When Fiona Bruce MP launched her grandly-titled ‘Parliamentary Inquiry into Abortion on the Grounds of Disability’ in January, this was clearly not going to be a sensible, sensitive investigation into the problems facing those who find themselves confronted with a diagnosis of fetal anomaly and go on to terminate the pregnancy.

These women, and their partners, face a host of difficult and often heartbreaking challenges. Their struggles are compounded by the way that campaigners and policymakers continually try to politicise terminations for fetal anomaly, presenting women’s personal, painful decisions as morally-deficient public statements about the worth of disabled people.

In this issue of Reproductive Review, we counter the insensitive, inaccurate portrayal of the issues involved in terminations for fetal anomaly by focusing on the issues that should preoccupy those with a genuine desire to help women who have taken the decision to terminate a pregnancy in these circumstances. Dr Richard Lyus discusses the evidence about medical and surgical abortion techniques and women’s preferences. Jane Fisher, director of the charity Antenatal Results and Choices (ARC), reflects on the ‘chilling effect’ upon doctors of previous attempts to cast doubt on the legality of terminations performed for particular conditions, and where this has left women in these difficult circumstances.

We also announce the programme for ‘Diagnoses and Dilemmas’, a conference organised jointly by ARC and bpas to address these issues, to be held in central London on Monday 9 September. At a time when more anomalies are being picked up through improved diagnostic techniques, when antenatal screening services are being reorganised, and when initiatives such as the Bruce inquiry remind us of the ongoing attempt to use termination for fetal anomaly as part of a wider campaign to reduce access to later abortions, this conference will be an important opportunity to work through the key issues facing antenatal screening services and abortion providers in the near future.
**Clinical Update**

Methods of termination for fetal anomaly

By Dr Richard Lyus, treatment doctor, British Pregnancy Advisory Service

1) How many terminations for fetal anomaly are there in the UK?

In England and Wales, about 2,000 abortions for fetal anomaly are recorded each year, under Ground E. However, the real figure is higher than this. Some abortions undertaken in fetal anomaly cases may have another primary indication, such as concerns for a pregnant woman’s health, which means that the abortion is recorded under Ground C. According to 2011 Department of Health abortion statistics, of abortions carried out under Ground E, 1,054 were for congenital malformations; 890 were for chromosomal abnormalities, of which 512 were for Down’s syndrome; and 363 were for other conditions. (1)

Screening tests for Down’s Syndrome are offered at 11-14 weeks of pregnancy, and a detailed ultrasound scan of the fetus at 18-20 weeks’ gestation. As a result, most fetal abnormalities are not diagnosed until the second trimester. Most terminations take place before the 24-week ‘time limit’: in 2011, only 146 abortions were carried out over 24 weeks’ gestation. By law, abortions after 24 weeks must be undertaken in an NHS hospital and cannot be performed at BPAS.

2) For women seeking a termination, what options are available?

When fetal anomalies are diagnosed in the second trimester, there are two options for pregnancy termination. The first is medical induction of labour, typically using the progesterone antagonist mifepristone and prostaglandin analogues to induce uterine contractions and cause the passage of the fetus and placenta intact. This can be a lengthy process: the mifepristone is administered 48 hours before admission, and the induction can take up to 24 hours and may require further surgery to remove retained tissue. It will usually take place on a labour ward.

The second option is surgical abortion, which involves instrumental removal of the fetus and placenta in small pieces through an artificially dilated cervix, under appropriate anaesthesia, typically taking 10-15 minutes. This is done as an outpatient procedure (‘day surgery’), and does not usually require admission to hospital.

3) Which method is safer?

Department of Health (DH) data from England and Wales show that surgical abortion is 6-11 times safer than medical abortion in the second trimester. (1) While there are limitations to the complication statistics produced by the DH, the rates are in keeping with other reports, including randomised controlled trials, which show surgical abortion to be not only safer, but more effective, cheaper, quicker, preferred by women and associated with better emotional outcomes than medical abortion in the second trimester. The higher rate of complications with medical induction is largely due to the significant minority of women who require additional surgery to remove retained tissue. This can also result in bleeding requiring blood transfusion.

For example:

- A US study by Bryant et al published in 2011 compared the safety and effectiveness of dilation and evacuation (D&E) and labor-induction abortion performed for fetal anomalies or fetal death in the second trimester. The authors concluded that ‘dilation and evacuation is significantly safer and more effective than labor induction for second-trimester abortion for fetal indications’, and that ‘Women facing this difficult decision should be offered a choice of methods and be provided information about their comparative safety and effectiveness’. (2)

- A randomised controlled trial by Kelly et al in Britain comparing medical versus surgical termination of pregnancy at 13-20 weeks of gestation found that women found surgical termination less painful and more acceptable than medical termination. (3)

- A US literature review by Grossman et al on complications following second trimester surgical and medical abortion in 2008 concluded that ‘current evidence suggests that, given trained providers and where otherwise feasible, D&E is preferable to medical induction’. The authors recommended that a larger randomised controlled trial was needed, that ‘directly compares outcomes between the two methods, examines acceptability to women and explores clinicians’ perspectives on providing them.’ (4)

- A US study by Whitley et al published in 2011 concluded that midtrimester D&E is associated with fewer complications than prostaglandin induction. (5)

4) Which method do women prefer?

In cases of termination for fetal anomaly, there are reasons why women might prefer either a surgical method, or medical induction. For example, some women may prefer to go through labour and delivery, and have an intact fetus that they can see and hold. Others may find a surgical procedure under general anaesthetic easier to cope with.

For second-trimester terminations in general, research evidence strongly suggests that women have a preference for surgical procedures. Indeed one US trial comparing the two methods was unable to proceed because so few patients were willing to be randomised to the medical induction arm. (6) Among the 18 participants enrolled, nine were randomised to treatment with mifepristone-misoprostol and 9 to D&E. Compared with D&E, mifepristone-misoprostol abortion caused more pain and adverse events, although none was serious.

When the termination is undertaken for fetal anomaly, the key factor is women’s choice. In 2011, a qualitative study by Kems et al of women terminating a pregnancy for fetal or maternal complications found that ‘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.’ (7)

The lower acceptability rates of medical induction may be due to the fact that it takes significantly longer, is more painful and causes heavier bleeding. Some women may also find the experience of labour extremely distressing in these circumstances.
5) Which method do clinicians prefer?

DH data show that approximately three-quarters of all abortions done in the second trimester for indications not related to fetal abnormality are done surgically. However, the proportion is dramatically different for those abortions undertaken because of a fetal abnormality: only 16% are performed surgically. (1, 8)

There are a number of possible reasons for this disparity. Women will generally be diagnosed with fetal anomaly and managed in the NHS, where access to surgical abortion (especially D&E) is limited. (9) Another reason may be the perceived importance of delivering an intact fetus for post-mortem (PM) examination. However, there is a lack of clear guidance as to which abnormalities benefit from detail fetal PM. It is unlikely to be of any benefit in the majority of abnormalities. (10)

Given the relatively small proportion of women who undergo surgical abortion for fetal abnormality, it has been hypothesised that clinicians have a bias against surgical abortion, despite it being safer and preferred by a majority of women. More research is needed to confirm if this is the case, and is so, why.

It is important that decision making about method of abortion for fetal anomaly should be shared between patients and clinicians, and both medical and surgical abortion should be offered wherever appropriate. However, the research is clear: surgical abortion is safer and preferred by most women. It is therefore incumbent upon clinicians and commissioners to better understand why so few women in the UK with fetal abnormality undergo surgical abortion. There may be multiple reasons, but if this disparity is due to clinicians' bias against surgical abortion this would represent a serious contravention of the principles of medical ethics. (11)

References

(8) Department of Health, personal communication November 2012
Post-24 week termination for fetal anomaly – the chilling effect of the Jepson campaign

By Jane Fisher, Director, Antenatal Results and Choices (ARC)

Terminations for fetal anomaly are legally sanctioned in England, Scotland and Wales through Section 1 (1) (d) of the Abortion Act of 1967 (as amended in 1990), if: ‘two registered medical practitioners are of the opinion, formed in good faith, (d) 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).

This clause in the law does not have a gestational age limit and is listed on the abortion certification form as ‘Ground E’. The imprecise wording of the clause was designed to enable doctors to use their clinical judgement on whether to offer termination on an individual case by case basis. Numbers of abortions taking place under Ground E after 24 weeks have always been small, representing approximately 0.1% of all abortions. There were 146 such abortions in 2011 (2).

Advances in antenatal screening and testing technologies mean the majority of fetal anomalies are detected before 24 weeks. At the same time it remains the case that the major screen for structural abnormalities is scheduled between 18 and 20+6 weeks’ gestation (3). Some women will have their scans later than this. Some will be recalled later due to the difficulty of obtaining optimal fetal anatomical surveys in women who are significantly overweight (4). If a problem is detected, there will almost always be the need for onward referral for further testing. Some women will have anomalies detected at third trimester scans scheduled for reasons such as monitoring fetal growth or placental position.

So the law as it stands should allow for doctors to afford women the opportunity to make the difficult decision to end their pregnancy post-24 weeks if a significant anomaly is found. In reality, however, research has suggested (and ARC has noted anecdotally, through contact with women on its national helpline) that there has been variation in practice in recent years, around the offer of post-24 week terminations for fetal anomaly. For example, some units will offer a termination after 24 weeks following a diagnosis of Down’s syndrome, while others do not consider this lawful. Some hospitals have now set up expert ethics panels to decide on the legality of post 24-week terminations. A doctor interviewed as part of a study on attitudes to late terminations in fetal medicine units, by Statham et al (5), noted the change in attitude:

‘Whereas people used to say, yes, Down’s is a permanent condition, you can have a termination after twenty-four weeks, [there are] lots of people now who say, well, maybe not… I think there’s a climate change in society generally against them.’

One likely contributory factor to more cautious professional practice in this area was the publicity generated in 2003 around what has come to be known as the ‘Jepson case’ (6). Joanna Jepson, a young Anglican curate, sought a judicial review of the decision by the police not to prosecute doctors who terminated a pregnancy at 28 weeks’ gestation where the fetus had been diagnosed with bilateral cleft lip and palate.

The police authorities had undertaken an investigation of the case and were satisfied that the abortion was ‘legally justified and procedurally correctly carried out’. Rev Jepson challenged this decision on the basis that bi-lateral cleft lip and palate was not a ‘serious handicap’ and therefore the abortion had been unlawful. After a detailed re-investigation it was announced in March 2005 that the doctors involved would not face prosecution. Although Jepson was unsuccessful, there was intense media interest in the story, and one of the doctors involved was named and pictured in a popular national daily newspaper (7).

In the media coverage of the Jepson case and the reporting of ‘abortion for trivial reasons’ (8), what is largely overlooked is that structural anomalies such as cleft lip and palate vary in severity and amenability to surgery and can sometimes be indicators of a serious underlying chromosomal or genetic syndrome. In other words, there will be circumstances when such a finding clearly represents ‘substantial risk of a serious handicap’. ARC hears regularly from women who have had a number of structural anomalies picked up by their 20-week ultrasound scan which in themselves may not cause serious impairment but, when found together, significantly raise the risk of an underlying genetic syndrome.

Unfortunately prenatal genetic diagnosis cannot keep pace with the increasing range of anomalies that sophisticated ultrasound equipment now picks up. Some women may want to continue the pregnancy in these circumstances hoping for the best, others will feel unable to cope with the possibility of serious problems manifesting after birth. In this situation, the wording of the law enables doctors to accommodate choice for the latter. Sadly, the ‘Jepson effect’ means that many doctors are reluctant to do so.

There is no hard evidence to prove that women are being denied what would be a legally sanctioned termination. The number of post-24 week terminations documented by the DH has remained fairly constant in the last ten years. But these statistics do not tell us how many women were denied the option of termination, nor do they indicate how many women made a ‘pressured’ decision before 24 weeks, fearing the option would be taken away. ARC has anecdotal evidence from our support work with women that both situations occur. Women have disclosed to us that an explanation they have had for the clinical caution was ‘worries since that cleft lip and palate case’.

While Jepson may have failed in her legal challenge, it appears she has succeeded in making an already distressing situation for expectant parents and their doctors even more difficult.

References

(1) Abortion Act 1967
(3) NHS FASP 18 to 20 weeks Fetal Anomaly Scan: National Standards and Guidance for England 2010 http://fetalanomaly.screening.nhs.uk/standardsandpolicies
(7) Mills J. Doctor may be charged over late abortion. Daily Mail (London). 23 September 2004
(8) Marsh B. Hidden abortion of imperfect babies. Sunday Times, 3 February 2013
**APRIL 2013**

**Ireland: Medical misadventure verdict in Savita inquest**

The jury in the inquest has heard the cause of Savita Halappanavar's death was septic shock and E coli. The coroner, Dr Ciaran MacLoughlin, said the verdict does not imply individual failings in systems at the hospital contributed to Savita's death. The jury's verdict in the inquest was unanimous.

The jury endorsed the coroner's nine recommendations. The first was that the Irish Medical Council lay out new guidelines on when doctors can intervene to save the life of a mother. The coroner said the guidelines would remove doubt and fear among doctors and reassure the public. Other recommendations are that blood samples are always followed up to ensure errors do not occur; that proper sepsis management and training and guidelines are available for hospital staff and that there is effective communication between staff on call and those coming on duty in hospitals. The coroner had also recommended that a dedicated time should be set aside at the end of each shift for this to happen. The other two recommendations are that medical and nursing notes are kept separately and that no additions are made to notes, where the death of a person will be subject to an inquest.

Dr MacLoughlin passed on his sympathies to the widower of Mrs Halappanavar, Praveen Halappanavar. The coroner said Mr Halappanavar had shown tremendous loyalty and love to his wife during her final days. Speaking after the verdict, Praveen Halappanavar said he still had no clarity as to why his wife had died. He told reporters that he owed it to his wife and her family to pursue the truth of what had happened. Mr Halappanavar described the treatment his wife received in the days after she was admitted to hospital as 'horrendous' and said somebody had to take ownership for that.

[19/4/13](http://www.reproductivereview.org/index.php/rr/article/1399/)

**US: North Dakota bans abortions after 20 weeks**

The law is the latest among a raft of measures passed in North Dakota this session that are meant to challenge the US supreme court’s 1973 Roe v Wade ruling that legalised abortion up until viability, usually at 22 to 24 weeks. North Dakota’s Republican governor Jack Dalrymple in March signed a law that bans abortion as early as six weeks, or when a fetal heartbeat is detected, making North Dakota the most restrictive state in the US to get the law passed. It makes the state the first to ban abortions based on genetic defects such as Down’s syndrome and require a doctor who performs abortions to be a physician with hospital-admitting privileges. The measures also ban abortion based on genetic selection.

At least 10 states have passed bills banning abortions after 20 weeks of pregnancy on the premise that a fetus can feel pain at that stage. North Dakota politicians also moved in March to seek a referendum defining life as starting at conception, in effect banning abortion in the state.

[17/4/13](http://www.reproductivereview.org/index.php/rr/article/1395/)

**Comment and opinion**

- **Remaking the case for a woman’s right to choose**
  Writing on spiked, BPAS chief executive Ann Furedi argues that in replacing the ideal of reproductive choice with ‘reproductive justice’, feminists underestimate women’s capacity for autonomy.

- **There is no magic word: why we are and must remain ‘pro-choice’**
  Both choice and reproductive justice have a place in our battle for women’s autonomy. But one cannot take the place of the other, writes Jon O’Brien, president of Catholics for Choice, on RH Reality Check.

- **Irish abortion law is a poor law**
  As the inquest begins into the death of Savita Halappanavar, Ann Furedi, writing in the Daily Telegraph, argues that before we can learn lessons from her death, we need to learn what truly happened.
  [8/4/13](http://www.reproductivereview.org/index.php/rr/article/1390/)

- **Savita case exposes the cruelty of Irish law.**
  It’s time to face down the Irish Constitution and its bizarre elevation of ‘fetal rights’ over women’s rights, writes Barbara Hewson on spiked.
  [24/4/13](http://www.reproductivereview.org/index.php/rr/article/1403/)

- **Focus on: The politics of childbirth**
  Our new ‘Focus on…’ essays will examine the big issues relating to women’s reproductive choices in the 21st century. Here, Jennie Bristow reviews the historical controversy surrounding the decision over where, and how, it is best to give birth.
  [2/4/13](http://www.reproductivereview.org/index.php/rr/article/1376/)

- **Commentary: ‘The new face of social conservatism in America’**
  An interesting piece by Tim Wigmore in the Daily Telegraph argues that ‘there is an interesting juxtaposition in American social values today: while attitudes to gay marriage are being liberalised, states are also tightening anti-abortion restrictions’.
  [19/3/13](http://www.reproductivereview.org/index.php/rr/article/1371/)

**MARCH 2013**

**UK: Government publishes ‘A Framework for Sexual Health Improvement in England’**

This long-awaited document sets out the government’s ambitions for improving sexual health, in relation to contraception, abortion, STIs, and sex and relationships education. These include:

- **A fall in the number of unwanted pregnancies.** The focus on unwanted pregnancy rather than abortion represents a move away from the problematising of abortion that initially was feared to be the case.
fusing the egg-cell nucleus of the affected mother with an egg cell which will result in IVF babies effectively inheriting genetic

UK: Support for ‘three-person IVF’

A series of public consultations on mitochondrial replacement, which will result in IVF babies effectively inheriting genetic information from three biological parents, has found that most people would support its legalisation in order to help families at risk of the genetic disorder. Mitochondrial replacement involves fusing the egg-cell nucleus of the affected mother with an egg cell from an unaffected donor.

The law covering IVF, the Human Fertilisation and Embryology Act, does not allow germ-line gene therapy, when the sperm or eggs are genetically altered, or the genetic modification of IVF embryos. However, in 2008 the Act was amended to allow the Secretary of State for Health to permit techniques that prevent the transmission of mitochondrial disease. In January 2012, the Government asked the Human Fertilisation and Embryology Authority to seek views on mitochondrial replacement before it was made legal. As a result, the authority commissioned a series of public consultations.

Sarah Norcross, director of Progress Educational Trust, said: ‘Techniques to prevent inherited mitochondrial disease received the green light from the Nuffield Council on Bioethics last year, and have now received the green light from the general public. We urge the government not to create unnecessary roadblocks, and to pass legislation so that families blighted by mitochondrial disease can benefit from these techniques.’ 20/3/13

http://www.reproductivereview.org/index.php/rr/article/1374/

FEBRUARY 2013

UK: Statistics show increase in conceptions to over-40s

The Office for National Statistics data found that the under–18 conception rate for 2011 is the lowest since 1969 at 30.9 conceptions per thousand women aged 15–17. But conception rates in 2011 increased for women aged 30 years and over, staying the same for women aged 25–29 and decreased for women aged under 25 years. The largest percentage increase in conception rates occurred among women aged 40 and over (3.7%). Smaller increases in conception rates were recorded among women aged 30–34 and 35–39, rising by 1.2% and 2.1% respectively. Conception rates for women aged under 20 and 20–24 have decreased by 7.6% and 2.5% respectively.

In 2011 conceptions outside of a marriage/civil partnership accounted for 57% of all conceptions in England and Wales, compared with 52% in 2001. In 2011 the proportion of conceptions outside marriage/civil partnership which resulted in a marriage was 69%, compared with 93% of conceptions inside marriage/civil partnership. The percentage of conceptions leading to a legal abortion varies by age group. Over the last two decades this figure has generally increased for women aged under 20 but decreased for women aged 35 and over. For women in their twenties and early thirties the percentage of conceptions leading to a legal abortion generally increased between 1991 and 2001 but decreased steadily until 2009-2010, before increasing slightly in 2011. Among women over 40, there is a striking decrease since 1991 in the percentage of conceptions leading to abortion, suggesting that a higher proportion of women are having intended pregnancies in their 40s.

British Pregnancy Advisory Service (BPAS) commented: ‘The 2011 conception statistics, like those from previous years, confirm that teenagers form a very small proportion of the women needing access to contraception and abortion services. Policy makers would do well to widen their focus from teenagers, and invest in the struggling contraceptive services that all women need.’ 26/2/13

http://www.reproductivereview.org/index.php/rr/article/1332/

UK: Documentary attempts to clarify the abortion law

The BBC’s flagship documentary series Panorama on 4 February screened ‘Abortion: The Great Divide? Presented by Victoria Derbyshire, the programme noted that abortion in Britain has become ‘more controversial than ever, with pro-life activists challenging pregnant women as they try to enter clinics’, and that ‘doctors in most of the UK are signing off terminations on questionable mental health grounds, while in Northern Ireland women and doctors risk life in prison over abortion’. The question raised by the programme was, ‘Is our legislation hopelessly outdated?’

http://www.reproductivereview.org/index.php/rr/article/1332/
the circumstances and broader implications of his trial. 31/1/13

abortions, has been absolved of all charges. Jennie Bristow discusses

sentence of 273 years in prison for practising almost a hundred

Dr Carlos Morín, the Barcelona abortion doctor facing a possible
denial. such doctors are not circumventing or breaking the law;
abortion procedure carries less risk to the woman than would its
end it in abortion. Many doctors believe “in good faith” that an
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‘Pregnancy and childbirth are not risk-free, especially when the
involve risk, greater than if the pregnancy were terminated, of injury
to the physical or mental health of the pregnant women.”

‘Victoria Derbyshire states that the abortion law is “being
circumvented or broken” when doctors in England provide abortion to
a patients who requests the termination of an unwanted pregnancy.
She is wrong. Ground C of the Abortion Act allows an abortion when
two doctors agree 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 women.”

The programme attempted to tackle a wide range of issues within half
an hour, and did so with various degrees of success. The programme
also contained some inaccuracies. In a letter to the Times (London) on
6 February, BPAS chief executive Ann Furedi wrote:

‘Victoria Derbyshire states that the abortion law is “being
circumvented or broken” when doctors in England provide abortion to
a patients who requests the termination of an unwanted pregnancy.
She is wrong. Ground C of the Abortion Act allows an abortion when
two doctors agree that “the continuance of the pregnancy would
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‘Pregnancy and childbirth are not risk-free, especially when the
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end it in abortion. Many doctors believe “in good faith” that an
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denial. such doctors are not circumventing or breaking the law;
abortion procedure carries less risk to the woman than would its
end it in abortion. Many doctors believe “in good faith” that an

http://www.reproductivereview.org/index.php/rr/article/1325/

UK: Poll suggests decline in anti-abortion feeling
A YouGov poll found that the percentage of the population
wanting a ban on abortion has fallen from 12% in 2005 to 7%,
while support for keeping the current 24-week ‘time limit’ on
terminations has risen by about one third to a clear majority
(57%) among those who expressed a view. The survey, for the
Westminster Faith debates, also found that factors such as gender,
age and voting preference did not make much difference to
attitudes on abortion. People who were most likely to be hostile
towards it were those who believe in God with most certainty,
rely most strongly on scripture or religious teaching for guidance,
and whose religion has a strong anti-abortion message. Only 8% of
the population fits this profile, according to the research, and one
third of this 8% support a ban on abortion.

Of the religious people who were surveyed, Catholics, Muslims
and Baptists are the most hostile to abortion, but only half said
that they wanted to see the law changed. Only 14% of Catholics
supported a ban, while 33%would like to see the 24-week limit
lowered. Among Muslims, 30% supported a ban while 16% would
like to see the 24-week limit lowered. In other findings, 44% of
those polled believe that human life begins at conception, but
most of this group believe that abortion should be legal.
6/2/13

http://www.reproductivereview.org/index.php/rr/article/1329/

Comment and opinion

• Can you say breast isn’t (always) best?
‘I’ve been placed in the same camp as Holocaust deniers and
advocates of cold fusion’: US academic Joan Wolf talks to Jennie
Bristow about why advocates of the ‘Breast in Best’ message find
her book so hard to swallow. 28/1/13

http://www.reproductivereview.org/index.php/rr/article/1320/

• What the Spanish abortion law has meant for European women
Dr Carlos Morín, the Barcelona abortion doctor facing a possible
sentence of 273 years in prison for practising almost a hundred
abortions, has been absolved of all charges. Jennie Bristow discusses
the circumstances and broader implications of his trial. 31/1/13

http://www.reproductivereview.org/index.php/rr/article/1323/

New bpas publication

Britain’s Abortion Law: What it says, and why

The papers in this publication have been written
by academics and lawyers to clarify the British
abortion law, through explaining both its origins
and its application today. These papers explain that
the 1967 Abortion Act was very carefully worded
to provide doctors with the discretion to manage
the abortion question, according to their own
professional judgement. The abortion regulations,
similarly, are designed to support the law, which has
at its heart the discretion of the doctor.

There is no ambiguity to the law, nor has there been any
failure in its ability to act as Parliament intended when
it was passed in 1967. The failure was in the ability of
many in 2012 to understand the law correctly. Britain’s
Abortion Law: What it says, and why aims to correct
this failure of understanding, and reassure medical
professionals where they stand in relation to the
authorisation of abortions in Britain today.

Contents
• Key questions and answers about the abortion law
• Recent myths and misunderstandings about the abortion
law. By Dr Ellie Lee. Reader in Social Policy at the
University of Kent; author, Abortion, Motherhood and
Mental Health
• The letter and spirit of the Abortion Act. By Sally Sheldon,
Professor of Law, University of Kent; author, Beyond
Control: Medical Power and Abortion Law
• The legality of abortion for fetal sex. By Emily Jackson,
Professor of Law, London School of Economics
• Certifying abortions: the signing of HSA1 forms.
By Dorothy Flower, Partner, RPC
• Abortion for fetal anomaly:
The legacy of the Jepson case.
By Jane Fisher, Director, Antenatal Results and Choices

Download

Britain’s Abortion Law:
What it says, and why
for free here:

http://www.reproductivereview.org/images/
uploads/Britains-abortion-law.pdf
In the fast-moving world of prenatal testing, we need to ensure we retain the goal of providing high quality woman-centred services. This one-day conference brings together experts working in the field to explore latest developments and the challenges they present to practice. The day will cover both clinical advances and psychosocial implications for parents.

Organised by Antenatal Results and Choices (ARC) and British Pregnancy Advisory Service (BPAS), this conference will have something to offer all professionals involved in providing antenatal care and those with an interest in this ethically-charged area of healthcare.

Programme

9.30: Registration and coffee
10.00: Chair’s welcome
10.10: Opening address
   Dr Catherine Calderwood – NHS Clinical Director, Maternity and Women’s Health.
10.30: Supporting women’s choices
   Jane Fisher – Director of Antenatal Results and Choices
10.45: Avoiding disability: choices, means and ends
   Professor Jenny Hewison – Professor of the Psychology of Healthcare, University of Leeds
11.00: Coffee
12.00: Choice of TFA method: the role of the independent sector
   Dr Richard Lyus – BPAS clinician
12.30: Choice of TFA method: the NHS experience
   Karen Creed – Antenatal Screening Co-ordinator, BsuH NHS Trust
1.00: Discussion
1.15: Lunch
2.15: Improving outcomes in high risk pregnancies
   Professor Steve Robson – Professor of Fetal Medicine, Institute of Cellular Medicine, Newcastle University

2.45: Non-invasive Prenatal Testing – where are we now and what’s next?
   Professor Lyn Chitty – Professor of Genetics and Fetal Medicine, UCL Institute of Child Health, Great Ormond Street and UCLH NHS Foundation Trusts, London
3.15: Latest developments in detecting fetal anomaly through ultrasound
   Professor Kypros Nicolaides – Director of the Harris Birthright
3.45: Chair’s closing remarks

Booking fees

£110 Doctors, health service managers
£85 Midwives, sonographers, nurses
£60 Students

Fees include lunch and all refreshments, attendance certificate and delegate materials.

How to book a place:

You can book a place online here:
http://www.arc-uk.org/arc-shop/arc-bpas-conference-for-health-professionals

To make a telephone booking, please call: 020 7713 7356

To pay by post, send a cheque payable to ‘ARC’ to:
ARC, 345 City Road, London, EC1V 1LR

Events

Diagnoses and Dilemmas
The Kings Fund, 11 Cavendish Square, London, W1G 0AN. Monday 9 September 2013

BPAS BLOG

Views and comment from bpas on a range of reproductive healthcare issues

Recently on the bpas blog:

• Pro-choice campaigners react to Irish abortion bill
• The impact of anti-abortion protesters on clinic staff and on the women accessing care
• “We don’t choose to miscarry. We should at least get a choice about how it is handled.”

http://bpasblog.blogspot.co.uk/
**UK: The policing of abortion services in England**


An article by Sam Rowlands reviews the rationale for the Care Quality Commission ‘swoop’ of 2012, and its impact on the abortion service. Rowlands begins by noting that in 2012, abortion services in England came under intensive scrutiny, with the Care Quality Commission (CQC) conducting synchronised inspections of all abortion providers. In the light of some procedural irregularities that were found, doctors and nurses were reported to their professional bodies. A team set up by the Metropolitan Police continues to investigate possible criminal activities. This article examines the laws that may have been infringed, what brought about this reaction, the detailed findings, whether or not the inspections were justified and their knock-on effects.

In the discussion section of the article, Rowlands concludes:

‘Lord Scarman said in *R v Smith* that “a great social responsibility is firmly placed by the law upon the shoulders of the medical profession”. The wording of the Abortion Act is simple and clear. The doctors taking part in the certification are asked to give their opinion in good faith, taking into account the woman’s actual or reasonably foreseeable environment, which includes her individual circumstances and that of any existing children. Whatever pressures are driving her decision-making can be taken into account by the doctor. The reason behind the request for abortion is not part of the legal process. In practice, the woman’s history will often have been taken by a nurse specialist and discussed with doctors.

‘Millions of pounds were spent during 2012 on an un-needed large-scale investigation into abortion services in England. The CQC diverted resources from inspection of health and social care facilities, disrupting their programme of work in order to be able to descend on all abortion providers in England in a matter of a few days so that the providers were not forewarned of the impending inspections. The professional regulators for doctors and nurses have allocated resources to dealing with the fall-out from the CQC swoop. And the police have mounted a large-scale operation, diverting resources away from investigation of homicide, serious crime and child abuse.

‘The Secretary of State has a legitimate interest in the quality of abortion services. If there were any suggestion of criminal actions in the services named by the Daily Telegraph then this would be a matter for the police. The Health Secretary’s response to events was heavy-handed and disproportionate. Additionally, the CQC is an independent body that should not be beholden to the DH. It is sad that politically-driven intense regulation is being played out at a time of major financial pressure on limited resources, without any gain for service users.

‘A possible outcome of the CQC swoop is that in the 14 NHs Trusts that were censured, waiting times may be extended and average gestations at abortion may creep upward. This would be most unfortunate and might truly lead to poor outcomes of care. Another possible outcome might be lesser use of nurses in abortion care, which would certainly be another retrograde step.

‘One clear outcome of the CQC investigation is to add to the significant stigma already experienced by abortion services. This has inevitably lowered morale amongst staff. Many professionals involved in abortion care felt truly fearful at the time of the swoop, and some continue to live with the uncertainty of the long-term outcome on their professional lives. Looking towards the future workforce, these events will undoubtedly jeopardise recruitment in a field already struggling with a shortage. It is to be hoped that the police investigation will come to nothing and that clinicians with professional restrictions placed on them will have these lifted.

‘The next step required is for the DH to provide greater clarity on how it expects abortion services to operate, without issuing unduly restrictive guidance that goes further than the law requires. Consideration should be given to the redesign of the HSA4 form with regard to the grounds for abortion. Clinical staff need to get back to concentrating on doing their jobs to the best of their ability, continuing to place the woman in her distressing situation at the forefront of their attention.’

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http://www.reproductivereview.org/index.php/r/article/1389/

**UK: Whither abortion policy in Britain?**


The commentary begins by setting out the ways in which the policy of the Coalition Government appears to differ from that of the New Labour administration. It notes that 2012 brought furious debate about abortion services, focusing on counselling, ‘sex-selection’ abortion, signing of HSA1 forms and, most recently, the upper time limit, and discusses what has emerged to date from these furores. Finally, thoughts are offered on how to respond to the problems raised by the current approach of policymakers. In a JFPRHC podcast, available to listen for free here, Dr Ellie Lee discusses how moral qualms are being presented as medical arguments, and how the attitudes of our politicians prevents implementation of good evidence based practice.

http://www.reproductivereview.org/index.php/r/article/1309/

**USA: More than poverty: disruptive events among women having abortions in the USA.**


The authors note that in the USA, abortion has become increasingly concentrated among poor women. For many, poverty represents difficulties meeting financial obligations, but the authors expect it is also associated with a range of potentially difficult life circumstances that may influence women’s pregnancy decisions. This mixed methods study relied on two data sources. Quantitative data came from a national sample of 9493 women obtaining abortions in 2008 and examined exposure to 11 potentially disruptive events. The authors also examined associations between disruptive events, poverty status and contraceptive use. Qualitative information from 49 in-depth interviews was used to provide insights into patterns that emerged from the quantitative analysis.
More than half (57%) of the women obtaining abortions experienced a potentially disruptive event within the last year, most commonly unemployment (20%), separation from a partner (16%), falling behind on rent/mortgage (14%) and/or moving multiple times (12%). Poverty status was significantly associated with several of the events, particularly those that could directly impact on a family’s economic circumstances, for example losing a job or having a baby. Information from the in-depth interviews suggested that disruptive events interfered with contraceptive use, but the quantitative survey found no difference in contraceptive use by exposure to disruptive life events, even after controlling for poverty status. The authors concluded that many abortion patients make decisions about their pregnancies in the midst of complex life circumstances.

http://www.reproductivereview.org/index.php/rr/article/1378/

USA: Abortion law around the world: progress and pushback.


The authors note that there is a global trend toward the liberalisation of abortion laws driven by women’s rights, public health, and human rights advocates. This trend reflects the recognition of women’s access to legal abortion services as a matter of women’s rights and self-determination and an understanding of the dire public health implications of criminalising abortion. Nonetheless, legal strategies to introduce barriers that impede access to legal abortion services, such as mandatory waiting periods, biased counselling requirements, and the unregulated practice of conscientious objection, are emerging in response to this trend. These barriers stigmatise and demean women and compromise their health. Public health evidence and human rights guarantees provide a compelling rationale for challenging abortion bans and these restrictions.

http://www.reproductivereview.org/index.php/rr/article/1340/

USA: The politicisation of abortion and the evolution of abortion counselling.


The author notes that field of abortion counselling originated in the abortion rights movement of the 1970s. During its evolution to the present day, it has faced significant challenges, primarily arising from the increasing politicisation and stigmatisation of abortion since legalisation. The author argues that abortion counselling has been affected not only by the imposition of antiabortion statutes, but also by the changing needs of patients who have come of age in a very different era than when this occupation was first developed. One major innovation - head and heart counselling - departs in significant ways from previous conventions of the field and illustrates the complex and changing political meanings of abortion and therefore the challenges to abortion providers in the years following Roe v Wade.

http://www.reproductivereview.org/index.php/rr/article/1382/

USA: Reproductive rights activism in the post-Roe era.


The authors note that since the US Supreme Court decision legalising abortion (Roe v Wade), there has been a constant and broad attack on all aspects of women’s reproductive and parenting rights. The consequences have been devastating, especially for women whose race, age, legal, or economic status makes them targets of discrimination. At the same time, these threats have galvanised activism. There has been tremendous growth in the number of organizations and coalitions working to protect abortion rights, as well as advocating for a broader reproductive rights, health, and justice agenda. This article describes the major activist trends in this period, focusing primarily on those that have been less visible.

http://www.reproductivereview.org/index.php/rr/article/1383/

WHO recommendations for misoprostol use for obstetric and gynecologic indications.


This comprehensive reference document was designed to enable clinicians and policy makers quickly to access and compare recommendations for the use of misoprostol in various reproductive health settings. The recommendations note that misoprostol, a prostaglandin E1 analog, stimulates uterine contractility and cervical ripening. A number of randomised trials and systematic reviews have evaluated its use in obstetric and gynaecologic conditions. Misoprostol is inexpensive, stable at room temperature, and available in more than 80 countries, making it particularly useful in resource-poor settings. WHO recognises the crucial role of misoprostol in reproductive health and has incorporated recommendations for its use into four reproductive health guidelines focused on induction of labour, prevention and treatment of postpartum haemorrhage, and management of spontaneous and induced abortion.

http://www.reproductivereview.org/index.php/rr/article/1337/

USA: Women’s and providers’ experiences with medical abortion provided through telemedicine: a qualitative study.


In 2008, Planned Parenthood of the Heartland in Iowa began providing medical abortion via telemedicine at clinics without an on-site physician. The purpose of this study was to evaluate patients’ and providers’ experiences with telemedicine provision of medical abortion. Patients and providers cited numerous advantages of telemedicine, including decreased travel for patients and physicians and greater availability of locations and appointment times compared with in-person provision. Overall, patients were positive or indifferent about having the conversation with the doctor take place via telemedicine, with most reporting it felt private/secure and in some cases even more comfortable than an in-person visit. However, other women preferred being in the same room with the physician, highlighting the importance of informing women about their options so they can choose their preferred service modality.

The authors concluded that the findings from this study indicate that telemedicine can be used to provide medical abortion in a manner that is highly acceptable to patients and providers with
minimal impact on the clinic. This information demonstrates the feasibility of telemedicine to extend the reach of physicians and improve abortion access in rural settings.


USA: Safety of aspiration abortion performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants under a California legal waiver.


The authors examined the impact on patient safety if nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) were permitted to provide aspiration abortions. The authors concluded that abortion complications were clinically equivalent between newly trained NPs, CNMs, and PAs and physicians, supporting the adoption of policies to allow these providers to perform early aspirations to expand access to abortion care.

http://www.reproductivereview.org/index.php/rr/article/1344/

USA: Who can provide effective and safe termination of pregnancy care? A systematic review.


The authors concluded that limited evidence indicates that trained mid-level providers may effectively and safely provide first-trimester surgical and medical termination of pregnancy services. Data are limited by the scarcity of RCTs and biases of the cohort studies.

http://www.reproductivereview.org/index.php/rr/article/1379/

Finland: Medical versus surgical termination of pregnancy in primigravid women - is the next delivery differently at risk? A population-based register study.


The study set out to compare the effect of medical versus surgical termination of pregnancy (TOP), performed in primigravid women, on subsequent delivery. This was a population-based register study set in Finland from 2000-2009. The population was all primigravid women (n = 8294) who underwent TOP during first trimester of pregnancy by medical (n = 3441) or surgical (n = 4853) method, and whose subsequent pregnancy resulted in singleton delivery. The main outcome measures were risk of preterm birth, low birthweight, small-for-gestational-age (SGA) infant and placental complications (placenta praevia, placental abruption, retained placenta, placenta accreta). The authors concluded that a history of one medical versus surgical TOP, performed in primigravid women, is associated with similar obstetric risks in the subsequent delivery.

http://www.reproductivereview.org/index.php/rr/article/1380/

Denmark: Attitudes among Danes toward prenatal testing and termination of pregnancy.


The authors note that Denmark offers public financed prenatal testing (PNT) to all pregnant women, but results are typically not available until after 12 weeks gestation, which is also the time limit for termination of pregnancy (TOP) on request. Committees decide on requests for later TOP. In a questionnaire survey, they investigated attitudes among Danes toward these issues. They also asked for opinions on two claims commonly found in the debate concerning women’s right to decide on TOP in relation to PNT.

One thousand people aged 18-45 years were drawn randomly from the national personal register. The response rate was 49%. Women and older respondents were overrepresented and may have caused a bias toward conservative attitudes. A majority supported the current PNT program and time limit for TOP on request, but only one-third supported committees deciding on all cases of late TOP. The implications of prenatal testing results becoming more accessible are discussed.

http://www.reproductivereview.org/index.php/rr/article/1385/

USA: The family medicine residency training initiative in miscarriage management: impact on practice in Washington State.


The authors note that non-complicated spontaneous abortion cases should be counselled about the full range of management approaches, including uterine evacuation using manual vacuum aspiration (MVA). The Residency Training Initiative in Miscarriage Management (RTI-MM) is an intensive, multidimensional intervention designed to facilitate implementation of office-based management of spontaneous abortion using MVA in family medicine residency settings. The purpose of this study was to test the impact of the RTI-MM on self-reported use of MVA for management of spontaneous abortion.

The authors concluded that their findings suggest that the RTI-MM was successful in influencing the practice of management of spontaneous abortion using MVA in this population and that support staff knowledge may impact physician practice. Integrating MVA into family medicine settings would potentially improve access to evidence-based, comprehensive care for women.

http://www.reproductivereview.org/index.php/rr/article/1341/
UK: Human chorionic gonadotrophin (hCG) for preventing miscarriage.


The authors note that recurrent miscarriage (RM) is defined as the loss of three or more consecutive pregnancies. Further research is required to understand the causes of RM, which remain unknown for many couples. Human chorionic gonadotrophin (hCG) is vital for maintaining the corpus luteum, but may have additional roles during implantation which support its use as a therapeutic agent for RM. This study set out to determine the efficacy of hCG in preventing further miscarriage in women with a history of unexplained RM.

The authors searched the Cochrane Pregnancy and Childbirth Group’s Trials Register (30 September 2012) and reference lists of retrieved studies. The authors included five studies (involving 596 women). Meta-analysis suggested a statistically significant reduction in miscarriage rate using hCG. The number of women needed to treat to prevent subsequent pregnancy loss was seven. However, when two studies of weaker methodological quality were removed, there was no longer a statistically significant benefit (risk ratio 0.74; 95% confidence interval 0.44 to 1.23). There were no documented adverse effects of using hCG. The authors concluded that the evidence supporting hCG supplementation to prevent RM remains equivocal. A well-designed randomised controlled trial of adequate power and methodological quality is required to determine whether hCG is beneficial in RM.

http://www.reproductivereview.org/index.php/rr/article/1384/

UK: ‘Miscarriage or abortion?’ Understanding the medical language of pregnancy loss in Britain; a historical perspective.


The author notes that clinical language applied to early pregnancy loss changed in late twentieth century Britain when doctors consciously began using the term ‘miscarriage’ instead of ‘abortion’ to refer to this subject. Medical professionals at the time and since have claimed this change as an intuitive empathic response to women’s experiences. However, a reading of medical journals and textbooks from the era reveals how the change in clinical language reflected legal, technological, professional and social developments. The shift in language is better understood in the context of these historical developments, rather than as the consequence of more empathic medical care for women who experience miscarriage.

http://www.reproductivereview.org/index.php/rr/article/1338/

Netherlands: Decision aids to improve informed decision-making in pregnancy care: a systematic review.


The authors note that rapid development in health care has resulted in an increasing number of screening and treatment options. The study’s objective was to determine the effectiveness of decision aids to improve informed decision making in pregnancy care. The authors concluded that their systematic review showed the positive effect of decision aids on informed decision making in pregnancy care. Future studies should focus on increasing the uptake of decision aids in clinical practice by identifying barriers and facilitators to implementation.

http://www.reproductivereview.org/index.php/rr/article/1381/

USA: Ethical arguments for and against sperm sorting for non-medical sex selection: a review.


The authors note that much has been written about the ethics of sex selection. Given that an effective sperm-sorting technology might soon be marketed in the USA and abroad, the authors have reviewed the ethical arguments in favour of and against the use of sperm sorting for sex selection for non-medical purposes. (One reason couples might want to use sperm sorting for sex selection is to avoid the risk of having a child with a sex-linked genetic disease such as Duchenne’s muscular dystrophy or haemophilia.) They also review the arguments for and against governmental regulation of this technology.

The authors conclude that, should this technology be approved by the FDA, there is not adequate evidence at this time that use of the technology would result in social harms to justify governmental prohibition.

http://www.reproductivereview.org/index.php/rr/article/1342/

What do you call a woman who’s had an abortion?


Abortion. No more names.

@bpas1968

#nomorenames

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