Views are invited on the following questions;

Q1. Several options have been put forward in chapter 4 to create an exemption in the criminal law on abortion, to provide for termination of pregnancy in cases of lethal foetal abnormality. The Department has set out its preferred option for defining what is meant by ‘lethal’ and ensuring that the law will apply only to such cases. The paper seeks views from respondents.

The differences between the four options are somewhat blurred: all the options would rely on a degree of clinical judgement; and the distinction between a foetus having ‘a lethal abnormality’ and being ‘incompatible with life’ is unclear.

Discussion in other parts of the consultation document uses different terminology again which adds further confusion about what might be meant by either phrase. For example in paragraph 9.5, it is stated that termination is available in NI if a foetus ‘cannot proceed to term, survive birth or sustain independent life’.

We note that the consultation document refers to ‘registered medical professionals’ when in fact the doctors involved will also need to have a licence to practise. (Since the introduction of revalidation some doctors are registered without a licence to practise.) We suggest it should therefore refer to ‘licensed medical practitioners’.

Our concern about option 4 is that it calls for an assessment that a condition is ‘incompatible with life because no treatment can be offered to improve the
chances of survival’. However, if the chance of survival could be improved from, say, ‘nil’ to 5% with treatment, that would increase the risk that different medical practitioners might reach different conclusions.

An alternative option you may wish to consider is the following:

- If ‘lethal’ and ‘incompatible with life’ are seen by NI healthcare practitioners as having the same meaning, perhaps the Act could use the phrase which is most widely used and provide a definition;

- For ourselves, we are not sure whether ‘lethal’ and ‘incompatible with life’ have the same meaning, and it is likely that a definition will be necessary whichever term is used; a condition may not be incompatible with life of any kind, but certainly incompatible with continuing life – ie more than a few minutes, hours or even days of life – and it will be necessary to make this distinction in order for the law to be clear;

- The Act could include the examples of those lethal abnormalities that would qualify for an exemption from the criminal law, but not attempt to provide an exhaustive list (eg ‘Lethal foetal abnormality includes, but is not limited to, anencephaly, xxxx, …’)

- You may wish to consider setting an expectation in the Act that, for example, two medical practitioners must agree that the condition in an individual case can be considered to be lethal (or incompatible with life, whichever term is decided on).

If such an approach were attractive – then the Department might want to explore whether it could be supported by national guidance from the Royal Colleges of Obstetricians and Gynaecologists, and Paediatrics and Child Health.

Q2. Should the law allow for abortion in cases of lethal foetal abnormality?

We do not have a role in determining either the law or government policy on matters such as abortion. If it is decided that the law will be changed, then the United Nations’ CEDAW Committee has given a helpful pointer that it would be in favour of a change to the legislation in Northern Ireland to align it more closely with that of the rest of the UK.

Lethal foetal abnormality, as described in your consultation document, would seem to fit within the concept of ‘substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped’ (wording taken from the 1967 Abortion Act).

Q3. If so, how is this best achieved?
We judge this question to be outside our remit.

**Q4. How would you define ‘lethal’?**

Please see the suggestion in our response to Question 1, which also outlines our concerns about the definition used in Option 4.

To define a ‘lethal foetal abnormality’ in legislation in terms of what would be judged by a doctor to be in the child’s best interests if that child were to be born might cause confusion. However, if this approach is taken, it may be helpful to consider our guidance for doctors on end of life care for neonates, where we say the following:

> If, when considering the benefits, burdens and risks of treatment (including resuscitation and clinically assisted nutrition and hydration) you conclude that, although providing treatment would be likely to prolong life, it would cause pain, or other burdens that would outweigh any benefits and you reach a consensus with the child’s parents and healthcare team that it would be in the child’s best interests to withdraw, or not start the treatment, you may do so.

**Q5. Do you agree that the best way is to allow clinical judgement to decide when a foetus is not compatible with life? This is option 4**

Please see the suggestion in our response to Question 1.

**Q6 Should the law also provide for abortion to be a choice in the event of rape?**

Please see our response to Question 9.

**Q7. Should the law allow abortion only for women who have been the victim of rape?**

Please see our response to Question 9.

**Q8. Should the law allow for abortion for victims of other sexual crime, such as sexual activity with a person under the age of 16, abuse of a position of trust, unlawful sexual activity with a vulnerable adult?**

Please see our response to Question 9.

**Q9. Should the law provide for abortion in cases of familial sexual activity with a person under 18, and sex between adult relatives?**

Answer to Qs 6-9: As we stated in response to question 2, we do not have a role in determining either the law or government policy on matters such as abortion.
Cases where women were seeking termination of a pregnancy resulting from rape, other sexual crime and familial sexual activity with a person under 18 or sex between adult relatives might be covered by cases where ‘the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family’ (wording taken from the 1967 Abortion Act).

Q10. Should it be necessary to have made a complaint to the police before accessing a termination?

No.

In the event of a change in the legislation, if a patient were to attend their doctor requesting termination of pregnancy because of the circumstances outlined above, we would not wish the doctor to be placed in the difficult situation where they are required to determine whether or not a patient has made a complaint to the police, before s/he can proceed to assess whether the woman’s circumstances are such that termination might be a legal option in her case. We do not feel it is a doctor’s role to gather or assess criminal evidence before providing treatment or care for their patient.

A doctor’s primary concern must be their patient’s care and, if the patient in front of them is in distress (which is likely in cases where a woman is seeking a termination of a pregnancy that results from rape, sexual assault or other criminal behaviour), to then require that patient to make a complaint to the police or show evidence of a complaint before proceeding would affect the timeliness of access to termination (if that was judged a legal option in her case); it might hamper the doctor’s ability to address that patient’s physical and mental health needs; and more generally it might adversely affect women’s trust in the medical profession.

Q11. Does this need to be time limited?

Please see our response to question 10. We would have concerns about introducing any processes that could create avoidable delays in decision-making and access to care which adversely affect women’s health.

Q12. Should a police report be required and what would this say?

Please see our responses to questions 10 and 11.

Q13. How would all this be achieved to allow for an early termination and is this an issue?

Please see our responses to questions 10 and 11.
Q14. Or should the exemption apply with no requirements, other than a declaration to her medical practitioner by the woman, that the pregnancy is the result of a sexual crime committed against her?

For the reasons outlined above, we would suggest that this is the option most likely to be compatible with doctors being able to provide a good standard of care to their patients.

Q15. In the case of incest, who is going to determine when an incestuous relationship has occurred and how is this proved?

For the reasons outlined above, if the law were to be changed to allow abortion in these circumstances, we do not feel it would be helpful to require doctors to send away vulnerable or distressed patients in order to obtain proof to establish a legal entitlement to termination of pregnancy.

Q16. In other words, how could we ensure that the law would work as intended, has no unintended consequences and that there would be legal certainty in these cases?

We support your concern to focus on the goals of any provision for abortion in cases of criminal sexual activity and to ensure the objectives are achieved.

Anonymised reporting about the women obtaining abortions on the grounds set out in the consultation document might satisfy any public concern about the potential misuse of the law. This approach is used in England to monitor abortion on the grounds of disability: there is a statutory obligation to report to the national register and to the Department of Health (England).

Conscientious objection

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

As for our answers to questions 2 and 9, we do not have a role in determining the law although we understand there are calls for the law in Northern Ireland to align more closely with that of the rest of the UK. We understand that the 1967 Abortion Act allows for a conscientious objection to participation in abortion except where the procedure is necessary to save life or prevent grave permanent injury.

We make similar provision in our own guidance Personal beliefs and medical practice for doctors to opt out of providing a particular procedure because of their personal beliefs and values, as long as this does not result in direct or indirect discrimination against individual patients or groups of patients, and provided that this opting out does not result in substantial delay to the patient accessing appropriate care:
You must bear in mind the patient’s vulnerability and act promptly to make sure they are not denied appropriate treatment or services.

As with the 1967 Act, the right to conscientious objection does not apply in emergencies:

In emergencies, you must not refuse to provide treatment necessary to save the life of, or prevent serious deterioration in the health of, a person because the treatment conflicts with your personal beliefs.

The proposals as set out in Chapter 9 of the consultation document are unclear, especially paragraphs 9.1, 9.3 and 9.4. And we wonder whether the situation under the 1967 Act is accurately represented? Nevertheless, we understand your proposal to be that, (setting aside cases involving life threatening emergencies or risk of severe permanent injury to the woman), conscientious objection would be allowed when abortion is on grounds of criminal sexual activity, but it would not be allowed in cases of lethal foetal abnormality. If that’s a correct understanding, it appears that you are making a distinction based on whether the foetus being aborted would otherwise be viable after birth? We are not able to comment on this approach other than to observe that both proposed grounds for abortion involve an element of choice for the woman concerned (unless it is considered that all women who learn that their foetus has a lethal abnormality have no choice but to terminate?).

18. Should that right be confined to involvement in the actual procedure which results in termination (e.g. giving the abortion medication, carrying out or assisting in the surgical procedure)?

The scope of conscientious objection is not specifically addressed in our guidance on Personal beliefs and medical practice. However, we do expect doctors who have a conscientious objection to a procedure requested by their patient (and to which that patient is entitled) to do the following:

a. Tell the patient that you do not provide the particular treatment or procedure, being careful not to cause distress. You may wish to mention the reason for your objection, but you must be careful not to imply any judgement of the patient.

b. Tell the patient that they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to.

c. Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.
13. If it’s not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made – without delay – for another suitably qualified colleague to advise, treat or refer the patient. You must bear in mind the patient’s vulnerability and act promptly to make sure they are not denied appropriate treatment or services. If the patient has a disability, you should make reasonable adjustments† to your practice to allow them to receive care to meet their needs. In emergencies, you must not refuse to provide treatment necessary to save the life of, or prevent serious deterioration in the health of, a person because the treatment conflicts with your personal beliefs.

14. You will not necessarily need to end a consultation with your patient because you have an objection to a treatment or procedure that may be appropriate for them. However, if you feel (or the patient feels) that your conscientious objection prevents you from making an objective assessment, you should suggest again that the patient seeks advice and treatment elsewhere.

15. You must not obstruct patients from accessing services or leave them with nowhere to turn.

16. Whatever your personal beliefs about the procedure in question, you must be respectful of the patient’s dignity and views.

19. Should the right cover participation in all treatment related to the abortion, including both pre and post procedure nursing care?

Our position is detailed in our response to question 18 above. However, we understand that the most recent judgment in the case of Greater Glasgow Health Board v Doogan and another appears more restrictive, in terms of the scope of the right to exercise conscientious objection under the 1967 Act, than set out at paragraph 9.9 of the consultation document.

20. Should it also cover all associated, but not direct duties, such as supervising and supporting other staff, and delegating tasks to staff involved in the provision of care to patients undergoing medical termination at any stage of the process?

Our position is detailed in our response to questions 18 and 19 above.