At the beginning of this year, the British Medical Journal (BMJ) revealed the ten individuals shortlisted for the BMJ Group Lifetime Achievement Award 2010, which will go to ‘the individual who has, over his or her working lifetime, made a unique and substantial contribution to improving health care, whether in clinical practice, health services, public health, health policy, medical education, or medical research’. Dr Wendy Savage, obstetrician, gynaecologist, academic and campaigner, has been shortlisted for this award, in recognition of the her tireless work in improving reproductive healthcare, both for women who need abortions and those who give birth.

To see the work of an ‘abortion doctor’ being given due recognition as a part of mainstream healthcare should not come as a surprise. Abortion has been legal in Britain for over 40 years, and during that time millions of women have been helped by doctors prepared to perform and perfect the procedure. ‘The same compassion and interest that motivates obstetricians’ and gynaecologists’ desire to make childbirth as safe and straightforward as possible, and to limit the pain and discomfort involved, has also motivated doctors involved in abortion care to minimise the complications of abortion. The result is that, for women in Britain today, abortion is extremely safe and widely available. Abortion is accepted as a necessary part of healthcare, and is funded accordingly through the National Health Service.

But unlike childbirth, the practice of abortion remains controversial. Delivering babies, or providing fertility treatment, are medical procedures for which social recognition and personal satisfaction can be taken for granted. Yet while modern British society firmly accepts the need for abortion, it is accepted as a necessary endeavour rather than promoted as a glamorous or fulfilling career move. Just as no woman ever wants to have to have an abortion, no doctor ever actively wants to perform abortions: doctors do it because they recognise that it has to be done.

Outside of the world of abortion provision and reproductive choice advocacy, the levels of skill required and compassion demanded of these doctors is rarely acknowledged.

As a generation of women has grown up secure in the knowledge that they have access to safe, legal abortion, maybe this situation is beginning to change. The horrific murder of the American abortion doctor Dr George Tiller in May 2009 led to countless testimonials from women about how much his work had helped them, and widespread recognition of the bravery demanded of those in the USA who are prepared to provide controversial, ‘late’ procedures.

In Britain, the sad death of Peter Diggory in November 2009 at the age of 85 gives us cause to reflect, with less shock but with equal respect, upon the extent to which the reproductive freedoms held by women today are due to the courageous and energetic work of the doctors, campaigners and parliamentarians who brought the 1967 Abortion Act into being. Diggory, alongside David Paintin, Malcolm Potts and others, was one of the doctors whose experience of treating women suffering from the consequences of unsafe, illegal abortions motivated him to play a key role in bringing about the social legislation that would save women from the physical and emotional costs both of bearing an unwanted child, and having unsafe abortions. Without the passionate commitment of the medical professionals involved in reforming the law back in the 1960s, the situation facing women in Britain today would be very different.

And without the continuing commitment and care shown by abortion doctors today, women would find themselves...
CLINICAL UPDATE

VACUUM ASPIRATION UNDER LOCAL ANAESTHETIC

By Patricia Lohr, Medical Director, BPAS

Q) What is vacuum aspiration under local anaesthetic?

Vacuum aspiration is a method of abortion where a cannula is inserted into the uterus and gentle suction is applied to remove the pregnancy. The suction is created by an electric vacuum machine or a hand-held syringe called a manual vacuum aspirator. Pain is managed with a combination of oral analgesia (such as ibuprofen) and local anaesthetic (lidocaine) injected into or next to the cervix. Lidocaine gel can also be used in the cervical canal. The injection or gel reduces discomfort from the passage of instruments or dilators through the cervix while the analgesic is intended to calm the pain from uterine cramping during the evacuation. Another important aspect of pain control during these procedures is good communication with the woman about what is happening and ‘vocal local’ - comforting or distracting conversation with the woman which is frequently done by an assistant and/or the surgeon.

Q) What advantages does this have over general anaesthetic?

Probably the greatest advantage of local over general anaesthetic is the length of the recovery period. The recovery period from a general anaesthetic is typically 2 hours but only about 30 minutes, or sometimes less, with a local anaesthetic. In addition, women do not experience drowsiness or other after-effects of sedating medication given with a general anaesthetic. This may help women feel more in control during the procedure and be important for women who need to drive after the procedure, work, or care for children or other family members or who do not have an escort to look after them afterwards. There is also no need to fast for a local anaesthetic. This can be very helpful for women with medical problems, such as diabetes. Finally, for some women, it may be safer to have a procedure under local rather than general anaesthesia, for example very obese women.

Q) What are the disadvantages?

Administration of analgesia and local anaesthetic reduces the pain associated with a vacuum aspiration but does not remove it completely. Experiencing any pain may be unacceptable to some women, as may remaining awake during the entire procedure. Although a vacuum aspiration is short in duration (about 10 minutes from start to finish, with the aspiration lasting only a few minutes), women who have this procedure will need to remain calm and controlled throughout for the procedure to be

The BMJ Group Lifetime Achievement Award 2010 was judged by a BMJ readers’ online poll, and will be announced on 10 March 2010. For more information, visit http://www.bmj.com
performed safely. It is important that women understand what they will experience during a procedure under local anaesthetic and actively choose to have their abortion by this method.

Q) To what gestation can vacuum aspiration under local anaesthetic be performed?

At BPAS, we currently offer manual vacuum aspiration under local anaesthetic to 12 weeks’ gestation. Electric vacuum aspiration can be performed to about 14-15 weeks’ gestation. This isn’t to say that there is an absolute gestational age limit to which abortion procedures under local anaesthetic can be performed. It is even possible to perform dilatation and evacuation under local anaesthetic safely and satisfactorily at advanced gestational ages.

Q) What is the scope of BPAS’ provision of this method?

At present, most surgical abortions performed at BPAS are done under general anaesthetic but our provision of local anaesthetic procedures is increasing. I would like to see BPAS expand the gestational ages at which abortions are performed under local anaesthetic as it offers yet another option, along with medical abortion, general anaesthetic and conscious sedation, for a woman to have the abortion procedure she feels is right for her. It may also allow us to care for some women with medical problems who cannot have a general anaesthetic in a freestanding clinic access their abortion with us. This is important because it can be difficult to locate an NHS provider for some women, particularly after about 16 weeks’ gestation.

In a joint RCOG/FSRH meeting on 11 February 2010, Patricia Lohr will be running a half-day training course in Manual Vacuum Aspiration.

- Learn confidently to fit together and operate a MVA
- Gain knowledge of appropriate pain relief
- Safely undertake MVA of uterine contents in model
- Learn to provide appropriate support for the woman and her partner/family.

For further information and to book a place, see: http://www.rcog.org.uk/events/training-course-manual-vacuum-aspiration

ABORTION REVIEW READERS’ SURVEY 2010 – PLEASE TAKE PART!

Abortion Review is entering its ninth year, and going from strength to strength. We have designed a short survey to find out from our readers what they like about Abortion Review, and what might improve the publication going into the future.

A paper copy of the survey is enclosed in this issue. Alternatively, you may find it more convenient to complete the survey online. Simply follow this link:

http://www.surveymonkey.com/s/TH96YF2

We appreciate your giving the time to complete this survey. All completed responses will be entered into a draw, and the winner will receive an Amazon token worth £50.

If you have any queries, please contact the editor, Jennie Bristow, at: editor@abortionreview.org

Many thanks,
Jennie Bristow
Ireland: Three women challenge the government’s ban on abortion at the European Court of Human Rights

The case of the women, known as A, B & C, was heard on the grounds that Ireland’s ban on abortion has jeopardised their health and wellbeing and violated their rights under the European Convention on Human Rights.

A version of this article, by BPAS chief executive Ann Furedi, was published in the Independent:

Ireland is a modern developed country where women expect to live modern lives. They expect to be educated and to have the chance to work. They expect to be able to plan their families. They expect to enjoy sex without fear of pregnancy. And, as contraception can’t always be relied on, this means they need access to safe legal abortion, just as we do here in Britain.

Every year, BPAS clinics see hundreds of women who have travelled from Irish cities, towns and villages to end crisis pregnancies. Nothing obvious marks them out from our English clients, except sometimes their accents. They come from the same social backgrounds and share the same mix of opinions and views, hopes, ambiguities and fears. But, whether they acknowledge it or not (some do, some don’t) they carry an additional burden of knowing that, in their own homeland, abortion is illegal; it violates the constitution.

The illegality of abortion at home has consequences even for those women wealthy enough, organised enough and informed enough to travel. It means they have limited opportunity for advice and counselling before they come here, and little access to support and aftercare when they return home. They carry the emotional burden of seeking an ‘illicit’ solution, and the financial cost of the treatment, travel and accommodation.

The practical arrangements often mean their treatment is delayed. Many suffer needless anxiety because, in a country when abortion is unlawful, to can be hard to know facts from myths, and to information is trustworthy. The lies about abortion are so rife that BPAS counsellors in Liverpool, who see hundreds of Irish women each year, lobbied for a dedicated website to tell the truth: http://www.bpas.ie/.

Part of truth is that legal abortion is safe and benefits society. Another part of the truth is that Ireland can only exist as a modern society because abortion clinics exist in England to help its citizens manage their reproductive lives. We are the safe, civilised alternative to clandestine, illegal abortion treatments, to abandoned infants and the burdens of forced, unwilling motherhood.

Women in Ireland have abortions but they have them here, while politicians turn away from taking responsibility for a society that allows women to have hopes and expectations of equality, but denies them the means to achieve it and makes them prisoners of their biology.

Something seems unfitting when the European Court challenges the right of a nation to set its own laws. Democracy and the right of nations to self-determination are principles that we abandon at our peril. But when a country fails to address issues that undermine the health and wellbeing of its own citizens, it needs to hear the voices of those beyond its boundaries.

Abortion is a fact of life for women in Ireland. And the Irish Government needs to face that fact.
UK: Scheme allows pharmacies to provide contraceptive pills over the counter
An NHS pilot scheme is providing the contraceptive pill to teenage girls without prescription in pharmacies.
http://www.abortionreview.org/index.php/site/article/650/

NOVEMBER 2009

UK: Public conference debates ‘The Battle for Reproductive Choice’
Commentaries based on the debate are published on Abortion Review:

• Abortion and fertility treatment: Whose right to choose? By Ann Furedi, chief executive of BPAS.
  http://www.abortionreview.org/index.php/site/article/630/

• A Doctor’s Right to Choose: The dishonesty of English abortion law. By Sally Sheldon, professor of law at Kent Law School.
  http://www.abortionreview.org/index.php/site/article/629/

• Three’s a crowd? The battle over population and reproduction. By Ellie Lee, co-ordinator of Pro-Choice Forum.
  http://www.abortionreview.org/index.php/site/article/628/

UK: No opt-out for sex education, government decides
Parents’ right to pull their children out of sex education classes in England is being ended once the pupils turn 15. All pupils will get at least one year of sex and relationship education before their 16th birthday once it becomes compulsory in 2011.

OCTOBER 2009

UK: Government ordered to publish late abortion stats
The Information Commissioner has ruled that the Department of Health should publish full data about the number of abortions carried out because of fetal abnormality. Ann Furedi, chief executive of BPAS, said:

‘I believe it’s better to have this information in the public domain, and to take measures to protect the confidentiality of patients and doctors. Abortion providers have nothing to hide, or be ashamed of. In fact, the statistics about abortion for fetal abnormality illustrate how serious the cases are and how desperate the parents terminating the pregnancy must be.’


• UK: DFID publishes policy position on safe and unsafe abortion
  Safe abortion is a right and a necessity, says the Department for International Development.
  http://www.abortionreview.org/index.php/site/article/619/

• ‘Abortion Worldwide: A decade of uneven progress’
  Restricting the availability of legal abortion does not appear to reduce the number of women trying to end unwanted pregnancies, a major report by the Guttmacher Institute suggests.
  http://www.abortionreview.org/index.php/site/article/620/

• UK: New contraceptive statistics released
  The condom has now caught up with the pill as women’s usual method of contraception, according to figures issued by the Office for National Statistics.
  http://www.abortionreview.org/index.php/site/article/620/

• Peru: Abortion bill prompts protests in capital
  Hundreds of people have demonstrated in Lima as a legislative panel approved a bill proposing legalising abortion in some cases.
  http://www.abortionreview.org/index.php/site/article/616/

• UK: Doctor found guilty of drink spiking to cause abortion
  A jury found Edward Erin guilty of attempting to poison his lover in a bid to induce an abortion.
  http://www.abortionreview.org/index.php/site/article/622/
SEPTEMBER 2009

Commentary: Motherhood in the 21st Century,
by Jennie Bristow

Two high-profile conferences raised important questions about the way that medical discourse is framing concerns about the ‘optimal’ time and circumstances in which women should reproduce.

Full report:
http://www.abortionreview.org/index.php/site/article/601/

• Poland: Ruling against Catholic magazine
A Polish court has awarded $11,000 (7,400 euros) in damages to a woman likened to a child killer for wanting an abortion.
http://www.abortionreview.org/index.php/site/article/602/

• Australia: Teenager charged with procuring own abortion
The Sunday Mail (Queensland) reports on the teenager facing the state’s first abortion trial in nearly 25 years.
http://www.abortionreview.org/index.php/site/article/600/

OCTOBER 2009

• UK: Women’s preferences for method of abortion and management of miscarriage
The authors concluded that medical abortion at home is a potentially popular choice for women having an abortion, with surgical abortion under LA less so. Both home medical management and surgery under LA would appear to be welcome service developments for women needing treatment for a miscarriage. Journal of Family Planning and Reproductive Health Care. 2009 Oct;35(4):233-5.
http://www.abortionreview.org/index.php/site/article/63/

• WHO: Use of combined oral contraceptives (COCs) post abortion
The authors concluded that evidence shows that COCs can be safely initiated immediately following surgical and medical abortion in the first trimester of pregnancy. Contraception. 2009 Oct;80(4):355-62.
http://www.abortionreview.org/index.php/site/article/61/

• Finland: Immediate complications after medical compared with surgical abortion
The authors concluded that both methods of abortion are generally safe, but medical termination is associated with a higher incidence of adverse events. Obstetrics and Gynecology. 2009 Oct;114(4):795-804.
http://www.abortionreview.org/index.php/site/article/65/

• UK: Trends in Down’s syndrome live births and antenatal diagnoses in England and Wales
The authors found that the expansion of and improvements in antenatal screening have offset an increase in Down’s syndrome resulting from rising maternal age. British Medical Journal. 2009 Oct 26;339
http://www.abortionreview.org/index.php/site/article/626/

ABORTION REVIEW SPECIAL EDITIONS

Key presentations from the landmark BPAS conference in June 2008 are published in special editions of Abortion Review, available to download for free at www.abortion.review.org

Special Edition One: Abortion, Ethics, Conscience and Choice

Special Edition Two: Abortion and Women’s Lives

Special Edition Three: Abortion and Clinical Practice

Forthcoming: Special Edition Four: Abortion, Policy, and Law
SEPTEMBER 2009

- **UK:** The role of feticide in the context of late abortion - health professionals' and parents' views
  The authors concluded that for health professionals who provide and facilitate feticide, and for parents making decisions about late abortion and feticide, the procedure is understood as a necessary rather than chosen activity. Parents' perceptions of feticide may differ, and good clinical care must be designed to cope with this variation. For health professionals, feticide seems more readily distinguished from other types of abortion activities and may evoke simultaneous positive and negative perceptions. *Prenatal Diagnosis.* 2009 Sep;29(9):875-81. [http://www.abortionreview.org/index.php/site/article/660/](http://www.abortionreview.org/index.php/site/article/660/)

- **USA:** Effectiveness of medical abortion with mifepristone and buccal misoprostol through 59 days
  The authors concluded that in conjunction with 200 mg of mifepristone, use of 800 mcg of buccal misoprostol up to 59 days of gestation is as effective as the use of 800 mcg of vaginal misoprostol up to 63 days of gestation. *Contraception.* 2009 Sep;80(3):282-6. [http://www.abortionreview.org/index.php/site/article/658/](http://www.abortionreview.org/index.php/site/article/658/)

- **USA:** Physicians' beliefs about conscience in medicine
  The study set out to explore physicians' beliefs about whether physicians sometimes have a professional obligation to provide medical services even if doing so goes against their conscience, and to examine associations between physicians' opinions and their religious and ethical commitments. *Academic Medicine.* 2009 Sep;84(9):1276-82. [http://www.abortionreview.org/index.php/site/article/656/](http://www.abortionreview.org/index.php/site/article/656/)

- **UK:** Late abortion - a comparison of obstetricians' experience in eight European countries

- **USA:** Effect of mifepristone on abortion access in the United States
  The authors concluded that mifepristone has become an integral part of abortion provision in the United States and likely has contributed to a trend toward very early abortions. However, expectations that approval of mifepristone would result in a wider range of providers offering abortion have not yet been met, and mifepristone has not brought a major improvement in the geographic availability of abortion. *Obstetrics and Gynecology.* 2009 Sep;114(3):623-30. [http://www.abortionreview.org/index.php/site/article/644/](http://www.abortionreview.org/index.php/site/article/644/)
Example of recent a campaign. Please contact marketing@bpas.org for more details.