CAN REGULATORY SYSTEMS MAKE MIDWIFERY AND CATHOLICISM INCOMPATIBLE? - AN INTERNATIONAL ANALYSIS.

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INTRODUCTION

Globally, 450,000 women died in childbirth in 2010 [1]. This figure is causing alarm in the various agencies that have pledged to meet the targets of the Millennium Development Goals[2]by 2015 as, out of all ten Millennium Development Goals, it is the target that appears the most likely not to be met. One of the solutions currently being promoted[1] is that of educating more midwives who, it might be expected, can appreciate and realise what human life is in itself[3].

In many countries, midwifery is a high status profession which the demand for education greatly outstripping the number of places available. People choosing to become midwives do so for many different reasons. Whether prospective midwives begin their studies immediately on completion of their schooling, seek a career change, or draw on their own experiences of motherhood, most are enthusiastic about helping women through pregnancy, to give birth or in the postnatal period[4]. It would thus seem that the obvious solution to the global problems is to increase the number of places available for the initial education of midwives.

There are, however, currently challenges to the commonly perceived role of the midwife as being with women during her childbirth experience. In 69% of the world's developed countries, abortion is available on demand with an estimated 43.8 million reported abortions in 2008[5]. Of these 22 million are estimated to be "unsafe" with 47, 000 reported deaths [6]. In an effort to reduce these deaths, it is to midwives that many countries are turning to provide safe abortion services.

This inevitably has potential impact on Catholics seeking to become midwives and who wish to remain true to their religious beliefs. This paper therefore examines some of the changes that are taking places both overtly and covertly and discusses some of the implications for Catholics who are

midwives or who may wish to become midwives. It examines the issue from a legal perspective as well as that of major United Nations organisations and professional bodies. It draws primarily on sources which focus on the midwifery profession while acknowledging also the relevance for other related professions such as nursing and medicine.

THE LAW IN SELECTED COUNTRIES

Throughout the developed world there is a great difference in if and how laws on abortion and the rights and requirements of practitioners have been interpreted. In some countries health practitioners generally are discussed but in other some other than doctors are specifically named and these most commonly refer to midwives as well as nurses. A few examples are presented here to show the complexity.

The UK Abortion Act[7] states that "no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection" with the burden of proof being the responsibility of individual practitioners. Other countries such as Zambia [8] and Israel [9] make similar provision to the UK. At the time of the introduction of the law in the UK those who registered their objection on conscience grounds did not have to participate in any procedure associated with abortion. This did not simply mean not providing direct care for the woman but extended to issues such as setting trolleys for operating theatre lists.

However, in early 2012 the case of two Glasgow based midwives who exercised their rights not to participate in abortion care was brought to the attention of the UK media. The situation arose in 2008 when, for resourcing reasons, services were rationalised between two maternity hospitals and in 2010 abortion services were moved from one maternity service provider to another in the city. The two midwives both held roles involving the overall coordination of the labour ward including delegation and supervision of more junior staff and the smooth running of the clinical area concerned. In addition they held the responsibility for the quality of care for all women and babies in

the area. Until 2008 the midwives were freely able to exercise of their rights in accordance with section 4 of the Abortion Act [7] not to participate in the treatment of women undergoing abortions.

However, negotiation with the new management team to address the growing number of staff unwilling to provide care to women undergoing abortions resulted in the conscience clause being interpreted more narrowly. This affected particularly midwives holding management roles, with management now maintaining that midwives concerned were not required to provide direct care but to only to allocate other staff accordingly. However, as the senior midwives on duty these midwives had a crucial role in that they carried ultimate responsibility for all women in their care and it is this to which they are objecting. Following internal grievance procedures at which the midwives' concerns were not upheld, the midwives sought legal advice and took their case to the Court of Session in Edinburgh in January 2012 which ruled against the midwives.

The case, now subject to appeal, is being followed with interest by many for ethical, religious or legal reasons. For many involved in policy making and strategic planning, it additionally raises questions for the whole future of the midwifery profession.

In other countries the law appears to offer more protection to midwives with the New Zealand[10] law for example stating that no doctor, nurse or "other person" is under obligation to assist in abortion, sterilisation or provision of contraceptive advice. Additionally they should not be denied employment if they have a conscientious objection to the carrying out of such duties. The fact that midwives are not named also suggests that abortion is not within a midwife's scope of practice. The complete separation of midwifery from nursing in New Zealand means that this while this is technically the case, the restructuring of public hospitals that has occurred in the last 20 years has resulted in changes. Nurses have been finding themselves more exposed to abortions as gynaecological services become integrated into mainstream general hospitals. To date, however there are no reported cases of nurses' conscientious objections to participating in abortions not being upheld as the nursing council has reiterated the rights of all nurses in the Contraception, Sterilisation and Abortion Act.

In Slovenia, the criminal code of the Republic[11] acknowledges the personhood of the unborn child from the moment of conception in accordance with church teachings[12, 13]. However, all women have the right to have abortion up to ten weeks of pregnancy without stipulating reasons. In later pregnancy, risks versus benefits are weighted up by a special commission comprising three appointed members from the local hospital. Of these one must be a gynaecologist, one any doctor and the third a social worker. If women do not accept the outcome they have the option to appeal to a national commission comprising three doctors (one of whom must be a gynaecologist) and a social worker. Abortions are generally carried out in gynaecological wards in which both nurses and midwives may be employed. Both a conscience clause[14] and code of ethics for midwives[15] exist, the former of which is legally binding. Both are strictly respected and as a result there have been no reported cases of any problems.

In Canada there are no legal restrictions to abortion with every woman has the right to seek abortion if she wishes. Many abortions care carried out in state hospitals in obstetric units. There are currently no laws to protect individual health care professionals' rights against having to participate in abortions. Several attempts since 1994 to introduce a protection of conscience law through amending the criminal code have failed. However midwifery itself has only been gradually recognised in Canada with the first province, British Columbia, legalising the profession in 1993. Midwives currently mainly practise in the community rather than hospitals and in the main are not required to participate in care of women undergoing abortions. The national code of ethics for nurses[16] offers guidelines for nurses with regard to procedures required to be undertaken that are contrary to a nurse's conscience. However they also warn, "nurses need to be aware that declaring a conflict of conscience may not protect them from formal or informal penalty" (p. 45).

Similarly in South Africa there is are no laws concerning protection of conscience and women have the right to abortion on demand up to 13 weeks of pregnancy. Their Act of 1997 specifically names registered midwives as being allowed to carry out the procedure itself up to 13 weeks gestation or determine that it is necessary thereafter[17]. Furthermore, section 10(1) c. specifies that "Any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years." As in Scotland, the high profile case of a midwifery sister who refused to participate in the care of women having abortions has not yet been

resolved, although it is now five years since it was referred to the Commission for Conciliation, Mediation and Arbitration.

While most of the laws provide a free choice for women there are considerable variations in the freedoms afforded midwives and other professionals concerning their rights not to participate in abortions. A proposed treaty between the Holy See and the government of Slovakia sought to define article 7 of the basic treaty in which "The Slovak Republic recognises the right of all to obey their conscience according to the doctrinal principles and morals of the Catholic Church. The extent and conditions of the application of this right will be defined by special Accord between the Holy See and the Slovak Republic" [18]. The historical context of this defined by Moravčíková [19] who links it to other similar treaties. However, when an independent expert committee for the EU evaluated the draft treaty[20], its members could not support it as they claimed it would violate the principles of equity both in Slovakia and generally in the EU.

There is thus clear difference between countries and even in those where conscience clauses do exist they are interpreted differently. For those seeking to become midwives, the options thus remain blurred, as it is unclear whether or not abortion services are part of their remit, and if so whether they can refrain from participating in these without sanctions.

To seek further clarification on the matter the position of relevant international organisations is now considered.

THE POSITION OF INTERNATIONAL ORGANISATIONS

Since its founding in 1948 the various United Nations agencies have produced a number of documents in relation to health policy and health professionals. One of the Millennium Development Goals focuses specifically on women's health [2] and, as indicated in the introduction to the paper, it is the targets associated with this which now appear to be in danger of not being met, prompting many other initiatives and reports. Because of the high mortality rate associated with abortion, many of the UN agencies are now pledging to make abortion services safer. The

Global Health Strategy for women's and children's health [21] for example, devised by a large group of stake holders, outline safe abortion care as a high global priority. Less attention is given to the need for midwives and other health professionals.

Yet the World Health Organization (WHO) first published an international definition of a midwife in 1966 [22]. It comprised a single paragraph which stated that: "A midwife is a person who is qualified to practise midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the post natal period, to conduct normal deliveries on her own responsibility and to care for the newly born infant". This was later developed further though remained fundamentally unchanged and was approved by the International Federation of Obstetricians and Gynaecologists (FIGO) and the International Confederation of Midwives (ICM) in 1972.

The latest revision of that in 2005 [23], which extends to four paragraphs, specifies the midwife's scope of practice as:

> Midwifery encompasses care of women during pregnancy, labour, and the postpartum period, as well as care of the newborn. It includes measures aimed at preventing health problems in pregnancy, the detection of abnormal conditions, the procurement of medical assistance when necessary, and the execution of emergency measures in the absence of medical help.

It also suggests that the work "may extend to …sexual and reproductive health".

While extended, there is little difference between the two versions and for most midwives who entered the profession prior to the 2005 definition it still embraces the art and science of midwifery. Nowhere does it suggest that midwives should be required to take part in the delivery of abortion services. Yet this is just what is being proposed by the World Health Organisation [24] which reports that:

countries need to:

> authorize all qualified health-care personnel, including nurses and midwives, to provide appropriate elements of abortion care;
>
> remove existing policy restrictions that allow only doctors to perform abortions;

establish regulations and training that support the capacity of mid-level providers to play a greater role in providing abortions.

Recent guidelines by WHO [6] build on this and suggest that well trained midwives are the ideal health care providers to carry out abortions both in the first and second trimesters of pregnancy and in community or in-patient settings. These guidelines build upon a randomised controlled trial carried out in two countries (South Africa and Vietnam)[25] in which midwives were the alternative care provider for the experimental arm of the trial. The study concluded that both medicine and "mid-level providers" (into which category the midwives fell) could both offer the same quality of service to women undergoing abortions. While reviewed by ethics committees this study did not address the issue of conscientious objection. Likewise in the newly released WHO guidelines, the short section on conscientious objection conveys a very negative message: "this practice can delay care for women in need of safe abortion, which increases risks to their health and Life". While acknowledging human rights, it also states that "international human rights law also stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others" (p. 106).

In another recent major policy document the United Nations Population Fund (UNFP) [1]reported on the State of the World's Midwifery pointing out (p. iii) that "increasing women's access to quality midwifery services was now the focus of a global effort". This document reiterated the large numbers of women who die each year during the course of pregnancy. Of this 13% occur during or immediately after abortions[6]. Yet the UNFP has developed a model in which midwives' competencies have been mapped to WHO's essential care packages and suggests that midwives should provide culturally safe and sensitive abortion related care.

The United Nations agencies work closely with professional organisations such as the International Confederation of Midwives (ICM). Representing midwives in 94 countries, the ICM is a powerful organisation which has been in existence for almost 100 years. Its stated mission is to "advance world-wide the aims and aspirations of midwives in the attainment of improved outcomes for women in their childbearing years, their newborn and their families wherever they reside"[26]. To enable it to meet its aim the ICM has developed global standards for midwifery education and international competencies which midwives should be expected to achieve[27].

The first edition of the competencies was introduced in 2002 based upon a Delphi study and comprised six domains in which the midwife could be expected to practise [28] and was validated in an international context [29]. The ICM's Board agreed to revise the competencies regularly and in 2011 the board approved the second edition of the competencies [27], which were based on a far less rigorous research approach, yet the results of which informed the introduction of a new core competency. This states, "Midwives provide a range of individualised, culturally sensitive abortion-related care services for women…". Within this competency the midwife is expected to possess the skill or ability to: "prescribe, dispense, furnish or administer drugs (however authorised to do so in the jurisdiction of practice) in dosages appropriate to **induce medication abortion**" (bold in the original). The list of skills also includes the carrying out of "vacuum aspiration of the uterus up to 12 completed weeks of pregnancy", the normal procedure for surgical abortion at this stage of pregnancy. It also includes counselling of the woman regarding availability of abortions services but neither in this or any other of the competencies is it suggested that the midwife have an option not to participate should this be contrary to her own conscience.

IMPLICATIONS FOR MIDWIFERY EDUCATION AND PRACTICE

What do the above legal documents and professional guidelines mean for midwives who want to practise their profession or for those who aspire to become midwives? In many countries great weight is placed upon the documents produced by the World Health Organisation and other United Nations Agencies. As the International Confederation of Midwives undertakes work in more countries their publications are also attracting international attention. For example at an international stakeholders' meeting concerning midwifery education in January 2012, several large organisations working in third world countries stated their support for the new ICM competencies. Furthermore, in the programmes which they were developing they were requiring local partners to adhere to these. This is the same issue with which Pope John Paul II stressed in his Encyclical Evangelium Vitae[30] in which, while regretting the ongoing global social problems, he identified sanctity of human life and personal dignity as central to moral reasoning of the times (EV:3). Using the analogy of Cain and Abel, he particularly condemned

abortion (EV:5, 58–63, cf EV:7-9) and aid packages given to countries on the proviso that they put wide scale contraceptive programmes in place (EV:18). That the problem persists and indeed has recently been reemphasised though the new initiative of the bill and Melinda Gates Foundation shows that little money and time has been invested into getting to the root of it but because of increasing financial constraints, midwives, arguably cheaper than doctors, are increasingly being drawn in with little power to voice their protests.

On a more day to day level during the course of my work I am frequently confronted by midwives in a variety of countries, many of whom are practising Catholics, who have been advised that caring for women having abortions is part of the duties expected of them. In some European universities which provide the initial education of midwives, applicants are required to sign a declaration that they agree to participate in caring for women who are having abortions. This leaves those who want to be midwives very vulnerable, especially in those countries without conscience clauses. However, it seems that those qualified midwives who object to abortion are, despite the conscience clauses in some countries, increasingly likely to face situations experienced by the two midwives in Glasgow. For many, it is an extremely difficult situation as by protesting they may lose their jobs.

CONCLUSION

Berry [31] speaks of the crisis of care in the national health service of England in relation to care of the elderly, however it is clear that such a crisis also exists in relation to the provision of women's health services. Not only are the health services failing to deliver the expected results in relation to the reduction of maternal mortality rates pledged in the Millennium Development Goals but rather than returning to first principles, safe abortion abortions services provided by midwives are actively being promoted as the way forward. In some countries which have conscience clauses, these are being ignored, while yet others ensure that all who wish to become midwives sign statements expressing their willingness to participate in abortions.

Catholic and indeed other midwives who want to remain true to their professional values of being with women though the childbirth experience and "Infusing into the spirit and heart of the mother and father the esteem, desire, joy, and the loving welcome of the newly born right from its first

cry[3]" have to be prepared to justify these principles in an increasingly hostile environment can not automatically be expected to have the support of their colleagues or professional body.

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