

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

A Submission

to the

**Select Committee on
Science and Technology**

By the Maranatha Community

August 2007

A. THIS DOCUMENT

This submission has been prepared in response to the Consultation “*Scientific developments relating to the Abortion Act 1967*” by the Select Committee on Science and Technology.

Select Committee on Science and Technology.
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B. THE MARANATHA COMMUNITY

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of people involved in the health and caring professions and in a wide range of voluntary work. Since its formation 27 years ago, it has been deeply involved in work amongst children and young people, people with drug and alcohol problems, the disabled and disadvantaged. It has taken the initiative in a broad range of projects directly contributing to the health of the nation and it also has extensive international experience.

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“We must courageously face the fact – finally – that human life of a special order is being taken.

The fierce militants of the Women’s Liberation evade this issue and assert that the woman’s right to bear or not to bear children is her absolute right.

On the other hand the ferocious Right-to life legions proclaim no rights for the women and absolute rights for the fetus.

Somewhere in the vast philosophic plateau between the two implacably opposed camps – past the slogans, past the pamphlets, past even the demonstrations and the legislative threats – lies the infinitely agonizing truth.

We are taking life, and the deliberate taking of life, even of a special order and under special circumstances, is an inexpressibly serious matter.”

Dr Bernard Nathanson. (Deeper into Abortion)
New England Journal of Medicine. 28 November 1974

1. Inescapable scientific and clinical considerations

- 1.1 While we respect the intention of the Select Committee to look “only” at the scientific evidence regarding abortion, there must be a recognition that abortion is not simply a medical or scientific issue. It is above all a moral or ethical issue. It is, therefore, inappropriate to “hide” behind “science” when science cannot give an answer as to whether one course of action is “right” or “wrong”.
- 1.2 There are two basic ethical positions regarding abortion. One is rooted in thousands of years of Judaeo-Christian tradition, based on the principle that life itself is of inestimable value and that one should not take life away. Associated with this is the concept of absolute moral values, i.e. that there are certain principles that are necessary for a society to function such as to have respect for life, to respect the individual, to seek truth etc. The other is rooted in a comparatively recent development of pragmatic morality, which is based solely on utilitarian principles. This position maintains that whatever solves a problem on a practical level must be considered as moral, that no action is inherently “right” or “wrong” in itself, and that the ends justify the means. This leads to moral relativism, which depends on the extremely doubtful theory that circumstances alone dictate what is right and what is wrong.
- 1.3 We cannot settle this philosophical argument. We would however wish to point out that in terms of scientific enquiry, moral relativism, where the end justify the means, becomes a very dangerous concept. Through following this concept enormous cruelties have been justified in the very recent past. The consequences of moral relativism are that a decision is being made that a certain type of life, for example that one of a healthy or young person, is worthy of protection, whereas another types of life is not considered worthy of protection. It raises the question of who decides whether the life of an old or terminally ill person, of a disabled baby in the womb, the life of which can be terminated. This is the philosophical basis of eugenics, a philosophy, which has led to the extermination of millions of people whose only “crime” it was to have certain characteristics, such as disability, mental illness, or belonging to a certain ethnic/religious group like the Jews. Scientific developments cannot be considered in isolation from ethical standards.
- 1.4 Fundamentally, the eugenics argument persists in the abortion debate. It is relevant to note that for example Marie Stopes, who opened the first family planning clinic and after whose name one of the largest abortion providers is named, was a eugenicist. In her *Radiant Motherhood* (1920) she called for the “sterilization of those totally unfit for parenthood (to) be made an immediate possibility, indeed made compulsory.” Her *The Control of Parenthood* (1920) declared that “utopia could be reached in my life time had I the power to issue inviolable edicts... I would legislate compulsory sterilization of the insane, feebleminded...”
- 1.5 Similarly, Margaret Sanger, who was the driving force behind the establishment of the International Planned Parenthood Federation (IPPF), the parent body to national family planning organisations, wrote an article on “*The Eugenic Value of Birth Control Propaganda*” where she praised Eugenics as “the most adequate and thorough avenue to the solution of racial, political and social problems”¹ Today, the family planning movement is at the forefront of calling for widespread access to abortion under the pretence of “sexual and reproductive rights”.

¹ Margaret Sanger. The Eugenic Value of Birth Control Propaganda. Birth Control Review, October 1921.

- 1.6 Those in favour of easy access to abortion are often called “pro-choice”. Those opposed to abortion may be called “pro-life”, however some may also call them “anti-choice”. Underlying this discussion is the issue of choice - that a woman has, or has not - the choice to continue or terminate the pregnancy. However, the word “pro-choice” is a euphemism, as the embryo/foetus has no choice in this matter whether his or her life is being taken away. The terminology “pro-choice” therefore should be dropped.
- 1.7 No-one can disagree that abortion is the deliberate taking away of a life. While there may – or may not be – “good” reasons given for an abortion (failed contraception, financial problems, unstable relationship, overcrowded housing, emotional instability, foetal disability, rape, serious threat to maternal health, etc) the fundamental question remains: can it ever be right to take a life away? If there is societal consensus that it can be “right” to take a life away, under which circumstances do we agree that life can be taken away? Is it acceptable to take a life away for financial reasons, for overcrowded housing, or not? Is it acceptable to take away a life in the case of rape but not “just” for failed contraception? It would be helpful if the committee could, at least, give consideration these questions, even though, perhaps, there may not be a universally agreed answer.

In the following sections, we comment on some of the specific questions raised by the Select Committee.

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2. **The 24-week upper time limit**

- 2.1 We maintain that the 24 week upper limit is by far too high in view of medical developments over the past decade. The upper limit needs to be lowered and brought into line with the limit of most European countries, to around 12 weeks.
- 2.2 Since Parliament last revisited the issue of upper limit to abortion in 1990, there has been a steady improvement in the survival of extremely premature babies so that the majority of 24-week-old premature babies survive. In some centres, the majority of infants born at 23 weeks gestation survive. There has been a recent report of an infant born after 21 weeks' gestation surviving.²
- 2.3 A recently published study found a significant improvement in rates of survival and major neurodevelopmental impairment in extremely low gestational age³. Infants were born at 23 to 27 weeks of gestation. Outcomes at one year adjusted age were compared for two epochs of birth: "epoch 1", July 1990 to June 1995 and "epoch 2", July 1995 to June 2000. The average survival of extremely low gestational infants as a percentage of live births, was 67% in epoch 1 (1990-1995) and 71% in epoch 2 (1995-2000). Major neurodevelopmental impairment was present in 20% of survivors in epoch 1 and 14% in epoch 2. In Epoch 1 11% of 23 weeks gestation infants survived. In Epoch 2 this had more than doubled to 25%; similarly in Epoch 1 44% of 24 weeks gestational infants survived, whereas in Epoch 2 60% survived.
- 2.4 A 15-year study of infants born between 23 and 26 weeks' gestation at one US specialist neonatal centre show a consistent improvement in outcome. Between 1986 and 1990, 40% of extreme premature infants of 23 weeks survived, this increased to 66% in the period between 1996 and 2000. The improvements in survival rates for infants born at 24 weeks were 49% for the earlier and 81% for the later period. Survival rates for infants born at 25 and 26 weeks are now 85 and 93% respectively.⁴
- 2.5 A particularly distressing situation occurs if, after abortion, the baby is born alive. A recent survey in the North West of England showed that there were 31 cases between 1996 and 2001. Some of the babies surviving the abortion were at 18 weeks' gestation and more than half under 22 weeks gestation. The babies lived for between 5 minutes and four hours after the termination. Some of the babies started breathing and gave an audible cry. The authors of the study recommended counselling women prior to the terminations that their baby might be born alive.⁵
- 2.6 The current abortion limit, allowing abortions up to 24 weeks therefore needs to be brought down significantly, as in some centres the majority of babies born after 23 weeks gestation survive.
- 2.7 We suggest that the upper limit be brought in line with the majority of European countries, which is 12 weeks⁶. The following European countries, all of which have a lower abortion rate than the UK, have 12 week limits: Austria, Belgium, Denmark,

² Olga Craig. Amillia shows 24 weeks is too late to abort. Sunday Telegraph, 25/02/2007

³ Washburn, LK et al. Survival and major neurodevelopmental impairment in extremely low gestational age newborns born 1990–2000: a retrospective cohort study. BMC Pediatr. 2007; 7: 20

⁴ Hoekstra RE et al. Survival and long-term neurodevelopmental outcome of extremely premature infants born at 23-26 weeks' gestational age at a tertiary center. Pediatrics. 2004 Jan;113:e1-6.

⁵ Vadeyar S, et al. Neonatal death following termination of pregnancy. BJOG: 2005;112, 1159–1162.

⁶ <http://news.bbc.co.uk/1/hi/world/europe/6235557.stm#top>

France, Germany, Greece, Italy, Luxembourg and the Netherlands (13 weeks). Portugal has a 16 weeks limit, Sweden 18 weeks, and Spain 22 weeks. The only European country with the same high gestation limits as the UK is Finland (24 weeks).

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3. **Definition of ‘serious abnormality’**

- 3.1 Abortion for “serious abnormality” is a problematic issue. This is fundamentally an ethical issue, whether or not life is worthy of preservation, even though there is the chance of an abnormality. The philosophical term which best describes this practice is eugenics, a rarely used term in view of its association with the euthanasia programme initiated in Nazi Germany in the 1930s and 1940s.
- 3.2 There has been the widely reported case of Joanna Jepson, a curate in the Church of England, who brought a legal challenge against the Police for failure to prosecute as illegal the late termination of a baby with cleft lip. This has highlighted the issue that there is no universally acceptable definition of disability.
- 3.3 Conversely, as there is the possibility of having an abortion for a baby with disability, there is the possibility of medical error, ie that a healthy baby may be aborted. It has been estimated recently, that if all pregnant women underwent amniocentesis for Downs syndrome it could lead to the termination of 3,200 healthy babies a year. As all antenatal tests have a false positive rate (ie the test suggests that the baby has Downs syndrome, while the baby is in fact healthy) there would be 160 healthy babies aborted for every 50 cases of Down's or Edwards Syndrome detected.⁷
- 3.4 There is anecdotal evidence which ties in with our experience that if through antenatal tests the possibility of a disability is raised, parents are being pressurised into having a termination, which some parents find difficult to resist⁸. It appears that the “default” procedure after the diagnosis of a foetal disability, however minor, is termination. We are aware of a recent case, where parents have been told that their unborn child – at that time 30 weeks gestation – could have slightly shorter legs and may have dwarfism. A termination was offered, which the parents refused. They had a healthy baby some weeks later.
- 3.5 In this context we would like to draw attention to a statement made by the Disability Rights Commission (DRC), a disability rights watchdog set up by the government. The DRC has labelled the Abortion Act as discriminatory, as it allows for abortions to be carried out at any time during pregnancy if there is a significant risk of the baby being born seriously disabled. The DRC stated:
*The Abortion Act “reinforces negative stereotypes of disability and there is substantial support for the view that to permit terminations at any point during a pregnancy on the ground of risk of disability, while time limits apply to other grounds set out in the Abortion Act, is incompatible with valuing disability and non-disability equally. In common with a wide range of disability and other organisations, the DRC believes the context in which parents choose whether to have a child should be one in which disability and non-disability are valued equally.”*⁹
This statement is particularly relevant, as the Government are currently embarking on a major review of anti-discrimination legislation.¹⁰
- 3.6 We therefore believe that there ought to be clear guidance on what constitutes “serious disability” in the context of the Abortion Act.

⁷ Rebecca Smith. Down's syndrome test 'risk to healthy babies'. Telegraph 20.8.2007

⁸ Should only healthy babies be born? BBC News. 19.3.03

⁹ Abortion Act 'discriminatory'. BBC News. 21.8.2001

¹⁰ *A Framework for Fairness: Proposals for a Single Equality Bill for Great Britain - A Consultation Paper.* Department for Communities and Local Government.

4. **Demographic impact of abortion.**

- 4.1 One area of the abortion debate is frequently not considered: After more than 6 million legal abortions since 1967, what has been the demographic impact of abortion on the total population and what are the projections for the next decade?
- 4.2 It is beyond doubt that the increase in the abortion rate has contributed to the decline in the birth rate since 1968. For several years after 1968, the shortfall of fertility below replacement level was approximately equal to the abortion rate. However in recent years the abortion rate has exceeded this.
- 4.3 Using a mathematical model in order to assess the demographic impact of abortion, “Lost Generations” have been computed to illustrate what the population might have been had there not been legalised abortion. The First Lost Generation is based on abortion numbers, assuming that 90% of abortions could have been live births six months later. The Second Lost Generation is then the children of the First Lost Generation whose fertility follows a birth rate augmented by 90% of the abortion rate. The Third Lost Generation is the children of the Second and grandchildren of the First. The 10% of abortions assumed not to have been possible live births are assumed to have been miscarriages or stillbirths, legal abortions on limited grounds or illegal abortions under the old law had it been enforced after 1968.
- 4.4 The absence of the Lost Generations results in the working age population that is 6.07 million (or 6.7%) smaller than it would have been had 90% of the aborted fetuses become live births. As a result of abortion, the working age population in 2017 is forecast to be 10.9% smaller (7.56 million in absolute numbers) than it might have been. The projection for 2027 is a reduction of the working age population of 11.3% (or 9.54 million) than it might have been without abortion.¹¹

¹¹ Dr Patrick S Carroll, PAPRI, (Pensions And Population Research Institute), personal communication; August 2007.

5. The risk of early abortion versus pregnancy and delivery: Mortality

- 5.1 The Guidance issued by the Royal College of Obstetricians and Gynaecologists makes an astonishing statement:
“(...) abortion is safer than continuing a pregnancy to term.”¹²
Taking into account the wording of Section C of the Abortion Act (by far the most common cause for terminations is under Section C) which allows an abortion if *“the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman”*
- 5.2 If indeed, abortion is safer than continuing a pregnancy to term, then, according to the wording of the Abortion Act, essentially every pregnancy could – or perhaps even should – be terminated as it would be in the interest of the mother.
- 5.3 However, the statement that abortion is safer than continuing a pregnancy is based on abortion-related mortality. based on the Confidential Enquiry into Maternal Deaths. However, we are not convinced that official data regarding the abortion-related mortality are accurate. Death certificates rarely mention abortion and there is evidence that – if one relies on death certificates alone – abortion-related deaths are not recognised.¹³
- 5.4 Better data can be achieved through record-linkage studies. A Finnish record-linkage study found that the maternal death rate after abortion was nearly three times greater than the maternal death rate after child birth.¹⁴ The all (natural) cause mortality rates for women who were pregnant or within 1 year of pregnancy termination was compared among Finnish women for a 14-year period, 1987 to 2000. The age-adjusted mortality rate for women during pregnancy and within 1 year of pregnancy termination was 36.7 deaths per 100,000 pregnancies. Maternal deaths within 12 months of end of pregnancy (per 100,000 women) in Finnish population:
- | | |
|-------------------|--------------|
| Births | 28.2/100,000 |
| Miscarriage | 51.9/100,000 |
| Induced abortions | 83.1/100,000 |
- 5.5 This study shows a nearly three-fold increase in total mortality after termination compared to carrying a pregnancy to term. The increased number of deaths after abortion are due to an increased number of violent deaths such as accidents, suicides and homicides but also an increase in overall mortality due to medical causes.
- 5.6 Using record-linkage among low-income Californian women also found a significant increase in mortality after abortion compared to pregnancy. This study noted that compared to women who delivered, women who had an abortion had a 60% increased mortality due to all causes, a 150% increased risk of suicide (after controlling for pre-existing psychiatric conditions) and an 80% increased risk of deaths from accidents over an eight-year period.¹⁵

12 Royal College of Obstetricians and Gynaecologists; The Care of Women Requesting Induced Abortion. September 2004; p. 29

13 Horon IL Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality. American Journal of Public Health; 2005, 95, 478ff

14 Gissler M, Berg C, Bouvier-Colle MH, Buekens P. Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000. Am J Obstet Gynecol. 2004 Feb;190(2):422-7.

15 Reardon DC et al. Deaths associated with pregnancy outcome: a record linkage study of low income women. Southern Medical Journal 2002; 95;834-41.

5.7 The Finnish and Californian studies show very clearly that abortion is *not* safer than continuing a pregnancy to term. We therefore urge the Royal College of Obstetricians and Gynaecologists to revise their guidance in the very near future.

6. The risks of early abortion versus pregnancy and delivery: Psychological and Psychiatric Consequences after abortion

Abortion is not such a harmless procedure. It has significant emotional consequences. In light of recent evidence, the psychological harm done through abortions can no longer be ignored.

6.1 Increase in suicide after abortion

6.1.1 Suicide rate. Studies from three different countries find a significant increase in suicide rate after abortion which is up to six times higher than after childbirth.

6.1.2 Finnish data find a six-fold increase in suicide rate after abortion¹⁶:

Maternal suicide rate within 12 months of end of pregnancy (per 100,000 women):

Births 5.9/100,000

Miscarriage 18.1/100,000

Induced abortions 34.7/100,000

The authors state: *'rather than being a relief, an abortion for them may be additional proof of their worthlessness and might contribute to suicidality and to the decision to commit suicide.'* The researchers also noted that only 11% of the suicides following pregnancy had this connection reported in their death certificate. Therefore there is a significant problem with underreporting of suicides following pregnancy outcome, especially abortion.¹⁷

6.1.3 Data from Wales. A study examining the effect of abortion on suicides was carried out in Wales among a population of 408,000 women¹⁸. Morgan and colleagues studied hospital admissions for attempted suicide among women post abortion, post miscarriage and postnatal. Following induced abortion, there was a doubling of suicide attempts compared to women who delivered normally.

6.1.4 A recent US study examining the medical records of over 173,000 low-income women who underwent a state-funded delivery or induced abortion in 1989. 8 years later, the suicide rate among aborting women was over 2.5 times the rate among women who had delivered.¹⁹

Deaths due to suicide in women who delivered a baby 23.9/100,000

Deaths due to suicide in women who had an induced abortion 62.0/100,000

Violent deaths in women who delivered a baby 233/100,000

Violent deaths in women who had an abortion 428/100,000

The mortality due to violent deaths (accidents, suicides and homicides) was 80% higher among women who had an abortion compared to women who had given birth.

16 Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland 1987-1994. *British Medical Journal* 1996; 313: 1431-4.

17 Gissler M, Hemminki E, Lonnqvist J. Letters section/Authors reply: Suicides after pregnancy in Finland 1987-1994. *British Medical Journal* 1997; 314: 902-3.

18 Morgan CL et al. Suicides after Pregnancy. Mental health may deteriorate as a direct effect of induced abortion. *British Medical Journal* 1997; 314: 902-3

19 Reardon DC et al. Deaths associated with pregnancy outcome. A record linkage study of low income women. *Southern Medical Journal* 2002; 95: 834-41

6.2 Increase in violent deaths after abortion

The increase in violent deaths and deaths due to accidents after abortion was also observed in Finland, where after abortion, there was a five-fold increase in mortality due to accidents and a ten-fold increase in mortality due to homicide after induced abortion.²⁰

Pregnancy-associated mortality per 100 000 pregnancies

	Pregnancy or birth	Spontaneous abortion or ectopic pregnancy	Induced abortion
All external causes	9.6	34.6	60.0
Unintentional injuries	3.9	14.3 (NS)	20.4
Suicide	5.0	16.0 (NS)	31.9
Homicide	0.7	4.2 (NS)	7.7

All data are statistically significant apart from (NS)

6.3 Increase in psychiatric hospitalisation after abortion.

Other “hard” data showing an increase in psychiatric morbidity after terminations are shown due to increased psychiatric hospitalisation after abortion. This study only included women with no previous psychiatric history. After abortion, twice as many women had to be admitted to a psychiatric unit for conditions such as adjustment disorder or single/recurrent depressive psychosis. The risk of admission for bipolar disorder was increased threefold after abortion.²¹

6.4 Increase in substance misuse after abortion

There is an increased risk of substance misuse after termination compared to women who continued with their pregnancies. A recent review of a large number of studies investigating this area found women who had an abortion were two to six times as likely to develop substance and/or alcohol abuse following abortion compared to women who continued with the pregnancy.²²

6.5 Increase in psychiatric morbidity after abortion.

Perhaps one of the most significant recent studies examining adverse psychological effects after abortion is a 25 year longitudinal study from New Zealand. This study followed 500 young women from birth up to age 25 with regular measurements of mental health. After adjusting for confounding factors, those women who had an abortion experienced twice the risk of anxiety disorder, three time the risk of major depression, four times the risk of suicidal ideation and over six times the risk of illicit drug addition compared to those who had given birth. The data analysis controlled for variables such as social background, education, ethnicity, previous mental health and exposure to sexual abuse.²³

In view of the above evidence, the RCOG statement that “(...) *abortion is safer than continuing a pregnancy to term.*”²⁴ cannot be maintained and needs to be revised urgently.

20 Gissler M et al. Injury deaths, suicides and homicides associated with pregnancy, Finland 1987–2000. *European Journal of Public Health*, 2005;5, 459–463.

21 Reardon DC. et al. Psychiatric admissions of low-income women following abortion and childbirth. *CMAJ* 2003;168:1253-6.

22 Coleman PK. Induced Abortion and Increased Risk of Substance Abuse: A Review of the Evidence. *Current Women’s Health Reviews*, 2005, 1, 21-34

23 Fergusson, DM et al. Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry* 47:1 (2006), 16–24.

24 Royal College of Obstetricians and Gynaecologists; *The Care of Women Requesting Induced Abortion*. September 2004; p. 29

7. Medical Abortions, home abortions and nurse-led abortions

- 7.1 Fundamental to the safety issues surrounding both home abortions and nurse-led abortions is the safety of the medical abortion regime, based on the use of two drugs, mifepristone (RU-486) and a prostaglandin, usually misoprostol. As mentioned in the previous section, abortions, whether carried out at home or performed in a hospital setting, have serious adverse physical, emotional and spiritual consequences.
- 7.2 **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 “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.”
- 7.3 **Safety and side effects.** In trials, almost all women using mifepristone for medical abortions experienced abdominal pain or uterine cramping; and a significant number experienced nausea, vomiting, diarrhoea. Vaginal bleeding or spotting lasts on average of nine to 16 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.²⁵
- 7.4 **Mortality.** 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.²⁶
- 7.5 Four of the US fatalities and the Canadian fatality resulted from infections with an 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.²⁷ 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.
- 7.6 Medical abortion has ten times the mortality of surgical abortion. 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.²⁸ As a result about these safety

²⁵ FDA-approved Data sheet on Mifepristone [Mifeprex, Danco Laboratories], July 2005; www.fda.gov/cder/foi/label/2004/020687lbl_Revised.pdf

²⁶ Written Answer by Rosie Winterton, House of Commons, Hansard; 28 April 2004

²⁷ Fischer M, et al. Fatal toxic shock syndrome associated with *Clostridium sordellii* after medical abortion. *N Engl J Med*. 2005;353:2352-60; and: Sinave C, et al. Toxic shock syndrome due to *Clostridium sordellii*: a dramatic postpartum and postabortion disease. *Clin Infect Dis*. 2002;35:1441-3

²⁸ Creinin M, et al. Mortality associated with mifepristone-misoprostol medical abortion. *MedGenMed*. 2006;8:26.

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.²⁹

- 7.7 There has been a case report of an adolescent girl dying following self-administration of misoprostol in order to induce abortion.³⁰

29 Some Doctors Voice Worry Over Abortion Pills' Safety. New York Times; April 1, 2006

30 Henriques A, et al. Maternal death related to misoprostol overdose. *Obstet Gynecol.* 2007;109:489-90

8. Conclusions

- 8.1 For the past 40 years there has been a steadily growing recognition of the immense social and clinical significance of abortion and of its real dangers to society, which we believe ought to be considered by the Select Committee on Science and Technology.
 - 8.2 There is growing recognition that the physical, emotional, spiritual and social consequences of abortion have been widely underestimated.
 - 8.3 Many matters such as the reality of foetal memory and evidence that the unborn child appears to feel pain and discomfort cannot continue to be ignored and are radically changing public attitudes to the value and sanctity of life in the womb. We believe the Select Committee cannot ignore this.
 - 8.4 We believe that it is crucial that the Committee should not divorce issues of ethics and morality from their scientific inquiries.
 - 8.5 There is now sufficient scientific and clinical evidence available to the members of the Committee to warrant them pressing for a fundamental reconsideration of all policies, which have led to the unprecedented level of abortion in our country today.
-