Anscombe Bioethics Centre response to Department of Health consultation on Procedures for the Approval of Independent Sector Places For Termination of Pregnancy

The Anscombe Bioethics Centre

1. The Anscombe Bioethics Centre[1] draws on and gives expression to a tradition of medical ethics which has its origin in the Oath attributed to Hippocrates[2] and, in modern times, the Geneva Declaration of the World Medical Association (especially in its original 1948 version).[3] Within this tradition deliberately causing a miscarriage of pregnancy is seen as the antithesis of ethical medicine.[4] The approach of the Centre to moral philosophy is to relate human goods and human rights to the virtue of justice as understood within the natural law tradition. According to this understanding, abortion, as a form of homicide, is a grave injustice to the unborn child. The Anscombe Bioethics Centre is a Roman Catholic institution and has a particular concern to make these ethical and philosophical resources available to the Catholic community, especially those who work in or make use of health care services. This religious perspective gives further reason to oppose abortion, for "the Church wishes to care with particular love and concern [for] unborn children, the most defenceless and innocent among us".[5]

Ethical aspects of abortion

2. In the definition of the scope of the consultation, it is stated that the consultation "does not seek views on the ethics of abortion."[6] However, if the procedures purport to ensure "the best quality of care",[7] "good practice,"[8] the "right to confidentiality",[9] the "interests of the child",[10] "consent",[11] and "locally agreed standards"[12] then it is clear that the document includes its own ethical judgments in relation to abortion. The recommendation of standards of good practice implies a wish to promote "ethical practice" of abortion as the authors see this. The attempt to exclude discussion of "the ethics of abortion" seems therefore to refer only to those ethical considerations related to the protection of the unborn child. This is an arbitrary and selective exclusion of some essential ethical concerns that should properly determine standards of good practice for all and any health professionals.

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[1] www.bioethics.org.uk
[2] Jones 1924; Jones 2003.
[3] Jones 2006.
[4] Kass 1985, p. 235: "If medicine is constituted by the task to assist living nature in human bodies to the work of maintenance and function and perpetuation, then one must wince at the monstrous because self-contradictory union that is the obstetrician-abortionist".
[5] Francis I 2013, paragraph 213
[6] Department of Health 2014, 7.1, p. 8.
[7] Department of Health 2013, p. 9.
[8] Department of Health 2013, RSOP 1, p. 10 and elsewhere.
[9] Department of Health 2013, RSOP 4, p. 12.
[10] Department of Health 2013, RSOP 7, p. 14.
[11] Department of Health 2013, RSOP 7, pp. 15-17.
[12] Department of Health 2013, RSOP 15, p. 21.

3. This exclusion of relevant ethical considerations also leads to a mischaracterisation of the rationale of the Abortion Act. That Act of Parliament represented a political compromise between the wish to maintain some legal protection for the unborn child and the wish to make abortion available for social reasons. The Act is an unjust law which is urgently in need of repeal and the protection it gives to the child is utterly inadequate. Nevertheless, it can be recognised that the restrictions it contains aim not only to protect women but also to give some limited degree of protection to the child. Without consideration of "the ethics of abortion"[13] it is simply impossible to understand the restrictions present in the Abortion Act, such as these are.

4. For example, in the consultation document, the paragraph on "Wider service provision" characterises these services as concerned with "needs beyond unwanted pregnancy".[14] This seems to imply that the abortion is "needed" simply in virtue of the fact that the pregnancy is unwanted. Such an attitude may reflect current practice but it does not reflect the requirements of the Abortion Act 1967, and still less does it reflect ethical requirements of protection for the unborn child.

The nature of the consultation

5. The Department of Health consultation on *Procedures for the Approval of Independent Sector Places for Termination of Pregnancy* was launched on 22 November 2013. It was initially directed to particular "stakeholders" such as NHS Trusts, Clinical Commissioning Groups, Royal Colleges and "Independent sector abortion providers". However, while the document admits that there are aspects of the practice of abortion which "raise particular *public* and professional concern"[15] the Department of Health seems not to have made any great effort to engage with the wider public in this consultation. Indeed, many interested parties were not made aware of the consultation. For example, while the Anscombe Bioethics Centre submitted evidence both to the Royal College of Obstetricians and Gynaecologists consultation on *The Care of Women requesting Induced Abortion* (February 2011) and to the Royal College of Psychiatrists consultation on *Induced Abortion and Mental Health* (June 2011), the Centre did not hear of this Department of Health consultation until it was highlighted in the media in mid-January.[16]

6. Whereas parliamentary committees, regulatory bodies and Royal Colleges provide details of the membership of working groups and the process by which draft guidance has been drawn up, the process is not apparent in the case of this guidance. Given the prominence of financial interests of independent sector providers in the outcome of this consultation, the lack of transparency of the process is of concern. The key ethical concerns for the Anscombe Bioethics Centre relate to the practice of abortion and the way in which these proposed changes may facilitate and accelerate this practice. The ethics of consultation are a secondary concern. Nevertheless there are real ethical issues related to honest and transparent processes of engagement, and failures in process can lead to or can reinforce failures of outcome. It seems that in this case the lack of transparency has led to outcomes that are beneficial to "independent sector abortion providers" but detrimental to women and to their unborn children.

[13] Department of Health 2014, 7.1, p. 8.
[14] Department of Health 2014, 5.1, p. 8.
[15] Department of Health 2013, RSOP 25, p. 27, emphasis added.
[16] Bingham and Donnelly 2014.

The nature of this response

7. Pope Francis has reminded us that the defence of unborn life is "closely linked to the defence of each and every other human right. It involves the conviction that a human being is always sacred and inviolable, in any situation and at every stage of development. Human beings are ends in themselves and never a means of resolving other problems. Once this conviction disappears, so do solid and lasting foundations for the defence of human rights, which would always be subject to the passing whims of the powers that be."[17]

8. At the same time the Pope has urged the Church and society as a whole "to adequately accompany women in very difficult situations, where abortion appears as a quick solution to their profound anguish".[18] In a similar way the Catholic Church in England and Wales, in its teaching document *Cherishing Life,* acknowledged that abortion harms not only the unborn child but also the mother and society in general.[19] In the UK as elsewhere, the Church as well as individual Catholics is involved in offering support for women with crisis pregnancies, as well as those affected by abortion.

9. As abortion is unethical, unjust, and contrary to Christian charity, a centre truly committed to ethics in health care could not offer guidance as to how to organise or arrange the performing of abortions within the "independent sector" (or indeed, outside that sector). This response should not therefore be understood as providing such guidance, or advice about how to structure such guidance. Nevertheless, as the proposed procedures make reference to the practice of medicine and the interpretation of law, and as these procedures if implemented would have an effect on the ease and availability of abortion, it is right for the Centre to comment on these things.

10. Because the Abortion Act 1967 is a gravely unjust law, it would be misleading to regard the minimal restrictions contained in the Act as "safeguards" that represented adequate respect or protection for the lives of the innocent. However, it can be reasonable to oppose efforts to further weaken these restrictions whether through amendments to the Act or by regulation, and it is in this spirit that we make the following points about the proposed guidance.

11. The kind of guidance we *would* accept, and that would be possible even without a tightening of the law, would not be "regulation" of independent sector (or other) abortions but simple instructions from the Department of Health as to which abortions would *not* be permitted (for example, abortions on grounds of gender, or other abortions that violate the conditions of the 1967 Act). It is also important that accurate guidance be given on respect for conscientious objection[20]: it is misleading to suggest, by mentioning the 1967 Act alone, that rights of conscientious objection are not also enshrined in human rights law and UK employment law.

[17] Francis I 2013, paragraph 213.
[18] Francis I 2013, paragraph 214, see also John Paul II 1995, paragraphs 59, 99.
[19] CBCEW 2004, paragraphs 173-176. For an exploration of the Christian tradition through the ages in relation to abortion see Jones 2004.
[20] Department of Health 2013, RSOP 2, p. 11.

Some comments on the proposed Required Standard Operating Procedures (RSOPs)

RSOP 1

12. The following statement in RSOP 1 appears to be disingenuous: "we consider it good practice that one of the two certifying doctors has seen the woman, although this is not a legal requirement".[21] In general, standards of "good practice" where these are expressed, for example, by General Medical Council or by other professional regulations can have real and serious legal effects. In contrast the proposed RSOPs imply that what is described as "good practice" is not in fact mandatory. Effectively RSOP 1 encourages doctors to conform only to the most minimal interpretation of the law.

13. This impression is reinforced by the contrast between what is said about the practice of neither doctor seeing the woman and what is said about the pre-signing of HSA1 forms. The pre-signing of forms is rejected as "unacceptable".[22] By implication the practice of not seeing the woman is *not* "unacceptable".

14. It is not our conclusion that the guidance should give particular advice as to what is "good practice" in performing or preparing for abortion, for there is no practice that can truly count as good practice in performing or preparing for abortion. Nevertheless, it is worth pointing out that the present guidance appears disingenuous and is doubly unjustifiable for that reason.

RSOP 2

15. Among the few concrete restrictions on abortion in the current law are (1) that abortion be performed by a registered medical practitioner and (2) that it be performed in an approved place. RSOP 2 seeks to undermine both these restrictions by claiming that a nurse or a midwife "may administer the drugs used for medical abortions"[23] and that women may be given an abortifacient drug with the foreknowledge that the women would be discharged to "their own home for the expulsion".[24] This RSOP effectively undermines the requirement that the abortion itself is performed by a doctor and that it actually occurs in an approved place.

16. Were it not for the need to evade the law it would seem hard to deny that deliberately administering an abortifacient drug is performing a medical abortion. If someone administered such a drug outside the terms of the current law they would surely be guilty of procuring a miscarriage. Furthermore, if abortion is sometimes defined as "the expulsion or removal from the womb of a developing embryo or fetus"[25] then it would also seem that the expulsion itself is an essential element of the definition of abortion. If the expulsion does not occur in an approved place then the abortion does not occur in the approved place. Again this is not to imply that abortion would be acceptable if the restrictions of the 1967 Act were followed, but rather it is to say that this RSOP fails to respect even these restrictions and thus represents a further weakening of the law. It also shows an approach to the interpretation of the law which seems to involve a significant element of duplicity.

[21] Department of Health 2013, RSOP 1, p. 10.
[22] Department of Health 2013, RSOP 1, p. 10.
[23] Department of Health 2013, RSOP 2, p. 11.
[24] Department of Health 2013, RSOP 2, p. 12.
[25] The first part of a definition given by the *Oxford English Dictionary* but many medical and general purpose dictionaries include expulsion or removal as part of the definition.

RSOP 3

17. RSOP 3 recommends that "follow up and post-abortion counselling"[26] should be available for women who have undergone abortion. However, the RSOP itself is cursory, consisting of but two sentences.

18. The need for such support subsequent to abortion is apparent from a review of the literature in relation to mental health and abortion. This shows a strong correlation between seeking abortion and factors that increase the likelihood of common mental health problems such as anxiety and depression. There is also some evidence that abortion is itself a factor that can precipitate or exacerbate such problems; for example, one (pro-choice) researcher has concluded that, "In general, the results lead to a middle-of-the-road position that, for some women, abortion is likely to be a stressful and traumatic life event which places those exposed to it at modestly increased risk of a range of common mental health problems."[27]

19. In our submission to the Royal College of Psychiatrists we argued that, in addition to the proper ethical concern for the unborn child, "the care of women who have had abortions, and those who present for abortion, is also a proper professional and ethical concern".[28] We therefore welcome the acknowledgement in RSOP 3 of the importance of care subsequent to abortion. However we do not think that it should be the place of abortion providers to deliver this care. Rather post-abortion support and counselling can and should be provided by sources independent of abortion provision. Nor need these providers be Pregnancy Advisory Bureaux as defined in these RSOPs, not least because counselling is distinct from advice. The Department of Health can and should commission post-abortion support services from counselling and psychotherapy providers not involved in the provision of, or referral for, abortion.

RSOP 7

20. This guidance states clearly that under Section 5 of the Sexual Offences Act 2003 sexual intercourse with a girl under 13 is a criminal offense.[29] However, RSOP 7 fails to state that under Section 9 of the same act, it is a criminal offense for an adult (over 18) knowingly to have intercourse with (or indeed to touch in a sexual way) a girl under 16. This omission adds to the impression that whereas protection of girls under 13 is "essential"[30] the issue of protecting girls under 16 is "complex".[31] This is a failure of care by omission.

RSOP 10

21. RSOP 10 suggests that in order to lower the risk of complications, "terminations should always be performed as early as possible after having received the woman's informed consent to the procedure".[32] This abstracts a single factor, the risk of complications, as the only factor relevant to the timing of abortion. It fails to acknowledge the *irreversible*

[26] Department of Health 2013, RSOP 3, p. 12.
[27] Fergusson 2008, p. 450.
[28] Anscombe Bioethics Centre 2011b, 89, 9, 6.3.
[29] Department of Health 2013, RSOP 7, p. 14.
[30] Department of Health 2013, RSOP 7, p. 14.
[31] Department of Health 2013, RSOP 7, p. 14.
[32] Department of Health 2013, RSOP 10, p. 18.

character of the procedure and fails to give any weight to the life of the child. It assumes the act in itself has no ethical significance other than in relation to risk, efficiency and preference satisfaction. The appearance of haste, rapidity, or urgency in expediting early elective procedures, with as little time as possible for further reflection, is among the most sinister elements of this guidance.

RSOP 11

22. The concept of "impartial"[33] information in relation to a disputed moral question such as abortion is itself contentious and in our view this guidance certainly does not represent impartial advice. It represents advice that abstracts from essential elements of the ethical reality of the situation and seems to be framed by the perspective of abortion providers.

RSOP 14

23. RSOP 14 conflates the respectful disposal of the remains of the child after miscarriage or stillbirth with the disposal of remains after procured abortion. This neglects important differences in the two situations in a way that has the potential to add to the distress of those suffering the grief of miscarriage. It is because of the importance of distinguishing these situations that the term "spontaneous abortion" has fallen out of common use.

24. In relation to procured abortion, while the remains of the child should indeed be disposed of sensitively, there is something inconsistent in advising the sensitive disposal of the remains of a child whose body was not respected in life. Reflection on the difference between disposal of fetal remains and disposal of tissue from a biopsy can help disclose the anomalous character of procured abortion. This helps illustrate why it is inadequate to understand abortion only as an elective procedure to be expedited as swiftly and efficiently as possible.

RSOP 25

25. In RSOP 25 it is stated that "abortions after 20 weeks gestation raise particular public and professional concern because of the possibility of live birth".[34] In this regard it is noteworthy that the rationale given for the current time limit for elective abortion,[35] 24 weeks, was allegedly that this represented the limit of viability. It is apparent from this quotation that the current legal limit of 24 weeks for most abortions[36] is not regarded as reliable even by those who defend abortion, and that from 20 weeks there is a possibility that the child might be born alive. However, from this tacit recognition the RCOG does not argue that the law should be changed, nor that practice should follow a more conservative approach and desist from abortion after 20 weeks. Rather, to address this "possibility" the RCOG recommend that the child be killed in utero before being expelled (what is termed feticide).

26. In previous evidence we submitted to the RCOG we argued that "feticide where the aim is to kill the unborn child can on our view never be justified"[37] and noted that "even among those who are broadly in favour of abortion prior to viability there are a number who would regard

[33] Department of Health 2013, RSOP 11, p. 19.
[34] Department of Health 2013, RSOP 25, p. 27.
[35] In the Abortion Act 1967 there is no right in law to abortion on request but in practice Grounds C and D are effectively interpreted as permitting elective abortion prior to 24 weeks.
[36] Grounds C and D are given as the legal justification for 98% of abortions in England and Wales.
[37] Anscombe Bioethics Centre 2011a, Recommendation 64.

feticide as unethical: 'Thus even those who accept a liberal position with regard to therapeutic abortion, should be concerned about these more recent developments'".[38] Here, as elsewhere, the proposed RSOPs seem to ignore the rationale of the current law and seek rather to offer the interpretation that will minimise any restriction of availability of abortion and maximise opportunity for independent sector abortionists.

27. In the context of discussion of feticide and late abortion performed for reason of the child's disability, RSOP 25 discusses fetal pain and fetal awareness. On the basis of a report of the working group of the RCOG, it argues that the child cannot feel pain before 24 weeks because connections within the brain are not fully formed, and that the child in the womb is in a state of induced sleep. The RSOP thus reiterates the conclusion of that report that analgesia has no benefit for a child prior to 24 weeks gestation.

28. It may be thought a curious coincidence that the limit for fetal pain should fit so exactly with the alleged limit for viability - and thus with the legal limit for elective termination.

29. It may also be noted that the topics of pain perception and consciousness are matters of philosophical analysis and dispute as well as psychological enquiry and that the RCOG working group neither included nor took evidence from philosophers. No account was taken of Wittgenstein's critique of the naïve subjectivist approach to the phenomenology of pain, or the importance Wittgenstein gave to behaviour that expresses pain or distress.[39] It should also be noted that the answer given to a question depends crucially on the way the question is framed and that, for example, an enquiry about the possibility of "distress" might give a very different answer to one about the possibility of perception of "pain".

30. The injustice to the child who is killed by abortion is not primarily a matter of the distress he or she experiences, which may be fleeting, but more fundamentally is a failure to acknowledge his or her humanity: a failure of respect for a life which is not merely lost, but is violently attacked. Nevertheless, causing distress adds to the injustice of abortion and a real concern in this regard is that denying the possibility of fetal awareness is related more to the perceived need to protect the current (arbitrary) time-limit for abortion than to the actual needs of the unborn child. This is not to argue that anaesthesia should be given to the unborn child prior to late term abortion – a fundamental injustice that, we believe, should not be performed nor prepared for – but that the potential "need" for anaesthesia helps disclose the humanity of the child and the injustice of the abortion. There is a place for the right kind of philosophical scepticism in the face of the claim that dismembering a very young child will cause it no distress.[40]

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[38] Anscombe Bioethics Centre 2011a, Recommendation 64 citing Pullman 2010, p.353, see also Gross 2002, Chervenak 2009, p.560.e3.
[39] Wittgenstein 1958, paragraph 281 and following.
[40] See Coope 2006, p. 18: "it is extraordinarily easy for a philosopher of modest ability to 'justify' the most monstrous conduct. This is one of the first things a student should learn on a course in 'practical ethics'. It induces the right kind of scepticism".

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