Conscientious Objection to Abortion Amongst Health Care Professionals in Northern Ireland

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Women's RESOURCE & DEVELOPMENT AGENCY
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SCOPING EXERCISE: CONSCIENTIOUS OBJECTION TO ABORTION AMONG NORTHERN IRELAND HEALTHCARE PROFESSIONALS.

Although abortion is decriminalised in Northern Ireland, provision falls far short of legal entitlement. Rather than availability on request until twelve weeks gestation and for health reasons later as legislated for, only medication abortion until 9 weeks 6 days is generally provided here. This requires a clinic visit, unlike in Great Britain and Ireland where telemedicine is offered. After this or for surgical provision, travel to GB is necessary. This system creates institutional barriers for patients, especially marginalised people, in addition to obstructions from anti-choice "clinics," clinic protestors, and social stigma.

Conscientious objection (CO), the practice of healthcare providers (HCPs) refusing care based on personal beliefs, can produce further impediments and delay care[1,2]. In NI the right of HCPs to object and refuse to participate in abortion is granted by Section 12 of the Abortion (NI) Regulations 2020[4]. The World Health Organisation, UN bodies and European Court of Human Rights say states allowing CO must ensure patients' rights take priority and are mitigated for[1,2,3]. UK case law establishes clear limits to objections[4] and professional bodies provide guidelines for best practice. Northern Ireland Abortion and Contraception Taskgroup (NIACT) recommends line managers keep and regularly review a record of objectors[5].

This research aims to establish whether investigation into CO locally is necessary, for example to establish levels of objection and potential impacts on HCPs and patients. There have been no recent NI studies of numbers of conscientious objectors in the wider NHS, but a 2020 survey of Obstetrics & Gynaecology staff found around a third were objectors, with 9% uncertain[6]. This group could indicate a lack of training or information. The research included conducting both primary and secondary research. Secondary research reviewed legal status of CO and guidance provided. Primary research was carried out in the form of interviews with Dr Kellie Turtle, an academic and activist (Int1); Naomi Connor, an activist assisting abortion seekers and campaigning (Int4); and two anonymised patient facing staff, Shauna from a sexual health charity, who speaks regularly to contraception or abortion seekers and HCPs (Int2) and Emily, an NHS patient-facing HCP in GP services (Int3.)

Interviewees felt strongly that improvements were needed and raised several issues with current provision, including with the booking system. The booking service not being locally based creates confusion, trepidation, and mistrust (Int2, 4) with patients concerned they will need to travel, regardless of gestation, or uncertain where confidential information input into online forms will be sent. Shauna

and Naomi felt patients were overwhelmed by information found online, especially when anxious, and needed reassurance; someone to talk to, clearer confirmation of bookings, next steps, and navigating the process. Despite decriminalisation and introduction of partial provision, both are still supporting abortion seekers daily. Naomi noted the service doesn't account for the additional needs of migrants and asylum seekers. HCP Emily raised a lack of information both for patients and professionals in the NHS on the services available or how to access them, which suggests a public awareness campaign, as recommended by WHO[3] after a law change, and staff training are needed. Along with concerns that there is no GP pathway (Int2 and 3), other clinical settings were flagged as not being ideal, for example pre- and post-abortion care situated in maternity units (Int1,2,4). While in Naomi's experience some Maternity staff were sensitive, warning post-abortion patients what to expect in the unit, Shauna found some members of staff were less supportive pre-abortion. Kellie highlighted worries about a disempowering environment for patients in Maternity in general.

The current system ignores the reality of women's lived experience (Ints2 and 4): for example, needing to attend a clinic rather than using telemedicine can be problematic in terms of geography, time, cost, childcare, and privacy. The current cut-off of 9 weeks 6 days, and no surgical provision, is restrictive. Interviewees felt services were improving due to the effort and attitudes of willing clinicians (Ints1,2,4) but all four said obstructions were coming from 'top down', because of the previous Health Minister, lack of an Executive, and inaction from Department of Health (DoH) or Trusts. Former minister Robin Swann was described as himself being a 'conscientious objector' who had created a departmental chill factor (Int1.)

Together with these obstructions, global research[1] has found that health workers' anti-choice feeling impacts both abortion seekers, and the HCPs willing to provide services. Key difficulties caused for patients are abortion delays and financial, physical, and psychological costs, especially where objection is prevalent, policies are unclear or inconsistently implemented, and where regulation of objection is poorly followed. Vulnerable people were shown to be disproportionately affected. In NI, Naomi has found migrants are more likely to attend anti-choice "clinics" than long-term residents and has encountered objection from translators to helping abortion seekers. Shauna discussed how CO was perceived by people she spoke to; not as a reflection of the professional's ethical beliefs, but as judgement on the patient's choices or behaviours, which only served to reinforce the longstanding stigma about abortion and make people feel ashamed. Emily highlighted that her anti-choice colleagues say they would try to change abortion seekers minds as well as refusing to help. Studies suggest some

staff may use CO as justification for choosing which patients they help, based on judgement of the individual, or as a way of managing workload[1].

For HCPs in inconsistent or unclear circumstances around CO, workload (including emotional workload in these often demanding job roles) can increase, and pressure to participate or opt out can be accompanied with a sense of stigmatisation. Staff have been ostracised by colleagues after expressing willingness to participate in surgical abortions (Int1.) Emily described a heated work atmosphere during discussion of abortion training she had done. Lack of knowledge of the legal limitations on objection is a potential workers' welfare issue (Int4) as UK case law is clear that only active participation in procedures is included, not ancillary care[4] (Ints1, 4.) Emily attempted to explain this to colleagues, being aware from her training course there were potential employment or legal liabilities, and professional body guidelines on behaviour. She is certain they were unaware of this. There has been no mandatory NHS training on abortion or CO, and no information provided to staff about their responsibilities, and there are no plans to date to offer any through the DoH (Int4). Doctors for Choice, the Royal College of Nurses and Alliance for Choice have however delivered voluntary workshops on this.

All participants expressed concern about effects of conscientious objection. Shauna considered it an unhelpful judgement on her clients with no place in medical services. All other participants accepted a right to object, but felt clarity and communication are needed, considering the subject a training gap (Int1,3 and 4). Discussion of managing objection in practical terms was less clear cut, particularly around NIACT's recommendation of a register. Emily saw this as a necessity for best patient care, so that anti-choice staff could "remove themselves from the situation." Kellie viewed it as polarising, inflaming 'culture wars,' with potentially damaging consequences for workplace relations. Naomi felt (as in international studies reviewed[1]) it gave staff an opportunity to opt out of care, where they might not have otherwise. Shauna did not support a register as it legitimises CO.

Taken with previous global research showing the effects conscientious objection can have on both staff and patients, the concerns raised by participants suggest study into levels of conscientious objection and awareness of its legal limitations among the NHS would be useful. More information for abortion seekers and patient facing staff is a relatively minimal but urgently needed improvement to abortion services here.

CASE STUDY: Shauna, Reproductive Health Charity Worker.

Shauna has worked in the area of sex and relationships education, STI testing, contraception, and abortion for over twenty years. She works in the community and on a telephone helpline. She describes herself as having been 'on the frontline' for abortion seekers during Covid lockdowns when travel became almost impossible. She is passionately pro-choice and frustrated by obstacles faced by clients.

Shauna's work is essential for several reasons. People can find online information overwhelming or difficult to follow, especially when anxious. They may be reluctant to complete online forms because they don't know where their information goes, whether they'll receive post, or if their doctor will be notified. Sometimes they want reassurance what they've found is correct, or simply to talk about their decision as many haven't told anyone. Stigma and shame is an ongoing problem.

"When it comes to abortion in this country, it has been a service that has been so discriminated against for so long, there's such a huge stigma. That's not going to go away overnight."

There is uncertainty in the community around the law change. Some people assume full services exist, but most aren't aware of how to find them. The partial services available are stabilising because of the work of providers, but are still insufficient due to lack of decision-making, commissioning and funding from Stormont, and NIACT

travel shouldn't be necessary. Shauna wonders if NI might develop a hierarchy if provision stays as it is, with those who travel more stigmatised. There is a lack of trust in services because they aren't fully locally based or accessible via a GP and there is so little information.

"I would love to see a regional service, like a one contact phone number for abortion services in Northern Ireland. That it would be local and that it would be funded, and they would get local support, right from the very beginning to the very end."

In community work, Shauna finds abortion conversations becoming easier and feels healthcare professionals are growing more comfortable too, but there are exceptions, leaving patients feeling shamed around abortion or contraception. She knows of maternity staff, GPs and receptionists being cold and unsupportive, and describes a young woman feeling judged by a pharmacist who pointed out she obtained emergency contraception twice in a few months as if she had done something wrong. Shaming is how conscientious objection is perceived in communities she works with, in her experience: not as the professional's personal beliefs, but as coldness, unhelpfulness and judgement, reinforcing

stigma. Shauna feels that medicine is intervention to help patients so there should be no room for objection in healthcare roles. She describes conscientious objection as **"a fancy term to give justification for an academic judgement,"** being validated by legal and medical systems and dismissing patients' needs.

Having helped abortion seekers since long before decriminalisation, for Shauna,

"It's an academic perspective. It's not the reality of community. Because the truth of community is, if a woman wants an abortion, and is desperate enough to get an abortion, they will go to the end of the world to get it."

CASE STUDY: Emily, NHS employee.

Emily works in a in a busy health centre offering general practice and other services.

When abortion was decriminalised in Northern Ireland in 2019, Emily expected to receive information about the new legislation and any provision introduced. She actively "kept an eye out," wanting to be aware of any new responsibilities and able to answer queries. To date, no information on access has been made available to clinical staff or patients. Early in the Covid pandemic all information leaflets and posters were removed from the health centre; these are now back in use, but Emily has seen nothing referencing abortion.

She sought training, finding a remotely delivered module through her trade union in early 2021. She did it in her own time as there was no voluntary module from HSCNI. She checked their Clinical Education Centre and her Trust's education website again recently and says that hasn't changed. The training was useful, covering law, abortion at different gestations, and conscientious objection, but didn't feel she should have needed to do it outside work as training is the Trust's responsibility. She was worried colleagues didn't have the same information and wouldn't be able to answer questions or signpost care, saying, **"I honestly couldn't say for definite that somebody would get the right sort of advice."**

Of particular concern was what she learned about conscientious objection, knowing of anti-choice feeling among her team. Emily didn't think staff knew there were limits on what they could refuse, or on what they should say to abortion seekers. **"I felt once I had that kind of knowledge, I should have been sharing it with my colleagues. So that they knew where they stood."**

Emily took copies of presentations to show teammates and says the conversation "got a bit heated." Some said they would outright refuse information or referral and tell patients their views.

"...there was a lot of 'Oh no I think I would have to say, I think that's wrong, and the Bible says...'"

While she's worried about colleagues getting into trouble, Emily's chief concern is for patients, and for that reason she generally supports the right to conscientiously object, and a register of objectors kept by a line manager. She's unsure how other staff such as GPs feel about abortion, believing it would be best if everyone knew who wouldn't help abortion seekers, so care is timely and accessible. She explained, **"I think if you're looking at it from a patient point of view, to get appropriate advice to people when they need it, some staff might be safer removing themselves from the situation."**

Ideally, she would like to see a designated contact, perhaps a female GP, to refer to, mandatory staff training, and more information on hand for patients.

"...I think the law changed here, but nothing really changed in the same respect, that health service-wise, everybody's just kind of doing what we did, nobody knows anything more about it, there's no more information available. At the end of the day, it's the patients who are going to suffer for it."

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