

BPAS response to the consultation on updating Guernsey's abortion law

June 2020

The British Pregnancy Advisory Service (BPAS) is a British reproductive healthcare charity that offers abortion care, contraception, STI testing, and pregnancy counselling to 100,000 women each year via our clinics in Great Britain. We also treat clients from Northern Ireland, Ireland, and Europe, particularly where their domestic laws prevent them accessing the care they need.

As part of our advocacy work to enable the women we treat to get the best possible care, we campaign for the decriminalisation of abortion. We do not believe there are circumstances where it is ever appropriate to imprison a woman for making a decision about her own pregnancy.

Our position

BPAS strongly supports the proposals of the Health and Social Care Committee and the desire to ensure that abortion law in Guernsey is brought up to date and into line with human rights standards – recognising that abortion is a healthcare decision that should be made between a woman and her doctor and governed by relevant medical law.

BPAS supports an approach to abortion legislation which enables healthcare professionals to develop best practice as evidence and techniques develop, and to provide services which meet international standards.

Decriminalising women

Currently, the law in Guernsey is the same as underlies provision in England and Wales. Although passed in 1997, it is based on a piece of legislation passed in Westminster in 1861 – long before women even had the vote. It carries the harshest penalty in the world for a woman ending her own pregnancy at any stage – life in jail.

The current law is out of step with the western world and goes further than laws even in the most restrictive of abortion regimes. Countries as diverse as France, the United States of America, Canada, several states in Australia, Ireland, Northern Ireland, and even the strongly anti-abortion Poland do not criminalise women.

With regards to this legislation and its impact on the Article 3 rights of all citizens to be free from inhuman or degrading treatment, Lord Kerr's portion of the NIHCR Supreme Court ruling on the operation of the same law in Northern Ireland in 2017¹ said:

261. We need to be clear about what the current law requires of women in this context. It is not less than that they cede control of their bodies to the edict of legislation passed (in the case of the 1861 Act) more than 150 years ago and (in the case of the 1945 Act) almost 75 years ago. Binding the girls and women of Northern Ireland to that edict means that they may not assert their autonomy in their own country. They are forbidden to do to their own bodies that which they wish to do; they are prevented from arranging their lives in the way that they want; they are denied the

¹ <https://www.supremecourt.uk/cases/docs/uksc-2017-0131-judgment.pdf>

chance to shape their future as they desire. If, as well as the curtailment on their autonomy which this involves, they are carrying a foetus with a fatal abnormality or have been the victims of rape or incest, they are condemned, because legislation enacted in another era has decreed it, to endure untold suffering and desolation. What is that, if it is not humiliation and debasement?

There is no place in modern law for the continued criminalisation of women seeking to end their own pregnancies.

BPAS strongly supports recommendation 1 to remove women ending their own pregnancy from the criminal law.

The role of healthcare professionals

The requirement for two doctors' signatures and for registered medical practitioners to lead on abortion provision is a requirement grounded in Great Britain's Abortion Act. When passed in 1967, the Abortion Act was designed to protect women's health – yet in the 21st Century it prevents the provision of the best possible medical care for women.

As the largest abortion provider in England and Wales, BPAS are familiar with the operation of the 1967 Abortion Act in practice, as well as the issues it presents for women seeking to access care. Many of the issues that are present in the 1967 Act are often exacerbated in small and/or remote communities such as Sark or Alderney where care can be unduly restricted and women may be unable to access the care they need. These issues are likely to be further exacerbated across the Bailiwick where healthcare professionals will need training and where the numbers of women seeking to access care would be relatively low.

Two doctors' signatures. The current law requires that two doctors approve each request for a termination. This is a legal requirement which serves no clinical or safety purpose, and is separate to the process of obtaining informed consent, clinical assessment, and safeguarding. The role of these doctors is detached from clinical involvement - established case law already makes clear that doctors do not have to see a woman in person, can rely on information obtained by a multi-disciplinary team, and do not have to be on the same premises as the woman being treated. No other comparable medical procedure demands legal authorisation by doctors in addition to the normal requirements of obtaining informed consent. This requirement can cause delays for women. This can harm their health as abortion – while extremely safe – is safer the earlier it is performed. On occasion it can even force women to continue pregnancies against their will, seriously jeopardizing their health.

Nurse-led care. Within the BPAS service, the vast majority of care is provided by qualified nurses and midwives – they provide consultations, they take medical history, they take consent for the client. However, the current law prohibits the full development of nurse or midwife-led services, as is already the case in Sweden, Norway, and France, and that are now the model in delivering woman-centred maternity care. There is no reason why suitably qualified nurses and midwives could not perform surgical abortions if they wished to train in this area – or, indeed, sign off on providing an Early Medical Abortion. Allowing those staff to offer this service would represent an important area of development, could reduce waiting times, and may often be preferred by women. This extension of the types of healthcare professionals allowed to provide abortions can also help in small communities where a single doctor with a Conscientious Objection may cause serious issues for the delivery of a timely service for women.

BPAS strongly supports recommendations 2 and 6 to remove the requirement for two doctors' signatures and to enable nurses and midwives to provide abortion services.

Time limit

An increase in the time limit to 24 weeks would bring Guernsey into line with the UK, including the newly-established law in Northern Ireland. This time limit is something we strongly support.

The current 12-week limit gestational limit for women's mental or physical health neglects to take into account the many reasons why women may present beyond this point – including that they were unaware of their pregnancy owing to contraceptive use which can make periods irregular and have side-effects which mimic pregnancy; that they have been misadvised about their fertility particularly with regard to menopause or breastfeeding and thus do not believe they can become pregnant; that they are young, scared, or unaware of what is happening to them; that they are traumatised as a result of sexual crime; or that they are in crisis situations where a previously wanted pregnancy is now not an option, such as having a partner who has died or an existing child with a newly-diagnosed serious illness.

Women do not present late for simple reasons – they are often in vulnerable situations which would be immeasurably worsened by forcing them to continue with a pregnancy.

At the same time, British abortion figures make clear that later presentations are rare and that the vast majority of women will continue to present within the first 12 weeks – even where abortion is available up to 24 weeks. A longer time limit enables women in difficult circumstances to opt to end their pregnancy – but it does not encourage other women to delay seeking care. In the most recent abortion statistics for 2018 from the Department of Health and Social Care:

- 82% of terminations occurred before 10 weeks;
- 92% were before 12 weeks;
- 99% were before 20 weeks; and
- 99.9% were before 24 weeks.

BPAS strongly recommends that the Health and Social Care Committee, when developing professional guidance on gestation, look to both the NICE guidance and the RCOG guidance on abortion provision – both of which provide for circumstances without routine scanning. BPAS has recently rolled out a service without routine scanning of clients – where scans are performed only where women are unsure of gestation or where there is reason to suspect an ectopic pregnancy. This enables women to access care without lengthy appointments, for hospitals to provide care without multiple appointments in different departments, and without the added stress for women of having a trans-vaginal scan at earlier gestations. It also enables remote services for women from other islands who may find travelling to hospital a barrier to care.

BPAS strongly supports recommendations 4 and 5 to increase the time limit to 24 weeks and to issue professional guidance on determination of gestation – which we would hope would include the provision of service without routine scanning.

Foetal anomaly

The removal of a time limit for terminations on the grounds of foetal anomaly (TOPFAs) would bring Guernsey into line with all parts of the United Kingdom. This provision has been debated numerous times in Westminster, with the current law remaining in place.

The 20-week anomaly scan

The current restriction of severe foetal abnormality diagnoses to 24 weeks' gestation limits women's access to clinical care after matters of concern are detected at a 20-week anomaly scan – restricting the time available to make an informed decision about their pregnancy.

The 20-week anomaly scan is the primary means by which around 40% of severe foetal anomalies are detected. Based on UK practice, this can occur at any point up to 23⁺⁰ as a result of routine re-scanning for some women with high BMIs, abdominal scarring, or suboptimal foetal positioning. 11 conditions are screened for as a minimum as part of the 20-week anomaly scan, which include open spina bifida, diaphragmatic hernia (where the intestine moves through a hole into the chest and impedes lung development), serious cardiac anomalies, and exomphalos (where the bowel and other organs develop outside the foetus).

If abnormalities are detected at this point, detailed assessment in the Fetal Medicine Unit at Southampton may include specialist ultrasound assessment, counselling, invasive diagnostic procedures, and invasive and non-invasive therapy. It is not generally possible to determine the severity or progression of a severe foetal abnormality based on the original scan – and further care, and thus time, is needed in order for women to make an informed choice.

As such, restricting women's choices beyond 24 weeks has the impact of increasing abortions prior to that point as women seek to exercise their rights before the legal deadline of 24 weeks.

Fatal Foetal Anomaly

We are aware that much of the discourse around later terminations is currently around the ethics of providing terminations for severe foetal anomaly as opposed to fatal foetal anomaly.

Restricting provision solely to 'fatal' foetal anomaly is not possible without forcing some women to continue pregnancies which will end in infant death, in contravention of their Article 8 rights as in the Supreme Court judgment in the matter of *Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.

The nature of medical practice is such that it is not always possible to determine how likely it is that a given foetus may have such a disorder as to precipitate intrauterine or intrapartum death. In many cases, multiple abnormalities are present and the ultimate effect cannot be determined beyond all reasonable doubt.

A recent study from Ireland in the *Prenatal Diagnosis* journal, *The incidence of fatal foetal anomalies associated with perinatal mortality in Ireland*, found that of the 2638 perinatal deaths between 2011 and 2016 in Ireland, only 42% of these could be classified as fatal for the purposes of the current abortion law (which allows only terminations on the grounds of fatal foetal abnormality and not severe foetal abnormality post-12 weeks). Under a fatal foetal abnormality framework, nearly 60% of women who miscarried, had a stillbirth, or whose babies died within a week of being born would not meet the criteria for a termination.

Down's Syndrome

We are also aware of the public discourse around terminations on the grounds of Down's Syndrome – and the use of this example to justify restricting the rights of women to make decisions about their pregnancies. It is our belief that as with any other decision on whether to continue or end a pregnancy, this decision must be allowed to rest solely in the hands of a woman and her doctor. The complexities of raising a child with special needs and/or additional medical conditions cannot be evaluated at a legislative level – this a clinical decision that has to take place at an individual level.

For instance, Down's Syndrome also carries with it a significantly higher risk of additional anomalies which may be serious. Approximately half of Down's Syndrome diagnoses also have a heart defect detected. These are related to the failure of the heart to properly develop during pregnancy and immediately after birth, and can result in new-borns presenting with heart failure, difficulty breathing, and failure to thrive. There are other concomitant disorders which mean that

although some children with Down's Syndrome may experience life with milder impairments, others will face significant additional medical challenges.

The rate of stillbirth and late miscarriage for Down's pregnancies is much higher than the overall rate for intrauterine death. A 2016 United States study published in the Prenatal Diagnosis journal found that the overall risk of intrauterine foetal demise after 20 weeks' gestation was 0.4% - compared to 7.4% among pregnancies with a diagnosis of Down's Syndrome. These figures are echoed in the England NCARDRS figures. Similarly, infant mortality rates for babies born with Down's Syndrome are significantly higher than the general population. The same study found that 6.5% of Down's Syndrome live births resulted in infant death before 1 year – compared to 0.4% of the general population.

Regardless of these risks, England figures show that there are more live births of babies with Down's Syndrome than terminations on the grounds of a Down's Syndrome diagnosis. Down's Syndrome only accounted for 0.33% of all abortions in England and Wales in 2017. Beyond 24 weeks, Down's Syndrome accounted for only 11 abortions – or 5% of abortions performed on the grounds of severe foetal abnormality at this point.

Information like this is key to ensuring that medical professionals are able to inform their patients and enable them to make the best decisions for themselves and their families. Placing a time restriction on this information risks causing emotional and psychological damage to women who have often received the worst news of their life.

BPAS fully supports recommendation 3 to remove the time limit from terminations on the grounds of severe foetal anomaly.

Location

The requirement that an abortion happens in a hospital or a licensed premises is taken directly from the Abortion Act 1967 – the purpose of which was to prevent surgical abortions being performed by backstreet abortion providers in unsafe conditions. As previously covered, that is not the purpose for which abortion law now exists.

The vast majority of abortion treatment is now provided using medically rather than surgically. Early medical abortion (EMA) is a non-invasive, non-surgical method of termination of pregnancy up to 70 days (10 weeks) gestation, using a combination of two drugs: mifepristone and misoprostol. Mifepristone is a synthetic steroid which blocks the hormone progesterone. Without this hormone, the lining of the uterus breaks down and the pregnancy ceases to be sustainable. Misoprostol is a prostaglandin, which causes the uterus to contract and expel the pregnancy.

EMAs are the most common type of abortion procedure. In England and Wales in 2018, 70% of all abortions were Early Medical Abortions.

EMA is very safe. No medical procedure is risk free, but the risks of early medical abortion are extremely small and considerably less than the risks of continuing a pregnancy to term. EMA can often be carried out as soon as a pregnancy is confirmed, and the earlier an abortion can be performed the lower the chance of any complications.

In a situation where home use of abortion pills are not allowed, a woman has to present to the hospital to take the medication. Even if her clinical history does not require a scan, and her gestation requires no further blood tests, she would still legally be required to administer the medication on the hospital premises.

In Great Britain, this requirement has now been removed – enabling women to take both sets of medication for an Early Medical Abortion at home. This provision has also enabled the

establishment of telemedical services which enable women who are not able to attend a hospital or clinic (such as women with health conditions, women in abusive relationships, women for whom travel or childcare or work commitments are an issue) to access legal care after a telephone or video consultation with a nurse or midwife.

Around 20,000 women have received a telemedical abortion in Great Britain since early April.

Other options include the potential for GP provision of abortion, and the provision of first trimester surgical procedures in clinics where, for instance, coils are fitted.

The removal of the location requirement would also support the development of a service where women in Sark and Alderney could access abortion without having to travel to Guernsey – which could particularly be a problem for women with existing children or with health issues such as severe morning sickness. This service could be run by the same team at the hospital, but post pills to women who are clinically suitable and would prefer not to travel.

BPAS strongly supports recommendation 7 to remove the location requirement for abortion, and recommends that any service established in Guernsey should aim to include Alderney and Sark with a common legal approach.

Conscientious Objection

Conscientious objection refers to the **refusal to perform certain activities on moral or religious grounds**. In the law related to abortion, conscientious objection refers to the legal right of healthcare professionals (including doctors, nurses, midwives, pharmacists, and other healthcare professions) who opt out of providing abortion services.

BPAS supports the legal provision of conscientious objection to allow healthcare professionals to practice in line with their personal beliefs, alongside guidelines that make clear the obligations of an individual with a conscientious objection to ensure their patient can access appropriate care.

Existing law

S5 of the Abortion (Guernsey) Law, 1997 provides for Conscientious Objection out of abortion provision along the same lines as the provision in the Abortion Act 1967. Specifically, it provides that:

‘no person shall be under any duty, where by contract or by any statutory or other legal requirement to participate in any treatment authorised by this Law to which he has a conscientious objection.’

The interpretation of these provisions was laid out most clearly in the Supreme Court judgment in Greater Glasgow Health Board v Doogan (2014) which found that under the Abortion Act legislation, “Participate”...means taking part in a “hands-on” capacity’:

‘Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital...the caterers who provide the patients with food, and the cleaners who provide them with a safe and hygienic environment. Yet all may be said in some way to be facilitating the carrying out of the treatment involved.’

Operation

Guidelines issued by medical bodies make clear that those individuals who have a conscientious objection have certain legal and ethical obligations to patients, including:

- Not refusing to treat a particular patient or group of patients, or the health consequences of lifestyle choices, because of an individual’s personal beliefs about them

- Doing their best to ensure that patients are aware of their objection in advance
- Being open with employers, partners, or colleagues about their conscientious objection
- Ensuring the patient has enough information to arrange to see another professional
- In an emergency, not refusing to provide treatment necessary to save the life of, or prevent serious deterioration in the health of, a person because the treatment conflicts with personal beliefs.

Proposals

The recommendations in the document go further than the law in Great Britain, but rightly seek to eliminate the impact of those professionals who go beyond Conscientious Objection to Conscientiously Obstruct patients from accessing legal medical care.

The legal provision for conscientious objection must seek to balance the rights of healthcare professionals to act within their own ethical principles and the rights of patients to access legal medical care. Healthcare professionals have a particular duty of care to their patients, which is not negated when they exercise their right to conscientious objection

It is essential to the functioning of an effective care system that patients can expect that regardless of which healthcare professional they encounter, their best interests will be at heart.

BPAS strongly supports recommendations 8, 9, and 10 to refine the laws around Conscientious Objection and ensure that patient care is not compromised.

Conclusion

BPAS strongly welcome these proposals and supports them in their entirety.

As an abortion provider, BPAS has detailed experience working within an Abortion Act framework which is similar to that currently in place in Guernsey. We are well aware of the shortcomings of the law and the impact on our ability to provide the best possible care to women.

The changes proposed to this law would ensure that women in the Bailiwick are able to access the best possible medical care in line with international best practice.

Contact

Rachael Clarke
Public Affairs and Advocacy Manager
British Pregnancy Advisory Service
+44 7985 351 751
rachael.clarke@bpas.org