches* examining late-term abortion. I featured in the programme and have commented on it elsewhere. (4) In brief, the programme argued for restricting abortion after 12 weeks because the fetus then starts to look, behave and feel like a baby. The programme featured Professor Stuart Campbell, who interpreted his 4D ultrasound images as proof of emotional experience in second trimester fetuses, and Professor KJS Anand, who claimed to have new evidence proving that a fetus of around 16 weeks' gestation could feel pain.

Following the programme, opponents of abortion began to argue that the Science and Technology Committee had suppressed the work of Anand. They cited a recently published review of fetal pain by Lowery, Anand and others, which was not mentioned by the committee, as evidence of suppression. (5)

In fact, the Committee considered the review in question but found it to be of little help or relevance. Briefly, the review agrees that a connection from the skin to the higher centres of the brain is not complete before 29 weeks' gestation. Most neuroscientists believe that this connection is necessary for an experience of pain. Lowery and colleagues, however, argue that pain is possible dependent upon lower brain regions or transitory fetal brain structures.

The possibility of pain arising from structures beneath the cortex is highly controversial. Some sort of experience from the lower regions has been discussed, (6) but most neuroscientists believe the cortex is intimately involved in mental experience. If we take the idea that mental experience is related to brain structures at all seriously then the idea of pain experience being unaffected when vast regions of the brain are missing is quite a reach.

Similarly it is reasonable to argue that the transitory brain structures that appear during fetal development perform a different function from the relatively fixed structures that appear later. Generally speaking it is believed that these transitory structures perform important maturational functions that allow the brain to develop appropriately. The idea that the transitory structures perform functions, including causing pain experience, is not very plausible. A structure that appears, provides for pain experience, and then disappears, in an environment where pain is of no obvious value and could be actively detrimental to survival, is a very odd proposal that needs extraordinary supporting evidence.

Lowery and colleagues also claim that noxious insult to the fetus could have long-term negative developmental consequences for the fetus, neonate and infant. That is true but obviously irrelevant in the case of abortion.

Finally, Lowery and colleagues sloppily suggest that the fetus responds to pain. *Pain is the response*; pain is not being responded to. It is the presence or absence of pain that needs to be explained and a review of fetal pain should not confuse the stimulus and the response. Lowery and colleagues confuse themselves over stimulus and response because they are confused about what pain is. Although they state that pain is a conscious experience, and not just a biological reaction, they are unable to account for pain

Many of the arguments over fetal pain are quite technical

subjectivity so pain appears in places it doesn't belong such as in the stimulus, or in specialised nerve fibres, or in lower brain loops and so forth. But pain cannot be boiled down to 'pain stimuli' or 'pain fibres' without boiling out pain, because only socially conscious beings can feel. Stimuli and fibres don't feel anything.

By now you might have noticed that many of the arguments over fetal pain are quite technical and far removed from political arguments. You would be correct. It is normal for scientists to argue over technicalities and it is usual for broader debate and experimentation to gradually resolve those arguments. If this were a normal scientific dispute then myself, Anand and other interested scientists would publish papers and commentaries on each other's work and would meet to discuss our different approaches at scientific conferences.

The only chance I have had to debate openly my differences with Anand, however, was via an invitation from Nadine Dorries to speak at a meeting in Westminster. (7) I declined in part because I was going to be on the platform with Anand and Stuart Campbell and in part because the meeting was essentially a pro-life rally. I didn't see the possibility of having a balanced scientific discussion and the question of fetal pain has only minimal relevance to the question of abortion.

The debate over fetal pain is interesting and provocative but it cannot resolve the question of whether abortion is right or wrong. That is something that I think myself, and professors Anand and Campbell might agree with. Unfortunately, for more than a decade, I have been largely arguing with Anand and Campbell through trial lawyers, journalists and ministerial committee meetings. Some of that is unavoidable and unproblematic but the concern is that both sides can become entrenched in a political rather than a scientific argument.

I am not suggesting that scientists refuse to engage the political debate; the issue has become politicised and that fact has to be dealt with. It is important that scientists bring their scientific knowledge to bear upon the politics as far as can be reasonably achieved and that is why the STC report is valuable and useful. (3) I don't, however, see the value in suggesting that abortion can be resolved with a decision about fetal pain or with technically spectacular 4D images. Failing to challenge the idea that the moral question of abortion can be resolved with science betrays an opportunist approach to politics and science that is narrow and self-serving.

There is a case for maintaining a scientific debate beyond the heat of a political argument and the need to reassure other scientists that there is a genuine scientific debate and not just a political fight. I have argued elsewhere that we should encourage debate about fetal pain to continue without reference to abortion as far as possible. (8) But when politicians, such as Nadine Dorries, drag science into a political arena then scientists should explain how the science does, or does not, resolve the political question to hand. Playing on the assumption that science can resolve moral questions takes opportunism to the point of cowardice.

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.

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The best practice approach would be a woman-centred one

CLINICAL UPDATE

By Patricia Lohr, Medical Director, BPAS

In a Q&A column for *Abortion Review*, BPAS' Medical Director examines developments and discussions in abortion provision. This edition:

Late abortion

Q) What is meant by a 'late abortion'?

Late abortion is an ambiguous term but generally refers to abortions performed in the latter part of the second trimester of pregnancy. Some authors have described 'early' second-trimester abortion procedures as those performed from 13-15 weeks' gestation, 'mid' at 16-19 weeks' gestation, and 'late' as 20-27 weeks' gestation, with 'late-term' reserved for abortions during third trimester, defined as 27 weeks' gestation or greater. (1) Others have used 'late abortion' to refer to terminations at 21 weeks' gestation or greater. (2)

Q) What is the law governing late abortion in Britain?

Abortion is legal up to 24 weeks' gestation when two doctors determine that the risk to a woman's physical or mental health or the risk to her child(ren)'s physical or mental health would be greater if she continues the pregnancy than if she has an abortion. There is no gestational age limit where two doctors agree that a woman's health or life is gravely threatened by continuing the pregnancy or where there is substantial risk of a child being born with severe physical or mental abnormalities. In the event that an abortion must be performed emergently, a second doctor's agreement is not required. (3, 4)

The regulations governing abortion in the United Kingdom (the Abortion Act of 1967 as amended by the Human Fertilisation and Embryology Act of 1990) do not apply in Northern Ireland, however, where abortion is only allowed in exceptional circumstances, such as when the woman's life is in danger if the pregnancy is continued.

Q) What proportion of abortions in Britain is carried out a) after 13 weeks; b) after 20 weeks; c) after 24 weeks?

Second trimester abortions constitute a relatively small proportion of the total number of abortions in England and Wales. In 2006, the latest year for which statistics are available, 9% of abortions among residents were performed between 13-19 weeks' gestation, 1.5% from 20-23 weeks, and 0.07% after 24 weeks. (5) There are no official abortion statistics generated from Northern Ireland. However, for women travelling from Northern Ireland to England and Wales for an abortion, 12% of were performed between 13-19 weeks' gestation and 2% were 20 weeks or greater.

Q) What is BPAS' role in providing late abortions?

BPAS provides both medical and surgical abortions to 24 weeks' gestation. There are few providers of abortion services in Britain who offer terminations to the gestational age limit allowable by law; thus we view this is an important aspect of our service provision.

Q) What procedures are used in late abortions in Britain?

Abortions in the second trimester may be performed with medications that induce labour or by surgical evacuation of the uterus. (6) The most common medical method employed in Britain involves a combination of mifepristone and misoprostol. Dilatation and evacuation (D&E) is the surgical procedure of choice. A D&E involves removal of the fetus and placenta through an artificially dilated cervix using a combination of forceps and vacuum aspiration.

Q) Is feticide routinely performed in late abortions?

Feticide is recommended by the Royal College of Obstetricians and Gynaecologists for medical abortion at 22 weeks' gestation or greater to avoid the possibility of a live birth. (7) Feticide is also used before D&E by some surgeons, though the true incidence of use is not known. (8) The gestational age at which feticide is employed before D&E differs among practitioners, but it is typically reserved for terminations above 18 weeks' gestation. The softening of bone that occurs after fetal demise is proposed to reduce the amount of cervical dilation necessary and to make the procedure easier and faster, thus reducing the risk of complications.

Data supporting the effect of fetal demise on the safety and efficiency of D&E are limited. One randomised-controlled trial showed no difference between feticide with intra-amniotic digoxin and placebo with regard to complication rates or procedure duration when administered prior to D&E at 20-24 weeks gestation. (9) Women in this study did, however, report a preference for fetal demise prior to the abortion.

Q) What, in your view, would be the best practice approach to offering a late abortion service?

Despite a general downward shift in the gestational age at which abortion is performed in the first trimester, the small proportion of women obtaining abortions in the second trimester has remained stable over time. (10) Contributing factors include late diagnosis of pregnancy or of fetal anomalies, logistic and financial barriers to abortion services, and the time that some women need to decide whether or not to have an abortion. (10, 11) This suggests that there are educational, counselling and policy measures that need to be enhanced, but that the retention of access to second trimester abortions will continue to be essential for some women.

Debate still exists as to whether surgical or medical abortion is optimal for second trimester pregnancy termination, and little is known about women's preferences. The current evidence appears to favour D&E over mifepristone and misoprostol in terms of safety and efficiency, but large randomised trials are needed before definitive conclusions can be made. (12, 13) An additional challenge to the provision of second trimester surgical abortion is the

availability is a large pool of skilled surgeons. Specialised training and the maintenance of an adequate caseload are required to perform D&E safely; yet training opportunities are often limited. (7, 14, 15) The best practice approach would be a woman-centred one, where a range of services is offered by skilled and competent providers and is easy to access. This requires an understanding that provision of second trimester abortions is important, that adequate training is available, and a commitment to the maintenance or, in some cases, enhancement, of clear and well-funded pathways to services.

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IN BPAS' EXPERIENCE: WHY WOMEN NEED LATE ABORTIONS

During the controversy whipped up by the anti-abortion lobby around the 24-week 'time limit' for abortion, some wild generalisations and assumptions were made about who these women were, and what their reasons for abortion might be. To counter such misinformation, BPAS conducted a case-note analysis of all women requesting abortion at our clinics between 22 and 24 weeks' gestation.

A complete cohort of 32 women who requested abortion above 22 weeks' of pregnancy in a randomly chosen 28-day period in 2008, show complex and difficult circumstances leading to delays in abortion requests.

The women requesting abortion included young teenagers, women on drug rehabilitation programmes, and those with children in care. Others had a diagnosis of fetal abnormality. Their situations were such that the women were either not aware of their pregnancy earlier, or not in a position to seek an abortion at an earlier gestation.

Key findings from the audit of BPAS case notes:

- Individuals requesting abortion above 22 weeks' gestation ranged from 14 years old to 31 years old. 10 of 32 were teenagers.
- 11 of 32 already had children. Many requested to end this pregnancy in order to be able to cope with the needs of their existing family. Some mothers had children in care.
- Others felt unable to be 'good enough' mothers to a new baby at this point in their lives. 3 of 32 were on drug treatment programmes or drug users.
- 1 of 32 had reported her partner to the police for abusing her daughters.
- 2 of 32 women could not be found a treatment appointment despite presenting before 24 weeks, because of the lack of national capacity for late abortion care. These women were referred into antenatal care to continue the pregnancy.
- 8 of 32 did not know they were pregnant until some time into the pregnancy, others went into 'denial', or 'hoped it would go away'.
- 1 of the 32 women decided to continue with her pregnancy, after non-directive support and information from the BPAS team. As she became confident of her decision, she was referred into antenatal care.
- The pregnancies of 6 of the 32 women were found to be beyond the 24-week time limit. They were referred into antenatal care. (BPAS receives requests from approximately 100 women each year whose pregnancies are found to be beyond 24 weeks and 0 days.)

Commenting on these findings, Ann Furedi, chief executive of BPAS, said:

'It is hard to see how anyone can believe that any one of these women should be denied an abortion because they presented above 22 weeks. Many of these women are already struggling to keep their families together, some are still children themselves, others know they could not be adequate mothers. The serious problems presented by their pregnancies will not disappear because an abortion is denied.

'We need politicians to face the uncomfortable truths of women's lives, rather than seeking to impose further burdens on them. Politicians must legislate for life as it really is.'

OBITUARY:

RUPERT WALDER

The reproductive health advocate Rupert Walder died suddenly of a heart attack on 29 April 2008, aged 42. Ann Furedi pays tribute to her friend and colleague.

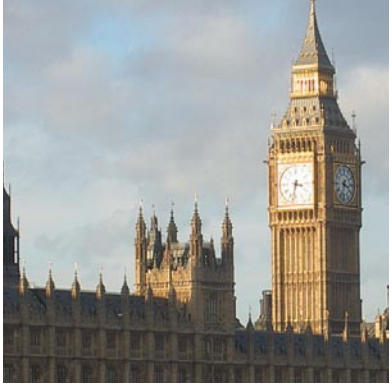
The world of sexual and reproductive health care sometimes seems too 'worthy', too politically-correct and too self-righteous, and the people involved in it, too egotistical, too self-interested and too concerned with what their donors are thinking. Rupert was an antidote to all this. He was scathing, irreverent and genuinely interested in what he appeared to be interested in. He was unambitious to a fault; recognising the talents of others easily, but often underestimating his own.

I first got to know Rupert in 1994, when we were both working on a conference to reform the abortion law in Northern Ireland. He worked for International Planned Parenthood Federation, I was running an advocacy charity, Birth Control Trust. From then on we worked on many projects together. It was Rupert who developed the first BPAS material for the male partners and friends of our clients. He was the best of colleagues, and the best of friends.

At work, he took responsibility and made problems evaporate. He had a special ability to pay attention to people. As Public Affairs Manager at the UK Human Fertilisation and Embryology Authority, he was taken on to manage the 'great and the good' – parliamentarians and members of 'the Authority' - which he did with the skill that one would expect of a former Eton-boy called 'Rupert'. When he worked for BPAS, he charmed the nurses, counsellors and receptionists - treating them with the same respect he had shown to peers and bishops. There were tears in our London clinic when they heard of his death.

As a friend, he was loyal, attentive, caring and just one of the most entertaining people I have ever met. Every memory I have of him makes me smile; that's a rare and a precious legacy.

If there is an afterlife, Rupert will not be resting in peace. He'll be stirring up some campaign for social justice and partying like there's every tomorrow.




FUTURE of ABORTION Controversies & Care

25-26 June 2008 ■ QEII Conference Centre, London ■ www.futureofabortion.org

From ethics to care: exploring the future of abortion

The **Future of Abortion: Controversies & Care** will bring together medical and nursing professionals, commissioners, regulators, policymakers, Parliamentarians, sexual health and rights organisations, academics and lawyers. Together they will explore the latest legal, ethical and clinical debates centring on the provision and delivery of abortion and contraceptive services, with updates on best practice in abortion care from the UK and other countries.

Delegates can attend for one or two days

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- **Kathy French**
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- **Professor Mitchell Creinin**
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- **Dr Stuart Derbyshire**
  Director of the Pain Research Laboratory, University of Birmingham
- **Professor John Harris**
  Institute of Medicine and Bioethics, University of Manchester

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