DEPARTMENT OF HEALTH SOCIAL SERVICES
AND PUBLIC SAFETY

DRAFT TERMINATION OF PREGNANCY GUIDANCE

SUMMARY OF CONSULTATION RESPONSES RECEIVED

October 2013
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1. INTRODUCTION

Following agreement from the Northern Ireland Executive, the Department of Health, Social Services and Public Safety ran a 16 week public consultation on a draft guidance document entitled “The limited circumstances for a lawful termination of pregnancy in Northern Ireland: A guidance document for health and social care professionals on law and clinical practice”.

This document summarises the main issues raised during the consultation.

The purpose of the consultation was to seek views on the production of guidance on the existing law. Whether the law should be changed is outside the scope of this summary. The summary will focus on the content of the guidance.

In Northern Ireland it is illegal to perform a termination of pregnancy unless it is necessary to preserve the life of a pregnant woman, or there is a risk of real and serious adverse effect on her physical or mental health, which is either long term or permanent. In any other circumstances it is unlawful to perform such a procedure.

The issue of termination of pregnancy is one that raises strong, divergent opinions in the general population and health professions. Recent events in the Republic of Ireland have highlighted the need to ensure that health professionals have a clear understanding of when they can act within the law to save the life, or health, of their patients. Health professionals need to have confidence that they can make decisions that are lawful and enable them to meet women’s health needs.

Since the 2004 Court of Appeal judgement into termination of pregnancy, the Department has carried out a series of consultation exercises, met with a range of interested groups and produced draft guidance that has been subject to legal challenge.

The guidance is intended to explain the application of the laws extant in Northern Ireland, not to extend those laws.
2. SUMMARY OF CONSULTATION RESPONSES

OVERVIEW

1. The Department received 86 consultation responses from a range of stakeholder groups and individuals. A full list of respondents is attached at Annex A.

2. The responses cover the wide range of divergent opinions on the issue, and range from short personal statements through to detailed submissions from national and international organisations. This summary does not seek to individually respond to every point raised, but groups the substantive issues together into specific policy areas.

3. The main issues raised in the consultation have been grouped into the following categories:
   I. The Law on Termination of Pregnancy
   II. Mental Health Grounds
   III. Certification by Two Doctors
   IV. Conscientious Objection and Second Opinions
   V. Provision of Counselling Services
   VI. Patient Confidentiality and Data Collection
   VII. Equality and Human Rights
   VIII. Miscellaneous

4. It is notable that some of the wording that passed without comment in previous drafts has been subject to additional scrutiny and comment. Public interest has clearly been raised by recent events north and south of the border.

5. The implications of issues raised during consultation on the guidance document will be considered.
I. THE LAW ON TERMINATION OF PREGNANCY

Issue: The current legislation framing termination of pregnancy in Northern Ireland is no longer appropriate and should be reformed.

6. A number of respondents raised this issue and related areas including:
   - Abortion Act 1967 being extended to Northern Ireland.
   - Amending legislation to include issues of rape, incest and fetal abnormality.
   - A public consultation being held to consider reform of the law.
   - Legislation is not cognisant of medical advances and should be changed.
   - Wording of the 160 year old act means health professionals might be criminalised for managing a complex issue.

7. Those who felt that the law in its current form was inadequate included the Royal College of Nursing (NI), Amnesty International, Women’s Resource and Development Agency, National Union of Students and the Union of Students in Ireland, Reproductive Health Matters, Doctors for a Woman’s Choice on Abortion and the Labour Party in Northern Ireland.

8. The Women’s Resource and Development Agency suggested that ‘all policy’ regarding termination of pregnancy should fall to DHSSPS as it was not appropriate that issues of women’s health were dealt with in relation to criminal law and the Department of Justice.

9. A number of respondents referenced comments by the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) who have been calling for consultation on reform of the law for several years.

Discussion
10. The Department of Justice is responsible for the law governing termination of pregnancy in Northern Ireland; sections 58 and 59 of the Offences Against the Person Act 1861, and section 25 of the Criminal Justice Act (Northern Ireland)
1945. It is for the Department of Health, Social Services and Public Safety to ensure that lawful terminations are carried out safely and that patients receive the best possible treatment.

11. There are a full range of responses on the matter of changing the law in Northern Ireland, ranging from those who want the law to be liberalised, those who want the law to be updated and those who are content that the current law is adequate.

12. Changing the law was outside the scope of the consultation exercise which was on the draft guidance document and how it reflects the law.

**Issue: The guidance document fails to provide accurate clarity on the law and uses inappropriate terminology.**

13. Respondents highlighted a number of related areas including:

- Emotive words such as ‘unborn child’ and ‘mother’ should be replaced with medical terminology.
- It contains too many ‘mays’ and ‘may nots’.
- References to probability and possibility should not be quoted without evidential basis.
- Potentially misleading to clinicians on ethical rights, legal rights and their obligations.
- Terminology, tone and title may frighten practitioners from carrying out lawful terminations and have a ‘chilling effect’.
- The punitive language puts patients at risk.
- Concern about requirement to report potential offences and patient confidentiality.
- The law is inadequately represented in the document e.g. the statutory defence against the offence of child destruction does not follow from the Bourne decision.
- The document is not clear on where the burden of proof lies in the event of a prosecution.
• There is a body of professional guidance that covers many of the issues contained in the draft guidance.
• Health professionals should not be required to interpret and enforce the law.
• The guidance should not refer to a woman’s ‘options’ or ‘choices’.

Discussion
14. The issue of inappropriate tone and terminology was raised by a range of organisations including British Medical Association, Family Planning Association, Women’s Resource and Development Agency, Marie Stopes International, Sinn Fein, Amnesty International, Royal College of Obstetricians and Gynaecologists (NI), Royal College of Midwives (NI), Royal College of General Practitioners (NI), Anna Lo, MLA, and the International Federation of Abortion and Contraception Professionals.

15. Precious Life stated that the guidance document misinterpreted the law and was a permissive interpretation.

16. It is apparent from consultation responses that there is no agreed vocabulary between the different interested groups on what constitutes a termination of pregnancy/abortion with some parties suggesting that genuine life saving treatment for a pregnant woman, that has the unintended consequence of the death of the fetus, is not, in fact, a termination/abortion. Definitional differences hinder effective discussion and consultation.

17. Some consultees stated that that contradictions between GMC guidance and criminal law needed to be clarified – e.g. when should a health professional report a crime.

18. Medical professionals suggested that the draft guidance introduces a level of doubt rather than the clarity that is required.
19. There is a balance to be struck between the need expressed by some respondents for a list of health conditions where a termination may be justified, and the recognition that a trained and experienced health professional faced with a pregnant woman needs to be able to treat the woman on the basis of her needs at that time.

20. The issue of incorrect representation of the law on Bourne and child destruction was raised by Association of Catholic Lawyers and Society for the Protection of Unborn Children. They state that the defence against child destruction does not follow from the Bourne judgement.

21. The burden of proof issue was raised by a range of organisations including the Royal College of Obstetricians and Gynaecologists (NI) and the South Eastern Health and Social Care Trust. They felt that the draft guidance appeared to suggest that in the event of a prosecution, health professionals needed to prove that they acted within the law. In fact, the precedent from the Bourne case, and the defence created in the 1945 Act, require the prosecution to prove that the defendant did not act in good faith to preserve the life of the woman.

II. MENTAL HEALTH GROUNDS

**Issue: The involvement of a consultant psychiatrist in relation to assessments of termination of pregnancy on mental health grounds.**

22. A range of opposing views were expressed on this matter including:

- The recommendation has no basis in law and is unnecessary.
- A consultant psychiatrist can assess current mental health but is not the most appropriate person to assess long term effects.
- Implications to other areas where registered practitioners have historically undertaken mental health assessments.
- Compelling a women to undergo a psychiatric assessment may result in mental distress.
• Staffing capacity issues in dealing with mental health assessment.
• Agreement that specialist expertise in this area is appropriate.
• Resource implications for psychiatric services.

Discussion
23. Some respondents felt that a requirement for a woman to be seen by a consultant psychiatrist was too prescriptive or inappropriate. These included the Association of Genetic Nurses and Counsellors, a group of genetic nurse/counsellors Belfast Trust, the Faculty of Sexual and Reproductive Health (RCOG), Amnesty International, Brook NI, the Family Planning Association, Genetic Alliance UK, the International Federation of Abortion and Contraception Professionals, the Royal College of Obstetricians and Gynaecologists (NI), the Royal College of Midwives (NI), the Royal College of General Practitioners (NI), the Royal College of Nursing (NI) and the British Medical Association (NI).

24. The General Medical Council (GMC) guidance 'Good Medical Practice' requires all doctors to recognise and work within the limits of their competence and to consult other doctors or make a referral where a patient’s condition is too complex or outside their area of competence. The RCOG stated that assessing mental health, as opposed to treating mental illness, is part of general medical training and this requirement may have implications for other areas where medical practitioners are expected and permitted to make medical health assessments.

25. The Royal College of Psychiatrists (NI) noted the GMC’s requirement that doctors should recognise and work within the limits of their competence. They mentioned research that concluded that rates of mental illness were similar in cases where women carrying an unwanted pregnancy had the pregnancy terminated and where they had taken the pregnancy to term. Given the lack of evidence, they noted the difficulty in predicting the impact of pregnancy on a woman’s long term mental health. They noted evidence that a termination of pregnancy can have psychiatric sequelae.
26. Life NI acknowledged that assessment of women’s health should be done by those with greatest expertise but raised concern that this could lead to more frequent abortions on mental health grounds.

27. Some groups felt that a consultant psychiatrist requirement was appropriate including the Northern Ireland Evangelical Alliance, the Northern Catholic Bishops and Supervisors of Midwives in the Belfast Area.

28. Belfast Health and Social Care Trust welcomed the clarity that a consultant psychiatrist should be involved as a co-signatory in relation to grounds for a women’s mental health. The Western Health and Social Care Trust welcomed their involvement but asked for further clarity in relation to the breadth of application of this recommendation.

29. The General Medical Council agreed that appropriate specialist support should be made available to women provided it does not provide a barrier to a patient being able to access timely and appropriate care.

30. A wide range of mental health issues were identified by respondents, ranging from the risk or threat of suicide, through to the long term future mental health impact of giving birth to a baby that is not expected to, or cannot, survive. The point was made that in many of these scenarios the services of a consultant psychiatrist are not appropriate.

**Issue:** The guidance document does not recognise medical advances, the complexity of issues of lethal fetal abnormality and the effect that this can have on the mental health of a woman.

31. Respondents highlighted a number of related areas including:
   - Medical advances in genetics and antenatal screening programmes provide information to doctors and families not available when the law was drafted.
• The guidelines make no provision in relation to complex cases of fetal abnormality that are not compatible with life.
• Carrying a fetus with some abnormalities, especially fatal ones, may hold risks to the present or future mental health of a woman.
• Fetal viability is not adequately dealt with in the document.
• Long term distress on a woman’s mental health may result from raising a child with a severe genetic condition.

Discussion
32. The issue was raised by a wide range of respondents including the Society for Mucopolysaccharide Diseases, Genetic Alliance UK, a group of Genetic Nurse Counsellors from Belfast Health and Social Care Trust, Obstetricians and Fetal Medicine Consultants at the Royal Jubilee Maternity Service and the Association of Genetic Nurses and Counsellors.

33. The issue of a lethal fetal abnormality which is incompatible with life outside the womb was raised by respondents including the South Eastern HSC Trust and Belfast HSC Trust.

34. The Royal College of General Practitioners noted concerns on the issue of viability, and whether a child is capable of being born alive because of the potential implications on the clinical management of the delivery.
III. CERTIFICATION BY TWO DOCTORS

Issue: The guidance recommends that two doctors should certify a termination of pregnancy, whilst acknowledging that this may not be possible during emergency situations.

35. Respondents raised a range of issues including:
   - There is no basis in law for two doctors to be involved.
   - The requirement may cause delays in accessing care.
   - Perception that it offers protection to a fetus and safeguards the law.
   - Perception that it protects a doctor from prosecution.
   - An additional doctor can bring additional skill and experience to assessment
   - Clarification sought on levels of skills and competencies required.

Discussion

36. Respondents in favour of two doctors with appropriate skills and experience included the Society for Mucopolysaccharide Diseases, Obstetricians and Fetal Medicine Consultants at the Royal Jubilee Maternity Service, the Belfast Health and Social Care Trust, the Northern Ireland Evangelical Alliance and LIFE NI.

37. The Royal College of General Practitioners (NI) agreed that where a woman requires a termination that meets the legal requirements, two doctors are needed to make the case for referral to a secondary care service.

38. Those who felt that one doctor certifying terminations was more appropriate or stated that two doctors had no basis in law included UNISON, the British Pregnancy Advisory Service and Alliance for Choice (Belfast), the International Federation of Abortion and Contraception Professionals and the Labour Party in Northern Ireland. The Royal College of Nursing (NI) stated that the guidance was unclear on requirements in this area.

39. While many respondents drew attention to the fact that there is no legal or good practice basis for requiring two doctors to certify, opinions were mixed as to
the purpose. Some respondents clearly viewed the requirement as protective to
the doctor certifying the need for a termination; others regarded it as protective to
the fetus in that it may prevent a termination.

40. The General Medical Council guidance ‘Good Medical Practice’ requires all
doctors to recognise and work within the limits of their competence and to consult
other doctors or make a referral where a patient’s condition is too complex or
outside their area of competence.

41. The views raised will be considered in any further guidance produced by the
Department.

IV. CONSCIENTIOUS OBJECTION AND SECOND OPINIONS

Issue: The application of conscientious objection

42. A wide range of respondents raised issues including:
   • There is no right in Northern Ireland law to conscientiously object.
   • Welcome the fact that conscientious objection is recognised.
   • Need to recognise impact of recent Scottish case in this area.¹
   • Section confuses conscientious objection with a situation where a member
   of staff believes a procedure is unlawful.
   • Department should reissue 2010 version on conscientious objection.
   • Potential to discriminate on grounds of religious belief
   • Recognition that in an emergency scenario, staff must participate.
   • Asserting conscientious objection without a supporting statutory framework
   leaves staff with no recourse in law
   • HSC management should ensure adequate provision to allow staff to
   conscientiously object
   • Conscientious objection should extend to institutions whose ethos does not
   permit a procedure.

¹ http://www.scotcourts.gov.uk/opinions/2013CSIH36.html
43. Those who found the section on conscientious objection helpful included Supervisors of Midwives in Belfast Area. The Northern Catholic Bishops welcomed the section and asked that the right should also extend to institutions.

44. Those organisations that stated that the section did not adequately reflect the issue or expressed concern included Sinn Fein, Brook NI, the Royal College of Obstetricians and Gynaecologists (NI), the Royal College of Midwives (NI), the Royal College of Nursing (NI), the Pharmaceutical Society NI, the Northern Ireland Human Rights Commission, Dr Catherine O’Rourke, Professor David Albert Jones. Precious Life stated that the section on conscientious objection should be removed.

Discussion
45. There is a right to conscientiously object set out as part of the Abortion Act 1967. However, there is no statutory right under UK law to conscientiously object in Northern Ireland, though there are limited provisions in European Human Rights law.

46. Consultees felt that the section needed to be redrafted to correctly state the situation in Northern Ireland, taking account of Human Rights law, which gives health professionals a limited right to conscientiously object. It also guarantees the rights of a woman to be seen by a health professional who is able to recommend the best course of action to their patient.

Issue: Women should be offered the opportunity for a second opinion
47. Respondents highlighted a number of related areas including:
   - No framework exists to resolve differences of opinion.
   - Provision should be made to give women a right to appeal.
   - Citation of Tysiak v Poland (2007).
   - Fails to acknowledge a woman’s right to make decisions about her own health.
   - Women should be made aware if a doctor has a conscientious objection.
Discussion

48. The issue that the guidance should engage with a patient’s desire for a second opinion or appeal was raised by Marie Stopes International, the Northern Ireland Human Rights Commission, Amnesty International, Anna Lo, MLA, Sinn Fein, the British Medical Association (NI), the Royal College of Psychiatrists (NI) and Unison.

49. A number of respondents raised the case of Tysiac v Poland. The European Court of Human Rights noted that Poland did not provide a framework to resolve differences in opinion that may arise between pregnant woman and doctors in relation to abortions. Abortion is illegal in Poland except when a women’s health is at risk, when pregnancy is a result of a criminal act, or when the fetus is severely deformed.

50. The Department recognises that there are circumstances where a patient may wish to seek another medical opinion. Assessment of whether a woman meets the grounds for a termination of pregnancy is no different in this regard. GMC guidance recognises that patients should be with treated with respect and that they have a right to reach decisions on treatment and care in conjunction with their doctor. Good clinical care includes referring a patient to another practitioner when this is in the patient’s best interests.

51. There is no legal right to a second opinion in the HSC. The decision to seek a second opinion is a matter for the clinician and the HSC Trust, taking into account the particular circumstances of the patient’s case. The health service will normally try to accommodate a patient’s request where possible.

52. If a woman disagrees with her doctor on whether a termination of pregnancy would meet the legal framework in Northern Ireland, it is expected that she should have access to another opinion. However, all decisions taken will be on a case by case basis.
V. PROVISION OF COUNSELLING SERVICES

Issue: Providing advice on termination of pregnancy and services in other UK areas.

53. Respondents raised this issue and related areas including:
   • Citation of the Open Door and Dublin Well Women centre v Ireland shows that providing information on services outside the UK is not illegal and is not a grey area
   • Restrictions on information provision are not permissible under Article 10 of the European Convention of Human Rights
   • Confusing when read with section 2.7 in the guidance.
   • Women should have access to full range of psychological services
   • Counselling services should be non-directional
   • Unclear whether services should be provided ‘in-house’ by Trusts.
   • Additional resource requirements.
   • There is no legal framework for counselling in Northern Ireland
   • Inappropriate to refer to selective community or religious support services.
   • Definition is require of what is an appropriately trained counsellor

Discussion

54. The issue of counselling was raised by a wide range of respondents including British Association of Counselling and Psychotherapy, Antenatal Results and Choices, Causeway Care in Crisis, British Pregnancy Advisory Service, Pharmacy Forum NI, Local Supervising Authority NI and Belfast Health and Social Care Trust.

55. Respondents raised a wide range of issues on this section including who should provide and pay for counselling services, and whether it is part of, or distinct from the normal range of psychological services available to any patient.
VI. PATIENT CONFIDENTIALITY & DATA COLLECTION

Issue: The collection of information in relation to grounds for a termination of pregnancy in Northern Ireland.

56. Respondents highlighted a number of related areas including:

- Need to protect patient confidentiality due to small numbers in Northern Ireland.
- Statistics should be collected from statutory and non-statutory organisations.
- Recording system should be regularly scrutinised.
- Will add rigour and traceability to decision making process.
- Data collection should be used to inform policy decisions and ensure adequate allocation of resources.

Discussion

57. Removal of recording reasons for a termination of pregnancy in doctor’s notes was raised by Amnesty International and Anna Lo, MLA.

58. Respondents expressing concerns regarding the potential impact on patient confidentiality included the British Medical Association (NI), the Royal College of Nursing (NI), the Royal College of Obstetricians and Gynaecologists (NI) and Judith Thurley RGN.

59. The Western Health and Social Care Trust welcomed the development to add rigour to the decision making process. Amnesty International noted that any information collected should conform with human rights principles and be used to inform policy and decision making around health care practice, and to review and monitor health services.

60. Brook (NI) stated that sexual health data in Northern Ireland is limited and could be improved by the collation of this information.
61. Recording of the reason for termination in medical health notes is important for case history and to diagnose future patient symptoms. This information is for medical professionals and patients only.

**Issue: Requirement to disclose information in relation to terminations of pregnancy that health professionals believe may be illegal in Northern Ireland**

62. Respondents highlighted a number of related areas including:

- Negative impact on patient trust which is central to relationship with doctor.
- Further clarity required in relation to the responsibilities of disclosure.
- May lead to breach of patient confidentiality.
- The document suggests professionals, not privy to full clinical background, should make legal judgements on actions of colleagues.
- Clarity required on definition of ‘secondary party’.
- Issue of purchasing abortifacients from internet sites.
- May lead to reluctance of patients to seek medical attention.
- Potential implications across patient management for the whole health service.

**Discussion**

63. Respondents suggested there was a negative impact on patient trust and the ability of medical professionals to treat patients. A number of respondents specifically highlighted the issue of patients presenting with complications who had procured a termination in other UK administrations, or who have purchased drugs on the internet or by other illegal means.

64. Concern was raised by the General Medical Council, the Northern Ireland Ambulance Service, Supervisor Midwives in the Belfast Area, the Royal College of Midwives (NI), the Royal College of Obstetricians and Gynaecologists (NI), Anna Lo, MLA, the Pharmaceutical Society NI, the British Medical Association (NI) and the Royal College of Nursing (NI).
65. The issue of purchase of abortifacients via the internet was raised by the Belfast Health and Social Care Trust, the Northern Ireland Christian Medical Fellowship and Obstetricians and Fetal Medicine Consultants at the Royal Jubilee Maternity Service.

66. The Belfast HSC Trust stated further guidance was required for front line staff regarding individuals who freely admit to having purchased abortifacients over the internet. The Northern Ireland Christian Medical Fellowship stated the situation regarding abortifacients purchased via the internet needed to be addressed.

67. The General Medical Council’s confidentiality guidance acknowledges that disclosure of personal information about a patient without consent may be justified in the public interest, if failure to disclose may expose others to risk of serious harm.

68. In general, there is no offence of importing any medicinal product for personal use. However there are possible offences linked to procuring and administering abortifacient medicines in some circumstances under the Offences Against the Persons Act 1861.

69. It is important to note that the draft guidance consulted on reflects the law as it has been interpreted by courts. It does not introduce any new law or practice on health professionals.

70. The Criminal Law Act (Northern Ireland) 1945 introduced penalties for assisting offenders and penalties for concealing offences. These offences exist outside any guidance document issued by the Department.
VII. EQUALITY AND HUMAN RIGHTS

Issue: The Department is keen to meet its equality obligations as set out in Section 75 and invited interested parties to respond.

71. Respondents highlighted a number of issues including:

- Women unable to access services available in England, Scotland and Wales.
- Cost pressure placed on those from lower socio economic groups.
- Application of law resulting from guidance will impact upon women.
- Restrictive barriers to safe abortions are gender discriminatory.
- Document violates women’s human rights.
- Potential impact on staff dealing with women who have had an illegal termination.
- Dealing with termination of pregnancy may impact on religious beliefs of some health and social care staff members.
- Guidance should include information on provision of non English language services.

Discussion

72. Issues of equality were raised by a range of respondents including the Northern Ireland Ambulance Service, Amnesty International, the Irish Congress of Trade Unions, Alliance for Choice, the Royal College of Midwives (NI) and Doctors for a Women’s Choice on Abortion.

73. The South Eastern Health and Social Care Trust noted that women may be impacted upon by the draft guidance but that this is not necessarily an adverse impact. They noted that there may also be a potential impact on other groups including racial, religion and those with a disability.

74. Reference was made by a number of respondents to comments made by the Committee on the Elimination of Discrimination against Women (CEDAW).
75. In asking about Section 75/equality issues, the Department was seeking opinions on whether the guidance generates any adverse impacts on section 75 groupings to determine whether an Equality Impact Assessment would be required. It is important to note that the need for guidance arose in part because there was some evidence that women were unable to access lawful treatments.

76. The purpose of the guidance is to ensure that women, who are legally entitled to treatment under the law receive that treatment, and that health professionals providing treatment have a degree of certainty that they are providing treatment that is legal.

77. In regard to pregnant women, the guidance is only relevant to women of childbearing age. It has no relevance to men, as men will never be treated under the guidance. Women from the other Section 75 categories should not face issues (as far as guidance on the law on termination of pregnancy in Northern Ireland is concerned) different from pregnant women generally.

78. As no actions could be taken, or not taken, to improve equality of opportunity for the target group in the context of guidance, it is proposed that the guidance should be screened out for equality purposes in the context of women as patients. Formal screening has not yet been carried out.

79. This assessment does not address the continued differences in treatment between pregnant women in Northern Ireland in relation to pregnant women in GB, but that is outside the scope of Section 75. Section 75 issues would clearly have to be fully reconsidered in the event of any possible future changes to the law in Northern Ireland.

80. In regard to the people who provide healthcare to pregnant women, the guidance could conceivably impact on those with certain religious beliefs. Some healthcare professionals may for reasons of religious belief have an objection to participation in any of the processes around a termination of pregnancy,
regardless of legality. Recent case law in Scotland, albeit in a different legal and policy context, suggests that conscientious objection may apply wider than just the individuals involved in treatment, but also to supervisors and ancillary staff.

81. Consultees highlighted that in Northern Ireland, there is no statutory right to conscientious objection. However, General Medical Council guidance, and case law from the European Court of Human Rights, suggests that where treatment is planned or anticipated, individuals may be able to refuse to participate as long as the health authority is able within a reasonable timescale to provide any treatment to which the woman is legally entitled.

82. However, in unplanned treatment such as an emergency situation, health professionals are obliged to act in the best interests of the patient.

83. For Section 75 purposes, there may be a differential impact on those with religious beliefs and an equality screening may well be necessary for Trusts as they consider how to implement any eventual guidance.

**Issue: Compliance with Human Rights Act 1998 and International Treaties**

- Chilling effect on legal abortions that may emerge from legal uncertainty.
- Mechanisms to resolve disputes between doctors and patients should be in place.
- Citation of the Open Door and Dublin Well Women centre v Ireland.
- Restrictions on information provision are not permissible under Article 10 of the European Convention of Human Rights.
- Comments made by the Committee of Elimination of Discrimination Against Women.

84. Specific concerns were raised by the Northern Ireland Human Rights Commission, Amnesty International UK, Dr Catherine O’Rourke, Senior Lecturer in Human Rights and International Law at the University of Ulster (in a personal capacity) and the Committee on the Administration of Justice, regarding the UK’s

Discussion

85. Under the Human Rights Act, primary and secondary legislation must be read and given effect in a way which is compatible with Convention Rights, and it is unlawful for a public authority to act in a way which is incompatible with a Convention right.

86. Attention was drawn in the consultation to the European Court of Human Rights, which has ruled that Article 8 of the Convention requires Governments to provide legal clarity on when an abortion is permitted, and that there must be no obstruction in a woman receiving the treatment to which she is legally entitled. In particular, court judgements have noted the ‘chilling effect’ on the ability of women to receive lawful treatment that is caused by legal uncertainty and the risk of criminal liability on medical professionals. It notes that women may be deterred from seeking treatment, and doctors from providing it, due to this chilling effect. In Tysiaç v Poland the Court stated that ‘..the applicable legal provisions must, first and foremost, ensure clarity of the pregnant woman’s legal position….Once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it.’

87. A range of professional bodies stated that the guidance does not make clear that the burden of proof in any prosecution in Northern Ireland lies with the prosecution to prove that the termination was not carried out in good faith only to preserve the life of the mother.

88. Consultees drew attention to European Court rulings on situations where there is a difference of opinion between a woman and her doctors, or between doctors themselves. It has held that authorities should provide an appeals mechanism, which should give the woman a right to be heard, and record the
reasons for its decision. The NIHRC has advised that this section should be redrafted to reflect Court judgements. This matter was also raised by Anna Lo, MLA.

89. The Court has addressed issues of conscientious objection by medical professionals. It has held that health services are obliged to ensure that exercise of freedom of conscience by health professionals does not prevent patients from obtaining access to services. This obligation is wider than the ‘right’ set out in the current draft. The NIHRC has advised that this section should be redrafted to reflect court judgements.

90. Finally, many respondents raised European Court judgements on the right to receive and impart information. The court has clearly ruled that restrictions on the receipt and provision of information regarding options for termination of pregnancy are not permissible under the convention. The NIHRC has advised that the guidance should explicitly clarify the right of women to access this information. They also advise that the ‘grey area’ statement on advocating or promoting a termination of pregnancy in para 5.12 of the guidance, is likely to be in violation of the Convention, in that the legal position is not sufficiently clear.

91. Amnesty International draws attention to CEDAW’s General Recommendation 24 (Women and Health), which states that ‘laws that criminalise medical procedures only needed by women punish women who undergo these procedures’. This has resulted in recommendations from CEDAW to the UK calling on the UK to remove measures imposed on women who undergo abortion. CEDAW has asked that that legal abortion not only covers cases of threats to the life of a pregnant woman, but circumstances such as threats to her health and in cases of rape, incest and serious malformation of the foetus.

92. Consultees have suggested that some sections of the document may not be compliant Human Rights law.
VIII. MISCELLANEOUS

Issue: Whether it is appropriate to seek a second opinion in Great Britain?

93. This issue was raised by the Royal College of Obstetricians and Gynaecologists (NI) and Belfast Health and Social Care Trust.

Discussion:
94. Normal procedures in relation to referral pathways should be followed should a practitioner require a second opinion. A decision on whether a second opinion in GB is necessary must be made on medical grounds, assuming that the necessary expertise is not to be found in Northern Ireland.

Issue: Development of a Regional Pathway and information sheet for health and social care staff.

95. Respondents highlighted a number of related areas including:

- Standardised tools assure decisions are taken within the legal framework
- Regional pathways allow effective decision making in the service.
- Pathways and processes should be developed with Royal Colleges
- Recognition of the important role of primary care services including pharmacists,
- Usefulness of regionally developed information sheets.

Discussion:
96. This issue was raised by a number of respondents including the South Eastern Health and Social Care Trust, the Southern Health and Social Care Trust, the Family Planning Association and the Royal College of Nursing (NI).
Issue: Training and competencies of health professionals
97. The Family Planning Association suggested that the Department should annex a list of competencies required by health professionals involved in carrying out termination of pregnancy or providing after care for women.

Issue: Prominence of sexual offences section
98. The Family Planning Associate queried the prominence given in the guidance to the issue of sexual violence, given that sexual violence is a criminal offence, and there is no provision in the law for abortion for reasons of rape or incest.

Issue: Prominence of ensuring consent.
99. Antenatal Results and Choices queried the prominence given in the guidance to the issue of securing consent. They stated that the necessity of gaining consent is a well established principle in any medical procedure.

Issue: Inclusion of R v McDonald in the ‘legal cases’ annex.
100. R v McDonald is included in the list of judicial cases because in hearing this case, a judge provided a definition of ‘capable of being born alive’ in interpreting the Criminal Justice Act 1945. While some have welcomed his definition in the context of termination of pregnancy, others point out that the McDonald case has no relevance to this guidance, and that 24 weeks is now the threshold of viability for a baby in the UK.
ANNEX 1 - FORMAL CONSULTATION RESPONSES RECEIVED

Alliance for Choice: Belfast
Alliance for Choice: Derry
Alliance Party
Amnesty International
Antenatal Results and Choices (ARC)
Association of Catholic Lawyers Ireland
Association of Genetic Counsellors and Nurses
Belfast Feminist Network
Belfast HSC Trust
British Medical Association (NI)
British Association for Counselling and Psychotherapy
British Pregnancy Advisory Service
British Psychology Society
Brook NI
Catholic Bishops of Northern Ireland
Causeway Care in Crisis
Choose Life Abortion Recovery Ministry
Christian Action and Research and Education
Christian Institute
Committee on the Administration of Justice
Doctor’s for a Woman’s Choice on Abortion
Evangelical Alliance
Faculty of Sexual and Reproductive Healthcare (of RCOG).
Family Planning Association
Fetal Medical Consultants (co-signatories)
Genetic Alliance UK
Genetic nurse/Counsellor group (co-signatories)
General Medical Council
International Federation of Abortion and Contraceptive Professionals
Irish Congress of Trade Unions (NI)
Labour Party NI
LIFE NI
Local Supervising Authority NI
Marie Stopes International
Maternal Fetal Consultants (Royal Hospital)
National Union of Student and Union of Students in Ireland
Northern Ireland Ambulance Service
Northern Ireland Christian Medical Fellowship
Northern Ireland Human Rights Commission
Northern Ireland Women’s European Forum
Pharmacy Forum NI
Pharmaceutical Society NI
Precious Life
Reproductive Health Matters x 2
Royal College of General Practitioners (NI)
Royal College of Midwives (NI)
Royal College of Nursing (NI)
Royal College of Obstetricians and Gynaecologists (NI)
Royal College of Psychiatrists
Sinn Fein
Society for Mucopolysaccharide Diseases
Society for the Protection of the Unborn Child
South Eastern HSC Trust
Southern HSC Trust
Supervisors of Midwives (Belfast Area)
UNISON
Western HSC Trust
Women’s Resource and Development Agency
Individual Responses

K H Anderson
S Anderson Counsellor
Carolyn A L Bailie (Dr) Consultant Obstetrician
Richard Barr (Dr) General Practitioner
Eileen Fegan,
Julie Hassell Campus Nurse
Gwyneth Hinds (Dr) General Practitioner
David A Jones (Professor) Director, The Anscombe Bioethics Centre
Elizabeth Laird
Anna Lo MLA
Donagh MacDonagh (Dr) General Practitioner
Noel McCune (Dr) Consultant Psychiatrist (retired)
Jennifer McIlwaine (Dr) Queen's University, Belfast
Shane McKee (Dr) Consultant, Genetic Medicine
Andrew McKeever
James Nelson (Dr) Psychiatrist
Catherine O'Rourke (Dr) Human Rights and International Law, Univ. of Ulster
Willie Patterson Form. Asst Direct, Family & Child Care, C'seway Trust
Danielle Roberts
Jane Robinson
Judith Savage
Fiona Stewart (Dr) – Consultant in Genetic Medicine
Judith Thurley - Registered General Nurse
Jawine Westland
Chris Wilson

Two individuals requested their identity withheld

Other

The Public Health Agency responded without comment.
CONSULTATION ON DRAFT GUIDANCE ON TERMINATION OF PREGNANCY

The Minister for Health, Social Services and Public Safety circulated draft guidance on termination of pregnancy to the Northern Ireland Executive on 7 March. The Executive considered the document, “The limited circumstances for a lawful termination of pregnancy in Northern Ireland: A guidance document for health and social care professionals on law and clinical practice”, at its meeting on 28 March and agreed that a 16 week public consultation should be held.

This draft guidance builds on previous versions that have been consulted upon. It provides guidance to health and social care professionals on the law in Northern Ireland. The new document confirms that terminations of pregnancy should only result under limited and exceptional circumstances. It recognises that treatment of a pregnant woman that leads to a termination of pregnancy will only have been carried out of the purpose of concern for the woman’s health. Any harm to an unborn child must only be incidental to that treatment.

The guidance document recommends that consultant psychiatrists should be involved in the assessment of a woman’s mental health when it is related to grounds for terminating a pregnancy.
A new section has been added in relation to accountability and information collection, emphasising that organisations must have robust systems in place to ensure compliance with the law.

The Department invites comments on the draft guidance during the consultation period which runs from 8 April to 29 July 2013. The guidance document can be accessed at www.dhsspsni.gov.uk/index/consultations/current_consultations.htm

Copies are available upon request by writing to the Family Policy Unit at Room C4.22, Castle Buildings, Stormont, BT4 3SQ, telephoning 028 9052 3310 or on text phone 028 9016 3426. Emailed copies are available upon request at familypolicyunit@dhsspsni.gov.uk. Alternative formats can be made available.

When responding it would be helpful if you could ensure your return include:

- Your name, organisation (if relevant), address, and telephone number
- Whether your comments represent your own view, the corporate view of your organisation, or the view of a group or team within your organisation

The Department is keen meet its equality obligations as set out in section 75 of the Northern Ireland Act 1998 and invites interested parties to respond to the following questions.

- Are the actions/proposals set out in the draft guidance document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.

- Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in the guidance document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Working for a Healthier People
• Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.

• Are there any aspects of this action plan/Policy where potential human rights violations may occur?

Before you submit your response please read the attached Annex A regarding the Freedom of Information Act 2000 on the confidentiality of responses to consultation exercises.

Yours faithfully,

Sean Holland
Deputy Secretary, Social Services Policy Group
ANNEX A - FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

The Department will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor’s Code of Practice on the Freedom of Information Act provides that:

- the Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department’s functions and it would not otherwise be provided

- the Department should not agree to hold information received from third parties “in confidence” which is not confidential in nature

- acceptance by the Department of confidentiality provisions must be for good reason, capable of being justified to the Information Commissioner.
For further information about confidentiality of responses please contact the Information Commissioner's Office (or see website at:
http://www.informationcommissioner.gov.uk/).