SPUC Resource to Assist with Responding to the Document by THE COMMITTEE FOR HEALTH & SOCIAL CARE regarding MODERNISATION OF THE ABORTION (GUERNSEY) LAW, 1997

This resource is structured so as to address each of the major proposals for abortion law reform that were raised in the Island of Guernsey *Committee for Health & Social Care* document of the 2nd March 2020. Each section describes a proposal in the document followed by one or more responses pointing out why the proposal is misguided and/or based upon false premises or inaccurate evidence.

Easier Access to Abortion

The proposals within this document are premised upon the idea that abortion should be as easy as possible to access, with minimal if any restraint.

Response:

Removing virtually all restriction on abortion borders upon treating abortion as a social good. While views about abortion vary within the community, ranging from full acceptance to full rejection, even among those who want it to remain a legal option, most do so reluctantly and in the hope that it will be 'safe, legal, and rare'. The hope that permissive legislation can achieve that goal has been misguided as evidenced by the expansion of abortion in most Western democracies. But there can be no doubt that the overwhelming majority wants fewer abortions rather than more. Recognition of the moral significance of abortion causes most people to want abortion to be discouraged, rather than encouraged. Yet this document proposes strategies that do the opposite and will maximize rather than minimise abortions, and in the process further trivialise and normalise them.

Abortion as a Medical Procedure

Pervasive throughout the document is the idea that abortion is no different to any other medical procedure and should therefore be treated in the same way.

For example:

- The committee argues that a 'problem' exists in "abortion provision being more restrictive than other medical procedures" (1.2 & 5.1).
- The two- doctor requirement is "out of step with all other medical and surgical procedures" (5.5).
- It is "considered illogical and unjust to apply different access and assessment criteria for a woman to access an abortion procedure compared with all other medical or surgical treatments" (5.9).
- Any abortion law must "provide seamless access to care and mitigate against delays" (5.59).
- Notably, for the purposes of the public meeting, Professor Lesley Regan, former president of the *Royal College of Obstetricians and Gynaecologists* will argue the case for the proposed changes. Professor Regan believes "abortions should be treated no differently from other medical procedures – including something as simple as removing a bunion."[1]

Responses:

[1] https://www.dailymail.co.uk/news/article-4889942/Top-medic-calls-looser-abortion-laws.html

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- One reason why abortion is unlike any other medical procedure is that it does not treat a pathology. The primary goal of medicine is to restore health. The primary goal of abortion is to abort an entirely natural process, to eliminate human life from the womb. In only a tiny fraction of cases is there a risk to the mother's life or health.
- Abortion has been the subject of intense human scrutiny for millennia by philosophers, theologians, ethicists, medical professionals, and intelligent lay people alike – and still is, as any perusal of the literature reveals. Even those who may rationalise abortion in some way must honestly acknowledge the gravity of the issue, and its unique status that distinguishes it from other medical procedures. To equate abortion with a simple medical procedure is as scientifically inaccurate as it is philosophically vacuous.
- This document is out of line with public opinion. The 2017 UK ComRes Poll revealed that the public wants more restriction on abortion, not less.[2] 70% of women want the gestational limit reduced, not raised, and 77% of respondents want doctors to be required to verify that there is no pressure from a third party to abort. The public does not hold such views on medical procedures generally because they acknowledge that abortion is unique.

Role of Second Medical Practitioner

The committee argues for the removal of the current requirement for two doctors to see a woman seeking abortion.

The argument is based upon:

- The 2-doctor rule does not hold for other medical procedures (5.5, 5.8 & 5.9).
- The 2-doctor rule "incurs additional cost" and is a "direct financial barrier" (5.5).
- The 2-doctor rule "serves no purpose other than compelling a woman to seek an unsafe abortion" (5.6).
- The committee also gives favourable mention to the situation on the Isle of Man, where up to 14 weeks gestation, women do not need to see a doctor at all. The committee is not proposing this approach – "at this time" (5.1).

Responses:

- Because abortion is not like any other medical procedure, specific safeguards like the two- doctor rule exist for a procedure of this gravity. Evidence exists that ambivalence is common in an abortion decision[3], and therefore streamlining and trivialising what a woman is dealing with does her a disservice. The two-doctor rule minimises coercion and rash decision-making, protects the doctor and the woman, and limits bias. Many people seek a second opinion about serious health treatment issues because they know that a single doctor's judgements are not perfect, or necessarily the best evidence based practice. For something as serious as ending the life of a developing human being, the two-doctor rule is quite unsurprising.
- There is no evidence that financial matters (argued to be exacerbated by the two-doctor rule) stop women from having an abortion any more than financial matters stop any woman from receiving treatment for a health condition. Why preference abortion, which is overwhelmingly *not* health treatment, above standard medical treatment?
- The claim that the two-doctor rule compels women to seek unsafe abortions is without evidence and hence speculative. In any case, by arguing for medical abortions to actually occur in the home (see 5.39), the document is promoting unsafe abortions. The WHO definition of an unsafe abortion is

[2] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf
[3] Kero A, Högberg U, Jacobsson L & Lalos A (2001) Legal abortion: a painful necessity. *Social Science and Medicine* 53:1481-1490.

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quoted at 5.6 as follows: '*a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not confirm to minimal medical standards, or both.*' The home environment does not conform to minimum medical standards.

- By analogy with another controversial issue, namely euthanasia, even in the permissive regime in the Netherlands, a range of restrictions is in place, one being a requirement for a second doctor.
- What is the point of raising the extremely permissive situation in the Isle of Man if not to flag it as a future desirable development for Guernsey? A good question to ask proponents of abortion law reform such as Professor Regan is whether she thinks the Isle of Man approach is appropriate, and if not, whether it can be ruled out.
- In the Care Quality Commission inspection of more than 250 UK abortion clinics, it was estimated that between 15% and 20% may be breaking the law by having pre-signed consent forms available, thereby flouting the legal requirement for two doctors to agree to the abortion.[4] If these doctors are prepared to act illegally under the 2-doctor rule, why would anyone think they would not also be prepared to act illegally under a 1-doctor rule – perhaps by providing pre-signed consent forms so that a woman does not see a doctor at all?

Gestational Thresholds

The committee proposes two changes to the law regarding the gestational age of the child:

1. That abortions for "significant foetal abnormality" (5.29), which are currently legally permitted up to 24 weeks gestation, be permitted up till birth.
2. That abortions where "*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"* (section 3(1)(d) of the current law), which are legally permitted up to 12 weeks gestation, be permitted up to 24 weeks.

The argument for the first is based upon the fact that for some rare conditions, diagnosis and testing may need to occur close to the 24 week threshold (5.17). An example is then provided of a rare condition that occurs once every 8 years (5.18 & 5.19).

Responses:

- Specific permission to abort a disabled child is a powerful statement about how disability is viewed, as this legal category specifically targets the disabled child but not the non-disabled child. Increasing the threshold right up to birth amplifies this discrimination.
- The examples used by the document to argue for the change are rare. The overwhelming majority of abortions of unborn disabled children in the UK were before 24 weeks (99.9%).[5]

The argument for the second change is based upon timing of an abortion sometimes being out of a woman's control (5.22, 5.23 & 5.24), while as a consequence, financial costs for post-12 week abortions will unfairly disadvantage poorer women (5.25, 5.26, 5.27 & 5.28).

Responses:

- The committee itself acknowledges that the changes in the UK from a 12-week threshold to a 24 week threshold for this category have not changed the proportion of abortions occurring under 12 weeks (5.21). This is evidence that the change was unnecessary, and the arguments used unfounded.

[4] https://www.theguardian.com/society/2012/mar/23/abortion-forms-pre-signed-spot-checks
[5] Abortion Statistics, England and Wales: 2018. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf

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Most abortions in this category are for social reasons, so any change further trivialises the lives of unborn children.

- Arguably, abortion providers have been acting illegally for decades by providing abortions in this category without any evidence that the abortion would be less of a risk than continuing the pregnancy. It has become the 'abortion on demand' category. The law requires proof of *less* risk from abortion. Rather than even equal risk, the risk of physical and mental harm to women is *greater* from abortion compared with continuing pregnancy across several domains – mental health, breast cancer (delivery confers a protective effect), subsequent preterm birth, mortality.
- The argument that timing of an abortion is out of a woman's control is weak. The examples given are speculative, and in any case, as noted, the experience in the UK shows that raising the threshold to 24 weeks has not changed the proportion of abortions under 12 weeks.
- The suggestion that domestic violence may stop a woman accessing abortion services (5.24) is undercut by research showing that rather than stopping access to abortions, intimate partner violence is related to coercion and violence in the direction of *seeking* abortion.[6] It is both unbalanced and disrespectful to women that the only reference to domestic violence in this document is to argue for the expansion of access to abortion, rather than instead dealing with the reality of coercion and pressure to abort identified in many studies. Women may instead keep their child if supported and protected from coercion and violence.[7]

Role of the Criminal Law

The committee proposes the following:

1. Removing criminal sanctions from women who procure their own abortions, on the grounds that " … criminal sanctions that surround the procedure may indeed prevent some women from accessing services … " (5.33), and that "While the criminal sanction remains in the Law there is also a risk that a woman who experiences complications from the use of abortifacients, now widely available online, may not seek timely emergency medical care." (5.33). The committee also believes criminal sanctions will lead some women to self-induce an abortion outside of the available services (5.32).
2. Removal of any " … extant, archaic provisions on the statute book … " (5.35).

Responses:

- There is no evidence that the current criminal sanctions stop women from accessing abortion services. This is speculative.
- There is no evidence that women will not seek emergency care because of criminal sanctions. This is speculative.
- Criminal sanctions should remain because of the gravity of abortion. Retaining criminal sanctions has educative value about this gravity. To remove them will further trivialise the life of the unborn child.
- Without explaining what 'archaic' provisions exist, it is not clear what is being proposed. This is important for several reasons, one of which relates to circumstances where a pregnant woman has been attacked and lost her unborn child. This is rightly seen as doubly cruel – direct harm to the mother *and* loss of her child. There must remain in the criminal code a means of protecting women

[6] Silverman JG, Decker MR, McCauley HR, Gupta J, Miller E, Raj A & Goldberg AB (2010) Male perpetration of intimate partner violence and involvement in abortions and abortion-related conflict. *American Journal of Public Health* 100 (8):1415-1417.
[7] Kirkman M, Rosenthal D, Mallett S, Rowe H & Hardiman A (2010) Reasons women give for contemplating or undergoing abortion: A qualitative investigation in Victoria, Australia. *Sexual and Reproductive Healthcare* 1:149-155.

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in such circumstances. Depending on how far the proposals extend, decriminalising abortion may remove an appropriate means of punishing the perpetrator and risk an increase in crimes against women that are intended to kill the child she carries. As it is there is a well-established link between intimate partner violence and abortion. Decriminalising abortion in these circumstances protects the perpetrator from the consequences of taking the life of someone very precious to a mother.

Location of Abortion Services

The committee "…recommends that the primary legislation is amended to remove the requirement for medical abortions to take place only at the Princess Elizabeth Hospital" (5.39), on the grounds that medical abortions have "decreased risks", and " … that upon strict reading, it could be interpreted that Health & Social Care is in breach of the Law and that given changing practice, it is appropriate for the Law to be updated" (5.37).

Responses:

- It is incorrect to say that medical abortions have decreased risks compared with surgical abortions. In a large Finnish register study, the overall incidence of adverse events was four times higher after medical abortion compared with surgical abortion.[8] The *National Institute for Health and Care Excellence* (NICE) claims the risk of *serious* complications is roughly the same for medical and surgical abortions.[9] However, medical abortion has a failure rate in controlled studies of at least 5%[10], so about one in 20 women will have a surgical follow up abortion. In a large Swedish study the complication rate was 8.2%, having doubled from 4.2% in 2008[11], possibly because medical abortions have been increasingly occurring away from medical care, such as in the home. Also, about 40% of women described their pain during medical abortion as severe [12], and some describe the psychological aspects of seeing the results of their abortion, possibly at home and alone, as traumatic. [13] Consistent with this, medical abortion is associated with increasing the risk of developing possible Post Traumatic Stress Disorder compared with surgical abortion.[14]
- If Health & Social Care are prepared to flout the current law, they are not acting as exemplars for the community, but instead bring the law into disrepute. Can they be trusted to act differently under any new law?

Professionals who can perform abortion procedures

The committee proposes that registered nurses and registered midwives should be able to perform medical abortions (5.42). The justification seems to be to "reflect modern practice", which is that it is "nurses and midwives who administer medication" (5.42).

Response:

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[8] Niinimaki M *et al.* (2009) Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. *Obstet Gynecol* 114:795–804.

[9] https://www.nice.org.uk/guidance/ng140/resources/abortion-before-14-weeks-choosing-between-medical-or-surgical-abortion-patient-decision-aid-pdf-6906582255

[10] Raymond EG *et al.* (2013) First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* 87:26-37.

[11] Carlsson I *et al.* (2018) Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 18:158.

[12] Goldstone P *et al.* (2012) Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study. *Medical Journal of Australia* 197:282-286.

[13] Hedqvist M *et al.* (2016) Women's experiences of having an early medical abortion at home. *Sexual & Reproductive Health Care* 9:48-54.

[14] Rousset C *et al.* (2011) Posttraumatic stress disorder and psychological distress following medical and surgical abortion. *Journal of Reproductive and Infant Psychology* 29(5): 506-517.

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- The committee is arguing from current practice that nurse and midwives who *administer* drugs for abortion should now be permitted to *perform* them. It is not clear what this means, but if the proposal is to in any way diminish the role of a medical practitioner in the abortion process, women will be placed at increased risk. Only medical practitioners have the requisite experience and knowledge.

Conscientious Objection

The committee proposes three changes with regard to conscientious objection:

1. The first change is not made absolutely clear, and hence it is difficult to know what is really being proposed. However, basically it appears to include a legal requirement that (in addition to the existing exemption to save the life of a pregnant woman) does not permit conscientious objection that may risk grave and permanent injury to the health of a woman. What is not clear is whether this includes injury to the mental health of a woman, although it appears it may (5.44).
2. That a "suitable regulation-making power" be set up in the Law to determine the "precise scope" of the obligations regarding participation. The document proposes that conscientious objection should only apply to "direct participation in the abortion procedure itself" (5.54). Hence, refusal to participate in the preparatory events leading up to an abortion would not be permitted (5.47).
3. That a clinician with a conscientious objection be required to refer a patient to another clinician known not to have a conscientious objection (5.59).

Responses:

- Some overriding of conscientious objection may be defensible where urgent treatment is needed that focuses on the woman's own body, not her child's – e.g. removing a damaged tube in the case of an ectopic pregnancy is not an abortion, as the child is impacted only as an unintended side-effect. Entirely different would be any proposal that conscientious objection to actual abortion be overridden, even perhaps in the case of a supposed risk of serious and permanent harm to *mental* health. Permitting abortion on mental health grounds has effectively enabled abortion on demand because of very loose interpretation of those grounds. Paralleling this in the area of conscientious objection would likely incur the same risk and result in pressuring doctors with a conscientious objection to perform an abortion because others may argue that mental health would be adversely affected by the abortion.
- The right of medical professionals to conscientiously object to participation in abortion and any other practice which conflicts with their conscience is well established in the history of ethical deliberations, the various codes of ethics of peak medical bodies and international law. That right is usually interpreted widely enough so as to genuinely provide the opportunity for medical personnel to refrain from participation, as they typically interpret it, in practices which conflict with their "basic, identity-conferring, moral, religious, and philosophical convictions." That right has been eroded in recent years, particularly with regard to abortion. The reasons have less to do with patient access and care, and more to do with silencing dissent, forcing compliance, and for those who resist, forcing exit from their professions.
- For a medical practitioner who conscientiously objects to a practice, the requirement to refer a patient to another practitioner who does not conscientiously object has been recognised by the *Joint Committee on Human Rights* (12th Report, 2003-04 session) as constituting a breach of Article 9(1) of the *European Convention on Human Rights.*[15] This should not be surprising, because for someone

[15] House of Lords House of Commons Joint Committee on Human Rights Scrutiny of Bills: Fifth Progress Report, Twelfth Report of Session 2003-04, p26, see http://www.publications.parliament.uk/pa/jt200304/jtselect/jtrights/93/93.pdf

who believes that abortion is the killing of an innocent human being - a belief that has been held by millions if not billions the world over for centuries – enabling an abortion to happen *is* participation. The law recognises that aiding and abetting is wrong, for example with respect to suicide, because to do so is to enable suicide. Onward referral is aiding and abetting and therefore constitutes participation in procuring an abortion.

- The committee is worried that conscientious objection contributes to stigma (5.45 & 5.53). If that is so, the answer is not to restrict the rights of those with a conscientious objection. Those who think there should be no stigma are free to argue their case in the public square, but they have no right to use the force of law to threaten others into believing (or seeming to believe) what they believe.
- Setting up a regulation-making power gives those involved a free hand to interpret and apply the scope of conscientious objection without the knowledge or participation of those most directly affected. The scope should be made absolutely clear at the outset so the medical community knows what they are being asked to respond to. The regulation-making power should not be permitted.
- In a similar vein to the question of legally enforced onward referral, medical staff should not be forced to participate in the events leading up to an abortion. Many will see this as aiding and abetting an abortion and understandably wish *not* to participate. Care provided after an abortion, in an emergency situation, is a different matter, and medical staff should carry out their normal duties of care.

Will Loosening Restrictions Mean More Abortions?

The document quotes WHO as follows: '*whether abortion is legally restricted or not, the likelihood that a woman will have an abortion for an unintended pregnancy is about the same*' (5.6).

However, the document later acknowledges "The abortion rate for Guernsey and Alderney is lower than in England and Wales. Should it be the case that the lower rate is, in part, due to the current legal restrictions, it is acknowledged that the recommended changes to the Law may result in an increase in the number of abortions that take place" (6.1).

Response:

The reference to WHO raises complex and difficult assessments of abortion in legal versus illegal regimes that are notoriously inaccurate. The idea that legal restriction makes no difference is both illogical and in fact false. A more accurate way to assess the impact of legal changes is *within* a country once the change has occurred. In the UK, the legal change of 1967 led to a rapid rise in the number and rate of abortions – the number has increased by 275% in England and Wales since 1969, more than doubling between 1969 and 1971.[16] In the Australian state with the most accurate data, South Australia, after legalisation the rate nearly trebled from 6.0 per 1000 women of reproductive age in 1970 (the year after the change) to 17.6 in 2000.[17]

[16] https://abort73.com/abortion_facts/uk_abortion_statistics/

[17] Annual Reports of the South Australian Abortion Reporting Committee, Parliament of South Australia.

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