

Women and Equalities Committee

Oral evidence: [Abortion Law in Northern Ireland](#),
HC 1584

Tuesday 12 February 2019

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Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Angela Crawley; Vicky Ford; Anna Soubry.

Questions 339–397

Witnesses

I: Professor Colin Melville, Medical Director and Director of Education and Standards, General Medical Council; and Sharon Burton, Head of Policy, Standards and Ethics, General Medical Council.

Examination of witnesses

Witnesses: Professor Melville and Sharon Burton.

Q339 **Chair:** I welcome our witnesses and people who are watching online or in the public gallery. This is part of a series of evidence sessions for our inquiry into abortion law in Northern Ireland. We are incredibly grateful to the General Medical Council for coming before the Committee today. I particularly thank you for being so accommodating on the timing of the meeting. As you may be aware, the Prime Minister is making a statement, and trying to fulfil all our obligations today is proving quite difficult, so huge thanks from the entire Committee. We were keen to have you in front of us today.

Before we start the questions, could I ask you to say your name and your position within the organisation?

Sharon Burton: I am Sharon Burton. I am the head of policy for standards and ethics at the General Medical Council.

Professor Melville: I am Professor Colin Melville. I am the medical director and director of education and standards at the GMC. I am also a clinician with a licence to practise on the GMC's register. I used to practise intensive care medicine, which I ceased in January 2017. That is just by way of background context.

Q340 **Chair:** That is incredibly helpful. I am going to start the questioning. This is very much exploring the questions with you. We are trying to better understand how the system of regulation of medical professionals works in Northern Ireland. Our Committee looks at equality issues; we are not experts in health. We wanted particularly to explore something the chief medical officer for Northern Ireland said to us in a previous session held in Belfast.

He said that doctors were "not able to fulfil their duty of care" to women in cases of fatal foetal abnormality because of the law, and that that was, for him, a matter of significant concern. It was also set out in the working group's report on fatal foetal abnormality in 2016, which was eventually published in 2018.

From your professional and ethical viewpoint, I want to understand what action you, as an organisation, are taking about doctors who feel that they are, as the chief medical officer said, unable to fulfil their duty of care to patients. What action is being taken?

Professor Melville: It might be helpful to give a little bit of background to be able to answer the question. The General Medical Council regulates doctors as individual professionals. It is not a system regulator. I think Michael McBride also highlighted that point. Therefore our guidance is not law. It is guidance designed to help doctors to be consistent with what the law says. It is designed to set a high bar of professional standards.



We have as our overarching guidance a document called "Good Medical Practice," which again I think Michael referred to. It covers the whole of the profession and sets out the core principles. We have a number of other documents that, by way of explanation, sit behind that to try to help, and that are relevant in this case. That is the duty of confidentiality, the consent guidance and what to do with personal conflicts. Those three things are relevant.

We believe the challenge for doctors lies in how the duty of confidentiality operates when there is an overriding duty in terms of the law. In Northern Ireland it is a crime, except in certain circumstances, for abortion. It is also a crime to be complicit in that in their legislation. The professional is conflicted in their duty of confidentiality to the patient on the one hand, and in the potential that their actions or inactions may be interpreted in law as contrary to what their duty of confidentiality requires.

I do not know if I have made that sufficiently clear. The conflict lies in the difference between what the guidance sets out as their duty and what the law prescribes as requiring them to report.

Q341 **Chair:** But the duty of care, when the chief medical officer was specifically talking about it, was in relation to the ability of doctors to do the right thing for their patients in cases where a particular woman was faced with abnormalities in her pregnancy that would inevitably lead to the foetus not being born as a healthy or indeed a live baby. I understand the issue around confidentiality and abortion, but we are particularly interested in the way the law is working alongside the medical judgment of doctors.

Professor Melville: We say in our guidance that you have to exercise professional judgment in the context of the particular clinical case of each patient you see. The tension that was illustrated in those examples is where the duty of care would be to take an action to protect the mother and the health of the mother that would be contrary to the law in relationship to the unborn child or foetus.

Q342 **Chair:** Sharon, do you want to comment?

Sharon Burton: Many points have been raised about the challenge around foetal abnormality and circumstances where doctors would wish to be able to recommend abortion to women as one of the options for addressing issues in the pregnancy. At the moment, I think there is lack of clarity about how far doctors might be able to go, both in raising that and discussing it with the woman; and how to meet their responsibility if they considered and the woman considered that abortion would be a pathway that she wanted to follow and where it seemed that the law would prevent that. We understand, especially among the medical community who are trying to work with women and are faced with those difficult situations, that there is a real tension between what they see as



their professional responsibility to support the woman and provide the best possible care, and the constraints they meet at law.

There is guidance from the Department of Health in Northern Ireland—the 2016 guidelines, which I believe others have brought to the attention of the Committee. They give some reassurances about the fact that doctors can raise abortion as an issue or an option in the care of those women, and talk about the extent of the steps that it may be possible to take.

On the one hand, there is guidance that is helpful, but it does not go as far as those clinicians would like it to go. That is because of uncertainties about the steps that are within the law as it stands at the moment. We have worked with the Department in developing that 2016 guidance to try to make sure that there is some guidance available for doctors who are grappling with those challenges.

Q343 Chair: As the organisation that regulates doctors, you make sure that doctors are performing in accordance with their Hippocratic oath, the law and your guidance. What view does your organisation take about whether or not there might be a shortfall in the law in Northern Ireland in terms of abortion or clarity of the law? If you are not worried about that, are you worried about doctors failing to correctly interpret the law?

Professor Melville: Obviously we are a regulator, not a lawmaker. We cannot give legal advice to doctors. We monitor the performance of doctors. If an instance was to come into the public domain, we would pick it up through our monitoring. If a responsible officer, the person who oversees the conduct of doctors in an organisation, was to alert us to a problem, we would investigate that.

We looked through allegations that have been notified to us, back to 2006. We have not been able to identify any case that has been notified to us, but we appreciate—

Q344 Chair: We are going to come on to that. You assess fitness to practise. That is what you do. You assess whether somebody is fit to practise medicine. How are you balancing that with this uncertainty in the law? You say that you are not lawmakers, but you have to look at the law to assess whether or not somebody is fit to practise.

Professor Melville: Our guidance is framed within the law to make sure that the law is interpreted correctly in the guidance we give to doctors. Our role in fitness to practise can only be executed if we have a concern about a doctor. To some extent, we can do that through the proactive processes or if a case is notified to us, but we do not go out as an organisation individually to test doctors' fitness to practise. Through the revalidation process, a doctor would demonstrate to their responsible officer that they are meeting the standards we set. We take the advice of a responsible officer that that doctor is meeting our standards, unless we have some information to suggest otherwise.



HOUSE OF COMMONS

Q345 **Chair:** If you were to have somebody referred to you for not having given advice on abortion when a woman was diagnosed with a very clearly terminal condition in her foetus, do you think that person is fit to practise?

Professor Melville: Obviously every case has to be considered on its merits. If such a case was notified to us, we would investigate to determine whether or not there was a question of their fitness to practise and, if there was a question of their fitness to practise, we would take appropriate actions and sanctions against that doctor.

Q346 **Chair:** You are aware that a woman died in the Republic of Ireland as a result of not accessing the right care, so we are dealing with women's lives. It is not an abstract notion.

Professor Melville: No. I absolutely respect that. It is a very contentious area with strong views on either side. I am not sure whether the person you refer to in southern Ireland was a UK citizen or a southern Ireland citizen. We do not regulate southern Ireland.

Q347 **Chair:** No, I am just underlining that these things have grave consequences.

Professor Melville: Yes.

Q348 **Chair:** Sharon, do you want to comment on that from an ethical point of view?

Sharon Burton: It might be helpful in the situation you described to think about the guidance that is available on giving advice and supporting women in those circumstances. Certainly, our expectation as the regulator is clear about the need to ensure that women are receiving appropriate and relevant advice and information, which would include advice and information about abortion if it was something that was relevant in the case of that woman or something the woman wished to pursue—as does the guidance from the Department of Health.

In our guidance, and that guidance, it is quite clear that women should not be left in a situation where they do not have information and where they are not receiving advice about what is clinically appropriate care for them in their circumstances. Doctors who may have, for example, conscientious objection to abortion nevertheless still have a responsibility to provide women with information and advice.

In scenarios where that is not happening and we receive a complaint into fitness to practise, it seems to me that the standards we expect are quite clear. That is what we would be taking into account in looking at the case.

Q349 **Chair:** The evidence we have is clear that there are some women—we cannot quantify that—who are not getting that advice. Indeed, the Royal College of Obstetricians and Gynaecologists told us that draft guidance for healthcare professionals about abortion in Northern Ireland means



HOUSE OF COMMONS

that they no longer have confidence to practise. It is not just me; the Royal College of Obstetricians is saying that.

What are you doing to ensure that doctors have the confidence that they should have to practise within the law? It feels to me that at the moment there is a big gap and that doctors are, for whatever reason, feeling unconfident. I am not hearing from you that anything is being done to fill that gap, or am I wrong?

Sharon Burton: From our understanding of the evidence, it is pointing to the impact of draft guidance in 2013. We would point out that there is guidance later than that. The 2016 guidance deals with a number of the issues that doctors are feeling uncomfortable about and, to a great degree, offers reassurance in the areas that have been flagged. There is certainly a question about the extent to which the guidance that is helpful is actually known to the community. That is an area that can be, and should be, explored. Raising the profile of that guidance may well be very helpful to a number of doctors.

Q350 **Chair:** What do you plan to do on that, if we bring evidence to you that people are not aware? They might be aware of the guidance, but they do not believe that they are not going to end up on the wrong side of the law.

Professor Melville: We are absolutely committed to working with the Department of Health in Northern Ireland and other stakeholders. We have an office ourselves in Northern Ireland, and we have been having some conversations with them about what more we can do to raise awareness of the guidance as it stands.

The dilemma comes in two areas. One is where the guidance and the law cause conflict, which we have alluded to. The second is the possibility that it seems that there is evidence that doctors may not be acting in accordance with the guidance, but we are not aware of it. Therefore, to date we have not been able to take any action.

Q351 **Chair:** Before I hand over to my colleague, so that I am clear, you say that there are areas of the guidance and the law where there is conflict. Can you tell me exactly what that is?

Professor Melville: The law in Northern Ireland sets out areas where it is a crime to carry out an abortion, and a crime to be complicit in an abortion. The issue as we would see it is that a doctor may believe that the duty of care to a woman should include the possibility of an abortion, particularly in the context of fatal foetal abnormalities, but the law says they cannot do that. That is creating a conflict for them.

The other tension is that they are allowed to give a woman information on where else she can obtain treatment, but they cannot make a referral, because that would be complicit under the law. That question, as I understand it, has not been tested in court to know whether it would be acceptable or not. Again, I think Dr McBride referred to that.



HOUSE OF COMMONS

For us, that appears to be where the degree of conflict lies; it is between what our standards require in terms of a duty of care that might suggest, in conversation with a woman or girl, that an abortion is the appropriate way to proceed, and the law that says they cannot.

Q352 **Chair:** Whose responsibility is it to get clarity? We cannot expect professionals to deal with guidance and law that is in conflict. Who is responsible for getting that sorted? I know it is not you, but you must know who it is.

Professor Melville: To be honest, Chair, I am not sure that we do. In the absence of an Executive in Northern Ireland, it is not clear to us where that responsibility now falls.

Q353 **Chair:** If the Executive were in place, whose responsibility would it be?

Professor Melville: As I understand it, health is devolved in Northern Ireland, as is justice, and therefore the Executive would be empowered to make that decision.

Q354 **Chair:** How dangerous is it that we have this conflict between guidance and the law?

Professor Melville: You made reference to the possibility or probability that a woman had died, so in that sense it has potential to be dangerous for women and girls.

Q355 **Chair:** How dangerous?

Professor Melville: I do not think I can answer that because we do not have sufficient information to be able to take a view.

Q356 **Chair:** But you are prepared to say that it is a dangerous position. You have just said that it has the potential to be dangerous.

Professor Melville: It is certainly unacceptable when a doctor is in that position.

Chair: I want to bring in Anna before I bring in Tonia. Anna, can I remind you to make your declaration of interests, because you have just joined the Committee?

Anna Soubry: Yes. I make my declaration of interests as registered in whatever register it is. It is public.

Chair: Perfect.

Q357 **Anna Soubry:** It is many a long year since I did jurisprudence but there is a higher authority established in jurisprudence, which is what is called natural law. It goes even above any law of any state. It may be that that is something worth exploring, because there is a clear conflict, as you have identified, between what you as a professional body would expect from your doctors and the reality in Northern Ireland because of the state of the criminal law.



HOUSE OF COMMONS

I do not believe that as yet the Committee has heard from various practitioners actually working in Northern Ireland. I heard from one when I went to Belfast, who told me in no uncertain terms that there is a growing body of evidence that doctors, especially younger doctors, simply give no advice whatsoever when faced with a patient with a pregnancy that she, in all the circumstances, seeks to terminate. There is no advice at all. Does that concern you?

Professor Melville: Yes, it does. It would not be consistent with our guidance. Our guidance sets out that you can have your own beliefs, but if you have beliefs that are contrary to or in conflict with those of the patient you are dealing with, you have a duty to establish contact with another professional who can advise such a patient.

Chair: I do not think there is any indication that this is about beliefs; it is about fear of being prosecuted.

Q358 **Anna Soubry:** It is absolutely as our Chair described. It is the law. It is not their own personal beliefs. They seem very able to almost completely step back and take out their own views, which is, arguably, concerning. Instead, they rely on the law as it exists in Northern Ireland.

Professor Melville: My interpretation of that circumstance is that there is an issue that has not been tested in law, which is the extent to which they can give advice or refer to another practitioner. I suspect it is that sensitivity, and the risk of being exposed to criminal prosecution under those circumstances, that is preventing them from referring or signposting to another practitioner.

Q359 **Anna Soubry:** It may be evidence that we seek to get, Chair, but my understanding is that some of it is quite clearly in public pronouncements of the Attorney General for Northern Ireland—that doctors will be in that position.

Does it concern you that the evidence that this Committee may hear, and certainly that some of us as individuals have heard, is that the referral is simply not occurring, not even the telephone number of some charity that might give a woman some advice? There is not even that; it is a complete blank-off.

Sharon Burton: It certainly is a concern when you consider that the 2016 guidance actually makes it clear that doctors can have those conversations, can talk about the options and can provide information and advice. It flags up the difficult area of formal direct referral, but it says that doctors can have those discussions.

Q360 **Anna Soubry:** Where does it say that?

Sharon Burton: In the 2016 guidance.

Q361 **Anna Soubry:** But does it concern you that with all your great guidance the practice is that it is not happening? I heard from a midwife as well. Women are simply not even given the telephone number of somebody



HOUSE OF COMMONS

who might give some advice. Does that bother you?

Sharon Burton: If it suggests lack of awareness of what is actually possible and reasonable, both in terms of the guidance issued in 2016 and the expectations we have as the regulator, it is a concern. If it is a suggestion that, in spite of good guidance and the expectations we set, the level of anxiety about the risk of criminal action is preventing doctors from following the guidance that has been published, that is a concern. The question would be how you can reassure individuals when there are areas of the law that remain open to interpretation, and there has not been a test case.

Q362 **Tonia Antoniazzi:** We have heard concerns about standards of care by doctors in Northern Ireland when it comes to abortion. How many complaints have you had about doctors treating or advising women and girls in relation to abortion in Northern Ireland?

Professor Melville: I apologise for trying to answer that question earlier. We looked back to 2006. The reason we can go back to that date is that we have electronic records from 2006 forwards. Our earlier records are on paper, so we have not been able to search quite so exhaustively.

We have not been able to identify any allegation notified to us that relates to a termination of pregnancy in Northern Ireland, but it seems that you may have heard of cases. If you were able to pass those details to us, we may be able to look into them further. As I say, we have not been able to identify any cases since 2006.

Q363 **Tonia Antoniazzi:** Are the number of complaints in the rest of the United Kingdom on the same basis? Do you have that data?

Professor Melville: Yes. I asked that question before I came out, thinking that you might ask. I do not know, but we can certainly get that information and forward it to the Committee. That is not a problem.

Q364 **Tonia Antoniazzi:** Have doctors or other medical professionals raised concerns with you about the standard of care offered by other doctors in Northern Ireland? Has there been nothing?

Professor Melville: That should, or would, fall under the same question. An allegation can be either at a high level by a responsible officer, or by a member of the public or another doctor. That is the catch-all answer I gave you before.

Q365 **Chair:** To be clear, the answer is that you have not had any doctors in Northern Ireland raise concerns about the standard of care offered by other doctors.

Professor Melville: We have had no allegations of concern about the practice of a doctor from another doctor or from members of the public since 2006, in the search we have done.



HOUSE OF COMMONS

Q366 **Tonia Antoniazzi:** Isn't that a red flag to an organisation such as yourselves? There is obviously a disparity. You do not have the data about the rest of the UK.

Q367 **Chair:** Particularly given the Supreme Court case. This is not an issue that has been hiding from the headlines; it has been smack bang in the headlines, yet you are not receiving any concerns. The Supreme Court say that in any other circumstances they may well have found the situation in Northern Ireland to be breaching human rights law.

Professor Melville: I absolutely accept that point. It may be that we are not hearing for the same reasons as we gave before on other things; it is about fear of what might happen. There is some work for us to do. We have already referred to the need to raise awareness with health professionals, but we can also work with other bodies in Northern Ireland to try to raise awareness for women and girls about the issues and their rights to raise concerns if they feel there are concerns.

Q368 **Tonia Antoniazzi:** As a public body, you are subject to equality legislation. Your guidance on personal beliefs and medical practice states clearly that doctors should not discriminate. How do you ensure that any discrimination is identified and addressed in relation to women seeking abortion in Northern Ireland?

Sharon Burton: Again, it is about understanding the scope of our role. As you say, the guidance speaks to the individual doctor. We are attempting to set out as clearly as we can what the expectations are on doctors in Northern Ireland and the rest of the UK.

We do not directly regulate the system, nor are we an investigatory body in that sense. In terms of ensuring that doctors are aware of our guidance, there are many steps that we take to try to keep the profile of our guidance at the front of doctors' minds. I do not know whether you wish us to describe them. We have liaison staff in Northern Ireland who have been very recently appointed. Part of our goal is to raise the profile of the GMC in Northern Ireland and to build the relationships that we have with professional bodies and patient organisations in Northern Ireland as a way of raising knowledge overall about our guidance and what the standards are.

Q369 **Tonia Antoniazzi:** That is interesting, Sharon, because you are talking about patients. How do they know how their doctor should be behaving? For example, how would a woman know that their doctor is not complying with the guidance by not advising her that abortion may be an option? Does your service provide a liaison service with patients? Does it go as far as to provide that information?

Sharon Burton: As an organisation, as a regulator, we are open to giving advice to anyone—doctors, patients or members of the public—who wishes to know the standards we set for doctors, either broadly or in particular areas. We take a number of calls and inquiries from doctors and the public every year on a range of issues, and we advise what the



HOUSE OF COMMONS

standards are and what it is reasonable to expect from a doctor in a range of situations. We certainly can provide advice in that way.

It goes back to your earlier question about awareness of the General Medical Council and of the fact that we give guidance. We are hoping that through the work of our Northern Ireland office we will be able to raise our profile as a body that sets standards and can be consulted about these issues.

Q370 Vicky Ford: Have you read the evidence that was given to the Select Committee in Belfast two and a half weeks ago?

Professor Melville: I have played back the video of the session with Dr McBride.

Vicky Ford: In answer to my questions he was enormously clear that the evidence he has had from doctors and other medical professionals in Northern Ireland is that they cannot perform their duty of care obligations to their patients. What have you done, as the GMC, since you heard the chief medical officer on the record giving that advice to a Select Committee of this Parliament, to make contact with the chief medical officer and make sure that you know what he knows that doctors and other health professionals are saying?

Professor Melville: I had a telephone conversation with him yesterday afternoon at 3 o'clock on that very issue.

Q371 Vicky Ford: Do you agree that there is evidence, based on what he said, that doctors and other medical professionals—I think he cited the Royal College of Obstetricians and Gynaecologists in Northern Ireland—are concerned that they cannot perform that duty of care?

Professor Melville: Yes, we have that concern.

Q372 Vicky Ford: And, therefore, you have a role in helping to resolve that. Correct?

Professor Melville: We have a role in the sense that we have guidance, and we can help to steer people through that guidance. The issue we perceive is not an issue of guidance; it is an issue of the law. That is not within our remit. We can do more to raise awareness of the guidance—the document we referred to—and the 2016 Department of Health guidance. We contributed to that, and part of our guidance is actually quoted in that guidance. He identifies, rightly, areas where the guidance is not sufficient to offer doctors the kind of support they need in maintaining high standards of duty of care to women.

Q373 Vicky Ford: He recommends a very specific change regarding fatal foetal abnormalities. That is an area where the law needs to be changed to address that gap. Do you agree with his analysis on that, or have you any reason to doubt it?



Professor Melville: I do not have any reason to doubt it. As a clinician, although it is not my professional area—I worked in intensive care medicine—I would personally share that view, as he does, if I was working in Northern Ireland. In that sense, yes, I agree.

Q374 **Anna Soubry:** If a doctor in Northern Ireland does not advise a woman seeking abortion that she can travel to England for treatment, and if her situation does not fall within the narrow scope of the law in Northern Ireland, would she be able to complain to you about that doctor? On the basis that she could travel to England for treatment because it does not fall within the terribly narrow scope of the existing law in Northern Ireland, and the doctor does not give her that information, the question is: would she be able to complain to you about that doctor?

Professor Melville: Anyone can record a complaint about a doctor to us. We would then consider, on the precise nature of the complaint and the context, whether or not there was particular concern about a doctor's fitness to practise. It would depend on the precise details. My sense in listening to what you read is that this falls into the potentially ambiguous area of signposting versus referral, where giving information is lawful but the peculiar and particular issue of making a direct referral would not be. It is the potential ambiguity about how you define those two things that makes it difficult for doctors in Northern Ireland. If it was referred to us, we would look at it on its case merits and determine whether or not any action should be taken.

Q375 **Anna Soubry:** The Committee has been told that there are real concerns that medical students are no longer getting the necessary training in the termination of pregnancies. I did not hear that but I do not doubt it, because I heard evidence, for what it is worth, as well when I went to Northern Ireland. Do you have a role as the GMC in ensuring that students get proper training when it comes to abortion? Obviously that is in all aspects of it.

Professor Melville: One of our core functions as the GMC is to oversee all stages of medical education. We oversee both undergraduate and postgraduate medical education. In the context of undergraduate education, we determine the outcomes that they must achieve by the end of the course. There is a document that clearly sets those out.

We conducted a quality assurance visit to Northern Ireland in 2017. That report is freely available on our website. No issues were identified about the teaching of undergraduate medicine at Queen's Belfast.

Q376 **Anna Soubry:** Is it an identifiable outcome?

Professor Melville: Because we set the high level outcomes and not the precision of the curricular content, we can only say that on the visit we did, they met our outcomes.

Q377 **Anna Soubry:** Is being able to terminate a pregnancy part of the outcomes, or are they much more general?



Professor Melville: They are more general.

Q378 **Anna Soubry:** It does not exist anyway, so you would not be aware of it.

Professor Melville: It may come up because people would mention it or refer to it. As I said, that report is publicly available. There is no mention of it in there and we were satisfied with the quality.

Q379 **Anna Soubry:** But if it is not an outcome, so that you cannot tick the box, obviously you would not know about it.

Professor Melville: I accept that point. A multitude of precise elements of the curriculum are not reflected in the high level outcomes. It would need a considerable tome to produce such a document. What I am very clear about, however, is that the textbooks recommended for students to use in Northern Ireland are the same as the ones used in the rest of the UK, and would have the same level of detail.

Q380 **Anna Soubry:** Obviously you can practise and train in Northern Ireland and then get a job in another hospital in the rest of the United Kingdom. If it is right that students are not receiving the sort of training that they would if they were at Nottingham University Hospitals Trust, which obviously I have a bias towards, wouldn't that concern you as the GMC? Somebody who was trained in Northern Ireland and goes for a job in another part of the United Kingdom might not be up to the same level of knowledge on the issue of termination as students who trained in other parts of the United Kingdom.

Professor Melville: We would expect our professional standards and ethical guidance to be taught similarly across all four jurisdictions. We would not expect there to be a difference. I am sensing that you may be suggesting that there is. If so, I am not aware of it.

Q381 **Anna Soubry:** That is the evidence we have had, isn't it?

Professor Melville: Again it might be helpful, if that is a concern, if you were to forward the detail, and we can look at it in more precise terms.

Chair: We are getting rather good at sending regulators information and then they take action. We are quite delighted about that, so we would be happy to do that.

Q382 **Anna Soubry:** It could be quite significant, on the basis that somebody trained in a particular part of the United Kingdom must be at exactly the same level as anybody else in the United Kingdom.

Professor Melville: I don't know the answer to your precise question, but I hope and suggest that both in undergraduate and postgraduate medical education—I was the head of three medical schools, albeit all in England—the standards and ethical guidance variation is covered for the very reasons you suggest: a person might train in one place but work in another. That would apply not only in the undergraduate context but in the postgraduate context. Someone could be receiving part of their



HOUSE OF COMMONS

training in England and then move to Northern Ireland or to another part of the UK.

Q383 Angela Crawley: Your role as a regulator applies to the UK. I appreciate that there are differences in the devolved areas, Scotland being a prime example. Which other regulators and bodies do you work with to ensure that women and girls in Northern Ireland seeking abortion receive the highest standard of care? Is it the same approach as in the rest of the UK?

Professor Melville: We have been developing a much more coherent approach with other health regulators across the whole of the UK. That process is ongoing and developing. I have already referred to the fact of my conversation with the CMO yesterday. We work very closely. We have an office in Northern Ireland that will be much more closely connected for us with regulators in Northern Ireland. We do not distinguish in different jurisdictions, so we have similar arrangements with bodies in Scotland, Wales and England.

Q384 Angela Crawley: You will appreciate that the Committee has heard evidence of the chilling effect of the 2013 guidance in Northern Ireland. Even though many of the other jurisdictions have offered those medical services to women, if they are in a position to travel, there are still examples of medical practitioners not providing that information. Do you accept that that is an issue?

Professor Melville: Yes. Again, we have said that our role is to regulate doctors and not the system in which they work. Therefore any concerns about the practice of an individual doctor could be raised with us.

Q385 Angela Crawley: Sharon, do you have anything to add?

Sharon Burton: As well as the national level, and the ways we are trying to work with the regulators and build stronger relationships with them, we try to understand the particular situation in each of the countries and to work with other regulators where an issue has been identified to us as something that, in a sense, cuts across professional systems and policy as to how services are delivered. We try to work with the relevant bodies, the Department of Health in Northern Ireland, the RQIA and others in that context to see how together, collectively, we might be able to improve the way services are provided.

Q386 Angela Crawley: In this instance, who should be responsible for regulating the standard of care in this area and, for example, monitoring the discrepancies we heard about between different trusts across Northern Ireland?

Professor Melville: I would probably have to defer to the CMO's answer in the sense that we regulate individuals but not the system. My understanding from what he explained was that the trusts in Northern Ireland are arm's length bodies of the Department. That is different from England, of course. Therefore they are, as it were, accountable.



HOUSE OF COMMONS

Q387 **Angela Crawley:** But do you accept that there are anomalies within different trusts in terms of healthcare provision for women? Some women could go to one trust and receive a certain standard of care, but could go to another trust area and receive a very different standard of care.

Professor Melville: If that is the evidence you are hearing, I am not going to dispute it.

Q388 **Angela Crawley:** Is there a regulatory gap in the standard of care for women accessing abortion in Northern Ireland?

Professor Melville: I would probably say no, but there is more that we can do, in the sense that the gap in Northern Ireland pertains to the interpretation of the law, which is not in our remit. We can do more with the profession, as we stated earlier, to try to ensure that there is a clearer understanding of the 2016 guidance from the Department of Health, a clearer understanding of our overriding guidance on good medical practice and the related documents to which we referred, and clearer understanding for the public, particularly women, about what their options are when they do not feel they are getting the kind of advice that is necessary for the decisions they need to make.

Q389 **Angela Crawley:** Is that an undertaking that you will take away from the Committee—that you will do those things?

Professor Melville: Yes, we are quite content to do that.

Q390 **Chair:** I want to ask for some clarification. You have talked about being concerned about the law and you felt there was a problem with the law. You have just said that you are concerned about the way the law is being interpreted. Is it that there is a problem with the law, or is there a problem with the way the law is being interpreted, which is leaving doctors feeling that they cannot undertake their duty of care to patients? I am not trying to be clever, but we need to give doctors the confidence to be able to practise their profession. In your opinion, are we going to be able to give them that confidence if we simply clarify, or does there need to be a change?

Professor Melville: I think the answer is both/and, as I would understand it. As the CMO said in his evidence, there is uncertainty about some of the interpretation of the law because it has not been tested. There is also a question about how the law could be changed to be more appropriate for use in Northern Ireland. I am not trying to be ambiguous; I think it is both. The law as it stands is an issue and the document that referred to the report on fatal foetal abnormalities is one example where they show that there is a concern about what the actual law states. Secondly, there is the particular question about the ambiguity around when signposting is referral, given that referral itself, under the current 1861 law, would also be considered a crime.

Q391 **Chair:** Sharon, are you worried about the ethical position that doctors in Northern Ireland are put in as a result of the situation you have heard



HOUSE OF COMMONS

about?

Sharon Burton: If doctors feel that they cannot fully meet their ethical responsibilities in Northern Ireland, which is certainly what a number of doctors and others are saying, that really is a very difficult position for them to be in. We have a great deal of sympathy and concern about that.

In a sense, it goes back to where the answer lies in terms of resolving the tension that clearly exists between the law, and what we understand the law to permit or make possible in the care of women with fatal foetal abnormality as a diagnosis, and what doctors in Northern Ireland see as their ethical responsibilities.

Q392 **Chair:** We are focusing this session very much on the particular issue of fatal foetal abnormality, but obviously we are interested in your views more broadly about the issue. I am conscious of the fact that we are very short of time in this session.

Are there any other areas of healthcare in connection with your role where you have had this sort of concern expressed to you? You are hearing quite a deep level of concern, I would say, from us as Members of Parliament. Can you think of anything similar, just to give us some context? What would you put alongside it? Are there any other areas that come to mind?

Sharon Burton: If we look at abortion law and the 1967 Act for England, Wales and Scotland, there have been concerns expressed in recent years about the way the Act is interpreted on the ground of approaches to assessment. There is some lack of clarity, or different views, about how to apply them in practice.

As a result of that, in 2014, the Department of Health in England took the step of working with a number of other organisations, including ourselves, to issue guidance to try to address some of those areas of concern or doubt about what good practice looks like, certainly in England. That is an example that is still within the area of abortion and some of the challenges around interpreting the law.

Q393 **Chair:** That is really helpful. Can you think of any other area where there is a level of uncertainty among highly trained medical professionals about how to act within the law?

Professor Melville: I was trying to think back in my own career as a doctor about the things that worried me. The only one that comes anywhere near it, but is much clearer now, was the duty of confidentiality and the right to breach confidentiality. It does not feel to me as if it is in the same space as the issue you are wrestling with, in that it does not feel of the same order of magnitude in my judgment. As I said, if I was in Northern Ireland, it would be the thing that would dominate my thinking, even though it would not be part of my primary clinical practice.

Q394 **Vicky Ford:** When we took evidence in Northern Ireland, we heard from



HOUSE OF COMMONS

BPAS, which I understand receives funding from the Northern Ireland Executive in some way to provide advice to women. We heard that some medical professionals are not prepared to hand on contact details of BPAS even though, clearly, it is funded by the authorities to give advice in those circumstances, whereas other doctors feel comfortable to hand on that advice. There seems to be even that inconsistency.

Could you investigate that inconsistency? It seems to me to be an area where some clear guidance, as in, "If you do not want to give the advice yourself, at least take the Government funded organisation that is there to give the guidance," might be helpful.

Professor Melville: I absolutely take that. I was thinking that I could talk to Michael about how we can work together to clarify the particular issue you raise. I am not certain that such a thing will get rid of the problem completely, but I hope it would go a long way. I suspect it comes back to the question of signposting versus referral and the interpretation of which is which in law. Again, that is not my area.

Vicky Ford: They have had the guidance, which is clearly chilling, about getting involved, but they need some advice about what is clearly within the law, giving advice about contact with BPAS.

Anna Soubry: I am presuming you can give advice because it is legal advice. It is what is within the law as it exists in Northern Ireland on the handing over of, literally, a telephone number.

Q395 **Chair:** Surely there are other issues that you provide guidance on about how you stay within the law—euthanasia and issues like that.

Professor Melville: If it is acceptable to you, Chair, I will have a further conversation with the CMO and explore the extent to which they can augment or supplement the guidance from 2016 to cover that particular issue, or whether it is possible to add further clarification outwith any legal challenge or decision. I think that is the tension.

Q396 **Chair:** How do we bring these issues up with the people you regulate? You can imagine as a professional yourself that they are of pressing concern. How do medical professionals bring up these pressing concerns so that they can be resolved? What is the mechanism? We are not medics.

Professor Melville: Let me make a comment, and then Sharon can answer the second part. On the negative side, it is the bit we have covered. If there is a concern it can come to us, but we also have an ethical inquiry service that is part of Sharon's role and I think she will probably be much better able to talk about how that works.

Sharon Burton: One of the things that might be useful to put in the context around it is that doctors bring issues to our attention, sometimes through what we call the ethical inquiry service. When we are carrying out consultations on guidance, as we have done recently on consent to treatment, and prior to that on confidentiality issues, doctors also take



the opportunity to bring questions to our attention. For example, during that consultation we discussed some of the issues on confidentiality around abortion and the law. In our Northern Ireland office, they have good relationships with medical organisations, so issues are brought to our attention through that outreach work as well.

There are a number of ways in which, as an organisation, we are accessible and engage with doctors at the frontline. They get an opportunity and they take opportunities to raise concerns.

Q397 **Chair:** Do people on the ground in Northern Ireland contact your outreach office and raise the issues that we have been raising today?

Sharon Burton: In anticipation of some of the questions, we looked back to see whether we had examples where doctors practising in Northern Ireland raised issues with us, particularly in this area. We have a very small number of inquiries that have formally come to us through our inquiry service, where doctors have explored questions around assessment of women within the criteria of the law, and flagged to us issues around the criminal law Act requirements for reporting serious crime.

There are channels and we respond. We try to be as helpful as we can in addressing particular issues, whether in terms of immediate guidance or when we look at the review of our professional standards.

Chair: It has been an incredibly helpful session today. I apologise again for having to change the time. I am sure we could speak for the rest of the afternoon, but pressures elsewhere mean that that is not going to be possible. You have very graciously said that you will come back to us on a number of issues. That would really help and assist with our inquiry. I hope that when we publish our report it might help with the work that you are doing as well. I hope that most sincerely. Thank you very much. I close this public session.