

**Scientific  
Developments  
relating to the  
Abortion Act  
1967**

**Submission  
to the  
Select Committee on Science and Technology  
by the Council for Health and Wholeness**

September 2007

## **A. THIS DOCUMENT**

This submission has been prepared in response to a new inquiry by the Select Committee on Science and Technology: Scientific developments relating to the Abortion Act 1967. Contact details: Ana Ferreira, Clerk to the Science and Technology Committee, House of Commons, Westminster, London.

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## **B. THE COUNCIL FOR HEALTH AND WHOLENESS**

The Council is a multi-disciplinary body embracing doctors drawn from a variety of specialisms, nurses and various medical auxiliaries, counsellors, chaplains and others. It has close links with the healing ministry of the Christian church and is involved in a broad range of research projects.

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# 1. INTRODUCTION

In this submission, we would like to focus on the safety issues surrounding “medical abortions” and home abortions.

We recognise that there are increasing efforts to offer “consumer-friendly” abortion, for example “medical abortions” which usually don’t require a surgical intervention; nurse-led abortions; and abortions at home.

We would like to express our serious concerns about the physical, emotional, social and spiritual impact of all types of induced abortion. While we are aware that this enquiry is not focusing on the moral or ethical aspects of abortion, nevertheless there is a need to recognise that there are serious ethical and moral issues involved in the abortion debate.

# 2. CLINICAL REVIEW

## 2.1 Adverse psychological effects after abortion

While it is generally stated that abortions are usually safe and have few, if any, adverse psychological effects, recent research paints a different picture.

Recent evidence points to adverse psychological effects after abortion, even in women with no previous psychological problems. (Fergusson DM et al. Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry* 47:1 (2006), 16–24). This very important prospective longitudinal study followed up 500 New Zealand girls and young women from the time of their birth to 25 years of age. Each woman’s mental health was measured at age 16, 18, 21 and 25. The women who had had an abortion experienced nearly twice the level of mental health problems as those who had either given birth or never been pregnant. They also had three times the risk of major depressive illness compared to the other groups. These results were statistically significant even after controlling for previous mental health, and persisted across a series of ages.

We are aware of several recent review articles on the issue of psychological adverse effects of abortion. Thorp *et al* reviewed a number of studies up to 2002 which contained more than 100 women per study, all followed up for more than 60 days. (Thorp, JM et al. Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence. *Obstet Gynecol Survey* 2002; 58, 67-79.) Their summary states: *“of particular note is the association between induced abortion and either suicide or suicide attempt<sup>1</sup>. This is an objective rather than a*

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<sup>1</sup> The following studies are quoted in this section by Thorp:

- Hunton R, Bates D. Medium term complications after termination of pregnancy. *Aust NZ J Obstet Gynaecol* 1981;21:99–102.
- Gissler M, et al. Suicides after pregnancy in Finland, 1987–94: Register linkage study. *BMJ*; 1996;313:1431–1434
- Morgan C, et al. Suicides after pregnancy (Letter). *BMJ* 1997;314:902
- Coleman PK, et al. State-funded abortions versus deliveries: A comparison of outpatient mental health claims over 4 years. *Am J Orthopsychiatry* 2002;72: 141–52.
- Reardon DC, et al. Deaths associated with pregnancy outcome: A linkage based study of low income women. *South Med J* 2002;95:834–841
- Gilchrist A, Hannaford P, Frank P et al. Termination of pregnancy and psychiatric morbidity. *Br J Psychiatry* 1995;167: 243–248
- Reardon D, Ney P. Abortion and subsequent substance abuse. *Am J Drug Alcohol Abuse* 2000;26:61–75

*subjective outcome, and because the effects are seen after induced abortion rather than before indicates either common risk factors for both choosing abortion and attempting suicide, such as depression, or harmful effects of induced abortion on mental health. This phenomena is not seen after spontaneous abortion.<sup>2</sup>*

## **2.2. Home abortions and nurse-led abortions**

The discussion about “home abortions” and/or “nurse-led abortions” is essentially a discussion about the safety of the medical abortion regime, based on the use of two drugs, mifepristone (RU-486) and a prostaglandin, usually misoprostol.

## **2.3 Mifepristone (RU-486)**

Mifepristone is a synthetic steroid that essentially acts as anti-progesterone. Progesterone is the hormone that maintains a pregnancy. In medical abortion, mifepristone blocks progesterone receptors which leads to endometrial degeneration and softening and dilatation of the cervix. Mifepristone reduces production of the hormone HCG, which in turn causes decreased production of progesterone. Following administration of mifepristone, a prostaglandin – misoprostol – is given and this usually produces a medical abortion.

## **2.4 Medical Abortion**

Royal College of Obstetricians and Gynaecologist (RCOG) guidance (Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion*. September 2004) recommends medical abortion using mifepristone plus prostaglandin as the “most effective method of abortion at gestations of less than 7 weeks” and describes medical abortion as an “appropriate method for women in the 7–9 week gestation band.” According to the RCOG guidance, this method, however, can be used up to 24 weeks as it “has been shown to be safe and effective.”

In medical abortions up to 9 weeks, a dose of mifepristone orally is followed 1–3 days later by a dose of misoprostol (a prostaglandin, that induces uterine contractions) vaginally. If the pregnancy is beyond 9 weeks and up to 24 weeks, this regime is then followed by up to four further doses of misoprostol, either vaginally or orally.

## **2.5 Effectiveness of medical abortion**

Medical abortion has a “success” rate that ranges from 75–95%, with about 2–4% of failed abortions requiring surgical abortion and about 5–10% of incomplete abortions (not all tissue is expelled, requiring surgical intervention), depending on the stage of gestation and the medical products used. (*Trupin, SR et al. Abortion on www.EmedicineHealth.com, June 2007*)

## **2.6 Safety and side effects of medical abortion**

In trials, almost all women using mifepristone for medical abortions experienced abdominal pain or uterine cramping; and a significant number experienced

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2 Major B, et al. Psychological responses of women after first-trimester abortion. *Arch Gen Psychiatry* 2000;57:777–784.

nausea, vomiting, diarrhoea. Vaginal bleeding or spotting lasts an average of nine to sixteen days, while up to 8% of patients bleed for 30 days or more. Pelvic inflammatory disease (PID), a serious complication, occurred in about 1%. Between 4.5 and 7.9% of women required surgical intervention following medical termination for a variety of reasons, including treatment of bleeding, incomplete expulsion of the pregnancy and ongoing pregnancy after medical abortion. It is estimated that medical abortions are 5 to 10 times as likely to “fail” as surgical ones, therefore requiring surgical intervention in a then-advanced pregnancy. (FDA-approved Data sheet on Mifepristone [Mifeprex, Danco Laboratories], July 2005; [www.fda.gov/cder/foi/label/2004/0206871bl\\_Revised.pdf](http://www.fda.gov/cder/foi/label/2004/0206871bl_Revised.pdf))

In a recent review, complications involving hospitalisation were at least twice as likely following medical terminations than following surgical terminations: 1.5% of women required hospitalisation after medical termination as opposed to 0.6% after surgical termination (Goodyear-Smith F, First trimester medical termination of pregnancy: an alternative for New Zealand women. *Aust N Z J Obstet Gynaecol.* 2006 Jun;46(3):193-8.)

Teratogenic effects may result from the use of prostaglandins, including misoprostol, in human beings. Skull defects, cranial nerve palsies, delayed growth and psychomotor development, facial malformation and limb defects have all been reported after exposure during the first trimester of pregnancy. (FDA-approved Data sheet on Mifepristone [Mifeprex, Danco Laboratories], July 2005; [www.fda.gov/cder/foi/label/2004/0206871bl\\_Revised.pdf](http://www.fda.gov/cder/foi/label/2004/0206871bl_Revised.pdf))

## **2.7 Mortality due to medical abortion**

By early 2006, at least 5 women had died in North America (5 in US and 1 in Canada) as a result of taking Mifepristone followed by misoprostol. In the UK, there have been two possible cases of death following medical termination. (Ms Rosie Winterton, Written Answer, House of Commons Hansard; 28 April 2004)

Four of the US fatalities and the Canadian fatality resulted from infections with a virulent bacterium (*Clostridium sordellii*). The cases have been described as deaths due to endometritis and toxic shock syndrome associated with this bacterium that occurred within one week after medically induced abortions. (Fischer M, et al. Fatal toxic shock syndrome associated with *Clostridium sordellii* after medical abortion. *N Engl J Med.* 2005;353:2352-60; Sinave C, et al. Toxic shock syndrome due to *Clostridium sordellii*: a dramatic postpartum and postabortion disease. *Clin Infect Dis.* 2002;35:1441-3.)

The disturbing features were that all the women who died were young and healthy; they had apparently successful terminations with no complications, the initial presentation of the toxic shock syndrome were unspecific abdominal cramps, which commonly occur after medical termination, and all women died within 5 days of administration of medication. All died less than 24 hours after hospital admission. Of note is that all five women who died of infections had inserted misoprostol vaginally. It is estimated that around half of medical abortions carried out in the UK use vaginally administered misoprostol.

A recent review concludes that the risk of death with medical termination, while low (1 in 100,000), is still 10 times greater than that with surgical abortion. (Creinin M, et al. Mortality associated with mifepristone-misoprostol medical abortion. *MedGenMed.* 2006;8:26.) As a result of these safety concerns, a number of US doctors have been quoted as expressing serious concerns about the safety of medical

abortions and some have actually stopped providing medical abortions altogether. (Some Doctors Voice Worry Over Abortion Pills' Safety. New York Times; April 1, 2006)  
There has been a case report of an adolescent girl dying following self-administration of misoprostol in order to induce abortion. (Henriques A, et al. Maternal death related to misoprostol overdose. *Obstet Gynecol.* 2007;109:489-90)

## **2.8 Psychological effects of medical/home abortions**

Whereas there is no specific evidence on the psychological effects of home or medical abortions it is worth noting that the propensity for this type of abortion to induce psychological sequelae is not insignificant. For this method of abortion the woman usually has to take the abortifacient medication herself and/or has to insert a pessary into her vagina, thereby procuring the abortion herself. While with a surgical abortion it is easier to "blame the doctors" for what happened, with a medical abortion this is not so easily done.

## **2.9 Anecdotal experience**

While some surveys describe similar satisfaction with medical as with surgical abortions, there is some anecdotal evidence that medical abortions can be very traumatic:

*I have been through a medical termination at five weeks, and it was the most traumatic event of my life. Whilst I wholeheartedly agree with a woman's right to have a termination, I would hate to see this made available at home. It's not an easy thing to go through.* Anon, UK (Should home abortions be allowed?)

[http://news.bbc.co.uk/1/hi/talking\\_point/3025318.stm](http://news.bbc.co.uk/1/hi/talking_point/3025318.stm)

There are a number of women who have had both a medical and surgical termination. While there are those who appear to prefer the medical termination, there are also women who found medical terminations very distressing as it is essentially like "having a baby":

*Anne Hawkins, 36, also of New York, said she, too, had had both pill-based and surgical abortions. But taking RU-486, she said, "was the worst experience, the most physically and emotionally painful thing, that I've ever been through." Ms. Hawkins had another abortion in March, and she chose surgery. "It was 10 minutes, max, and then it was over," Ms. Hawkins said of the surgical procedure. "The pill for me was the experience of having a baby. Contractions for 10 hours, sweating, screaming, being by myself. It was emotionally scarring and physically horrible."* (New York Times, May 11, 2006)

## **2.10 Black Market**

An important consideration needs to be given to the possibility of the drugs used for medical abortions being available on the black market and/or sold over the internet. There is evidence for a thriving black market for mifepristone and/or misoprostol in Brazil, China and the US. (US embassy in Beijing report; November 2000; Misago C, et al. Determinants of abortion among women admitted to hospitals in Fortaleza, North Eastern Brazil. *Int J Epidemiol.* 1998;27:833-9; The New York Times, October 2, 2005.) The FDA recently issued a warning not to buy mifepristone over the internet. Please note that the black market is not limited to countries which have restrictive abortion laws, but also occur where abortion has been legalised, such as in the US and China. With the proposed increase in availability for medical abortions, it is very likely that there will be an increase in the black market for the drugs used, with all the adverse consequences.

### 3. SUMMARY OF CONCERNS

- 3.1 To propose “home abortions” and extend the availability of nurse-led abortions essentially constitutes an attempt to normalise abortion, to increase the availability of abortion and to downplay any concerns about this procedure.
- 3.2 The advisability of medical abortions being carried out as early in pregnancy as possible leaves little time for a proper, balanced consideration of whether abortion is the right course of action. This is more likely to result in a pressurised decision to abort a pregnancy with possible later regret.
- 3.3 Abortions, whether carried out at home or performed in a hospital setting, have serious adverse physical, emotional and spiritual consequences.
- 3.4 There is increasing robust evidence linking abortion to adverse psychological effects. A 25-year longitudinal study found that women who had an abortion experienced nearly twice the level of mental health problems and three times the risk of major depressive illness compared to those who had either given birth or never been pregnant, even after correction of confounding factors.
- 3.5 Medical abortion is not as safe as perhaps commonly assumed. Medical abortion has ten times the mortality of surgical abortion. There have been at least five deaths in North America following medical abortion using mifepristone (RU-486) and a prostaglandin, usually misoprostol. The women who died in North America following medical abortion using mifepristone died through a rapidly progressing condition due to an infection with *Clostridium sordellii*.
- 3.6 Although it is stated that the Committee will not be looking at the ethical or moral issues associated with abortion time limits, we would strongly urge the Committee to consider moral and ethical questions about abortion as an *increasingly* used method of birth control, not least as they come into quite sharp focus when considering medical abortions and home abortions. If there is a moral wrong committed through abortion – and it is probably correct to state that a very large proportion of the population, while perhaps not condemning abortion, have a degree of unease about abortions – then this is made more acute through home abortions and medical abortions.
- 3.7 There can be no disagreement that abortion involves the deliberate taking of a life. This inevitably raises questions such as: Under which circumstances can the taking of a life be “right”? Would it be acceptable to take away the life of an unborn child because of poverty or poor housing situation? Would it be acceptable to take away a life because the mother already has too many children or there are serious relationship issues? Would it be acceptable to take away the life of an unborn child because it might be handicapped or because it was conceived through rape? Would it be acceptable to take away the life of an unborn child because the pregnancy itself endangers the life of the mother?
- 3.8 We do not purport to present universally acceptable answers to these questions; however, our standpoint is based on the Judeo-Christian tradition, which have been foundational to British society for generations and which emphasises the sanctity of all life, irrespective of circumstances and irrespective of whether a child may or may not be disabled. The ambiguity surrounding statements about the “status” of the unborn child needs to be addressed when considering the

serious matter of abortion. At what stage of pregnancy does a foetus become a child with value? Does the child born prematurely at 23 weeks gestation have a greater right to medical help to live than the child aborted, for whatever reason, at the same gestational age? Irrespective of one's moral or ethical stance, the "Golden Rule" states *"treat others as you would like to be treated."* Using the Golden Rule, the concept of abortion becomes morally and ethically questionable.

- 3.9 We are seriously concerned about the implications of "home abortions" and remain firmly opposed to an extension of abortion availability through either "home abortions" or increased nurse-led abortions.