Ethics briefings

Abortion: England, Scotland, and Wales

In mid-summer 2004, the moral debate surrounding abortion continued to gather momentum in the British media, centring on calls to review the 24 week limit currently set for most abortions (although it is lawful to terminate up to term in certain circumstances). It was proposed that the parliamentary science and technology committees should jointly review the Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990.[1] The act sets a 24 week limit for abortions carried out when ''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 or any existing children of her family''. Critics have frequently pointed out, however, that continuation of pregnancy invariably involves more risk than termination.

Medicine has advanced in many ways since the act was passed nearly 40 years ago. In 1990, amendments were made changing the original limit of 28 weeks' gestation to 24. Current calls for review—possibly to a 22 week limit—also focus on medical advances in monitoring fetal development and increasing survival rates of premature infants.[2]

Discussion about late abortion (after 24 weeks' gestation) was also the subject of debate at the British Medical Association's (BMA) 2004 annual meeting. A resolution was passed calling upon the association ''…to work with the General Medical Council, NHS [National Health Service] and appropriate royal colleges to ensure that babies born alive as a result of termination of pregnancy procedures receive the same full neonatal care as that available to other babies''. Proposers of the motion made clear that they were not calling for automatic transfer of all such babies to intensive care but rather that the same consideration be given to their treatment as for any other child born alive.

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Legally, late abortions are permitted to prevent grave permanent injury to the pregnant woman or if there is a substantial risk that the child would suffer from serious abnormalities. Where the pregnancy is terminated to save the mother's life, it may well be that parents also hope the child will survive. Where the reason for termination is severe fetal abnormality, clearly the intention is to avoid a live birth. Guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) states that ''when abortion is induced at a gestation at which the fetus, after birth, might be capable of remaining alive by breathing through its lungs it is imperative that the fetal heart is arrested before delivery: that is part of the legal abortion''.[3] Although it is rare for babies to survive late termination, published BMA advice is that from birth all people have the right to expect care and treatment appropriate to their needs.[4]

In 2002 114 abortions were performed beyond 24 weeks' gestation for residents of England and Wales.[5] This represents 0.065% of all abortions performed for residents in that year. Four of these abortions were performed on grounds of permanent injury to the mental or physical health of the woman and the remaining 110 were because of serious handicap.

Sexual Offences Act 2003

In November 2003 the Sexual Offences Act received royal assent. Essentially the UK act introduced new legal provisions in relation to sexual offences. It contains measures for protecting the public and vulnerable people in particular from sexual harm. One new provision, section 8(1), makes it an offence for any individual intentionally to cause or incite a person under the age of 13 to engage in sexual activity. Subsequent to its enactment, there was some confusion amongst health care professionals regarding this aspect of the act. Concerns centred specifically on how it might affect contraceptive, sexual, and reproductive health advice and treatment given to young people, especially those aged 13 or under. This could be particularly problematic for the UK which has one of the highest teenage pregnancies rates in Europe and where government initiatives in recent years have sought to reduce such unplanned pregnancies. In 2001, for example, there were 7891 conceptions in 13–15 year olds in England and Wales.[6]

Organisations such as the BMA received queries from doctors as to whether providing contraceptive advice and treatment could be considered to be inciting sexual activity in under-age patients under the act. Some doctors also questioned whether the act might also impose a statutory obligation on them to report young people of 13 or under who appeared to be sexually active, on the grounds that responsible professionals might have a duty to report potentially criminal acts. In fact, however, the new act does not have such a requirement although there remains a general obligation to take some action in cases where health professionals suspect that a young person might be being exposed to abusive or involuntary sexual activity or exploitation.

Section 73 of the act addresses doctors' concerns in relation to the provision of contraceptive advice or sexual health services. Essentially, health care professionals do not commit an offence if they act: to protect the young person from sexually transmitted infection; protect the physical safety of the young person; to prevent the young woman from becoming pregnant, or to promote the young person's emotional wellbeing by the giving of advice. In relation to the confidentiality of young patients, the BMA has had long established guidelines, drawn up jointly with the Health Education Authority, Brook Advisory Centres, the Family Planning Association and the Royal College of General Practitioners. *Confidentiality and People under-16* sets out the legal and ethical position in relation to young patients.[7] The association will be revising this specifically in order to allay doctors' fears about a duty to report. The BMA remains committed to the view that it is essential that competent young people's confidentiality continues to be respected both to ensure a good doctor/patient relationship and to encourage young people to seek timely contraceptive advice.

In the meantime, in the summer, guidance was published by the Department of Health on contraceptive, sexual, and reproductive health advice and treatment for young people under 16. This includes guidance on the new act and helps to clarify best practice for health care professionals. It also

emphasises that competent young people should be secure in the knowledge, when seeking contraceptive, sexual, and reproductive health advice and treatment, that it will continue to be in confidence.

USA: doctors choosing their patients

It is a deeply rooted belief that doctors should be non-judgmental and not discriminate unfairly in offering medical care. In the UK, for example, the General Medical Council warns doctors that they must not permit their personal beliefs to affect the care they provide to patients and that they must treat every patient considerately.[8] The BMA offers similar advice, warning that doctors might be in breach of the human rights legislation if they seek to discriminate between patients who are entitled to care, on grounds other than assessment of relative clinical need.[9] Furthermore, the World Medical Association's Declaration of Geneva, states: ''I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patients''.

A couple of recent stories from the USA, however, challenge this widely held belief.

a) Conscientious objections: ethical, moral, or religious grounds

Firstly, in Michigan, a package of conscientious objector bills is, at the time of writing, going through the state's legislature. One states that ''a health care provider may object as a matter of conscience to providing or participating in a health care service on ethical, moral, or religious grounds''.[10] The provision is only intended to apply to non-emergency care and would have no effect, for example, if a patient's condition required immediate action and no other qualified health care provider was available to provide it, or in the event of a public health emergency. In addition, some groups or classifications of patient cannot be refused care because of pre-existing antidiscriminatory civil rights legislation. Particular concern has been expressed, however, that the civil rights exemption does not include any prohibition on discriminating against people on the grounds of their sexual orientation. Speakers against the proposed bill have stated that, if passed, the new Michigan legislation could permit health care providers to refuse to treat non-urgent cases if they have an objection to the patient's sexual orientation. Thus, despite the wide ranging exemptions, the draft legislation reflects a fundamental change in emphasis in the relationship between health care providers and patients. The Michigan State Medical Society, the Michigan Hospital Association, and the Michigan Nurses Association are all reported to be opposed to the bill, whereas the Michigan Catholic Conference and the Michigan Right to Life organisation are reported to be supporters of the bill.

b) Malpractice lawyers and their spouses

Secondly, at the American Medical Association's (AMA) House of Delegates 2004 annual meeting, a motion was debated asking the association to ''notify physicians that, except in emergencies and except as otherwise required by law or other professional regulation, it is *not* unethical to refuse care to plaintiffs' attorneys and their spouses''. The proposer of the motion has been reported as publicly stating that he would not treat (except in an emergency) one attorney who campaigned against limits on malpractice suits.[11]

Although the motion was not actually adopted by the AMA, the very fact it was on the agenda and debated reflects a growing tension in the USA between the delivery of health care and malpractice law. The motion's inclusion on the agenda was also intended to highlight the lack of progress in establishing a comprehensive federal medical liability reform law. The AMA currently lists 20 US states that are in ''medical liability crisis''—states where doctors are limiting the scope of their medical practice or leaving altogether, due to the high cost of medical liability insurance or, in some cases, an inablility to obtain it. The AMA has expressed grave concerns that, as a result, increasing numbers of doctors are no longer providing crucial medical services such as delivering babies and trauma care, ultimately to the detriment of patients.

Similar concerns have long been expressed in the UK—for example, that medical students would be deterred from entering specialties such as obstetrics because of the higher risks of litigation and rising insurance costs. The prediction that doctors generally will increasingly practise ''defensive medicine'' to the detriment of patient care has also long been with us. Such fears were further fuelled by a series of public inquiries and high profile legal cases in the late 1990s which focused attention on failings in some areas of medical practice, such as pathology. Organ retention scandals and consequent tightening of regulations governing autopsies, for example, raised concerns about the training and availability of future pathologists. In July 2004, the BMA's annual conference included a motion highlighting the increasing reluctance of paediatricians to undertake child protection work following the overturning of cases such as Sally Clarke's[12] and the discrediting of the earlier paediatric medical evidence provided.

Clearly a balance is needed which minimises defensiveness and maximises openness when errors occur. This is one of the issues discussed in the BMA's 2004 publication, *Medical Ethics Today: the BMA's Handbook of Ethics and Law* (BMA,[4] ch 21).

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