Memorandum 34

Submission from Christian Medical Fellowship

Executive Summary

1-4. We introduce Christian Medical Fellowship's status, submissions, and relevant core beliefs. We regret the exclusion of an ethical dimension to the consultation, the short time scale, and the brevity required.

5-7. Upper time limit - survival has improved year-on-year for extremely preterm infants born at 24 weeks' gestation or less. We should be careful using historical data when considering the present and the future. Parliament should review the 24-week upper time limit on most legal abortions.

8-10. Definitions - neither Parliament nor the courts have defined 'serious abnormality' or 'serious handicap'. Guidance to doctors is inadequate and the profession is failing to regulate itself. While rigorous definitions would help, Parliament should reconsider abortion for foetal abnormality. The upper limit for abortion for disabled babies should not be higher than that for able-bodied babies.

11-12. Demography - abortion is partly responsible for fertility rate being well below population replacement rate. Together with longevity there are significant economic and care implications. Any change in the law that might increase abortion totals should be resisted.

13-17. Relative risks - mortality following abortion is higher than currently recognised. Much is causally related and occurs regardless of the gestation at which abortion is performed. The RCOG should update its guidance, women should be counselled accordingly, and psychiatric indications for abortion should be removed.

18-20. Two signatures - the 1967 Act never made abortion legal; it conferred upon doctors a possible defence against illegality. The requirement for two signatures reflects Parliament's medico-legal concerns, and should remain.

21-24. Nurse/midwife abortions – medical abortion is less safe than often assumed. Morbidity and mortality are described. CMF agrees with the BMA there should be no extensions of current practice.

25. Acute complications – those reviewed by the RCOG are listed. They are usually obvious, short term, and well managed by gynaecologists.

26-29. Subsequent pre-term delivery - there is robust evidence that induced abortion increases risk of premature birth in subsequent pregnancies. Such premature births cause neonatal mortality and ongoing disability, with significant economic costs.

30-32. Mental health problems – there is overwhelming recent evidence that abortion causes significant rates of serious mental health problems. CMF calls for the RCPsych urgently to review its published guidance.

33-34. Breast cancer – there is some evidence suggesting that abortion is a significant risk factor, and CMF believes women should be counselled accordingly.

35. Conclusion – we have summarised the many scientific developments which cause concern for women, but the ethical debate cannot be avoided.

Christian Medical Fellowship's status and relevant core beliefs

1. The Christian Medical Fellowship (CMF) is an interdenominational Christian organisation with more than 4,500 British doctor members, practising in all branches of the profession. Through the International Christian Medical and Dental Association we are linked with like-minded colleagues in over 100 other countries.

2. CMF regularly makes submissions on ethical and professional matters to Government committees and official bodies. In January 2007 we responded to the House of Commons Science and Technology Committee's Inquiry into Government Proposals for the Regulation of Hybrid and Chimera Embryos. All submissions are on our website at www.cmf.org.uk/ethics/submissions/.

3. One of CMF's aims is 'to promote Christian values, especially in bioethics and healthcare, among doctors and medical students, in the church and in society'. We are very concerned at the large numbers of abortions performed in the UK, but note that 'the Committee will not be looking at the ethical or moral issues associated with abortion time limits'. Whilst reluctantly restricting ourselves to the science in this Submission we wish to emphasise that law cannot be divorced from ethics and morality and that science must be undertaken within an ethical framework.

The consultation

4. We further regret the short time scale for this consultation, over the summer holiday period, and question how this vast subject can possibly be considered adequately when 'Submissions should be as brief as possible'. In this Submission we present summaries of key findings.

The scientific and medical evidence relating to the 24-week upper time limit on most legal abortions

Foetal viability

5. Since 1990 there have been many relevant developments. Mortality and morbidity remain relatively high, but survival has improved steadily year-on-year for extremely preterm infants born at 24 weeks' gestation or less. Whilst the widely quoted 1995 EPICURE study in the UK and Ireland showed that average survival to discharge was only 11% for babies born live at 23 weeks and 26% at 24 weeks[261], by contrast Hoekstra et

[261] Wood NS *et al*. Neurological and developmental disability after extremely preterm birth. EPICure Study Group: *New England Journal of Medicine.* 2000; 343: 378-384

al's data published in 2004[262] for outcomes in a 15-year study of infants born between 23 and 26 weeks' gestation at one US specialist neonatal centre show a consistent year-on-year improvement. Between 1996 and 2000 there was an overall survival rate of 66% at 23 weeks and 81% at 24 weeks' gestation. At University College London Hospital a prospective long-term follow-up study has shown survival rates in 1996-2000 of 42% at 23 weeks and 72% at 24 weeks[263].

6. Long-term follow-up shows a minority of extremely preterm survivors have some neurodevelopmental impairment, with significant disability identified in 15-20%. But by their very nature, long-term outcome studies represent the outcome following a now outdated standard of care - EPICURE tells us about infants born in 1995. Obstetric and neonatal care are changing and improving rapidly: in facilities, in training, and with more in-utero transfer to major perinatal centres. After discharge there are more therapeutic resources and better educational and behavioural care available. For these reasons we should be careful using historical data when considering children born in the present, and the future.

7. Because of these continuing improvements in survival, CMF believes Parliament should review the 24-week upper time limit.

Definition of 'serious abnormality'

8. The Act provides for abortion to term if 'there is a substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped'. There is no definition of 'abnormalities' and Parliament has signalled its general concern about outcome in the expression 'seriously handicapped'. This is not defined either, and definitions have never come before the courts. The BMA[264] and the Royal College of Obstetricians and Gynaecologists[265] have issued guidance on factors that should influence individual decisions, including the probability of effective treatment, future ability to communicate, the probable degree of dependence on others, and the likely suffering of the child or their carers.

9. While we dispute the unnecessarily negative views of disability and dependence implicit in parts of this guidance, in practice we are concerned with the failure of the medical profession to regulate itself in this area. In 2001 a 28 week foetus was aborted for bilateral cleft lip and palate. There was public outrage. The Crown Prosecution Service declined to prosecute the two doctors involved, satisfied they had decided in good faith that the child, if born, would be seriously handicapped[266]. Other minor abnormalities also

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[262] Hoekstra RE *et al*. Survival and long-term neurodevelopmental outcome of extremely premature infants born at 23-26 weeks gestational age at a tertiary centre. *Pediatrics.* 2004; 113: e1-e6

[263] Riley K *et al*. Changes in survival and neurodevelopmental outcome in 22 to 25 weeks gestation infants over a 20 year period (abstract). *European Society for Pediatric Research, Annual Scientific Meeting.* 2004

[264] British Medical Association Ethics Department. Medical Ethics Today. The BMA's handbook of ethics and law. 2nd ed. BMJ Books. 2004: 242-3

[265] Royal College of Obstetricians and Gynaecologists. Termination of pregnancy for fetal abnormality in England, Wales and Scotland. RCOG Press. 1996: para 3.3.3

[266] Dyer C. Doctors who performed late abortion will not be prosecuted. *BMJ* 2005; 330:688

reported to have resulted in termination include webbed fingers and extra digits[267]. Improvements in in-utero surgery, neonatal intensive care, paediatric medicine and surgery, and educational care and community support mean that many abnormalities are now far less significant in the degree of handicap they cause. These developments mean that Parliament should review the whole question of abortion for foetal abnormality. Rigorous definitions would aid that process.

10. CMF supports the disability lobby's view that the upper limit for abortion for disabled babies should not be higher than that for able-bodied babies.

Medical, scientific and social research relevant to the impact of suggested law reforms on first trimester abortions

Demography

11. More than one in five of all pregnancies in England ends in abortion[268]. This contributes significantly to the fact that total fertility rates are now well below the rate needed for population replacement. Together with an increase in longevity, this decline in the birth rate with consequent reduction in the numbers of those of working age strains the funding of pensions and National Insurance, and at current rates the problem will worsen.

12. CMF is opposed to any change in the law to facilitate first trimester abortions believing this would lead to an increase in the total number of abortions. Should such considerations take place in Parliament, we urge that the medium and long term demographic implications are taken into account.

The relative risks of early abortion versus pregnancy and delivery

13. The RCOG maintains that at any gestation the risks to a mother of induced abortion are lower than continuing the pregnancy to term.[269] Many doctors therefore interpret the Act so that any woman requesting an abortion is offered one because continuing the pregnancy would pose a 'greater risk to her physical and mental health, than if she had an abortion'.

14. This claim, based on the Confidential Enquiry into Maternal Deaths[270], is questionable because of under-reporting of late deaths, the deliberate hiding by women of previous abortion, and reluctance by some health professionals to explore possible previous history of abortion.

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[267] http://www.timesonline.co.uk/tol/news/uk/article669212.ece

[268] Birth statistics published annually by ONS, Office for National Statistics. Abortion statistics published annually by ONS and from 2002 by the Department of Health for England & Wales

[269] The care of women requesting induced abortion. RCOG, September 2004:29

[270] Why mothers die, 2000-2002. The Sixth Report of the Confidential Enquiries into Maternal Deaths in the UK. Chapter 1

15. 'Linkage studies' are more reliable. These identify women of child-bearing age who have died and then explore their medical history from records. Two such studies have been published. The Finnish study[271] collected national data on all women who died between 1987 and 1994 for one year after abortion or delivery. Researchers found that compared to women who delivered, those who had an abortion had increased mortality – from both natural and unnatural causes. The 'age-adjusted odds ratio' is the number of times more likely that a woman of a certain age after an abortion dies in a particular way than if she kept her baby. Odds ratios were 1.63 for deaths from natural causes, 4.24 for deaths from accidents, 6.46 for deaths from suicide, and 13.97 for deaths from homicide. Relevant to the question of facilitating first trimester abortion, the suicide rate was independent of the gestation of abortion[272]. Avoiding late abortions would therefore not affect the raised mortality from suicide.

16. The Californian study confirmed the increased mortality associated with abortion, with broadly comparable findings[273]. Whether these findings are causally or independently associated with abortion is considered in Paragraph 30ff.

17. CMF holds that mortality and morbidity following abortion, especially for psychiatric reasons, are higher than currently recognised. Much of this mortality is causally related to the abortion and occurs regardless of the gestation at which abortion is performed. The RCOG should update its guidance, women should be counselled accordingly, and psychiatric indications for abortion should be removed.

The role played by the requirement for two doctors' signatures

18. It is suggested the law be changed to allow what would effectively be 'abortion on demand' in the first trimester, with the signature of only one doctor, as per a consent form for any other operation. The recent discussion has been entirely about practice, with claims that the current requirement is unnecessarily obstructive and has caused potentially dangerous delays.

19. However, the requirement for two signatures is a medico-legal one which reflects Parliament's recognition in 1967 (not altered in 1990) that any doctor facing a woman requesting abortion has two patients to consider, and that it is being proposed intentionally to end the life of the more vulnerable one. The Act never made abortion legal; it conferred upon doctors a possible defence against illegality. In the requirement for two signatures, and as with cremation certificates, the two doctors are expected to 'police' each other. Properly performed, there would be the incidental benefit of two opportunities for counselling.

20. That the profession at large has failed in this, and that the process has often become a sham, is not a reason for removing this provision from law.

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[271] Gissler M *et al*. Pregnancy associated deaths in Finland 1987-1994. *Acta Obstetrica et Gynecologica Scandinavica*. 1997; 76:651-657

[272] Gissler M. Personal communication to Drs Mark Houghton and Chris Richards. Data available from author

[273] Reardon DC *et al*. Deaths associated with pregnancy outcome: a record linkage study of low income women. *Southern Medical Journal*. 2002; 95: 834-841

The practicalities and safety of nurse/midwife abortions

21. The proposal that nurses or midwives should carry out abortions, and that the second stage of early medical abortions could occur in patients' homes is essentially a discussion about the safety of the medical abortion regime, using two drugs, mifepristone (RU-486) and a prostaglandin, usually misoprostol.

22. Medical abortion is not as safe as commonly assumed and it is not always effective. Failed and incomplete abortions require surgery. In trials, almost all women using mifepristone for medical abortions experienced abdominal pain or uterine cramping; and a significant number experienced nausea, vomiting, diarrhoea. Vaginal bleeding or spotting lasts on average 9-16 days, while up to 8% of patients bleed for 30 days or more. Pelvic inflammatory disease occurs in about 1%[274]. In a recent review[275], complications involving hospitalisation were more than twice as likely following medical abortions than surgical ones: 1.5% after medical abortion as opposed to 0.6%.

23. By early 2006, there had been at least six deaths in North America as a result of taking mifepristone plus misoprostol. Four US fatalities and the Canadian one resulted from infections with Clostridium sordellii causing endometritis and toxic shock syndrome[276] [277]. In the UK, there have been two possible deaths following medical abortion[278]. All the women who died were young and previously healthy.

24. Abortion whether surgical or medical always has potential risks to the woman. CMF agrees with the BMA that there should be no extensions of current practice.

Evidence of long-term or acute adverse health outcomes from abortion or from the restriction of access to abortion

Acute complications

25. The RCOG lists the major acute complications of surgical abortion as haemorrhage, uterine perforation and rupture, cervical trauma, failed abortion, and post-abortion infection[279]. These usually present obviously, are generally short term, and are successfully managed by gynaecologists. Of more concern are the following three long term complications, which generally involve paediatricians, psychiatrists, and surgeons and oncologists.

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[274] FDA-approved Data Sheet on Mifepristone (Mifeprex, Danco Laboratories), July 2005; www.fda.gov/cder/foi/label/2004/020687lbl_Revised.pdf

[275] Goodyear-Smith F. First trimester medical termination of pregnancy: an alternative for New Zealand women. *Aust N Z J Obstet Gynaecol*. 2006; 46(3):193-8

[276] Fischer M *et al*. Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion. *N Engl J Med*. 2005; 353:2352-60

[277] Sinave C *et al*. Toxic shock syndrome due to Clostridium sordellii: a dramatic postpartum and postabortion disease. *Clin Infect Dis*. 2002; 35:1441-3

[278] Ms Rosie Winterton, House of Commons *Hansard*; 28 April 2004

[279] The Care of Women Requesting Induced Abortion: RCOG Evidence Based Guideline Number 7. September 2004. Recommendations 16:1-6

Subsequent pre-term delivery

26. There have been many reputable studies investigating the association between abortion and pre-term delivery. Thorp et al's detailed 2003 review analysed results for 24 published studies[280] and reported that 12 found a positive association with increased risk ratios which were consistently between 1.3 and 2.0. Seven published studies found a dose-response effect: the risk estimate increased with increasing numbers of induced abortions.

27. Rooney and Calhoun's 2003 review[281] showed at least 49 studies had demonstrated a statistically significant increased risk of premature birth or low birth weight following an induced abortion. Again most studies showed a dose response relationship. Only eight failed to show an increased risk of preterm delivery, and none demonstrated any protective effect of previous abortion.

28. This association, further supported by two more recent European studies (EPIPAGE[282] and EUROPOP[283]), is significant for health outcomes in subsequent pregnancies and for their economic costs. Extremely preterm delivery is associated with high risk of neonatal death and of permanent brain damage causing long term disability. Approximately 50% of all abortions in England and Wales are undertaken in women under 25, whereas 75% of all live births occur to mothers aged over 25[284]. Thus most women considering abortion will subsequently deliver one or more live children, who will face these risks. Women should be adequately counselled about abortion and subsequent pregnancies.

29. Appreciation of this association is a recent development, and must be given full consideration should Parliament review abortion law.

Psychological and psychiatric consequences

30. Until recently, any association between abortion and mental health problems was effectively dismissed not as causal, but as incidental due to other confounders. But since 2000, there has been much evidence from robust and methodologically sound controlled studies that abortion does cause the following:

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[280] Thorp JM *et al*. Long-term physical and psychological health consequences of induced abortion: review of the evidence. *Obstetrics Gynecology Survey*. 2003; 58: 67-69

[281] Rooney B, Calhoun BC. Induced abortion and risk of later premature births. *Journal of American Physicians & Surgeons*. 2003; 8: 46-49

[282] Moreau C *et al*. Previous induced abortion and the risk of very preterm delivery: results of the EPIPAGE study. *BJOG*. 2005; 112: 430-437

[283] Ancel PY *et al*. History of induced abortion as a risk factor for preterm birth in European countries: results of the EUROPOP survey. *Human Reproduction*. 2004; 19: 734 – 740

[284] Birth Statistics 2005, Office for National Statistics, London

31. Increased psychiatric hospitalisation (admission rates were higher post-abortion than post-partum when those with a prior psychiatric history were excluded[285]); **increased psychiatric outpatient attendance** (outpatient funding claims were higher in the post-abortion group when prior psychological problems were controlled[286]); **increased substance abuse during subsequent pregnancies carried to term** (women who had aborted were significantly more likely to abuse cannabis, other illicit drugs and alcohol during a subsequent pregnancy[287]); **increased death rates from injury, suicide, and homicide** (a controlled study in Finland 1987-2000[288]); and perhaps most relevant for UK comparison, a landmark 2006 New Zealand controlled population study[289] showed **higher rates not due to prior vulnerability of major depression, suicidal ideation, illicit drug dependence, and overall mental health problems.**

32. There is also qualitative evidence from women's accounts, but quantitative evidence that abortion causes significant rates of serious mental health problems is now so overwhelming that the American Psychological Association has removed its guidance and is reviewing it. CMF calls on the Royal College of Psychiatrists and the RCOG urgently to do likewise.

A possible link with breast cancer

33. Breast cancer rates have been rising in Europe and North America for several decades and are projected to rise further[290]. There is evidence suggesting that having an abortion may increase a woman's risk of breast cancer in later life.[291] A 1997 review that pooled 23 studies found that the risk increased by 30%[292] but authors of a 2001 review have denied a link[293]. There are clearly powerful vested interests on both sides of this debate and space precludes an in-depth review. However, it is undisputed that a full term pregnancy protects against subsequent breast cancer, and that significantly pre-term deliveries make it more likely. The link is therefore biologically plausible.

34. CMF believes that it is prudent to acknowledge that 'the jury is out', advocates further research to conclude the debate, and in the interests of informed consent believes

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[285] Reardon DC *et al*. *Canadian Medical Association Journal*. 2003; 168 (10): 1253-6

[286] Coleman PK *et al*. *American Journal Orthopsychiatry*. 2002; 72,1: 141-152

[287] Coleman PK *et al*. *American Journal of Obstetrics and Gynaecology*. 2002; 187,6: 1673-1678

[288] Gissler M *et al*. *European Journal of Public Health*. 2005; 15, 5: 459-463

[289] Fergusson D *et al*. *Journal of Child Psychology and Psychiatry*. 2006; 47(1): 16-24

[290] Carroll P. *Abortion and other pregnancy related risk factors in female breast cancer.* London: Pensions and Population Research Institute. 2001

[291] Gardner G. Abortion and breast cancer - Is there a link? *Triple Helix*. 2003; Winter: 4-5

[292] Brind J *et al*. Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis. *J. Epidemiology and Community Health*. 1997; 50:465-467

[293] Davidson T. Abortion and breast cancer: a hard decision made harder. *Lancet Oncology*. 2001; 2 (Dec):756-758

every woman considering abortion should be offered as much information about the possible risks as she wishes.

Conclusion

35. CMF is grateful for this opportunity to express its concerns about the recently realised risks to women of induced abortion. We have confined ourselves to scientific developments, but cannot end without a reminder that abortion is always a procedure with a 50% mortality. The ethical debate cannot be avoided. We wish the Committee well in their deliberations and would like to give oral evidence.

September 2007