

Department of Justice, Northern Ireland

A CONSULTATION ON AMENDING THE CRIMINAL LAW ON ABORTION

FOR LETHAL FETAL ABNORMALITY AND SEXUAL CRIME

The Northern Ireland Department of Justice seeks a change in the law that would permit abortion in cases where the unborn baby has a 'lethal fetal abnormality'. Further, the Department is also considering doing so in relation to cases of rape and incest. Finally, they are considering if there should be a right to conscientious objection for those asked to participate in such procedures, if legalised. They are now consulting with the public on whether the law should be changed.

The Christian Medical Fellowship (CMF) is an interdenominational organisation with over 4,000 British doctor members in all branches of medicine. A registered charity, it is linked to about 70 similar bodies in other countries throughout the world. Of these, approximately 350 are members in Northern Ireland.

1. Should the law allow for abortion in cases of lethal fetal abnormality?

- 1.1 Accurately assessing the degree of disability in the womb is very difficult. The option 4 recommendation “to allow women to choose to have a termination in the circumstances where a foetal condition has been assessed by medical practitioners as being incompatible with life, that is that there is a *substantial* risk that if the child were to be born at full term it would be *unlikely* to survive birth, or *unlikely* to be capable of maintaining vital functions after birth” (emphasis added) uses terms that recognise this. The outcome and length of survival cannot be predicted with accuracy. The diagnosis may be ambiguous, despite the aid of scans, and even where the diagnosis is clearly known there are unpredictable variations in survival times. Occasionally, even the most confident diagnosis has been shown to be wrong (1).

This raises further practical difficulties not considered by the consultation: is there a level and rate of misdiagnosis that would be considered acceptable under the law? If so, what should that be? Will a post mortem be carried out on every child who is aborted under this proposed legislation to confirm the diagnosis? Will there be a report to the Coroner for all such abortions in order to ensure that the law is being upheld and if so, would this require a change in the law to cover still births? (2)

- 1.2 In practice, once any so-called 'right' is established in law, incremental extension takes place over time as activists apply pressure to expand the categories of people who qualify for it. The Abortion Act 1967 used terminology similar to that quoted above in 1.1, and

illustrates how this incremental extension occurs such that the Act now permits a degree of latitude never intended by those who originally drafted it. For example, the Act allows abortion for 'serious handicap' but is now used routinely to terminate those with Down's Syndrome and sometimes where the 'handicap' is club foot or cleft palate, conditions wholly compatible with life. Although the suggested wording of Option 4 is somewhat 'tighter', history and experience suggests that creeping extension will occur.

- 1.3 "Unlikely to be capable of maintaining vital functions" is particularly open to a breadth of interpretation. There are many congenital conditions that could fit this description but that are eminently treatable. For example, certain cardiac shunts that can be 'closed' surgically. Other conditions, like spina bifida, can be treated surgically at birth so as to prevent death, but may leave the child with a greater or lesser degree of disability. Would the recommended option exclude the termination of such unborn children? It would be possible to argue that permanent paralysis of the bladder is a failure of capacity to maintain vital functions, yet such a condition is not incompatible with life. This illustrates how one phrase within the recommended option can be used to extend the provision beyond the "lethal abnormality incompatible with life" wording.
- 1.4 The DoH figure for the number of Irish women coming to England and Wales for terminations of pregnancy on Ground E (those for fetal abnormality) in 2011 was 51. Of those, we are not told how many were for *fatal* fetal abnormalities but 60% (31 in total) were for chromosomal abnormalities including Down's syndrome (11), Edward's syndrome (7) and Patau's syndrome (7). Of these the latter two conditions are very serious. Half of infants with Edward's syndrome do not survive beyond the first week of life. The median lifespan is 5–15 days. About 8% of infants survive longer than one year. More than 80% of children with Patau's syndrome die within the first year of life. Today the average life expectancy for a person with Down's syndrome is between 50 and 60. A considerable number of people with Down's syndrome live into their 60's. So, even given the fact that these are all life-limiting conditions, it is extremely unlikely that any of these 31 babies, if born, would have died within minutes of birth, and some not within months (3). Even babies born with anencephaly, a condition which is cited as justification for a new law, do not necessarily die within minutes of birth. 45% of babies with anencephaly, who are not aborted, survive birth and can live for hours, days, weeks or occasionally years.
- 1.5 The recommended wording leaves the judgment entirely to the discretion of two doctors and their interpretation of the ambiguous wording. Whilst it is to be hoped that doctors will always act in the best interests of their patient, in these situations they have two patients whose best interests may not coincide. Only one of those patients can speak in her own defence and doctors will be under pressure to 'prefer' the interests of the mother, whether or not they reflect the best clinical judgement. In the case of the Abortion Act, it is clear that the 'two doctor rule' has been widely abused and we are concerned that the recommended option in this case is open to similar abuse.

- 1.6 The Parliamentary Inquiry into Abortion for Disability 2013 found a strong presumption from doctors in England, Scotland and Wales that parents with disabled babies would choose to have them aborted (4). This leads to subtle or more direct pressure being placed on parents who were either unsure or did not want to have an abortion. Parents said they were repeatedly asked to reconsider their decisions and treated like pariahs. A change to the law may well result in similar pressure being placed on parents in Northern Ireland.
- 1.7 We are concerned that there is no specification as to who the medical practitioners should be. For example, what training, qualifications and expertise should be required of them? Also, who will have oversight of the process and will there be penalties for misdiagnosis? In other words, how will the law be upheld if the diagnosis is left to the 'opinion' of doctors: 'two registered medical practitioners are of the opinion, formed in good faith, that a foetal condition has been assessed as being incompatible with life...'.
- 1.8 Abortion for fetal abnormality is not an 'easier option'. Such abortions will commonly take place later in a pregnancy, often after the 20 week scan. By this stage of any pregnancy, strong bonds of attachment between the mother and baby have generally developed. Abortion will be traumatic psychologically as well as physically (5). To follow the tragic news of severe fetal abnormality with the additional trauma of a late abortion is to compound the 'wounding'. At the time, it may appear as a 'quick fix' but the reality is often very different. Women who terminate for fetal anomalies can experience grief as intense as that of parents experiencing a spontaneous death of a baby. One long-term study found that a substantial number showed post-traumatic stress and another found, 14 months after termination, that nearly 17% of women were diagnosed with a psychiatric disorder such as post-traumatic stress, anxiety or depression (6). Their families are also not immune with even very young children and those sheltered from knowledge of the event showing reactions to their parents' distress and maternal absence (7). Some may experience an acute grief reaction or be plagued by guilt and fear that can precipitate marital breakdown. Additionally, there is a risk that through striving to eradicate congenital disability, a community risks promoting a cult of perfectionism that may have discriminatory effects on disabled people (8). By contrast, current data on children and families affected by disabilities indicate that disability does not preclude a satisfying life. Many problems attributed to the existence of a disability actually stem from inadequate social arrangements that public health professionals should work to change (9). This, along with the psychological morbidity often accompanying abortion for fetal disability has led many to conclude that abortion for even severe fetal disability, as well as taking the life of a disabled person, is also worse for the parents and families concerned. This is underlined by a case report in which a mother, against advice, chose to carry an eventually stillborn baby with anencephaly to term. It was found afterwards that she was 'managing well and was more emotionally stable than the majority of women who underwent termination on genetic grounds' (10).

- 1.9 We believe there are alternative, positive options for women carrying babies with fatal abnormalities, involving perinatal hospices and palliative care of the newborn that offers food and fluids, human warmth and comfort. We believe it is important to the grieving experience of the family that there should be opportunity to ‘say goodbye’, to hold their baby, to recognise and celebrate that this is indeed a member of the family, no matter for how brief a time. The personal experiences shared by parents at ‘Every Life Counts’ illustrates this well (11). In a British study, when parents were offered perinatal hospice as an alternative option, 40% chose to continue with their pregnancy (12). We recommend that, rather than change the law on abortion in NI, added funding for improvements in neonatal intensive care, palliative care and perinatal hospices be prioritised. Babies with fatal abnormalities are still fully human beings, deserving of the same protection and access to the same resources as any other person. For as long as they live they should be treated as having ‘lives worth living’. Any tendency to ‘dispose’ of those with potentially fatal fetal abnormalities is bound to have a negative impact on public attitudes towards disabled people. We propose that resources be made available to educational initiatives that help induce positive public attitudes towards those with disabilities.

For these reasons we do not support a change in the law in NI to permit the abortion of those with fetal abnormalities incompatible with life. We believe that the terms of recommended Option 4 are too vague and could not be ‘policed’, that incremental extension would be inevitable, that doctors would be vulnerable to pressure (either from the patient/family or by their own views). Further, we believe that it is in the best interests of a healthy grieving process to allow pregnancy to go to term and for priority to be given to the improvement in delivery of neonatal palliative care.

2. Should the law provide for abortion for rape or incest and/or criminal sexual behaviour?

- 2.1 It is difficult to see how a law that allowed abortion in cases of rape (or non-consensual sex), or where pregnancy resulted from sex with a family (or ‘extended’ family) member, could be framed. Highly restricted access (as in Isle of Man) is deemed to be too narrow, but increased accessibility will inevitably lead to any unplanned pregnancy being ‘labelled’ coercive or non-consensual, producing little short of abortion on demand, even if this was not intended. The same incremental extension as described above (see 1.2) would occur.

The consultation reviews several situations where there has been unwanted sexual activity and where abortion would be demanded. There are numerous other situations where pregnancy may be the result of unwanted sexual activity or ‘criminal sexual activity’ (13). We believe it would be unworkable to limit the exceptions to the two categories proposed in the consultation, and that widening the criteria would be equally unenforceable in practice.

- 2.2 Rape is a terrifyingly traumatic experience, a crime that nothing can ‘undo’. Fortunately,

pregnancy resulting from rape is very rare (14). There are two victims – the woman who has been raped and the fetus so conceived. We believe that **both** persons deserve protection under the law. Seeking to ameliorate the trauma of rape by inflicting further trauma is not, in our opinion, the way to aid recovery and restoration. The options of adoption or fostering provide more healthy alternatives. The Rape Crisis Network Ireland has found that most women who become pregnant through rape or incest did not want an abortion (15). Other research has found that those who had an abortion said it increased and compounded the trauma they had experienced from the rape (16). Getting rid of the pregnancy does not ‘solve’ the problem for women who are pregnant as a result of rape (17). Such women need sensitive support and resources to help them cope with both the immediate shock and trauma and also the demands and adjustments of an unplanned pregnancy. Women and girls who become pregnant from rape or incest need a safe environment to consider their options, with holistic support, accurate information and resources to meet their needs. Too often, however, they are denied this opportunity because most people just assume that abortion will ‘solve’ the problem. Some women will choose abortion, but we do not subscribe to the theory that every woman would want an abortion after rape, or that it is necessarily the ‘best’ and most compassionate response.

For these reasons we do not support a change in the law. We believe that any such provision would be unworkable and would lead to a process of incremental extension. We believe that both the woman and the fetus should enjoy protection under the law and that resources should be given to provide centres that offer ongoing support through pregnancy and improved access to adoption and fostering services.

3. Should there be a right to conscientious objection for those who participate in treatment for abortion in respect of (i) lethal foetal abnormality and (ii) sexual crime?

- 3.1 We are not in favour of any changes to the existing law in NI. Where abortions are carried out under the terms of the existing law, we believe that there should be provision to respect conscientious objection for all clinical staff engaged at any stage of the process, as per the General Medical Council guidelines (18). We would be very concerned if new legislation undermined the right to conscientious objection in any way.

References

1. Parliamentary Inquiry into Abortion on the Grounds of Disability. July 2013. p23-4.
2. Parliamentary Inquiry into Abortion on the Grounds of Disability. July 2013.p47.
3. <http://pjsaunders.blogspot.co.uk/2013/12/irish-member-of-parliament.html>
4. Parliamentary Inquiry into Abortion on the Grounds of Disability. July 2013. p32-4.

5. 'Studies have all found that around 20% of women, between one and two years after an abortion for fetal anomaly, have a psychiatric condition, usually a complicated grief reaction, a depressive disorder or post-traumatic stress disorder. Parliamentary Inquiry into Abortion on the Grounds of Disability. July 2013. p31.
6. See Zeanah 1993, Kersting 2004, Davies et al 2005, Korenromp et al, 2005, Kersting 2009. http://admin.cmf.org.uk/pdf/publicpolicy/Anencephaly_briefing_1013.pdf.
7. Furlong RM, Black RB. Pregnancy termination for genetic indications: the impact on families. Soc Work Health Care 1984; 10(1):17-34(Autumn).
8. Chandler M, Smith A. Prenatal screening and women's perception of infant disability: a Sophie's Choice for every mother. NursInq 1998;5(2):71-6 (June).
9. Asch A. Prenatal diagnosis and selective abortion: a challenge to practice and policy. Am J Public Health 1999; 89(11):1649-57(November).
10. Watkins D. An alternative to termination of pregnancy. Practitioner 1989;233(1472):990,992 (8 July.)
11. <http://www.everylifecounts.ie/about/>
12. Parliamentary Inquiry into Abortion on the Grounds of Disability. July 2013, p25.
13. For example in cases of prostitution, or sexual activity with vulnerable adults, with those with mental disorders, or with women who lack capacity to agree to the activity.
14. The consultation states that one Sexual Assault Referral Centre (SARC) in England reported that just three women who had been raped became pregnant as a result of rape and of these only one chose abortion. p42.
15. In 90 cases of pregnancy through rape only 17 women and girls chose to have a termination. <http://www.rcni.ie/rape-pregnancy-and-abortion-in-ireland-rcni-release-new-figures-today/>
16. <http://www.theunchoice.com/victimsandvictors.htm>
17. David C. Reardon, Julie Makimaa, and Amy Sobie, eds. Victims and Victors: Speaking Out about Their Pregnancies, Abortions, and Children Resulting from Sexual Assault. Springfield, IL: Acorn Books, 2000.
18. http://www.gmc-uk.org/guidance/ethical_guidance/21171.asp.

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