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Abortion in the first trimester

Give women the right to choose

Twenty five years after the Abortion Act became law most people are in favour of giving women more choice in the matter: four out of five British adults support women's right to choose an abortion in the first three months of pregnancy.[1] People support abortion on request because they recognise, often from their own experience, that pregnancy at the wrong time can adversely affect a woman's life; children should be born only when adequate resources are available for their care; the personal regulation of sexuality can be difficult; and all existing contraceptive methods have problems.

People who maintain that abortion is always wrong because it results in the destruction of a fetus are simplifying a complex subject and may be concealing from themselves, and those they seek to influence, less obvious reasons for their objections. These may include the belief that sexual behaviour is threatening and should be tightly regulated and that, for women, bearing children should take priority over all other aspects of life. Actions are ethical only if all relevant factors have been considered, and many decisions necessitate some compromise between conflicting moral principles.

For many couples the prevention of unwanted pregnancy is under only partial control. The expression of sexuality is a fundamental human need and, particularly in young people, is driven by biological forces that can be difficult to regulate. Young people often come from homes where adults set a bad example in their own relationships or answer questions about sex inadequately and anxiously. If such young people do not attend schools where sex education provides accurate facts and helps them to establish standards for enjoyable, safe sexual behaviour they become adults whose behaviour is similar to their parents'. They have difficulty in sustaining relationships and, within a relationship, have difficulty in planning sexual activity that is mutually rewarding and safe. Poor communication can lead to unplanned intercourse that may be exploitive rather than rewarding and from which unwanted pregnancies may result. Most of us have some problems with this aspect of behaviour; labelling people whose unprotected intercourse has resulted in unwanted pregnancy as irresponsible is often unjust and simplistic.[2]

Some people consider that an obligation to continue a pregnancy acts as a sanction controlling individual sexual behaviour and regard the easy availability of abortion as facilitating a hedonistic sexuality in which abortion replaces contraception. This is wrong on two counts: it results in the pregnancy and the resulting child being used punitively against the woman and is also against data on the proportion of pregnancies ending in abortion in England and Wales. Every year since 1972 the proportion of conceptions to married women that have ended in legal abortion has been 8% and for single women about 37%.[3] The rise in abortions among women resident in England and Wales from 108 565 in 1972 to 173 900 in 1990[4] is due not to increased use of abortion by individual married and single women but to the fall in the number of married women and the substantial rise in cohabitation. The lack of change in the proportion of pregnancies ending in legal abortion suggests that the behavioural factors that lead to unwanted conception and abortion are intrinsic to our society and that easy availability is not a primary factor in the decision concerning abortion.

The difference in the use of abortion by married and unmarried women might be due to couples who choose to marry being more skilful in planning sexual activity, but it is more likely that women who choose to marry have accepted that childbearing and motherhood take priority over other aspects of personal development. Married women are more likely than single women to continue an unplanned pregnancy, even if the single women have a stable relationship with a partner. This rejection of traditional marriage does not necessarily result in a fall in the quality of care of children; the maturity and love of the caring adults are more important than the possession of a marriage certificate.[5]

If the decline in marriage is an inevitable consequence of increasing equality for women society should seek to maximise the advantages rather than to deplore change. Unless they have close control over their fertility women are unable to plan their lives and to develop their abilities fully. With the present inadequate provision of sex education and the problems posed for many couples by currently available methods of contraception, having the option of abortion is essential. Abortion is less wrong than continuing an unwanted pregnancy that would impose serious stress on the woman, her partner, and the resulting child.

Although women should have the right to choose abortion, they must not be coerced into abortion by circumstances that could be remedied if the political will existed. Many women who would like a child, even when supported by their partner, feel obliged to have an abortion because of low income, poor housing, loss of employment or educational opportunity consequent on the pregnancy, few day nurseries, and no income tax relief for the provision of child care.

Women entitled to a right to choose also have a right to expect that sympathetic and adequate services will exist to meet their needs. In 1990 fewer than half the abortions for women living in England and Wales were provided from NHS beds or paid for by the NHS through agency arrangements.[4] Abortion is the only acute health need that is not met without question by the NHS, and parallels may be drawn between unwanted pregnancies and other combinations of behavioural difficulties and social circumstances—such as motor cycle accidents in young men. For these the NHS provides immediate, free, and sympathetic treatment; women who have reluctantly decided on termination of their pregnancy should not be obliged to pay for what is an essential service.

Does the current law on abortion give the right to choose? At present a woman can exercise the right only if two doctors agree with her decision. Abortion is legal if performed to protect the mental health of the woman. Health is defined by the World Health Organisation as a state of physical, mental, and social wellbeing; doctors must agree that the stresses of a continuous pregnancy would threaten the woman's mental wellbeing. Most women who request abortion are convinced of this, and most doctors accept that the woman is the person best placed to make this decision. The doctors' role is to check that she has considered all aspects of her situation and that she has accurate knowledge of the risks of both abortion and continuing the pregnancy. If a woman has made a firm and well informed decision that an abortion is necessary the doctors can support her choice, but she is dependent on their interpretation of the law and personal attitude to abortion.

A national survey of consultant gynaecologists in 1989 found that 73% believed that a woman should have the right to choose abortion.[6] Nevertheless two doctors still have to sanction the abortion, and this means that the right to choose is qualified and uncertain. Many European countries, such as Denmark, France, Italy, Norway, and Sweden, give the woman the right to choose in the first trimester. This minimises delay and enables abortions to be done earlier, when the methods are straightforward and uncomplicated. British abortion law should be amended to make this possible.

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Abusing old people

Elder abuse needs to be looked for, quantified, and treated

Alex Baker, the first director of the Hospital (now Health) Advisory Service, called it granny battering.[1] The meaning of this robust, if patronising, phrase is plain, but the concept has since been widened. The current term, "elder abuse," includes psychological (verbal), financial, and even sexual as well as violent abuse causing distress to a person past retirement age.[2] The abuse may be active or by neglect, and it may take place in a domestic or an institutional setting. Indeed, if uncaring, disrespectful, or disparaging behaviour in hospitals and homes is to be included agism might seem as appropriate a term as abuse.

The issue should not, however, be blurred by more general concern for elderly people. Regrettable as it may be when an old person admitted to hospital is addressed breezily at first acquaintance as Joan or Gran or placed on a commode in view of other patients and passers by in the ward, this hardly compares with direct beatings causing bruises, welts, wounds, cuts, punctures, bone fractures, abrasions, lacerations, sprains, burns, and scaldings.[3,4] At present many doctors and others feel righteous indignation about the whole range of slights and injustices to old people (which could even extend to those health trusts and authorities that have abandoned long stay beds and expect elderly patients and their families to make their own arrangements for continuing care, or send them a distance to where homes are cheap enough for the costs to be met by social security subsidies). Anger about these mean minded moves may possibly overshadow the smaller but important problem of elder abuse.

The term needs precise definition if the concept is not to be distorted and exaggerated. Prevalence ranges from 5% to 65% according to different criteria used by agencies likely to have had contact with abused elderly people.[5] A figure of 4% for the "battered elder syndrome" in the United States was deemed authoritative enough to result in hearings by Congress, which concluded that less than one sixth of cases ever came to official attention.[6] Reporting of suspected abuse is now mandatory in many states.[7]

Here in Britain Homer and Gilleard interviewed patients referred to geriatric wards for respite care over six months and their carers.[8] While the patients were guarded, 45% of the carers admitted to some form of abuse and 14% to physical abuse—pushing, grabbing, slapping, or hitting with a weapon. Nor was this all one way: according to their carers, 18% of the patients had been physically abusive, suggesting a cat and dog variation on the helpless victim scenario. Abusive carers were characterised by alcohol consumption, abuse by the dependant, "caseness" on the general health questionnaire and its depression subscale, having stopped work to care for the dependant, and greater social disturbance and communication difficulties in their dependants. Other characteristics of abusers may be a history of mental illness and recent decline and relying on the dependant for a home and money.[9]

This was, like most, a study of those at risk. On p 998 Ogg and Bennett report results of structured interviews (through the nationwide Office of Population Censuses and Surveys omnibus survey) with almost 600 people aged 65 or over and 1366 adult members of households in regular contact with a person of pensionable age.[10] One in 20 old people reported some kind of abuse, but only one in 50 reported physical abuse (being pushed, slapped, shoved, or otherwise roughly treated). Though 10% of adults admitted to verbal abuse, only 1% acknowledged physical abuse.

This study probably indicates the lowest likely level of abuse—but one that is quite high enough to warrant concern. The statutory measures designed to curb child abuse do not apply to elderly people. The Social Services Inspectorate's report *Confronting Elder Abuse* found no pattern in the first response to abuse by social workers, a fairly rapid reduction in

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