Abortion issues today - a position paper
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Summary

Outright opposition to all abortion is now a minority view. Most debate about abortion now focuses not on the issue of abortion *per se* but on specific types of abortion or certain reasons for abortion. In this paper we examine why opposition to all abortion has become a minority view; we then discuss examples where abortion remains controversial, and put forward arguments in support of a woman's right to choose in these instances; and finally consider, and refute, the case made mainly by opponents of abortion, that abortion on various grounds constitutes a risk to women's health.

Key points:

On the place of abortion in British society today....

- Society today expects individuals to plan their families, and as a result, abortion can be considered an essential back-up to contraception. Abortion in itself is not a problem. Rather it can be a solution to a problem.

The most contentious areas of discussion are:

Abortion at later gestations of pregnancy
Abortion on grounds of fetal abnormality

There are also concerns raised about the health risks of abortion

On 'late' abortion....

- While most people have no difficulty accepting the legality of abortion at early stages of pregnancy, fewer are so sure about their position as pregnancy progresses – especially when the fetus is perceived to be ‘viable’. The most frequent kind of measure proposed to reform abortion law of late has been to reduce the legal time limit.

- It is incorrect to assume that the need for late abortion could be removed by expanding access to early abortion. Most abortions in the second trimester take place for reasons that could not have been anticipated earlier in the pregnancy.

- In practice the law plays little role in preventing late abortions. There are few requests for abortion in the later stages of pregnancy because women do not request them and doctors are not prepared to perform them.

On abortion for fetal abnormality....

- Where in 1967, when abortion was made legal, fetal abnormality was construed a 'good' reason for abortion, today the opposite seems the case. This kind of abortion is now considered at best ethically difficult, at worst a manifestation of anti-disability views.

- Does abortion for abnormality encourage discrimination against disabled people? No it does not, since it is possible to make a judgment or express an attitude towards a particular condition, without in any way imputing an attitude towards the value of people who suffer from that condition.

- A woman who opts for this kind of abortion is not making a social or political statement about the abnormality, or about born people with that disability. She is making a statement about herself; what she feels she can cope with and what she wants.

On the 'health risks' of abortion....

- The Royal College of Obstetricians and Gynaecologists guideline, *The Care of Women Requesting Induced Abortion* (1), provides evidence based on systematic literature reviews to show that abortion cannot be considered a serious risk to women's physical or mental health.

- Claims by opponents of abortion that abortion leads to breast cancer, future infertility, or mental ill-health can be understood as a political strategy, not an objective evaluation of the likely effects of abortion for a woman's health.

Further comment about the issues discussed in this briefing can be found on the following sites:
www.prochoiceforum.org.uk (research papers and comment)
www.bpas.org (facts/statistics and comment)
www.statistics.gov.uk (key tables)
www.rcog.org (policy and research papers)

1. Abortion is a fact of life

These days, abortion has an accepted place in fertility regulation. It *is* a method of family planning - if by that we mean that women use abortion to control whether or when they have children. Women may not intend to rely on abortion as a means of family planning, but in reality that is often the way it works out.

Women today *expect* to have control over their fertility and are *expected* to control their fertility. The need for 'family planning' is almost universally accepted even among the most conservative thinkers. But the evidence shows that women cannot manage their fertility by means of contraception alone. Contraception fails, and couples sometimes fail to use it effectively (2). A recent survey of more than 2,000 women requesting abortion at clinics run by BPAS, Britain's largest abortion provider, found that almost 60 per cent claimed to have been using contraception at the time they became pregnant, nearly 20 per cent said they were on the pill. Other studies have shown similar results (3).

The number of women who claim they experienced a split or slipped condom, or missed just a couple of pills, is undoubtedly inflated. Unprotected sex is stigmatised and some women requesting abortion may falsely claim to have used contraception believing that they will be treated more sympathetically if the pregnancy is 'not their fault'. But even so, it is clear that contraceptives let couples down. All methods have a recognised failure rate (4). Whether the pregnancy occurred because the condom split or because the couple failed to get it out of the packet is not very important. The tens of thousands of women who seek abortion each year are not ignorant of contraception – most have tried to use it and, indeed, may have used it and become pregnant regardless.

Policy makers and legislators implicitly understand women's need for abortion – this is why abortion is provided at NHS hospitals throughout the country. Most democratic societies hold that women should expect, and be expected, to make a broader contribution to society than bearing and caring for the next generation. Motherhood is still regarded as 'natural' at some time in a woman's life, but most people assume that motherhood will be an interval sandwiched on both sides by an income-generating 'job' if not a 'career'. Girls from appropriate (middle class) backgrounds are expected to progress to a university education.

Society currently places a high premium on '*planned* parenthood'. The belief prevails that children should be wanted, that parents should be able to support them, and be willing to make sacrifices for them. Growing social concern about 'unfit' or 'problem' parents does not easily co-exist with a disposition to force people to bear children they do not want and by their own

admission cannot care for. This ethos creates a framework where even social conservatives who disapprove of abortion in principle can perceive abortion as a ‘responsible choice’.

Surveys of public opinion suggest widespread tolerance of legal abortion. A national opinion poll carried out three years ago by the UK’s main polling agency MORI found that 64 per cent of those asked agreed that: abortion should be legally available to all who want it. 25 per cent disagreed. The remainder neither agreed nor disagreed or said they did not know. The proportion of those who agreed had increased by 10 per cent since 1980 (5). Birth Control Trust, for whom the poll was commissioned, suggested that this demonstrated a growing acceptance of legal abortion and a widespread belief that belief that the law should not be used to prevent women ending pregnancies.

Women today are at particular risk of unplanned pregnancy. Sex is an accepted part of an adult relationship for which we do not expect to suffer unwanted consequences. Pregnancy is seen by an increasing number of women as an unwanted consequence that they are not prepared to adapt to. The fact that more women are delaying starting a family until they are in their thirties, that many are deciding to opt out of parenthood altogether, suggests increased numbers of sexually active women who do not want a child. Is it any wonder then that the number of abortions remains high?

A relatively high abortion rate is not necessarily a sign of the failure of sex education and family planning programmes: it may be a symptom of a society where women wish to combine a sex life with ambition. Of course it is preferable for unwanted pregnancies to be prevented rather than ended. Abortion is safe, but contraception is safer and more convenient. Nevertheless, today abortion is an essential method of family planning and should be accepted it as such.

Public opinion in Great Britain and Northern Ireland supports legal abortion

A MORI poll commissioned in February 1997 by BPAS and Birth Control Trust showed that 64 per cent of those asked agreed with the statement 'Abortion should be made legally available for all who want it', while 25 per cent disagreed. The proportion of British adults who agreed with the statement had increased by 10 percent since 1980, while the proportion that disagreed had fallen by 11 percent.

Abortion should be made legally available for all who want it (%)

Agree very strongly	15
Agree strongly	15
Agree	34
Neither agree nor disagree	9
Disagree	13
Disagree strongly	5
Disagree very strongly	7
Don't know	2

Circumstances when people approve or disapprove of abortion (%)

	Approve	Disapprove	Don't know
When the woman's life is in danger	93	3	4
When the woman's health is at risk	88	6	6
In a case of rape	88	6	6
When the child would have a mental disability	67	20	13
When the child would have a physical disability	66	21	13
When the woman was under 16	58	29	13

The case for 'late' abortion

For the reasons discussed above, there is a high degree of support for access to abortion. However, the degree of support seems to differ depending on what stage in gestation the abortion occurs. Public opinion polls appear to indicate that while most people have no difficulty accepting the legality of abortion in the earlier stages of pregnancy, fewer are so sure about their position as pregnancy progresses. The most frequent kind of reform to the abortion law proposed of late, including by those who not involved with anti-abortion organisations, has been to lower the legal time limit (6).

The difficulty many have in accepting the case for abortion at later gestations can in part be explained by people's own experience of abortion. Given that early abortion (during the first three months of pregnancy) is extremely common, experienced by 35 to 40 per cent of women by the time they reach 45, the sheer volume of those with some experience of this kind of abortion mitigates against claims that it is morally wrong, or should be illegal. In contrast, the numbers of women with experience of abortion at later gestations is small. In 1999, 89 per cent per cent of abortions took place in the first 12 weeks of pregnancy (7). Only one per cent of abortions are carried out at 20 weeks gestation and beyond: a total of 1, 745. This means there is no broad constituency who are sympathetic to abortion at later gestations as a result of their own experience. In contrast, there is a widespread experience of what it means to have a *wanted* pregnancy at this stage.

Abortions in England and Wales 1999 by gestation (total 173, 701)

	Number	% of total
Under 9 weeks	73, 882	43
9-12 weeks	80, 800	46
13-19 weeks	17, 274	10
20 weeks and over	1, 745	1

Some in the medical profession shares public unease about late abortion. Developments in neo-natal medicine have created a situation where, sometimes - albeit very rarely – babies born as early as 22 weeks gestation, two weeks earlier than the legal time limit for most abortions, can be kept alive. Influential columnist and science writer Greg Easterbrook has unsettled both pro- and anti-choice lobbies in the US with an article in *The New Republic* (8) that calls for a reshaping of the abortion debate to incorporate new scientific understanding. Easterbrook argued that, in the past, law and religion defined our understanding of abortion because science had little to say. This, he claims, has changed. The case for liberal provision of early abortion is strengthened by evidence that the natural termination of potential life through spontaneous miscarriage in early pregnancy is far more common than previously assumed - but discoveries about the brain activity of the more developed fetus stand as an argument against late abortion. Easterbrook believes this is a message those of us who support women's right to abortion are keen to ignore lest we are compelled to trade off liberal earlier abortion for restrictions on those in later pregnancy.

As Easterbrook contends, published studies of fetal brain activity and neurological responses have helped to create a sense that post 21 week fetuses should be treated like new-borns. The fact that these studies are contested has failed to halt a sense, even within the medical profession, that the termination of fetal life at this stage is something in need of review. The number of gynaecologists prepared to carry out late abortions is declining, and increasingly NHS trusts refer their 'late cases' to the specialist abortion provider, British Pregnancy Advisory Service.

Under British law, the shift of concern as pregnancy progresses away from the woman, and towards the fetus, is in fact already formalised. 'Fetal viability', is accepted as the criteria by which the legality, or illegality, of abortion is determined, and as a result, after 24 weeks, abortion is in general not legally permissible.

(a) Fetal viability and third trimester abortion

According to the 1967 Abortion Act (as amended), the point at which abortion ceases to be legal in most cases, is at 24 weeks. The specification of a time limit of 24 weeks was added to the Abortion Act in 1990, as part of the Human Fertilisation and Embryology Act (HFEA). The key argument made for doing so was that at this point in gestation it becomes possible for a fetus to be kept alive outside of the womb. Aiding the survival of the fetus, it was suggested, becomes at this point more important than a woman's desire to end a pregnancy. Previously, the upper time limit had been 28 weeks as this was seen to be the time at which a child would have a reasonable chance of survival if born alive.

The criteria of fetal viability thus introduces an ethical distinction in abortion law between second and third trimester abortions which is essentially fetus-centred. The circumstances of the fetus are allowed to take priority over the circumstances of the woman.

The 1967 Abortion Act (as amended) (main clauses)

Section 1(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinon formed in good faith -

(a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
(d) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

1(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph a) or b) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably forseeable environment.

Yet the viability distinction is not something that can be precisely defined. It is determined not only by the state of the biological being of the fetus, but also the way society can provide mechanisms to enable the severely premature baby to survive. It is not the case therefore, as many would suggest, that at this point the fetus is a 'life', but rather that medical technology can intervene to enable it to survive. Viewed in this way, making viability a point of great moral and ethical significance is in some ways arbitrary and random. It is possible to point to number of other points in the progress of a pregnancy which you could be given moral weight.

In fact the Human Fertilisation and Embryology Act highlights a very much earlier point as being of great moral significance. It draws attention to the development of the primitive streak. This is the point at which certain cells in the embryo differentiate, at about 14 days after conception. Traditional Catholics pinpoint the point of conception as when a human life develops on the grounds that at this point the fertilised ovum is genetically distinct and therefore, they contend, has great moral significance. It could also be argued that within abortion law, the point of implantation is given weight, which is usually a couple of days after conception. This legally determines the difference between abortion and contraception. It is legally accepted that contraception is something that prevents pregnancy before implantation, which is not seen as a matter for legal regulation. In contrast abortion ends pregnancy after implantation, and this is subject to regulation. Ultimately pregnancy is a progression, a continuance of life forming and many points of development can be identified.

Arguably, there are three defining moments in pregnancy. The first is conception, which is where something genetically distinct emerges. The second is implantation which is the point at which the woman becomes pregnant. The third is the point of birth, which is morally significant for the simple reason that at this point action can be taken that was not possible previously. The woman and baby are separate and the latter can be looked after without imposing on the autonomy of the woman.

One of the reasons why it is unethical for late abortion to be restricted is because it undermines the principle of *bodily autonomy,* now accepted in medical law that states no woman or man should be forced to undergo medical procedures against their will (9). It is in this light

problematic that a woman should remain pregnant and undergo childbirth out of an obligation to maintain the life of the fetus.

It is in fact an obligation we do not impose even in respect of born children. There is no law that can obligate a person to undergo medical treatment in order to save the life of another person. Many people may not agree with a woman's reasons for seeking a late abortion, and may think it wrong for that woman to end her pregnancy. But others' agreement and approval should be of no consequence. Abortion should be subject to no more legal constraints than any other clinical procedures.

It is important to recognise that, even if the law were different, there is no reason to believe that many women would opt for a third trimester abortion. Prior to 1990, in Scotland, unlike England and Wales, no time limit for abortion could be inferred from existing abortion law, since the 1929 Infant Life Preservation Act (from which a time limit of 28 weeks was inferred, prior to the HFEA) did not apply there. The rate of later term abortion did not suddenly decrease in Scotland after 1990 however, indicating that it is not the law which prevents women from aborting late in term.

The reason there are relatively few late abortions, even before 24 weeks, is not because women are refused such operations, but because few requests are made. Late abortion is not an easy option for women. Often, almost always in NHS hospitals it involves an induced labour similar to that which the woman would have experienced at term - the difference being that prior to the induction a doctor will have passed a needle through her abdomen into the fetal heart so as to make sure there is no live birth. Those women, fortunate enough to be cared for in services where they are offered a surgical alternative under general anaesthetic still endure a emotionally taxing time.

Women requesting such procedures are not a callous breed set apart from other women. Abortion counsellors confirm that women frequently want to know details of the procedure, and what the fetus will feel. Often they want to know what will happen to the fetal remains and they are concerned that they will be treated with rather and not just discarded.

In 1998, of the 88 abortions carried out after 24 weeks, six were at 35 weeks or later. The latest was carried out at 38 weeks. There are two ways to respond to this abortion. Either the woman concerned can be considered as somebody who needed to be constrained by law and forced to complete the rest of her pregnancy. Alternatively, the awfulness can be pondered of the situation that made her, undoubtedly with the approval of her doctors, decide that it was better that the pregnancy ended without a live birth, even so close to term. In which case you might conclude that she must have been the most desperate woman in the world.

It is important to defend women’s access to late abortion in law and in practice. The few women that request abortions later on in pregnancy do so because they have specific circumstances that drive them to conclude that it is better if their pregnancy does not result in a child. Neither advances in fetal physiology nor the development of fetal medicine and neonatal intensive care will affect these circumstances. These have wonderful implications for those with problem pregnancies where the baby is wanted – but have little relevance to women who feel unable to carry their pregnancy to term. A woman who feels repulsed by her pregnancy now that she has learnt that her partner is leaving her for another woman is unlikely to be moved by the latest knowledge about nociception.

Women do not request late abortions because they are ignorant of fetal development. Science may now be able to tell us more than ever before about fetal development, and there is clearly

lots to more to learn, but it is arguable whether this is relevant to abortion decisions, and that such decisions will be – or should be – affected by it.

(b) Mid-trimester abortion

It is not only third trimester abortion which has come to be considered less acceptable than early abortion. Second trimester abortion is also seen a somehow less justifiable than abortion early in pregnancy. 'If a woman needs an abortion why doesn't she request it earlier?' is the often-asked question.

Pro-choice organisations often suggest that their aim is in part to eradicate later abortion, and claim that if it were made easier for women to get abortions at early gestations, later abortions would become unnecessary. Whilst of course it should be made as easy as possible for women to access early abortion, it is misplaced to suggest that late abortion might, on this basis, disappear.

In the past, those of us who justified later abortion could point to delays in the system. A woman might request an abortion at ten weeks pregnant and suffer months of delays while she waited for an appointment. Today such delays are far less common. One recent study showed that only 13 per cent of second trimester abortions could have been managed earlier by service improvements (10). Most women requesting later abortions had not realised they were pregnant, had denied the pregnancy or were in circumstances where a wanted pregnancy had become unwanted.

Abortion, after the first twelve weeks of pregnancy, will not become unnecessary, however much access to abortion improves. It is essential that those women who find themselves needing abortion when their pregnancy has reached the second, or third trimester, can avail themselves of the service they require. In a context where support for abortion seems to be increasingly dependent on the extent of fetal development, rather than what women need, it is more important, not less, that those who are pro-choice make the case for late abortion.

Late presentation for abortion (10)

An article by Anna George, clinical medical officer and Sarah Randall, consultant in family planning, both of the Ella Gordon Unit, St Mary's Hospital, Portsmouth, reported on reasons women gave for late abortions. Reasons given were grouped into unpreventable or preventable. The records of all 111 women who had an appointment during the first year of a second trimester Unplanned Pregnancy Counselling Clinic (UPCC) were examined retrospectively. Ninety women received counselling. Seventy one of the 90 women counselled had reasons recorded for late presentation. Just 12 potentially preventable late presentations were found. Reasons for late presentation were various: concealed teenage pregnancies, perimenopausal women, or women with irregular menstrual cycles, who did not associate amennorhea with pregnancy, pregnancies that were initially wanted.

(c) Fetal pain

One focus for the discussion of the 'problem' of late abortion has been based on the claim that a fetus feels pain. The debate about fetal pain originated with discussion which began in the late

1980s, as a consequence of research which indicated that a fetus is capable of a behavioral response to sensory stimulation (11).

Advances in fetal surgery, which include placing valves into the heart and injecting red blood cells into the liver to prevent anaemia, meant that neonatal surgeons and experts in embryology were becoming more and more concerned about the potential consequences of invasive fetal surgery. This concern was given a major boost when Dr Anand, then of the John Radcliffe Hospital, Oxford, demonstrated that new-born babies (neonates) undergoing surgery did better if they were given anaesthetics of a kind usually used only in adult surgery (until very recently, neonates were not given anaesthetic before surgery). In 1992, the *New England Journal* ran an editorial calling on clinicians to 'Do the Right Thing' concluding that 'it is our responsibility to treat pain in neonates and infants as effectively as we do in other patients' (12). Since this time, and extensive discussion has taken place in the pages of medical journals, about the nature of pain, with many eminent scientists concluding that they have much more to learn about this phenomenon.

Greater knowledge about the causes of pain can only be beneficial to society, and it is important that clinicians do 'do the right thing' where neonates and infants are concerned. It is however extremely unfortunate that a discussion about best clinical practice for new-born babies has led to a debate, based on the notion that a fetus can feel pain, about the 'problem' of late abortion.

It is important to be clear that, as far as late abortion is concerned, medical practitioners have only one patient, the woman. In this respect, the only ethical issue at stake is how to ensure she gets the best care possible, and that the abortion is carried out in a way that does not damage her health. Given that the object of the exercise in late abortion, unpalatable as many may find it, is to ensure that the fetus is not born alive, discussions of fetal pain are substantively irrelevant in this context. The only sense in which 'fetal pain' matters, with regard to abortion, is where, as we discuss later, women express concern about it.

It would be easy to imagine that the reason why the question of pain and late abortion have become connected is because the anti-abortion lobby have exploited the issue. Undoubtedly this has happened to some degree, especially in the U.S.. It is however noteworthy that more recently, anti-abortion activists have distanced themselves from argument against abortion made on this ground. For example, in an article written in anticipation of a conference about fetal pain to be held in November 2000 at the prestigious Royal Institution, Jack Scarisbrick, chairman of LIFE made it clear that fetal pain is irrelevant to the anti-abortion cause: 'Our primary objection is that abortion is wrong because it is a violation of the right to life' (13).

The main cause of the debate about abortion and fetal pain is in fact public pronouncements made by scientists with no connection to the anti-abortion lobby. Professor Vivette Glover of Queen Charlotte's Hospital for example, has ensured the issue has stayed in the news, with her frequently expressed concern that fetuses undergoing late abortion may feel pain. Her case is that the present state of knowledge about pain does not allow us to be sure that fetuses do not feel pain, hence we should 'err on the side of caution' and give fetuses anaesthetic when a late abortion is to be performed on a woman (14).

Issues associated with the science of pain have been discussed extensively elsewhere (15). For the purposes of this briefing we will simply state our position very briefly. The ascribing of the term 'pain' to the responses of a fetus to stimuli is perhaps best understood as an emotional process on the part of those who do so, rather than an objective analysis of pain. Since a fetus moves, or screws up its face, it can *appear* to be 'suffering pain'. However, the fact that no-one

has any memory of being born - which if a fetus can indeed feel pain would be expected to be a very painful process indeed - suggests that there is a great deal of difference between what might look like pain, and what the experience in fact constitutes. What needs to be said is that fetuses do not, an cannot, feel pain - not at 10 weeks, 26 weeks or 30 weeks - because pain-experience depends on consciousness and fetuses are not conscious.

The key issue for us however, and one which is simply not taken seriously in most debate, is the implications of 'erring on the side of caution' for women undergoing abortion. Professor Glover has stated that she does not want to alarm women who have late abortions, with her pronouncements about the pain abortion may cause to their fetuses. But this is inevitably the outcome the kind of statement she makes.

There is much anecdotal evidence now to attest to the fact that women presenting for abortion, in fact at earlier and earlier gestations, are now extremely concerned about whether their action in choosing abortion will cause a fetus to suffer. It is important to remember that those women who attend for late abortion will frequently be aborting a much wanted pregnancy, where disability has been diagnosed in the fetus. The procedure they will undergo is long and arduous - much like labour. The emotional strain is surely enough already, without the additional (albeit unintended) strain of believing they are causing the fetus to suffer by opting for abortion.

In all abortion, but perhaps especially in the case of late abortion, ensuring clinical practice takes steps to reduce the concerns of the woman is paramount. It is for this reason that in the UK, the RCOG recommends that measures to stop the fetal heart should be taken in all terminations after 21 weeks gestation. This is to ensure that there is no possibility of the abortion resulting in a live birth (16).

After 26 weeks the guidelines suggest that it is not possible to know the extent to which the fetus is aware and so after this gestation it is suggested that ‘methods used during abortion to stop the fetal heart should be swift and involve a minimum of injury to fetal tissue.’ Even if the fetus is not aware, these guidelines are appropriate to avoid unnecessary distress to the woman, and it is this concern that should be at the centre of abortion practice. The paramount interests of the woman in abortion procedures is an important principle. The pregnant woman is the patient while the fetus is cared for on her behalf.

Abortion for fetal abnormality

Together with late abortion, another kind of abortion, where the procedure takes place because fetal abnormality of some kind is strongly suspected, has become increasingly contentious (17). Where in 1967, when abortion was made legal, fetal abnormality was construed a 'good' reason for abortion, today the opposite seems the case. This kind of abortion is now considered at best ethically difficult, at worst eugenic. The problematisation of abortion for abnormality can be discussed with reference to three groups, whose views have, to differing degrees, shaped the debate.

(a) The medical profession

Under British law, one exception to the general prohibition of abortion after 24 weeks gestation is where it is agreed that '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'. The terms of this clause of the Abortion Act are in line with the general privileging of the exercise of medical

judgement in British abortion law (in all instances, abortion is only legal if two medical practitioners agree that the woman meets one of the conditions for abortion specified in the act, all of which are framed in medical terms). The clause which caters for abortion for abnormality is worded in an imprecise way. There is no specification of what is a 'substantial risk' or what is a 'serious abnormality'. This vagueness reflects the outlook of the medical profession at the time the Act was passed, which was reluctant to allow parliamentarians to interfere with matters of clinical judgement.

Today, in contrast, it is more the case that many in the medical profession are uncomfortable with the onus placed on them under the law to make judgements about whether a particular request for abortion meets the terms of the Abortion Act. Rather than wanting to 'play God', many doctors, in contrast, would prefer it more specific guidelines were drawn up to guide them when they make decisions about whether a request for an abortion on the grounds of fetal abnormality is legal. This has led to call for there to be lists which specify which conditions are 'serious' and which are not. For example, some eminent professors have argued that abortion in the third trimester should be deemed ethically impermissible unless the fetus has an abnormality that can be diagnosed with certainty as leading to early death or cognitive developmental capacity, ruling out Down's syndrome or spina bifida as conditions warranting legal abortion (18).

Whilst restrictions on the range of conditions for which abortion is legally permissible may relieve doctors from the pressure of having to make difficult decisions, it is important to note the implication of such a measure regarding a woman's reasons for abortion. If only those conditions on a designated list are deemed sufficiently 'serious' to enable a woman to have an abortion, then other reasons, not included on such a list, are presumably deemed trivial in comparison.

We have to be careful about suggesting that a woman's reasons for abortion are trivial. They may seem so to other people, but to her they may have a different meaning. A very senior expert in fetal abnormality has commented about the distress he felt when presented with a request for abortion on the grounds that the fetus had a cleft palate. This expert made the point that he was horrified because he thought this to be a rather trivial abnormality, until he looked at the woman sitting in front of him and noticed she had a severe cleft palate herself. What he regarded as a quite trivial disability, this woman honestly regarded as being so serious that she was willing to put herself through the process of late abortion and end what she already saw as the life of a child that she wanted (19).

(b) The disability rights movement

A social movement that has become increasingly influential in recent years is the movement for the rights of disabled people. With the completion of the mapping of the human genome, the prospect of the detection of a increasing number of genetic markers has generated a great deal of debate, which centres on the notion that 'eugenic' abortion may result. Many disability rights activists suggest that as knowledge increases about the human genome, it will bring with it attempts to 'screen out' embryos and fetuses whose genes are not 'perfect' (20).

This raises the question What do we mean by eugenics? This term is used very loosely and often wrongly in discussions of abortion and ante-natal screening today. Defined properly, eugenics is the view that society can be improved through the manipulation of genetic inheritance, and that social problems can be resolved biologically, largely through the control and shaping of human reproduction.

It is arguable that the abortion law in Britain, when first introduced was motivated to some degree by a eugenic outlook. It could be argued that some clauses in the Abortion Act were motivated by a desire to tackle the social problems caused by poverty deprivation and hardship by shaping people's reproductive patterns (i.e. making easier for them to limit family size) rather than to making greater social resources available to them. This was, however, not the case in particular with regard to the clause in the law about abortion for fetal abnormality. This clause was largely a response to the thalidomide tragedy - a response to women who feared they were to give birth to a severely disabled child and were unable to prevent it.

Regardless of the motivation of some of those who supported the legalisation of abortion in 1967, today it is in any event very definitely the case that abortion is not seen by doctors, policy makers, or women themselves, as an aspect of social engineering. The context for abortion today is one where its provision meets the request of a woman who no longer wants to be pregnant. That is the case when we are talking about the ending of unwanted pregnancies that have been conceived unintentionally, and is so where abortion for abnormality is at issue.

The overwhelming majority of women who discover that they are carrying a fetus affected by Down's Syndrome currently choose to have an abortion. A study by ante-natal screening expert Professor Eva Alberman shows that just eight per cent of women who discover they are carrying a fetus affected by Down's syndrome decide to continue the pregnancy (21).

It is not difficult to understand why women choose to abort abnormal pregnancies. Many women find that they feel differently about their condition when they find their baby would be born disabled. The discovery that the child is 'not normal' may challenge a woman's hopes and expectations about what her future family life will be.

A woman whose attitude to her pregnancy changes in this way when she finds it is affected by an abnormality is not making a social or political statement about the abnormality, or about born people with that disability. She is making a statement about herself; what she feels she can cope with and what she wants.

To accept the notion that the views of some disability rights activists should be able influence abortion law or policy is to privilege the views of those who experience a condition over women who carry fetuses affected by it. Why should the experience of, say, spina bifida entitle someone to a voice in the most personal decision a woman has to make?

(c) The anti-abortion lobby

The argument that abortion on the grounds of abnormality is eugenic has also been promoted, disingenuously, by those who oppose abortion in all circumstances. The anti-choice organisation LIFE produces a leaflet called 'Pre-Birth Screening: Something Wrong With Baby?' This argues that '...to destroy a child because he or she is not perfect is especially unjust and elitist. Of course it is not always easy to cope, but eugenic abortion recreates and legitimises primitive phobias against mental and physical illness just when society seems to be making real progress in outgrowing them.' The leaflet asks '...are we not really sending a message to the disabled: you are inferior, you should never have been born?' (22). The Society for the Protection of Unborn Children makes the point that '...abortion of the handicapped is both a reminder of the inhumanity of abortion, attacking the most vulnerable, those most in need of help, and an offence to the disabled, sending them the message that they are inferior and of less value than the able bodied' (23).

Does abortion for abnormality encourage discrimination against disabled people? No it does not, since it is possible to make a judgement or express an attitude towards a particular condition, without in any way imputing an attitude towards the value of people who suffer from that condition.

Most people would say they thought malaria was a bad thing, and that it would be better if people did not suffer from it. This does not mean they take a negative attitude towards people who suffer from that illness. The same applies with abortion for fetal abnormality. There is no reason to assume that a woman's choice not to bear a child which suffers from spina bifida or Down's syndrome implies she believes such people should not be born, or be supported. It simply implies that she does not wish to be a mother to one.

Issues relating to disability rights and those relating to abortion are completely different. At the heart of the issues of abortion (as the anti-choice lobby knows full well) is autonomy in reproductive decision making, and, whether the fetus is abnormal or not, the ability for individuals to make such decisions must be primary. In a similar vein, the demand from some people *with* disabilities to be able to screen their pregnancies in such a way that a child with a disability results can also be defended on the same grounds. Since women, and their partners, disabled or not, have to live with the consequences of reproductive decisions, they must be able to make the decisions they perceive to be moral and appropriate.

Ultimately this is the issue which is at the heart of the abortion debate. However, the failure of anti-choice organisations to make a convincing argument against reproductive autonomy means they now try to duck the issue, and instead cloak their arguments in the language of disabled rights.

Is abortion a health risk?

(a) Physical health

Much evidence exists which attests to the low rate of risk to physical health associated with abortion. In 2000, the British Royal College of Obstetricians and Gynaecologists (RCOG) published an evidence based guideline, *The Care of Women Requesting Induced Abortion* (24). Based on systematic literature review, and synthesis of the best available research results, the guideline advises that women considering abortion should be given certain information on the possible complications of abortion. For example, hemorrhage at the time of abortion is rare, occurring in around 1.5/1000 abortions overall. The rate is lower for early abortions (1.2/1000 at <13 weeks gestation and 8.5/1000 at >20 weeks). Uterine perforation at the time of surgical abortion is also rare. The incidence is of the order 1-4 per 1000 abortions. The rate of damage to the external cervical os at the time of surgical abortion is no greater than 1 percent. The rate for complications is lower when abortions are performed early in pregnancy by experienced clinicians. Genital tract infection of varying degrees of severity, including pelvic inflammatory disease, occurs in up to 10 percent of cases. The risk is reduced when prophylactic antibiotics are given or when lower genital tract infection has been excluded by bacteriological screening.

For comparison, an American specialist in abortion services, Warren Hern, the author of the medical text, *Abortion Practice*, notes lower complication rates. In various published series, Hern reports a major complication rate (including haemorrage requiring transfusion) of 0.2 per cent (2 per 1000) in second trimester abortion from 15 - 34 menstrual weeks. His 30,000 first trimester patients have experienced a major complication rate of 0.01 percent with no uterine perforations. By contrast, patients carrying pregnancy to term in the United States routinely

experience a caesarian rate of 25 - 30 percent, a major complication rate more than a hundred times greater than second or third trimester abortion and more than 2500 times greater than that experienced by first trimester abortion patients (25).

Regardless of the evidence to attest to the safety of abortion, the idea that abortion constitutes a health risk remains however the subject of debate. In particular, there has been some discussion in recent years that abortion leads to future infertility, breast cancer, or psychiatric illness. Women's concern about these conditions may have been heightened by claims made mainly by opponents of abortion. The decreasing levels of support for opposition to all abortion has meant that anti-choice groups have developed a strategy which might be termed the 'feminisation' of anti-abortion argument. There has been a marked tendency for opponents of abortion to increasingly make their case on the grounds that abortion is bad for women's health. In this kind of argument, the apparent motivation for opposition to abortion stems for concern with women's well-being. Scientific evidence finds no support for these claims however.

The RCOG reviewed available evidence about breast cancer for its guideline, and found that available evidence on an association between induced abortion and breast cancer is currently inconclusive. They noted however, that the validity of the evidence gathered from studies which compare incidence of breast cancer in women who have and who have not had an abortion may be questionable because of the reluctance of women studied to reveal whether they had an abortion. Studies based on national registers are less prone to inaccuracy because they do not rely on subject recall. Such studies have not shown any significant association between abortion and breast cancer. The guideline therefore states that when only those studies least susceptible to bias are included, the evidence suggests that induced abortion does not increase a woman's risk of breast cancer (26).

The RCOG guideline states that women with previous induced abortion appear to be at an increased risk of infertility in countries where abortion is illegal, but not in those where abortion is legal. It notes that published studies strongly suggest that infertility is not a consequence of induced abortion where there are no medical complications. British gynaecologist David Paintin has observed that in so far as abortion and reduction in fertility are linked, a proportion of the one or two per thousand women who have serious abortion complications are likely to experience reduced fertility or inability to conceive again because of these complications, but not where complications are absent (27).

(b) Mental health

It is important to emphasise that assessment of the physical effects of abortion, and the relationship between abortion and a woman's emotional state, must be approached differently. Key to the latter is *context-dependence*. Where a discussion is to be had of women's emotional responses to abortion, attention must be focused on the social and personal situation in which abortion takes place. It therefore to makes no sense to contend that in a general, de-contextualised way, abortion has a particular, uniform mental health outcome.

Unfortunately, in much discussion of women's feelings about abortion, there is a general tendency to treat women seeking abortion as a homogeneous group, and to fail to contextualise the decision to abort a pregnancy. Many reports do not consider age, marital status, wantedness of pregnancy, gestational age, previous reproductive history, or sociocultural setting. These and other characteristics can have a substantial effect on a woman's motivation and may also influence the risk of negative psychological consequences.

The most extreme example of a de-contextualised approach to the relationship between abortion and emotion is the claim made by opponents of abortion that women suffer from 'Post Abortion Syndrome'. In this approach, rather than paying attention to the context in which abortion decisions are made, a woman's emotions after an abortion are pathologised as a form of mental illness.

Post Abortion Syndrome (PAS) was initially described by Rue in 1981 in United States Congressional Testimony as a variant of post-traumatic stress disorder. He claimed that psychological stressors were capable of causing post-traumatic-stress disorder and that: 'Post-Abortion Syndrome (PAS) is a specific type of post-traumatic stress disorder' (28). Subsequently, anti-abortion organisations in Britain adopted Rue's approach, and as a result the claim for PAS has become a feature of anti-abortion argument in British debate (29).

According to the American Psychiatric Association (APA), Post Traumatic Stress Disorder (PTSD) is a disabling condition '....following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury'. (30) Likely stressors cited by APA as examples of PTSD include military combat, violent personal assault, terrorist attack, and being held hostage. Notwithstanding the substantial difficulties associated with the PTSD diagnosis in general (31), it is quite a stretch to claim abortion as a stressor likely to induce PTSD.

One of the criteria for PTSD is experiencing '...an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone' (32). Considering that around a third of British women will have an abortion at some point it can hardly be said that the abortion experience is outside the range of usual human experience. There has been no reported increase in public or private mental health services for women attributing their current psychological problems to abortion.

Many empirical studies have been conducted to investigate the emotional aftermath of abortion, and there is not space here to detail them all. In one example, reported in 1995 in the *British Journal of Psychiatry*, information was obtained about 13 261 British women, through volunteer GPs. This included age, marital status, social status and previous psychiatric and obstetric history. As a result, four comparison groups were obtained, of 6151 women who did not request abortion, 6410 who obtained an abortion, 379 who requested the operation but were refused and 37 who requested the abortion and changed their minds. In the study, GPs were asked to record diagnoses of women they saw by grouping psychological or psychiatric disorders into three categories: major mental illness (including puerperal psychosis, schizophrenia, and manic depression), minor mental illness (depression, anxiety or other emotional disorders) and deliberate self-harm (drug overdoes, self cutting). Key findings reported were that in women with no past psychiatric histories there was no significant difference between comparison groups in rates of psychiatric illness; that women with a previous history of psychosis were more likely to experience a psychotic illness than those with no such history; and that termination of pregnancy did not appear to increase the risk (33).

Another piece of typical recent research is that by Russo and Zierk. They reported findings from a U.S. based 1992 study, which found that the wellbeing of 773 women, interviewed annually in a national sample of 5 295 women, was unrelated to their abortion experience eight years earlier. The study considered many factors that can influence a woman's emotional wellbeing, including education, employment, income, the presence of a spouse, and the number of children. Higher self-esteem was associated with having a higher income, more years of education, and fewer children. Women who had experienced an abortion in fact had a

statistically significant *higher* global self-esteem rating than women who had never had an abortion. This difference was even greater when comparing aborting women with women delivering unwanted pregnancies (who had the lowest self-esteem). Women who had experienced repeat abortions did not differ in self-esteem from women who had never had an abortion. In all, the evidence confirmed earlier findings that factors *other than the abortion experience itself* determine post abortion emotional status. Some women continually reconstruct and reinterpret past events in the light of subsequent experience and can be pressured into feeling guilt and shame long afterwards (34).

In the light of the substantial amount of evidence against PAS it is perhaps surprising that the claim for PAS retains any credibility. In part the continued debate about whether or not there is such a syndrome can be explained by the confusing degree of variation in the 'symptoms' that are said to be associated with the putative condition. As we have already noted, Rue claimed that PAS is a form of PTSD. As such it would constitute a severe psychiatric disorder. If its occurrence could be measured on this basis, it would be found to be non-existent.

However, proponents of PAS tend to shift in their writings from a definition of the PAS 'symptoms' where the proposed comparison with PTSD is made clear, to a much broader collection of 'symptoms' that could perhaps more accurately be described as negative feelings (35). Rue has listed a wide range of feelings, and forms of behavior that he argues might be evident in women who have had an abortion. These include feelings of helplessness, hopelessness, sadness, sorrow, lowered self-esteem, distrust, regret, relationship disruption, communication impairment and/or restriction and self condemnation.

Associating this broad range of 'symptoms' with a diagnosis of PAS allows those who put forward the case for PAS to argue that large numbers of women may suffer from the syndrome. As the 'diagnostic criteria' for PAS become broader, it is easier to claim that many women may suffer from the 'syndrome'. A link between mild and severe psychological responses is generated: all become less serious versions of the same response. Feelings a woman might have after abortion, such as sadness or regret, are seen as a less serious version of a psychiatric disorder. If an accurate assessment of the psychological effects of abortion is to be made, an approach which combines psychiatric illness with negative feeling is unacceptable. As Stotland argued in a 1992 Commentary in the *Journal of the American Medical Association*, a symptom or a feeling is not equivalent to a disease (36). Some women who undergo abortion experience feelings of sadness, regret and loss, but this does not mean they are suffering from an illness.

In sum, for the vast majority of women, an abortion of an unwanted pregnancy will be followed by a mixture of emotions, with a predominance of positive feelings and relief. The time of greatest stress is likely to be before the abortion decision is made. Evidence from the research literature suggests that, in the aggregate, legal abortion of an unwanted pregnancy does not pose a psychological hazard for most women. They tend to cope successfully and go on with their lives. As previously noted, there is no credible evidence for the existence of Post Abortion Syndrome.

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