Memorandum 6

Submission from ProLife Alliance (PLA)

1 Introduction

1.1 The ProLife Alliance (PLA) was established in 1997 with the aim of securing the right to life of all human beings from conception to natural death.

1.2 PLA takes this opportunity to submit to the Science and Technology Committee's current inquiry in relationship to the Abortion Act 1967, but we consider lamentable the Committee's decision to exclude from the discussion the ethical and moral aspects of abortion. Abortion will always be a matter of serious moral concern and whilst we welcome the decision to revisit the Act, such an exercise cannot be relegated simply to an assessment of scientific developments.

2 Fetal viability

2.1 The ProLife Alliance will always be opposed to intentional abortion and therefore any arguments based on time limits and viability cannot be logically justified. We understand nevertheless that it is more difficult for society to accept abortion at a stage when the baby is capable of living outside the womb, and whilst never deviating from our absolute defence of the unborn child, we are prepared to make some observations in relationship to fetal viability.

2.2 The current 24-week upper time limit was set in 1990 following Parliamentary debate on the gestational age at which a fetus was considered viable at the time. We acknowledge that neonatal medicine has progressed since then and premature babies are capable of surviving below that time limit. At the very least one would expect consensus in the country against the abortion of a viable baby, with the benefit of the doubt always on the side of the baby.

2.3 Defining fetal viability is a complex task dependent upon a number of factors, including of course age. Even with today's sophisticated diagnostic tools we still cannot be 100% accurate in assessing gestational age, with significant margins of error acknowledged as many studies have highlighted.

"Beyond 20 weeks, accuracy of ultrasonic gestational age assessment is limited to +/- 10-14 days. A fetus deemed to be 22+ weeks might therefore be more mature than expected and viable." (Clarke et al)[20]

2.4 It is claimed by the pro-choice lobby that younger women need late abortions either because they do not realize that they are pregnant until late in pregnancy or because they are afraid to acknowledge their pregnancy. It should be noted that it is increasingly difficult to accurately measure gestation when women present late in pregnancy.

2.5 There have, without doubt, been major medical advances over the past seventeen years in relation to the care of premature babies. This means that we now have a situation where babies of similar gestational age do not have equal rights, such rights depending on whether the baby is wanted or unwanted. Fetal surgery in utero will be performed on wanted babies and they will receive intensive neonatal care at birth, while the baby of similar gestational age but destined for abortion will be subjected to feticide, and should it subsequently survive the abortion will be left to die without intervention.

3 Abortion Survival

3.1 Abortions continue to be performed at a stage in pregnancy when babies are capable of being born alive. Statistics show that in 2006, 3,292 babies were aborted after 20 weeks in England, Wales and Scotland:

England and Wales residents	- 2,948[21]
England and Wales non-residents	- 296[22]
Scotland	- 48[23]

[20] An infant who survived abortion and neonatal intensive care, P. Clarke, J. Smith, T. Kelly and M. J Robinson, Obstetric Case Reports DOI: 10.1080/01443610400025945
[21] Department of Health Statistical Bulletin, Abortion Statistics, England and Wales: 2006
[22] Department of Health Statistical Bulletin, Abortion Statistics, England and Wales: 2006
[23] Scottish Health Statistics 2006, NHS National Services Scotland, ISD Scotland

3.2 There is increasing evidence of babies born alive after abortion within this gestational range. A paper published by a Neonatal Intensive Care team at Hope Hospital, Salford[24] detailed the failed abortion of a male infant at a bpas clinic. The mother had been admitted to the clinic on a Thursday at 23+1 weeks' gestation.

"Following removal of 200 ml of amniotic fluid, she underwent intra-amniotic injection of 80 g of urea. An intravenous oxytocin infusion continued over a 36-hour period. On Friday she was given a course of 5 x 1 mg gemeprost (a prostaglandin E1 analogue) pessaries. On Saturday she was given misoprostol (also a prostaglandin E1 analogue) 800 μg vaginally, then 1.6 mg orally over 12 hours. On Sunday following an ultrasound scan she was informed that the fetus was dead. Because labour had not been induced she was discharged home on antibiotics, with re-admission scheduled for 4 days later.

During the 3-hour train journey home she felt fetal movements for the first time, and changed her mind about the abortion. That afternoon she developed abdominal pains and was admitted to hospital in early labour. She was counselled about the poor prognosis for her infant, but requested that resuscitation be attempted. She received dexamethasone and nifedipine. Four days later at 24+1 weeks' gestation her son was delivered as a vaginal breech weighing 690 g." (Clarke et al)

3.3 This infant survived three abortion attempts and premature delivery. He eventually went home with his mother at seven months.

3.4 In the previous case the abortion was not performed for fetal anomaly, but survival is being recorded after abortion for disability as well.

3.5 A paper published in May 2007 in BJOG: an International Journal of Obstetrics

[24] An infant who survived abortion and neonatal intensive care, P. Clarke, J. Smith, T. Kelly and M. J Robinson, Obstetric Case Reports DOI: 10.1080/01443610400025945

and Gynaecology[25] presents data on termination of pregnancy for fetal anomaly from a large population-based cohort of births occurring within a 10-year period from 1995 to 2004 in the West Midlands region of the UK. The authors found that out of a total of 3,189 cases of termination for fetal anomaly, 102 (3.2%) babies were born alive.

3.6 These live births following abortion for fetal anomaly occurred in 18 out of the 20 maternity units in the West Midlands, and the proportions at different gestations are as follows:

14.7% between 16 and 20 weeks
65.7% between 20 and 24 weeks
19.6% at or after 24 weeks

3.7 Although the authors noted a reduction in the number of live births from 1995 to 2004, in particular those of 22-23 weeks gestation (which they attribute to the RCOG recommendation that feticide should be offered after 22 weeks), their data shows that there is still a significant chance of live birth at 20 and 21 weeks (3.5% and 5.4% respectively).

3.8 In April 2007 the Confidential Enquiry into Maternal and Child Health (CEMACH) launched their report, *Perinatal Mortality 2005,*[26] detailing stillbirths and neonatal deaths in 2005. The report indicates that, in 2005 alone, 66 babies were born alive after abortion but subsequently died. The report does not include data relating to aborted babies who were born alive but did not die.

3.9 The evidence in relationship to numbers of babies born alive following abortion is already deeply disturbing but the figures are likely to be even higher according to experts in neonatal medicine, due to the ad hoc nature of recording such data. Consultant Neonatalogist, Paul Clarke, points out that,

[25] Termination of pregnancy for fetal anomaly: a population-based study 1995 to 2004, M. P. Wyldes, A. M. Tonks, DOI: 10.1111/j.1471-0528.2007.01279.x
[26] Confidential Enquiry into Maternal and Child Health, Perinatal Mortality 2005, April 2007 England, Wales and Northern Ireland

"The number of infants born alive following procured abortion in the UK is unknown; this information is not collected by the Department of Health in its detailed annual abortion statistics. There is no existing official mechanism by which to report such cases, and no apparent statutory requirement to do so."[27]

4 Definition of serious abnormality

4.1 Abortion on the grounds of disability, serious or otherwise, is particularly abhorrent and is a eugenic practice totally at odds with other legislation in this field. The UK legislates in favour of equality between disabled and non-disabled persons at all levels except in respect of the pre-born disabled. The healthy fetus receives the protection of the law from 24-weeks' gestation whilst the fetus suspected of having an impairment can be aborted up to birth.

4.2 Any attempt to define disability into lists of 'serious' and 'not serious' for whatever purpose must be resisted, but it is always worth noting how arbitrary such lists are likely to be anyway. With abortions taking place for cleft palate and clubfoot, the interpretation is clearly highly subjective.

4.3 The PLA is totally opposed in principle to defining disability in order to determine who should live and who should die. We would on this occasion, however, like to draw the Committee's attention to a subsidiary concern, namely the high level of diagnostic inaccuracy in this field

4.4 A cohort study[28] undertaken in 2003, analysing a period between 1991-2002, showed that the diagnostic technologies most frequently used to detect fetal anomaly for the purpose of abortion were ultrasound scan in 152 (49%) of the cases, abnormal karyotype (chorionic villus sampling, fetal blood, amniocentesis) in 141 (46%) of the cases or molecular tests of DNA in 16 (5%) of the cases.

[27] An infant who survived abortion and neonatal intensive care, P. Clarke, J. Smith, T. Kelly and M. J Robinson, Obstetric Case Reports DOI: 10.1080/01443610400025945

[28] Autopsy after termination of pregnancy for fetal anomaly: retrospective cohort study, P. A. Boyd, F. Tondi, N. R. Hicks, P. F. Chamberlain, BMJ doi:10.1136/bmj.37939.570104.EE (published 8 December 2003)

4.5 From autopsy results each aborted unborn baby was then grouped by the lethality or degree of lethality of the anomaly found to be present and then placed into one of the following categories: Lethal Anomaly, Possibly Lethal Anomaly or Possible Survivor (compatible with survival beyond one year).

4.6 It was found that in only 55% of the unborn babies was the prenatal diagnosis identical to the postnatal autopsy diagnosis. As diagnosis frequently depends on the skill of the ultrasonographer, it is obvious that less capable practitioners will have higher levels of misdiagnosis.

4.7 Inadequate ultrasound skill is not the only concern. Some tests are more invasive and the test can itself cause the death of the baby in utero. The Downs Syndrome Association advises that both chorionic villus sampling and amniocentesis carry a 1-2% chance of miscarriage.

5 Early abortion versus pregnancy and delivery

5.1 The PLA can see no logic in the Committee's decision to compare the relative risks of early abortion against pregnancy and delivery. Arguments are often put forward that in developing countries it is riskier to have a baby than an abortion, and this rationale is used to justify the wholesale provision of abortion in the relevant countries. Severe poverty and inadequate health services are the real causes of maternal risk in such countries and addressing those causes would change the whole perspective of maternal health. It is facile and unworthy of an affluent society such as the UK to attempt to draw conclusions from such comparisons.

6 Medical Consequences of Abortion

6.1 Where it would certainly be appropriate to draw parallels between abortion and pregnancy is in relationship to the effect of abortion on subsequent pregnancies, particularly when multiple abortions are involved. Researchers have found that induced abortion increases the risk of premature birth, miscarriage and ectopic pregnancy in subsequent pregnancies.

6.2 A French study[29] to evaluate the risk of very preterm birth (22-32 weeks gestation) associated with previous induced abortion found that,

"Previous induced abortion was associated with an increased risk of very preterm delivery. The strength of the association increased with decreasing gestational age."

6.3 A list of fifty-nine studies on the link between abortion and premature birth is attached in appendix 1 (not printed), and we feel the Committee should consider this issue very seriously.

7. Psychological Consequences of Abortion

7.1 Numerous studies document the link between abortion and subsequent mental health problems. One of the most recent is a 25-year longitudinal study to examine the extent to which abortion has harmful consequences. The researchers found that those who had an abortion had,

"*elevated rates of subsequent mental health problems including depression, anxiety, suicidal behaviours and substance use disorders."*[30]

[29] Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study, BJOG: an International Journal of Obstetrics and Gynaecology, C. Moreau, M. Kaminski, P. Y. Ancel, J. Bouyer, B. Escande, G. Thiriez, P. Boulot, J. Fresson, C. Arnaud, D, Subtil, L. Marpeau, J. C. Roze, F. Maillard, B. Larroque, EPIPAGE Group, DOI: 10.1111/j.1471-0528.2004.00478.x

[30] Abortion in young women and subsequent mental health, D. M. Fergusson, L. J. Horwood, E. M. Ridder, Journal of Child Psychology and Psychiatry 47:1 (2006), pp 16–24 doi:10.1111/j.1469-7610.2005.01538.x

7.2 A list of eight other published papers on the psychological effects of abortion are attached in appendix 2 (not printed).

8. Suicide Associated with Abortion

8.1 The authors of a study conducted in Finland[31] examining suicide after pregnancy found that the incidence of suicide after abortion was almost six times higher than after birth.

"The mean annual suicide rate was 11.3 per 100 000. The suicide rate associated with birth was significantly lower (5.9) and the rates associated with miscarriage (18.1) and induced abortion (34.7) were significantly higher than in the population."

8.2 They concluded that,

"The increased risk of suicide after an induced abortion indicates either common risk factors for both or harmful effects of induced abortion on mental health."

9. Two doctors, nurses and abortion at home

9.1 The provision for two doctors to sign the abortion referral form was introduced with the 1967 Act as a safeguard both for the best interests of the woman herself, but also for the baby. Current practice indicates that doctors are signing these forms without even seeing the patient at all. The continual huge increase in annual abortion figures (from some 50,000 initially to over 200,000 in 2006 and growing) indicates that doctors are not fulfilling their intended role, but simply rubber-stamping requests. In the light of our previous comments regarding the medical and psychological effects of abortion, we feel that the

[31] Suicides after pregnancy in Finland, 1987-94: register linkage study, M. Gissler, E. Hemminki, J. Lonnqvist, *BMJ* 1996; 313:1431-1434 (7 December)

signature of a doctor who has not even seen the patient should not be accepted as meeting the legal requirement for a second signature.

9.2 The proposal to allow abortion to be performed by nurses is simply a pragmatic response to concerns expressed by the RCOG and others at the increasing shortage of medical students who are willing to train in termination of pregnancy. We should be asking serious questions as to why so many doctors are opting out of abortion. Is it perhaps because of the very moral and ethical grounds that the Committee has chosen to exclude from its focus? Why would nurses be more willing? The medical and psychological sequelae are simply likely to increase were such a recommendation to be adopted.

9.3 In relationship to abortions at home, these would be performed by medical rather than surgical means. The PLA is concerned about the possible psychological impact of such abortions, when expulsion of the fetus takes place at home and the mother is required to check that the process is completed. One cannot imagine the psychological effects of this harrowing experience. The RCOG itself acknowledges that medical complications can arise with the abortion pill[32] and one has to question whether nurses would be able to deal with these. Usage of the abortion pill has already increased hugely and greater implementation of medical abortions is likely to lead to even further incidences of medical and psychological sequelae.

10 Long-term or acute adverse health outcomes from abortion or from the restriction of access to abortion

10.1 Long-term or acute adverse health outcomes from abortion are detailed extensively in sections 6 & 7.

10.2 With UK abortion figures the highest they have ever been, and surpassing the majority of countries in Western Europe, it is difficult to argue that there is

[32] Maggie Blott of the RCOG quoted on BBC Online, 28th November 2006, http://news.bbc.co.uk/1/hi/health/6188890.stm

restriction of access to abortion.[33] It is always worth remembering that the Abortion Act 1967 was never intended to give an unfettered right to abortion, but rather to make it no longer a criminal act if it could be shown to be necessary under certain conditions. The negotiation of those conditions was to be determined by scrupulous assessment.

10.3 In 2006 there were 214,254 abortions in England, Wales and Scotland, 89% of which were carried out under 13 weeks gestation (68% under 10 weeks gestation). 97% of these abortions were performed under ground C of the Abortion Act, which states 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."

10.4 It is absolutely impossible to accept that such a large number of abortions under ground C conform to the terms of the Abortion Act.

10.5 If patients are not being refused on strictly medical grounds, what about issues of conscience. It is equally difficult to sustain that patients are being denied access to abortion for this reason. The RCOG publication, *About abortion care: what you need to know,*[34] answers the question,

"Can my doctor refuse to give me an abortion?"

as follows:

"A doctor or nurse has the right to refuse to take part in abortion on the grounds of conscience, but he or she should always refer you to another doctor or nurse who will

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[33] Abortions reach highest ever number in England and Wales, BMJ Allison Barrett, BMJ 2005;331:310 (6 August), doi:10.1136/bmj.331.7512.310-f

[34] About abortion care: what you need to know, Royal College of Obstetricians and Gynaecologists, published September 2004 by the RCOG

help. The General Medical Council's Duties of a Doctor says that doctors must make sure that their "personal beliefs do not prejudice patient care". The Nursing and Midwifery Council's Code of Conduct provides similar guidance to nurses."

10.6 Further statements from the RCOG confirm the actual state of play in the UK, which is born out by the high rates of abortion we are registering:

"Most doctors feel that the distress of having to continue with an unwanted pregnancy is likely to be harmful and so will refer a woman for an abortion."[35]

10.7 This position is shared by NHS Direct information, which details the grounds under which abortion is permitted but then goes on to say,

"In practice, this gives doctors a great degree of flexibility in referring women for abortions."[36]

11 Conclusion

The PLA maintains its absolute opposition to abortion. We urge the Government to commit itself to genuine attempts to reduce the abortions taking place in the UK. Abortion is now virtually on demand in this country, has caused the tragic loss of 6.6 million unborn lives since 1967, with annual figures continually on the rise. It is impacting negatively on the medical and psychological health of women. Abortion on the grounds of fetal abnormality makes a complete mockery of our commitment to disability rights.

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[35] ibid.
[36] NHS Direct, Health encyclopaedia, Abortion, Why is it necessary? http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1&sectionId=37