



PRENATAL TESTING AND ABORTION FOR FETAL ABNORMALITY: TECHNICAL ADVANCES AND POLITICAL PREJUDICES

By Jennie Bristow, Editor, *Abortion Review*

Of the approximately 200,000 women who have abortions in England and Wales each year, a very small proportion will terminate a wanted pregnancy following a diagnosis of fetal abnormality. Screening and testing for genetic or other abnormalities often occurs in the second trimester of pregnancy: therefore abortions for these indications often take place later in pregnancy, making them clinically and emotionally more demanding than first trimester abortions. Abortion for fetal abnormality has become a point of controversy, with Parliamentary and media attention tending to focus on abortion for disabilities such as Down's Syndrome or cleft palate, conditions that vary in severity and may not be incompatible with life.

Women seeking abortion following a diagnosis of fetal abnormality have to contend with a number of pressures: their own emotions and resources for coping with a new baby with special needs, or a baby that cannot survive; service constraints; and a backdrop of media controversy and public misinformation, in some cases encouraged by groups as part of anti-choice campaigns. Advances in prenatal testing seem set to make the process of diagnosing certain fetal anomalies technically easier and available earlier in pregnancy, although these techniques may be some years away from the clinic. One would hope that society would focus its resources on helping the minority of women who find themselves in such a situation. Unfortunately, while scientific developments are yielding some exciting possibilities for prenatal testing, the political context in which these developments are discussed risks trivialising and restricting women's decision-making.

What the numbers tell us

Abortions for fetal abnormality constitute a tiny proportion of the total. In 2007, 1,900 abortions (one percent) were performed under ground E: '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' (1). Abortions under ground E are legal beyond 24 weeks, but these are rarer still. In 2007, there were a total of 135 terminations for fetal abnormality after 24 weeks in England and Wales: 0.07% of the total abortion figure for that year.

Those abnormalities which prompt women to opt for abortion are typically chromosomal abnormalities or congenital malformations. In 2007, chromosomal abnormalities were reported for 39% of cases under ground E, and congenital malformations in about 46%. The most commonly reported malformations were of the nervous system (24%

of all ground E cases) and the musculoskeletal system (6%). Down's Syndrome (23% of all ground E cases) was the most commonly reported chromosomal abnormality.

It should be noted that not all abortions for fetal abnormality are recorded as such. Some prenatal testing, particularly for Down's Syndrome, takes place earlier in the pregnancy than in the past, with screening now available at 11-13 weeks. This enables a diagnosis to take place before 24 weeks, and thus an abortion is legal under the more common ground C: 'the pregnancy has not exceeded its twenty-fourth week and 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'. For women or clinicians who feel uncomfortable with specifying their reason to have an abortion in terms of fetal abnormality, the ability to record the abortion in more general terms is important.

Developments in prenatal testing

For a woman carrying a wanted pregnancy and attending antenatal care, the first sign that there may be a problem with the fetus is through screening. With their consent, pregnant women are routinely screened according to National Screening Committee guidance, to assess their risk of carrying a fetus with a number of conditions, including spina bifida and Down's Syndrome. If the screening flags up a potential problem, the woman will then be invited to undergo a diagnostic test. This is likely to involve an invasive procedure, such as amniocentesis or chorionic villus sampling (CVS), both of which carry a small risk of miscarriage and of which need to be carried out after 11 weeks of pregnancy.

For several years, the search has been on for an accurate form of non-invasive diagnostic testing that can be carried out earlier in pregnancy. Prenatal tests based on free fetal DNA (ffDNA) circulating in the woman's bloodstream are now being developed. A useful explanation of ffDNA is provided by Tessa Homfray, Consultant in Medical Genetics at St George's University Hospital, London:

For decades, attempts to identify intact fetal cells in the maternal circulation have been unsuccessful - too few cells were present, and the few that were identified could remain in the circulation for years. Cell-free DNA is also present in the circulation and probably arises from apoptosis (controlled cell death) of cells. Fetal DNA arises from dying trophoblast cells and comprises 3-6 per cent of the total cell-free DNA in the maternal circulation.

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ffDNA was first demonstrated in the maternal circulation in 1997, it consists of short fragments of DNA, not whole chromosomes. It can be first identified from the fourth week of gestation and increases throughout pregnancy. It is rapidly cleared from the maternal circulation after delivery and is undetectable by two hours [after the birth]. (2)

The identification of ffDNA is a major breakthrough, allowing for diagnostic testing using a maternal blood sample well within the first trimester of pregnancy. The technique is easy to carry out, through a simple blood test, but challenging in terms of analysis. Scientists are still at the early stages in being able to use it accurately to diagnose a variety of fetal abnormalities. However, already two clinical uses of ffDNA are currently in frequent use in the UK. Rhesus typing enables clinicians to identify Rhesus positive babies carried by Rhesus negative women, and to try and prevent isoimmunisation of the fetus by using anti-D immunoglobulin. Fetal sex determination is another use, which is offered to women who are either carriers of a X-linked disorders and who only need to have a CVS if they are carrying a male, or women at a one in four risk of having an affected baby with congenital adrenal hyperplasia, who can be treated early on with dexamethasone. (3)

As Tessa Homfray notes, these two uses for ffDNA 'are only the very beginning for what is potentially possible with this technology.' Screening for Down's Syndrome and other major trisomies (conditions caused by having three, rather than two copies of a particular chromosome) is one future possibility, as is identifying single gene disorders. Such developments would, as Homfray says, 'transform prenatal diagnosis and screening', making the diagnostic process earlier in pregnancy and without the risks associated with invasive tests.

Implications for abortion

The use of accurate diagnostic testing earlier in pregnancy has some clear implications for abortion. Women who opt for abortion following a diagnosis of fetal abnormality will be able to have the procedure earlier in gestation, giving them easier access to treatment and a wider choice of methods. Abortions in the second trimester of pregnancy constitute a minority – approximately 10% – of all procedures, and involve lengthier and more complex interventions. Among women seeking surgical abortion for fetal abnormality, there has already been a small shift to using independent providers, because some NHS units will not provide surgical abortions after about 13 weeks, and many women are reluctant to undergo medical induction. (4)

Access to less risky and more widely available diagnostic methods would be a positive development for women who find themselves having to terminate a previously wanted pregnancy. That does not mean, however, that women will be more likely to opt for abortion, or that they will undertake it any more lightly. As Jane Fisher, Director of the charity Antenatal Results and Choices (ARC), explains, we should not assume 'that an earlier diagnosis will necessarily be easier for parents to cope with. Making painful decisions about the future of what is most often a wanted pregnancy is difficult at any gestation. There is no evidence that earlier terminations for fetal abnormality have substantially less

emotional impact on women and couples than those carried out later in the pregnancy.' (5)

Fears that earlier prenatal diagnosis will encourage women to abort fetuses that they would otherwise have carried to term trivialise women's strong emotional investment in wanted pregnancies, and the seriousness with which they consider the decision to terminate following a diagnosis of fetal abnormality.

At a public discussion of ffDNA-based prenatal tests organised by Progress Educational Trust in September (6), members of the audience also raised concerns that early knowledge of fetal sex would encourage women to practice sex selection. This fear, often articulated by anti-abortion organisations, also indicates the degree to which women's abortion decisions are over-simplified. Women in the UK are not known to demand abortions following their mid-pregnancy scan because the fetus is the 'wrong' sex, and there is no reason to assume that they would do so earlier on in pregnancy. As we have seen with the introduction of other important and exciting medical technologies, developments such as this one have tended quickly to lead to unfounded concerns about a 'slippery slope'. The reductive argument posits that women given the opportunity to make decisions about their severely disabled fetuses will begin to request abortions for trivial and cosmetic reasons and is a discomfiting reminder of the skewed political and media environment in which abortion for fetal abnormality is often discussed.

Fetal abnormality and abortion law

At the time of writing, at least two amendments have been tabled to the Human Fertilisation and Embryology (HFE) Bill, proposing changes to the UK abortion law as it deals with fetal abnormality. Nadine Dorries, Conservative MP for Mid-Bedfordshire, is seeking to have written into legislation that the ground of abortion where there is risk that the fetus is 'seriously handicapped' should not include club foot, cleft lip, cleft palate and cleft lip and palate. An amendment tabled by Charles Walker MP, Conservative MP for Broxbourne, attempts to rewrite ground E, substituting 'seriously handicapped' with the phrase 'so seriously handicapped that the child would be incapable of having or achieving a recognisable quality of life.' Both these amendments trivialise the decision-making made by women and their doctors, who grapple with their decision in the context of clinical judgement and the unique pressures of their lives.

The amendment tabled by Nadine Dorries is a clear example of gesture politics, picking up on an emotive issue given prominence by a long-running anti-choice campaign and attendant media coverage. The issue of 'abortion for cleft palate' burst into the public arena in 2002-3, when Joanna Jepson, a photogenic curate who had had a congenital malformation of the jaw corrected, succeeded in bringing a judicial review of a case in which a woman had aborted a fetus after 24 weeks because of a similar anomaly that was likely to have been a marker for other much more serious conditions. The case, and the coverage of it, ran for several years, and involved the identification in the press of the doctors involved and a police investigation. The Crown Prosecution Service eventually decided that there was no evidence on which to base a prosecution, but the

The notion that better testing may lead to abortion for trivial reasons is an insult to women

chilling impact of the case upon medical confidence was significant. For example, some health authorities now have an ethics panel to deal with each case of a post-24-week abortion: leading to further uncertainty and delay for the woman in that position, and raising ethical concerns about the duty of doctors signing for abortion delegating their responsibilities.

With the attempts to place further legal restrictions on women having abortions for fetal abnormality, anti-abortion campaigners are, says Jane Fisher, 'trying to suggest that the law is too open, and that women are making all these outrageous decisions: and we know that's not true. Women are not having terminations for minor clefts at 24-plus weeks, and it's an insult to suggest they are.' For example, cleft palate can sometimes indicate a more serious underlying genetic or chromosomal syndrome, which cannot be diagnosed with certainty. (7) By the same token, the assumption that giving a minority of unfortunate women bad news about their pregnancies earlier in gestation could lead to a wave of frivolous terminations is an insult to all women, implying that they cannot be trusted with information about their pregnancies.

There are some genuine ethical considerations surrounding fDNA-based prenatal testing. For example, some women will not always want diagnostic tests, and it is important that women are properly informed of the distinction between the standard blood test for screening, and a blood test that might give a diagnostic result. There are also genuine ethical considerations surrounding abortion for fetal abnormality. The greatest of these is surely that women seeking abortion of a previously wanted pregnancy because of the discovery of fetal anomalies should not have to endure even more pressure and difficulty because of legal and service provision issues, and that screening and diagnostic tests should be the best available to prevent the possible loss of wanted pregnancies due to the testing procedures.

This is why advances in testing, which will allow those abortions to take place earlier, are to be welcomed. It is also one reason why retaining the 24-week 'time limit' for abortion is so important. Currently, women who have a diagnosis of abnormality at their mid-pregnancy (18-20 week) scan will find themselves having an abortion at a later gestation, as a result of waiting for further tests and needing the time to make their decision. While extremely few abortions happen after 20 weeks – about 1.5% - it is crucial to give women struggling with these difficult decisions the time and space to decide what to do.

Additional resources

Antenatal Results and Choices
<http://www.arc-uk.org/>

BioNews: news, information and comment in assisted reproduction and genetics <http://www.bionews.org.uk/>

Progress Educational Trust
<http://www.progress.org.uk/>

Safe Network (The Special Non-Invasive Advances in Fetal and Neonatal Evaluation Network)
<http://www.safenoe.org/>

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ABORTION AND MENTAL HEALTH

In August 2008, the American Psychological Association (APA) issued findings from a comprehensive two-year review of published research on abortion and mental health. The APA concluded that there is 'no credible evidence that a single elective abortion of an unwanted pregnancy in and of itself causes mental health problems for adult women'. (1)

The APA evaluated studies published in peer-reviewed journals since 1989. They found that some women experience sadness, grief and feelings of loss following an abortion, and some may experience 'clinically significant disorders, including depression and anxiety.' However, the task force found 'no evidence sufficient to support the claim that an observed association between abortion history and mental health was caused by the abortion *per se*, as opposed to other factors.'

The report noted that other co-occurring risk factors, including poverty, prior exposure to violence, a history of emotional problems, a history of drug or alcohol use, and prior unwanted births predispose women to experience both unwanted pregnancies and mental health problems after a pregnancy, irrespective of how the pregnancy is resolved. According to the report, women terminating a wanted pregnancy, who perceived pressure from others to terminate their pregnancy, or who perceived a need to keep their abortion secret from their family and friends because of stigma associated with abortion, were more likely to experience negative psychological reactions following abortion.

The task force's conclusions are consistent with the conclusions of a similar APA review of studies published prior to 1989. Results of that review were published in *Science* in 1990 and in the *American Psychologist* in 1992. In the UK, the Royal College of Obstetricians and Gynaecologists' Guideline on induced abortion states: '[S]ome studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared with women who give birth and to non-pregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions'. (2)

Here, Dr Ellie Lee, author of *Abortion, Motherhood and Mental Health*, discusses why the anti-abortion lobby persistently claims that abortion damages women's mental health, despite the fact that scientific investigation persistently fails to find such a link.



DEBATING ABORTION IN A THERAPY CULTURE

By Dr Ellie Lee

As a sociologist, my interest lies in the way societies define social problems. The abortion issue is particularly noteworthy because arguments about why abortion should be considered a problem have changed considerably.

Writing in the 1980s, the American philosopher L.V. Sumner stated: 'Abortion is a moral problem...What is at stake for the fetus is life itself...What is at stake for the woman is autonomy – control of the use to be made of her body'.

In the early 21st century the issue appears far less clear. A whole range of issues – fetal viability, fetal sentience, and range of areas relating to the effects of abortion for women's health – are just as likely as moral questions to animate participants in the abortion debate. What these issues have in common is their (pseudo) scientific and medical character. In all these examples the language of risk and safety replaces that of right and wrong. Heated debates about 'the evidence' take the place of that about political outlook.

The debate about abortion and its mental health effects is an example *par excellence* of this development in the abortion debate. This is not to say that there is no 'proper' research that considers the relation between abortion and women's state of mind. There is: and the recently-published review by the American Psychological Association (APA) does a fine job of summarising what this research tells us.

But the reason why mental health has come to feature so often in the public debate about abortion, and the reason why so many claims are now made about whether abortion makes women depressed, is not because most of those who talk the talk about the health risks of abortion have made a sober assessment of this body of work. Rather it is because many involved in the abortion debate have made a decision to de-moralise their arguments, in favour of talking up scary stories about the effects of abortion for women. The main culprits here are abortion opponents.

This phase of the abortion debate began some time ago, in the early 1980s in the USA. At this time, the major American anti-abortion organisations began to make reference to a newly discovered mental illness, 'Post-Abortion Syndrome' (PAS), in their publications and in their comments in the press. The abortion opponent Dr Vincent Rue has been credited with first developing the argument for PAS and its diagnostic criteria, a condition he claimed is 'a variant of Post-Traumatic Stress Disorder' (PTSD). His argument was that abortion is sufficiently stressful to lead to women developing form of PTSD afterwards, and he explicitly compared the 'symptoms' of PAS and

those which are said to be characteristic of problems first identified by psychiatrists in soldiers returning from the Vietnam war.

It is understandable why those opposed to abortion developed this line of argument. Firstly, by the early 1980s it had become evident that moral arguments against abortion were unlikely to succeed in overturning the 1973 Supreme Court decision, in *Roe v Wade*, to make abortion legal. Another sort of argument was needed. Secondly, there was the emergence of what has been termed a 'post-traumatic culture', 'therapy culture' and 'victim culture'.

In the USA first of all (and later in other countries including Britain), 'trauma' and 'PTSD' came to be used routinely to describe more and more experiences and their effects on people. If PTSD started the 1980s as a condition associated with war veterans, it latterly came to be viewed as a problem of everyday life. Its 'victims' have been identified as women who have been raped, women who have just given birth, people involved in car crashes, people who have been bereaved, and journalists reporting from war zones, and many more. PAS emerged as just one of many psychologically-oriented claims for victim status.

The argument for PAS had its greatest influence in the USA between 1987 and 1989. It was during this time that the then US Surgeon General, Everett C. Koop, undertook, at the behest of President Ronald Reagan, an enquiry into the health effects of abortion, in large part in response to claims there had been an underestimation of the damage done by abortion. Recognition of this damage, it was suggested, should lead to a revision of the law allowing women to terminate pregnancies. However, professional organisations, including the American Psychological Association, who contributed to the enquiry found no evidence to support the claim for PAS. To the great chagrin of those opposed to legal abortion, no changes were, as a result, made to the law at this point.

The report published by the APA this year in effect updates its work from the late 1980s. One notable point is the disparity between what has taken place in the world of research, and that of public and legal debate. As the APA review makes clear, there is very little evidence from the past 20 years which suggests abortion is any more depressing than was considered the case previously. Yet the volume of claims-making about mental health risks, and the place of this issue in the political and legal arena, has expanded significantly.

In the USA, the failure of the Koop enquiry to lead to restrictions on legal abortion did not diminish the impetus to medicalise arguments against abortion. American campaigners against abortion have come to sound most frequently like counsellors and therapists, and have established countless agencies to warn women that abortion will damage their mental health. And legal debates have consistently made reference to mental health, and in some cases – for example the ban on the procedure D&X, often termed 'partial-birth abortion' – the idea that abortion severely affects women mentally has been the main justification for legal restrictions.(3)

The therapeutic approach of anti-abortionists reached British shores in the early 1990. In 1995, the anti-abortion lobby stage its own version of the Koop enquiry: the Rawlinson Commission. Headed by Lord Rawlinson and administered by the anti-abortion

The APA's intervention plays an important part in limiting the medicalisation of the abortion debate

group Care for Life, this was established purportedly to gather and assess evidence about the physical and mental effects of abortion, and explicitly not to consider the moral aspects of abortion. As with the Koop enquiry, the Commission was a failure from an anti-abortion perspective, leading to an angry exchange with the Royal College of Psychiatrists but no related legal or policy modifications. Yet as in the USA, abortion opponents have continued to pursue the argument and devoted time and resources to promoting objections to abortion on mental health grounds.

At present, it is likely that the new APA report will, quite rightly, influence the public debate in Britain, and the lack of substance in a research sense for the claims made by abortion opponents about the damage abortion causes will be further exposed. The intervention of those like the APA plays an important part in this way in limiting the medicalisation of the abortion debate. It encourages a sober assessment of the evidence, and helps calm the forces that seek to turn medical issues about the care of women seeking abortion into legal ones, about whether women should be able to have abortion in the first place.

However, those who feel uncomfortable with the turn to a medicalised abortion debate in Britain should only expect so much from effects of interventions like that of the APA. This is in part because this professional association remains something of a lone voice so far in the current British context. Indeed, it is notable that it is the hard work of an American scientific body that has proved most helpful for those in Britain who want to know what the research about mental health has to say.

By contrast, the relevant British organisations have tended either to stay silent - neither the Royal College of Psychiatrists (RCPsych) nor the British Psychological Society took the opportunity of submitting evidence to the 2007 Science and Technology Committee's investigation of the scientific and medical aspects of abortion - or provide comment that has, on balance, confused people further. This confusion appears to be the main effect of the statement published by the RCPsych earlier this year on the mental health effects of abortion, which stated that: 'The specific issue of whether or not induced abortion has harmful effects on women's mental health remains to be fully resolved. The current research evidence base is inconclusive - some studies indicate no evidence of harm, whilst other studies identify a range of mental disorders following abortion.' (4)

Since it is possible to read the content of this statement in contrasting ways, it has understandably be the subject of much claims-making, most obviously by anti-abortion groups worldwide, who have taken it as support for their views. (5) The RCPsych's position statement was reported in one national UK newspaper under the headline 'Royal college warns abortions can lead to mental illness', and continued: 'Women may be at risk of mental health breakdowns if they have abortions, a medical royal college has warned'. (6) Noticeably, the RCPsych has made no subsequent public comment to clarify its position.

More broadly, arguments about the damaging mental effects of abortion are rarely fundamentally challenged. Sometimes counter-claims simply replace one set of scare stories about risk with

another. Hence, argue some, the real risk for women is childbirth and motherhood, both of which now tend to be routinely represented as a depressing and traumatic ordeal, associated with ballooning rates of PTSD and post-natal depression. While only some have so far suggested that pregnant women should be counselled about the damage childbirth and motherhood will wreak on their minds, the structure of the debate remains highly medicalised. Alternatively, debate gets stuck in the intricacies of the methodological soundness of studies about abortion and its psychological effects. This means few other than trained statisticians can find a way to understand what is being discussed, and most importantly what is at stake is rarely clarified.

Perhaps what is needed most of all is clarity about the remits of this discussion. A line need to be drawn between where research about mental health is and is not relevant. Some brave individuals, such as law professor Emily Jackson, have drawn some boundaries. (7) Ultimately, they have argued, the mental health issue is a red herring of a debate, for the law at least. Whether a woman should be able to have abortion is not a question that can be resolved by reference to psychologists' studies, however good they are. Put another way: even if some women do get depressed after abortion, the law should still allow women the free choice to have one. Access to rights is not contingent on the level of our happiness that results from us exercising them.

Ellie Lee is senior lecturer in social policy, University of Kent. A more developed account of the social history of the debate discussed here can be found in Ellie Lee's book *Abortion, Motherhood and Mental Health: Medicalizing reproduction in the United States and Great Britain* (Aldine Transaction 2003).

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FUTURE of ABORTION Controversies & Care

The Future of Abortion conference in London, June 2008, marked the fortieth anniversary of BPAS, Britain's leading abortion provider and a significant voice in policy developments and media debates. The two-day event took place in the midst of a major Parliamentary debate about amending the British abortion law, and brought together doctors, nurses, commissioners, politicians, philosophers, journalists, campaigners and abortion providers from across Europe and the USA.

Presentations were from leading international and UK experts in abortion and sexual health services with the intention of stimulating debate and presenting best practice in service delivery. The conference was opened by the **Rt Hon Dawn Primarolo MP**, Minister of State for Public Health. Many issues were discussed, and four main themes emerged:

- Abortion is a fact of modern life.
- A good abortion service puts the woman to be treated at the centre and is part of a 'joined-up' sexual health service.
- Abortion law should reflect developments in science and international clinical practice.
- The future of abortion should be determined by an honest, ongoing and rigorous debate.

Abortion is a fact of life

Opening the conference, the **Rt Hon Dawn Primarolo MP**, Minister of State for Public Health, recognised the role played by BPAS in lobbying Parliament ahead of the vote on the Abortion Act and the forthcoming Parliamentary debate, 'clearly putting across the challenges and issues faced by women.' She affirmed the government's view that the Abortion Act is working as intended, and announced a new funding of £6 million towards sexual health provision in further education sites over three years.

Ann Furedi, chief executive of BPAS, argued that we should not be concerned that the number of abortions has increased as access to services has improved. Women today want and expect to have sex without having to become mothers, and this implies a seriousness about parenthood that should be welcomed. She stressed the need for abortion as a back-up to contraception, evidenced by the extent of contraceptive failure, and noted that abortion is an accepted part of life.

Discussing the issue of 'repeat abortion', **Dr Sam Rowlands** of Warwick Medical School demonstrated that the proportion of repeat abortions is a predictable consequence of women having access to legal abortion over the course of their whole reproductive life. He argued that there is no basis for viewing the population of women who have repeat abortions as any different to those who have one abortion.

The presentation by **Professor James Trussell** of Princeton University, USA, noted that half of all pregnancies in the USA are unintended, and that 48% of unintended pregnancies resulted from

contraceptive failure. Professor Trussell highlighted the superior reliability of Long Acting Reversible Contraceptives (LARCs) – 'fit and forget' methods that women do not have to think about taking every day. This generated considerable media coverage, with headlines such as 'The Pill "has had its day as an effective contraceptive"' (*The Times* (London))

Addressing the question 'what use is emergency contraception?', **Kate Guthrie**, clinical director of Hull and East Riding Sexual and Reproductive Healthcare Partnership, examined research showing that increased access to EC does not reduce pregnancy and abortion rates. She argued that the public health impact of EC should not be over-sold, but that the benefit to individuals should be stressed, as 'everyone deserves a second chance to prevent an unintended pregnancy'.

A good abortion service puts the woman to be treated at the centre and is part of a 'joined-up' sexual health service

Chris Plummer of BPAS discussed the shift in British abortion provision from providing a service from a delivery viewpoint, using private clinics, to contracting from a purchaser viewpoint, using public money via the NHS. He suggested that the future of abortion care is client-focused: offering women as much choice as possible, and managing expectations where compromises are needed.

Simon Henning, sexual health network coordinator for Cheshire and Merseyside PCT, discussed the challenges involved in commissioning sexual health and abortion services. **Donagh Stenson** of BPAS drew upon the organisation's 40 years of experience to suggest 'what makes a good contract', and drew attention to innovations such as offering Chlamydia testing online, which show how willingness to challenge the status quo can result in a better service.

Reviewing the National Sexual Health Strategy, **Baroness Gould of Potternewton**, chair of the Independent Advisory Group on Sexual Health & HIV, situated abortion care firmly within a broad approach to contraception provision and the treatment of STIs, emphasising the need to provide a seamless service.

The emphasis on providing a woman-centred service was endorsed from a clinical perspective. **Dr Christian Fiala**, a specialist in obstetrics and gynaecology in Vienna, Austria, described the historic shift in abortion care from 'women's domination' to 'respecting women', and from 'decision-based evidence-making' to 'evidence-based decision-making'.

Discussing possible improvements in the provision of early medical abortion (EMA), **Mitchell D. Creinin**, MD, professor of obstetrics, gynaecology and reproductive sciences at the University of Pittsburgh drew attention to the safety and acceptability of women's home use of misoprostol – which is permitted in several countries, but not in Britain. He also examined research on shortening the interval between mifepristone and misoprostol administration, which may increase acceptability for women.

Presenting new research areas in medical and surgical abortion, **Daniel Grossman**, MD, of Ibis Reproductive Health, suggested that routine use of ultrasound after EMA may lead to excessive intervention at follow-up. He noted that in second-trimester abortion, complications are less frequent with dilatation and evacuation (D&E) than with induction of labour, and that many women prefer D&E.

Referring to the high proportion of second-trimester abortions carried out by D&E in the USA compared with the UK, **Eleanor Drey**, MD, EdM, of the University of California, San Francisco, raised concerns that, despite the retention of the 24-week time limit in the British abortion law, second-trimester abortion may become 'endangered' through lack of public, political and medical empathy with the woman.

Abortion law should reflect developments in science and international clinical practice

Dr Ellie Lee of the University of Kent drew upon her research into why women have abortions in the second trimester to show why Britain's 24-week 'time limit' continues to be necessary. She noted that women's failure to realise they were pregnant (often due to contraceptive failure), and the time spent deciding whether to have an abortion, are two of many reasons why women present for abortion at later gestations.

Other aspects of the UK law were discussed in relation to following international practice by permitting home use of misoprostol, and permitting nurses to carry out early medical and surgical abortions.

Mary Fjerstad of Planned Parenthood reported that provision of EMA by nurses in the USA has greatly enhanced access to abortion in rural areas. Sexual health advisor **Kathy French** argued that the UK should follow international practice by allowing nurses with the appropriate training to provide early surgical abortions, and to prescribe the abortion medication used in EMA. Presenting an international perspective, **Marge Berer**, editor of *Reproductive Health Matters*, noted that research and experience show that it is safe and beneficial for trained mid-level providers to play a greater role in abortion provision.

A panel discussion on 'challenging abortion laws' drew attention to the specific legal issues facing reproductive health advocates in different countries.

The future of abortion should be determined by an honest, ongoing and rigorous debate

Speaking at a lively evening debate asking 'What's so bad about abortion?', **Jon O'Brien** of Catholics for Choice argued that Catholics have a duty to follow their own consciences, and should not be forced to follow the teachings of the Church.

Josephine Quintavalle of Comment on Reproductive Ethics argued that abortion is an 'intrinsically illicit' choice, and doubted the possibility of the pro-choice and anti-abortion movements finding common ground.

The journalist **Dominic Lawson** thanked BPAS for providing a much-needed dialogue and wondered how one balances the rights of a woman and those of an unborn child. **Ann Furedi**, BPAS' chief executive, argued that she accords the embryo/fetus some value – abortion is not like a tonsillectomy and BPAS' clients know this too. But abortion 'doesn't take place in the abstract', and 'I don't accord that life that is not yet aware it is alive the same value as a woman's.'

The importance of self-awareness in determining the value of life was central to the presentations given by **Dr Stuart Derbyshire** of Birmingham University, and **Professor John Harris** of the University of Manchester. Harris argued that to have a view on the ethics of abortion is to have an answer as to what makes life valuable. Derbyshire argued that 'anatomical answers' to the question of fetal pain are insufficient to address the complexity of the pain experience, which can be understood only through a broader understanding of what makes human beings develop.

Commenting on the conference, **Ann Furedi**, Chief Executive of BPAS, said:

'We are proud to be able to host an event of this significance at an important time for abortion legislation. For us this was an opportunity to demonstrate that through providing abortion, we understand it. It was a chance to show that we do not ignore ethical concerns about the value of life and importance of conscience, but consider and address them. It was a space to discuss new developments in clinical practice and a platform to argue for the legal and regulatory frameworks that we believe would best serve women and those who provide the services they need.'

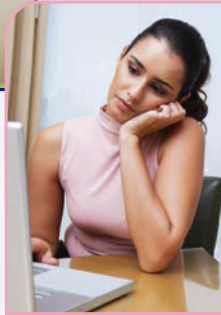
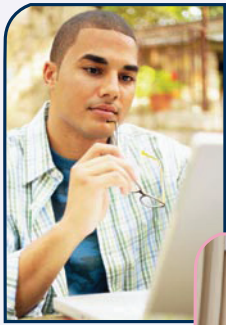
Further information about 'The Future of Abortion' conference is available on the conference website: www.futureofabortion.org

Key presentations from the BPAS conference will be published in special editions of Abortion Review, available online at www.abortionreview.org

In Issue One:

- **The problem with pain: what the fetus feels. By Dr Stuart Derbyshire.**
- **The value of life: when does it begin, when does it matter? By John Harris.**
- **Presenting the case for conscience. By Jon O'Brien.**
- **Presenting the case for choice. By Kirsten Moore.**
- **How late is too late for providers? By Lisa H Harris.**
- **Who is ethical, who is moral? By Ann Furedi.**

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Canada: The British Columbia Appeal Court has upheld the province's so-called 'bubble zone' anti-protest law even though it curtails free speech rights around abortion clinics.

India: In a study published in the *Journal of Health, Population, and Nutrition*, women in a small coastal village were asked to explain their preference for female sterilization over modern contraceptive methods.

Comment and opinion: 'Is a lower abortion rate better?' Jennie Bristow looks at some of the implications of the USA's declining abortion rate.

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