Response to Northern Ireland Office on A new legal framework for abortion services in Northern Ireland

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The Royal College of Midwives' response to A new legal framework for abortion services in Northern Ireland

The Royal College of Midwives (RCM) is the professional organisation and trade union that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in professional leadership, representation, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

The RCM welcomes the opportunity to respond to this consultation and our views are set out below.

Question 1: Should the gestational limit for early terminations of pregnancy be:	Yes	No
Up to 12 weeks gestation (11 weeks + 6 days)		X
Up to 14 weeks gestation (13 weeks + 6 days)		X

If neither, what alternative approach would you suggest?

The RCM supports the decriminalisation of abortion and believes that abortion should be regulated in the same way as other medical treatments. Every woman should have control over her own body and her fertility. In all other areas of medicine, the principle of informed consent is paramount. Each individual has the autonomy to make decisions regarding their own healthcare. Women should not have different standards applied to their reproductive health.

There is no rational reason for imposing an arbitrary limit of 12 or 14 weeks on abortion without conditionality. Experience from Canada, where there have been no legal restrictions on abortion for more than 20 years, is that there is no difference in how women present for abortion care – the vast majority will present early in pregnancy, with those few presenting at higher gestations being the most vulnerable (e.g. where the women is experiencing mental health issues, abuse, trauma, or is underage).[1]

This also means the imposition of an arbitrary limit of 12 or 14 weeks will have an overwhelmingly negative and disproportionate effect on vulnerable women. Further, in routine antenatal care in England and Wales, first trimester screening occurs at around 12 weeks, with results from diagnostic tests available soon after. This is likely to be the case in Northern Ireland. As such, having a lower gestational limit may force women who would rather wait, into opting for an abortion based on preliminary screening.

It should also be considered that the failure to make provision for the availability of abortion in circumstances of rape or incest at all gestations fails to fulfil the obligations set out under Section 9 (1) of the *Northern Ireland (Executive Formation) Act 2019* which require that the recommendations in paragraphs 85 and 86 of the Committee for the Elimination of Discrimination Against Women report ('the CEDAW report') are implemented in respect of Northern Ireland. Paragraphs 85 and 86 of the CEDAW report recommend:

- First, that sections 58 and 59 of the *Offences against the Person Act 1861* should be repealed - the effect of which would be to decriminalise abortion up until the fetus is 'capable of being born alive' (henceforth referred to as 'viability') pursuant to section 25 of the *Criminal Justice (Northern Ireland) Act 1945* in Northern Ireland;

- Second, that Northern Ireland should *'[a]dopt legislation to provide for expanded grounds to legalize abortion at least in the following cases: …Rape and incest…*"

The words 'expanded grounds' indicate clearly that the Committee intended that abortion be additionally legalised beyond 'viability' in circumstances of rape or incest. In other words, that there

[1] Abortion Rights Coalition of Canada (2019) *Statistics - Abortion in Canada.* Retrieved 6 December 2019 from http://www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf

be no 'term limit' in these circumstances. As such, limiting the availability of abortion in circumstances of rape or incest will open the Government to the possibility of judicial review.

In addition, to prevent women and girls from accessing abortion services after becoming pregnant as a result of rape or incest constitutes a grave violation of their human rights. This fact has been acknowledged by the United Kingdom Supreme Court and multiple United Nations bodies including Committee on the Elimination of Discrimination Against Women, the Human Rights Committee, and the Committee against Torture.

In the UK Supreme Court decision *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* a majority of the court concluded that obliging a woman to bear a child against her will in cases of rape and incest was incompatible with the fundamental right to bodily integrity.[2] In that case Lord Mance stated '[*t*]*he additional burden and torment of being expected to carry to birth and thereafter to live with a baby who is the product of a rape can only be imagined*. *Sexual crime is, as Horner J said at para 161 "the grossest intrusion on a woman's autonomy in the vilest of circumstances". This is a situation where the law should protect the abused woman, not perpetuate her suffering.'*[3]

When discussing cases involving incest, the Court focused on the extreme suffering of victims of abuse, who are often children. The Court also acknowledged the likelihood that women and girls who are pregnant as a result of rape or incest are likely to face considerable barriers in accessing abortion services. Women and girls who have become pregnant as a result of rape or incest are more likely to be in domestic violence situation. These women may have their movement restricted; and/or they may feel that they are required to conceal the pregnancy for their own safety. Similarly, women and girls who have become pregnant as a result of incest are more likely to be underage. This means they are less likely to notice the early signs of pregnancy. These factors are likely to cause delayed presentation.[4]

The Human Rights Committee and the committees which monitor compliance with the *Convention on the Elimination of all forms of Discrimination Against Women* and the *Convention on the Rights of the Child*, the *Committee on Economic, Social and Political Rights* have called for access to safe abortion for women and girls who are pregnant as a result of rape.[5] The Committee which monitors compliance with the *Convention Against Torture* has also recognised that denying a woman or girl

[2] *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27; Office of the High Commissioner for Human Rights (2018) *Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women.* Retrieved 27 November 2019 from https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf.

[3] *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.

[4] See for example: Amnesty International (2019). *She is not a criminal.* Retrieved 27 November 2019, from https://www.amnestyusa.org/pdfs/Ireland_She_Is_Not_A_Criminal.pdf; *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27

[5] Amnesty International (2019). *She is not a criminal.* Retrieved 27 November 2019, from https://www.amnestyusa.org/pdfs/Ireland_She_Is_Not_A_Criminal.pdf

access to an abortion when a pregnancy is a result of rape can be a form of torture, inhuman or degrading treatment.[6]

Noting the gravity of the potential breach, it is unacceptable to justify the limitation of women and girl's rights on the basis of procedural difficulty. These difficulties are easily avoided by a system which allows women to access abortion without conditionality. Alternatively, procedural difficulties could be avoided by a system in which women are enabled to make a disclosure regarding rape or incest to a doctor, nurse, or midwife, who is empowered to use their own judgement, and perform the procedure or refer onwards to abortion services without being required to take additional steps to certify the claim. This is the typical procedure in England, Wales, and Scotland, and is in line with the recommendations made by the World Health Organisation in their publication *Safe abortion: technical and policy guidance for health systems*.[7]

To facilitate this such a system, the Attorney General of Northern Ireland should produce updated guidance for health professionals to clarify their obligations with respect to section 5 of the *Criminal Law Act (Northern Ireland) 1967* duty to report a crime. This guidance should be absolutely equivocal that in circumstances in which a disclosure of rape or incest is made in the context of a statutory purpose unconnected with criminal investigation there will be no duty to report.

[6] Amnesty International (2019). *She is not a criminal.* Retrieved 27 November 2019, from https://www.amnestyusa.org/pdfs/Ireland_She_Is_Not_A_Criminal.pdf

[7] World Health Organisation (2019) *Safe abortion: technical and policy guidance for health systems*. Retrieved 27 November 2019, from https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/.

Question 2: Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy?	Yes	No
		X

If no, what alternative approach would you suggest?

Requiring certification by a healthcare professional is clinically unnecessary and provides no additional safeguards for women or doctors.[8] The provision of medical and surgical treatments, including abortion, is heavily regulated. The independent regulators of the healthcare professions,[9] as well as the independent regulators of healthcare services,[10] ensure that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to clinical best practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration. No additional form of oversight is necessary or justified in the case of abortion.

In addition, requiring certification by a healthcare professional is likely to cause unnecessary barriers to access. In England, Wales, and Scotland the requirement that two doctors certify the need for an abortion is known to have caused delays in access to abortion services.[11] These delays occur where women struggle to make prompt GP appointments or where they face negative attitudes and struggle to get a referral.[12]

The regulatory system for abortion in Northern Ireland should avoid implementing clinically unnecessary, obstructive and administratively burdensome requirements for certification, and instead aim to facilitate access and timely treatment. Ensuring access and timely treatment is particularly important where time limits are placed on the availability of abortion, to ensure procedural delays do not interfere with women's ability to access legal, safe abortion services. Timely access can also lead to a decrease in adverse events.[13] This is because although abortion is a safe procedure, it is safer the earlier it is performed.[14] In addition, substantial cost savings can be achieved if women are enabled to present earlier for abortion.[15] This is because early medical abortion is considerably less expensive than surgical abortion.

In light of the evidence discussed above, the recently published NICE guideline on Abortion Care recommends a system of self-referral. A system of self-referral not only reduces the likelihood of delays but could improve women's experiences by allowing them to avoid stigma and negative attitudes when requesting an abortion.[16] A system of self-referral also presents the least burdensome system in terms of administration and cost. The RCM recommends that this approach, which is founded on the best available evidence, is taken in Northern Ireland.

[8] Select Committee on Science and Technology. (2007). *Twelfth Report.* Retrieved 27 November 2019 from https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/104507.htm.

[9] These include the Nursing and Midwifery Council, the General Medical Council, and the Pharmaceutical Society of Northern Ireland.

[10] In Northern Ireland, the Regulation and Quality Improvement Authority.

[11] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact.

[12] Ibid.

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

Question 3: Should the gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be:	Yes	No
21 weeks + 6 days gestation		X
23 weeks + 6 days gestation	X	
If neither, what alternative approach would you suggest?		

Answer: 23 weeks + 6 days gestation at a minimum

The RCM would caution very strongly against setting a gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family at 21 weeks + 6 days gestation.

This proposed time limit (21 weeks + 6 days) is based on the incorrect assumption that 'due to advances in medicine and healthcare, it could be possible that a fetus having reached a gestation of 21 weeks + 6 days is viable and thus being capable of being born alive.' The scientific basis for this simply does not exist. While survival rates have improved for extremely premature births, most babies born at 22 weeks sadly do not survive. The most recent paper on this issue, published by the British Association of Perinatal Medicine, using data from MBRRACE, found that if a woman goes into spontaneous labour at 22 weeks, there is only a 3 per cent chance that the baby will survive to its first birthday. For spontaneous labour during week 23, less than 20 per cent of babies survive to their first birthday.[17]

In addition, the RCOG's most recent paper on care for women delivering at the threshold of viability highlights the continued international consensus that at 22 weeks' gestation there is almost no hope of survival;[18] and the Nuffield Council on Bioethics' guidelines on intensive care for extremely premature babies states that at 22 weeks, "standard practice should be not to resuscitate the baby". Between 23 weeks + 0 days and 23 weeks + 6 days, they state that "precedence should be given to the wishes of the parents" but that "clinicians should not be obliged to proceed to treatment wholly contrary to their clinical judgement."[19]

Even though doctors will attempt to save the lives of some babies born before 24 weeks, where that is what parents wish, the very high risk of mortality or very serious complications means that intensive

[17] British Society of Perinatal Medicine (2019) *Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation*. Retrieved 27 November 2019 from https://hubble-live-assets.s3.amazonaws.com/bapm/attachment/file/176/Extreme_Preterm_22-10-19_FINAL.docx.pdf.
[18] RCOG (2014). *Perinatal Management of Pregnant Women at the Threshold of Infant Viability (The Obstetric Perspective* Retrieved 27 November 2019 from https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_41.pdf.
[19] Nuffield Council on Bioethics (2006) *Critical care decisions in fetal and neonatal medicine: ethical issues.* Retrieved 27 November 2019 from https://nuffieldbioethics.org/publications/neonatal-medicine-and-care/guide-to-the-report/guidelines-on-intensive-care-for-extremely-premature-babies.

care treatment is not always provided. If parents do not wish for their baby to receive intensive treatment it is ethical to provide palliative care at delivery, and the revised framework supports this.[20]

As prominent medical ethicist Dr Dominic Wilkinson notes, 'this reflects the ethical importance of respecting the wishes of parents when it comes to treatment that is so risky and uncertain. Arguably, if a woman decides not to continue a pregnancy at 22 or 23 weeks' gestation, and obstetricians support this choice, that is completely consistent with the ethical framework that applies in newborn care.'[21]

However, it should be considered that the failure to make provision for the availability of abortion in circumstances of rape or incest at all gestations fails to fulfil the obligations set out under Section 9 (1) of the *Northern Ireland (Executive Formation) Act 2019,* which requires that the recommendations in paragraphs 85 and 86 of the CEDAW report are implemented in respect of Northern Ireland. Paragraphs 85 and 86 of the CEDAW report recommend:

- First, that sections 58 and 59 of the Offences against the Person Act, 1861 should be repealed - the effect of which would be to decriminalise abortion up until the fetus is 'capable of being born alive' (henceforth referred to as 'viability') pursuant to section 25 of the *Criminal Justice (Northern Ireland) Act 1945* in Northern Ireland;

- Second, that Northern Ireland should *'[a]dopt legislation to provide for expanded grounds to legalize abortion at least in the following cases: Threat to the pregnant woman's physical or mental health, without conditionality of "long-term or permanent" effects*'.

The words 'expanded grounds' indicate clearly that the Committee intended that abortion be additionally legalised beyond 'viability' in circumstances where the there is a threat to the woman's physical and mental health. In other words, that there be no 'term limit' in these circumstances. As such, limiting the availability of abortion where there is a threat to the woman's physical or mental health to 22 or 24 weeks gestation will open the Government to the possibility of judicial review.

The RCM rejects that, if provision for abortion in the above circumstances is made without gestational limit (in compliance with the requirements of section 9) 'it would require a doctor to assess… the viability of the fetus'. In fact, the only relevant assessment would be of the threat to the woman's physical or mental health. If the threat was assessed to necessitate an abortion, an abortion could be legally provided, regardless of whether or not the pregnancy is 'viable'.

Nevertheless, the RCM appreciates that, as a result of the continued criminalisation of abortion after the fetus is 'viable' pursuant to section 25 *Criminal Justice (Northern Ireland) Act 1945*, healthcare professionals are likely to seek to determine whether the fetus is 'viable' prior to performing an abortion, to avoid falling foul of the criminal law.

This issue can be readily resolved via one of two routes:

1. Repeal section 25 of the *Criminal Justice (Northern Ireland) Act 1945*; or

[20] Wilkinson, D. (2019) *Lifesaving Treatment for Babies Born at 22 weeks Doesn't Mean Abortion Law Should Change*. Retrieved 28 November 2019 from http://blog.practicalethics.ox.ac.uk/2019/10/lifesaving-treatment-for-babies-born-at-22-weeks-doesnt-mean-abortion-law-should-change/.
[21] Ibid.

2. Make provision on the face of the regulations which states that 'viability' within the meaning of section 25 of the *Criminal Justice (Northern Ireland) Act 1945* can be understood to mean 24 weeks.

Both routes would ensure that doctors are not put in the difficult position of having to determine 'viability' before providing an abortion after 22 or 24 weeks. However, it should be considered that, if section 25 of the *Criminal Justice (Northern Ireland) Act 1945* is retained, the continued criminalisation of abortion after 24 weeks is likely to have a 'chilling effect' on the provision of abortion. As discussed above, this will disproportionately impact vulnerable women.

Question 4: Should abortion without time limit be available for fetal abnormality where there is a substantial risk that:	Yes	No
The fetus would die in utero (in the womb) or shortly after birth	X	
The fetus if born would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life	X	
If you answered 'no', what alternative approach would you suggest?		

The RCM supports the proposal to allow abortion in cases where the fetus would die in utero or shortly after birth, and where the fetus would suffer a severe impairment including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life, without gestational limit. This is in line with the legal obligations set down by section 9 *Northern Ireland (Executive Formative) Act 2019* to implement the recommendations made by paragraphs 85 and 86 of the CEDAW report.

The RCM would caution against limiting the availability of abortion to circumstances of fatal fetal abnormality. Medical evidence shows that determinations of which conditions will constitute a 'fatal' abnormality are complicated and can leave doctors and women in difficult situations, particularly where the threat of criminal law still applies. Allowing only 'fatal' diagnoses thus risks forcing women to carry an extremely sick child to term.

Opponents of abortion often raise emotive arguments about how children born with particular disabilities can still have a good life. '[T]his obscures the emotional anguish and practical difficulties experienced by women who receive a diagnosis of fetal anomaly in an otherwise wanted pregnancy, and who cannot see their way to raising a child with a serious disability.'[22] 'Women's reasons for terminating a pregnancy on grounds of fetal anomaly may include the emotional and financial cost of raising a disabled child; the effect on a woman's ability to care for her existing children; and the feeling that it is cruel to have a child that will need constant medical intervention and may live in pain.'[23]

Furthermore, the RCOG reports that 'there is increasing evidence that the fetus never experiences a state of true wakefulness in utero and is kept, by the presence of its chemical environment, in a continuous sleep-like unconsciousness or sedation. This state can suppress higher cortical activation in the presence of intrusive external stimuli.'[24] As such, there is no exiting scientific basis for placing limitations on the availability of abortion the above circumstances.

The RCM would also caution against setting any strict definition for severe fetal impairment, noting advice from the RCOG that such a definition is unnecessary and impractical. This is 'because we do not have sufficiently advanced diagnostic techniques to detect malformations accurately all of the time and it is not always possible to predict the 'seriousness' of the outcome (in terms of the long-term physical, intellectual or social disability on the child and the effects on the family)…' As such 'the

[22] BPAS. *Termination of pregnancy for fetal anomaly*. Retrieved 27 November 2019 from https://www.bpas.org/get-involved/campaigns/briefings/fetal-anomaly/.
[23] Ibid.
[24] RCOG (2019). *Fetal Awareness: Review of Research and Recommendations for Practice*. Retrieved 27 November 2019, from https://www.rcog.org.uk/en/guidelines-research-services/guidelines/fetal-awareness---review-of-research-and-recommendations-for-practice/.

interpretation of 'serious abnormality' should be based upon individual discussion agreed between the parents and the doctor.'[25]

One example of this difficulty is explicit in the recent calls for cleft lip and/or cleft palate to be excluded from being classified as a 'serious handicap' within the context of the *Abortion Act 1967* which applies to England, Wales, and Scotland. This view is contested by the medical view put forward by the RCOG that in some cases, a cleft lip and/or cleft palate are symptoms of more serious conditions.

[25] Ibid.

Question 5: Do you agree that provision should be made for abortion without gestational time limit where:	Yes	No
There is a risk to the life of the woman or girl greater than if the pregnancy were terminated?	X	
Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?	X	
If you answered 'no', what alternative provision do you suggest?		

Cases in which abortion is requested on these grounds, at later gestations, are extraordinarily rare. Last year in England and Wales, only 145 or 0.07 per cent of abortions were performed in these circumstances, after the pregnancy had reach 24 weeks.[26] Typically, these are extreme cases in which decisions to perform an abortion occur in the context of a multidisciplinary team providing wrap around care to a woman who is experiencing severe health problems.

Pursuant to the legal precedent set down in *R v Bourne*,[27] the RCM notes that abortion is already legal in the above circumstances in Northern Ireland, that is, in circumstances in which there is a risk to the life of the woman or girl greater than if the pregnancy were terminated, or where necessary to prevent grave permanent injury to the physical or mental health of the woman. However, it is clear that the lack of clarity surrounding the precedent set by *Bourne*, coupled with insufficiently clear guidance for health professionals, has had a 'chilling' effect on service provision, whereby doctors and health professionals were unwilling to provide legal abortion services or referrals for fear of prosecution.[28] This led to an unacceptable situation in which women who should have been able to access legal abortion services were prevented from doing so, forcing them to continue their pregnancy at grave risk to their health, or travel to access abortion services elsewhere.[29]

As such, the RCM agrees that provision should be made for abortion in the above circumstances within the regulatory framework for abortion in Northern Ireland, to assist in providing clarity to women and healthcare professionals.

However, it should be considered that the continued criminalisation of abortion after the fetus is 'capable of being born alive' pursuant to section 25 *Criminal Justice (Northern Ireland) Act 1945* will continue to have a 'chilling effect' on the provision of abortion at or after the fetus has reach 'viability'. Elsewhere in our response, the RCM has recommended that the government repeal section 25 to ensure this does not occur.

The RCM also wishes to note a preference for replacing the term 'mental and physical health' of the woman, with 'wellbeing' of this woman, as this is a more accurate and encompassing term.

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[26] UK Government (2019). *Abortion statistics.* Retrieved 27 November 2019, from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf.

[27] *R v Bourne* [1939] KB 687.

[28] Women and Equalities Committee (2019). *Abortion law in Northern Ireland.* Retrieved 27 November 2019 from https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158402.htm.

[29] Select Committee on Science and Technology. (2007). *Twelfth Report. Q304* Retrieved 27 November 2019 from https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158405.htm#_idTextAnchor014.

Question 6: Do you agree that a medical practitioner or any other registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body's requirements and guidelines?	Yes	No
	X	
If you answered 'no', what alternative approach do you suggest?		

The regulatory system for abortion in Northern Ireland should facilitate access and timely treatment. By allowing for flexibility with regard to the healthcare professions that are legally allowed to provide abortion services, provided they have appropriate training, access can be improved.

Ensuring timely access is particularly important where time limits are placed on the availability of abortion, to ensure procedural delays do not interfere with women's ability to access legal, safe abortion services. Timely access can also lead to a decrease in adverse events.[30] This is because although abortion is a safe procedure, it is safer the earlier it is performed.[31] In addition, substantial cost savings can be achieved if women present earlier for abortion.[32] This is because early medical abortion is considerably less expensive than surgical abortion.

In England, Wales, and Scotland, the *Abortion Act 1967* requires that abortions be performed by a registered healthcare professional, meaning a doctor. At the time this restriction was written into law - in the late 1960's - abortion was a far more technically demanding and risky procedure. Conversely, today, abortions at most gestations are relatively simple procedures, and in 2018, 83 per cent of abortions in England and Wales were early medical abortions.

As such, while late surgical procedures still require the training and skill of an experienced doctor, earlier procedures may be performed equally well by other trained professionals. However, as a result of the law in England, Wales and Scotland, they are prevented from doing so. Thus it can be seen that placing rigid restrictions risks impeding the efficient delivery of services so as to delay timely access to abortion.[33]

In Northern Ireland, the RCM recommends that determinations as to which healthcare professions are competent to perform medical or surgical procedures, including abortion, are left to the regulatory bodies responsible for regulating the medical professions and healthcare services, [34] just as they would be for any other treatment. These bodies are responsible for ensuring that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to best clinical practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration.

[30] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact.
[31] Ibid.
[32] Ibid.
[33] Sheldon, S. (2015). The Decriminalisation of Abortion: An Argument for Modernisation. Oxford Journal Of Legal Studies, 36(2), 334-365. doi: 10.1093/ojls/gqv026.
[34] These include the Nursing and Midwifery Council, the General Medical Council, the Pharmaceutical Society of Northern Ireland and the Regulation and Quality Improvement Authority.

Allowing abortion to be regulated in this way, without imposing additional legislative restrictions, will ensure that clinical best practice and cost efficiency are not obstructed by legislation which was developed on the basis of outdated evidence.

The RCM would also like to note the availability of evidence that women prefer abortion care led by nurses or midwives; and that there is shorter time between referral and assessment in nurse-led services compared with physician-led services.[35]

[35] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact.

Question 7: Do you agree that the model of service delivery for Northern Ireland should provide for flexibility on where abortion procedures can take place and be able to be developed within Northern Ireland?	Yes	No
	X	
If you answered 'no', what alternative approach do you suggest?		

It is vitally important that abortion care services are accessible to women, including women in vulnerable circumstances and those from geographically isolated communities. Provided safety standards are met, it is entirely appropriate for abortion care services to be extended to a range of services. By allowing for flexibility on where abortion procedures can take place, access can be improved.

Ensuring timely access is particularly important where time limits are placed on the availability of abortion, to ensure procedural delays do not interfere with women's ability to access legal, safe abortion services. Timely access can also lead to a decrease in adverse events.[36] This is because although abortion is a safe procedure, it is safer the earlier it is performed.[37] In addition, substantial cost savings can be achieved if women present earlier for abortion.[38] This is because early medical abortion is considerably less expensive than surgical abortion.

In England, Wales, and Scotland, the *Abortion Act 1967* requires that abortions be performed in a hospital or other premises approved by the Secretary of State. These restrictions are unsupported by any current medical evidence base.[39] At the time these restrictions were written into law - in the late 1960's - abortion was a far more technically demanding and risk procedure.[40] Conversely, today abortion is a very safe procedure and in 2018, 83 per cent of abortions in England and Wales were early medical abortions.[41]

Early medical abortion, from a medical provisions point of view, is markedly different from surgical abortion. The procedure is low risk. In most countries, early medical abortions are routinely self-administered by women at home. In America, where misoprostol is routinely self-administered at home, the estimated case-fatality rate for medical abortion is 0.8 deaths per 100,000 procedures, which is statistically indistinguishable from the risk of death from miscarriage, 0.7 per 100,000 miscarriages.[42]

[36] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact
[37] Ibid.
[38] Ibid.
[39] Sheldon, S. (2015). The Decriminalisation of Abortion: An Argument for Modernisation. Oxford Journal Of Legal Studies, 36(2), 334-365. doi: 10.1093/ojls/gqv026
[40] Ibid.
[41] UK Government (2019). *Abortion statistics.* Retrieved 27 November 2019, from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf.
[42] Select Committee on Science and Technology. (2007). *Twelfth Report.* Retrieved 27 November 2019 from https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/104507.htm.

As such, and particularly in the case of early medical abortion, it can be seen that the restrictions that exist in England, Wales and Scotland impede the efficient delivery of services so as to delay timely access to abortion.

The RCM recommends that determinations as to where medical or surgical procedures, including abortion, can take place are left to the regulatory bodies responsible for regulating the medical professions and healthcare services, [43] just as they would be for any other treatment. These bodies are responsible for ensuring that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to best clinical practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration.

Allowing abortion to be regulated in this way, without imposing additional legislative restrictions, will ensure that clinical best practice and cost efficiency are not obstructed by legislation which was developed on the basis of outdated evidence.

Additional note regarding home use of abortifacients

In 2017 and 2018, Scotland, England and Wales adjusted regulations to allow women to take the second drug administered for an early medical abortion, misoprostol, at home. Prior to this change, because of the restrictions on the premises in which abortion services could be legally provided, women were required to visit a clinic or hospital twice, first to have mifepristone administered and then 24-48 hours later, to have misoprostol administered.

The need for this second visit to the clinic acted as a barrier to women accessing safe, regulated abortion care, was medically unnecessary and incurred significant costs. In addition, as a result of being required to take misoprostol within a clinic or hospital, some women would begin to miscarry before or during their journey home. This was a particular problem for women who lived in rural areas, who's journeys were long or subject to unexpected delays.[44]

It is absolutely vital that Northern Ireland ensures that similar outcomes are avoided in respect of Northern Ireland.

[43] These include the Nursing and Midwifery Council, the General Medical Council, the Pharmaceutical Society of Northern Ireland and the Regulation and Quality Improvement Authority.
[44] BPAS (2019) *Home use of misoprostol.* Retrieved 27 November 2019 from https://www.bpas.org/get-involved/campaigns/briefings/home-use-of-abortion-drugs/.

Question 8: Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?	Yes	No
		X

If you answered 'no', what alternative approach do you suggest?

There is no justification for placing any additional restrictions on premises beyond 22/24 weeks within the regulatory framework for abortion in Northern Ireland. As has been discussed at question 6 and 7, over the course of time abortion care has become safer, making it possible to provide abortion services in a range of healthcare settings, including community healthcare settings. In the future, it is possible that changes in safety and risk profiles will mean that it will become safe to provide abortion procedures at later gestations outside acute sector hospitals. If this does occur, it is most appropriate that change can be directed through clinical recommendations and enforced via regulatory channels. This will ensure that clinical best practice and cost efficiency are not obstructed by legislation developed on the basis of outdated evidence – as has been the experience in England, Wales and Scotland.

Question 9: Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland?	Yes	No
		X
Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/14 weeks gestation?		X

If you answered 'no' to either or both of the above, what alternative provision do you suggest?

Requiring certification by a healthcare professional is clinically unnecessary and provides no additional safeguards for women or doctors.[45] The provision of medical and surgical treatments, including abortion, is carefully regulated. The independent regulators of the healthcare professions, as well as the independent regulators of healthcare services, ensure that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to best clinical practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration. No additional form of oversight is necessary of justified in the case of abortion.

Requiring certification by a healthcare professional is likely to cause unnecessary barriers to access. In England, Wales, and Scotland the requirement that two doctors certify the need for an abortion is known to have caused delays in access to abortion services.[46] These delays occur where women struggle to make prompt GP appointments or where they face negative attitudes and struggle to get a referral.[47]

The regulatory system for abortion in Northern Ireland should avoid implementing clinically unnecessary, obstructive and administratively burdensome requirements for certification, and instead aim to facilitate access and timely treatment. Ensuring access and timely treatment is particularly important where time limits are placed on the availability of abortion, to ensure procedural delays do not interfere with women's ability to access legal, safe abortion services. Timely access can also lead to a decrease in adverse events.[48] This is because although abortion is a safe procedure, it is safer the earlier it is performed.[49] In addition, substantial cost savings can be achieved if women present earlier for abortion.[50] This is because early medical abortion is considerably less expensive than surgical abortion.

In light of the evidence discussed above, the recently published NICE guideline on Abortion Care recommends a system of self-referral. A system of self-referral not only reduces the likelihood of delays but could improve women's experiences by allowing them to avoid stigma and negative attitudes when requesting an abortion.[51] A system of self-referral also presents the least

[45] Select Committee on Science and Technology. (2007). *Twelfth Report.* Retrieved 27 November 2019 from https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/104507.htm.
[46] Ibid.
[47] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact.
[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] Ibid.

burdensome system in terms of administration and cost. The RCM recommends that this approach, which is founded on the best available evidence, is taken in Northern Ireland.

Question 10: Do you consider a notification process should be put in place in Northern Ireland to provide scrutiny of the services provided, as well as ensuring data is available to provide transparency around access to services?	Yes	No
		X

If you answered 'no', what alternative approach do you suggest?

The RCM agrees that there should be central collection of abortion data, subject to strict confidentiality protections, to ensure future services are fit for purpose. However, the RCM is aware that this data will be accessible through existing systems for recording of procedures in Northern Ireland. As such, it is not necessary to implement an additional notification process. The RCM advocates strongly against the implementation of any additional notification process which will impose additional legal and administrative burdens on healthcare professionals. This is unnecessary and will create an additional cost burden on the healthcare system.

In addition, in a newly decriminalised system like Northern Ireland, with high profile government and administrative officials who are openly and vocally anti-abortion, a notification system could result in women avoiding services due to fear of being identified. If a decision is made to implement a notification process, the RCM advises strongly that all steps be taken to ensure the data collected is appropriately anonymised and is not shared with any other government bodies.

Question 11: Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the United Kingdom, covering participation in the whole course of treatment for the abortion, but not associated ancillary, administrative or managerial tasks?	Yes	No
	X	
If you answered 'no', what alternative approach do you suggest?		

The RCM supports midwives' right to conscientious objection but believes that professionals must be fully conversant with the requirements of the law and of codes of professional conduct, which exist to protect women from discrimination when in a midwife's care.

The RCM understands that the current position with regard to conscientious objection in England, Wales, and Scotland is as follows:

Section 4 of the *Abortion Act 1967* permits healthcare professionals to refuse to participate in any abortion treatment to which he or she has a conscientious objection, provided the treatment is not necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.[52] The United Kingdom Court of Appeal has confirmed that 'participation' within Section 4, is to be given its ordinary meaning. As such, the conscientious objection clause is limited to those who take part in the administration of the procedure in a hospital or approved clinic. Accordingly, healthcare professionals do not have a legal right to claim exemption from giving advice or performing the preparatory steps to arrange an abortion. Thus, all healthcare professionals should be prepared to care for women before, during and after a termination in a maternity unit under obstetric care.

In addition to their right to conscientiously object, healthcare professionals, including midwives, must also bear in mind that the Nursing and Midwifery Council (NMC) (and other healthcare professions regulators) expect them to take a non-judgemental approach in the exercise of their caring role, and to be selective is to demonstrate unacceptable conduct. This issue is addressed by NMC's The Code (2015), which states:

> *Clause 1: Treat people as individuals and uphold their dignity. To achieve this, you must:*
>
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *1.5 respect and uphold people's human rights*
>
> *Clause 4.4 states: Tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care.*

[52] *Abortion Act 1967*

Clause 20.7 states: make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way.[53]

Similar clauses exist within the professional codes of conduct for doctors[54] and pharmacists.[55]

Based on the above, the RCM expects midwives to balance their own views and principles with the rights of women to receive full and unbiased information. Specifically:

- Every midwife has a duty of care to ensure that women receive all appropriate information and advice before antenatal screening, even if this may result in a decision to terminate pregnancy. This is also applicable to midwives giving family planning information and advice.

- Every woman has the right to be given the necessary information to make an informed choice regarding the opportunities provided within the law to terminate pregnancy.

The RCM believes that working within a team structure does not absolve a midwife from her individual responsibility and accountability in relation to the above good practice.

The RCM does recognise that it may be difficult for individual midwives to discuss the possible termination of a fetus or fetuses. In this situation a midwife has to weigh up whether it is practicable or in the woman's best interests to hand over her care to another midwife. In certain circumstances, this may necessitate providing counselling for the staff involved in these decisions.

The RCM is content that the conscientious objection provision should reflect the above understanding of practice in England, Wales, and Scotland.

[53] Nursing and Midwifery Council (2015) *The Code.* Retrieved 27 November 2019 from https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf.
[54] BMA - Abortion. (2019). Retrieved 27 November 2019, from https://www.bma.org.uk/advice/employment/ethics/ethics-a-to-z/abortion.
[55] Ibid.

Question 12: Do you think any further protections or clarification regarding conscientious objection is required in the regulations?	Yes	No
		X
If you answered 'yes', please suggest additional measures that would improve the regulations		

Question 13: Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?	Yes	No
	X	
If you answered 'no', what alternative approach do you suggest?		

The RCM wholly supports women's and healthcare professionals' rights to access legal healthcare services without fear of being intimidated or harassed. The RCM appreciates that there are a wide range of views about abortion but believes that the intimidation of women and staff who are providing a lawful and necessary service is unacceptable.

The impact of harassment not only causes great distress and confusion for women visiting the clinic, but has a direct impact on staff wellbeing, causing them to feel unable to properly support and protect patients. Midwives and other staff do not deserve to be faced with protests on a daily basis as they attend work to provide legal, safe care for women.

In addition, it should be noted that there is some evidence that protesting has made women delay or put off treatment.[56] As has been discussed earlier in our response, delayed access to abortion services can increase the likelihood of adverse experiences, limit women's ability to access safe, legal care, and increase costs to the health service.

Currently, in England, Wales and Scotland, the only solutions available to manage harassment and intimidation of women and staff outside abortion clinics are individual criminal claims or through the establishment of a Public Spaces Protection Order (PSPO), which can be instigated under the *Antisocial Behaviour, Crime and Policing Act 2014*. This mechanism is wholly inadequate for a number of reasons:

1. the establishment of a PSPO can lead to a protracted delay to protection while a Local Council goes through the motions of public consultation and then a vote by the Councillors;
2. justification for the PSPO has to be drafted and, when approved, they have a finite life of three years.
3. PSPO's are susceptible to obstruction;
4. the process it time consuming and creates a resource burden for resource-poor local Councils.

In addition, a PSPO is a singular solution which leads to a 'postcode lottery' whereby some women and staff will be protected while others are not.

The RCM advocates strongly for a national solution whereby 'exclusion or safe zones' are established outside all premises which provide abortion services. This will be particularly important in Northern Ireland, where provision of abortion services is likely to be spread across a range of services.

The RCM notes a recent decision by the Home Office which declined to establish buffer zones outside abortion clinics in England and Wales. The RCM believes this decision was inherently flawed. Having recently obtained the evidence pack which was provided to the Minister, the RCM is deeply concerned that the information provided to the Minister was not reflective of the evidence provided. In particular, we note that the evidence underplayed the experiences of women and did not mention

[56] RCOG, FRSH (2018) *Submission to the Home Office Abortion Clinic Protest Review.* Retrieved 27 November 2019 from https://www.fsrh.org/documents/rcog-fsrh-submission-home-office-review-protests-abortion-clinic/rcog-fsrh-submission-home-office-abortion-clinic-protest-review-2018.pdf.

the experiences of healthcare staff at all. The RCM has joined BPAS and 30 other charities in writing to the Home Office to express our concern and urge that the inquiry is reopened.[57]

When making a decision as to whether 'exclusion or safe zones' should be established, it should also be considered that in August 2019, the United Kingdom Court of Appeal upheld the legality of a Public Spaces Protection Order which imposed a 100 meter exclusion zone around an abortion clinic in Ealing on the basis that its establishment was appropriate based on a balancing of competing rights to privacy and to freedom of expression and association.

In its decision, the Court balanced the extent to which the PSPO interfered with the Appellant's (an anti-abortion protester) Article 9, 10 and 11 rights to freedom of expression and association on the one hand, versus the extent to which the PSPO was necessary to protect the Article 8 rights to privacy of service users on the other. It upheld the decision that the PSPO was justified because the protesters' activities were not merely such as to 'shock, offend or annoy': rather, Ealing and Turner J had both concluded that the activities were in fact having a detrimental effect and causing lasting harm to service users. This assessment is consistent with decisions made by the European Court of Human Rights.[58]

The RCM supports the Court of Appeal and the authoritative ruling on the balance of competing rights in these circumstances. Since the decision to decline to establish buffer zones around all abortion clinics was published in September 2018, 34 clinics in England and Wales have experienced anti-abortion activity, with 5 of these clinics never having experienced protests before. This is not a problem that starts and ends in Ealing – it is a national problem in need of a national solution.

[57] BPAS (2019) Charities call for urgent review of decision to reject buffer zones after evidence of women's experience outside abortion clinics suppressed in flawed consultation. https://www.bpas.org/about-our-charity/press-office/press-releases/charities-call-for-urgent-review-of-decision-to-reject-buffer-zones-after-evidence-of-women-s-experience-outside-abortion-clinics-suppressed-in-flawed-consultation/.
[58] *P v Poland* [2012] ECHR 1853.

Question 14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?	Yes	No
If you answered 'no', what alternative approach do you suggest?		

The RCM has no opinion on this matter.

Question 15: Have you any other comments you wish to make about the proposed new legal framework for abortion services in Northern Ireland?

Section 25 Criminal Justice (Northern Ireland) Act 1945

As previously stated, the RCM recommends that section 25 of the *Criminal Justice (Northern Ireland) Act 1945* be repealed on the face of the regulations.

If it is not repealed, the continued criminalisation of abortion after the fetus is 'capable of being born alive' pursuant to section 25 will continue to have a 'chilling effect' on the provision of abortion at or around viability, whereby doctors will avoid providing legal abortion services for fear of prosecution. This chilling effect will be amplified, as is has been in the past, because of the 'duty to report' a 'relevant' offence in Northern Ireland, under section 5 of the *Criminal Law Act (Northern Ireland) 1967.*

Although abortion at or after viability is extraordinarily rare, these cases are the most extreme. The vast majority of abortions which are requested at or after viability are in cases of fatal or severe fetal abnormality (which are often unconfirmed until 22 weeks). Other cases included where there is grave threat to the woman's life or health. As such, it is absolutely critical that the law create no impediment to the provision of legal abortion services in these circumstances.

Screening programmes and care pathways

Relatedly, the RCM is aware that recommended routine fetal anomaly screening measures have not been implemented to the same degree in Northern Ireland, as they have in the rest of the United Kingdom, and as a result antenatal screening practice has not been consistent. The RCM strongly recommends that the government ensure that screening measures in Northern Ireland be brought in line with the rest of the United Kingdom. This will ensure that fetal anomalies are routinely detected and women have sufficient time to consider their options.

Care pathways

Broadly, the RCM recommends that the regulations and subsequently developed care pathways follow the recommendations made in the recently published NICE guideline on Abortion Care.[59] This guideline includes recommendations on ensuring accessibility of services for women, including vulnerable women and women in geographically remote areas; reducing waiting times; pre and post abortion information needs and support; and caring for women who receive a diagnosis of fetal anomaly.

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[59] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact.