

## Letters to the editor

Caesarean section and the competent pregnant women to have abortions. While the two scenarios may appear similar, they are in fact very different and different rules apply. While a competent pregnant woman can always expect to have her refusal of the offer of a Caesarean section respected, a competent pregnant woman cannot at all times expect to have her request for a termination of pregnancy to be honoured.

The abortion law as it stands now is robust enough and does not need any amendments. The delivery of abortion services may be poor in some areas. The solution in such areas is to implement guidelines published by the Royal College of Obstetricians and Gynaecologists (RCOG),<sup>8</sup> which should ensure a high-quality service nationwide, rather than seek to amend the Abortion Act.

Abortion is an emotive issue for all concerned. We should direct our energies towards reducing the numbers of women seeking abortions by implementing the NICE guidelines on LARC nationwide. This approach will yield better results than an amendment of the Abortion Act.

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## Reply

Umo Esen is right to argue that the Abortion Act 1967 was 'well crafted', and my earlier article concurred that it has "served women, and their families reasonably well".<sup>1</sup> It is also true that a liberal interpretation of the law has enabled safe, legal abortion services to develop far more effectively in Britain than in many other countries with legislation that appears less restrictive. However, it is complacent to conclude that a review of the law is not needed and wrong to assert that it does not require change.

There are several areas where the law impedes good clinical practice.

The Royal College of Obstetricians and Gynaecologists guidelines state that women should be able to access a termination as early as possible, because the earlier in pregnancy an

abortion is performed, the lower the risk of complications. Ideally, the guidelines state, the abortion should be able to take place within 7 days of the decision being agreed and with a minimum standard of the procedure within 2 weeks.<sup>2</sup> The legal requirement that two registered medical practitioners certify that a woman meets the legal grounds for abortion frustrates this by creating the potential for unnecessary delay.

Despite an acknowledged shortage of doctors willing to carry out abortions,<sup>3</sup> nurses and midwives are prevented from carrying out procedures, such as manual vacuum aspiration, which are performed by colleagues with equivalent qualifications in other countries, because the Abortion Act specifies that abortion is only lawful when carried out by a "registered medical practitioner", which is interpreted as a General Medical Council registered doctor only. This remains the view of the Department of Health despite challenges that the law could be interpreted differently.<sup>4</sup>

Women undergoing early medical abortion with mifepristone and misoprostol are required to make additional, unnecessary clinic visits because both medications are regarded as abortifacient and so must be administered in a hospital or licensed premises. In other countries, such as the USA, it is possible for women to administer the misoprostol herself at home, thus reducing the cost and inconvenience of the procedure.<sup>5</sup>

Doctors' ability to interpret statutory ground C (section 1(1)(a)) of the Act liberally to allow the abortion of unwanted pregnancies has allowed the law to meet the needs of modern society. But, this openness to interpretation means that women can never be confident that their abortion request will be viewed sympathetically. Often, women feel they need to exaggerate their distress and to pretend that they will be psychologically damaged by their pregnancy, while their doctors pretend to believe them. This is a charade that demeans them both.

Women living in Northern Ireland suffer the additional burden of being required to travel to Britain for treatment as this part of the UK is excluded from the provisions of the existing Abortion Act.

It would be far better to have a law that specifically allows a woman to end a pregnancy that is unwanted without further justification, and permits abortions to be carried out by persons, and in premises, that are able to provide adequate care and support. In short, abortion should be available to women who request it, and regulated by the same principles and standards as other clinical procedures.

We can all agree that it would be better if unwanted pregnancies were prevented, and that increased use of long-acting reversible methods of contraception may contribute to this end. However, these methods are not suitable for, or acceptable to, all women. The rising number of abortions demonstrates that abortion is necessary as a backup to other methods of birth control, and this is likely to remain the case in a society that has a liberal attitude to sexual activity and values planned parenthood. Our experience is that the

social stigma of abortion is lessening in pragmatic response to this.

My earlier commentary argued that women, and their doctors, deserve "a flexible, fit-for-purpose law accepting that restrictions on abortion should be solely to protect health". The current review of the medical and scientific aspects of abortion by the House of Commons Science and Technology Select Committee and the forthcoming discussion of the Human Tissue and Embryos (draft) Bill provide an opportunity for Members of Parliament to align our abortion law with modern thinking.

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## Remember 1967? We do...

I read the comment from the Journal's Consumer Correspondent in the July issue with great interest. I was 2 years old when the Abortion Act was passed and I have been actively pro-choice since I was 14 years old. It's very interesting to note that the respondents to Ms Quilliam's questions have changed their views so much in the intervening 40 years.<sup>1</sup> During that time it seems we have lost the ability to remember women dying from unsafe and illegal abortions in the UK, so the necessity for the law seems less urgent. As Quilliam notes, there still needs to be much better access to sex education and contraceptive services, particularly for young people. The fact the UK leads Europe in teenage pregnancies suggests that young women are not all turning to abortion as the solution to their unplanned pregnancies. Unfortunately, young people are amongst the most anti-choice because they have unrealistic expectations of parenthood. If frank information about sexual health and family planning could be better promoted for young people we could start to genuinely turn this situation around.

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## LETTERS TO THE EDITOR

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