1. The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK, including 95% of midwives in Northern Ireland. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, 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.

2. This submission has been informed by the professional views and judgment of RCM members in Northern Ireland.

Executive Summary

3. The RCM’s submission addresses the first of the three themes identified by the Women and Equalities Committee in its terms of reference for this inquiry. The key elements of the submission are:

- The RCM has a clearly stated position that advocates for *inter alia*, the decriminalisation of abortion. The RCM, as a four-country organisation, is of the view that there should be equitable access to abortion services for women and girls across the UK.

- The RCM contends that the continued absence of clear guidance regarding the law on abortion in Northern Ireland (NI) or how it is to be applied in practice means that healthcare staff in NI are currently working in an atmosphere of fear, erring on the side of caution in every circumstance.

- Throughout the last 10 years of consultations and court challenges, midwives in Northern Ireland have provided a professional service to the women and families that they care for in what has been, and remains, a challenging and sometimes confusing environment.

Definition of a Midwife

4. The role of the midwife is to provide skilled, knowledgeable, respectful, and compassionate care for all pregnant women, newborn infants and their families. They work across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum, and the early weeks of life, including women’s future reproductive health, wellbeing, and choices, as well as very early child development and the parents’ transition to parenthood. Midwives enable the human rights of women and children, and their priority is to ensure that care always focuses on the needs, views, and preferences of the woman and newborn infant.

5. The basis of the relationship between a midwife and pregnant woman is one of trust. For midwives to be able to provide safe and effective care to women they must take the fullest possible history of health and wellbeing, relevant to each pregnancy and they must create a relationship where women can disclose any issues pertinent to their health during the course of their pregnancy. During the course of a pregnancy midwives will need to probe many delicate, private and potentially sensitive issues. Midwives will ask women whether they smoke, drink alcohol or take illegal drugs, they will ask about previous pregnancies and miscarriages including where they ended in an abortion. This latter point may be very pertinent in relation a woman’s current mental health and wellbeing. They will ask about domestic violence, sexual abuse and
female genital mutilation. They will ask about sexually transmitted diseases and the sexual health of the woman and the baby’s father, even where this is not the woman’s partner. The expectation that antenatal care will include all of these subjects is clearly set out in the policy and guidance of the Northern Ireland government. Women’s safety is reliant on truthful and transparent responses. Women are only likely to give these if they believe midwives will respect their confidentiality and their wishes.

What are the views of the general public, women and medical and legal professionals in Northern Ireland about the law on abortion and whether it should be reformed? How have these views changed over time?

6. The RCM is committed to developing maternity services that meet the needs of women and their families. We believe that a maternity service based on woman-centred care is a vital contribution to public health. The RCM supports the primacy of women’s choice on the continuation of a pregnancy and the maintenance of confidentiality as an important aspect of the development of the necessary relationship of trust. This is consistent with the code of professional standards (“The Code”) in particular para.3.4 which requires midwives to:

...act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

7. In May 2016 the RCM produced a ‘Position Statement on Abortion’ in which it advocated for inter alia, the decriminalisation of abortion. The Position Statement derives from two strongly held positions of midwives in relation to the services they provide. One concerns the autonomy of the woman or girl, whilst the other is that abortion is fundamentally a healthcare issue and should be treated as such.

8. The position states:

- Every woman should have control over her own body and her fertility
- Every woman should have the right to exercise choice over all aspects of her maternity care, including whether to have a baby or not
- Abortion procedures should be regulated in the same way as all other procedures relating to women’s healthcare
- Every woman has the right to be given the necessary information to make an informed choice regarding her decision as to continuation of the pregnancy or not
- 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
- It is within the scope of midwifery practice in the UK for midwives to work with women who are considering whether to terminate their pregnancy and who have made the decision to terminate their pregnancy. Midwifery practice must always comply with the legal framework relevant to the provision of such services
- Access to safe abortion services is a fundamental healthcare issue for women wherever they live

---

2 Royal College of Midwives, ‘Position Statement Abortion’, May 2016, p.5
• Women who are citizens of the UK should have equitable access to all aspects of reproductive healthcare. Accordingly, the provision of abortion services in Northern Ireland should be brought into line with the rest of the UK.

9. That Position Statement should be seen in its context. The policy of the Government at Westminster and in the devolved UK countries, other than Northern Ireland, has come to recognise abortion as an important part of public health. For example, the 2013 Framework for Sexual Health in England recommends that: “For those women who request an abortion it is important that they have early access to services, as the earlier in pregnancy an abortion is performed the lower the risk of complications.”\(^3\) The RCM regards that recommendation, coupled with the fact that 98 percent of all abortions are funded by the NHS, as signifying the extent to which abortion is recognised as a public health issue, which is in keeping with its own ethos that women should be able to control their fertility and plan their families in accordance with what they want to do and achieve. Furthermore, it was in line with the RCM’s position borne out of years of experience, that women’s choice, including whether or not to proceed with a pregnancy, is pivotal to good quality and responsive reproductive health and maternity care.


11. The RCM supports the view that the continued criminalisation of abortion in the UK may drive some women to access abortion services that are neither safe nor legal and which may prove harmful:

   The criminal law framework cuts against important public health goals in a number of ways. First, it may deter women from seeking medically necessary aftercare in the rare cases where it is necessary. Second, it may discourage honesty in dealings with healthcare professionals or foster a ‘don’t ask, don’t tell’ attitude. Third, it may potentially increase recourse to far less safe abortion methods.\(^4\)

12. Midwives working in Northern Ireland fully understand that the 1967 Abortion Act does not apply and that abortion is only permissible where it can be clearly demonstrated that the woman will suffer ‘real or serious, long term or permanent damage to her physical or mental health’. Equally they are clear that there is no provision in law for termination of pregnancy based on fetal abnormality or where pregnancy occurs as a result of a criminal act such as rape or incest. This already causes professional and ethical dilemmas for midwives who are charged with providing personalised, sensitive and appropriate care to many women, including those who are vulnerable through age, social circumstances, asylum seekers, refugees or trafficked women whose pregnancies are not planned or wanted. These women’s safety relies on trust and open conversations. Not only are midwives unable by law to discuss the range of options available to these women and therefore give expert support they are potentially criminalised themselves if they subsequently find out that women have procured abortions in Northern Ireland.

Criminal Law Act (NI) 1967

13. The NI Department of Health, Social Services and Public Safety issued guidance in 2016 for health professionals on termination of pregnancy. Whilst aiming to assist professionals it only served to highlight the professional dilemma facing midwives from competing legal and clinical requirements. In relation to the disclosure of information the guidance states:

\(^3\) A Framework for Sexual Health Improvement in England; Department of Health; March 2013; p.34
14. Para 6.1: “If a health and social care professional knows or believes that a person has committed certain offences, including an unlawful termination of pregnancy, he/she has a duty under the Criminal Law Act (NI) 1967 to give to the police information likely to be of material assistance in securing the apprehension, prosecution, or conviction of that person. However the health and social care professional need not give that information if they have a reasonable excuse for not doing so; the discharge of their professional duties in relation to patient confidentiality may amount to such a reasonable excuse. Professionals should be clear; however, that patient confidentiality is not a bar to reporting offences to the police.”

15. This leaves unclear the circumstances in which midwives can rely on patient confidentiality as a reason not to report information they have acquired through caring for a woman. It is also at odds with The Code which places an emphasis on patient confidentiality. The failure to report is a criminal offence punishable on conviction by a maximum of 10 years imprisonment. There appears to be no scope for ‘taking into account’ the midwife’s assessment and judgment that a report would not be in the best interests of the woman for whom she is caring. The issue under s.5 of the CLA 1967 is not the interests of the woman or girl concerned, nor the impact of disclosure on access to and the quality of reproductive health care for the vulnerable. Rather, the midwife is simply being used as part of law enforcement with dire consequences for her if she fails to comply.

It goes on to say:

16. Para 6.8: “Unless the woman herself provides the information, a health professional is unlikely to be able to tell whether a miscarriage has occurred naturally or has been caused by abortifacient drugs and if it has been, whether the drugs were administered lawfully (in Great Britain, for example) or otherwise.”

17. This paragraph seems to imply that midwives should adopt a position of don’t ask, don’t tell. This is neither safe nor professionally acceptable. The woman’s underlying health, the risks of further complications and her on-going treatment will rely on her caregivers having the fullest possible information. A midwife deliberately not seeking to take the fullest possible information could be in breach of her professional code. This is a very important issue for midwives, as it potentially creates a conflict of interest between the discharge of their duties to the woman or girl under their care and their own concerns about the risks they face of prosecution for a criminal offence that carries a maximum term of 10 years should they be convicted.

18. Midwives in NI report that this creates a climate of fear and places an intolerable burden of additional stress on them which they have no power to mitigate. Despite a strong desire to provide empathetic, sensitive care they feel high levels of uncertainty, anxiety and distress when they become aware or even suspect that a woman presenting for care may have had an abortion. This can be especially difficult if they are working in the evenings and weekends, with limited access to more senior experienced staff. Members have reported huge levels of relief when they have been ‘rescued’ by an obstetrician who has taken the lead in the management of these cases.

19. Furthermore, the likelihood is that any midwife prosecuted under the CLA will also be disciplined at work and referred to the NMC; this could result in not just the loss of her job but of her registration.

20. The RCM believes this raises issues which undermine the provision of safe and effective midwifery care for all women. Firstly, midwives may feel unable to ask women questions where ‘abortion’ may be part of the answer, for fear of placing themselves in the position of being required under the Criminal Law Act to report this to PSNI. For midwives the requirements of the CLA and their own professional code of conduct would seem at odds. Midwives unsure of to
whom they owe the greatest duty of care – the woman, the state or themselves - may give inappropriate care.

21. Secondly, if women understand that they cannot confidentially divulge this information to their midwife, they may conclude that there is other information of a personal or sensitive nature that they also should not divulge. If a general perception develops that women cannot trust midwives, the impact will be on all pregnant women, not just those seeking or having procured an abortion, and could lead to inappropriate care being given to very many women.

Termination of pregnancy: fatal fetal abnormality and sexual crime

22. During pregnancy some women will request screening for genetic abnormalities. Such screening is always preceded and followed by counselling and supportive conversations that assist women understand the nature of the screening, its outcomes and the options available. Scientific advances mean that the range of potentially life threatening or life limiting conditions that can be detected in utero is increasing as is the safety of these screening tests.

23. Whilst abortion for fetal abnormality is not permissible in Northern Ireland, screening does take place and it is recognised that some women do travel to other jurisdictions to procure termination and this is not illegal. Such women may want to be able to discuss this with their midwife. They may seek guidance on where to go and what arrangements to make in terms of bringing the aborted fetus back to Northern Ireland for an autopsy and or burial. Midwives may well be in the position of caring for women who have procured abortion outside Northern Ireland after fetal abnormality has been detected.

24. Despite assurances by the Director of Public Prosecutions in 2017 that he can see no risk of criminal prosecution for NHS employees in Northern Ireland who refer women to NHS hospitals and clinics in the rest of the UK, midwives continue to lack confidence to have these discussions. The guidance from DHSSPSNI in 2016 remains extant despite a call for it to be revised and reissued.

25. The RCM believes that if woman choses to terminate a pregnancy based on fetal abnormality she should be enabled to have the termination carried out in Northern Ireland rather than requiring travel to England or elsewhere. She should be able to discuss all her options with a midwife she knows and trusts and she should be able to access the support of her local maternity team before and after termination.

26. The RCM is also of the view that there should also be equitable access to services for women or girls who become pregnant as a result of a criminal act. It is the view of the RCM that there is a need for consistency across the UK in relation to accessing healthcare treatment for women or girls who are pregnant as a result of rape or incest. As with fetal abnormality, women pregnant through rape to currently travel to other jurisdictions. They are missing out on the advice support and guidance of their midwife before and after termination.

Termination of pregnancy: conscientious objection

27. The Royal College of Midwives is both the professional organisation and trade union for midwives in the UK. We are therefore concerned not only with the professional aspects of maternity and midwifery practice but also with protecting the rights of our members. It is our view that the Supreme Court ruling in the case of Doogan and Wood v NHS Greater Glasgow and Clyde Health Board that the right to conscientious objection extends only to those who are directly concerned in the provision of treatment to women undergoing abortion gives extensive definition to complex clinical and other situations, in regard to whether conscientious objection
applies or not. Although the ruling is in relation to the 1967 Abortion Act, it would appear sensible to apply the same principles to Northern Ireland.

28. It is our view as stated above that midwives and other healthcare professionals should have a right to conscientious objection however this right should not be absolute and that in any event where there is a risk to the life of the mother then the woman’s right to life takes precedence over the right of a health care professional to exercise a conscientious objection to participation in abortion.

December 2018