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Lacking Guidance or Unclear Law?

A Study of Abortion in a Policy Process Context in Northern Ireland

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Abstract

In 2004, the Department of Health, Social Services and Public Safety in Northern Ireland (the DHSSPS) was ordered by the Court of Appeal to produce guidelines for healthcare professionals on the legal framework surrounding abortion in the region. The process, which came to last eleven long years, has been one characterised by intense struggle over meaning and been the main political battleground where the polarised opinions on abortion have been articulated. This thesis examines the process relating to the creation of the guidelines through Carol Bacchi's *"What is the Problem Represented to be?"* approach, focusing on the function of problem representations within policy processes. A wide overview is given of abortion in a policy context in Northern Ireland. The analysis shows that while the policy of guidelines implied the constructed problem to be *lack of guidance*, the process has in fact undermined its own problem representation and effectively encouraged a problem representation instead focused on the lack of clarity within the law itself.

Key words: abortion, policy process, problem representation, Northern Ireland, Carol Bacchi
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1 Introduction

Often framed as an issue over morality, abortion is a profoundly controversial topic in Northern Ireland. As the only region in the United Kingdom to which the 1967 Abortion Act has not been extended, Northern Ireland's abortion law remains founded in criminal legislation dating back to 1861 (DHSSPS 2016, p. 5). Under Northern Irish law, an abortion is only permitted if the woman's life is at direct risk or if continuation of the pregnancy is deemed to result in serious and long-term adverse effects to her mental or physical health (DHSSPS 2016, p. 6). In the period between April 2015 and March 2016 only 16 legal abortions were carried out in the region (DHSSPS 2017, p. 1). However, in 2015 over 800 Northern Irish women crossed the Irish Sea to obtain an abortion elsewhere in the United Kingdom (Department of Health UK 2016, p. 71). The Northern Irish law has been criticised extensively, and received both public and scholarly attention with the main criticism being the lack of clarity within the law, which creates a situation of uncertainty for both patients and healthcare professionals alike (Gentleman 2016; Bloomer & Fegan 2013). In 2004, a judicial review against the Northern Irish Department of Health, Social Services and Personal Security, henceforth referred to as the *DHSSPS*, resulted in the DHSSPS being convicted of failing its statutory duty "to secure provision of integrated health and personal social services to women seeking lawful termination of pregnancy in Northern Ireland" (FPA 2015, p. 5). The court subsequently urged the DHSSPS to create guidelines for healthcare professionals to provide guidance on the law: a process that proved exceedingly complicated and eventually came to last over a decade. The process of creating guidelines represents an interesting example of how controversial issues are handled within concrete policy processes. 'Political problems', such as that of abortion, do not arise out of the blue as objectively understood 'problems': they are social constructs that are partially shaped through the way they are represented within the policy processes meant to deal with them. What happens when a problem representation regarding an already very controversial law is forced upon government? This essay examines the eleven-year-long process of the creation of guidelines for healthcare professionals regarding the legal framework for abortion in Northern Ireland.

1.1 Aim & Research Question

The aim of this study is to investigate the way in which abortion as a political topic takes shape discursively within the process of drafting guidelines on the Northern Irish abortion law. The topic of guidelines on the Northern Irish abortion law has been chosen for a number of reasons. Firstly, Northern Ireland boasts one of the most restrictive abortion laws in a European context (Duncan et al 2016). Secondly, despite the salience of the abortion issue in the region, relatively little scholarly attention has been devoted to examining the issue from a political perspective and actively question how political discourse functions to maintain such salience (Thomson 2016, p. 484). Furthermore, the abortion issue in general provides an interesting case of a policy area often characterised by high levels of controversy based on moral disagreement. Provided that a policy process in any way involves some sort of deliberations between stakeholders with differing views, the process is bound to become inherently contested. This thesis thus seeks to address abortion as a political issue in Northern Ireland through closely interrogating the most prominent policy process relating to the question of abortion during the past decade: the creation of guidelines for healthcare professionals. The following research question has provided the basis for investigation with the scope of this project:

How can the process of creating guidelines for healthcare professionals on the abortion law in Northern Ireland be understood through Carol Bacchi's "What is the Problem Represented to be?" approach?

1.2 Previous Research

Abortion as a political issue has often within research been described as one relating to the understanding of abortion as a subject revolving around morality (see for example Garfield & Hennessy 1984; Munthe 1992; Tooley et al 2009). Kristin Luker (1984, p. 3) argues that "the moral status of the embryo has always been controversial". Cook et al (1992, p. 8) however also note that other aspects relating to morality also frequently affects the debate, particularly in regards to how abortion has often been condemned as a way for "loose women" to avoid the consequences of their immoral sexual behaviour. The understanding of abortion as a moral issue is an important aspect to acknowledge because of the way moral disagreement plays out within the sphere of politics. In their classic book *Democracy and Disagreement*, Amy Gutmann and Dennis Thompson (1996, p. 1) extensively discuss the implications of moral disagreement within the context of deliberative

democracies and argue that moral issues provide one of the biggest challenges to modern day democracy. A moral argument is in its most basic form one based on a principle of generality: "Moral arguments apply to everyone who is similarly situated in the morally relevant aspects". A moral claim "impute rights and wrongs, or ascribe virtue and vice, to anyone who is similar in the respects that the argument assumes to be morally significant" (Gutmann & Thompson 1996, p. 13). Often, due to the issue being framed as one of morality, the abortion debate also evokes strong religious sentiments (Cook, Jelen & Wilcox 1992, p. 93). Difficulty arises within the deliberative political process because of the morality aspect polarising the debate: there is no position that is mutually acceptable to the two opposing sides of the debate (Gutmann & Thompson 1996, p. 60). The notion of abortion as an issue founded in moral disagreement is an important part in acknowledging the way abortion is discussed within a political process.

Abortion in Northern Ireland has more commonly generated research by primarily legal and sociological scholars. Bloomer and Fegan (2013) collectively take a clear feminist stance against the current law and particularly criticise the law due to its lack of clarity which they claim have led to confusion and misinformation in the region. Fegan and Rebouche (2003, p. 221) argue that the greatest challenge to pro-choice advocacy within the region is that of a culture where pro-life discourse is dominant and pro-choice claims are silenced and actively ignored. Within the realms of sociology Lisa Smyth (2006, p. 672) has explored the cultural aspect of the issue as one that falls within the scope of politics on sexuality and reproduction and highlights how moral conservatism provides the main opposition against liberalising the law. Additionally, both Smyth (2006) and Thomson (2016) emphasise the way in which abortion as a political issue in Northern evokes deeply held Christian values found of both sides of the otherwise deeply divided Northern Irish society. As a result, the debate on abortion seems to transcend the otherwise very prominent division within the Northern Irish society between Protestants and Catholics[1] and instead generates both cross-community agreement and disagreement fuelled by the common denominator of moral conservatism (Smyth 2006, p. 694). As noted by McCormick (2010, p. 209), when it comes to issues of regulating female sexuality, there is more that brings the Catholic and the Protestant communities together than that drives them apart. Thomson (2016, p. 485) proceeds to suggests that precisely because of the issue's capacity to create cross-community agreement and disagreement, it should be further investigated because it provides

[1] As argued by Fegan & Rebouche (2003, p. 221): "The terms 'Catholic' and 'Protestant' reflect (at a general level) and have become synonymous with political affiliation in Northern Ireland, the former indicate a desire to re-unify (with the Republic of) Ireland and the latter, to remain constitutionally British and a part of the United Kingdom".

an insight into how new alliances are shaped over social issues within a post-conflict context.

Relatively little academic effort has been made to address political aspects of the abortion issue in the Northern Ireland. Jennifer Thomson (2016) attributes the gap in research on the issue in the field of political science to two specific factors. Firstly, research on Northern Irish politics tends to focus on ethno-national issues due to the conflict-ridden past and deeply divided nature of the society, which results in an overshadowing of issues relating to other types of social difference (Thomson 2016, p. 483). Likewise, in research on sexuality and gender politics, divided societies such as Northern Ireland are often deemed 'special cases' and thereby left out of the analysis (Thomson 2016, p. 483). Some effort has been made by feminist scholars to highlight such silences within the academic writings on Northern Ireland, but they have "tended to look at gender from a macro level, considering it as a structural force at the level of the state or peacebuilding operations, or a conceptual framework for the national community" (Thomson 2016, p. 484). The result of this is that relatively little attention has been devoted to examining specific policy issues in Northern Ireland and the political discourse surrounding social issues like abortion remains surprisingly unexplored (Thomson 2016, p. 484). It shall however be noted that there seems to have been an increase in interest academically for the issue in the past few years. For example, Fiona Bloomer and Claire Pierson (2016) recently contributed with a presentation to a Knowledge Exchange Seminar in Northern Ireland during which they discussed evidence based policy making and the importance of dispelling myths created through political discourse on abortion. In conclusion, while there seems to be relatively little research addressing the issue of abortion from a political perspective, there also seems to be an increasing awareness of the academic gap on the matter.

2 Timeline of the Process

The following timeline outlines the developments in the process of developing guidelines for healthcare professionals in Northern Ireland on the abortion law. All information has been obtained from the FPA's (2015, p. 5-6) summary of the legal process.

2001: The FPA initiates a judicial review against the DHSSPS for failing its duty to provide services and guidance to women seeking lawful abortions in Northern Ireland.
2002: The review takes place in March in Northern Ireland's High Court.
2003: Judgment is presented by the court in July and states that the DHSSPS has not failed its statutory duty. The court however argues that it would be prudent of the DHSSPS to issue guidelines for healthcare professionals. The FPA files for appeal.
2004: Appeal is heard in July and the court finds that the DHSSPS *has* "failed to perform its duties under Article 4 of the Health and Personal Social Services of Northern Ireland Order 1972, to secure provision of integrated health and personal social services to women seeking lawful termination of pregnancy" in the region (FPA 2015, p. 5).
2005: The DHSSPS initiates the process of drafting guidelines.
2007: A first draft is produced and debated in the Northern Irish parliament, but is rejected.
2008: A new draft is released and circulated for consultation.
2009: In March, guidelines are officially issued for the first time, five years after the court's initial ruling. In June, the organisation The Society for the Protection of Unborn Children (SPUC) initiate a judicial review claiming that the guidelines are faulty and include a misinterpretation of the law. During the autumn, the review is heard and the court finds that the guidelines has not misinterpreted the law, yet two sections (on counselling and the conscientious objection) are deemed to have failed to provide clear guidance. The guidelines are withdrawn with immediate effect.
2010: Interim guidance is released without the two questioned sections but is quickly withdrawn again as SPUC seeks another judicial review against the DHSSPS for not removing the document in its entirety. In July, a new draft is issued for consultation in which the questioned sections have been redrafted.
2013: Another new draft is circulated for consultation in April.
2016: A new set of guidelines are published in March which are currently, as of May 2017, still in effect.

3 Theory & Method

Theory and method will be discussed in correlation with each other within this section because of their intertwined nature within the approach adopted for analysis. A brief introduction will first be given to the idea of policy processes as argumentative practices, followed by an outline of the main theory and method adopted within this essay: Carol Bacchi's *"What is the Problem Represented to be?"* approach. Lastly, the section outlines considerations regarding choice of method as well as material selection.

3.1 Theoretical framework: The Argumentative Turn in Policy Analysis

Academic literature, and indeed governments and other political organisations, have over the years shown a clear tendency towards approaching policy making as an exercise in *problem-solving* (Boswell 2009, p. 4). So called *evidence based policy making* has been promoted extensively by both governments and academics, feeding into the frenzy and hegemony of a neoliberal, capitalist worldview inspired by economic ideals. The ideal promotes an understanding of governments as rational, reactive agents that simply respond to their environment, which has in particular led to an increased demand for expert knowledge by governments to inform decisions (Boswell 2009, p. 4). John S. Dryzek (1990) has extensively critiqued the ideal of *instrumental rationality* for being ineffective not only as an approach to actual policy making, but also as a way of approaching and conduct research within the realms of policy analysis. Instrumental rationality, according to Dryzek (1990, p. 5-6) promotes an idea that very complex social phenomena can be simplified to objectively understood problems with logical solutions. Dryzek (1990, p. 6) proceeds to argue against instrumental rationality because it relies on the faulty foundational premise of *objectivism,* which "is inspired by a false account of the science it idolizes". Similar arguments can be found within the vast depths of the classic Foucauldian conception of the inevitable connection between 'truths' as postulated *knowledge* and *power*: objective knowledge must be de-constructed as an idea in itself that relies on a faulty premise of our understanding of the world in which we are situated (Hall 1997, p. 75). In their anthology *The Argumentative*

Turn in Policy Analysis and Planning, Frank Fischer and John Forester (1993) along with a number of acclaimed scholars, such as Dryzek, propose that social scientists must acknowledge that policy processes are inherently *communicative* and indeed also *argumentative*, implying that policy processes are sights of struggle over meaning:

> "Theoretically, the focus on argumentation allows us to recognize the complex ways analysts not only solve but formulate problems, the ways their arguments express or resist broader relations of power and belief and the ways their practical arguments are inescapably both normative and descriptive". (Fischer & Forester 1993, p. 14)

The recognition of policy processes as argumentative practices that not only solve 'problems' simply by rational application of 'evidence' provides the theoretical framework upon which this thesis is based and the premise upon which the selection of Carol Bacchi's "*What is the Problem Represented to be?*" has been chosen. Bacchi's wide theoretical and methodological approach, which adheres to the argumentative turn, will now be developed as the main theory and method used specifically for analysis within this thesis.

3.2 Carol Bacchi's "What is the Problem Represented to be?" approach

Carol Bacchi, Emeritus Professor in Politics at the University of Adelaide, has created an extensive framework both entailing theory and methodology as to how policy processes can be approached known as the "*What is the Problem Represented to be?"* approach, henceforth referred to as the *WPR approach*. The WPR approach has been praised as "one of the most innovative analytical frameworks developed in recent times" and as a "remarkable tool for investigating a variety of social issues and responses" (Bletsas & Beasley 2012, p. 1). Bacchi (1999) has put her own framework to good use, for example in her book *Women, Policy and Politics*, which applies the framework to policy areas specifically relating to women's issues. In the book, she attempts to further an understanding of how women's inequalities have been understood in Western policy processes and combined it with feminist theory (Bacchi 2009, p. vii). Bacchi's specific focus is on *problem representations.* In aligning herself with Dryzek's (1990) and Fischer and Forester's (1993) rejection of the idea of governments as society's problem solvers, she argues that policy makers are crucial contributors in constructing and shaping 'problems' (Bacchi 2009, p. 2). Political 'problems' are not objectively understood problems: they are social constructs (Hajer 1993, p. 44). Therefore,

policy processes are not problem solving activities, but rather they are "problematizing activities" (Rose & Miller 1992, p. 181). While common agreement can perhaps be found regarding the undesirability of certain phenomena in society, the 'problem' can be represented in a variety of ways. Take the example of high levels of unemployment amongst youth: a phenomenon generally thought of as problematic and undesirable. One solution may be to implement a policy targeted at ensuring that more young people proceed into higher education, implying that the 'problem' is lack of education amongst young people. Another solution may be to increase subsidies for companies hiring young people in an attempt to create more jobs specifically for young people. Both representations reflect two fundamentally different policies that identify two different 'problems': lack of jobs or lack of education (Bacchi 2009, p. xiv). While the diagnosis might be 'there is high unemployment amongst youth' the reason, and the actual 'problem' may thus be expressed and addressed in a variety of ways, which contributes to constructing the 'problem'.

Bacchi (2009, p. 26) claims that we are governed by problematisations, as inspired by Foucault's concept *governmentality*, which can widely be understood as the thinking involved in different types of rule and government. A crucial part of the method is that it seeks to identify competing representations along with highlighting the potential effects of representations. Bacchi emphasises that the WPR approach asserts critical importance to the role of governments in shaping representations:

> "…governments play a privileged role because their understandings 'stick' – their versions of 'problems' are formed or constituted in the legislation, reports and technologies used to govern. Hence, these versions of 'problems' take on lives of their own. They exist *in the real.*" (Bacchi 2009, p. 33)

Bacchi has therefore developed a critical methodological framework through which problem representations can be investigated and questioned, based on a six question approach. These questions provide the frame through which analysis of the creation of guidelines for healthcare professionals in Northern Ireland has been conducted.

<u>Question 1: What is the 'problem' represented to be?</u>
The first question is described by Bacchi (2009, p. 55) as a "clarification exercise" that can be expected to generate a fairly straightforward answer. The aim is to identify the representations of the problem. In order to do this, the WPR approach takes it starting point in identifying what kind of change the policy is advocating. The idea is then to trace it 'backwards' to identify what the advocated change suggests that the underlying representations of the problem might be (Bacchi 2009, p. 3).

Question 2: What presuppositions or assumptions underlie this representation of the 'problem'?

In order to uncover the underlying presuppositions and assumptions shaping the problem representation, Bacchi (2009, p. 5) suggests an archaeological approach in a Foucauldian sense. To examine such imbedded features, a discourse analysis must be carried out in order to gain an overview of how meaning is created, focusing on *binaries, key concepts* and *categories* (Bacchi 2009, p. 7). *Binaries* are a type of hierarchical dichotomies, often used in policy contexts in a manner that inevitably simplifies complex relationships (Bacchi 2009, p. 7). Examples include *illegal/legal, moral/immoral or economic/social*. *Key concepts* must also be interrogated because policies often rely on concepts that are far from as straightforward as they may seem (Bacchi 2009, p. 8). In policies relating to increasing *equality*, what does the concept equality actually refer to or entail? Finally, policies tend to create *categories*, perhaps most significantly categories of people, in talking about for example *citizens* or *mothers* which has significant effects for the people who are both excluded and included within the framework of the category. As Bacchi (2009, p. 22) expresses it, categories "reflects a way of organising behaviours and people that has not always existed across space and time".

Question 3: How has this representation of the 'problem' come about?

When examining a problem representation, it is important to investigate how this particular representation came to thrive in the context discussed. Again, Bacchi (2009, p. 10) relies on Foucault, and propose a genealogical approach to uncovering the development of representations. Approaching the historical roots of a problem representation through genealogy means that we must incorporate non-discursive practices into our reflection, for example looking at specific decisions or developments that have had a particular effect in leading the representation to take its current shape.

Question 4: What is left unproblematic in this problem representation? Where are the silences?

Attention must also be given to the various problem representations that are excluded in the policy. By identifying areas on which the policy is silent, Bacchi (2009, p. 13) claims that we can gain a deeper insight into the limitations of the current representation of the problem which excludes other constructions of the problem.

Question 5: What effects are produced by this representation of the 'problem'?

Perhaps most importantly, Bacchi's theory is founded on an underlying assumption that the way in which a problem is represented has substantial effects because of

the way it sways governance in a particular direction. She identifies three distinct types of effects: *Discursive effects, subjectification effects, lived effects. Discursive effects* are the effects of a particular problem representation taking precedence rather than another and the way the representation makes it difficult to think outside of the framework which it creates (Bacchi 2009, p. 16). *Subjectification effects* rely on the idea that discourses create subjects of people: they affect "who we are – how we feel about ourselves and others" (Bacchi 2009, p. 16). Lastly, *lived effects* refer to the material effect of a problem representation, the way in which it directly affects people's lives (Bacchi 2009, p. 17).

Question 6: How and where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced?
The final question focuses on the possibility of representations being challenged and is closely related to the genealogical tracing in question 3. By having a basic understanding as to how the current problem representation came into place, one can also reflect on in what way it can be challenged. Because of the limited scope of this project, and due to high levels of internal struggle, this thesis does however not seek to address the way in which media has reinforced or challenged the problem representation studied. The implications of this choice will be brought up and discussed within the concluding remarks and suggestions for further research.

3.3 Methodological Considerations

This study is designed as a discourse analysis of the process relating to the creation of guidelines for healthcare professionals in Northern Ireland on the abortion law, based on Bacchi's six questions as described in the previous section. Discourse analysis as a method has over the past few decades gained momentum within the social sciences due to an increased focus on the importance of language (Bergström & Boréus 2012, p. 354). As Bergström and Boréus (2012, p. 354) express it, all discourse analytical perspectives are founded on a common assumption that language does not reflect reality in the real: it is through language reality, as we understand it, is constructed. Bacchi's questions involve both identification of discursive features as well as critical interrogation of the context through which such features must be understood. The concept of *discourse* is here used to broadly refer to "a system of meaning". It is necessary to emphasise that we as researchers within the realm of discourse analysis also contribute to the creation of such systems of meaning ourselves: we contribute to the creation of the discourses we study with our own interpretations. Because of the interpretative aspects of discourse analysis, *intersubjectivity*, in a narrow sense, is not achievable. Instead, as argued by Winther

Jørgensen and Phillips (2000, p. 111) we must practice *reflexivity* and problematize our own understanding and interpretation in order to not simply provide biased opinions through our conclusions – a point which will be brought up in the discussion.

As well as being a thoroughly established theory that is often used in research in relation to gendered issues such as abortion (see for example Chapter 8 in Bacchi 1999), Bacchi's six questions provide a practical framework through which analysis can be conducted. Because of the aim to address the lack of academic research into specific policy issues in Northern Ireland and how political discourse function within such processes, Bacchi's theory and method, which is focused on policy processes specifically, suits the aim of the project in a satisfactory manner.

3.4 Material

The material subjected to analysis is the guidelines and the various drafts that have been produced of the guidelines from 2007 up until 2016, as listed below. A parliamentary debate within the Northern Irish parliament on a motion to reject the proposed guidelines in 2007 has also been included as material in order to highlight the way the issue is discussed within political debates. The list of material is summarised below.

- Draft Guidelines circulated for consultation in 2007 (DHSSPS 2007)
- Draft Guidelines circulated for consultation in 2008 (Annex A)
- Official published Guidelines issued in 2009 (DHSSPS 2009)
- Draft Guidelines issued in 2010 (Annex B)
- Draft Guidelines issued in 2013 (Annex C)
- Official published Guidelines issued in 2016 (DHSPSS 2016)
- Transcript of Debate on motion to reject proposed draft guidelines in 2007 (Northern Ireland Assembly 2007)

The Royal College of Nurses, who were involved in the consultation process has kindly provided the drafts from 2008 and 2010 which have been placed under Appendices. The draft from 2013 has been removed after I obtained it from the DHSSPS's website and has therefore also been attached within Appendices. Some of Bacchi's questions also rely on historical investigations which must be informed by previous research on the matter. It shall also be noted that a vast amount of related material has been researched surrounding the process which has not in itself

been subjected to analysis, but has informed the understanding of the issue as it is expressed throughout this thesis.

4 Analysis

Each of the questions within the WPR approach will now be applied to the process of creating guidelines for healthcare professionals on the abortion law in Northern Ireland.

4.1 Question 1: What is the 'Problem' Represented to be?

The first step in a WPR approach is to identify the change suggested by the policy and work 'backwards' in order to reflect upon what the change advocated suggests that the problem might be (Bacchi 2009, p. 55). The creation of guidelines was initiated as a direct result of the court decision in 2004 which stated that the DHSSPS had to provide guidance to healthcare professionals (FPA 2015, p. 5). As such, the policy of guidelines has been forced upon the DHSSPS by demand of the court. Both earlier and later versions of the guidelines reflect the purpose and aim of the guidelines explicitly:

> "The purpose of this guidance is to explain the existing law relating to termination of pregnancy in Northern Ireland and how it relates to good clinical practice." (DHSSPS 2009, p. 7)

> "This guidance aims to provide clarity on the law framing termination of pregnancy in Northern Ireland." (DHSSPS 2016, p. 3)

In stating that the purpose is to outline, explain and provide clarity regarding the law for terminations in Northern Ireland the 'problem' is in its most basic form represented to be *lack of guidance*. The problem represented as lack of guidance assigns responsibility to the DHSSPS: it is the Department's job to provide guidance and thus clarity regarding the legal framework surrounding abortion. The problem representation is also enforced within the parliamentary debate held in 2007, where the first set of draft guidelines was discussed (Northern Ireland Assembly 2007). Several speakers spoke of the obligation and duty of the DHSSPS

to provide guidance and clarity, one of them was Basil McCrea from the Ulster Unionist Party:

> "The simple fact is that the Minister is required to produce a set of guidelines. He must do so, or he will fail in his ministerial responsibility: it is a legal imperative." (Northern Ireland Assembly 2007)

Importantly, the problem is identified to be lack of guidance on how to implement the law within healthcare services, rather than as an issue of the law in itself lacking clarity. As such, it is a problem representation that places the healthcare professionals and their implementation of the law in the centre of our understanding of the 'problem'. As Bacchi (2009, p. 55) argues, Question 1 is mainly a clarification exercise to which the answer can be expected to be quite straightforward. For now, it will therefore suffice to state that the problem is by the introduction of guidelines implied to be *lack of guidance*.

4.2 Question 2: What presuppositions or assumptions underlie this representation of the 'problem'?

Due to the policy of creating guidelines being forced upon the DHSSPS by the court it is vital to move beyond a rudimentary description of the representation of the problem. What do the guidelines provide guidance on and in what way does its content reflect certain underlying presuppositions and assumptions? Adhering to Bacchi's (2009, p. 7) suggestion of investigation of *binaries*, *concepts* and *categories*, the most prominent occurrences of each of these discursive features will now be identified and outlined.

4.2.1 Binary: Legality/Illegality

Because the problem is represented to be lack of guidance on the law, it is fairly unsurprising that a significant portion of the guidelines are devoted to clarifying under which circumstance abortion may be legal or illegal, usually within the very first section of the guidelines. One of the most prominent discursive features within the guidelines is therefore the binary between *unlawful* and *lawful* or indeed *legal* and *illegal*. Interestingly, focus shifts significantly throughout the process in relation to whether the guidelines emphasise the legality or the illegality of abortion. As an example, the first line on the section outlining legal principles within the first draft guidelines produced in 2007 reads as follows:

> "…operations in Northern Ireland for the termination of pregnancies are *unlawful* unless performed in good faith for the purpose of preserving the life of the mother" (emphasis added, DHSSPS 2007, p. 2)

The draft proceeds to state that the "life of the mother" also entails her mental and physical health (DHSPSS 2007, p. 7). Notice how terminations are described as "unlawful unless". In the most recent version of the guidelines, the emphasis however appears to have shifted and the same section reads "In Northern Ireland it is lawful to perform a termination only if…" (DHSSPS 2016, p. 5). There is a slight but important difference between the statement of "unlawful unless" and the latter version of "lawful only if". The latter phrasing seemingly tries to emphasis the circumstances under which termination is actual lawful, while earlier phrasings such as the one from the 2007 draft instead emphasise the general unlawfulness of the procedure. It reflects various interpretations of the law and ultimately contributes to conveying a general attitude towards the law.

The draft produced in 2013 provides a particularly interesting example of how the binary can be used to enforce a certain viewpoint (Annex C). While all other drafts have fairly neutral and similar titles, namely "Guidance on Termination of Pregnancy in Northern Ireland", the draft circulated for consultation in 2013 is titled "The Limited Circumstances for a Lawful Termination of Pregnancy in Northern Ireland" (Annex C). While the word lawful is used, it is preceded by the words "limited circumstances", which sets the tone for the document. On the very first page the circumstances for legal termination are described as "very limited circumstances" that are "highly exceptional" and adhere to "very strict and narrow criteria" (Annex C, p. 3). The draft was subjected to severe criticism during public consultation and eventually rejected and redrafted. While the draft cannot be seen as representative for the process in its entirety, it effectively illustrates the power of the binary between legal or illegal to reinforce a certain representation of the law. The heavy criticism the 2013 draft was subjected to when it was released also reflects that when the guidelines move to close to one particularly position preferring one binary over the other, one side of the abortion debate will vehemently oppose the guidelines.

4.2.2 Categories: Responsible Professionals and Vulnerable Women

The guidelines also further the creation of specific people categories. The two most prominent individuals identified within the guidelines are the healthcare professional and the woman seeking abortion. A third potential people category can be seen in the 'foetus' or the 'child'. The category of foetus/child will be discussed

briefly in relation to the woman seeking abortion along with the key concept life in the next section.

The healthcare professional is throughout the process identified as the figure assigned with responsibility and agency in the matter of deciding whether a woman is eligible for termination:

> "It is for a medical practitioner to assess, on a case by case basis, using their professional judgment as to whether the individual woman's clinical circumstances meet the grounds for a termination of pregnancy in Northern Ireland" (DHSSPS 2016, p. 5)

> "In keeping with the law of Northern Ireland, it will always be for the medical practitioner responsible for the care of the woman to decide, as a matter of professional clinical judgment, whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy". (Annex B, p. 5)

Through such statements, authority and agency is clearly prescribed to the healthcare professional. In correlation with this responsibility also follows the emphasis on the legal consequences of failing to comply with the law. Particularly within the draft from 2013 there is a repetitiveness and emphasis placed on the criminal nature of making a faulty judgment (Annex C, p. 7). Interestingly, one version of the guidelines also includes a quote from the Northern Irish High Court in which the gender of a general practitioner, and thus the healthcare professional, is assumed to be male:

> "In such a situation the GP's conscientious objection to abortion may be such that he could not give dispassionate advice" (Annex B 2010, p. 13)

The individual of agency, the healthcare professional, is hence assumed to be male. In contrast, the woman seeking termination is most commonly referred to simply by her gender – in most of the documents she is 'the woman'. Very rarely throughout the process is she placed in a more general category such as simply as 'patient', effectively downplaying her role as patient and individual in this context. While such terminology contributes to acknowledging the gendered nature of the abortion issue, it is perhaps more fruitful to address the way in which the content of the guidelines "fills" the people category of "woman" seeking abortion with meaning. A notable amount of the guidelines, both within earlier and latter drafts emphasise practices under circumstances where the patient is either a minor or an 'incapable adult' (see for example Annex A, p. 8). Because of focus on highlighting such circumstances a conceptualisation is created where women seeking out abortions are depicted as most likely young or mentally incapable. Interestingly, significant attention is also devoted to the explaining the process of obtaining

consent – a standard procedure within all medical practices, yet it receives extensive attention in almost all of the drafts produced. Emphasis is created on the importance of informed consent, ensuring that the, presumably incapable woman, has actually understood the procedure she is consenting too. Abortion is portrayed as a procedure that a woman in her right mind surely would not consent to. The underlying assumption of abortion as something undesirable that women should be discouraged from having can even been seen in the judgment by Lord Justice Nicholson, who's final remark in his judgment reads as follows:

> "This judgment is written in the hope that the department will seek to reduce the number of women and girls going away to seek an abortion and to encourage those seeking an abortion in Northern Ireland to make a different choice. It must surely be the concern of all right-thinking persons in the United Kingdom that the number of abortions which are carried out is so high." (*FPA vs. The Minister of Health, Social Services and Public Safety* 2007)

Furthermore, the word 'woman' is sometimes substituted with the word 'mother', often accompanied by reference to 'the unborn child' (DHSSPS 2007, p. 2-3; Annex C, p. 1). Such terminology reflects a presupposition of the understanding of the situation of a pregnancy which is found on an assumption of when and where life and motherhood takes its beginning. In the most recent draft of the guidelines, such terminology has been removed as a result of a majority of healthcare professionals during the public consultation arguing that it is inappropriate and medically incorrect (DHSSPS 2013, p. 5-6). It shall however be noted, that the Northern Irish law on abortion in itself includes usage of terminology of 'mother' and 'unborn child'. Mentions of the 'foetus', as it is referred to in the final version of the guidelines, are mostly diminished to technical explanations of regarding the capacity to be born alive (DHSSPS 2016, p. 7). Yet, within debates on the guidelines, the foetus/unborn child becomes a focal point of reference in conjunction with the key concept underpinning the abortion debate: the concept of life.

4.2.3 The Concepts of Life and Rights

There are two prominent key concepts that are highly intertwined and contested within the process: *life* and *rights*. Because of the prominence of binaries and categories, these concepts will only be briefly stated here. While carefully avoided within the actual guidance document as far as possible, the concept of life is clearly of key importance within the process which can be seen when the guidelines were debated by the Assembly in 2007. In the opening statement, Thomas Buchanan representing the Democratic Unionists Party made the following statement:

> "Pro-abortionists describe the unborn child in the early stages of pregnancy as a foetus, an embryo, a collection of cells, the potential for life, or mere human tissue in their attempts to dehumanise the child […] Therefore it is important to establish where, and when, the life of the child begins. That is not when the child is born, or when it reaches a certain stage in the mother's womb, or even at the point of implantation. Life commences at conception, and it is at that point the child becomes a real person." (Northern Ireland Assembly 2007)

The statement represents a view expressed by several other speakers during the debate. The idea of life commencing at conception also carries deep connections to the beginning of personhood and thus the beginning of rights. Pat Ramsey, from the Social Democratic Labour Party, stated that his party's stance against abortion is based on the principle that the "human right to life precedence over all other rights" (Northern Ireland Assembly 2007). Within the debate, strong anti-abortionist arguments are in general founded on the idea of the right to life of the 'unborn child'.

4.3 Question 3: How has this representation come about?

The question of how this representation of the abortion issue may have come about will only be addressed briefly due to the limited scope of this project. The idea is to show how problem representations are historical constructions that could therefore also have evolved differently. A key feature of the problem representation as lack of guidance regarding the law is that it relies on an understanding of abortion as a legal issue. Abortion however did not become a legal issue in the United Kingdom until the introduction of the Offences Against the Person Act in 1861 (Bacchi 2009, p. 11). This is particularly relevant for Northern Ireland because the act still provides the foundation for the current abortion law. The importance of the medical profession within the problem representation can also be traced within the history of the development of abortion law, and as Bacchi (2009, p. 11) argues we must acknowledge the way power relations in society allow some groups more authority to shape an understanding that 'sticks'. As Bacchi (1999, p. 148) notes, abortion was before the law considered a "common method of birth control". McCormick (2010, p. 210) further argues that for many women in Northern Ireland, this was still the line of thought even for the first half of the 20th century where for many women having an abortion "was more a fact of life, a regulation of menstruation or

a necessary prevention of pregnancy because of limited family planning alternatives". According to McCormick (2010, p. 210), it was not until the 1990s where organised opposition to abortion began appearing, particularly through the formation of organisations such as Precious Life, which is today the largest pro-life group in Northern Ireland. Precious Life embodies an interesting feature of the Northern Irish abortion debate as it is run by a Catholic woman married to a Protestant man (Smyth 2006, p. 670). As argued by McCormick (2010, p. 211), the abortion issue possesses the rare capacity to unite rather than divide the Catholic and Protestants communities within the region because of a shared view of the necessity of regulating female sexuality. McCormick goes on to argue regarding the importance of the ethno-national conflict in the region and its effect on the way female sexuality is regulated:

> "Both communities, across the religious and political divide, were united in the belief that women were both the moral guardians of the nation, as well as embodying the greatest threat to moral standards. The behaviour of women was linked to the identity of both unionist and nationalist communities in Northern Ireland"
> (McCormick 2010, p. 218).

Such unity, as it is particularly rare within Northern Ireland, should not be underestimated in its function in solidifying a certain approach to a political issue.

4.4 Question 4: What is left unproblematic in this problem representation? Where are the silences?

While what is included in the policy process may be important, what is not included may be of equal importance. An endless amount of potential aspects that are left out of the process could be identified and a choice has therefore been made to only given one specific example as well as one general example.

The first silence is one of high specificity: the guidelines make no mention of the possibility of a patient seeking termination as a result of rape. Sexual offences are treated within the documents, but only ever in relation to children and "people who are unable to consent to sexual activity because of a mental disorder" (Annex C, p. 20). The possibility of pregnancy as a result of sexual assault against a grown up woman who is physically and mentally capable of consent is omitted within the guidelines. Rape is not in itself recognised as a reason for termination under Northern Irish law, but it is interesting that the documents completely omits treating

the potential of women seeking abortions as a result of rape. Silencing the potential of pregnancy occurring as a result of rape effectively makes it clear that a woman with full mental capacities either does not end up in such a situation or that if she does she should not expect to be eligible for a termination. The guidelines omission clearly shows a lack of willingness to address the issue.

The second silence is one of more general character: what other problem representations does the creation of guidelines try to silence? The 'problem' represented as lack of guidance on how to interpret the law partially closes of the possibility of it law in itself being the source of confusion and uncertainty. However, this is a silence that is very much confronted within the process, which will be further elaborated on in Question 6.

4.5 Question 5: What effects are produced by this representation of the 'problem'?

As implied within Question 4, the main *discursive effect* generated by the problem as represented to be lack of guidance is that it relies on the assumption that the law in itself is clear – a claim which the eleven-year-long process itself effectively disproves. However, because the representation of the problem is constantly challenged throughout the entirety of the process, the creation of guidelines in fact opens up clear opportunity for challenging the current problem representation and raises the issue of the law in itself.

In regards to *subjectification effects* two subject positions are created for the women as well as the healthcare professional. Through the depiction of women seeking abortion as minors or 'incapable adults', women outside of these categories are alienated from the category of women who seek abortions. In correlation with the emphasis on the criminal legislation surrounding abortion, women who experience unwanted pregnancies may internalise the discourse and think of themselves as criminals, as immoral law-breakers from wanting an abortion. Here, the governing tactic is clear: it criminalises and penalises women who find themselves 'wanting' abortions in order to prevent them from having it. The stance against abortion is particularly clear through the complete omission of the situation where a woman might have been victim of sexual assault – it is not even acknowledged as an occurrence. Yet, since hundreds of Northern Irish women obtain abortions elsewhere it is clear to say that the effect is not that Northern Irish women no longer seek abortions. An effect may also be created in that women who do not identify with being young or 'incapable' are alienated within the document as unlikely to

qualify for an abortion. In regards to the healthcare professional, the subjectification effect is even more ambiguous. While it is the professional who is assigned with responsibility and authority, the overhanging threat of criminal persecution and the ambiguity of the various guidelines still questions whether the professionals is capable of making an adequate assessment in each case. A situation is created where it is better for a healthcare professional not to allow an abortion than to risk persecution of both themselves and their patient: a clear way in which the guidelines promote an anti-abortionist stance.

Generally, uncertainty becomes the main *lived effect* for all involved: both the healthcare professional and the patient seeking treatment. The problem being represented as lack of guidance and the subsequent process of providing such guidance taking eleven years and being highly disputed and constantly challenge creates a situation where there still seems to be uncertainty and confusion regarding the law. Effectively, this might lead to less abortions being carried out because healthcare professionals would rather not risk being imprisoned. Women who even under the current legal framework might be eligible for abortions may be forced, or feel forced, to seek care elsewhere because healthcare professionals are not certain enough to want to risk making a faulty assessment.

4.6 Question 6: How and where is this representation of the 'problem' reproduced, disseminated and defended? How could it be questioned, disrupted and replaced?

The problem as represented as lack of guidance is a result of the court decision back in 2004 when the FPA won the judicial review against the DHSSPS. Importantly, the result of this is that the DHSSPS are legally obliged to produce guidelines, whether they agree with the problem representation or not and the initiative is not one that has arisen through the DHSSPS's own efforts to try and ensure implementation of the law. It is the court who has said that there is lack of guidance and the DHSSPS are to blame. Struggle over the problem representation inevitably as a result of this becomes an inherent part of the process as representation of the law becomes the focal point of struggle. The DHSSPS are supposed to provide clarity, but whenever they get into specifics within the guideline document, or make a clear statement on the law, for example regarding the right to the conscientious objection and the legality of providing women with information regarding termination elsewhere, the guidelines are vehemently challenged. As Jim Wells, who was Health Minister for a short period of time between 2014 and 2015, stated when asked about the progression of the process in 2015:

> "I have no doubt that, whatever document is produced, it will be judicially reviewed. If it is seen as too liberal, it will be judicially reviewed by the pro-life groups; if it is judged to be too strong on the pro-life stance, it will be judicially reviewed by one of what are euphemistically called the pro-choice charities. It is one of those areas in which the problem is almost insoluble." (Northern Ireland Assembly 2015)

The difficulty of providing guidelines that are acceptable to both sides of the debate relates back to Gutmann and Thomson (1996, p. 60) arguing that there is no position that is mutually acceptable for the two polarised sides of the debate. Because the underlying disagreement is over the law, and the guidelines must somehow represent the law, which in itself is not very clear, the process was a hopeless quest to begin with.

The struggle is visible within the document itself, but perhaps more so throughout the consultation process. Each time a draft has been produced, it has been circulated for public consultation, effectively allowing anyone with an interest to contribute with feedback. Various organisations, pro-choice and pro-life, have argued for their stance but perhaps more importantly the problem representation has both been reproduced and challenged by healthcare professionals (DHSSPS 2013). Recall the responsibility and importance of the healthcare professional's as it is expressed throughout the people category within the guidelines. Unsurprisingly so, the voices of the medical profession are heard louder and clearer than other groups engaging in the public consultation, which can be seen in the summaries of consultations responses. It can also be noted that some politicians such as Alex Easton from the Democratic Unionists Party, have clearly expressed the process to be driven by a specific motive:

> "The guidelines that we debate are the result of a determined, and highly organised, campaign by the Family Planning Association, which supports abortion on the grounds that every woman has the right to end an unwanted pregnancy. They are the opening shots in a campaign to make abortion on demand freely available in the Province. The people who legislated in the past – in this Building – resisted such a situation, and it is incumbent on us to resist again. Any legislative body that endorses and provides for abortion on demand has totally lost it" (Northern Ireland Assembly 2007)

In summary, the 'problem' being lack of guidance is both reinforced but also challenged within the process through the use of public consultation. In a sense, the reaction of most organisations representing healthcare professionals enforce the problem representation and state that they are glad that guidance is being created, yet at the same time some organisations also take the opportunity to question if the

lack is not simply due to the law in itself being unclear (DHSSPS 2013). As such, the problem representation is produced and challenged in a variety of intertwined ways.

5 Discussion & Conclusion

5.1 Concluding Remarks

Born out of a desire to examine the salience of the abortion issue in Northern Ireland, this project has sought to critically investigate the process of creating guidelines for healthcare professionals surrounding the legal framework for abortion in Northern Ireland. An attempt has been made to address the lack within political research on Northern Ireland into specific policies on social issue that transcends the prominent ethno-national divide in the region and to investigate the use of political discourse within the process by tackling the following question:

How can the process of creating guidelines for healthcare professionals on the abortion law in Northern Ireland be understood through Carol Bacchi's "What is the Problem Represented to be?" approach?

By addressing abortion in Northern Ireland through a framework focused on the way in which policies construct and shape problem representations, a wide overview has been given of how the topic of abortion is addressed in a policy process context in the region. The main findings of the analysis will now be briefly summarised.

The analysis begun with clarifying that the creation of guidelines for healthcare professionals implied that the 'problem' was *lack of guidance* regarding the law. The policy of guidelines was forced upon the DHSSPS by the court who in 2004 argued that the DHSSPS had to provide guidance to ensure clarity regarding the law amongst healthcare professionals. The discourse analysis identified binaries, categories and key concepts that showed the assumptions and presuppositions underlying the 'problem' as represented through the guidelines. The most dominant discursive feature was identified as the binary between legal and illegal which had major effects for representation of the law. The guidelines also contributed to creating two distinct people categories of the women seeking abortion and the healthcare professional where all agency and responsibility was assigned to the professional and the woman seeking abortion was depicted as most likely 'incapable'. The concepts of life and rights were also explored, albeit they were

silenced within the guidelines themselves, they provided central to arguments heard within the debate on the guidelines in 2007. Within Question 3, a brief historical analysis was conducted as to how abortion became as a legal issue in Northern Ireland and how the stance had been maintained because of the rare occurrence of cross-community support against abortion. Two primary silences were identified. One specifically within the guidance document as how the potential situation where a woman finds herself pregnant as the result of rape has been omitted, the other a more general claim as to how the 'problem' represented as lack of guidance attempts to silence the possibility of the law itself being the cause of uncertainty. The potential effects of the problem represented as lack of guidance particularly emphasised the effects for women and healthcare professionals. Finally, the inherent struggle within the process was examined and it was concluded that the process, due to its contested problem representation, was doomed to fail its aim of providing guidance.

Perhaps the most interesting finding is how the process has become the focal point for struggle over the law, precisely because the problem representation fails to recognise that the law itself may be flawed. It raises an interesting question of how a policy process in its failure to address what other problem representations may actually fuel and feed into the legitimacy of other representations. Because of the guidelines lack of clarity, it has become clear that the law is very open to different types of representations and as such also interpretations and as such is ambiguous. Perhaps, as suggested by Jim Wells, be the process will in hindsight be seen as "the starting shots in a war to liberalise the law". It has certainly brought attention to the difficulty in interpreting the law, if nothing else. The process as such represents an interesting case of how political issue so inherently imbedded with controversy often end up resulting in incredibly muddled and unspecific policy measures.

This thesis embarked on an ambitious task to investigate the topic of abortion in a policy context in Northern Ireland through the use of the WRP approach developed by Carol Bacchi. An overview of the process has successfully been carried out which highlights how the problem representation within the given process has been particularly contested. As this study was a specific case study to provide insight into a process that has been rather unexplored the findings are not intended to be generalised. However, the project has provided an insight into how topic of abortion, because of its often controversial nature as a moral disagreement between the two sides, may muddle a process. In conclusion, this essay has provided a very wide overview of the topic of abortion in a policy context which highlights the need for even deeper analysis of the dynamics involved in it.

A brief comment shall also be made regarding the limitations of this essay. Within the confines of social constructivism, we must also acknowledge that researchers

construct the objects and subject they study: we actively participate in the creation of discourses. In identifying this specific process as worthy of investigation, I have indeed myself identified a research 'problem' and sought to articulate and understanding of it. Bacchi (2009) herself emphasize that because researchers themselves contribute to creating problems we must engage in *reflexivity*, a type of self-analysis. My own interest within the abortion issue and questions relating to women's rights has fuelled this analysis and cannot be kept entirely out of the interpretation. I am subjective in the sense that I do not claim to have uncovered a set 'reality' or a 'truth': I reject the positivistic understanding of objectivism in my theoretical positioning. Rather, this thesis embodies only one type of understanding that could (and should!) be challenged by others. Furthermore, the benefits of choosing a very comprehensive approach such as Bacchi's has also proven to be the source of difficulty: the approach is simply so wide-ranging that it is troublesome to fully utilise all aspects of the method within the scope of a small thesis like this one. It opens up many doors which I have sadly not been able to enter. One example was the need to exclude an investigation as to the media's role in shaping the problem representation which was imply deemed to comprehensive to address with the scope of this project. Another is developing the investigation of key concepts even further. Several lines of interrogation have simply been left untouched, which is why the final section of this thesis includes a vast range of suggestions for further research.

5.2 Suggestions for further research

A goldmine of potential topics for further projects lies within the scope of this thesis. If there is one conclusion to be concluded above all it is that abortion as a political issue in Northern Ireland, and presumably elsewhere as well, is a very complex topic which can and should be interrogated much further. Carol Bacchi's extensive framework opens up endless possibilities and some of her questions are comprehensive enough to provide the foundation for an entire thesis on their own. This thesis has addressed all 6 questions and thereby only provided an overview which needs to be further interrogated. More and significant discursive features can for example easily be identified within the scopes of Question 2 and the potential effects discussed in Question 5 can most likely be further inquired. Example of specific points of analysis that have been downplayed within this thesis are the role of media in producing, reproducing or challenging problem representations regarding abortion in Northern Ireland – undoubtedly a topic with enough depth to be basis for a thesis in itself. Another example of further research which I would highly encourage is to bring Northern Ireland's abortion law and its workings within policy processes into a comparative context perhaps with Britain and Ireland

in order to uncover similar patterns. Lastly, I would like to encourage further analysis specifically into policy processes in Northern Ireland on the abortion issue, particularly the efforts during the past year to try and change the abortion law in regards to cases of fatal foetal abnormalities. Even processes that fail are of importance in understanding the wider context of this issue and how efforts are made both to maintain the current law and how efforts are made to liberalise it and I therefore strongly encourage other writers to engage with this noteworthy topic.

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7 Appendices

ANNEX A – Draft Guidelines 2008

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland

The Department of Health, Social Services and Public Safety's Consultation Paper on the Termination of Pregnancy

16 July 2008

GUIDANCE ON THE TERMINATION OF PREGNANCY: THE LAW AND CLINICAL PRACTICE IN NORTHERN IRELAND

Within the scope of this Guidance and the law in Northern Ireland, each Health & Social Services Trust must ensure that its patients have access to termination of pregnancy services.

1 Purpose of guidance

1.1 The purpose of this guidance is to explain the law relating to the termination of pregnancy in Northern Ireland and how it relates to good clinical practice. It also to provides guidance on referral procedures, the giving of informed consent, the provision of aftercare services and rights of conscientious objection.

1.2 It is important to emphasise that this guidance cannot, and does not make any change to the law of Northern Ireland. In the event of any conflict between this guidance and decisions of the courts, the latter will always prevail.

2 Current Law on the Termination of Pregnancy

2.1 The law relating to termination of pregnancy in Northern Ireland is different from that in England, Wales and Scotland. The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, does not extend to Northern Ireland and the grounds on which abortion may be carried out here are more restrictive than those in England, Wales and Scotland.

Northern Ireland Legal principles

2.2 The law[1] governing the termination of pregnancy in Northern Ireland at present and in the cases where that legislation has been interpreted by the court can be summarised in the following principles:

(i) operations in Northern Ireland for the termination of pregnancies are unlawful unless performed in good faith for the purpose of preserving the life of the woman;

(ii) the 'life' of the woman in this context has been interpreted by the courts as including her physical and mental health;

(iii) a termination will therefore be lawful where the continuance of the pregnancy threatens the life of the woman, or would adversely affect her physical or mental health;

(iv) the adverse effect on her physical or mental health must be a 'real and serious' one, and must also be 'permanent or long term'. In most cases the risk of the adverse effect occurring would need to be more likely than not. However, in certain circumstances the possibility of an adverse effect may be sufficient if, for example, the imminent death of the woman was the potential adverse effect.

[1] In Northern Ireland, the law relating to the termination of pregnancy is contained in sections 58 and 59 of the Offences Against the Person Act 1861, and in section 25(1) of the Criminal Justice Act (Northern Ireland) 1945 as those provisions have been interpreted to date by the courts. The legislation has been interpreted and explained by the Northern Ireland Courts in a series of cases decided in the High Court in the 1990s and, more recently, in a decision of the Court of Appeal in 2004. Similar legislation applied in England, Wales and Scotland before 1967 and was interpreted in the leading English case of *R-v- Bourne* (1939). The *Bourne* decision, although an English case, remains highly relevant to Northern Ireland, and has been consistently applied in Northern Ireland cases. Further detail and relevant extracts from the law relating to abortion in Northern Ireland are provided at Annex A.

(v) it will always be a question of fact and degree whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy in a particular case.

2.3 In summary, it is lawful to perform an operation in Northern Ireland for the termination of a pregnancy, where there is:

- a threat to the life of the woman, or
- a risk of real and serious adverse effect on her health, which is either long term or permanent.

In any other circumstance it would be unlawful to perform such an operation.

2.4 Fetal abnormality is not recognised as grounds for termination of pregnancy in Northern Ireland. It will only be lawful to terminate a pregnancy in the case of actual or possible fetal abnormality if the continuance of the pregnancy threatens the life of the woman, or would adversely affect her physical or mental health. As in other cases, the adverse effect on the woman's physical or mental health must be a real and serious one, and must also be permanent or long term.

2.5 In keeping with the law in Northern Ireland, it will always be for the medical practitioner responsible for the care of the woman to decide, as a matter of professional clinical judgment, whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy. As with any exercise of clinical judgment, there will be occasions where this will be a difficult decision. Each case requires careful and sensitive assessment within the law as outlined in this guidance.

2.6 Termination of pregnancy beyond the time at which a child is 'capable of being born alive' is governed by the Criminal Justice Act (NI) 1945, which provides a statutory defence against the offence of child destruction where the act which caused the death of the child was done "*in good faith for the purpose of preserving the life of the mother*". The principles set out in paragraph 2.2 apply in such a case. In other words the legal justification for carrying out a termination of pregnancy in Northern Ireland is exactly the same both before and after the time at which a child is capable of being born alive. This follows from the *Bourne* decision and its application to the Northern Ireland legislation. Whether a child is 'capable of being born alive' would be a matter of evidence in the event of a prosecution in Northern Ireland.

2.7 It is important for practitioners to appreciate that anyone who unlawfully performs a termination of pregnancy is liable to criminal prosecution with a maximum penalty of life imprisonment. A person who is a secondary party to the commission of such an offence is liable on conviction to the same penalty. For this reason (unless in circumstances of an emergency) an assessment by two doctors (although not itself a legal requirement) is recommended (see section 3 below).

3 Clinical Assessment

3.1 Although not required by law in Northern Ireland two doctors, where practicable, who share prior knowledge of the woman and her clinical circumstances, should undertake the clinical assessment. However, in exceptional circumstances, such as an emergency, it may be sufficient for a single doctor to assess whether a termination of pregnancy is indicated. All clinical assessments should be completed in a timely manner and without undue delay and reasons for termination must be clearly recorded in the woman's note. See 5.13 for guidance.

3.2 In circumstances where the pregnancy is likely to cause adverse effects on the woman's mental health that are real and serious, and long term or permanent, those medical practitioners who have experience in these situations will be best placed to assess the long term likely impact on the woman's mental health. It is rare for pregnancy to cause adverse effects on mental health which are real and serious, long-term or permanent. A psychiatrist should be involved where there is a current history of severe mental illness or previous history of severe mental illness or a known history of severe learning disability. This might include current or past psychotic illness, severe affective disorder or other severe mental disorders.

3.3 There may be situations when the mental health of a woman with no prior history of mental illness needs to be assessed. For women aged 18 years or over this should be carried out by any Consultant General Adult Psychiatrist or a GP or consultant obstetrician with experience in assessing mental health. For those under 18 a Child and Adolescent Psychiatrist is appropriate. For those with a learning disability or where there is any doubt of mental competence a Consultant Psychiatrist specialising in Learning Disability is appropriate.

4 Conscientious Objection

4.1 Some staff may have a conscientious objection to termination of pregnancy on moral and/or religious grounds. No-one can compel staff to actively participate in the assessment or in performing a termination and the right to object on grounds of conscience should be recognised and respected – except in circumstances where the woman's life is in immediate danger and emergency action needs to be taken. Health and Social Care Trusts should also have appropriate arrangements in place to accommodate such requests from staff. However, staff with a conscientious objection cannot opt out of providing general care for women undergoing termination of pregnancy. The personal beliefs of staff should not prejudice general patient care.

4.2 Where a woman presents herself to her GP for advice or assessment in relation to a termination of pregnancy and that GP has a conscientious objection, he/she should have in place arrangements with; practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred.

4.3 The General Medical Council's (GMC's) *Good Medical Practice* (Nov 2006) states that:

'If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.'

This guidance is publicly available on the GMC website – http://www.gmc-uk.org

4.4 The Nursing and Midwifery Council (NMC), *The NMC Code of professional conduct: standards of conduct, performance and ethics* (April 2008) states:

"you must inform someone in authority if you experience problems that prevent you working within this Code or other nationally agreed standards."

The code also states that Nurses and midwives do not have the right to refuse to take part in emergency treatment:

"You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency."

This guidance is publicly available on the NMC website - www.nmc-uk.org/

5 Good practice issues

5.1 All healthcare professionals, especially those working in maternity and gynaecology units, should be familiar with the legal framework relating to termination of pregnancy in Northern Ireland and be aware of when termination of pregnancy can legally be provided.

Consent

5.2 It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing personal care. This principle reflects the right of individuals to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this may be liable both to legal action by the person and action by their regulatory body. Employing bodies may also be liable for the actions of their staff. While there is no statute here setting out the general principles of consent, in common law, touching an individual without valid consent constitutes the civil wrong and the criminal offence of battery. Further, if health or social care professionals fail to obtain consent and the individual subsequently suffers harm as a result, this may be a factor in a claim for damages against the health or social care professionals and staff involved. Poor handling of the consent process may also result in complaints from individuals through the HPSS complaints procedure or to regulatory bodies.

5.3 With consent to termination of pregnancy, as with consent for other medical procedures, there are certain criteria which must be met in order for the consent to be valid. The woman must have sufficient competence to understand the procedure and its alternatives in broad terms and to make a decision. It is also important that consent must be voluntary and the decision must be made on the basis of sufficient, accurate information. In those cases, where a termination is advised

and taking account of the urgency of the procedure, where possible, the woman should be afforded the time to consider the decision to have a termination

5.4 When a minor meets the grounds to have a termination within Northern Ireland the requirements relating to consent are the same as for any other medical procedure. Where a young person under the age of consent presents for a termination, staff should be aware of and comply with the reporting requirements relating to minors as set out in the relevant child protection guidance.

5.5 The Department has produced *A Reference Guide to Consent for Examination, Treatment or Care* (March 2003). It provides guidance on the law relating to consent. This document is publicly available on the DHSSPS website - www.dhsspsni.gov.uk/. Practitioners are strongly advised to read this guidance before carrying out any termination procedure. Particular attention is drawn to the chapters on adults without capacity ('incapable adults') and on children and young people. These chapters also explain the circumstances in which a referral should be made to the court for a ruling before a medical procedure or treatment is undertaken.

Counselling

5.6 When termination of pregnancy is considered appropriate within the law in Northern Ireland, adequate information, support and counselling by appropriately trained staff should be available for the woman both before and after the termination of pregnancy.

5.7 Women who are considering or who have undergone a termination of pregnancy, regardless of where it was carried out, should have access

to counselling services. Trusts must be satisfied that these services are being provided by competent, appropriately trained personnel[2].

5.8 In terms of best practice, the purpose of counselling for women considering termination of pregnancy is to offer support to enable them to make an informed choice about termination or its alternatives. The counsellor or psychotherapist will therefore need to be aware of the choices available including medical interventions, adoption services and support available for continuing with the pregnancy.

5.9 Women who proceed with the termination, should then have the offer of post-termination follow up/counselling to help her come to terms with the emotional impact of her choice, on herself and in some cases her partner and children.

Aftercare

5.10 Aftercare services should be available to any woman who presents with symptoms or complications following a termination of pregnancy, regardless of where it was carried out, so that she has access to appropriate treatment and counselling where required.

Confidentiality

5.11 Patients have a right to expect that doctors will not disclose any personal health information to a third party without consent. Women seeking termination of pregnancy are likely to be particularly concerned about the confidentiality of this information and doctors should be sensitive to this.

[2]Counselling is currently not a regulated activity in Northern Ireland. However, when considering what constitutes 'competent, appropriately trained staff', Trusts may wish to refer to the standards issued by the British Association of Counselling and Psychotherapy.

5.12 Paragraph 37 of the GMC's *Good Medical Practice* (Nov 2006), states:

'Patients have a right to expect that information about them will be held in confidence by their doctors. You must treat information about patients as confidential, including after a patient has died. If you are considering disclosing confidential information without a patient's consent, you must follow the guidance in Confidentiality: Protecting and Providing Information.'

Recording of clinical decisions

5.13 There should be consistency in the recording of clinical decisions. The record should show a full and clear rationale behind the decision to carry out a termination including any consultation with other medical professionals. The record should show that the decision is supported by appropriate information and counselling about the options available and implications of continuing with the pregnancy and that the woman has understood and given her informed consent to the termination.

Annex A

RELEVANT EXTRACTS FROM THE LAW ON ABORTION IN NORTHERN IRELAND

Offences Against the Person Act 1861

1. The grounding statute in Northern Ireland is the Offences Against the Person Act 1861 which contains in sections 58 and 59 the criminal offence of unlawfully procuring a miscarriage:

"58. *Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not be with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable…"*

"59. *Whosoever shall unlawfully supply or procure any poison or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to procure the miscarriage of any woman, whether she be or not be with child, shall be guilty of as misdemeanour, and being convicted thereof shall be liable…"*

Criminal Justice Act (Northern Ireland) 1945

2. Section 25 (1) of the Criminal Justice Act (Northern Ireland) 1945 also provides:

"…any person who, with intent to destroy the life of a child then capable of being born alive, by any wilful act causes a child to die before it has

existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to imprisonment for life. Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother."

The Bourne case 1939

3. The Bourne case, *R v Bourne* [1939] KB 687, centred on an obstetrician who was charged with having procured the miscarriage of a fourteen-year old girl contrary to section 58 of the 1861 Act. The girl was pregnant as the result of a rape. The obstetrician had attested that, having made an examination of the girl, he had concluded that the continuance of the pregnancy would severely affect her mental health.

4. In his charge to the jury, Mr Justice Macnaghten referred to section 1 (1) of the Infant Life (Preservation) Act, 1929 and pointed out that the proviso (that a person shall not be guilty of an offence if he acted in good faith to preserve the mother's life) did not appear in section 58. However, he went on to say:

"…but the words of that section (i.e. section 58 of the 1861 Act) are that any person who "unlawfully" uses an instrument with intent to procure miscarriage shall be guilty of felony. In my opinion the word "unlawfully" is not, in that section, a meaningless word. I think it imports the meaning expressed by the proviso in section 1 sub-section 1, of the Infant Life (Preservation) Act, 1929, and that section 58 of the Offences against the Person Act, 1861, must be read as if the words making it an offence to use an instrument with intent to procure a miscarriage were qualified by a similar proviso."

5. What this means is that a person who procures an abortion in good faith for the purpose of preserving the life of the woman shall not be guilty of an offence.

6. In terms of what is meant by "preserving the life of the mother", Mr Justice Macnaghten said this:

"...those words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother."

Cases in the Courts in Northern Ireland since 1993

7. In 1993, the Northern Ireland High Court heard the first of a series of cases which began to circumscribe the nature of lawful terminations. All of the cases involved individuals who were unable to consent for themselves by reason of diminished mental competence or age.

8. The 1993 case of *Re K* concerned a fourteen year old minor who was a ward of court. The Northern Health and Social Services Board sought an order permitting a termination of the pregnancy on the basis of the minor's statements that she would commit suicide if the pregnancy was not terminated. Having heard medical evidence that "...to allow the pregnancy to continue to full term would result in her being a physical and mental wreck", the judge found that a termination in such circumstances would be lawful.

9. In the 1994 case of *Re A.M.N.H.,* the pregnant woman was severely mentally handicapped and a ward of court. There was medical evidence that the continuation of the pregnancy would adversely affect

the woman's mental health. The judge held that abortion is lawful where the continuation of the pregnancy would adversely affect the mental or physical health of the woman. However, he said that the adverse effects must be real and serious. He found in the case that the termination of the woman's pregnancy would be lawful.

10. The 1995 case of *Re S.J.B.* involved a seventeen-year-old severely handicapped girl who was made a ward of court. On the basis of medical evidence presented to the court, the judge held that a termination of the pregnancy would be lawful.

11. The case of *Re C.H.,* also decided in 1995, concerned a sixteen-year-old girl who was a ward of court. She stated that she wished to have her pregnancy terminated and threatened to commit suicide if she was forced to continue with her pregnancy. On the basis of medical evidence, the judge held that it would be lawful for the pregnancy to be terminated.

12. In the case of R v MacDonald in 1999, in a decision during a criminal trial, the Crown Court considered the meaning of 'capable of being born alive' in s.25 of the Criminal Justice Act (NI) 1945. It ruled that it meant the foetus has a real chance of being born and existing as a live child, breathing through its own lungs, whether unaided or with the assistance of a ventilator and whether for a short time or a longer period.

13. In 2004 the Northern Ireland Court of Appeal, on a judicial review application brought by the *Family Planning Association for Northern Ireland*, considered the law relating to termination of pregnancy in Northern Ireland and ordered that the Department should issue legal guidance on the termination of pregnancy.

Annex B

RELEVANT EXTRACTS FROM THE LAW ON ABORTION IN ENGLAND, WALES AND SCOTLAND

Abortion Act 1967

1. Section 1 (1) of the Abortion Act 1967, as amended by Section 37 of Human Fertilisation and Embryology Act 1990, states that a registered medical practitioner may lawfully terminate a pregnancy, in a NHS hospital or on premises approved for this purpose, if two registered medical practitioners are of the opinion, formed in good faith:

   (a) that the pregnancy has not exceeded its twenty-fourth week and that 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; or

   (b) that the termination is necessary to prevent the grave permanent injury to the physical or mental health of the pregnant woman; or

   (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

   (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."

ANNEX B – Draft Guidelines 2010

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AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÂNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland

July 2010

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Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland

1. Current Law on the Termination of Pregnancy

1.1 In Northern Ireland, the law relating to the termination of pregnancy is contained in sections 58 and 59 of the Offences Against the Person Act 1861, and in section 25 of the Criminal Justice Act (Northern Ireland) 1945 as those provisions have been interpreted to date by the courts. The legislation has been interpreted and explained by the Northern Ireland Courts in a series of cases decided in the High Court in the 1990s and, more recently, in a decision of the Court of Appeal in 2004. Similar legislation applied in England, Wales and Scotland before 1967 and was interpreted in the leading English case of R-v- Bourne (1939). The Bourne decision, although an English case, remains highly relevant to Northern Ireland, and has been consistently applied in Northern Ireland cases. Further detail and relevant extracts from the law relating to abortion in Northern Ireland are provided at Annex A.

1.2 The law relating to termination of pregnancy in Northern Ireland is different from that in England, Wales and Scotland. The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, does not extend to Northern Ireland and the grounds on which abortion may be carried out here are more restrictive than those in England, Wales and Scotland.

Northern Ireland Legal principles

1.3 The law governing the termination of pregnancy in Northern Ireland at present and in the cases where that legislation has been interpreted by the court can be summarised in the following principles:

(i) operations in Northern Ireland for the termination of pregnancies are unlawful unless performed in good faith only for the purpose of preserving the life of the woman;

(ii) the 'life' of the woman in this context has been interpreted by the courts as including her physical and mental health;

(iii) a termination will therefore be lawful where the continuance of the pregnancy threatens the life of the woman, or would adversely affect her physical or mental health. The adverse effect on her physical or mental health must be a 'real and serious' one, and must also be 'permanent or long term'. In most cases the risk of the adverse effect occurring would need to be more likely than not. However, in certain circumstances the possibility of an adverse effect may be sufficient if, for example, the imminent death of the woman was the potential adverse effect.

(iv) it will always be a question of fact and degree whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy in a particular case.

1.4 In summary, it is lawful to perform an operation in Northern Ireland for the termination of a pregnancy, where:

- it is necessary to preserve the life of the 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 circumstance it would be unlawful to perform such an operation.

1.5 Fetal abnormality is not recognised as a ground, in itself, for termination of pregnancy in Northern Ireland. It will only be lawful to terminate a pregnancy in the case of actual or possible fetal abnormality if the continuance of the pregnancy threatens the life of the woman, or would adversely affect her physical or mental health. As in other cases, the adverse effect on the woman's physical or mental health must be a real and serious one, and must also be permanent or long term.

1.6 In keeping with the law in Northern Ireland, it will always be for the medical practitioner responsible for the care of the woman to decide, as a matter of professional clinical judgment, whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy. As with any exercise of clinical judgment, there will be occasions where this will be a difficult decision. Each case requires careful and sensitive assessment within the law as outlined in this guidance. Where termination of pregnancy is advised, the standard procedures for obtaining consent should be adhered to. (See para 5.2)

1.7 Termination of pregnancy beyond the time at which a child is 'capable of being born alive' is governed by the Criminal Justice Act (NI) 1945, which provides a statutory defence against the offence of child destruction where the act which caused the death of the child was done "*in good faith only for the purpose of preserving the life of the mother*". The principles set out in paragraph 1.3 apply in such a case. This follows from the *Bourne* decision and its application to the Northern Ireland legislation. Section 25(2) of the Act states that a fetus with a gestational age of 28 weeks is prima facie capable of being born alive. Whether a child is 'capable of being born alive' would be a matter of evidence in the event of a prosecution in Northern Ireland.

1.8 It is important for practitioners to appreciate that anyone who unlawfully performs a termination of pregnancy is liable to criminal prosecution with a maximum penalty of life imprisonment. A person who is a

secondary party to the commission of such an offence is liable on conviction to the same penalty. For this reason (unless in circumstances of an emergency) an assessment by two doctors (although not itself a legal requirement) is recommended. (See section 3)

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2 Purpose of Guidance

2.1 The purpose of this guidance is to explain the existing law relating to the termination of pregnancy in Northern Ireland and how it relates to good clinical practice. It also provides guidance on the giving of informed consent the provision of aftercare services and considers when there may be a right of conscientious objection.

2.2 It is important to emphasise that this guidance cannot, and does not make any change to the law of Northern Ireland. In the event of any conflict between this guidance and decisions of the courts, the latter will always prevail.

2.3 Within the scope of this Guidance and the law in Northern Ireland, each Health & Social Care Trust must ensure that its patients have access to termination of pregnancy services.

3 Clinical Assessment

3.1 Although not required by law in Northern Ireland two doctors, where practicable, who share prior knowledge of the woman and her clinical circumstances, should undertake the clinical assessment. However, in exceptional circumstances, such as an emergency, it may be sufficient for a single doctor to assess whether a termination of pregnancy is indicated. All clinical assessments should be completed in a timely manner and without undue delay and reasons for termination must be clearly recorded in the woman's notes. See Section 5 for guidance.

3.2 In circumstances where the pregnancy is likely to cause an adverse effect on the woman's mental health that is real and serious, and long term or permanent, those medical practitioners who are competent in making a clinical assessment in these situations will be best placed to determine the long term likely impact on the woman's mental health. It is rare for pregnancy to cause an adverse effect on mental health which is real and serious, long-term or permanent. To make this determination will require particular competence and experience. A psychiatrist should be involved where there is a current history of severe mental illness or previous history of severe mental illness or a known history of severe learning disability. This might include current or past psychotic illness, severe affective disorder or other severe mental disorders.

3.3 There may be situations when the mental health of a woman with no prior history of mental illness needs to be assessed. For those under 18, a Child and Adolescent Psychiatrist is appropriate. For those with a learning disability or where there is any doubt of mental competence a Consultant Psychiatrist specialising in Learning Disability is appropriate.

3.4 For women aged 18 years or over, assessment would most appropriately be carried out by a Consultant General Adult Psychiatrist.

A GP or Consultant Obstetrician, who has prior knowledge of the woman and her clinical circumstances, and who is both experienced and competent in making a mental health assessment in these situations would also be appropriate to carry out the assessment.

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4 Conscientious Objection

4.1 It is recognised that some healthcare professionals and Trust employees may have a conscientious objection to termination of pregnancy on moral and/or religious grounds. Subject to the important exception mentioned in paragraph 4.2 below, any objection on grounds of conscience will, as far as possible within the law, be recognised and respected. No one having a conscientious objection will normally be compelled to participate in assessing whether a woman satisfies the criteria for a lawful termination of pregnancy in Northern Ireland, or in the handling of fetal remains.

4.2 A practitioner or other healthcare professional *may not refuse* to participate in a termination procedure on grounds of conscience where the life of the woman is in danger and action by way of termination of her pregnancy needs to be taken without delay in order to save her life. In that circumstance the practitioner or other healthcare professional will be required and expected to participate in the procedure. The only exception to this is where another competent, appropriately qualified and experienced practitioner or other healthcare professional is *immediately* available and is willing and able to participate in circumstances such that the participation of the objecting practitioner or healthcare professional for the purpose of saving life is not necessary.

4.3 It is important that practitioners and healthcare professionals appreciate that they may be criminally liable for the consequences of omitting to act where they stand in such relation to their patient that they are under a duty to act. Where the result is death the offence will usually be manslaughter. It is beyond doubt that a doctor is under a duty of care to his patient. The circumstances must be such that a reasonably prudent person would have forseen a serious and obvious risk of death. In 2004 the English Court of Appeal said that:

"... the offence requires first, death resulting from a negligent breach of the duty of care owed by the defendant to the deceased, second, that in negligent breach of that duty, the victim was exposed by the defendant to the risk of death, and third, that the circumstances were so reprehensible as to amount to gross negligence.

...

A doctor would be told that grossly negligent treatment of a patient which exposed him or her to the risk of death, and caused it, would constitute manslaughter."[1]

4.4 The question of whether conscientious objection would ever afford a defence to a charge of manslaughter by gross negligence in such circumstances has, so far as the Department is aware, not yet come before any court either in Northern Ireland or in the rest of the United Kingdom. The Department believes that it is unlikely that conscientious objection would afford a defence in law in such circumstances. However, in the absence of any decided case law, any practitioner or other healthcare professional who thinks that he/she might at some time in the future find himself/herself in circumstances where he/she may wish to refuse to participate on grounds of conscience is strongly advised to obtain independent legal advice on the issue. Nothing in this Guidance should be taken as giving any support for the view that conscientious objection would afford a lawful justification for refusing to act in circumstances where a doctor or other healthcare professional was under a duty to provide treatment.

4.5 The General Medical Council's (GMC's) *Good Medical Practice* (Nov 2006) states that:

"If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict

[1] R v Misra and Srivastava [2004] EWCA Crim 2375

might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role."

Compliance with these obligations does not compromise any conscientious objection which the practitioner may have to termination of pregnancy, but ensures that the woman will be able, as is her right, to obtain advice and, if necessary, treatment from a practitioner who does not have a conscientious objection.

The GMC has also recently published guidance on *Personal Beliefs and Medical Practice* (March 2008) which expands on the principles set out in its core guidance *Good Medical Practice* 2006.

Both of these documents are publicly available on the GMC website – http://www.gmc-uk.org . Practitioners having a conscientious objection are advised to read, and act in accordance with that guidance.

4.6 The Northern Ireland High Court[2] has stated that the GMC's advice on good medical practice, as quoted above, accurately reflects the obligations of a medical practitioner. The Court also said:

"Clearly if a patient presents with a medical problem that indicates a risk to life or long-term health from continued pregnancy a general practitioner who objects to abortion on conscientious grounds remains obliged to take steps to ensure that her medical condition is properly catered for. It would appear obviously necessary for her to be referred to the

[2] *Re* application by Society for the Protection of Unborn Children for judicial review [2009] NIQB 92

appropriate clinicians. The general practitioner who failed to take steps to ensure proper treatment would be in breach of his duties of care and his duty to act consistently with the GMC's guidance on proper practice. There may be situations where, for example, a patient has been advised by her obstetrician to have a termination and in considering whether to consent she seeks advice from a GP. In such a situation the GP's conscientious objection to abortion may be such that he could not give dispassionate advice."[3]

4.7 The Nursing and Midwifery Council (NMC), *The NMC Code of professional conduct: standards of conduct, performance and ethics* (April 2008) states:

> *"you must inform someone in authority if you experience problems that prevent you working within this Code or other nationally agreed standards."*

The code also states that nurses and midwives do not have the right to refuse to take part in emergency treatment:

> *"You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency."*

This guidance is publicly available on the NMC website – www.nmcuk.org/

[3] Per Girvan LJ at paragraph [47]

5 Good practice issues

5.1 All healthcare professionals, especially those working in maternity and gynaecology units, should be familiar with the legal framework relating to termination of pregnancy in Northern Ireland and be aware of when termination of pregnancy can legally be provided. They must also comply with the guidance from their respective regulatory body.

Consent

5.2 It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing personal care. This principle reflects the right of individuals to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this may be liable both to legal action by the person and action by their regulatory body. See GMC guidance on *Consent: patients and doctors making decisions together* (June 2008). Employing bodies may also be liable for the actions of their staff. While there is no statute here setting out the general principles of consent, in common law, touching an individual without valid consent constitutes the civil wrong and the criminal offence of battery. Further, if health or social care professionals fail to obtain consent and the individual subsequently suffers harm as a result, this may be a factor in a claim for damages against the health or social care professionals and staff involved. Poor handling of the consent process may also result in complaints from individuals through the HPSS complaints procedure or to regulatory bodies.

5.3 With consent to termination of pregnancy, as with consent for other medical procedures, there are certain criteria which must be met in order for the consent to be valid. The woman must have sufficient competence to understand the procedure and its alternatives in broad terms and to make a decision. It is also important that consent must be

voluntary and the decision must be made on the basis of sufficient, accurate information. In those cases, where a termination is advised and taking account of the urgency of the procedure, where possible, the woman should be afforded the time to consider the decision to have a termination.

5.4 When a minor meets the grounds to have a termination within Northern Ireland the requirements relating to consent are the same as for any other medical procedure. The GMC publication *0-18 years – Guidance for All Doctors* gives guidance on assessing whether a minor is competent to provide consent.

5.5 The Department has produced *A Reference Guide to Consent for Examination, Treatment or Care* (March 2003). It provides guidance on the law relating to consent. This document is publicly available on the DHSSPS website - www.dhsspsni.gov.uk/. All Health and Social Care staff are strongly advised to read this guidance before carrying out any termination procedure. Particular attention is drawn to the chapters on adults without capacity ('incapable adults') and on children and young people. These chapters also explain the circumstances in which a referral should be made to the court for a ruling before a medical procedure or treatment is undertaken.

Child Protection

5.6 It is a criminal offence to fail to report to the police any sexual offence against a child under the age of 13 without reasonable excuse[4]. Where a young person under the age of consent presents for a termination, staff should be aware of and comply with the reporting requirements relating to minors as set out in the relevant child protection guidance. The law relating to sexual offences is found in the Sexual Offences (Northern Ireland) Order 2008; it is complex so, Health Care

[4] **Section 5 Criminal Law Act (NI) 1967.**

Professionals should always ensure that they continue to adhere to the current, relevant Area Child Protection Committee guidance and Departmental guidance about protecting sexually active children from abuse.

Counselling

5.7 'Counselling' in this context means the provision, in Northern Ireland, of information, support and/or counselling:

a) to a woman who expresses a wish to have a termination of pregnancy, or who wishes to consider options available to her, one of which is, or may be termination of her pregnancy, or

b) to a woman in the aftermath of having had a termination of pregnancy (regardless of where is was carried out).

5.8 Trusts should ensure that in both of these circumstances women have access to counselling, provided by competent and appropriately trained personnel[5].

5.9 Counselling has to be carried out lawfully under the law of Northern Ireland.

5.10 Trusts must ensure that counsellors are familiar with, and understand, the legal principles set out in section 1 of this Guidance.

5.11 When counselling is sought by any woman who has not yet had a termination of her pregnancy it is essential to explain to the woman, without delay, and in language which she could reasonably be expected to understand, that under the law of Northern Ireland she may

[5] Counselling is currently not a regulated activity in Northern Ireland. However, when considering what constitutes 'competent, appropriately trained staff', Trusts may wish to refer to the standards issued by the British Association of Counselling and Psychotherapy.

only have a termination of her pregnancy if, in the clinical judgment of a qualified medical practitioner, (a) a termination is necessary to preserve her life, or (b) there is a risk, if a termination is not carried out, of a real and serious adverse effect on her physical or mental health which is either long term or permanent. If there is any reason to suspect that either of these circumstances may apply the woman should be strongly advised, in the interests of her health, to consult a qualified medical practitioner as soon as possible for assessment. It is not the function of a non-medically qualified counsellor to make any such assessment.

5.12 Unless and until a qualified medical practitioner has made a clinical judgment that the woman satisfies one or other of the criteria for a lawful termination of pregnancy in Northern Ireland any counselling must reflect, and proceed on the basis that termination of the pregnancy in Northern Ireland is not an option that is lawfully available to the woman. The counsellor will need to be aware of the other choices available, including medical treatment, adoption services and support available for continuing with the pregnancy.

5.13 Counsellors should understand that they must also keep within the law of Northern Ireland when any counselling includes the provision of information relating to termination of pregnancy services lawfully available outside Northern Ireland. Provided that the termination of the woman's pregnancy outside Northern Ireland is neither advocated nor promoted, the Department believes that the provision in Northern Ireland of factual information relating to such services would not be unlawful. Counsellors should nevertheless appreciate that this issue has not been tested before the courts of Northern Ireland, and that if they provide such information they do so at their own risk. If in doubt they should seek their own legal advice.

5.14 The question of whether it would be lawful in Northern Ireland to advocate or promote, to a pregnant woman in Northern Ireland, the

termination of her pregnancy outside Northern Ireland, where that termination would be lawful in the place where it was to be carried out, but would not be lawful if it was being carried out in Northern Ireland, has never been considered by the courts. This is a 'grey area' in which, pending clarification by the courts, the lawfulness of such conduct would have to be regarded as uncertain. On no account should anything in this Guidance be taken as encouragement or approval of such conduct by the Department. Any counsellor wishing to engage in such conduct is strongly advised to take specific legal advice before doing so.

5.15 If an assessment has been made by a qualified medical practitioner that the woman satisfies one or other of the criteria for a lawful termination of pregnancy in Northern Ireland (i.e. (a) or (b) in paragraph 5.11 above) it is possible that she may thereafter seek counselling before she decides whether to consent to the procedure. In such circumstances counsellors should exercise extreme caution and consider carefully whether, and if so to what extent, it is appropriate for them to counsel the woman concerned. This is particularly so where, as may often be the case, the counsellor will not be privy to the medical practitioner's assessment of the relative health risks associated with proceeding, and alternatively not proceeding, with a termination. A counsellor should appreciate that the woman's account of her practitioner's assessment of those risks may, on occasions, be inaccurate or incomplete. It would be improper, and potentially dangerous, for a counsellor who did not have a full understanding of those risks to give any advice to a woman to the effect that she consider refusing her consent to a medical procedure, constituting potentially life-saving treatment, which had already been deemed necessary (and which in consequence would be lawful) by a qualified medical practitioner. A woman should never be subjected to emotional or moral pressure to give or to refuse her consent to such treatment.

5.16 Any woman who proceeds with a termination of pregnancy in Northern Ireland should be offered post-termination follow-up/counselling to help her to come to terms with the emotional impact of her choice, on herself and in some cases on her partner and children. Such post-termination follow-up/counselling should also be made available to any woman in Northern Ireland who seeks it even if she has undergone a termination of pregnancy outside Northern Ireland.

5.17 Trusts should make women aware of the chaplaincy services available should they wish to avail of them.

Aftercare

5.18 Aftercare services should be available to any woman who presents with symptoms or complications following a termination of pregnancy, regardless of where it was carried out, so that she has access to appropriate treatment and counselling where required.

Confidentiality

5.19 Patients have a right to expect that health professionals will not disclose any personal health information to a third party without consent. Women seeking termination of pregnancy are likely to be particularly concerned about the confidentiality of this information and staff should be sensitive to this.

5.20 Health professionals should refer to guidance on confidentiality available from their regulatory body including the GMC's Good Medical Practice (Nov 2006). The NMC also provides guidance on confidentiality in The Code: standards of conduct performance and ethics.

Recording of clinical decisions

5.21 There should be consistency in the recording of clinical decisions. The record should show a full and clear rationale behind the decision to carry out a termination including any consultation with other medical professionals. The record should show that the decision is supported by appropriate information and counselling about the options available and implications of continuing with the pregnancy and that the woman has understood and given her informed consent to the termination.

6 Service arrangements

6.1 Information should be available for both women and healthcare professionals on the choices available within the service and on routes of access to the service. Relevant Health and Social Care bodies should ensure that there are clear referral and care pathways in place.

6.2 Access to services should be ensured for women with special needs as appropriate. For example, special arrangements should be made for non-English-speaking women and those with speech or hearing impairment, physical or learning disability.

6.3 Any woman considering induced termination of pregnancy should have timely access to clinical assessment.

6.4 Appropriate information, support and counselling should be available for those who consider but do not proceed to termination of pregnancy.

6.5 The timeframe between the decision being taken and the termination of pregnancy being carried out will be dictated by clinical needs.

6.6 Where clinical circumstances permit the women should be afforded sufficient time to reflect on the treatment choices available, and access to counselling.

6.7 Service arrangements should be such that:

- Women admitted for termination of pregnancy should be cared for with great sensitivity in the most appropriate ward/location.
- Women having second-trimester terminations by medical means should be cared for by appropriately experienced staff. Ideally, they should have the privacy of a single room.

6.8 Aftercare services should be available to any woman who presents with symptoms or complications following a termination of pregnancy. (See section 5, para 5.18)

6.9 Clinical management guidance is available at: www.rcog.org.uk. However, where a legal issue arises, the guidance in this document should be followed.

7 Providing Information to Women

7.1 Any woman seeking a termination who does not meet the criteria in full in Northern Ireland should be treated sensitively and in a non-judgmental way. The GMC's Good Medical Practice (Nov 2006) paragraph 7 states:

'The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance.'

7.2 Health professionals should explore the woman's concerns and expectations to establish what kind of support she is getting or may expect to receive from her partner, family, social services, work colleagues or school/college authorities. It is important to discuss any difficulties she foresees if she continues with the pregnancy as well as any concrete measures that can be taken to help her particular situation. A woman should be offered information about alternatives to termination such as continuing with the pregnancy, adoption, etc. She should also be offered information on organisations which can offer support and advice.

7.3 Verbal advice should be supported by accurate, impartial printed information that the woman can understand and may take away to consider further.

7.4 Information for women and professionals should emphasise the duty of confidentiality by which, as for any form of health care, all concerned with the provision of induced termination are bound.

7.5 Clinicians involved with termination of pregnancy should be aware of the risk of possible complications and sequelae of termination and should discuss these with the woman so that she can give informed consent, recording discussions on a proforma similar to those used in *Consent of Examination, Care and Treatment*. The GMC's *Consent: Patients and Doctors making decisions together,* paragraphs 28 – 36 also gives guidance on discussing side effects, complications and other risks involved in a procedure.

Annex A

RELEVANT EXTRACTS FROM THE LAW ON ABORTION IN NORTHERN IRELAND

Offences Against the Person Act 1861

1. The grounding statute in Northern Ireland is the Offences Against the Person Act 1861 which contains in sections 58 and 59 the criminal offence of unlawfully procuring a miscarriage:

"58. *Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not be with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable…"*

"59. *Whosoever shall unlawfully supply or procure any poison or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to procure the miscarriage of any woman, whether she be or not be with child, shall be guilty of as misdemeanour, and being convicted thereof shall be liable…"*

Criminal Justice Act (Northern Ireland) 1945

2. Section 25 of the Criminal Justice Act (Northern Ireland) 1945 also provides:

(1)Subject as hereafter in this sub-section provided, any person who, with intent to destroy the life of a child then capable of being born alive,

by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to life imprisonment:

Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

(2)For the purposes of this and the next succeeding section, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child then capable of being born alive.

Case Law

In each case the court came to its decision after detailed consideration of medical reports by consultant psychiatrists and obstetricians.

The Bourne case 1939

3. The Bourne case, *R v Bourne* [1939] KB 687, centred on an obstetrician who was charged with having procured the miscarriage of a fourteen-year old girl contrary to section 58 of the 1861 Act. The girl was pregnant as the result of a rape. The obstetrician had attested that, having made an examination of the girl, he had concluded that the continuance of the pregnancy would severely affect her mental health.

4. In his charge to the jury, Mr Justice Macnaghten referred to section 1 (1) of the Infant Life (Preservation) Act, 1929 and pointed out that the proviso (that a person shall not be guilty of an offence if he acted in

good faith to preserve the mother's life) did not appear in section 58. However, he went on to say:

"...but the words of that section (i.e. section 58 of the 1861 Act) are that any person who "unlawfully" uses an instrument with intent to procure miscarriage shall be guilty of felony. In my opinion the word "unlawfully" is not, in that section, a meaningless word. I think it imports the meaning expressed by the proviso in section 1 sub-section 1, of the Infant Life (Preservation) Act, 1929, and that section 58 of the Offences against the Person Act, 1861, must be read as if the words making it an offence to use an instrument with intent to procure a miscarriage were qualified by a similar proviso."

5. What this means is that a person who procures an abortion in good faith for the purpose of preserving the life of the woman shall not be guilty of an offence.

6. In terms of what is meant by "preserving the life of the mother", Mr Justice Macnaghten said this:

"...those words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother."

Cases in the Courts in Northern Ireland since 1993

In each case the court came to its decision after detailed consideration of medical reports by consultant psychiatrists and obstetricians.

7. In 1993, the Northern Ireland High Court heard the first of a series of cases which began to circumscribe the nature of lawful terminations. All of the cases involved individuals who were unable to consent for themselves by reason of diminished mental competence or age.

8. The 1993 case of *Re K* concerned a fourteen year old minor who was a ward of court. The Northern Health and Social Services Board sought an order permitting a termination of the pregnancy on the basis of the minor's statements that she would commit suicide if the pregnancy was not terminated. Having heard medical evidence that "...to allow the pregnancy to continue to full term would result in her being a physical and mental wreck", the judge found that a termination in such circumstances would be lawful.

9. In the 1994 case of *Re A.M.N.H.,* the pregnant woman was severely mentally handicapped and a ward of court. There was medical evidence that the continuation of the pregnancy would adversely affect the woman's mental health. The judge held that abortion is lawful where the continuation of the pregnancy would adversely affect the mental or physical health of the woman. However, he said that the adverse effects must be real and serious. He found in the case that the termination of the woman's pregnancy would be lawful.

10. The 1995 case of *Re S.J.B. i*nvolved a seventeen-year-old severely handicapped girl who was made a ward of court. On the basis of medical evidence presented to the court, the judge held that a termination of the pregnancy would be lawful.

11. The case of *Re C.H.,* also decided in 1995, concerned a sixteen-year-old girl who was a ward of court. She stated that she wished to have her pregnancy terminated and threatened to commit suicide if she was forced to continue with her pregnancy. On the basis of medical

evidence, the judge held that it would be lawful for the pregnancy to be terminated.

12. In the case of R v MacDonald in 1999, in a decision during a criminal trial, the Crown Court considered the meaning of 'capable of being born alive' in s.25 of the Criminal Justice Act (NI) 1945. It ruled that it meant the foetus has a real chance of being born and existing as a live child, breathing through its own lungs, whether unaided or with the assistance of a ventilator and whether for a short time or a longer period.

13. In 2004 the Northern Ireland Court of Appeal, on a judicial review application brought by the *Family Planning Association for Northern Ireland*, considered the law relating to termination of pregnancy in Northern Ireland and ordered that the Department should issue legal guidance on the termination of pregnancy.

ANNEX C – Draft Guidelines 2013

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

April 2013

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1 INTRODUCTION

1.1 The aim of the health and social care system must be protection of both the life of the mother and her unborn child. The objective of interventions administered to a pregnant woman must be to save the mother's life or protect against real and serious long-term or permanent injury to her health. Intervention cannot have as its direct purpose the ending of the life of the unborn child.

1.2 Medical circumstances may dictate that it is not possible to save both lives. All health and social care professionals should be familiar with the legal framework relating to termination of pregnancy in Northern Ireland and be aware when they can be legally provided. They must also comply with the guidance from their respective regulatory body.

1.3 The circumstances where a termination of pregnancy is lawful in Northern Ireland are highly exceptional. This document is intended to guide clinicians on the application of the very strict and narrow criteria that are consistent with the law. It details the very limited circumstances under which a termination of pregnancy may be lawful in Northern Ireland. Examples of good clinical practice are provided throughout.

1.4 This document does not change the law that governs termination of pregnancy in Northern Ireland. In Northern Ireland it is illegal to perform a termination of pregnancy unless it is necessary to preserve the life of the 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.

1.5 The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990 does not extend to Northern Ireland. The provision of treatment that leads to a termination of pregnancy must therefore always be one of clinical necessity based on an assessment that it is the most appropriate medical treatment based on the woman's condition.

1.6 Should termination of pregnancy occur, support must be provided for individuals through aftercare services including counselling. Access to aftercare support must be provided for all women regardless of where a termination of pregnancy was carried out. It is the responsibility of Health and Social Care Trusts to provide this.

1.7 A data collection system is being developed to assess the grounds for termination of pregnancies taking place in Northern Ireland, to inform future policy and service decisions, and to reassure the public.

1.8 The Department of Health, Social Services and Public Safety has remained committed to the publication of guidance on this issue since the decision of the Court of Appeal in 2004. It has undertaken an extensive work programme which has included wide engagement with a range of stakeholder groups through formal consultation exercises and informal discussions.

1.9 It is important to emphasise that ***this guidance cannot, and does not, make any change to the law of Northern Ireland***. In the event of any conflict between this guidance and decisions of the courts, the latter will always prevail.

1.10 Treatment to a pregnant woman that results in the termination of a pregnancy must only be carried out for the purpose of treating the woman, and any harm to an unborn child must only be incidental to that treatment.

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2. LAW ON TERMINATION OF PREGNANCY IN NORTHERN IRELAND

2.1 This section of the document outlines the legal framework for termination of pregnancy in Northern Ireland. The law relating to termination of pregnancy in Northern Ireland is very different from that in Great Britain.

2.2 The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, does not extend to Northern Ireland and the grounds on which a termination of pregnancy may be carried out here are much more restrictive than those in Great Britain.

2.3 In Northern Ireland, the law relating to the termination of pregnancy is contained in sections 58 and 59 of the Offences Against the Person Act 1861, and in section 25 of the Criminal Justice Act (Northern Ireland) 1945 as interpreted by the courts. Further extracts from legal cases relating to termination of pregnancy in Northern Ireland are provided at Annex A.

2.4 Following the devolution of justice powers to Northern Ireland in 2010, responsibility for the criminal legislation underpinning termination of pregnancy in Northern Ireland resides with the Department of Justice.

2.5 The grounding statute in Northern Ireland is the Offences Against the Person Act 1861 which contains in sections 58 and 59 the criminal offence of unlawfully procuring a miscarriage:

> "58. *Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not be with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any*

instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable…"

"59. Whosoever shall unlawfully supply or procure any poison or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to procure the miscarriage of any woman, whether she be or not be with child, shall be guilty of as misdemeanour, and being convicted thereof shall be liable…"

2.6 Section 25 of the Criminal Justice Act (Northern Ireland) 1945 also provides:

(1)Subject as hereafter in this sub-section provided, any person who, with intent to destroy the life of a child then capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to life imprisonment:

Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

(2)For the purposes of this and the next succeeding section, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child then capable of being born alive

2.7 The law governing termination of pregnancy in Northern Ireland can be stated as follows:

i. In Northern Ireland termination of pregnancies are unlawful unless performed in good faith only for the purpose of preserving the life of the

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woman. The 'life' of the woman in this context has been interpreted by the courts as including her physical and mental health;

ii. A termination of pregnancy can therefore be lawful only where the continuance of the pregnancy threatens the life of the woman, or would adversely affect her physical or mental health in a manner that is 'real and serious' and 'permanent or long term'.

iii. In any other circumstance it would be unlawful to perform such a procedure. Health and social care professionals have a legal duty to refuse to participate in, and must report, any procedure that would not be lawful in Northern Ireland. A person who has knowledge of the carrying out of a procedure which is not lawful in Northern Ireland and who has information which is likely to be of material assistance in securing the apprehension, prosecution, or conviction of any person in relation to that lawful procedure is under a duty to give that information, within a reasonable time, to the police. If that person fails to do so without reasonable excuse, he or she may be liable, upon conviction, to maximum penalty of ten years imprisonment.

iv. Fetal abnormality is not recognised as grounds for termination of pregnancy in Northern Ireland.

2.8 It will always be a question of fact and degree whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy in a particular case. In certain circumstances the possibility of an adverse effect may be sufficient grounds if, for example, the imminent death of a woman was the potential adverse effect. In most other cases the risk of the adverse effect would need to be more likely than not.

2.9 The medical practitioners responsible for the care of the woman will assess, as a matter of professional clinical judgement and in keeping with the law in

Northern Ireland, whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy.

2.10 As with any exercise of clinical judgement, there will be occasions where this will be a difficult decision. Each case requires careful and sensitive assessment within the law as outlined in this guidance. In the event of a termination of pregnancy being required, the standard procedures for obtaining informed consent should be adhered to. Information on the issue of consent can be found in section 6 of this document.

2.11 It should be clearly understood that any conclusion that the risk to life or to the permanent or long-term health of the mother is sufficiently serious to justify a termination of pregnancy must be based upon reasonable grounds and with adequate knowledge.

2.12 Termination of pregnancy beyond the time at which a child is 'capable of being born alive' is governed by the Criminal Justice Act (NI) 1945, which provides a statutory defence against the offence of child destruction where the act which caused the death of the child was done "in good faith only for the purpose of preserving the life of the mother". This follows from the Bourne decision and its application to the Northern Ireland legislation. Section 25 (2) of the Act states that a fetus with a gestational age of 28 weeks is prima facie capable of being born alive. Whether a child is 'capable of being born alive' would be a matter of evidence in the event of a prosecution in Northern Ireland. A child may be considered capable of being born alive if he or she has a real chance of being born and existing as a live child, breathing through its own lungs, whether unaided or with the assistance of a ventilator and whether for a short time or for a longer time.

2.13 It is important for practitioners to appreciate that anyone who unlawfully performs a termination of pregnancy is liable to criminal prosecution with a maximum penalty of life imprisonment. A person who is a secondary party to the commission of such an offence is liable on conviction to the same penalty.

A secondary party will include any person who, with intent to procure an abortion, assists another person in carrying out an unlawful termination of pregnancy or indeed who encourages the carrying out of such a procedure. For this reason (unless in circumstances of an emergency) an assessment by two doctors (although not itself a legal requirement) is recommended. (See section 3).

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3 CLINICAL ASSESSMENT

3.1 This section recommends best practice procedures that health and social care professionals should follow when undertaking patient assessments.

Best practice

3.2 Although not required by law in Northern Ireland, where practicable, two doctors with the appropriate skills and experience should undertake the clinical assessment.

3.3 All clinical assessments should be completed in a timely manner without undue delay and reasons for termination of pregnancy must be clearly recorded in the woman's notes. Further clarity on this issue is provided at 3.10.

Exceptional circumstances

3.4 In exceptional circumstances, such as imminent death emergency, it may be sufficient for a single doctor to assess whether a termination of pregnancy is indicated.

Where the threat is to the mental health of the woman

3.5 In circumstances where the pregnancy is likely to cause an adverse effect on the woman's mental health that is real and serious, and long term or permanent, medical practitioners who are experienced and competent in making a clinical assessment in these situations will be best placed to determine the long term likely impact on the woman's mental health.

3.6 The issue of potential long term serious mental health impact as a result of continuation of a pregnancy will require very careful consideration. It is expected that cases with a prognosis leading to a termination of pregnancy will be very rare. Making this determination will require particular competence and experience. As such it is recommended that a Consultant Psychiatrist should

be involved where a mental health assessment is required. It is recognised that this may not be practicable at all times e.g. in an emergency.

3.7 Should medical practitioners decide to undertake such an assessment, they must ensure they are satisfied that they have the relevant qualifications, competence or experience to make an appropriate clinical judgement on the likely impact and immediacy of threat to the patient. Should a practitioner not have the relevant competence they should seek advice and support from a qualified source. All practitioners should ensure they comply with any guidance from their respective regulatory body. It is a GMC requirement that doctors recognise and work within the limits of their competence.

3.8 There may be situations when the mental health of a woman, needs to be assessed. For those under 18, a Consultant Child and Adolescent Psychiatrist is appropriate. For women aged 18 years or over, assessment would most appropriately be carried out by a Consultant General Adult Psychiatrist.

Women with a learning disability

3.9 For those with a learning disability, or where there is any doubt of mental competence, a Consultant Psychiatrist specialising in learning disability is appropriate.

Recording of clinical decisions

3.10 The record should show a full and clear rationale behind the decision to carry out a termination of pregnancy, why it is the most appropriate clinical management for the woman involved, and should include any consultation that has taken place with other medical professionals. The record should show that the decision is supported by relevant information, and that the woman where clinical urgency permitted, has received counselling regarding options available and the implications of continuing with the pregnancy. The record

should also show that the woman has understood and given her informed consent to the termination of pregnancy.[1]

3.11 Clinicians involved with termination of pregnancy should be aware of the risk of possible complications and sequelae of termination and should discuss these with the woman so that she can give informed consent, recording discussions on a proforma similar to those used in Consent of Examination, Care and Treatment. The GMC's Consent: Patients and Doctors making decisions together, paragraphs 28–36 also gives guidance on discussing side effects, complications and other risks involved in a procedure.

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[1] Reference should be made to guidance on record keeping – "*Good Medical Practice*" (GMC, 2006) and "*Record Keeping: Guidance for Nurses and Midwives*" (NMC, 2009)

4 THE RIGHT TO CONSCIENTIOUS OBJECTION

4.1 It is recognised that even in the very rare occasions in which a termination of pregnancy can take place lawfully in Northern Ireland, that some health and social care professionals and Trust employees may have a conscientious objection to termination of pregnancy. It is clear, however, that no-one is required to participate in a procedure that he or she may consider unlawful. No-one is obliged to participate in any procedure which they consider may have as its direct primary purpose the death of the unborn child.

Emergency situations

4.2 Healthcare professionals may not refuse to participate in a termination of pregnancy on grounds of conscience where the life of the woman is in danger *and* action by way of termination of her pregnancy needs to be taken without delay in order to save her life *and* where the death of the unborn child is not the direct primary purpose of any intervention.

4.3 In the circumstances set out in paragraph 4.2 above, healthcare professionals will be required and expected to participate in the procedure.

4.4 The only exception to this is where another competent, appropriately qualified and experienced healthcare professional is immediately available and is willing and able to participate in place of the objecting healthcare professional for the purpose of saving the life. Such life threatening situations are likely to occur very infrequently.

5 PROVISION OF COUNSELLING SERVICES

5.1 Counselling involves a deliberately undertaken contract with clearly agreed boundaries and commitment to privacy and confidentiality. It requires explicit and informed agreement. The counsellor should respect the woman's values, personal resilience and capacity for decision making within her cultural context.

5.2 The counsellor must adhere to the ethical standards and code of practice outlined in the following paragraphs by offering a supportive environment for the woman to explore her feelings.

5.3 Counselling should be available to a woman:

i. who expresses a wish to have a termination of pregnancy, or

ii. who wishes to consider options available to her, one of which is, or may be termination of her pregnancy, or

iii. following a termination of pregnancy regardless of where it was carried out.

5.4 Health and social care professionals should ensure that in any of these circumstances women have access to counselling, provided by competent and appropriately trained personnel[2].

Counselling within the NI legal framework

5.5 Counselling in Northern Ireland must be carried out within the legal framework.

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[2] Counselling is currently not a regulated activity in Northern Ireland. However, when considering what constitutes 'competent, appropriately trained staff', Trusts may wish to refer to the standards issued by the British Association of Counselling and Psychotherapy

5.6 Trusts must ensure that counsellors are familiar with, and understand the law as set out in section 2 of this document. A woman should never be subjected to emotional or moral pressure to give or to refuse her consent to treatment which is lawful and clinically appropriate.

5.7 When counselling is sought by any woman who has not yet had a termination of her pregnancy it is essential to explain to the woman, without delay, and in language which she could reasonably be expected to understand, that under the law of Northern Ireland she may only have a termination of her pregnancy if;

i. in the clinical judgment of qualified medical practitioners, a termination of pregnancy is necessary to preserve her life, or

ii. there is a risk, if a termination of pregnancy is not carried out, of a real and serious adverse effect on her physical or mental health which is either long term or permanent.

5.8 If there is any reason to suspect that either of these circumstances may apply the woman should be advised, in the interests of her health, to consult a qualified medical practitioner as soon as possible for assessment. It is not the function of a non-medically qualified counsellor to make any such assessment.

5.9 Unless, and until, qualified medical practitioners have made a clinical judgment that the woman satisfies one or other of the criteria for a lawful termination of pregnancy in Northern Ireland any counselling must reflect, and proceed on the basis that termination of the pregnancy in Northern Ireland is not an option that is lawfully available to the woman.

5.10 The counsellor will need to be aware of and inform the woman of the other choices available, including medical treatment, adoption services and support available for continuing with the pregnancy.

5.11 Counsellors should understand that they must also keep within the law of Northern Ireland when any counselling includes the provision of information relating to termination of pregnancy services lawfully available outside Northern Ireland.

Advice on services in other UK jurisdictions

5.12 The question of whether it would be lawful in Northern Ireland to advocate or promote, to a pregnant woman in Northern Ireland, the termination of her pregnancy outside Northern Ireland, where that termination of pregnancy would be lawful in the place where it was to be carried out, but would not be lawful if it was being carried out in Northern Ireland, has never been considered by the courts. This is a 'grey area' in which, pending clarification by the courts, the lawfulness of such conduct would have to be regarded as uncertain.

5.13 On no account should anything in this guidance be taken as encouragement or approval of such conduct by the Department. Any counsellor wishing to engage in such conduct is strongly advised to take specific legal advice before doing so.

Counselling women who meet requirements of the NI legal framework

5.14 If an assessment has been made by qualified, competent medical practitioners that the woman satisfies one or other of the criteria for a lawful termination of pregnancy in Northern Ireland (i.e. paragraph 2.8 and 2.9 above), where clinical urgency permits, she should be advised that she may seek counselling, if she wishes, before she decides whether to consent to the procedure.

5.15 In such circumstances counsellors should exercise extreme caution and consider carefully whether, and if so to what extent, it is appropriate for them to counsel the woman concerned. This is particularly so where, as may often be the case, the counsellor will not be privy to the medical practitioner's assessment of the relative health risks associated with proceeding, and alternatively not proceeding, with a termination of pregnancy. A counsellor

should appreciate that the woman's account of her practitioner's assessment of those risks may, on occasions, be inaccurate or incomplete.

Aftercare services

5.16 Any woman who proceeds with a termination of pregnancy in Northern Ireland should be offered post-termination follow-up/counselling to help her to come to terms with the emotional impact of her choice, on herself and in some cases on her partner and children.

5.17 Such post-termination of pregnancy follow-up/counselling should also be made available to any woman in Northern Ireland who seeks it even if she has undergone a termination of pregnancy outside Northern Ireland.

5.18 Aftercare services should be available to any woman who presents with symptoms or complications following a termination of pregnancy, regardless of where it was carried out, so that she has access to appropriate treatment and counselling where required.

Patient confidentiality

5.19 Patients have a right to expect that health and social care professionals will not disclose any personal health information to a third party without consent. Women seeking termination of pregnancy are likely to be particularly concerned about the confidentiality of this information and staff should be sensitive to this.

5.20 Health and social care professionals should adhere to the DHSSPS Code of Practice on Protecting the Confidentiality of Service User Information and the requirements of the Data Protection Act 1998.

5.21 They should also refer to guidance on confidentiality available from their regulatory body including the GMC's Good Medical Practice (Nov 2006), Confidentiality (2009) and the NMC guidance "The Code: standards of conduct performance and ethics".

6 ENSURING APPROPRIATE CONSENT

6.1 It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing personal care.

6.2 The Department has produced A Reference Guide to Consent for Examination, Treatment or Care (March 2003). It provides guidance on the law relating to consent. This document is publicly available on the DHSSPS website - www.dhsspsni.gov.uk

6.3 All health and social care staff are advised to read this guidance before carrying out any termination of pregnancy procedure. Particular attention is drawn to the chapters on adults without capacity ('incapable adults') and on children and young people. These chapters also explain the circumstances in which a referral should be made to the court for a ruling before a medical procedure or treatment is undertaken.

6.4 This principle of consent reflects the right of individuals to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this may be liable both to legal action by the person and action by their regulatory body.

6.5 Employing bodies may also be liable for the actions of their staff. While there is no statute here setting out the general principles of consent, in common law, touching an individual without valid consent constitutes the civil wrong and the criminal offence of battery.

6.6 Further, if health care professionals fail to obtain consent and the individual subsequently suffers harm as a result, this may be a factor in a claim for damages against the health care professionals and staff involved. Poor handling of the consent process may also result in complaints from individuals through the HPSS complaints procedure or to regulatory bodies. As with any

other procedure, the patient is entitled to obtain a second opinion before she gives consent.

6.7 With consent to termination of pregnancy, as with consent for other medical procedures, there are certain criteria which must be met in order for the consent to be valid. The woman must have sufficient competence to understand the procedure and its alternatives in broad terms and to make a decision.

6.8 It is also important that consent must be voluntary and the decision must be made on the basis of sufficient, accurate information. In those cases, where a termination of pregnancy is advised and taking account of the urgency of the procedure, where possible, the woman should be afforded the time to consider the decision to have a termination of pregnancy.

6.9 When a minor satisfies one or other of the criteria for a lawful termination within Northern Ireland the requirements relating to consent are the same as for any other medical procedure. The GMC publication 0-18 years – Guidance for All Doctors gives guidance on assessing whether a minor is competent to provide consent.

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7 CONSIDERATION OF SEXUAL OFFENCES

7.1 In some circumstances a patient presenting in relation to the issue of possible lawful termination of pregnancy may lead a health or social care professional having to consider if a sexual offence has been committed.

7.2 It is a criminal offence[3] to fail, without reasonable excuse, to report to the police a suspicion that a serious offence has been committed; this includes any sexual activity with a child under the age of 13, sexual activity between an adult and a child under the age of 16, or with a person who is unable to legally consent to sexual activity because of a mental disorder[4].

7.3 Sexual activity with a person with a mental disorder which does not impact on their capacity to consent, is an offence if it is procured by inducement, threat or deception, or if the person undertaking the activity is a care worker for that individual.

7.4 The Sexual Offences (Northern Ireland) Order 2008 provides the legislative framework for sexual offences in Northern Ireland, including offences against children and people with a mental disorder.

Child protection reporting requirements

7.5 Where a young person under the age of 16, the age of consent for sexual activity, presents for a termination of pregnancy, staff should be aware of and comply with the reporting requirements relating to minors as set out in the relevant child protection guidance.

7.6 Health and social care practitioners should always consider the possibility of abuse having occurred in a situation where a minor presents seeking a termination of pregnancy. Guidance to assist practitioners to determine

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[3] Section 5 Criminal Law Act (NI) 1967.

[4] As defined in the Mental Health (NI) Order 1986.

whether a sexual relationship may in itself be abusive can be found in Chapter 9 of the Regional Child Protection Policy and Procedures[5].

7.7 If it appears that the relationship which has resulted in the pregnancy of a minor has been an abusive relationship, the matter should be progressed in accordance with the Regional Child Protection Policy and Procedures. A referral should be made to the local Gateway Team in Children's Services.

Adult protection reporting requirements

7.8 In circumstances where an adult with a mental disorder presents for a termination of pregnancy, the reporting requirements set out in relevant adult protection guidance[6] should be followed.

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[5] http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf

[6] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance http://www.rqia.org.uk/cms_resources/Safeguarding_Vulnerable_Adults_-_3_Nov_06.pdf

8 ALTERNATIVE OPTIONS

> *''The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance.'*

Source - GMC's Good Medical Practice (Nov 2006) paragraph 7

If a woman does not meet the criteria for a termination of pregnancy

8.1 Any woman seeking a termination of pregnancy who does not meet the criteria in Northern Ireland should be treated sensitively.

8.2 Health and social care professionals should explore the woman's concerns and expectations to establish what kind of support she is getting or may expect to receive from her partner, family, social services, work colleagues or school/college authorities.

8.3 It is important to discuss any difficulties she foresees as well as any concrete measures that can be taken to help her particular situation.

Alternatives to termination of pregnancy

8.4 A woman should be offered information about alternatives to termination of pregnancy such as continuing with the pregnancy, adoption, etc. She should also be offered information on organisations which can offer support and advice.

8.5 Trusts should make women aware of the chaplaincy services available to them for spiritual and pastoral care should they wish to avail of them.

8.6 Verbal advice should be supported by accurate, impartial printed information that the woman can understand and may take away to consider further.

8.7 Information for women and health and social care professionals should emphasise the duty of confidentiality by which health and social care staff are bound.

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9 ACCOUNTABILITY AND INFORMATION COLLECTION

9.1 Health and Social Care Trusts have a statutory duty to deliver services that meet their local population requirements and are lawful. It is no different for treatments delivered to pregnant women that may lead in very limited circumstances to a lawful termination of pregnancy.

9.2 All services that Trusts provide are subject to robust systems of internal control. This ensures that policies and procedures for day-to-day activities are implemented and followed correctly. These systems provide reasonable assurance that objectives are met and risks are being reasonably managed.

9.3 Under existing accountability arrangements HSC Trust boards are required to have appropriate governance arrangements in place to ensure ongoing compliance with the law that governs termination of pregnancy in Northern Ireland.

9.4 A data collection system is being developed to provide additional detail on the termination of pregnancies in Northern Ireland. The system will collect information on the grounds for termination of pregnancies taking place and provide information to inform future policy management.

9.5 The data collection system will recognise the intrinsic right of confidentiality for patients and health and social care staff[7]. Data protection and the importance of anonymised information has underpinned thinking at every juncture in the development of the collection system.

9.6 All health and social care medical professionals working in Northern Ireland should be aware of the contents of this document and the limited circumstances under which termination of pregnancy is lawful in Northern Ireland. Similarly all organisations providing medical services to pregnant

[7] http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf

women have a responsibility to ensure their staff have considered this guidance. As outlined in 2.7(iii), health and social care professionals have a legal duty to refuse to participate in, and report, any procedure that would not be lawful in Northern Ireland.

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Annex A - CASE LAW ON TERMINATION OF PREGNANCY IN NORTHERN IRELAND

The High Court has considered a small number of applications in relation to young people and women lacking decision making capacity and has confirmed that the termination of pregnancy proposed would be lawful. In each case, the court came to its decision after detailed consideration of medical reports by consultant psychiatrists and obstetricians.

The Bourne case 1939

1. The Bourne case, R v Bourne [1939] KB 687, centred on an obstetrician who was charged with having procured the miscarriage of a fourteen-year old girl contrary to section 58 of the 1861 Act. The girl was pregnant as the result of a rape. The obstetrician had attested that, having made an examination of the girl, he had concluded that the continuance of the pregnancy would severely affect her mental health.

2. In his charge to the jury, Mr Justice Macnaghten referred to section 1 (1) of the Infant Life (Preservation) Act, 1929 and pointed out that the proviso (that a person shall not be guilty of an offence if he acted in good faith to preserve the mother's life) did not appear in section 58. However, he went on to say:

> *"... but the words of that section (i.e. section 58 of the 1861 Act) are that any person who "unlawfully" uses an instrument with intent to procure miscarriage shall be guilty of felony. In my opinion the word "unlawfully" is not, in that section, a meaningless word. I think it imports the meaning expressed by the proviso in section 1 sub-section 1, of the Infant Life (Preservation) Act, 1929, and that section 58 of the Offences against the Person Act, 1861, must be read as if the words making it an offence to use an instrument with intent to procure a miscarriage were qualified by a similar proviso."*

3. What this means is that a person who procures an abortion in good faith for the purpose of preserving the life of the woman shall not be guilty of an offence.

4. In terms of what is meant by "preserving the life of the mother", Mr Justice Macnaghten said this:

> *"... those words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother."*

Cases in the Courts in Northern Ireland since 1993

In each case the court came to its decision after detailed consideration of medical reports by consultant psychiatrists and obstetricians.

5. In 1993, the Northern Ireland High Court heard the first of a series of cases which began to circumscribe the nature of lawful termination of pregnancies. All of the cases involved individuals who were unable to consent for themselves by reason of diminished mental competence or age.

6. The 1993 case of *Re K* concerned a fourteen year old minor who was a ward of court. The Northern Health and Social Services Board sought an order permitting a termination of the pregnancy on the basis of the minor's statements that she would commit suicide if the pregnancy was not terminated. Having heard medical evidence that "...to allow the pregnancy to continue to full term would result in her being a physical and mental wreck", the judge found that a termination of pregnancy in such circumstances would be lawful.

7. In the 1994 case of *Re A.M.N.H.,* the pregnant woman was severely mentally handicapped and a ward of court. There was medical evidence that the continuation of the pregnancy would adversely affect the woman's mental health. The judge held that abortion is lawful where the continuation of the pregnancy would adversely affect the mental or physical health of the woman. However, he said that the adverse effects must be real and serious. He found in the case that the termination of the woman's pregnancy would be lawful.

8. The 1995 case of *Re S.J.B. i*nvolved a seventeen-year-old severely handicapped girl who was made a ward of court. On the basis of medical evidence presented to the court, the judge held that a termination of the pregnancy would be lawful.

9. The case of *Re C.H.,* also decided in 1995, concerned a sixteen-year- old girl who was a ward of court. She stated that she wished to have her pregnancy terminated and threatened to commit suicide if she was forced to continue with her pregnancy. On the basis of medical evidence, the judge held that it would be lawful for the pregnancy to be terminated.

10. In the case of R v MacDonald in 1999, in a decision during a criminal trial, the Crown Court considered the meaning of 'capable of being born alive' in s.25 of the Criminal Justice Act (NI) 1945. It ruled that it meant the foetus has a real chance of being born and existing as a live child, breathing through its own lungs, whether unaided or with the assistance of a ventilator and whether for a short time or a longer period.

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Annex B - MEETING PATIENTS NEEDS

1. Information should be available for both women and health and social care professionals. Although the number of terminations will be small, relevant Health and Social Care providers should have arrangements in place to deal with those circumstances where the need for a termination arises.

2. Access to services should be ensured for women with special needs as appropriate. For example, special arrangements should be made for non English speaking women and those with speech or hearing impairment, physical or learning disability.

3. Where termination of pregnancy is being considered there should be timely access to clinical assessment.

4. Appropriate information, support and counselling should be available for those who consider but do not proceed to termination of pregnancy.

5. The timeframe between the decision being taken and the termination of pregnancy being carried out will be dictated by clinical needs. The immediacy of the harm of the mother (and consequently the urgency of the action to terminate the pregnancy) may be a relevant factor in making a defence.

6. Where clinical circumstances permit the women should be afforded sufficient time to reflect on the treatment choices available, and access to counseling.

7. Service arrangements should be such that:

    i. Women admitted for termination of pregnancy should be cared for with great sensitivity in the most appropriate ward/location.

ii. Women having second-trimester termination of pregnancies by medical means should be cared for by appropriately experienced staff. Ideally, they should have the privacy of a single room.

8. Aftercare services should be available to any woman who presents with symptoms or complications following a termination of pregnancy.

9. Clinical management guidance is available at: www.rcog.org.uk/ However, where a legal issue arises, the guidance in this document should be followed.

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