

Abortion in the modern world – the current realities

This article is one of a series on the topic of abortion which are all available at the website

johnwyatt.com

The articles are:

Abortion in the modern world

Abortion and infanticide in the ancient world

Contemporary secular philosophers and abortion and infanticide

When is a person? Christian perspectives on the beginning of life

Abortion – ethical dilemmas and compassionate responses

Abortion has become a highly polarised and toxic issue in our society. It seems as though those who argue for and against abortion lob verbal grenades at one another, without any kind of genuine dialogue or understanding. Very often there is no real engagement, or meeting of minds. But I believe that when we try to enter this battleground, our Christian task is first to listen and to understand, to empathise. Only in this way are we going to be able to speak with integrity, with authenticity and with compassion. As with so many ethical issues the reality of abortion is one of human pain, anxiety, suffering and uncertainty.

In Britain, as in most countries, intentional abortion was illegal from the medieval period. The Offences against the Person Act 1861 made abortion a felony with a maximum sentence of penal servitude for life. The Infant Life (Preservation) Act of 1929 made it an offence to 'destroy the life of a child capable of being born alive'. The Act made a gestational age of 28 weeks the point at which there was *prima facie* proof that this stage had been reached. The only exception allowed under the 1929 Act was an abortion carried out in good faith to preserve the life of the mother.

Up until the 1960's medical abortion was being practised on a small scale by gynaecologists, but it was not widely available, except for wealthy. On the other hand everybody knew that there were a large number of criminal abortions being performed by 'back-street' abortionists who could be found in every part of society. Many women suffered from the consequences of criminal abortion, with the risk of serious infections and infertility, and a few died. In the nature of things the exact number of criminal abortions was not known, and estimates have varied wildly. Probably the most authoritative estimate is that from a 1966 report from the Royal College of Obstetricians and Gynaecologists which concluded that the annual number of abortions at that time was about 14,600, although other estimates were much higher. In 1966 the number of maternal deaths which were known to be due to criminal abortion was approximately thirty.

The 1967 Abortion Act

David (now Lord) Steel introduced his Private Member's Bill to reform the abortion law in 1966 and it was passed in 1967. It is clear that the motivation of David Steel and many of the original framers of the Bill was genuinely humanitarian. The great concern that was expressed at the time was the need to prevent the litany of death and misery from criminal abortions and illegal abortionists, and to provide a legal remedy for the victims of rape and those found to be carrying seriously malformed infants. The abortion debate was also coloured by the thalidomide tragedy, in which hundreds of fetuses were severely damaged by a sedative taken by their mothers. Medical abortion was seen as a way of reducing the number of severely handicapped children being born every year. Another quoted reason was to reduce the terrible evil of child abuse (which was being increasingly recognised by paediatricians), by reducing the number of unwanted children.

Some of the supporters of legalisation claimed that the Abortion Bill would not make abortion easily available, but rather that it would reform and clarify the law, enabling doctors to carry out abortions in 'hard cases' without fear of prosecution. Interestingly, the radical liberal argument that women had the right of abortion on demand, out of respect

for their moral autonomy, was not a feature of the parliamentary debate. David Steel stated explicitly '... it is not the intention of the promoters of the Bill to leave a wide open door for abortion on request.'

Forty years later, writing in 2008 David Steel wrote 'We did not create abortion on request, we created a state of law where there is a balance between the right of the fetus to develop to full life and the right of the women to have what I would call in the biblical phrase 'abundant life'. And that is a balance which only the medical profession can make.'

Although the 1967 Act was amended by Parliament in 1990, the core of the legislation remains unchanged. It states that an abortion is legal if two doctors agree in good faith on one of the following grounds:

- A. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
- B. The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- C. The continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman, greater than if the pregnancy were terminated.
- D. The continuance of the pregnancy would involve risk of injury to the physical mental health of any existing child(ren) of the family of the pregnant woman, greater than if the pregnancy were terminated.
- E. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

or in the rare conditions of a genuine medical emergency:

- F. To save the life of the pregnant woman
- G. To prevent grave permanent injury to the physical or mental health of the woman.

Abortion statistics

The Abortion Act came into force in 1968 and the numbers of legal abortions in England and Wales rose steadily from 54,000 in the first complete year to over 169,000 by 1974. Since then the total number of abortions has continued to rise and in 2017 the number was approximately 195,500. For comparison the number of live births in 2017 was 679,000, indicating that about 1 in 5 established pregnancies end in an induced abortion. (It's estimated that 10-20% of pregnancies end in a spontaneous miscarriage but the precise numbers are uncertain). To the despair of sexual health professionals, despite the almost universal availability of contraceptives and compulsory sex education in schools, the rate of abortions per 1000 of population has remained at a high level year on year.

Although the intention of the original supporters of the Bill may not have been to allow abortion on request, the wording of the Bill was capable of remarkably elastic interpretation. In particular, because the risk to the mother of a completely normal delivery at term is greater than the risk of an early abortion, ground C can be interpreted to allow abortion in any pregnancy. In fact it is difficult to conceive of a situation in which an abortion would not be 'legal' under the current wording of the Act.

In 2017 abortion in England and Wales was commonest in the 20-24 age group whilst less than 10% were in women under 18 years. Single women represented 82% of the total, and 32% had had one or more previous abortions. About 75% of abortions were performed at less than 10 weeks gestation and only about 1.5% at 20 weeks or more. About 1.7% of abortions were performed because of clause E, a 'substantial risk' of a child who is 'seriously handicapped'. Less than 1 in 1000 of all abortions were performed because of a risk to the life of the mother. About 98% of all abortions in England and Wales were funded by the NHS although the majority were carried out in private clinics.

The reality of the current situation in the UK is that abortion is available for the large majority of women on request. In other words the stated intention of the 1967 Act is being widely flouted, even if doctors can claim to remain technically within its wording. It is estimated that on average 1 in 3 women in the UK will have an abortion in their lifetime. What this means is that the abortion touches virtually all of us in UK society, not just women but their partners, husbands, friends. And yet it is rarely if ever talked about. We can talk about our sexual experiences, about cancer, about Alzheimer's disease, even our experiences of child abuse. But we can't talk about our personal experience of abortion. It's like a silent wound penetrating our society.

The experience of abortion

It's vitally important to listen to the first-hand accounts of women who have had abortions and that of their partners. Otherwise it's easy for our opinions to be formed by popular stereotypes and prejudices. Many personal accounts of the experience of abortion can be found on internet websites and many are unedited, honest, moving and sometimes searingly painful. Many of them express mixed emotions of relief combined with regret and loss.

'After the abortion I felt relief. I was just pleased to have made a decision. However, as time goes by, I realise what I have lost. I miss my child. I feel empty and guilty. It was a horrific experience which will stay with me for a long time. I don't blame myself because I know I was upset and confused...'

'On the day of the procedure I was petrified, and I cried for hours. I felt like the worst person in the world. I couldn't understand how I was about to murder my own child? I loved children dearly and had previously worked as a nanny. I just didn't know where all my emotions were coming from...After the procedure for the next three days, I felt a great sense of relief, like the burden had been lifted and I had a chance to start living my life again.'

Sadly this lasted no longer than about a week... Now I think about it every day. I think about how selfish I am. I have nightmares of giving birth, of looking for my lost child. I fear that this has been made worse by the lie to my partner, and the guilt I feel as he too is struggling with the situation.'

'The day I 'terminated' my baby is the day my life changed forever. I have three beautiful children and whenever I say that to people, I always feel a lump in my throat as I so want to say 'four'. When I look back (four years ago now), I see so clearly the huge mistake my husband and I made but it is so weird that at the time you just don't see it. Maybe your mind is fogged with sickness, financial worries, or lots of other 'reasons' that seem so acceptable at the time. As soon as I woke from the anaesthetic I cried and cried, not from relief but from regret... I carried on, though, to the outside as if nothing had happened, but it really doesn't take all that long for the effects to surface one way or another. My husband tried to understand but kept saying I needed to move on, 'we have three beautiful children', and I would say 'yes, but we should have four'.

'I spent the next ten years crying and hating myself, drinking and getting drunk to temporarily blot out the feelings of hate and loathing I developed about myself. Fourteen years on, I went on to have a beautiful baby boy and have been in a lovely supportive relationship for the past seven years, and we are trying for another baby.'

A male account: 'All I could think was, what have I done? What have I done to the girl I love, and the baby I could've had? The reason I wrote so much about what happened at the clinic is because, that's the reality. If anyone reading this is considering abortion, go to a clinic and just sit, and watch the people waiting for a loved one. No one says a word, the silence is scary. I will always regret this one thing'.

When I read these accounts, I feel a deep sadness at the sense of silent despair and grief carried by so many in our society. The statistics demonstrate just how many people in our

community are touched by it, although for most the pain is never revealed, not even to their closest friends and confidants. This is why the violent rhetoric of the public abortion debate seems to me to be so unhelpful, if not positively damaging. Whenever the evils of abortion are declared in a harsh and condemnatory fashion, it is as though a knife was being silently twisted in the hearts of so many who listen.

I also feel deeply ashamed for my gender: ashamed at the cynical psychological abuse perpetrated by men on women who find themselves in the exquisitely vulnerable position of an unwanted pregnancy. The strange irony is that abortion on request, effectively legalised by the 1967 Abortion Act, was hailed by feminists as empowering woman and liberating them from patriarchal oppression. Yet the paradoxical effect of the emphasis on the woman's autonomy is the disempowerment and disengagement of men from the entire issue of abortion. When a woman tells her boyfriend that she is unexpectedly pregnant, the boyfriend, well-educated in the liberal attitudes of the age, will usually respond, "Well it's your choice, it's your body. Whatever you decide I will back you up." But in reality what she hears is, "You're on your own darling. Don't expect me to take responsibility." So at the moment of an a crisis pregnancy, when many women feel acutely vulnerable, they are often met with male disengagement, even abandonment.

When a woman chooses to have an abortion because her partner has said I'll leave unless you get rid of the baby, when the firm says promotion is only available to those who work full-time, when social services says sorry we can't support single mothers, when society has discriminatory and prejudiced attitudes to disabled people, is it really a triumph of reproductive autonomy? The focus on personal autonomy masks the powerful distorting societal forces under whose influence women make choices about pregnancy and childbirth. The context of the decision about abortion is not neutral – it is predetermined by society and in particular by the dominant male interests and power relations within that society. Women end up making apparently autonomous choices which frequently serve other people's interests.

The truth is that abortion on request has become a means for others, principally men, cynically to exploit and manipulate pregnant women. Most women, confronted with an unplanned pregnancy are not able to exercise free choice, unconstrained autonomy as expounded by the philosophers. Once abortion is freely available women must provide their partners with a reason, not for having an abortion, but for the reverse, an adequate reason for *continuing* with their pregnancy. The prominent feminist lawyer Professor Catharine MacKinnon agrees that liberal abortion rules allow men to use women sexually with no fear of any consequences of paternity. Against the reasoning that abortion should be regarded as a private matter for women to decide, she argues that this supposes that women are really free to make decisions for themselves within the private space they occupy. In fact, she insists, women are often very unfree in the so-called private realm. Men often force sexual compliance upon them in private. In the brutal language of another feminist, a liberal abortion policy allows men 'to fill women up, vacuum them out, and fill them up again'.

The emotional consequences of abortion

According to gynaecologists and abortion providers, psychological problems following abortion are generally uncommon and minor. But this contrasts markedly with the experiences of many who offer counselling and support for those who seek help following an abortion (23). For understandable reasons, many women are reluctant to return to the clinic where an abortion was performed, or to the doctor who authorised the procedure, and hence medical staff and abortion clinics are frequently unaware if long term distress occurs.

The desire to minimise the psychological trauma of abortion has led to divergent views on how to improve practical abortion arrangements. Those in favour of a liberal abortion policy have argued that abortion should be made as straightforward and uncomplicated as

possible. Some clinics offer a one-stop walk-in walk-out abortion service where women are able to leave the clinic after 60 minutes.

Here is another example of medical science being employed as a quick technological fix to meet complex human and social issues. The adverse implications of an unwanted pregnancy in our modern society are due to a complex mix of psychological, relational, spiritual, social, financial, employment, and gender issues. Abortion seems to offer a neat, apparently uncomplicated technological solution to a complex problem. But as so often, the solutions offered by technology come with a high price tag.

The well-known American feminist Naomi Wolf published an uncompromisingly honest account of growing up as a young woman in the sexually liberated atmosphere of Los Angeles in the 1960s, entitled *Promiscuities* (24). She interviewed many of her friends and contemporaries about their experiences. 'Among the events described by the women I interviewed, it was only the accounts of their teenage abortions that they insisted on confiding anonymously, compartmentalised from the rest of their stories. Out of all the difficult sexual events the women experienced, it was the abortions alone that seemed, even twenty years later, just too painful to integrate....'.

One of the women recounted the story of her abortion at seventeen – 'We were so young.... Logically I thought, OK, this is what you do in this situation. I had no idea what the emotional ramifications would be. It was the strong, smart, emancipated thing to do. We had no idea of the enormity of it. We were just kids.' (25)

Adoption figures

Adoption has always been an alternative to abortion when a mother feels unable for whatever reason to raise and care for her baby. The number of legal adoptions in England and Wales was rising in the 1950s and 1960s and reached a peak of 24,800 per year in 1968, the year that the Abortion Act became law. Since then, the number of adoptions has been

falling steadily year on year, and in 2017 4350 adoptions were legalised. Of these only 350 babies were adopted under the age of 1 year. At the same time 72,000 children were in the care of the local social services.

Perhaps it is inevitable that as abortion has become more common and socially accepted, the number of babies being offered for adoption has fallen. Yet this trend has meant that it has become progressively more difficult for childless couples to adopt a child. Of course adoption is not without problems and adopted children may suffer complex emotional difficulties in later life. But the lack of babies for adoption has undoubtedly contributed to the pressure on health professionals and medical services to develop and provide new techniques and treatments to help infertile couples. To health professionals who work in the field it sometimes seems as though half the world is desperately trying to have a baby, while the other half is equally desperately trying to get rid of one. This is the practical reality of what philosophers have called the right to 'procreative autonomy'.

Late abortion or 'feticide'

In 1990 the UK Parliament amended the 1967 Abortion Act. The gestational age at which abortion could be carried out under the 'social' clauses (grounds C and D) was reduced to 24 weeks. However abortion for strictly 'medical' reasons (grounds A,B,E F and G) could now be carried out at any gestational age, up to and including term.

Thus abortion can be performed at any stage of pregnancy if 'there is a substantial risk [undefined] that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped [undefined]'. The wording of the Act seems deliberately vague, allowing considerable latitude for interpretation by doctors and lawyers. What exactly is a 'substantial risk'. In private conversation an experienced lawyer told me that a court would probably conclude that a risk of 10% was within the definition of 'substantial'. Similarly the definition of 'serious handicap' is open to considerable variation in interpretation, and might include abnormalities such as achondroplasia.

The case highlighted by Joanna Jepson was of a late feticide carried out at 28 weeks in a fetus with bilateral cleft lip and palate. She asked the High Court to declare that cleft lip and palate did not constitute a 'serious handicap' in the context of the Abortion Act but the Crown Prosecution service declined to continue the case. In practice the decisions of doctors on the interpretation of this aspect of the Act have never been put to legal. In 2017, 245 abortions were performed beyond a gestational age of 24 weeks. The commonest abnormalities were of the central nervous system followed by chromosomal abnormalities. Although late feticides are uncommon compared to the large numbers of 'social' abortions performed each year in the UK, nonetheless they cause great unease and emotional distress to obstetricians, paediatricians and to the staff of neonatal intensive care units. The paradox is that late feticides may only be performed in major NHS hospitals, and it is those very same hospitals which have seen dramatic improvements in my own specialist area of intensive care for premature babies.

The practice of late feticide has led to a somewhat surreal situation. Imagine the scene in two adjacent operating theatres in one of our major National Health Service hospitals. In one operating theatre a group of highly trained professionals are engaged in a sophisticated medical procedure whose sole aim is to salvage an unborn baby whose life is seen as precious and uniquely valuable. Paediatricians and neonatal nurses are present to resuscitate the infant immediately after birth and commence sophisticated intensive care. Yet, in the adjacent operating theatre a group of highly trained professionals are engaged in a sophisticated medical procedure with the sole aim of destroying an identical unborn baby who is seen as in some sense disposable and whose life has effectively been rejected by both parents and society.

The contradictory activities in the two operating theatres may collide in an even more startling way. Suppose the fetus in the second operating theatre, instead of being killed within the womb, should accidentally be delivered alive. There is now a living but critically

unwell baby whose life is technically protected both by law and by traditional medical ethics. Do the doctors have a duty to preserve his or her life now that the baby is delivered? Should the paediatricians from the first operating theatre be called to initiate intensive care of this baby, who just moments previously was under sentence of death? How is it possible for one medical system, one body of law and one society to encompass and approve of such mutually contradictory procedures?

It seems to me that one way of understanding this paradox is to recognise that it is as if the two operating theatres are functioning under two mutually contradictory ethical traditions. In the first operating theatre the view of the newborn is derived ultimately from the Judaeo-Christian tradition, whereas in the adjacent theatre the ethical viewpoint is much closer to the ancient Graeco-Roman perspective.

And what is the ultimate reason for the different activity in the two theatres? Answer: the wishes of the parents. In fact it is ultimately the wish of the mother alone, as, in this particular area fathers have few legal rights. It is the philosophical principle of autonomy, the right to choose within a liberal society, being worked out in practice. It is a view which regards the value of unborn life as a social construct. The value of your life is the value I give to it.

In response to public and professional unease, and occasional tragic cases in which botched abortions have led to the birth of live babies, the UK Royal College of Obstetricians and Gynaecologist published guidelines entitled *Termination of Pregnancy for Fetal Abnormality* first published in January 1996. The document makes rather grisly reading:

'Abortion..... is the deliberate termination of a pregnancy for the benefit of the woman. The intention of an abortion is that the fetus should not survive - that the process of abortion should result in its death. A fetus that is born alive becomes a "child" even if the reason for the birth was a legal abortion procedure. A deliberate act that causes the death of a child

is murder..... Consequently a doctor could be accused of murder when the deliberate act in question was the performance of a lawful abortion by a method that was followed by a live birth and the subsequent death of the child, perhaps because of immaturity. Consequently a legal abortion must not be allowed to result in a live birth. Within defined limits the law allows the destruction of a fetus but not of a child.'

'The fetus is entitled to respect throughout the pregnancy. Up to 26 weeks gestation the method of abortion should be selected to minimise the physical and emotional trauma to the woman. After 26 weeks it is not possible to know the extent to which the fetus is aware. So, in the later weeks of pregnancy, methods used during abortion to stop the fetal heart should be swift and should involve a minimum of injury to fetal tissue.' (28)

I have witnessed at first-hand the psychological unease and distress which may be caused not only to parents but also to health staff who are involved, sometimes rather unwillingly, in these distressing procedures.

A 1995 survey of obstetricians in the UK found that over 95% would perform an abortion at beyond 20 weeks of gestation for Down's syndrome or spina bifida and the percentage who would perform an abortion beyond 24 weeks were 13% for Down syndrome, 21% for spina bifida and 64% for anencephaly (29). 13% also agreed with the statement that "The state should not be expected to pay for the specialised care of a child with a severe handicap in cases where the parents had declined the offer of prenatal diagnosis". The opposite view, that late abortion is only justified for conditions which are inevitably fatal, has also been forcibly stated by several obstetricians. It is clear that many obstetricians feel uneasy about agreeing to a request to perform a late abortion under these circumstances. However the widespread availability of abortion of perfectly normal fetuses for social reasons may mean that some obstetricians find it hard to refuse to perform an abortion at the parent's request when the fetus is abnormal.

For Christian responses to abortion please see the two articles on the website johnwyatt.com:

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