Northern Ireland Office: A new legal framework for abortion services in Northern Ireland

RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 53,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The College is an independent professional body with expertise in patient-centred generalist clinical care.

This is the official response of the RCGP. Our members may wish to respond in a personal capacity however they will not be representing the College.

In 2018, after a consultation with our membership and local faculties the RCGP took a position of supporting the decriminalisation of abortion. Therefore, this change to the law in Northern Ireland is in line with current RCGP policy.

Our UK Council Chair at the time Professor Helen Stokes-Lampard said “Ultimately, this is about providing non-judgemental care to our patients so that patients who face the difficult decision to proceed with an abortion are not disadvantaged by the legal system.”

The College has consistently lobbied for a clearer guidance on abortion and lawful access to abortion in Northern Ireland. It is essential that our members and other healthcare professionals receive regular updates on what is expected of them and how they can best assist their patients during this transitional period. Clarity and certainty for the medical profession are critical in this regard. There is still a need for access to guidance on non-judgemental aftercare and prescribing for patients who have travelled abroad.

In responding to the questions in this consultation the College finds that there are some areas of key importance for our members, their teams and patients.
There must be clear guidance on conscientious objection for healthcare professionals. This guidance should cover the parameters of objection for example, if limited to treatment, what constitutes ‘treatment.’ For example prior to decriminalisation there was a lack of clarity about whether referring a patient to services or signposting to other services constituted treatment. It would also be useful for guidance to be explicit with regard to the level to which medical professionals can and should disclose any conscientious objection and this guidance must balance rights of patients and obligations of medical staff.

It is crucial that appropriate training is planned, provided and funded in any service model, including access to training on, and use of ultrasound equipment. Too often training medical professionals is left out of service planning. It will be important to scope the number of medical professionals who will be willing to take on these services with appropriate funding, support and training provided. Government should take responsibility for this and work with relevant medical college so provision can be at an acceptable level.

The consultation

Q1. Should the gestational limit for early terminations of pregnancy be: Up to 12 weeks gestation (11 weeks + 6 days) Up to 14 weeks gestation (13 weeks + 6 days)?
The gestational limit for terminations of pregnancy is not something that the RCGP has a position on. With regard to best practice in this area, we would defer to the National Institute for Health and Care Excellence (NICE) guidelines on abortion care and the guidance for doctors practicing abortion care from our colleagues at the Royal College of Obstetricians and Gynaecologists (RCOG).

Q2. Should a limited form of certification by a healthcare professionals be required for early terminations of pregnancy?
The College is against a system of abortion care that jeopardises the doctor-patient relationship by criminalising either access to or provision of abortion services. The College previously advocated for clearer guidance on where a healthcare professional can assist, signpost, counsel or treat a patient in this circumstance within the law. In particular given the content of Section 5 of the Criminal Law Act (Northern Ireland) 1967, anyone aware of a potential crime is obligated to report it.

A form of verification rather than certification for patients confirming their gestational age to inform appropriateness of treatment would be useful to medical professionals involved in any aspect of abortion care. This would ensure that patients who were unsure of their gestational age were not incorrectly given Early Medical Abortion (EMA) and therefore put at risk of failed abortion or complications such as bleeding.

Q3. 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: 21 weeks + 6 days gestation 23 weeks + 6 days gestation?
The College does not have a position on abortion, in the context of cases outlined in this question, beyond when Early Medical Abortion (EMA) is clinically advisable. We would defer to NICE guidelines for clinical practice but the ethical side of this is not something that we have consulted our members on and is not something that we would expect GPs as a matter of course deal with.

Q4. Should abortion without time limit be available for fetal abnormality where there is a substantial risk that: The fetus would die in utero (in the womb) or shortly after birth 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?
The College would defer to NICE guidelines or the clinical advice provided by our colleagues at the Royal College of Obstetricians and Gynaecologists (RCOG) on the availability of abortion in the circumstance described in the question.

Q5. Do you agree that provision should be made for abortion without gestational time limit where: There is a risk to the life of the woman or girl greater than if the pregnancy were terminated? Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?
The College believes that abortion without gestational limit should be made available from appropriately trained and regulated medical professionals in both of the circumstances outlined in the question.

Q6. 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?
Provided they have had adequate training and do not conscientiously object to doing so, there is no reason why a nurse, midwife, GP or another member of the multi-disciplinary team (MDT) could not prescribe pills or refer patients for an EMA. However, ensuring that any health professional involved in providing termination of pregnancy services at any level is adequately trained and regulated and is working in accordance with guidelines is essential. We would defer to the opinion of our colleagues at RCOG on their views on MDT involvement in later term abortions.

Q7. 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?
Flexibility in patient access to abortion services in Northern Ireland will be crucial to ensure that patients have equal and appropriate access to the relevant care. The location of any procedure should be appropriate to the treatment, gestational age, risk of complication and support for the patient.

It would be advisable to make standards of care equal across the UK so professional bodies can advise their members more comprehensively, in particular with regard to taking misoprostol at home which is permitted in the rest of the country. This step would remove extra barriers to women accessing safe, regulated abortion without incurring extra costs to the health service. It will also stop women going through needless distress and embarrassment when travelling between venues after taking the second pill.

Q8. Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?
Limiting terminations after 22 or 24 weeks to only providers in acute sector hospitals limits women’s choice about where their care might be provided (for example private clinics). Therefore, any provision around this should be careful to ensure that women can access safe abortion in the way that they choose as long as safety and competency concerns have been addressed.
Q9. 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? 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?

The RCGP would not anticipate abortions post 14 weeks taking place in community settings and so would defer to our colleagues at RCOG on their position on certification during this period.

This question does not address certification by two doctors prior to 14 weeks. Given the lack of knowledge about the number of medical professionals willing to participate in abortion services in Northern Ireland, it may not be practical for service delivery if services could only be provided once two clinicians had certified the procedure. Certification by two clinicians is a term requirement for abortion borrowed from the 1967 Abortion Act which applies in England and Wales. This Act was designed to protect patients from dangerous abortions performed by untrained professionals in a regulated way. It can however cause barriers to access and delays to treatment. It is also an administrative and legal burden for medical professionals.

Q10. 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?

A notification process that is digitised, confidential and anonymised would be useful in assessing the need for abortion services and help with service planning and quality control. Patients must be reassured of its confidentiality. Any notification service should be data secure and not subject to sharing with other government departments. It should also be designed in a way that does not burden medical professionals with extra administrative work.

Q11. 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?

The RCGP believes that medical professionals should have a right to conscientiously object to actively participating in an abortion. This should not extend to ancillary, administrative or managerial tasks.

Similarly to the British Medical Association’s (BMA) guidance on the law and ethics of abortion, the RCGP also believes that doctors with a conscientious objection to abortion may not impose their views on those who do not share them. A medical professional is not obliged to share their reason for not providing a service to a patient. RCGP values include “equitable access to, and delivery of, high quality and effective primary healthcare for all”. It is important that all patients requesting abortion are treated in an equitable way. Medical professionals cannot refuse to provide emergency and other medical care for patients around this procedure.

A licensed self-referral service should be established to address fears of access in the case of conscientious objection.

12. Do you think any further protections or clarification regarding conscientious objection is required in the regulations?

It is essential to issue clear guidance on conscientious objection. The College is worried by the lack of practical detail in this section of the consultation. There is no existing normalised culture around abortion outside of emergency care or other extreme cases.
The current guidance has created a lack of clarity on what constitutes participation in treatment versus other tasks. This distinction should be drawn into guidance.

Prior to decriminalisation previous advice from the Department of Health (previously known as DHSSPS) in Northern Ireland put medical professionals under threat of prosecution if they took part in any acts that could be deemed ‘complicit’ in termination of pregnancy. This was distressing for medical professionals and patients and caused confusion after provision was made available for travel to England. This distinction will have to be clarified so that medical professionals are clear on their boundaries and that patients can access services.

13 Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?
Enforceable exclusion or safe zones are essential for the safety of patients and healthcare professionals and must be a part of planning for any service. Harassment of patients accessing healthcare and medical professionals into work is unacceptable. Practical space must be allowed for essential patient care to be given unhindered.

14. Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?
Healthcare professionals and patients should be free from harassment while choosing to provide or access medical care.

15. Have you any other comments you wish to make about the proposed new legal framework for abortion services in Northern Ireland?
Medical professionals in Northern Ireland who have not trained or worked outside this jurisdiction have had no formal training in management of EMA. Those practitioners who would want to engage in service provision will need access to training and support. This support may include training to use and access to ultrasound equipment. All medical professionals would require training regarding post treatment complications and management, as well as the psycho-social issues requiring GP support and management.

The Northern Ireland Office should do a scoping exercise in mapping how many healthcare professionals are willing to participate in abortion services to assess if there is a disparity or inequity in access to services regionally.

The College notes that this document does not suggest a model of delivery for this service. A mixed model of access and delivery would suit Northern Ireland, with self-referral as a key part of this. The burden of provision should not be placed solely on one part of the health service.