The barrier to abortion is politics

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TWO STATEMENTS BY 100 USA PROFESSORS

In 1972, 100 American professors of obstetrics published a statement setting out the benefits they believed legalised abortion could deliver for their nation and for its women.[1] Forty years later, the next generation of professors have weighed their colleagues' expectations against their own professional experience, and state: "We have had 40 years of medical progress but have witnessed political regression that the 100 professors did not anticipate".[2]

The 100 American professors writing today document a barrage of policy and legal assaults that have impeded the development of the abortion services that their mentors strived to achieve. Abortion *per se*, they conclude, is no cause for clinical concern – but political opposition to abortion is. Conservative resistance to abortion has, according to the authors of the statement[2] published in the *American Journal of Obstetrics & Gynecology* and reprinted in *Contraception*, brought threats to: the autonomy of the doctor-patient relationship; evidence-based medical practice; the training of students and residents; and, ultimately, the health of patients.

In short, insofar as abortion is a problem today, it is a matter of its politics, not its practice.

ADVANCES IN TECHNOLOGY

Today's obstetrics and gynaecology professors know, as a matter of proven fact, that high-quality, affordable, acceptable abortion services *can* be developed and that they bring social and personal benefits. Their concern is whether such services *may* be developed. When it comes to abortion, the question is: will governments *allow* doctors to do their best for patients?

The tremendous advances in reproductive health during the past 40 years are indisputable. In most countries in the developed North, women are better able to prevent pregnancy with a wider choice of more effective contraceptive methods. If abortion is necessary, in early pregnancy mifepristone and misoprostol provide an experience of early abortion that is similar to a 'spontaneous miscarriage' and in later pregnancy allow a much improved, and safer, experience of medical induction. Manual vacuum aspiration equipment provides low-cost treatment in low-technology settings, while improved anaesthesia allows conscious sedation and has lessened the risks when a general anaesthetic is required. Early abortions can now be provided in settings equivalent to doctors' offices. Second-trimester abortions seldom require an overnight stay.

USA POLITICAL PRESSURES

But while technology has progressed, the political discourse has regressed. In the 1960s and 1970s, medical developments took place in the context of the social reforms and more liberal attitudes that have come to be regarded as characteristic of the 'permissive society'. Today, social and political views are more muddled, and seem more concerned with restriction than permission. Doctors in both the USA and the UK practise in an environment where they must balance pressure to perform evidence-based medicine with pressure to conform to a social consensus that still sees abortion as a 'problem', regardless of clinical evidence.

Abortion doctors exist in a difficult and contradictory space because abortion straddles two worlds – medicine and politics – and so is contested like no other safe and legal procedure that a doctor undertakes.

Today's American professors describe how, in 2011 alone, 24 states passed 92 restrictions on abortion.[3] Waiting periods after consent are now law in 26 states, despite medical evidence that the few clinical risks of abortion increase with increasing gestation. Eight states require patients to view ultrasound images, and four require them to listen to fetal heartbeats. Laws in 27 states force doctors to provide "deceptive counseling including false statements about the risks of breast cancer, infertility and mental health"; some "include laws to limit second-trimester abortion under the guise of protecting the

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fetus from pain".[4] In Arizona, Kansas and Texas, laws prohibit abortion training in public institutions, and "another seven states ban abortion in public hospitals, precluding training in them".[5] All of this has taken place without challenge to the ruling on the Constitutional right to privacy, enshrined in the landmark 1973 Supreme Court decision in *Roe v Wade*, which provided women (conditional) rights to abortion.

IS THE UK ENVIRONMENT AS RESTRICTIVE?

In Britain, unlike the USA, the law has barely changed in the past 40 years. The only amendments to the 1967 Abortion Act were made in 1990, in the context of broader legislation to regulate embryology and assisted reproduction; and these amendments did little more than introduce a 24-week gestational limit for most abortions while removing the time limit for abortion for fetal anomaly. Despite this, UK abortion providers have experienced the consequences of a climate of 'political regression' very similar to that in the USA. Our abortion doctors, like their American colleagues, face political threats "to the autonomy of our patient relationships, to evidence-based medical practice, to the training of our students … and, ultimately, to the health of patients".[2]

Increasingly, British politicians have sought to intrude into issues of abortion-related clinical practice, fuelling concern that abortion is unsafe and poorly regulated, despite substantial evidence to the contrary. In the past 2 years alone, government ministers have initiated investigations into allegations that women are denied appropriate counselling prior to abortion and that doctors provide unlawful abortions for the purposes of sex selection. The latter investigation cost more than £1 million and diverted the health care regulator, the Care Quality Commission (CQC), from other work while it deployed almost all its inspectors on a 3-day swoop of unannounced inspections of all UK abortion clinics.[6]

The CQC found no evidence of illegally authorised abortions; nor did the regulator find that "any women had poor outcomes of care".[7] However, an official investigation of doctors' administrative practices regarding the certification of abortion has resulted in the suspension of several doctors from related duties and their referral to the General Medical Council, despite no evidence that a single unlawful abortion has been carried out as a result of 'pre-signing' of certification forms. A Department of Health working party is currently drafting guidance on this matter, despite the fact that doctors have managed to practise lawfully for the past 40 years.

While official resources have been thrown at unnecessary measures to reinforce restrictions on abortion, attempts to redesign service delivery in line with clinical practice have been strenuously opposed. In 2011, the Secretary of State for Health strenuously opposed a High Court challenge brought by British Pregnancy Advisory Service (bpas) that would have allowed women home administration of the misoprostol required to complete early medical abortion – the 'abortion pill', used at gestations of 9 weeks and under.[8] The Government's intransigence means that women in Britain are unable to benefit from some of the advantages of these medications, such as the way that the relative flexibility of the 'abortion pill' can allow women to manage childcare and work commitments more easily, and improve access for women from rural areas.

The reason British women are denied these advantages of early medical abortion – which are taken for granted in the USA, Sweden and other parts of the world – is that politicians deem the change to be too controversial. We are told that officials understand that the current restrictions are clinically unnecessary, but are concerned that any move to lift them will attract allegations that abortion is being liberalised. In short, to avoid abortion-related controversy, women in Britain are exposed to increased inconvenience; and the National Health Service, which pays for more than 80 000 early medical abortions every year,[9] is being subjected to unnecessary costs.

We face more restrictive limits than our US colleagues on who can perform abortions, and where they can do it. In the UK, the law dictates that only registered medical practitioners, not nurses, can perform abortions and the growing climate is not conducive to young doctors opting for this specialism, nor for hospitals to offer and promote abortion training. Without these restrictions, most (early and straightforward) procedures could be undertaken by nurses, and could be provided in a wider variety of settings, as they are in the USA.[10]

As in the USA, there are parts of the UK where women are unable to access any legal services at all. Abortion is no less clinically safe or necessary in Newcastle County Down than in Newcastle-upon-Tyne. Yet the legislation that permits legal abortion for unwanted pregnancy in England, Scotland and Wales has never applied to the six counties of Northern Ireland.

The political environment in the USA is very different to that in the UK. But the dislocation between the potential of clinical developments in abortion care, and the brake that political conservatism places on its practice, is similar. We do not experience the extremity of anti-abortion protest that has become wearily familiar to our American colleagues, and the invective of British politicians is more subtle: British doctors wear regulatory straightjackets, not bullet-proof vests.

Yet on both sides of the Atlantic, the problem is the same. Politics is allowed to trump medicine.

NOT A PROBLEM BUT A SOLUTION

The political establishment sees abortion as a problem. Some politicians see it as a moral wrong to be prevented; others see it as a controversial inconvenience to

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be avoided. We, who work to care for women with problem pregnancies, see things through a different lens. We understand that abortion is a necessary fact of life in a society that values planned families. Abortion is not a problem; it is a solution to the problem of unwanted pregnancies. Politicians need to stand with doctors to address how best to deliver safe legal services of the highest clinical standard. Any laws and regulations that fail to facilitate this have no place in a civilised society. How excellent it would be for 100 British professors of obstetrics and gynaecology to stand with their American colleagues and examine what needs to be done to achieve this here.

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