Abortion Review

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ABORTION POLITICS IN BRITAIN: THE ANTIs UP THE ANTE

By Jennie Bristow,
Editor, *Abortion Review*

In recent months we have seen the systematic introduction of ideas and tactics that have been tried and tested across the Atlantic. A number of things have come together to create a distinctly hostile climate for women who seek abortions and the doctors, clinics, and healthcare professionals who provide them. What this will ultimately mean for abortion law and provision is not yet clear. But already, a 'chilling effect' has settled over abortion provision, with disturbing implications for those who support reproductive autonomy.

The most overt attacks on abortion have come from anti-abortion campaigners. Women attending abortion clinics are routinely stopped and interrogated about their decision, and organisations that provide 'crisis pregnancy counselling' as a means to encouraging women to think again about their decisions now operate across the country, presenting themselves as neutral services. This attempt to take anti-abortion persuasion directly to the woman considering abortion is a tactic familiar from the US anti-abortion movement, which in recent decades has preferred not to debate abortion politically, but rather to attempt to influence women's decisions in more subtle, direct and dishonest ways.

What distinguishes most anti-abortion activity today from political 'pro-life' campaigns of the past is their attempts to bypass public arenas of debate and aim for a direct effect on the emotions and experiences of women seeking abortion. For example 'counselling', in its various guises, has emerged as a significant way of attempting to achieve this aim. Thus attempts have been made in the USA to 'inform' women about abortions through laws that force them to view ultrasound images of their fetuses, or provide them with misleading or downright inaccurate information about the impact of abortion on a woman's physical or mental health. Such attempts often go under the guise of 'Right to Know' laws, which use the language of empowerment to justify what is essentially a project of therapeutic manipulation.

'Counselling' strategies have been relatively successful as they appear kinder, and more oblique, than the overtly aggressive tactics that we also see in the USA, and which in some cases have led to physical violence against abortion doctors and other clinic staff. But there is nothing soft or sympathetic about 'counselling' a woman to think of her abortion as murder. It is a thoroughly cowardly tactic that eschews either a genuine engagement with a woman's own circumstances, or an upfront principled discussion about the morality of abortion.

Political climate

A startling shift in the politics of abortion has been its prominence in political debate – and the form that the debate has taken. A recent example is the effect of Nadine Dorries MP's proposal that women seeking abortion be offered 'independent counselling' about their decision – instead of, or at least in addition to, the pregnancy options discussion that abortion providers give as a standard part of the abortion consultation. This proposal, which is on the face of things quite anodyne, has sparked a significant realignment of political thinking about abortion provision. Thus despite the spectacular defeat of the 'Dorries amendment' in the House of Commons, the Department of Health quickly set in motion a consultation on abortion counselling, drawn up by a working group that includes Nadine Dorries, and which appears to favour a reform of the way abortion counselling is provided. This is despite the fact that there is no evidence that the current situation is problematic.

On the face of it, the extent to which the government and the Department of Health have run with the agenda of counselling reform makes little sense. It makes sense only if we understand the impact of the Dorries amendment as a more subtle version of the anti-abortion tactics discussed above, bringing American-style law-changing into a British context, where abortion law and policy is so different. In an immediate giveaway, Dorries named her counselling campaign 'Right to Know', and much of her rhetoric has been skilfully borrowed from would-be legislators in the USA.

The broader sympathy for the Dorries amendment seems to come from a coterie of individuals within and around the government who share both Dorries's antipathy to abortion, and also promote a version of politics that puts more emphasis on process than Parliament.

It is interesting that on one hand, there seems to be no desire to have a Parliamentary debate about Britain's abortion law, or to go anyway near the (necessary) question of reforming the outdated 1967 Abortion Act. The New Labour government ducked this question in 2008, and Parliamentary reform is hardly top of the Conservative-Liberal Democrat Coalition's agenda for today. But on the other hand, there is a clear unwillingness to leave things alone. This has resulted in some concerted attempts to change the way in which the current law is interpreted, and abortion is provided.

In this regard, women's access to abortion could be restricted via reforms of abortion counselling, as discussed above. Access could also be restricted through putting pressure on doctors, professional bodies and lawyers to interpret the 1967 Abortion Act in a far more limited way than it has been for the 40 years since it was passed.

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The chilling effect

This trajectory became clear at the beginning of March, when a strange, and rather inconclusive, investigation by the *Daily Telegraph* newspaper into whether women were being granted abortions on the grounds of 'sex selection' (answer – generally, they are not), resulted in a next-day opinion piece by the Health Secretary Andrew Lansley about how serious a problem this was, and how the full force of the law would be brought in to deal with it. Nadine Dorries wrote the next day on the influential Conservative Home blog that this showed how the 1967 Act was a 'badly drafted piece of legislation' that allowed too many loopholes, and crowed that 'this is about to change', and 'the spotlight is full on abortion practice'.

In all the heat and bluster generated by the *Telegraph* 'sex-selection' story, it has become clear that a number of policymakers and professional bodies neither understand Britain's abortion law, or are clear about how it has been – and can be – applied, as Professor Sally Sheldon explains overleaf. This has immediately resulted in a chilling effect on abortion providers, who are confident about the legality of their own practice, but made nervous about whether those who run the country understand why and how it is legal. That is bad news for abortion doctors and their clients, for sure, but it's really bad news for those who believe in the principles of democratic debate and decision-making.

We know that the 1967 Abortion Act is vulnerable to changes in interpretation, brought about by media campaigns and shifts in political opinion. This was the unfortunate upshot of the 2002 Joanna Jepson campaign, where a curate brought about a police investigation into a case of an abortion carried out after 24 weeks' gestation on the grounds of fetal anomaly. The law did not change as a result of the Jepson campaign, and nobody has been prosecuted. But those few doctors who are prepared and skilled enough to carry out the small number of abortions that take place after 24 weeks because a fetal anomaly has been detected have been made very nervous about the implications for them if they take the clinical decisions that they are allowed to under the law. This is a serious indictment of a democratic society, which allows doctors to use their judgement about permitting and performing abortions in rare and tragic cases, but then threatens to hound them – and their patients – for making these judgements.

A similar threat now hangs over doctors performing any abortions under the 1967 Abortion Act. If Parliamentarians want to reform this outdated law, then well and good – for all its prochoice protestations, the New Labour government did women and doctors a great disservice by refusing to vote on this debate last time Parliament had an opportunity. But the law should be debated and reformed democratically, not by stealth. As for the antis – abortion is an important moral question, and a democratic society benefits from open and impassioned debate precisely these issues. But a strategy aimed at merely upsetting women seeking abortion and intimidating the doctors who provide them is cowardly and wrong.

Abortion for reason of sex: correcting some basic misunderstandings of the law

By Sally Sheldon, Professor of Medical Law at the University of Kent.

In March 2012, two undercover reporters from the *Daily Telegraph* filmed a doctor prepared to offer an abortion to a woman who didn't want to give birth to a female child. In the widespread coverage that followed the 'sting', it has been repeatedly asserted that abortion for reason of sex selection is illegal. This, however, is far from clear.

Some commentators on the *Telegraph* story (including some who should really know better) appear to confuse abortion with embryo selection. The latter is tightly regulated by the Human Fertilisation and Embryology Act (1990), which was amended in 2008 to prohibit the screening of embryos for the purposes of sex selection prior to implantation, except where necessary to rule out a sex-linked disability. It was presumably this provision that the President of the Royal College of Obstetricians and Gynaecologists had in mind when he said: 'sex selection is illegal in this country and abortion based on the baby's gender for non-medical purposes is unlawful. Abortion is already heavily regulated in the UK and sex selection is only allowed in very specific conditions such as in the case of hereditary disease as stated in the HFEA Act 2001*[sic]*'. Yet the 1990 Act is not relevant to sex selective abortion so its mention here is, at best, misleading.

Others have noted that the Abortion Act says nothing about permitting sex selection. This is true. Yet neither does it make specific mention of the availability of an abortion where pregnancy results from rape or incest and most people (including the Parliament that introduced the 1967 Act) would agree that abortion should be legally available in those circumstances. Rather, the Act offers a defence against the charge of 'unlawful procurement of miscarriage' under the Offences Against the Person Act (1861), where two doctors believe, in good faith, that one of a number of broad contraindications to pregnancy is present. One contraindication is that continuing the pregnancy would pose a greater risk to a woman's physical or mental health than would abortion.

The doctor who authorises a termination on the basis of rape or incest would rely on the likely harm to the woman's mental health of continuing a pregnancy conceived in this way. The legal question in the case of sex selective abortion – which is far less clear than has been assumed by many commentators – is whether the doctor who performs an abortion on the basis of fetal sex might do likewise.

Imagine a woman with two female children who comes from an ethnic group which places a very high value on sons. She and her husband live with her in-laws, who threaten to throw them out if she gives birth to another daughter. Imagine another whose husband beats her and tells her that she will be subject to far worse violence if she gives birth to a daughter. In each of these situations, we would wish for the woman to be able to leave an abusive situation or, better, to live in a world where such things do not happen. But while we wait for that world, a doctor who authorises a termination in such circumstances could make a strong legal case that she had acted in good faith to preserve the mental health of her patient.

So let's now consider the *Telegraph* 'sting'. From the limited information which we have from the film clips made available, these extreme scenarios were not involved. In the first clip, a pregnant woman says merely that a female child was "not really appropriate for us right now, we were hoping for a boy." Had the abortions gone ahead, whether these doctors would be liable for prosecution under the Offences Against the Person Act would be likely to turn upon whether they were able to make a convincing argument that they formed opinions in good faith that continuing with a pregnancy would pose a greater risk to the woman's mental health than would a termination.

How do we establish that an opinion is formed in good faith? To the best of my knowledge, there has been just one successful prosecution

for 'unlawful procurement of miscarriage' where a doctor had acted with the necessary second signature foreseen with the 1967 Act. (1) The doctor concerned had neither examined internally nor enquired about the medical history of his patient, agreeing nonetheless to perform the operation on the payment of a fee of £150 (a sizable sum in 1974, when the prosecution was brought). It was held that the doctor had no defence under the Abortion Act, as he had allowed himself no opportunity to form a bona fide opinion regarding the balance of risks between termination and continuation of pregnancy. Where a doctor has indeed gathered sufficient information to form a good faith opinion, however, there may appear to be limited scope for her opinion to be second guessed by a court.

After all, as Sir George Baker famously noted in a different case: '[n]ot only would it be a bold and brave judge who would seek to interfere with the discretion of doctors acting under the [Abortion] Act, but I think he would really be a foolish judge who would attempt to do any such thing, unless possibly, there is clear bad faith and an obvious attempt to perpetrate a criminal offence.' (2) Prosecutors may also consider, however, whether a charge might lie in perjury (if abortion notification paperwork is believed to have been falsified) and, of course, the doctors might face sanction from the GMC. If paperwork has been falsely completed then that might also be used as evidence of a lack of good faith.

Despite the amount of media time given to this story over the last week, there does not seem to be any evidence to suggest that requests for sex selective abortions are common. The *Telegraph* journalists report acting on 'specific information' to identify the clinics which ultimately agreed to perform terminations on the basis of fetal sex and it seems that many others refused their request point blank. It would be unfortunate if the recent attention given to the 'sting' operation were allowed to distract from more basic inadequacies of the Act. It would be doubly so if this controversy serves to fuel broader agendas to restrict access to the good, safe and lawful abortion services that remain an essential part of women's ability to control their own fertility.

References
1) R v Smith [1974] 1 All ER 376, 1 WLR 1510, 58 Cr App Rep 106.
2) Paton v BPAS [1978] 2 All ER 987 at 992.

Dr Sally Sheldon is author of Beyond Control: Medical Power and Abortion Law (1997), and a trustee of BPAS.

ABORTION NEWS

FEBRUARY 2012

USA: Compromise announced on contraceptive coverage row

The White House in February announced modified plans to require all women to have access to contraception, attempting to stem anger from Catholic leaders about by the new rule, which required Church-linked institutions to offer health insurance including birth control. But the White House changed the scheme to allow health insurers to provide cover directly if employers object. Under the new plan put forward by the White House, health insurance companies, rather than the employer, will be required to offer contraception directly to employees of religious-linked institutions if requested. The institutions - such as universities or hospitals - would not be required to subsidise the cost of offering birth control to their employees, nor would they be asked to refer them to organisations that provide it. Women could obtain contraceptives directly from their insurance provider, free of charge, the White House said. The adjustment to the policy 'accommodates religious liberty while protecting the health of women', the White House added.

In November, Catholics for Choice president Jon O'Brien was invited to testify before the US House of Representatives Committee on Energy and Commerce Subcommittee on Health, to address the question, 'Do New Health Law Mandates Threaten Conscience Rights and Access to Care?' O'Brien argued: 'I firmly believe the requirements under the Affordable Care Act, and the slate of regulations being created to implement it, infringe on no one's conscience, demand no one change her or his religious beliefs, discriminate against no man or woman, put no additional economic burden on the poor, interfere with no one's medical decisions, compromise no one's health—that is, if you consider the law without refusal clauses.' However, 'When burdened by refusal clauses, the new health law absolutely threatens the conscience rights of every patient seeking family planning and of every provider who wishes to provide comprehensive care to their patients.' *2/11/11, 10/2/12*
http://www.abortionreview.org/index.php/site/article/1059/
http://www.abortionreview.org/index.php/site/article/1138/

UK: Scottish midwives lose conscientious objection case

Two Roman Catholic midwives have lost a legal battle to avoid taking part in abortion procedures, claiming that to do so violated their human rights. The women had sought to challenge NHS Greater Glasgow and Clyde on the issue. But a judge at the Court of Session ruled the midwives did not have direct involvement in terminating pregnancies. At the court in Edinburgh, Lady Smith said Ms Doogan and Mrs Wood were Roman Catholics and objected on religious grounds to participating in abortions. She said: 'Nothing they have to do as part of their duties terminates a woman's pregnancy. They are sufficiently removed from direct involvement as, it seems to me, to afford appropriate respect for and accommodation of their beliefs.' *29/2/12*
http://www.abortionreview.org/index.php/site/article/1144/

UK: Christians and conservative voters not opposed to abortion, say polls

Recent indications of public opinion, commissioned from different sources, cast doubt on the presumption that voters who identify themselves as Conservative or Christian favour a tightening of the abortion laws. *14/2/12*
http://www.abortionreview.org/index.php/site/article/1135/

Sex selection and the abortion counselling conspiracy

The *Daily Telegraph's* allegations about sex selective abortion are part of a shameless attempt to discredit abortion providers and provide a justification for the Department of Health's reforms to abortion counselling services, argues Jennie Bristow. *27/2/12*
http://www.abortionreview.org/index.php/site/article/1141/

JANUARY 2012

UK: Abortion counselling reform back on the agenda

The government is pressing ahead with changes that could see women considering abortion given the right to 'independent counselling' - despite publicly backing down last year. Subsequently, the shadow health minister Diane Abbott resigned from the cross-party group put together to discuss these proposals, criticising it as a 'front' for those who want it outlawed. *21/1/12, 26/1/12*
http://www.abortionreview.org/index.php/site/article/1100/
http://www.abortionreview.org/index.php/site/article/1101/

UK: Advertising rules allow private abortion clinics to advertise

Private clinics that charge for pregnancy services including abortions will be able to advertise on television and radio under new rules. The Broadcast Committee of Advertising Practice (BCAP) said there was no justification for barring clinics offering post-conception advice services. Pregnancy clinics that run on a not-for-profit basis are already allowed to advertise on television and radio. *21/1/12*
http://www.abortionreview.org/index.php/site/article/1099/

DECEMBER 2011

UK: Systematic review of induced abortion and women's mental health published

A major review into the mental health outcomes of induced abortion, published by the Academy of Medical Royal Colleges (AOMRC), concludes that having an abortion does not increase the risk of mental health problems. The best current evidence suggests that it makes no difference to a woman's mental health whether she chooses to have an abortion or to continue with the pregnancy.

The review was commissioned by the AOMRC and carried out by the National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists. The review's Steering Group and the NCCMH carried out a systematic and comprehensive search of the literature and identified 180 potentially relevant studies published between 1990 and 2011. The Steering Group was careful to ensure only the best quality evidence was used, so all studies were subject to multiple quality assessments. In total, 44 papers were included in the review.

On the basis of the best evidence available, the Steering Group concluded that:

- Having an unwanted pregnancy is associated with an increased risk of mental health problems. However, the rates of mental health problems for women with an unwanted pregnancy are the same, whether they have an abortion or give birth.
- The most reliable predictor of post-abortion mental health problems is having a history of mental health problems. In other words, women who have had mental health problems before the abortion are at greater risk of mental health problems after the abortion.
- Some other factors may be associated with increased rates of post-abortion mental health problems, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion, or experiencing other stressful life events.

Dr Roch Cantwell, a consultant perinatal psychiatrist and Chair of the Steering Group, said: 'Our review shows that abortion is not associated with an increase in mental health problems. Women who are carrying an unwanted pregnancy should be reassured that current evidence shows they are no more likely to experience mental health problems if they decide to have an abortion than if they decide to give birth.' *9/12/12*
http://www.abortionreview.org/index.php/site/article/1089/
http://www.abortionreview.org/index.php/site/article/951/

Debate: Abortion: how late is 'too late'?

Women who choose to terminate a pregnancy have a moral obligation to do it as early as possible, argues William Saletan, in a debate published on *Abortion Review*. Ann Furedi argues that policymakers should butt out of late abortion and trust women to work out what's in their best interests.
http://www.abortionreview.org/index.php/site/article/1086/
http://www.abortionreview.org/index.php/site/article/1087/

NOVEMBER 2011

UK: New evidence-based guideline on abortion published

The RCOG published its revised guidelines on the care of women requesting induced abortion on 23 November 2011. The clinical guidelines are for all healthcare professionals and aim to ensure that all women considering induced abortion have access to a high quality service based on national standards. The recommendations cover commissioning and organising services, possible side effects and complications, pre-abortion management, abortion procedures and follow up care.

The RCOG's press release highlights a number of new recommendations, including:

- Services should identify issues which make women particularly vulnerable, for example child protection needs and domestic abuse, and refer them on to appropriate support services in a timely manner.
- Services should provide women with information about the physical symptoms and sequelae that may be experienced after abortion such as pain and bleeding and gastrointestinal symptoms.
- Service providers should inform women about the range of emotional responses that may be experienced during and following an abortion.
- Providers should be aware that women with a past history of mental health problems are at increased risk of further problems after an unintended pregnancy.
- During pre-abortion assessment women should be offered screening for STIs and there should be a system for partner notification and referral to a sexual health service.
- All appropriate methods of contraception should be discussed with women at the initial assessment and a plan agreed for contraception after the abortion.
- Women should have access to counselling and decision-making support, however, women who are certain of their decision should not be subjected to compulsory counselling.
- A 24-hour telephone helpline number should be available for women to use after abortion if they have any concerns.
- Doctors should also discuss ongoing contraception and offer screening for sexually transmitted infections.

Ann Furedi, chief executive of BPAS, said the 'rights and wrongs of abortion are subject to opinion, but clinical risks are a matter of fact'. She added: 'We welcome the clear guidance on the offer of counselling. We also note the conclusion that home use of misoprostol in early medical abortion is safe and supported by the evidence but currently not permissible within the law. We trust the necessary steps will be taken soon so that this can be offered to women in Britain, thus allowing us to provide a service in line with international best practice.'

Julie Bentley, chief executive of the Family Planning Association (FPA), said: 'We believe these are sensible guidelines which will improve women's experience of abortion services and care. We are pleased to see that they confirm the evidence that abortion is not a direct cause of poor mental health and that there isn't a link between abortion and breast cancer. We also welcome the recommendation that women can complete the second stage of medical abortion at home if they choose and it's safe to do so.'
http://www.abortionreview.org/index.php/site/article/1080/

USA: 'Personhood' amendment fails in Mississippi

A constitutional amendment that would have defined a fertilised egg as a person failed on the ballot in Mississippi. *8/11/11*
http://www.abortionreview.org/index.php/site/article/1062/

BPAS BLOG

TAKING STOCK OF THE MORNING-AFTER PILL

By Clare Murphy, Director of External Affairs, BPAS

BPAS was delighted to win the sought-after award for 'Adult sexual health service/project of the year', as part of the UK Sexual Health Awards, produced by sexual health charities Brook and FPA. The award was given in recognition of the scheme run by BPAS during December 2011, which enabled women to request the morning-after pill for free over the internet so she could have it at home in advance of need over the festive period, when pharmacies and clinics might be closed. A nurse would phone her to make sure she was medically suitable, ensure it was not being requested for immediate use, and provide all the necessary information on how and when to use it – then, all things being equal, the emergency contraceptive pill (ECP) would be posted to her home address.

It was interesting to note the difference in response between the enthusiasm of the women who wanted to use the scheme (so many requests in the first 48 hours we couldn't guarantee Xmas delivery) and that of officials, who were not so keen. The Health Secretary Andrew Lansley, who despite having his hands full with NHS reform, still found the time to express his opprobrium, noting that emergency contraception should be just 'for emergencies, not everyday use', and that ideally it would be available in person, so that 'any decisions were made with the benefit of face-to-face advice'.

It's a bit odd to describe a woman requesting one solitary pill as someone who is planning on popping it daily - but there you go. What was however prevalent among the women who contacted us was that many had experienced difficulties obtaining the medication in the past, and appreciated being able to speak to someone over the phone who they knew was not judging them, but rather recognising that they were doing a sensible thing. They weren't planning on being reckless, but wanted to ensure that they had immediate access to an effective way of protecting themselves against an unwanted pregnancy if they needed it. And they perhaps didn't feel the need - or desire - for time-consuming 'face-to-face advice' about the decision whether or not to take the morning-after-pill should the situation arise.

You can't help thinking that if we'd been offering Viagra free of charge to men in need we would have been slapped on the back, such is still the contradiction in attitudes towards male and female sexuality. Indeed it was interesting to compare the *Daily Telegraph's* outrage that a 'penny-pinching NHS' was curbing men's sex lives by rationing erectile dysfunction drugs to two doses per month with its excoriating reaction the same week to our free morning-after pill scheme. That paper lined up no fewer than five critics, including Nadine Dorries MP, whom somehow we just can't seem to please: she doesn't like it when we are providing abortions, but appears equally aggrieved when we are trying to prevent the need.

The morning-after pill - much like long-acting reversible contraceptives (LARCs) - was never going to be a silver bullet to cut unwanted pregnancy. Many women do not know their contraception has failed, or believe they are at a time in their cycle when they are unlikely to get pregnant. But did we give up too quickly on it? We know that the cost, inconvenience and embarrassment of obtaining the morning-after pill can put women off obtaining it when they think their risk is low. Our own surveys show that women also worry about the health implications of using ECPs – even though post-coital contraceptives have been around for decades and there is no evidence of any long-term health consequences. But it is not surprising that women have reservations about using ECPs when all the messages around its use in this country have always been so very mixed: use it, but don't ever need to use it.

This message needs to change. Research is currently being conducted in the USA into using post-coital contraception as a regular form of contraception for women who do not have frequent sex – a 'before sex' pill, if you like. It may well alter the narrative around ECP use, from being seen as something to be embarrassed about to becoming recognised as a planned, responsible, course of action. In the meantime, the morning-after pill should be viewed as a legitimate and welcome back-up for women to control their fertility as often as they need to, well deserving of its place on the contraceptive menu.

Read Clare Murphy's BPAS blog online, here: http://www.abortionreview.org/index.php/site/C39/

MEDICAL UPDATE

USA: How women anticipate coping after an abortion.

Foster DG, Gould H, Kimport K. Contraception. 2011 Dec 14.

The authors note that there has been some study of women's emotional and psychological well-being after an abortion but no research into women's expectations, at the time of seeking an abortion, of how they will cope after the abortion. Researchers abstracted counselling needs assessment forms of 5109 women who sought an abortion at a clinic in 2008.

The results found that the most common emotions that women anticipate feeling after their abortion are relieved (63%) and confident (52%). A significant minority anticipate feeling a little sad (24%) and a little guilty (21%); 3.4% anticipate poor coping. Women with fetal abnormalities, women who do not have high confidence in their decision, women who have spiritual concerns about abortion, women with a history of depression, women who feel that they were pushed into having an abortion and teenagers are more likely to anticipate poor coping postabortion. The authors concluded that the vast majority of women expect to cope well after their abortion. A small number make the decision to terminate their pregnancies even though they anticipate difficulty coping after the procedure.
http://www.abortionreview.org/index.php/site/article/1124/

Canada: Abortion counselling and the informed consent dilemma.

Woodcock S. Bioethics. 2011 Nov;25(9):495-504. doi: 10.1111/j.1467-8519.2009.01798.x. Epub 2010 Feb 3.

The author notes that an obstacle to abortion exists in the form of abortion 'counselling' that discourages women from terminating their pregnancies. This counselling involves providing information about the procedure that tends to create feelings of guilt, anxiety and strong emotional reactions to the recognisable form of a human fetus. Instances of such counselling that involve false or misleading information are clearly unethical and do not prompt much philosophical reflection, but the prospect of truthful abortion counselling draws attention to a delicate issue for healthcare professionals seeking to respect patient autonomy. This is the fact that even accurate information about abortion procedures can have intimidating effects on women seeking to terminate a pregnancy.

Consequently, the author argues, a dilemma arises regarding the information that one ought to provide to patients considering an abortion: on the one hand, the mere offering of certain types of information can lead to intimidation; on the other hand, withholding information that some patients would consider relevant to their decision-making is objectionably paternalistic on any standard account of the physician-patient relationship. This is an unsettling conclusion for the possibility of setting fixed professional guidelines regarding the counselling offered to women who are considering abortion. Thus, abortion ought to be viewed as an illuminating example of a procedure for which the process of securing informed consent ought to be highly context-sensitive and responsive to the needs of each individual patient. This result underscores the need for health care professionals to

cultivate trusting relationships with patients and to develop finely tuned powers of practical judgment.
http://www.abortionreview.org/index.php/site/article/1078/

UK: Telephone follow-up and self-performed urine pregnancy testing after early medical abortion: a service evaluation.

Cameron ST, Glasier A, Dewart H, Johnstone A, Burnside A. Contraception. 2012 Jan 5.

Telephone follow-up with a self-performed low-sensitivity urine pregnancy (LSUP) test was introduced at the Royal Infirmary of Edinburgh, Scotland, as an alternative to routine ultrasonography for confirming successful abortion at 2 weeks following early medical abortion (<9 weeks' gestation). Women who screened 'positive' at telephone follow-up on the basis of ongoing pregnancy symptoms, scant bleeding or LSUP test result subsequently attended the clinic for a confirmatory ultrasound.

Opting for telephone follow-up were 476 out of 619 women (77%). Four women (1%) attended the clinic before telephone follow-up because of pain or bleeding. A total of 410 (87%) of the remaining 472 women were successfully contacted by telephone. Sixty women (15%) screened 'positive', three of whom had ongoing pregnancies, and one woman falsely screened 'negative'. The sensitivity of the telephone follow-up was 75%, and specificity was 86%. The negative predictive value was 99.7%, and positive predictive value was 5%. All women surveyed (n=75) would recommend telephone follow-up to a friend. The authors concluded that a telephone follow-up and a LSUP test at 2 weeks are effective for detecting ongoing pregnancy, have good follow-up rates and are popular choices for women.
http://www.abortionreview.org/index.php/site/article/1116/

UK: Assessment of a 'fast-track' referral service for intrauterine contraception following early medical abortion.

Cameron ST, Berugoda N, Johnstone A, Glasier A. Journal of Family Planning and Reproductive Health Care. 2012 Jan 31.

A 'fast-track' referral system for intrauterine contraception was established in 2007 between the medical abortion service at the Royal Infirmary of Edinburgh and the principal family planning clinic (FPC) in Edinburgh. This was case note review of women fast-tracked for intrauterine contraception after medical abortion between January 2007 and June 2009. The authors concluded that only half the women fast-tracked for intrauterine contraception actually attended and these tended to be women who were pre-existing clients of the FPC. Consideration should therefore be given to provision of immediate insertion where possible.
http://www.abortionreview.org/index.php/site/article/1102/

USA: The comparative safety of legal induced abortion and childbirth in the United States.

Raymond EG, Grimes DA. Obstetrics and Gynecology. 2012 Feb;119(2 Pt 1):215-9.

The authors estimated mortality rates associated with live births and legal induced abortions in the United States in 1998-2005. They found that the pregnancy-associated mortality rate among women who delivered live neonates was 8.8 deaths per 100,000 live births. The mortality rate related to induced abortion was 0.6 deaths per 100,000 abortions. In the one recent comparative study of pregnancy morbidity in the United States, pregnancy-related complications were more common with childbirth than with abortion. The authors concluded that legal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion. Similarly, the overall morbidity associated with childbirth exceeds that with abortion.
http://www.abortionreview.org/index.php/site/article/1105/

EU: Terminations of pregnancy in the European Union.

Gissler M, Fronteira I, Jahn A, Karro H, Moreau C, Oliveira da Silva M, Olsen J, Savona-Ventura C, Temmerman M, Hemminki E; the REPROSTAT group. BJOG. 2011 Nov 30. doi: 10.1111/j.1471-0528.2011.03189.x.

Data were collected on legislation and statistics for terminations of pregnancy, from a population of women in reproductive age in the 27 EU member states. The results found that Ireland, Malta and Poland have restrictive legislation. Luxembourg permits termination of pregnancy on physical and mental health indications; Cyprus, Finland, and the UK further include socio-economic indications. In all other EU member states termination of pregnancy can be performed in early pregnancy on a women's request.

In general, the rates of termination of pregnancy have declined in recent years. In total, 10.3 terminations were reported per 1000 women aged 15-49 years in the EU in 2008. The rate was 12.3/1000 for countries requiring a legal indication for termination, and 11.0/1000 for countries allowing termination on request. Northern Europe (10.9/1000) and Central and Eastern Europe (10.8/1000) had higher rates than Southern Europe (8.9/1000).
http://www.abortionreview.org/index.php/site/article/1085/

USA: A need to expand our thinking about 'repeat' abortions

Weitz TA, Kimport K. Contraception. 2011 Oct 27.
The authors note that women who have more than one abortion are often the 'targets' for social and clinical interventions geared at preventing 'repeat abortions'. Such an approach ignores the unique circumstances that may surround each abortion. The authors qualitatively analysed the history of 10 women who have had more than one abortion who were participating in a larger study of women's emotional experiences following abortion.

Overall, women in the sample reported that each abortion was different and some abortions were more emotionally difficult than others, suggesting that the phrase 'repeat' can be a misnomer and discounts the unique circumstances surrounding each abortion. Rather than use the term 'repeat abortions,' the authors advocate for the use of the less loaded term 'multiple abortions,' in which each abortion is understood as a unique experience.
http://www.abortionreview.org/index.php/site/article/1070/

World Health Organization: Medical methods for first trimester abortion.

Kulier R, Kapp N, Gülmezoglu AM, Hofmeyr GJ, Cheng L, Campana A. Cochrane Database of Systematic Reviews. 2011 Nov 9;11:CD002855.

The authors of this Cochrane review concluded that safe and effective medical abortion methods are available. Combined regimens are more effective than single agents. In the combined regimen, the dose of mifepristone can be lowered to 200 mg without significantly decreasing the method effectiveness. Vaginal misoprostol is more effective than oral administration, and has less side effects than sublingual or buccal. Some results are limited by the small numbers of participants on which they are based. Almost all trials were conducted in settings with good access to emergency services, which may limit the generalisability of these results.
http://www.abortionreview.org/index.php/site/article/1069/

USA: Intrauterine contraceptive insertion postabortion: a systematic review.

Steenland MW, Tepper NK, Curtis KM, Kapp N. Contraception. 2011 Nov;84(5):447-64. Epub 2011 May 4.

This systematic review was conducted to evaluate the evidence regarding the safety and effectiveness of intrauterine device (IUD) insertion immediately following spontaneous or induced abortion. The authors concluded that intrauterine device insertion immediately after abortion is not associated with an increased risk of adverse outcomes compared with use of other contraceptive methods or with no IUD insertion after abortion and compared with IUD insertion at times other than immediately after abortion. Intrauterine device expulsion rates, while generally low, were higher with insertions that occurred after later first-trimester abortion compared with after early first-trimester abortion and higher with IUD insertion after second-trimester abortion compared with after first-trimester abortion.
http://www.abortionreview.org/index.php/site/article/1073/

IN BRIEF

USA: A cost-effectiveness analysis of surgical versus medical management of early pregnancy loss.
Rausch M, Lorch S, Chung K, Frederick M, Zhang J, Barnhart K. Fertility and Sterility. 2012 Feb;97(2):355-360.e1.

The authors concluded that surgical or medical management of early pregnancy failure can be cost effective, depending on the circumstances. Surgery is cost effective and more efficacious when performed in an outpatient setting. For incomplete or inevitable abortion, medical management is cost effective and more efficacious.
http://www.abortionreview.org/index.php/site/article/1123/

USA: Patients' attitudes and experiences related to receiving contraception during abortion care.
Kavanaugh ML, Carlin EE, Jones RK. Contraception. 2011 Dec;84(6):585-93. Epub 2011 May 4.

This study documents attitudes of abortion patients about contraceptive services during their receipt of abortion services and identifies patient characteristics associated with desire for contraception and interest in using a long-acting reversible contraceptive method (LARC).
http://www.abortionreview.org/index.php/site/article/1131/

UK: Contraception in obese older women.
Cochrane RA, Gebbie AE, Loudon JC. Maturitas. 2012 Jan 10.

The authors note that the prevalence of obesity and the high rates of contraceptive use amongst older women mean that any increase in associated risk is likely to be of public health concern.
http://www.abortionreview.org/index.php/site/article/1111/

New Zealand: Impact of long-acting reversible contraception on return for repeat abortion.
Rose SB, Lawton BA. American Journal of Obstetrics and Gynecology. 2012 Jan;206(1):37.e1-6. Epub 2011 Jul 13.

The authors concluded that this study provides strong support for the promotion of immediate postabortion access to LARC methods (particularly intrauterine devices) to prevent repeat abortion.
http://www.abortionreview.org/index.php/site/article/1122/

USA: Women's decision making regarding choice of second trimester termination method for pregnancy complications.
Kerns J, Vanjani R, Freedman L, Meckstroth K, Drey EA, Steinauer J. International Journal of Gynaecology and Obstetrics. 2012 Mar;116(3):244-8. Epub 2011 Dec 12.

This qualitative study set out to describe how women terminating a pregnancy for fetal or maternal complications decide between surgical (dilation and evacuation [D&E]) and medical abortion. Key themes that emerged from the interviews were valuing the ability to choose the method, and the importance of religious beliefs, abortion attitudes, and emotional coping style. Women's preferences for a method were largely based on their individual emotional coping styles.
http://www.abortionreview.org/index.php/site/article/1125/

South Africa: Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order.
Vincent L. Culture, Health and Sexuality. 2012 Feb;14(2):125-38. Epub 2011 Nov 15.

This paper describes how abortion counselling has historically, in many different contexts, been saturated with questionable assumptions about women and their bodies. The authors conclude that specifying an appropriate model for the provision of state-sponsored abortion counselling in the public health sector of a secular constitutional state provokes more of a hornet's nest of dilemmas than is sometimes supposed.
http://www.abortionreview.org/index.php/site/article/1137/

UK: To meta-analyse or not to meta-analyse: abortion, birth and mental health.
Kendall T, Bird V, Cantwell R, Taylor C. British Journal of Psychiatry. 2012 Jan;200:12-4.

The authors argue that to improve further the mental health outcomes associated with an unwanted pregnancy we should focus practice and research on the individual needs of women with an unwanted pregnancy, rather than how the pregnancy is resolved.
http://www.abortionreview.org/index.php/site/article/1119/

UK: Clinical outcomes from a prospective study evaluating the role of ambulation during medical termination of pregnancy.
Ojha K, Gillott DJ, Wood P, Valcarcel E, Matah A, Talaulikar VS. Contraception. 2011 Oct 27.

The authors concluded that ambulation during medical termination of pregnancy neither appears to influence the amount of bleeding or pain nor hasten the process of medical termination of pregnancy.
http://www.abortionreview.org/index.php/site/article/1077/

USA: Attitudes toward prenatal testing and pregnancy termination among a diverse population of parents of children with intellectual disabilities.
Kuppermann M, Nakagawa S, Cohen SR, Dominguez-Pareto I, Shaffer BL, Holloway SD. Prenatal Diagnosis. 2011 Oct 26. doi: 10.1002/pd.2880.

The authors concluded that that although many parents of children with intellectual disabilities believe they would desire information regarding their fetus in a future pregnancy, most feel they would not opt to terminate their pregnancy. As new tests for intellectual disabilities become available, determining what would be most useful to prospective parents should become a high priority.
http://www.abortionreview.org/index.php/site/article/1071/

USA: Induced abortion: incidence and trends worldwide from 1995 to 2008.
Sedgh G, Singh S, Shah IH, Ahman E, Henshaw SK, Bankole A. Lancet. 2012 Jan 18.

The study found that the global abortion rate was stable between 2003 and 2008, with rates of 29 and 28 abortions per 1000 women aged 15-44 years, respectively, following a period of decline from 35 abortions per 1000 women in 1995.
http://www.abortionreview.org/index.php/site/article/1107/

UK: A Request for Abortion.
Allan Templeton, M.D., and David A. Grimes, M.D. New England Journal of Medicine 2011; 365:2198-2204. December 8, 2011

This article begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the authors' clinical recommendations.
http://www.abortionreview.org/index.php/site/article/1090/

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