



All-Party Parliamentary Pro-Choice and Sexual Health Group

Chair: Baroness Gould, House of Lords, London SW1A 0PW. Tel: 020 7219 3138

Campaigning to raise awareness in parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK.

WHY WOMEN NEED LATE ABORTION

18th December 2006

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Introduction

The purpose of the All-Party Parliamentary Pro-Choice and Sexual Health Group is to raise awareness in Parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK.

This is the report of a meeting held on 18th December 2006. In recent years there has been a concerted effort by anti-choice organisations to influence public opinion on abortion, and they have gained widespread press coverage and some Parliamentary support. A Ten Minute Rule bill with a view to reducing the abortion time limit, as well as imposing waiting periods and counselling upon women seeking an abortion was defeated on 31st October 2006; while this was enough to dissuade any MP from championing the issue as a Private Member's Bill in the subsequent ballot, the pressure to restrict abortion continues from the Proposer of the initial Ten Minute Rule Bill, Nadine Dorries MP, and she has resubmitted her Termination of Pregnancy Bill for 23rd March 2007.

A recent MORI poll by the British Pregnancy Advisory Service (bpas) demonstrated that the majority of people in the UK continued to support a woman's right to have an abortion. In addition, using a split sample concerning the issue of late abortion, the results showed that the more information the public was given about the circumstances surrounding an abortion at a later stage, the more likely they were to be sympathetic and supportive.

Given the increasingly anti-choice climate, it is crucial that members of the APPG are informed why women sought abortion at a late stage, and whether there is any justification for a reduction in the abortion time limit.

The All-Party Parliamentary Pro-Choice and Sexual Health Group wishes to sincerely thank Liz Davies of Marie Stopes International, Dr Donald Peebles of the University College Hospital London and Jane Fisher of Antenatal Results and Choices for providing evidence to the group.

Background

Despite being legal in England, Scotland and Wales and in restricted circumstances in Northern Ireland for nearly 40 years, abortion continues to receive little balanced coverage in the media, politics or formal education. Instead, abortion is viewed with moral outrage in some sections of the media or is the subject of polarised debate in politics and schools.

In Great Britain, legal termination of pregnancy may be carried out provided that two registered medical practitioners agree that:

a) Up to 24 weeks:

- 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. (The woman's actual or reasonably foreseeable future environment may be taken into account.)

b) With no time limits:

- The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman
- There is a risk to the life of the pregnant woman, greater than if the pregnancy were terminated
- There is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(Abortion Act 1967, amended by the Human Fertilisation and Embryology Act 1990)

Governments in England, Wales and Scotland have published policy documents which address sexual health issues and services. These include recommendations for improving abortion services, and ensuring equitable access and minimum waiting times between the initial referral and the abortion.

Detailed guidance from the Royal College of Obstetricians and Gynaecologists aims to ensure that all women considering abortion have access to a service of uniformly high quality. This guidance should be used as the basis for the development of local protocols or guidelines in the United Kingdom.

Abortion services are also included in broader recommended standards for sexual health services from the Medical Foundation for AIDS and Sexual Health. Although specifically intended to support the implementation of the Government's sexual health policy in England, they can be applied elsewhere.

The 1967 Abortion Act does not apply in Northern Ireland and women from Northern Ireland are not entitled to an NHS abortion in Britain.

Abortion is legal in Northern Ireland only in exceptional circumstances - if the life or the mental or physical health of the woman is at serious or grave risk. In the absence of clear guidelines, the law remains ambiguous and the provision of abortion is often determined by the moral views of individual doctors or by a reluctance to test the law.

In a Judicial Review of abortion and abortion services initiated by **fpa** the Belfast High Court of Appeal ruled that the Department of Health, Social Services and Public Safety had actively sought to avoid its responsibilities in this area and ought to investigate the issue. In response to this, in 2005 the DHSSPS instigated a formal investigation into the provision of abortion services in Northern Ireland, and released draft guidelines on abortion to health professionals in January 2007 for an eight week consultation. Full guidelines will be produced in the coming months.

In the rest of the UK, opinion polls highlight the considerable confusion among the British public as to the detail of how women can obtain an abortion. Although the 24 week time limit is well documented, women may encounter various obstacles if they present after 12 weeks, due to a shortage of abortion providers in the locality, or as a result of conscientious objection by the doctor they approach.

In 2004, the debate about abortion in the UK was reignited with Professor Stuart Campbell's 4-dimensional scans of the fetus 'walking' in the womb. The high definition images, as well as alleged scientific and medical advances in neonatology, have led to calls by some anti-choice campaigners to ban abortion altogether, or persuaded others to call for a reduction in the current 24 week time limit. Efforts have been made to shift the focus from the woman to the fetus, resulting in an increasingly negative portrayal by the media of women who access abortion.

Despite this sustained campaign, a 2006 MORI poll showed that the majority of people in Britain continue to back a woman's right to an abortion, and that support increased with information about the circumstances when an abortion would be granted, or the specific difficulties encountered by the woman that made her seek abortion in the first place.

The All-Party Parliamentary Pro-Choice and Sexual Health Group believes that women should be granted an abortion as early as possible and as late as necessary. It is with a view to determining how 'late' is necessary that the meeting was convened.

Evidence from Liz Davies , UK Director of Marie Stopes International (MSI).

Liz Davies presented the findings of the Marie Stopes International report on Late Abortion (2005) – a research study of women undergoing abortion between 19 and 24 weeks gestation. Given the current climate, with moves to review the 24 week upper limit on abortion focusing on alleged scientific and medical advances, the debate has shifted from the woman to the fetus, to the detriment of any real consideration of the emotions, reasoning and experience of women seeking abortion at later gestations. MSI wanted to investigate the reasons why women undergo late abortion, to better inform opinion. The study looked at 114 women who completed a survey by MSI following an abortion at 19-24 weeks between January –April 2005.

The study illustrates the situations that lead to late abortion and how the woman came to the decision to have an abortion; issues of responsibility; and what consequences they would face had an abortion been prohibited.

Key findings

For the majority of women taking part in this study, the signs and symptoms of pregnancy were not recognised until an advanced stage, making late abortion an inevitability rather than a conscious choice on their part.

'I had no symptoms of pregnancy. I did not gain weight, I did not experience nausea and until two weeks ago I didn't even notice a bump, considering I'm 20 weeks pregnant' (age 22)

Others put recognisable pregnancy symptoms down to other physiological factors peculiar to them, such as a history of erratic periods, a recent pregnancy, or the consequences of using particular methods of contraception.

'I didn't think too much about having missed periods as I'd experienced this before for about eight months... I was tested for PCOS [polycystic ovary syndrome] but it turned out it was stress related. [I] assumed, following a negative test, that my lack of period was stress related' (age 27)

'I've been on the mini-pill which means you don't actually get periods so I didn't have the classic case of periods stopping and thinking, you know, that it was something to worry about' (age 42, gestation 22 weeks)

A small minority of women taking part were aware of the pregnancy at an early stage but were either in denial, or subsequently faced a significant change in their circumstances that forced them to re-evaluate their pregnancy

'My partner is violent but when he found out I was pregnant he promised he would get help and change and for a few weeks he did but he then beat me with a baseball bat so I don't think it's right to involve a child in that' (age 24)

'When I found out I was pregnant I just wanted to forget about it. But I contacted my GP to be referred to have a termination. But why I left it so long was I hoped it would go away and I didn't have to make a decision' (age 23)

Some women reported significant delays in accessing services once a pregnancy had been detected and a decision to terminate made - these included encounters with obstructive medical practitioners and protracted waiting times for consultations. This caused considerable distress and anxiety to those women affected by such delays.

'I had to move homes and GP. It was difficult to register with a local GP in the area that I moved in. That was the main cause of the delay. I contacted the GP as soon as I registered. By then I had already missed three periods' (no age given)

'I did a home test on Thursday, couldn't get an appointment with my GP until Tuesday. Didn't get a hospital appointment for a further three weeks. Was a shock when I had a scan and it said I was 20 weeks' (age 35)

'Because of my age I had an amniocentesis done. This was done at 16½ weeks. It took two weeks to get the result - the baby had Down's syndrome. It took one week to make arrangements - this is why my pregnancy went to 19½ weeks' (age 45)

'The doctor I went to see refused to give me a referral letter... it was horrifying because she just said it was too late for your abortion but I know the legal limit is 24 weeks and I was only about 20 weeks' (age 35, gestation 23 weeks)

Many of the women taking part found the decision to terminate particularly difficult to make, and reported taking a considerable amount of time to fully consider their options before deciding to proceed with abortion.

'It's a very difficult decision to make. The extra time is often needed. Better that than unwanted children' (no age given)

'People have different circumstances and it takes a lot of courage for someone to admit this is actually what they want to do and go through with it... until you are put in the situation yourself you can't really judge, you can't say what's right or wrong until you're there' (age 21, gestation 20 weeks)

'I'm sure nobody makes the decision lightly' (age 42, gestation 22 weeks)

Most women did not act in isolation, but consulted and were supported by partners, family and friends most women reported a combination of factors influencing their decision to terminate - every woman's situation was unique and most felt that they were the only person capable and qualified to make the decision

'My husband - he's been very supportive; he knows what I want to do; and then my friend was very supportive as she has gone through this as well' (age 35, gestation 23 weeks)

Considerations of the impact of continuing the pregnancy on partners and existing children exercised a significant influence on most women's decision to seek abortion. Current and future responsibility was weighed up.

'If I had not been able to have a termination my daughter and I would have lost our house and all our security. She is my priority' (age 37)

'I would have resented the fact that I had to have it. That's the bad thing about it. I know I would have resented it and I don't want to feel like that about my children' (age 34, gestation 20 weeks)

'I've only been with my partner for six months now... and neither of us are ready to take on that and I'm doing my degree... something I really want to finish... I'm not really ready for a child at the moment' (age 24, gestation 22 weeks)

'I love my girls so much...I'm doing this for the right reasons and the right reasons for my other two children' (age 24, gestation 22 weeks)

The vast majority of women felt that the current legal upper gestational limit of 24 weeks should be left intact, and that to have been unable to access services because of a change in the law would have caused emotional trauma - two respondents even reported that they might have taken their own lives.

'If I couldn't have done it [had an abortion] I don't know what I would have done. Probably committed suicide. I will never go through this again; it's a terrible situation to be in. Everyone's got a different story and if you haven't been there, you'll never understand the thoughts that go through our minds. It's not an easy decision to come to, there is so much stress that you have to go through. It really does hurt to know that other people want the limit to be lowered. I don't know if those people have ever been in the situation like me, but it's terrible. (age 21)

'People who say after 20 weeks you can't do it just haven't been there and they don't know the individual circumstances. I'm sure nobody makes the decision lightly, everyone's got a really good reason and nobody should condemn people for making that choice' (age 42, gestation 22 weeks)

Many women feel that the media's depiction of abortion is biased and unfair, and called for more balanced and considerate treatment for women who find themselves in this situation.

'The media have recently been pressurising and frightening women like me and trying to attach a stigma to termination. Women should be given support, not bullied' (age 24)

'Abortion is more widely talked about and accepted than it ever used to be which is good. But it's still not talked about with enough of a two-sided debate' (age 20)

'It is not an easy decision to make and I think the media should support us for the right to choose. After all it's us women who have to live with the decision for the rest of our lives' (age 27)

'Despite [the fact that] I knew I was making the right decision, I felt ashamed to tell people close because of the guilt and shame created by the media' (age 27)

In conclusion, there were four key findings of the report into why women had an abortion at a later stage:

- The signs or symptoms of pregnancy were often not recognised, making abortion at a later gestation an inevitability rather than a conscious choice.
- Some women went into denial about the pregnancy, leading to late presentation when they could no longer wish the pregnancy away.
- Some women had initially planned the pregnancy but due to a change in circumstances, for example domestic violence, were unable to continue with the pregnancy and needed time to access an abortion.
- Some women were delayed through the referral process.

MSI believes the current abortion time limit must be upheld. The research has shown that women do not make the decision to terminate later in pregnancy lightly. They consider their options, think carefully and deeply about the decision and are generally supported by others

MSI contends that lowering the upper gestational limit for termination of pregnancy will not end demand for late abortion, but will merely increase the hardship and emotional suffering of women seeking them. Accurate information on methods of contraception available, side effects, return to fertility and on the signs and symptoms of pregnancy, as well as improving access to abortion are essential elements of any attempt to reduce the proportion of women undergoing abortion between 19 and 24 weeks.

Evidence from Dr Donald Peebles, University College Hospital, London

Dr Peebles addressed the APPG on fetal development and how it informs medical and public debate. The emergence of high definition ultrasounds in recent years have elicited an enormous emotional response from the general public. Another factor that should be considered is the stage of fetal development necessary to enable the detection of fetal abnormality.

Organogenesis (organ development) occurs within the first twelve weeks of gestation. Critics of abortion have equated this with a post-natal state of development. However, as the structure and function of some organs, in particular the brain and lungs, continue to develop throughout pregnancy and into postnatal life, it is therefore difficult to define a point of “transition” to viability in the life spectrum.

Showing a map of the brain at various gestations throughout pregnancy (APPENDIX 1), the brain is seen to be a primitive organ at 24 weeks, with none of the ‘folds’ associated with our knowledge of an adult brain. Although the nerve cells are present at 20 weeks, the sophistication of the cortical development develops in the second half of pregnancy. It does not compare to an adult brain until after birth.

Similarly, diagrams of the lungs throughout the pregnancy show that the airways are not viable until at 17 weeks; between 17 and 26 weeks, they start to function; but only after 26 weeks does the alveoli (allowing oxygen to move between the lungs and the blood) develop. The development is as follows:

- Pseudo-glandular – until 17 weeks; tubes invade connective tissue
- Canalicular – 17-26 weeks; tubes end in primitive saccules and start to differentiate specialised cells
- Saccular – until birth; continued division to form alveolae with large surface area.

The EPICURE study (established in 1995 to determine the outcomes of premature babies) followed the outcomes of 241 babies born at 23 weeks during a period of 10 weeks. 11% of the babies survived (26 babies), and only 3% of these had either no or a mild impairment.

On these grounds, the outcomes are clearly very poor. Because the brain and lungs are only partially developed at that stage, the majority of premature babies die, mostly from lung immaturity or necrotising enterocolitis (where portions of the bowel undergo necrosis, or tissue death) or brain complications.

This debate came to a head with Stuart Campbell’s emotive and highly impressive images.



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PROOF BABIES SMILE IN WOMB

ASTONISHING new pictures show for the first time that babies smile in the womb.

Pioneering scanning techniques have allowed London obstetrician Professor Stuart Campbell to capture images which show that fetuses smile, yawn, blink and cry as early as 26 weeks after conception. Experts believe the breakthrough could lead to advances in

By Isabel Oakeshott,
Health Correspondent

baby health for a whole range of conditions. But anti-abortion campaigners are likely to seize on the development as further evidence against the case for terminations, which can legally be carried out as late as 24 weeks.

Full story and more pictures: Page 7



Happiness: an unborn baby smiles in the womb in a picture taken using new scanning techniques

The fetal features are very clear, and as it is in 4D (i.e. including real time movement) you can see the movements that they make. The images were construed as evidence of babies feeling emotion – ‘proof that babies smile in the womb’ (Evening Standard, 12th September 2003). Scientifically, this is an over-interpretation of the images, which adds an intellectual angle, equating the feature of a smile with feelings of happiness, in that instance. Medical experts know that the brain of the fetus is not able to cortically function at the stage of the 4D images so they cannot tell us about the fetus’ state of mind.

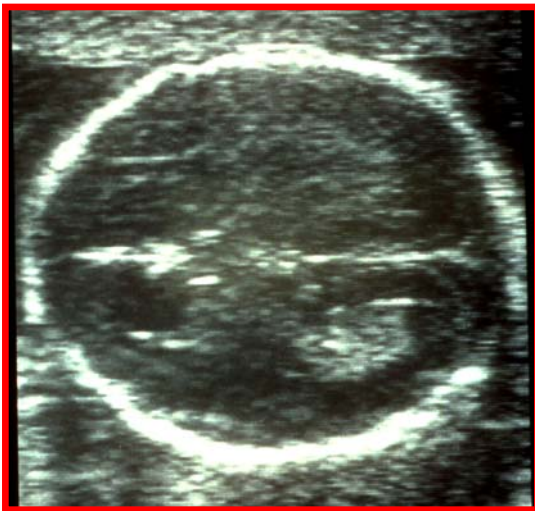
The 1990 amendment of the HFE Act reduced the upper time limit for abortion from 28 to 24 weeks, and included a clause E to enable termination of pregnancy for fetuses with a severe handicap.

Termination of pregnancy at any gestation is permitted if “there is a substantial risk that if the child were born it suffer from such physical or mental abnormalities as to be severely handicapped”

Dr Peebles set out a case study of how a fetus with a congenital abnormality would be managed.

Mild Ventriculomegaly

“Mild” = 10 - 15mm



“Moderate – severe” > 15mm



The fetal anomaly or ventricular scan (the scan that takes place at 20 weeks to detect abnormality) might show a borderline abnormality of fluid in the brain – in 90% of cases, this could rectify itself; in 10%, it could result in a life-threatening disability.

Isolated mild ventriculomegaly is a marker of:

- **Aneuploidy** (where the number of chromosomes is abnormal due to extra or missing chromosomes)
- **Intracerebral anomalies**
- **Developmental delay**

The prognosis often only becomes clear with serial scanning, so a further scan would be taken at 22 weeks, to investigate whether the condition had gone away or deteriorated. A diagnostic test (e.g. amniocentesis) would also be offered. Test results would be awaited. Following the results, if the prognosis is not good, a multi-disciplinary meeting will be held, with a neonatologist or neonatal surgeon, the parents and other experts. Adequate time must be allowed for decision making.

Because certain problems may not be detected before the brain has begun to grow, the ventricular scan can only take place after 20 weeks, and as has been shown, time is needed to determine if there is an abnormality, and if it is likely to recede or cause severe injury to the fetus. Many problems may not become apparent up to and after 24 weeks, but the current law provides the time to detect the great majority of severe abnormalities. Clause E also means that an abortion may still be permitted for severe fetal abnormality if it is detected after the 24 week limit.

The continuous development of the brain is a big factor in diagnosing this abnormality, as parents do not want to take the risk of aborting a wanted pregnancy unless they are sure that the outcomes for the child will be severe. The current time limit allows parents to make the right decision.

Evidence from Jane Fisher, Director of Antenatal Results and Choices (ARC)

ARC was set up by a group of health professionals who recognised that greater support was needed for women who had undergone a termination following diagnosis of fetal abnormality. These were women with wide ranging and complex needs. It had been thought that because women had made a choice their needs would be minimal. Instead they found they were taking longer to recover and were presenting with more problems.

In 1988 support was focused primarily on providing support for women who had already had a termination. However, with the introduction of screening programmes, ARC began to receive an increasing number of calls prior to termination, wanting questions answered about the procedure itself, and about the various tests - including help with interpreting the results they had been given, and with making their decision.

Jane Fisher stressed that although ARC provides support to parents around decision-making, the organisation does not get involved with the decision itself. They are interested in supporting the process and have no vested interest in the outcome. The primary concern of ARC is that parents make an informed choice, and that they make the right decision for them. All counselling is non-directive and ARC provides a helpline, internet support and training for health professionals.

There were 186,416 abortions in 2005; of these, 1,916 took place under Clause 'E'. For clarification, this means that abortion is permitted:

When there is substantial risk that if the child was born it would suffer from physical or mental abnormalities as to be seriously handicapped' (Clause E Abortion Act 1967)

This has been a static percentage of the overall total in recent years. It was stressed that abortion under Clause E is a response to serious disability, not a quest for designer babies.

23% of the abortions under Clause E were carried out following a diagnosis of Down's Syndrome. The remaining 77% followed diagnoses of other conditions, and the majority were diagnosed at a late gestation. 137 abortions were carried out after 24 weeks, which is permitted by the law.

Early scans which may show the incidence of Down's Syndrome may take place at 11-13 weeks, but these scans are only available in 30% of maternity units in the UK, so for the majority of women they are not an option. Additionally, and corresponding with Dr Peebles' evidence, many symptoms of fetal abnormality may not be apparent until 20 weeks when the brain and lungs have become more developed. This, along with the wait for results, means that it can be quite

late in a woman's pregnancy before she has been reassured about the health of her baby, or learns the news of a fetal abnormality.

There are a series of antenatal tests which may be offered during a pregnancy – not all women will receive these tests. They are outlined in the table below.

WHAT?	WHEN?
<i>Early ultrasound scans</i>	
Fetal viability scan	6 – 10 weeks
Dating scan	10 – 12 weeks
<i>Screening tests</i>	
Sickle cell & thalassaemia blood test	8 – 10 weeks
Nuchal translucency (NT) scan	11 – 13 weeks
Combined test (NT and blood tests)	11 – 13 weeks
Integrated test (NT and blood tests Then further blood tests)	11 – 13 weeks 16 – 20 weeks
Serum screening (blood tests)	16 – 20 weeks
Fetal anomaly scan*	18 – 24 weeks
<i>Diagnostic tests</i>	
Chorionic villus sampling (CVS)	11 – 13 weeks
Amniocentesis	15 – 24 weeks
Fetal anomaly scan*	18 – 24 weeks

The news that your child may be severely disabled is completely devastating, and it can take some time to recover from the shock in order to make a decision. Deciding to have the baby screened for fetal abnormality does not necessarily mean that the parent has made a decision about the prospect or possibility of such news. It is very different to consider this in the abstract, and to be faced with the actual decision following such heartbreaking news.

According to ARC, parents who have made this decision do not regret making the decision, but obviously regret that their baby's condition was so severely life-threatening.

Time is needed to take on board what it means to be affected by a condition, and expectations, built up throughout the pregnancy, need to shift.

The Impact of Diagnosis

My husband and I felt everything crumble around us in the face of that news. Convictions previously held and decisions previously made seemed superficial and hastily arrived at now that the reality of the situation was upon us.'

The decision to terminate

'It was the most difficult decision I have ever had to make and I feel the gravity and enormity of the responsibility was glossed over by one or two professionals... for us it wasn't an inevitable consequence. It was something we gave a lot of thought to, and a decision we both found very difficult. Whilst we don't regret the decision, we still regret aspects of the process of the decision.'

DIPEX interview

'If I did this 100 times, this decision again I wouldn't change my decision. Knowing what I now know about the condition that the babies had, I don't have any dissonance about ending a pregnancy. I have a great sadness that I needed to face that decision and go through what we went through, but I never for a moment think either of the babies should have been born and been allowed to wither or survive for moments or days or whatever.'

What I, I think I feel uncomfortable with is people not understanding it fully enough, and drawing their own conclusions about why we did it. And perhaps viewing it as kind of designer baby stuff; somehow this baby was mildly imperfect and that we ended its life. Because in a sentence you can't get across, you know, why we did it and why we believe it was the right thing for us to do.'

DIPEX interview

'I don't think we did take it all in. I think we came home - even the leaflets and things - it felt like it wasn't, 'real'. It was just, and that there was so much information and, there was almost a sense of - not urgency but they wanted us to make decisions quite quickly - and I mean obviously medically they knew exactly what was wrong, and exactly, you know, what we were faced with - but for us, it was a huge thing to decide.'

DIPEX interview

The mid-pregnancy scan

'It was a sunny morning three days before Christmas when we went for our 22-week scan, excited about seeing our baby, confirming the sex and hopefully getting some good pictures for the grandparents...'

...tears started rolling down my cheeks...my head was spinning... how can all these things be wrong? The sonographer said we should go to another hospital for further scans.'

The need for time

'It wasn't until I saw the consultant that I decided to end the pregnancy. It was evident from all the scans and advice I had received that George's condition was extremely serious, but during the four weeks I had tried to cling on to a glimmer of hope that things wouldn't be that bad in the end.'

The need for information

'We were referred to another hospital and after a difficult two-day wait we were given the awful diagnosis that the baby had ruptured posterior urethral valves. We were told we could continue with the pregnancy regardless, terminate or wait for three weeks for a follow up scan. We were in a state of shock but decided to wait for further news.'

Pressure to make a decision

'We decided that because of all the other problems that our baby had as well as Down's syndrome it wasn't fair to bring him into the world when his quality of life would have been so poor. I literally had one day to decide. I didn't want to have to make that decision and I wish someone could have decided for me.'

'My baby has Edward's syndrome and they have told me because I'm nearly 24 weeks I have to decide quickly if I want a termination otherwise a panel of experts has to meet to authorise the procedure.'

After a diagnosis of fetal abnormality parents need:

- Information
- Time to consider their options
- Individualised support

While there is a clause in the current legislation to extend the termination limit to birth, there is still a perceived cut-off point at 24 weeks. Some health professionals will allow an abortion and others will not. Ethics committees are often established to decide, taking the individual decision away from the consultant and the parents, but this procedure takes time and prolongs the agony for the parents.

Since the Jepson case, when Revd Joanna Jepson took legal action against West Mercia Police after they failed to investigate doctors who carried out what she claims was an unlawful abortion (after 24 weeks, as the scan of the fetus displayed a cleft palate) ARC is aware that some professionals have become

very cautious about authorising an abortion after 24 weeks in case of legal action. Although Joanna Jepson was unsuccessful, women and their families are now suffering as a result of this caution.

Baroness Gould extended the thanks of the group to Liz Davies, Dr Peebles and Jane Fisher for their presentations, and opened the discussion.

Discussion

Baroness Flather was very impressed with the presentations – the information was new, and the arguments covered showed all the sides of the issue. It was excellent preparation for members to receive this. She asked **Dr Peebles** if additional time was needed to detect abnormality (and allow for serial scanning) than was currently available.

Dr Peebles said no: the current law provided for time to detect the great majority of severe abnormalities, and that Clause E meant that an abortion was still permitted if it were detected at a later date.

The **Earl of Listowel** raised the issue of looked after children and what counselling and support was available for young women who might not have the family support network to make a difficult decision.

Liz Davies said that in MSI clinics, all women under the age of 16 were offered a counsellor as a matter of course, and provided with information about their options. In ambivalent circumstances, MSI would refer the young women to Brook, who run a specialised service, but an individualised approach is taken. Further counselling is offered after the abortion takes place.

The **Earl of Listowel** asked if consistent levels of support could be expected.

Liz Davies could only speak for MSI, and they apply their policy in all their clinics. The support young women received from GPs if they sought an abortion on the NHS was difficult to tell. She said more support was certainly needed.

Alyson Elliman (Faculty of Family Planning) made the point that Personal, Social and Health Education was needed, as one of the reasons for late presentation had been that the women affected did not initially realise they were pregnant. There is also a lack of access to contraceptive services to suit the individual woman, and possibly a reluctance to come forward, fearing a negative reaction from health professionals.

Liz Davies said that it was crucial that services were seen to be confidential, and she and Alyson agreed that better signposting to these was necessary.

Lisa Hallgarten (Education for Choice) explained that she visits schools and provides information to young people on issues around abortion. It is up to the individual school what information about abortion is delivered. She reported that young people are very aware of their bodies, afraid that their confidentiality will be compromised, but any debate held about abortion in schools tends to focus on the moral or abstract arguments, rather than informing pupils where abortion can be accessed. The 24 week time limit, however, was something that young people are very much aware of, but she thought they should be informed about how systems work in practice, and early access to abortion should be promoted. Abortion is taught in Religious Education, where the ethics are debated, rather

than sex and relationships education, which removes it from the correct context of sexual health.

Baroness Gould asked **Jane Fisher** if they had many young people seeking information from ARC?

Jane Fisher said that the majority of women seeking information and counselling from ARC were from the mid-twenties and above age groups. She said that the young women they did see had a double dilemma – they were initially unaware and unprepared for pregnancy, then had the crisis of severe fetal abnormality to also deal with.

Baroness Gould asked what support women could expect from social workers and other health professionals, on top of the information provided by the organisations represented at the meeting.

Liz Davies said that many of the young women who came to them were extremely reluctant to inform anyone of their pregnancy or abortion. Some were accompanied by a friend or an aunt, but it was a dilemma for them, and although they were asked to return for follow up counselling, many did not.

Tamara Kubba (fpa) has done some research on this issue. She reported that it was a lucky young woman whose GP will access ancillary services for them. Her hospital had three social workers to help everyone, and they were severely overstretched. She also made the point that denying a woman an abortion based on the GP's conscientious objection, even if onward referral or signposting to another GP was swift, it still implied an initial moral judgement to the woman.

Baroness Gould asked what action the GMC would take against doctors who refused to refer women on for an abortion.

Anne Weyman (fpa) said that we knew from the previous MSI research (*General Practitioners: attitudes to abortion, June 1999*) that small numbers of doctors do not refer women for abortion, and they do not abide by the GMC code. The woman doesn't know what the views of the doctor are, and if she is met with a refusal, or told that she is not eligible for an abortion, she is in an extremely difficult situation.

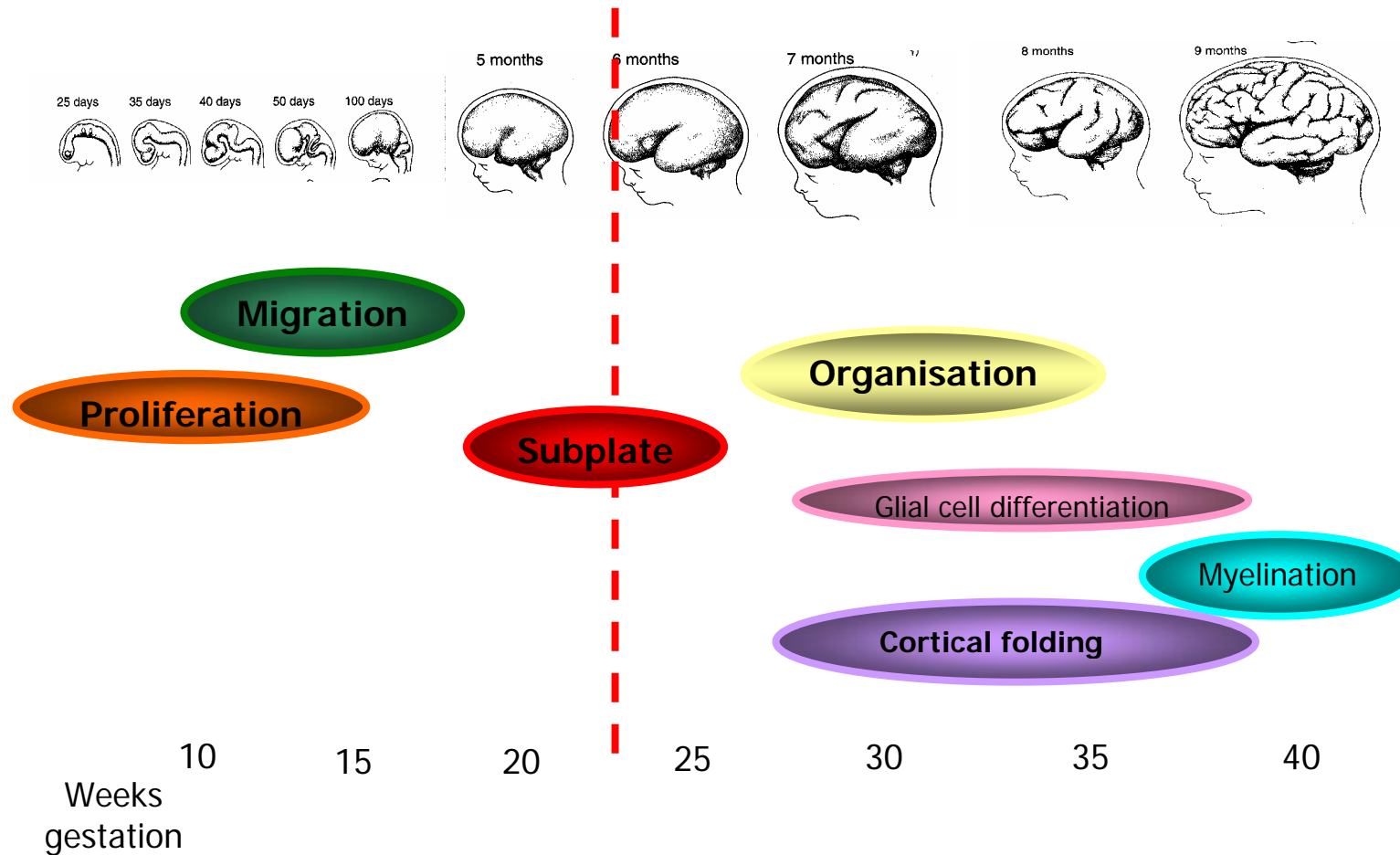
Anne Weyman also spoke about the Gillick court case, which attempted to prevent those aged under 16 from accessing sexual health services.

Baroness Flather called for more family planning advice to be given to all women, especially after an abortion or as part of postnatal care.

Dr Peebles cautioned against too much attention to be focused on young women; each case should be weighed up on its individual merits.

The meeting concluded at 5.30pm.

Milestones of Development in relation to NICU*



*NICU stands for Neonatal Intensive Care Unit - the slide shows how much brain development has to occur after the red dotted vertical line that represents the earliest gestation at which neonatal intensive care might be provided.

Appendix 2 – meeting attendance.

Present: Baroness Gould, Baroness Flather, Earl of Listowel, Viscount Craigavon, Dr Donald Peebles (UCLH), Liz Davies (MSI), Jane Fisher (ARC), Anne Weyman OBE (**fpa**), Hayley Blackburn (**fpa**), Rachel Stewart (**fpa**), Lisa Hallgarten (EFC), Alyson Elliman (FFPRHC), Diana Halfnight (FFPRHC), Anne Quesney (AR), Tony Kerridge (MSI), Tamara Kubba (**fpa**), Mary Jo Bishop (on behalf of Natascha Engel MP), Becky Purvis (on behalf of Evan Harris MP).

Apologies: Jacqui Lait MP, Rudi Vis MP, Lord Rea, Emily Thornberry MP, Kelvin Hopkins MP, Lord Walton, Barbara Follett MP, Anne Milton MP, Bill Etherington MP, David Lepper MP, Lord Hodgson, Baroness Dean, Baroness Gibson, Gwyneth Dunwoody MP, Joan Ruddock MP, Christine Robinson (FFPRHC).