Britain's Abortion Law
What it says, and why

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DEDICATION:

This publication is dedicated to Alan Naftalin, consultant gynaecologist, whose pioneering work in East London helped so many women. Alan inspired much of the work done in 2012 to clarify the law and support doctors during this uncertain time. He died in December 2012, following a long illness. Alan is sadly missed.

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Introduction

By Jennie Bristow, conference and publications manager,
British Pregnancy Advisory Service; editor, *bpas Reproductive Review.*

Since the 1967 Abortion Act became law in April 1968, millions of women have had access to safe, legal abortion in Britain. The Abortion Act made abortion legal when two doctors agree in good faith (a) that the continuance of the pregnancy would involve risk to the life of the pregnant women, or risk of injury to the physical or mental health of the pregnant woman or of any existing children in her family, greater than if the pregnancy were terminated; or (b) that there was a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. The law allowed doctors to take into account the woman's 'actual or reasonably foreseeable environment'.

The 1967 Abortion Act, which still regulates abortion practice, did not grant women the right to end an unwanted pregnancy. The Act gives doctors the discretion to decide whether there are medical grounds to support a woman's request for abortion. The law does not allow a woman to end her pregnancy simply because she wants to; there must be evidence that the pregnancy would threaten her physical or mental health or that of her children.

Nevertheless the law can be interpreted liberally by doctors who understand that it is detrimental to a woman's health to force her to endure a pregnancy and to become a mother against her will. The vast majority of abortions end unwanted pregnancies and are carried out by doctors who accept that it is damaging to the physical or mental health of a woman to force her to endure a pregnancy against her will. The papers in this publication explain that this interpretation is entirely within the spirit of the Act. Indeed, it is arguable that without such liberal interpretation the Act would have been unworkable.

Events in 2012, however, appeared to throw into question the interpretation of the Abortion Act, as it has stood for over 40 years. This questioning was prompted by a 'sting' operation launched by the *Daily Telegraph* newspaper in February 2012, which claimed to find that three doctors acted illegally by authorising abortions for reasons of 'sex selection'.[1] The newspaper investigation was followed by a three-day series of unannounced inspections by the healthcare regulator, the Care Quality Commission (CQC), in March 2012 – instigated by the Secretary of State for Health Andrew Lansley in response to concerns that some abortion doctors were signing the HSA1 abortion forms in advance of the patient having been assessed.[2]

Over the course of these events, many statements were made about the legality of current abortion practice that were based on a misinterpretation of both the letter and the spirit of the 1967 Abortion Act. The ensuing confusion has had two significant consequences.

[1] 'Abortion investigation: Available on demand – an abortion if it's a boy you wanted.' By Holly Watt, Claire Newell and Zahra Khimji. *Daily Telegraph*, 23 February 2012
http://www.telegraph.co.uk/health/healthnews/9099925/Abortion-investigation-Available-on-demand-an-abortion-if-its-a-boy-you-wanted.html

[2] Abortion clinics get spot-checks. BBC News Online, 23 March 2012
http://www.bbc.co.uk/news/health-17474191

One is that doctors involved in abortion care have become nervous about their everyday practice, as it no longer seems clear what is legal and illegal, or which aspects of standard abortion practice may be suddenly highlighted as problematic by the regulators. This extends throughout the abortion service, to nurses, midwives and managers; and to other doctors working in gynaecology or psychiatric services, who are not directly involved in abortion care but may be called upon to provide the 'second signature' on HSA1 forms.

Another consequence has been that some critics of abortion law feel justified in criticising the British abortion law for being 'badly drafted', or the abortion regulations for being weakly enforced.

The papers in this booklet have been written by academics and lawyers to clarify the British abortion law, through explaining both its origins and its application today. These papers explain that, far from being 'badly drafted', the 1967 Abortion Act was very carefully worded to provide doctors with the discretion to manage the abortion question, according to their own professional judgement. The abortion regulations, similarly, are designed to support the law, which has at its heart the discretion of the doctor.

There is no ambiguity to the law, nor has there been any failure in its ability to act as Parliament intended when it was passed in 1967. Where there has been a failure is in the ability of many in 2012 to understand the law correctly. This booklet aims to correct this failure of understanding, and reassure medical professionals where they stand in relation to the authorisation of abortions in Britain today.

We begin with a 'Q&A' section designed to correct some of the recent confusions. This is followed by four short papers, written by academics and lawyers and which were presented at a briefing for doctors and policymakers at the Medical Society of London on 27 June 2012. Other material in this booklet includes the text of relevant law and regulations pertaining to abortion, official correspondence, and letters written to official bodies and to the press in order to correct the misinterpretations of the law.

In 2013, rumblings are beginning of further attempts to distort the facts around abortion law and practice, as it relates to terminations of pregnancy for fetal anomaly. For this reason we include a commentary by Jane Fisher, director of the charity Antenatal Results and Choices, explaining the legacy of the Joanna Jepson case of 2003, following which doctors have become more wary about carrying out lawful terminations on these grounds.

What does the Abortion Act do?

The 1967 Abortion Act renders lawful activities that would otherwise constitute a crime under the Offences Against the Person Act (OAPA) 1861. The OAPA makes it a crime for a woman to 'procure a miscarriage', or for another person to help her do so. The Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) states that an abortion is legal if it is performed by a registered medical practitioner (a doctor), and that it is authorised by two doctors, acting in good faith, on one (or more) of the following grounds (with each needing to agree that at least one and the same ground is met):

(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 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.

The 1967 Act does not apply to Northern Ireland, where the abortion law remains governed by the Bourne Decision (see Appendix).

What does it mean for doctors to 'act in good faith'?

To show that an opinion has been formed 'in good faith' does not mean that authorising an abortion must be the 'right' course of action, simply that the doctor has not been dishonest or negligent in forming that opinion. What makes an abortion lawful is the doctor's opinion that there are lawful grounds for the procedure, rather than the fact that those grounds exist.

So, for example, if two doctors *believe in good faith* that abortion carries less risk to a woman's physical or mental health than carrying the pregnancy to term, this makes the abortion legal – even if, in the eventuality, it would have been safer to carry the pregnancy to term (for example, if the abortion resulted in death or injury). Similarly, if a woman states that she cannot afford to continue the pregnancy, the doctor is not obliged to check that she really is lacking in funds.

What does 'risk to health' mean?

These circumstances under which doctors can authorise an abortion include risk to a woman's physical or mental health, which, under Section 1(1)(a), is defined relative to the risk of giving birth. Prior to 1967, it was already established in law, by the 1938 Bourne decision, that an abortion was legal if the doctor was 'of the opinion on reasonable grounds and with adequate knowledge of the probable consequences' that continuing the pregnancy would 'make the woman a physical or mental wreck'. This was significant because it confirmed that the grounds for a lawful abortion extended not merely to saving the woman from death but also to considering her mental and physical wellbeing.

The 1967 Abortion Act took the concept of wellbeing further, by indicating that an abortion was lawful if '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' (emphasis added). In 2012, medical evidence is clear that, purely on a physical level, abortion carries less risk of maternal mortality and morbidity than does childbirth. In terms of mental health impacts, authoritative reviews of the evidence in the USA and Britain are clear that aborting an unwanted pregnancy has no adverse psychological sequelae, compared to carrying that pregnancy to term[1].

Thus it could be argued that any abortion carried out under Section 1(1)(a) (the ground on which 98 per cent of abortions are carried out) would always be lawful, provided the authorising doctors were acting on the basis of a good faith reliance on this medical evidence base.

Is it legal to terminate a pregnancy because of a woman's social or financial circumstances?

Yes. This is provided by Section 1 (2) of the Abortion Act, which states that doctors may take account of the pregnant woman's actual or reasonably foreseeable environment when making a decision about the impact of the continuance of a pregnancy on a woman's health.

Here again, the law bestows upon doctors a gatekeeping role in terms of deciding who may have an abortion, but within that role provides for a great deal of latitude in making their decision. The law does not state that doctors 'must' take account of a woman's environment, but that they 'may' do so. There is an implicit recognition that it is not always possible to separate the mental or physical health effects of abortion from a woman's wider social circumstances - such as her income, her housing situation, her support network. Doctors may take all this into account in determining whether to authorise an abortion.

Thus, it would be entirely reasonable for a doctor to decide that a woman who presents for an abortion saying that she cannot afford to continue the pregnancy can lawfully be provided with the abortion, as to refuse her might have relatively negative consequences for her health.

- *The Care of Women Requesting Induced Abortion - full guideline.* Royal College of Obstetricians and Gynaecologists, November 2011. **http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf**
- *Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses.* Academy of Medical Royal Colleges (AoMRC), December 2011. **http://aomrc.org.uk/publications/reports-a-guidance/doc_download/9432-induced-abortion-and-mental-health.html**

Is abortion for reasons of fetal sex illegal under the Abortion Act?

No. The law is silent on the matter. Reason of fetal sex is not a specified ground for abortion within the Abortion Act, but nor is it specifically prohibited. Other reasons for abortion that are widely accepted as 'good' reasons - for example, if the woman has been raped - are not specified either.

Part of the reason why some initially claimed that it is illegal to authorise an abortion for reason of fetal sex was because of a confusion with another piece of legislation. The Human Fertilisation and Embryology (HFE) Act 1990 (as amended, 2008), which regulates fertility treatment, prohibits pre-implantation genetic diagnosis (PGD) for the purpose of non-medical sex selection. However this provision does not apply to abortion.

Does the fact that there is such broad discretion for authorising abortions mean that British women have access to 'abortion on demand'?

No. The construction of the law around a doctor's good faith opinion was motivated firstly by a concern about the health consequences of unwanted pregnancy and backstreet abortion for women and their families, and secondly by an unwillingness to legislate for abortion on demand. Women in Britain cannot obtain abortions 'just because' they want them – doctors have to agree that they are warranted.

That there is no right to abortion on demand is illustrated in three ways. First, the law makes very clear that the decision rests with two doctors, according to their own judgement about the impact of abortion versus childbirth on the woman's physical or mental health. Second, on the question of the woman's social circumstances, the law does not state that doctors 'must' take account of a woman's environment, but that they 'may' do so. This means that doctors are not compelled to take these broader factors into account.

Third, the Abortion Act allows doctors the right to conscientious objection to authorising or performing abortions, except where this is necessary to save the woman's life or to prevent grave, permanent injury to her health. This means that women do not have the right to demand that any doctor performs an abortion for her.

The fact that women do not in practice have access to 'abortion on demand' was well illustrated by the *Daily Telegraph* 'sting' operation, of 2012, in which an undercover journalist visited a number of clinics asking for an abortion on the grounds of fetal sex. In all but three cases, the doctors refused to authorise the request because they did not believe it was right to do so.

Do doctors have to examine the woman in person before signing the HSA1 form?

The Abortion Act legislates that two doctors must decide 'in good faith', that a woman meets the legal requirements for an abortion. It also requires the government to make further provision regarding the certification of such decisions. These regulations regarding certification currently provide that two doctors must specify on what ground/s an abortion can be provided (with both needing to agree that at least one and the same ground is met) along with providing other prescribed information. Current regulations stipulate that they can do so through filling in a particular official document – the HSA1 form; or by providing the same information on signed certificates.

It was established in the 1981 case *Royal College of Nursing of the United Kingdom v. Department of Health and Social Security* that abortion should be considered as a procedure that would be carried out by a medical team comprising doctors, nurses, midwives, and other qualified staff, acting in accordance with good medical practice; and that while a doctor should accept responsibility for 'all stages of the treatment for the termination of pregnancy', he/she did not personally have to conduct every stage of the procedure.

Therefore it has, for many years, been considered good practice for doctors to rely on the information gathered by other members of their team in determining whether a woman meets the criteria for an abortion, just as it is considered good practice for nurses to administer medications. There is no legal requirement for the doctor personally to examine the woman, or review her records in depth. That is why there is the option, on the HSA1 form, for both doctors to certify that they have not seen or examined the woman.

Is pre-signing HSA1 forms illegal?

While the Abortion Regulations provide that the form must be completed before treatment is provided, there is no specific legal prohibition of pre-signing and, indeed, it has been suggested that this practice is clearly legal when done to facilitate speedy treatment of a woman in some circumstances (eg where the doctor pre-signs forms knowing that s/he will be away from a clinic, with the intention of discussing the cases by telephone with a colleague, who can then complete other details with the doctor's approval).

The legality of pre-signing forms on the basis of a good faith reliance on the fact that early termination is statistically safer than continuing a pregnancy is less clear. The fact that the HSA form requires specific information regarding the individual patient might serve to suggest that the judgement must be an individualised one concerning the specific woman seeking an abortion. However, while pre-signing forms on this basis is not advisable, there appears to be nothing on the face of the statute to prohibit it.

Commentaries

Recent myths and misunderstandings about the abortion law.

By Dr Ellie Lee, Reader in Social Policy at the University of Kent; author, *Abortion, Motherhood and Mental Health.*

This paper, and those that follow, are the outcome of a briefing for doctors and policymakers, which I organised at the Medical Society of London on 27 June 2012. The motivation for this was that I, along with colleagues working in the fields of social policy, law and medical ethics, found myself increasingly bemused by the misinformation about the abortion law that has circulated in the public domain since the *Daily Telegraph* sex selection 'sting' in February.

It became apparent that there were several levels of factual misunderstandings and misrepresentations of both the letter and the spirit of Britain's abortion law. Particularly startling was that factual inaccuracy was not only being put across by those opposed to abortion, but also by those upon whom doctors and policymakers rely to understand the law correctly.

Below are some examples of statements published immediately after the *Daily Telegraph's* 'sex selection sting' that contained at least one factual inaccuracy. The following papers in this publication explain in depth why these errors are important to understand and correct.

Andrew Lansley, the Secretary of State for Health, wrote in a comment piece published in the *Daily Telegraph*:[1]

> Carrying out an abortion on the grounds of gender alone is in my view morally repugnant. It is also illegal. Whatever an individual's opinion on abortion, and I recognise that there are strongly held views on this issue, abortion laws in this country are decided by Parliament, not by individual doctors. If some professionals disagree with the law as it stands they should argue their case for change. Simply flouting them in a belief that they know better is unacceptable.

This statement confuses a principled objection to abortion for reason of fetal sex with its legal status. While some doctors may share the view that 'sex selection abortions' are morally wrong, and are therefore permitted by law to refuse to authorise abortions on this basis, it is also the case that a doctor may, in a particular case, decide in good faith that an abortion for *those* reasons in the case of *that* woman is less harmful to her physical or mental health than carrying the pregnancy to term. This discussion is reviewed in Emily Jackson's commentary.

[1] 'Health professionals must not think they know better than the law.' By Andrew Lansley, Health Secretary. *Daily Telegraph*, 24 February 2012
http://www.telegraph.co.uk/health/healthnews/9102811/Health-professionals-must-not-think-they-know-better-than-the-law.html

Niall Dickson, chief executive of the General Medical Council (GMC), issued the following statement:

> Sex selection through abortion is illegal in this country and is a clear breach of our guidance for doctors. Doctors involved in such activity are putting their registration and careers at risk. The law in the UK is clear: terminating a pregnancy on the grounds of a foetus's sex is illegal under the 1967 Abortion Act unless specific hereditary diseases are involved. (This is set out in the Human Fertilisation and Embryology Act 2001.)

This statement again misrepresented the way that the law rests on a doctor's discretion as to an individual woman's particular circumstances: the Abortion Act does not list specific 'reasons' why abortion may be legal. Thus rape is not covered as a specific reason for abortion, but it is understood that most doctors would authorise an abortion on this basis, because of the comparative risk to the woman's health of carrying the pregnancy to term.

The GMC's statement also referred erroneously to provisions in the Human Fertilisation and Embryology (HFE) Act 2001. There is no such legislation – the HFE Act in question is the HFE Act 2008 – and this legislation applies to the use of preimplantation genetic diagnosis (PGD) in fertility treatment, not to abortion. Again, this confusion is examined in Emily Jackson's paper.

The GMC corrected its statement to take account of the error in referring to the HFE Act 2001, but its correction maintained the confusion between the Abortion Act 1967 and the HFE Act 2008. Its updated version read:

> Sex selection through abortion is illegal ... terminating a pregnancy on the grounds of a foetus's sex is illegal under the 1967 Abortion Act (where this applies) unless specific hereditary diseases are involved.
>
> *Clarification: We have updated this story to clarify the legislation that applies to abortion. Terminating a pregnancy is an offence except in the circumstances specified in the Abortion Act 1967 where this applies. Terminating a pregnancy on grounds of the foetus's sex is not covered in the Act and therefore remains illegal.*

The GMC's correction continued to state that the legality of abortion for fetal sex depends on the absence of this ground from the legislation – a grave misrepresentation of the doctor's discretion. It also implied that abortion for fetal sex may be legal in cases of hereditary disease – a provision that exists for PGD within the HFE Act 2008, but does not exist at all within the abortion law.

In July 2012, a group of eminent legal scholars wrote to the General Medical Council to highlight the errors in this guidance, and to ask the GMC to rectify these for the sake of providing much-needed clarity to doctors working within the field. This letter is reproduced in the Appendix.

A portion of the statement initially released by the Royal College of Obstetricians and Gynaecologists (RCOG) replicated many of the GMC's errors, including the reference to the non-existent HFE Act 2001. The statement was then corrected to refer to HFE Act 2008, and read as follows:[2]

> Sex selection is illegal in this country and abortion based on the baby's gender for non-medical purposes is unlawful. Abortion is already heavily regulated in the UK and sex selection is only allowed in very specific conditions such as in the case of hereditary disease as stated in the HFEA Act 2008.

It is credit to the RCOG that, following the 27 June briefing at the Medical Society of London, this statement was corrected further and, at the time of publication of this booklet, read:

> Abortion is already heavily regulated in the UK. Doctors must work within the law.
>
> Anecdotally, there are social and cultural reasons for preferring one gender over another and we need to know more about why these occur. The issues are complex. For instance, women may be coerced or threatened with violence into having an abortion. The priority would be to identify who these women are and to provide them with support.
>
> The government has announced an urgent enquiry into these claims and we await the findings.

The Chief Medical Officer, in a letter circulated to those responsible for abortion services, gave a correct summary of the law. The Royal College of General Practitioners similarly gave correct guidance to their members. These letters are reproduced in full in the appendices. However, in the public discourse, the damage had already been done.

A striking example of the extent to which the widespread confusion has been transmitted to the general public and – most worryingly – women seeking abortion, was given by a programme produced by national Radio Five Live in May.[3] This was a broadcast live from an abortion clinic, and much of it was very good; but it began with a discussion was about the abortion law, with one of the clinic's healthcare assistants, and betrayed a startling degree of misinterpretation.

> *Interviewer:* Let's talk about the legal side of things...[reads out the law]. Tell us what sort of reasons women give?
> *Clinic:* Ladies give reasons as we talked about earlier....we have ladies who say it's financial, they wouldn't be able to afford it, and that's not a legal reason, it's not good enough. Financially is not a reason to terminate a pregnancy. Like I said before, we do have rape victims, we have people who come in and they have young babies, under the age of 2, 3, they say they physically couldn't cope with more children, so ladies have they reasons, those reason have to be legal.
>
> *Interviewer:* So if I came to you and said I'm pregnant, and I can't afford to keep this baby, you would say no.
>
> *Clinic:* Yes, we would say no, it's not a good enough reason to have that done.
>
> *Interviewer:* And you would use those words to her, say that's not a good enough reason?
>
> *Clinic:* Yes, yes.

It highlights the levels of anxiety and confusion within the present climate that even somebody who works for an abortion service would argue, on a radio broadcast, that a woman who requests and abortion because she cannot afford to raise a child would not be permitted an abortion by law. In fact, there are few reasons that women would actually give that would be more easily able to be understood as perfectly legal under the terms of the Abortion Act. These points are developed in the papers by Sally Sheldon and Dorothy Flower.

[2] Dr Tony Falconer, President, RCOG. Full statement available at: **http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-response-daily-telegraph-report-%E2%80%98baby-g**

[3] 'A week in radio: Victoria Derbyshire visits an abortion clinic.' By Elisabeth Mahoney. *Guardian*, 24 May 2012 **http://www.guardian.co.uk/tv-and-radio/2012/may/24/victoria-derbyshire-at-abortion-clinic**

The letter and spirit of the Abortion Act.

By Sally Sheldon, Professor of Law, University of Kent; author, *Beyond Control: Medical Power and Abortion Law.*

The aim of this paper is to provide an brief overview of the parameters of the abortion legislation and how it works in practice. We should begin by locating the legislation in its historical context because this reminds us what the law was trying to achieve: it was the historical reasons for producing the legislation that dictated the form that the law was to take.

In Britain in the mid-1960s, the relevant piece of legislation on the statute books was the Offences Against the Person Act (1861), or the OAPA. This statute creates the offence under which a doctor or a pregnant woman who unlawfully attempts to procure a miscarriage can be convicted.[1] In summary, it provides that:

> s.58: A pregnant woman who unlawfully attempts to procure her own miscarriage, or any third party who unlawfully attempts to procure such a miscarriage, whether or not the woman is pregnant, commits an offence.
>
> s.59: Anyone who unlawfully supplies any drug or instrument to procure such a miscarriage commits an offence.

The statute does not contain a defence to prosecution, and it does not distinguish between early and late pregnancy. However, while the OAPA remains operative throughout England, Wales and Northern Ireland today, subsequent law has carved out a series of exceptions, rendering lawful conduct which would otherwise fall foul of these offences.

The Bourne exception

A creative judge sitting in the late 1930s read in a defence to the OAPA by looking at that word 'unlawfully'.[2] His reasoning was that if the Offences Against the Person Act talks about an offence of *unlawful* procurement of miscarriage, by implication there must be circumstances in which procurement of miscarriage can be lawful.

This was the 1938 case of Dr Alex Bourne, who sought to clarify the law. He carried out an abortion on a 14-year-old rape victim and invited the police to prosecute him for his actions. In his directions to the jury, Judge McNaghton borrowed an interpretation of the word 'unlawful' from another piece of law, and advised the jury in the Bourne case that a procurement of miscarriage could be lawful where it was performed by a doctor acting in good faith for the purpose of preserving the life of his patient. Directing the jury on how to interpret that phrase, he continued:

> I think those words [that the law allows termination of pregnancy for preserving the life of the mother] ought to be construed in a reasonable sense and, if the doctor is of the opinion on reasonable grounds and with adequate knowledge of the probable consequences, that continuing the pregnancy would 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.

Dr Bourne was acquitted. And, as a result of this decision, by the 1960s there was already a well-established means of avoiding prosecution under the OAPA which was predicated on the idea of doctors acting in good faith. This paved the way for the introduction of the Abortion Act some thirty years later.

Unwanted pregnancy as a public health problem

It is important to take account of the social context of Britain in the mid-1960s in order to understand why the legislation was framed in the way that it was. We know that abortions were being carried out at that time but we don't know how many: estimates vary wildly between different commentators, who cite anything from 10,000 to 250,000 abortions per year. Some of those were abortions performed openly, by doctors relying on the defence that had been created in the Bourne decision, others were performed in the backstreets.

One of the concerns in the 1960s was the massive social inequality in accessing abortion, where rich women could pay to have a termination in Harley Street, but poor women didn't have that privilege. And the medical consequences of illegal abortion were significant maternal morbidity and mortality: official figures note 35-40 maternal deaths per year but it is generally agreed that the real figure would have been far higher as doctors would often lie on the death certificate in order to save the reputation of the woman and her family. There was great concern at that time about the broader consequences of this, and an awareness of the effects that rippled out if the mother, a central figure in the family, was not able to cope with the pregnancy or was injured in an illegal abortion. There would be children taken into care, there would be families unable to cope.

Also very significant in the 1960s were the views of medical bodies. The legislation as it operated at that time did not provide a good basis for the professional activities of their members: it restricted clinical autonomy and it created inequalities in access to abortion. That was the situation which the Abortion Act was introduced to remedy and the solution that it adopted was unashamedly one of medical management. Thus we have the recognition of a huge public health problem, combined with the belief that doctors are the appropriate people to manage that problem.

David Steel, the Member of Parliament who introduced the Medical Termination of Pregnancy Bill (as the Abortion Act then was), said in 1966: 'if we can manage to get a [pregnant, unmarried] girl ... into

[1] The relevant text from the OAPA is reproduced in Appendix Two.
[2] *R v Bourne* 3 All ER [1938] 615. The relevant text of the Bourne decision is reproduced in Appendix Three.

the hands of the medical profession, the Bill is succeeding in its objective'. The clear intention was that reform of the abortion law would get women into doctors' surgeries, and that doctors would manage the problem.

It is also very clear that the discretion accorded to doctors in 1967 was intended to be broadly drawn. Doctors were not only charged with managing a medical problem, they were also asked to manage this far wider social problem. In 1971, after the Abortion Act was been passed, David Steel MP wrote: 'social conditions cannot be and ought not to be separated from medical considerations. I hope that the Abortion Act by its very drafting has encouraged the concept of socio-medical care'.

It is important to remember the centrality of the concept of socio-medical care, because the legislative solution put forward in the Abortion Act makes perfect sense in this context. The prevailing view was that unwanted pregnancy and abortion were massive social and public health problems, with doctors to be charged with the significant responsibility of addressing them.

The doctor's discretion

The text below is from Section 1 of the Abortion Act. It stipulates that a person will not be guilty of an offence under the Offences Against the Person Act 1861 when the pregnancy is terminated by a doctor; and where two doctors are of the opinion, formed in good faith, that the abortion fits into one of the four grounds set out in the legislation. In making that judgement, doctors are advised that they can take account of the woman's *actual or reasonably foreseeable environment* - so socio-economic factors are an essential part of that determination.

> s.1(1) Subject to the provisions of this section, a person is not guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner and 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 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.
>
> (2) In determining whether the continuance of pregnancy would involve such risk of injury to health as is mentioned [in ss.1(a)-(b)], account may be taken of the woman's actual or reasonably foreseeable environment.

It can be seen here that the idea of discretion is absolutely central: it is in the DNA of the legislation. As such, some of the comments recently made to the media by the Secretary of State for Health and others regarding doctors 'arrogating powers' to themselves, are profoundly misleading. The emphasis on medical management was a deliberate choice on the part of the legislator, who sought to carve out very broad grounds for the exercise of medical discretion. This is illustrated by the advice given by George Baker, President of the Family Division of the High Court, in the 1978 case *Paton v BPAS*:

> Not only would it be a bold and brave judge who would seek to interfere with the discretion of doctors acting under the [Abortion] Act, but I think he would really be a foolish judge who would attempt to do any such thing, unless possibly, there is clear bad faith and an obvious attempt to perpetrate a criminal offence. Even then, of course, the question is whether that is a matter which should be left to the DPP [Director of Public Prosecutions] and the AG [Attorney General].[3]

According doctors the discretion to determine when abortion is indicated by particular circumstances is thus fundamental to the operation of the legislation. Of course, there are limits on the operation of that discretion: doctors have to certify that one of those four very broad grounds set out in the Abortion Act are met, and doctors have to form that view in good faith.

Defining 'good faith'

How then should the good faith requirement be understood? Here, we can refer to the 1974 case of *R v Smith*, which provides the one reported conviction for unlawful procurement of miscarriage of a doctor who had obtained the second signature necessary under the 1967 Abortion Act. It is the only such case of which I am aware in the 45 years since the Act was passed, so it is highly significant. In *Smith*, another very eminent jurist, Lord Justice Scarman in the Court of Appeal, says:

> The Act that renders lawful abortions that before its enactment would have been unlawful, does not depart from the basic principle of common law as declared in *R v. Bourne*, namely that the legality of an abortion depends on the opinion of the doctor. It has introduced the safeguard of two opinions; but, if they are formed in good faith by the time the operation is undertaken, the abortion is lawful. Thus a great social responsibility is firmly placed by the law on the shoulders of the medical profession. If a case is brought to trial which is of questions the *bona fides* of a doctor, the jury, not the medical profession, must decide the issue... By leaving the ultimate question to the jury, the law retains its ability to protect society from an abuse of the Act.[4]

As indicated above, the placing of social responsibility for regulating abortion on the shoulders of the medical profession was an entirely deliberate choice of Parliament.

[3] *Paton v BPAS* [1978] 2 All ER 987 at 992.
[4] Scarman LJ, R v Smith [1974] 1 All ER 376, 381.

Good faith determinations are a question of fact to be determined by the jury. So a successful prosecution will require that it is shown, beyond reasonable doubt, that the doctor was not acting in good faith where he performed or recommended the termination. Jury deliberations are secret, so we do not know what the factors are that carried the most weight in the jury room in *Smith*. But in this case, we have the judgement of the Court of Appeal, considering whether the conviction was safe, and setting out all of the factors that might have weighed on the jury's mind when it was making that decision. These records provide a good idea of the kinds of factors that a jury would want to consider.

In the *Smith* case, Dr Smith was a General Practitioner with a private practice in abortion services. A woman of 19 was referred to him seeking a termination and Dr Smith spent a little under 15 minutes with her. He asked her why she didn't want to continue with the pregnancy and she responded that she was not in love with the father and that she was scared of childbirth. Dr Smith did not perform any medical tests, he did not ask about her medical history, and he did not conduct an internal examination of the woman. He told her that if she could give him £150 in cash (a little under £3,000 in today's money)[5] on that day, he could perform the termination the following morning. The woman replied that it would take her a while to get the money together and Dr Smith booked her in for a termination the following week.

The kinds of factors that may have been relevant to the jury here, and which were certainly relevant to the Court of Appeal in its discussion of this case, are firstly the fact that the money is asked for in cash, which would have raised some suspicion. Secondly, that Dr Smith said immediately that he could do the termination the following morning suggests that he was not concerned about seeking a second opinion. Thirdly, the fact that Dr Smith was acting significantly out of line with received medical practice would have been very important. Lord Justice Scarman, in the Court of Appeal, said that the matter of how other doctors would have acted at this time should not be taken to be determinative but that it would nonetheless be a very significant fact for the jury to take into account.

The most damning thing of all for Dr Smith, however, was that having recommended the termination, he had tried to conceal his tracks. There was evidence that the register of the nursing home where the woman was admitted for the termination had been falsified and when the police initially asked Dr Smith for his case notes and the relevant certification of this abortion, he initially denied having any of that information. The jury found that he had lied about other aspects of what had gone on. So there was a clear attempt to mislead, to conceal, and to perform the termination in a clandestine way, as well as the very large fee wanted in cash. Good faith was thus found to be absent.

What can be seen from this brief historical overview, then, is the centrality of medical discretion, subject to the important limitation that it is exercised in good faith. These factors remain central to the current operation of the law as will be seen in the presentations to follow.

[5] Calculated as a proportion of average earnings. See **http://www.measuringworth.com**

The legality of abortion for fetal sex.

By Emily Jackson, Professor of Law, London School of Economics

This paper discusses how the law works in relation to abortion on the grounds of fetal sex. The *Daily Telegraph* sting on abortion clinics was immediately followed by statements that termination of pregnancy on the grounds of fetal sex is 'illegal', or 'unlawful'- and as Ellie Lee's paper explains, such statements came from Andrew Lansley, the Secretary of State for Health; from the General Medical Council (GMC), and from the Royal College of Obstetricians and Gynaecologists (RCOG).

By complete coincidence I was teaching abortion law to my students at the London School of Economics that week. We began the seminar by considering the statement that abortion on the grounds of fetal sex is illegal in the UK. I asked the students whether that was correct; whether it was what the law actually says. Some of them argued that abortion on the grounds of fetal sex is not a specific ground for abortion – that is, it is not one of those four grounds listed in the Abortion Act. Those students reasoned that as it is not on the list and not specifically mentioned as a good reason, it is therefore not a good reason for the purposes of the Act.

But this is not how the Abortion Act works. We can see this by taking another example of a reason why a woman might want an abortion – rape. You could say that the fact that a woman is pregnant as a result of rape is not one of the four grounds listed in the Abortion Act: it is not set out as one of the criteria within the Act which enables an abortion to be lawful. But the fact that it is not on the face of the Act does not mean that it is a bad reason, or that abortion on the grounds of rape would not be a lawful abortion. Thus the fact that fetal sex is not specifically included in the Act does not necessarily mean that abortion on the grounds of fetal sex would be unlawful, just as is the case with rape.

What the law does, very deliberately, is to leave it up to the doctors to decide in good faith whether the woman's circumstances fit within one of these four statutory grounds:

> (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 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.

Obviously the first ground for abortion – Section 1(1)(a) – is incredibly widely drawn. All that needs to be established is that in good faith, two doctors believe that continuing the pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the woman's physical or mental health.

'Health' has a wide meaning here. We know that it doesn't need to mean that continuing the pregnancy would leave the woman a mental or physical wreck, because under the 1938 Bourne exception, abortion was lawful before 1967 on those grounds.[1] The Act is introducing a wider ground than the Bourne exception. It is, very simply, a comparative judgement: does the doctor believe that a woman's circumstances are such that continuing the pregnancy would be worse for her mental health than a termination? So it is therefore possible that in extreme circumstances a doctor could conclude that the prospect of giving birth to a sixth son, or yet another daughter, would pose a risk to the woman's mental health, greater than termination.

Of course, in the vast majority of pregnancies, whether a fetus is one sex or the other is unlikely to affect the woman's mental health. But there *could* be cases where it would. And there *could* be cases where the doctor has formed that opinion in good faith. 'Good faith' effectively means that the doctor has formed his or her opinion non-negligently, that is he has acted as a reasonable doctor would.

There will be doctors who have conscientious objections to carrying out abortion on the grounds of fetal sex: and such doctors would be entitled to have that respected, unless the woman's life was at risk. But it is simply wrong to say that abortion on the grounds of fetal sex is unlawful in the UK. That is not what the law says.

It is also wrong for the RCOG and GMC to state, as they did in their initial statements following the *Daily Telegraph* 'sting', that the Human Fertilisation and Embryology (HFE) Act applies to abortion. It does not. The provision that was being referred to here is a provision from the 2008 reforming HFE Act which prohibits preimplantation genetic diagnosis (PGD) for social sex selection.

One could take the fact that Parliament had decided, in 2008, that PGD for social sex selection shouldn't be allowed and suggest that, if asked, maybe Parliament would not be in favour of permitting abortion for the purposes of social sex selection. But the fact is that Parliament has never debated this, and the words of the Abortion Act are clear and unambiguous.

It has been suggested that more specific guidance might be issued on how the Abortion Act should be interpreted; and that part of the process of introducing greater clarity might introduce some statement about abortion on the grounds of fetal sex. But usually guidance would only be given on what words actually mean if those words are ambiguous - and there is no ambiguity in section 1(1)(a). Doctors have discretion over the decision as to whether the pregnancy poses a greater risk to a woman's health than abortion.

[1] See the text of the 1938 Bourne decision in Appendix Three.

Absolutely clear evidence as to the breadth of the doctor's discretion in deciding whether an abortion is lawful is provided by the fact that, according to section 1(1)(a), it is the doctor's *opinion* that makes the abortion lawful. The criterion is not that the grounds must actually exist. So an abortion would be lawful if two doctors had formed the opinion, in good faith, that those grounds were satisfied, even if they were not.

The Abortion Act does not say that abortion is lawful only if the continuing the pregnancy does pose a risk to her physical or mental health that is greater than the risk posed by continuing the pregnancy. It is the doctor's *opinion* of this comparative risk assessment that is the trigger for the legality of abortion.

There are a number of reasons why one could criticise the Abortion Act for giving doctors control over abortion decision-making. Many critics, including myself, have argued that the decision to have an abortion should be for the woman herself, rather than dependent upon the doctor's opinion of her circumstances: but that is not what the law says. The Abortion Act unambiguously states that the legality of the abortion depends on the doctor's opinion that it would be better for the woman than the alternative.

Certifying abortions: the signing of HSA1 forms.

By Dorothy Flower, Partner, RPC.

As a practising solicitor, I am concerned with statutory and regulatory meaning and interpretation, but I am much more concerned about what the enforcers of statutory regulation might do if any of my clients comes under criticism. In the work I do, I always aim to be objective and dispassionate – so while I am personally in favour of a woman being able to exercise choice when it comes to abortion, I am also willing to advise any client on his or her legal position, no matter on which side of the 'pro' or 'anti' divide that client falls.

This paper looks at the very specific question of the signing of HSA1 forms. I will address this under four headings: 1) what the Abortion Act says; 2) what the Abortion Regulations say; 3) what information doctors need before they sign; and 4) what happens if it all goes wrong.

What the Abortion Act says

The crucial provision in section 1 of the Abortion Act is that, for an abortion to be lawful, two registered medical practitioners must form the opinion, in good faith, that one of the four statutory grounds is met. (See text of the Abortion Act in Appendix One). For the purpose of signing the HSA1 form, it is the words "*opinion formed in good faith*" that really count. This essentially means that the opinion is a genuinely held, honest opinion.

The concept of good faith is not restricted to medical law or abortion law; in every area of law where the good faith concept arises, it is associated with openness, fairness, and the exercise of discretion.

'Good faith' applies in company law, for example, when directors of a company make decisions about what is in the best interests of the company. In that context, the courts have made it absolutely clear that the duty to act in good faith is entirely subjective. It is not therefore a question of whether the act turned out to be in the interests of the company; or whether a court might objectively, looking at it in hindsight, think it would have done something different. As Mr Justice Parker said in his judgment in the case of *Regentcrest v Cohen,*[1] *"the question is whether the director honestly believed that his act or omission was in the interests of the company"*. Good faith, therefore, is about honest belief.

In exactly the same way, when it comes to the Abortion Act the courts recognise that a doctor's good faith opinion is one that is reached subjectively. In the 1974 case, *R v Smith*[2], the Court of Appeal made it very clear that whether Dr Smith had reached his decision in good faith could not be determined by the court on the basis of expert medical opinion, for example, or what the medical profession might think was a reasonable decision. It was for the *jury* to decide whether the decision was the doctor's honest opinion, reached on that doctor's *own* assessment of whether a statutory ground was met. The question of whether a woman's request to end her pregnancy comes within the grounds (a) to (d) in section 1 of the Abortion Act is for the doctors to decide honestly.

The Abortion Act states, in subsection 2, that "*account may be taken of the woman's actual or reasonably foreseeable environment*". This is helpful in framing the scope of the doctor's discretion, in two ways. First, it means that the doctor can look much more widely than just the clinical picture, and can take account of all the woman's circumstances - not just as they are now, but as they might become as a result of the decision that the doctor makes.

Second, the word 'may' is very important: in law, that means that the doctor *can* take the woman's actual or reasonably foreseeable environment into account, but does not have to.

What the Abortion Regulations say

The wording below is from the 2002 Abortion Regulations[3]:

"Certification of Opinion

3(1) Any opinion to which section 1 of the Act refers shall be certified –
(a) in the case of a pregnancy terminated in accordance with s.1(1) of the Act, either –
(i) in the form set out in Part 1 of Schedule 1 to these Regulations; or
(ii) in a certificate signed and dated by both practitioners jointly or in separate certificates signed and dated by each practitioner stating: -
(a) the full name and address of each practitioner;
(b) the full name and address of the pregnant woman;
(c) whether or not each practitioner has seen or examined, or seen and examined, the pregnant woman; and
(d) that each practitioner is of the opinion formed in good faith that at least one and the same ground mentioned in paragraph (a) to (d) of s.1(1) of the Act is fulfilled.

(2) Any certificate of opinion … shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates."[4]

These provisions are specific to the HSA1 form, stating the steps by which doctors are required to confirm that they have reached that good faith decision. There are certain practical requirements:

- the opinion has to be certified, so it has to be put it in writing, and it has to be signed;
- the HSA1 form is convenient, but it is not essential. In fact, two doctors can sign two different forms – the signatures do not have to be on the same piece of paper;
- the certificate must give certain minimum information, as listed in the Abortion Regulations;

[1] [2001] 1BCLC 80
[2] [1974] 1 All ER 376, 1 WLR 1510; 58Cr App Rep 106

[3] The Abortion Regulations 1991, and the Abortion (Amendment) (England) Regulations 2002, are reproduced in Appendix Four.
[4] Certification requirements for abortions provided under s.1(4) (emergencies), omitted.

- the doctors have to sign the certificate before treatment begins;
- the two doctors have to agree on the same ground for abortion, so a doctor could believe that more than one ground applies, but the two have to agree on at least one.

The HSA1 form does not follow precisely the grounds set out in the Act. There are four grounds in the Act, and five categories in the HSA1, as listed below. Categories C and D on the HSA1 form are all contained within sub-paragraph (a) of the Act. The HSA categories are:

"A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;

B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

C the pregnancy has NOT exceeded its 24th 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;

D the pregnancy has NOT exceeded its 24th 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 any existing child(ren) of the family of the pregnant woman;

E 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".

What information doctors need before they sign

The question of precisely what information doctors need before they sign the HSA1 form has become vexed of late. If you are a doctor, the real answer to this question is that it is up to you. *You* can decide what information *you* need to enable you to form that opinion in good faith.

This suggests a high level of discretion, and, so it may be worth providing an indication of the kind of factors in which a court might be interested for determining whether a doctor's decision has been made in good faith.

First, there will be some general questions and answers that a doctor will have in mind, because of his or her experience, qualifications and expertise. For example: what does the doctor know about the physical risks of abortion when compared to the physical risks of continuing a pregnancy to term and giving birth? This is a question for a medical professional to answer, rather than a lawyer, but my understanding is that, as a general rule, abortion is physically safer than childbirth. This is indicated by the Royal College of Obstetricians and Gynaecologists' evidence-based guideline on induced abortion.[5]

[5] *The Care of Women Requesting Induced Abortion - full guideline*. Royal College of Obstetricians and Gynaecologists, November 2011. **http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf**

Another question will be, what does the doctor know about the psychological and psychiatric risks of abortion as against pregnancy and birth? To assist in answering that, we have the recent review, published in December 2011, by the National Collaborating Centre for Mental Health, which found that the risk factor for an adverse mental health outcome is the unwanted pregnancy, regardless of whether the pregnancy ends in abortion or birth.[6] The review also supports the idea that a woman is less likely to suffer an adverse mental health response if the resolution of the *unwanted pregnancy* is of her choosing - in other words, if she has some control in the decision-making, in the choice that she has made.

Therefore, according to the National Collaborating Centre on Mental Health, a woman who clearly decides that she wants an abortion but is refused is just as likely to suffer an adverse response as a woman who is forced to have an abortion against her will. So if a woman is seeking abortion and is very clearly determined that this is what she wants, the assumption must be that her mental health is better protected by allowing her to make that choice.

So those are general factors. Based on those alone, a doctor could be justified in signing an HSA1 form without knowing even the name of the woman, which means that there could be a basis for saying that pre-signing an HSA1 is not in breach of the law. There is, however, a requirement to include, for example, the name and address of the woman, and because of the stance that the regulators have taken, my personal view is that pre-signing HSA1 forms is not advisable. However, I do not consider that it is in breach of the Abortion Act.

A doctor can take into account other factors, specific to the woman, which might alter the balance of the doctor's opinion. There are two main points here. The first is that it is up to the doctor who is asked to sign the HSA1 form to request whatever specific information he or she wants to see before signing. In some cases, it might be appropriate to see all of the medical records - notes of the consultation, details of past medical history, and so on. But in the vast majority of cases, reviewing those records will probably make no difference to a doctor's decision.

I realise that this is quite a bold statement, so it is worth illustrating it with an example. A woman seeking abortion does not say, 'I want an abortion because the risk to my health of continuing the pregnancy is greater than if I had an abortion'. She might say, 'My family's complete'. Or she might say, 'Financially, things are a mess, and I can't afford to have a baby'. Or she might say, 'I've broken up with my boyfriend'.

None of these reasons is expressly one of the four grounds in the Abortion Act. Each one of them is, however, a relevant factor for the doctor to take into account, which might tip the balance of the mental health impact of the unwanted pregnancy, and make it more likely that an adverse reaction will follow continuing with the pregnancy and giving birth. They are therefore quite important factors. Similarly, if a woman has revealed that she suffered from pre-eclampsia in her previous pregnancies, or another serious complication, this might tip the balance of the doctor's opinion so far as concerns the impact on a woman's physical health of continuing the pregnancy.

[6] *Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses*. December 2011. This review was commissioned and published by the Academy of Medical Royal Colleges (AoMRC). It was funded by the Department of Health, and carried out by the National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists. **http://aomrc.org.uk/publications/reports-a-guidance/doc_download/9432-induced-abortion-and-mental-health.html**

Does this mean, then, that the doctor has to check the woman's records to look for that kind of tipping-the-balance information? This leads to the second point. The law recognises that, in the provision of abortion services, doctors work as a team, with nurses and other staff involved. In the 1981 case *Royal College of Nursing of the United Kingdom v. Department of Health and Social Security*[7], a case that went all the way to the House of Lords, Lord Diplock said that *"Parliament contemplated that … like other hospital treatment, [abortion] would be undertaken as a team effort … [and it would be] in accordance with accepted medical practice to entrust [treatment] to a member of staff possessed of their respective qualifications and experience".*

Again to illustrate this point by way of example: part of the certification process for categories C and D is that a pregnancy has not exceeded its twenty-fourth week. But that does not mean that the signing doctor has to scan every woman, or examine her, in order to check gestation. The doctor is not even required to see the woman. She or he is entitled to rely on the assessment of gestation that is performed by an appropriately-qualified member of the team. If that person has some doubt, she or he could seek the advice of a doctor. But if the team is experienced, that will probably be very rare, if not the exception.

In exactly the same way, the doctor must be entitled to rely on the appropriately-qualified and experienced members of the team to draw to his or her attention any factor which might make the doctor think a little bit harder in the balancing exercise, about the relative risks of abortion versus continuation of the pregnancy.

What happens if it all goes wrong

Finally, this paper considers the defences that might be available to a doctor against allegations of breach of the law in the signing of HSA1 forms. I am aware of a recent example where things could potentially have gone wrong for a clinic, in which a Care Quality Commission (CQC) inspector decided that doctors could not sign the HSA1 form without seeing the woman's records. The CQC report stated that there was a "lack of proper information" available to the doctors who signed, and that this resulted in a "failure to ensure that people were protected against the risks of unsafe and inappropriate care and treatment". This was said to be in breach of the regulations.

This comment is inconsistent with wider practice and regulatory enforcement: it is noticeable that other CQC inspectors in other clinics where the practice was identical were finding that there had been compliance. It is also inconsistent with the legal requirements, for all the reasons explained above. It is simply not for the regulator to prescribe how any individual doctor reaches his or her decision in good faith.

For an individual doctor, when things go wrong it is likely to mean that there is an allegation that the decision in an individual case was not reached in good faith, and so the abortion that followed the certification was unlawful. That has the potential to be very serious for the doctor – there would be the involvement of the General Medical Council (GMC), there could also be a criminal prosecution and possibly a civil claim. In defending such allegations the evidence will be all-important. This will be the doctor's own evidence, about how he or she reached the decision; but it will also be the wider evidence that underlies the doctor's decision-making. That wider evidence will include reviews and studies that inform a gynaecologist's expert knowledge, and the practice and expertise of the staff and the clinic, on which the doctor relies.

I conclude by making two points in reassurance. First, the 1974 case of *R v. Smith* is the only decision since 1967 where a doctor, having obtained the second signature for authorising an abortion, has been convicted of an offence for not having acted in good faith, and this case was 40 years ago. So there is no reason at all to think that a case today would be decided in the same way as the *Smith* case, not least because the attitude of any jury should be very different now from in the early 1970s.

Second, the Crown Prosecution Service is likely to think very hard indeed before bringing a prosecution now on any but the most obvious criminal grounds. Certainly in civil law, the court has shown huge reluctance to make any kind of decision which at a stroke turns a whole raft of law-abiding citizens into potential criminals, which is what such a decision would mean. That was put into words by Lord Keith, in the *RCN v. DHSS* case, where he expressed relief that it was *"unnecessary to reach a decision"* that would make *"very large numbers of medical practitioners … who have participated in the relevant procedures over several years, guilty of criminal offences".*

In a different case (that of *Smeaton v Secretary of State for Health*[8], in which the Society for the Protection of Unborn Children challenged the legality of pharmacists dispensing the emergency contraceptive pill), Mr Justice Munby said that to hold what thousands of *"ordinary, honest, law-abiding citizens have been doing … is and always had been criminal"* would be *"grievously wrong".*

[7] [1981] AC 801

[8] [2002] EWHC610 (Admin)

Post-24 week termination for fetal anomaly – the chilling effect of the Jepson campaign

By Jane Fisher, Director, Antenatal Results and Choices

Terminations for fetal anomaly are legally sanctioned in England, Scotland and Wales through Section 1 (1) (d) of the Abortion Act of 1967 (as amended in 1990), if: *'two registered medical practitioners are of the opinion, formed in good faith- (d) 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'*[1].

This clause in the law does not have a gestational age limit and is listed on the abortion certification form as 'Ground E'. The imprecise wording of the clause was designed to enable doctors to use their clinical judgement on whether to offer termination on an individual case by case basis. Numbers of abortions taking place under Ground E after 24 weeks have always been small, representing approximately 0.1% of all abortions. There were 146 such abortions in 2011[2].

Advances in antenatal screening and testing technologies mean the majority of fetal anomalies are detected before 24 weeks. At the same time it remains the case that the major screen for structural anomalies is scheduled between 18 and 20+6 weeks' gestation[3]. Some women will have their scans later than this. Some will be recalled later due to the difficulty of obtaining optimal fetal anatomical surveys in women who are significantly overweight[4]. If a problem is detected, there will almost always be the need for onward referral for further testing. Some women will have anomalies detected at third trimester scans scheduled for reasons such as monitoring fetal growth or placental position.

So the law as it stands should allow for doctors to afford women the opportunity to make the difficult decision to end their pregnancy post-24 weeks if a significant anomaly is found.

In reality, however, research has suggested (and ARC has noted anecdotally, through contact with women on its national helpline) that there has been variation in practice in recent years, around the offer of post-24 week terminations for fetal anomaly. For example, some units will offer a termination after 24 weeks following a diagnosis of Down's syndrome, while others do not consider this lawful. Some hospitals have now set up expert ethics panels to decide on the legality of post 24-week terminations. A doctor interviewed as part of a study on attitudes to late terminations in fetal medicine units, by Statham et al[5], noted the change in attitude:

> 'Whereas people used to say, yes, Down's is a permanent condition, you can have a termination after twenty-four weeks, [there are] lots of people now who say, well, maybe not... I think there's a climate change in society generally against them.'

[1] Abortion Act 1967
[2] Department of Health, *Abortion Statistics, England and Wales: 2011*. Bulletin 2012/01, 2012 (London: DH, 2012)
[3] NHS FASP 18 to 20 weeks Fetal Anomaly Scan: National Standards and Guidance for England 2010 **http://fetalanomaly.screening.nhs.uk/standardsandpolicies**
[4] Hendler, I., et al. 'The impact of maternal obesity on midtrimester sonographic visualization of fetal cardiac and craniospinal structures.' International Journal of Obesity 28.12 (2004): 1607-1611.
[5] Statham H, Solomou W, Green J. Late termination of pregnancy: law, policy and decision making in four English fetal medicine units. BJOG: An International Journal of Obstetrics and Gynaecology 2006;113(12):1402-1411.

One likely contributory factor to more cautious professional practice in this area was the publicity generated in 2003 around what has come to be known as the 'Jepson case'[6]. Joanna Jepson, a young Anglican curate, sought a judicial review of the decision by the police not to prosecute doctors who terminated a pregnancy at 28 weeks' gestation where the fetus had been diagnosed with bilateral cleft lip and palate.

The police authorities had undertaken an investigation of the case and were satisfied that the abortion was 'legally justified and procedurally correctly carried out'. Rev Jepson challenged this decision on the basis that bi-lateral cleft lip and palate was not a 'serious handicap' and therefore the abortion had been unlawful. After a detailed re-investigation it was announced in March 2005 that the doctors involved would not face prosecution. Although Jepson was unsuccessful, there was intense media interest in the story, and one of the doctors involved was named and pictured in a popular national daily newspaper[7].

In the media coverage of the Jepson case and the reporting of 'abortion for trivial reasons'[8], what is largely overlooked is that structural anomalies such as cleft lip and palate vary in severity and amenability to surgery and can sometimes be indicators of a serious underlying chromosomal or genetic syndrome. In other words, there will be circumstances when such a finding clearly represents 'substantial risk of a serious handicap'. ARC hears regularly from women who have had a number of structural anomalies picked up by their 20-week ultrasound scan which in themselves may not cause serious impairment but, when found together, significantly raise the risk of an underlying genetic syndrome.

Unfortunately prenatal genetic diagnosis cannot keep pace with the increasing range of anomalies that sophisticated ultrasound equipment now picks up. Some women may want to continue the pregnancy in these circumstances hoping for the best, others will feel unable to cope with the possibility of serious problems manifesting after birth. In this situation, the wording of the law enables doctors to accommodate choice for the latter. Sadly, the 'Jepson effect' means that many doctors are reluctant to do so.

There is no hard evidence to prove that women are being denied what would be a legally sanctioned termination. The number of post-24 week terminations documented by the DH has remained fairly constant in the last ten years. But these statistics do not tell us how many women were denied the option of termination, nor do they indicate how many women made a 'pressured' decision before 24 weeks, fearing the option would be taken away. ARC has anecdotal evidence from our support work with women that both situations occur. Women have disclosed to us that an explanation they have had for the clinical caution was 'worries since that cleft lip and palate case'.

While Jepson may have failed in her legal challenge, it appears she has succeeded in making an already distressing situation for expectant parents and their doctors even more difficult.

[6] Jepson v. The Chief Constable of West Mercia [2003] EWHC 3318. From: Scott R. The uncertain scope of reproductive autonomy in preimplantation genetic diagnosis and selective abortion. *Medical Law Review* 2005;13:291–327.
[7] Mills J. Doctor may be charged over late abortion. *Daily Mail* (London), 23 September 2004
[8] Marsh B. Hidden abortion of imperfect babies. *Sunday Times*, 3 February 2013

Appendices

Appendix One: The 1967 Abortion Act as amended by the 1990 Human Fertilisation and Embryology Act

Medical termination of pregnancy.

1. (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner 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 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.

1. (2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection (1) of this section, account may be taken of the pregnant woman's actual; or reasonably foreseeable environment.

1. (3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.

1. (3A) The power under subsection (3) of this section to approve a place includes power, in relation to the treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places.

1. (4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Notification.

2. (1) The Minister of Health in respect of England and Wales, and the Secretary of State in respect of Scotland, shall by statutory instrument make regulations to provide -

(a) for requiring any such opinion as is referred to in section l of this Act to be certified by the practitioners or practitioner concerned in such form and at such time as may be prescribed by the regulations, and for requiring the preservation and disposal of certificates made for the purposes of the regulations;

(b) for requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination and such other information relating to the termination as may be so prescribed;

(c) for prohibiting the disclosure, except to such persons or for such purposes as may be so prescribed, of notices given or information furnished pursuant to the regulations.

2. (2) The information furnished in pursuance of regulations made by virtue of paragraph (b) of subsection (1) of this section shall be notified solely to the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department respectively.

2. (3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations under subsection (1) of this section shall be liable on summary conviction to a fine not exceeding one hundred pounds.

2. (4) Any statutory instrument made by virtue of this section shall be subject to annulment in pursuance of a resolution of either House of Parliament.

Application of Act to visiting forces etc.

3. (1) In relation to the termination of a pregnancy in a case where the following conditions are satisfied, that is to say:

(a) the treatment for termination of the pregnancy was carried out in a hospital controlled by the proper authorities of a body to which this section applies; and

(b) the pregnant woman had at the time of the treatment a relevant association with that body; and

(c) the treatment was carried out by a registered medical practitioner or a person who at the time of the treatment was a member of that body appointed as a medical practitioner for that body by the proper authorities of that body, this Act shall have effect as if any reference in section 1 to a registered medical practitioner and to a hospital vested in a Minister under the National Health Service Acts included respectively a reference to such a person as is mentioned in paragraph (c) of this subsection and to a hospital controlled as aforesaid, and as if section 2 were omitted.

3. (2) The bodies to which this section applies are any force which is a visiting force within the meaning of any of the provisions of Part I of the Visiting Forces Act 1952 and any headquarters within the meaning of the Schedule to the International Headquarters and Defence Organisations Act 1964; and for the purposes of this section-

(a) a woman shall be treated as having a relevant association at any time with a body to which this section applies if at that time-

(i) in the case of such a force as aforesaid, she had a relevant association within the meaning of the said Part I with the force; and

(ii) in the case of such a headquarters as aforesaid, she was a member of the headquarters or a dependant within the meaning of the Schedule aforesaid of such a member; and

(b) any reference to a member of a body to which this section applies shall be construed-

(i) in the case of such a force as aforesaid, as a reference to a member of or of a civilian component of that force within the meaning of the said Part I; and

(ii) in the case of such a headquarters as aforesaid, as a reference to a member of that headquarters within the meaning of the Schedule aforesaid.

Conscientious objection to participation in treatment.

4. (1) Subject to subsection (2) of this section, 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:
Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

4. (2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

4. (3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

5. (1) No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act.

5. (2) For the purposes of the law relating to abortion, anything done with intent to procure a woman's miscarriage (or, in the case of a woman carrying more than one foetus, her miscarriage of any foetus) is unlawfully done unless authorised by section 1 of this Act and, in the case of a woman carrying more than one foetus, anything done with intent to procure her miscarriage of any foetus is authorised by that section if:

(a) the ground for termination of the pregnancy specified in subsection (1)(d) of that section applies in relation to any foetus and the thing is done for the purpose of procuring the miscarriage of the foetus, or

(b) any of the other grounds for termination of the pregnancy specified in that section applies.

Interpretation.

6. In this Act, the following expressions have meanings hereby assigned to them:
"the law relating to abortion" means sections 58 and 59 of the Offences against the Person Act 1861, and any rule of law relating to the procurement of abortion; "the National Health Service Acts" means the National Health Service Act 1946 to 1966 or the National Health Service (Scotland) Acts 1947 to 1966.

Short title, commencement and extent.

7. (1) This Act may be cited as the Abortion Act 1967.

(2) This Act shall come into force on the expiration of the period of six months beginning with the date on which it is passed.

(3) This Act does not extend to Northern Ireland.

Appendix Two: The 1861 Offences Against the Person Act

The Offences Against the Person Act became law on l November 1861. It contains 79 paragraphs and covers a wide range of possible offences including: administering poison, sending letters threatening to murder, placing wood on a railway with intent to endanger passengers, assaulting a magistrate, rape, child stealing, bigamy and concealing the birth of a child. In the midst of this are two paragraphs on abortion. They read, in full, as follows:

(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 be not 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...to be kept in penal servitude for life...

(59) Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor, and being convicted thereof shall be liable...to be kept in penal servitude...

Appendix Three: The 1938 Bourne Decision

In England, in 1938, Dr Alex Bourne deliberately challenged the law in order to clarify what constituted legal practice in relation to abortion when the abortion was not directly necessary to save the woman from death. He carried out an abortion on a 14-year-old rape victim, and at the subsequent trial brought evidence that if the young woman had been forced to continue with the pregnancy she would have become a mental and physical wreck. Dr Bourne was acquitted. At the trial Judge McNaghton restated that the law allows termination of a pregnancy for preserving the life of the mother and continued:

'I think those words [that the law allows termination of pregnancy for preserving the life of the mother] ought to be construed in a reasonable sense and, if the doctor is of the opinion on reasonable grounds and with adequate knowledge of the probable consequences, that continuing the pregnancy would 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.'

Appendix Four: The Abortion Regulations 1991 and The Abortion (Amendment) (England) Regulations 2002

STATUTORY INSTRUMENTS

1991 No. 499

MEDICAL PROFESSION

The Abortion Regulations 1991

Made

4th March 1991

Laid before Parliament

7th March 1991

Coming into force

1st April 1991

The Secretary of State for Health, in exercise of the powers conferred by section 2 of the Abortion Act 1967(**1**) and now vested in him(**2**), and of all other powers enabling him in that behalf, hereby makes the following Regulations:-

Citation and commencement

1.-(1) These Regulations may be cited as the Abortion Regulations 1991, and shall come into force on 1st April 1991.

(2) These Regulations extend to England and Wales only.

Interpretation

2. In these Regulations "the Act" means the Abortion Act 1967 and "practitioner" means a registered medical practitioner.

Certificate of opinion

3.-(1) Any opinion to which section 1 of the Act refers shall be certified-

(a)in the case of a pregnancy terminated in accordance with section 1(1) of the Act, in the form set out in Part I of Schedule 1 to these Regulations, and

(b)in the case of a pregnancy terminated in accordance with section 1(4) of the Act, in the form set out in Part II of that Schedule.

(2) Any certificate of an opinion referred to in section 1(1) of the Act shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates.

(3) Any certificate of an opinion referred to in section 1(4) of the Act shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates or, if that is not reasonably practicable, not later than 24 hours after such termination.

(4) Any such certificate as is referred to in paragraphs (2) and (3) of this regulation shall be preserved by the practitioner who terminated the pregnancy to which it relates for a period of not less than three years beginning with the date of the termination.

(5) A certificate which is no longer to be preserved shall be destroyed by the person in whose custody it then is.

Notice of termination of pregnancy and information relating to the termination

4.-(1) Any practitioner who terminates a pregnancy in England or Wales shall give to the appropriate Chief Medical Officer-

(a)notice of the termination, and

(b)such other information relating to the termination as is specified in the form set out in Schedule 2 to these Regulations,

and shall do so by sending them to him in a sealed envelope within 7 days of the termination.

(2) The appropriate Chief Medical Officer is-

(a)where the pregnancy was terminated in England, the Chief Medical Officer of the Department of Health, Richmond House, Whitehall, London, SW1A 2NS; or

(b)where the pregnancy was terminated in Wales, the Chief Medical Officer of the Welsh Office, Cathays Park, Cardiff, CF1 3NQ.

Restriction on disclosure of information

5. A notice given or any information furnished to a Chief Medical Officer in pursuance of these Regulations shall not be disclosed except that disclosure may be made-

(a)for the purposes of carrying out their duties-

(i)to an officer of the Department of Health authorised by the Chief Medical Officer of that Department, or to an officer of the Welsh Office authorised by the Chief Medical Officer of that Office, as the case may be, or

(ii)to the Registrar General or a member of his staff authorised by him; or

(b)for the purposes of carrying out his duties in relation to offences under the Act or the law relating to abortion, to the Director of Public Prosecutions or a member of his staff authorised by him; or

(c)for the purposes of investigating whether an offence has been committed under the Act or the law relating to abortion, to a police officer not below the rank of superintendent or a person authorised by him; or

(d)pursuant to a court order, for the purposes of proceedings which have begun; or

(e)for the purposes of bona fide scientific research; or

(f)to the practitioner who terminated the pregnancy; or

(g)to a practitioner, with the consent in writing of the woman whose pregnancy was terminated; or

(h)when requested by the President of the General Medical Council for the purpose of investigating whether there has been serious professional misconduct by a practitioner, to the President of the General Medical Council or a member of its staff authorised by him.

Revocations

6. The whole of the Regulations specified in Schedule 3 to these Regulations are revoked.

William Waldegrave
Secretary of State for Health

4th March 1991

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STATUTORY INSTRUMENTS

2002 No. 887

MEDICAL PROFESSION, ENGLAND

The Abortion (Amendment) (England) Regulations 2002

Made

27th March 2002

Laid before Parliament

28th March 2002

Coming into force

18th April 2002

The Secretary of State for Health, in exercise of the powers conferred by section 2 of the Abortion Act 1967(**1**) and now vested in him(**2**), and of all other powers enabling him in that behalf, hereby makes the following Regulations:-

Citation, commencement, interpretation and extent

1.-(1) These Regulations may be cited as the Abortion (Amendment) (England) Regulations 2002, and shall come into force on 18th April 2002.

(2) In these Regulations "the principal Regulations" means the Abortion Regulations 1991(**3**).

(3) These Regulations extend to England only.

Substitution of regulation 2

2. For Regulation 2 (interpretation) of the principal Regulations substitute-

"**2.** In these Regulations-

"the Act" means the Abortion Act 1967;

"electronic communication" has the same meaning as in section 15 of the Electronic Communications Act 2000(4);

"practitioner" means a registered medical practitioner;

"solicitor" means a person who is qualified to act as a solicitor as provided by section 1 of the Solicitors Act 1974."(5).

Amendment of regulation 3

3. For regulation 3(1) of the principal Regulations (certificate of opinion) substitute-

"**3.**-(1) Any opinion to which section 1 of the Act refers shall be certified-

(a)in the case of a pregnancy terminated in accordance with section 1(1) of the Act, either-

(i)in the form set out in Part I of Schedule 1 to these Regulations; or

(ii)in a certificate signed and dated by both practitioners jointly or in separate certificates signed and dated by each practitioner stating:-

(a)the full name and address of each practitioner;

(b)the full name and address of the pregnant woman;

(c)whether or not each practitioner has seen or examined, or seen and examined, the pregnant woman; and

(d)that each practitioner is of the opinion formed in good faith that at least one and the same ground mentioned in paragraph (a) to (d) of section 1(1) of the Act is fulfilled.

(b)in the case of a pregnancy terminated in accordance with section 1(4) of the Act, either-

(i)in the form set out in Part II of Schedule 1 to these Regulations; or

(ii)in a certificate giving the full name and address of the practitioner and containing the full name and address of the pregnant woman and stating that the practitioner is of the opinion formed in good faith that one of the grounds mentioned in section 1(4) of the Act is fulfilled.".

Amendment of regulation 4

4. In regulation 4 of the principal Regulations (notice of termination):-

(a)in paragraph (1)-

(i)in sub-paragraph (b) omit the words "in the form set out";

(ii)for the words "in a sealed envelope within 7 days of termination" substitute the words "within 14 days of the termination either in a sealed envelope or by an electronic communication transmitted

by an electronic communications system used solely for the transfer of confidential information to him.";

(b)in paragraph (2)(a) insert the figure "79" before the word "Whitehall".

Amendment of regulation 5

5. In regulation 5 of the principal Regulations (restriction on disclosure of information):-

(a)after paragraph (a)(ii) there shall be added-

"(iii)to an individual authorised by the Chief Medical Officer who is engaged in setting up, maintaining and supporting a computer system used for the purpose of recording, processing and holding such notice or information; or";

(b)after paragraph (h) there shall be added-

"(i)to the woman whose pregnancy was terminated, on her supplying to the Chief Medical Officer written details of her date of birth, the date and place of the termination and a copy of the certificate of registration of her birth certified as a true copy of the original by a solicitor or a practitioner.".

Substitution

6. For Schedule 2 to the principal Regulations (abortion notification) there is substituted the Schedule set out in the Schedule to these Regulations.

Signed by authority of the Secretary of State for Health

Yvette Cooper

Parliamentary Under Secretary of State,

Department of Health

27th March 2002

Regulation 6

SCHEDULE

Regulation 4

"SCHEDULE 2

Information to be supplied in an Abortion Notification

1. Full name and address (including postcode) of the practitioner who terminated the pregnancy and the General Medical Council registration number of the practitioner.

2. In non-emergency cases particulars of the practitioners who gave a certificate of opinion pursuant to section 1(1) of the Act and whether they saw or examined, or saw and examined the patient before giving the certificate.

3. Patient's details-

(a)patient's hospital or clinic number or National Health Service number or (if unavailable) patient's full name;

(b)date of birth;

(c)in the case of a patient resident in the United Kingdom, her full postcode or, if the postcode is unavailable, her address;

(d)in the case of a patient resident outside the United Kingdom, her country of residence;

(e)ethnicity (if disclosed by the patient);

(f)marital status; and

(g)parity.

4. Name and address of place of termination.

5. Whether the termination was paid for privately or not.

6. Date and method of foeticide if appropriate.

7. In a case where the termination is by surgery-

(a)date of termination;

(b)the method of termination used; and

(c)in cases where the dates are different, the date of admission to the place of termination and the date of discharge from the place of termination.

8. In a case where the termination is by non-surgical means-

(a)the date of treatment with antiprogestrone;

(b)the date of treatment with prostaglandin;

(c)the date on which the termination is confirmed;

(d)in cases where the place of treatment with prostaglandin is different from the place of treatment with antiprogestrone, the name and address at which the prostaglandin was administered;

(e)details of other agents used and the date of administration; and

(f)the date of discharge if an overnight stay is required.

9. Number of complete weeks of gestation.

10. The ground(s) certified for terminating the pregnancy contained in the certificate of opinion given pursuant to section 1(1) of the Act together with the following additional information in the case of-

(a)the ground specified in paragraph (a), whether or not there was a risk to the patient's mental health and if not, her main medical conditions;

(b)the grounds specified in paragraphs (b) and (c), the main medical condition(s) of the patient;

(c)the ground specified in paragraph (d), any foetal abnormalities diagnosed, together with method of diagnosis used, and any other reasons for termination.

11. The ground(s) certified for terminating the pregnancy contained in the certificate of opinion given pursuant to section 1(4) of the Act and the patient's main medical conditions.

12. In cases of selective termination the original number of foetuses and the number of foetuses remaining.

13. Whether or not the patient was offered chlamydia screening.

14. Particulars of any complications experienced by the patient up to the date of discharge.

15. In the case of the death of the patient the date and cause of death.".

Appendix Five: The HSA1 form

IN CONFIDENCE CERTIFICATE A

ABORTION ACT 1967

Not to be destroyed within three years of the date of operation

Certificate to be completed before an abortion is performed under Section 1(1) of the Act

I, ...

.....

.....

(Name and qualifications of practitioner in block capitals

of.....

.....

.....

(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....

.....

.....

(full address of place at which patient was seen or examined)

on .....

.....

and I .....

.....

(Name and qualifications of practitioner in block capitals)

of .....

.....

.....

(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....

.....

.....

(Full address of place at which patient was seen or examined)

on .....

.....

We hereby certify that we are of the opinion, formed in good faith, that in the case of .....

.....

(Full name of pregnant woman in block capitals)

of .....

.....

.....

(Usual place of residence of pregnant woman in block capitals)

(Ring appropriate letter(s))

A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater appropriate than if the pregnancy were terminated;

B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

C the pregnancy has NOT exceeded its 24th 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;

D the pregnancy has NOT exceeded its 24th 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 any existing child(ren) of the family of the pregnant woman;

E 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.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case.

Signed .....**Date**.....

Signed .....**Date**.....

* Delete as appropriate DdDH005329 4/94 C8000 CC38806 Form HSA1 (revised 1991)

Appendix Six: Accurate accounts of the law, from the Chief Medical Officer and the Royal College of General Practitioners

Letter from the Chief Medical Officer, Professor Dame Sally C Davies, 23 February 2012

To: All Independent Sector Abortion Clinics SW1A 2NS
Medical Directors – NHS Trusts
Medical Directors – NHS Foundation Trusts Tel: +44 (0)20 7210 5150-4
Medical Directors – Primary Care Trusts Fax: +44 (0)20 7210 5407
Copy: Chief Executive of Monitor

Gateway reference: 17305

Dear Colleague

ABORTION ACT 1967 (AS AMENDED): TERMINATION OF PREGNANCY

In light of recent media coverage, I am writing to remind all those involved in providing and commissioning treatment for termination of pregnancy of the need to fully comply with all the requirements of the Abortion Act 1967 (the Act). This is extremely important because, unless performed under the conditions set out in the 1967 Act, abortion remains a criminal offence under the Offences Against the Persons Act 1861.

In particular, unless an emergency abortion is required under s 1(4) of the Act, a pregnancy may only be terminated if two registered medical practitioners have certified that they are of the opinion, formed in good faith, that at least one and the same ground for abortion in section 1(1) of the Act exists. The certification takes place in the light of their clinical judgement of all the particular circumstances of the individual case.

If there is evidence that either certifying doctor has not formed the opinion in good faith, then the doctor performing the termination is not protected by section 1(1) of the Act and has potentially committed a criminal offence by terminating the pregnancy. It is also possible that the doctor could be acting contrary to their professional duties.

Sex selection is not one of the lawful grounds for termination. It is illegal for a practitioner to carry out an abortion for that reason alone, unless the certifying practitioners consider that an abortion was justified in relation to at least one of the section 1(1) grounds. A sex-linked inherited medical condition may be relevant to the practitioner's consideration of whether any of the section 1(1) grounds are met in a specific case.

The section 1(1) grounds for an abortion are:

(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 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."

* There is no time limit on the term of the pregnancies to which grounds (b) – (d) may apply.

Any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State, NHS Trust, Primary Care Trust or NHS Foundation Trust; or, for the private and independent sector, in a place approved by the Secretary of State.

In addition the termination of pregnancies is prescribed as a regulated activity under the Health and Social Care (Regulated Activities) Regulations 2010. Anyone (in England) who carries on a regulated activity without being registered by the CQC in respect of it is guilty of an offence under the 2008 Act. Regulation 20 of the Health and Social Care (Registration) Regulations 2009 specifies various requirements relating to termination of pregnancies that apply to a registered person who carries on or manages the regulated activity consisting of the termination of pregnancies; and is not an English NHS body.

Places approved by the Secretary of State must also continue to comply with Departmental guidance in the form of Required Standard Operating Principles (known as the Yellow Book). Failure to comply with or maintain the standards required by the Secretary of State will lead to a withdrawal of approval at any time during the approval period, and individual doctors may be referred to the GMC.

Registered medical practitioners in England are legally required to notify me as Chief Medical Officer through Form HSA4, of every completed abortion they have performed within 14 days of the procedure.

All those who commission and provide treatment for termination of pregnancy are accountable for ensuring all staff involved with this area of provision are fully aware of, and comply with, the requirements of the Abortion Act. Organisations should be monitoring compliance in this area. I would be grateful for your support in ensuring there is full compliance with these requirements.

PROFESSOR DAME SALLY C DAVIES

[NB: This position statement applies only to England, Scotland & Wales. A separate statement will be produced for Northern Ireland in recognition of the different legislative context.]

The role of the RCGP Sex, Drugs and HIV Group (SDHIVG) is to provide support to the College's work in sexual health and in the area of drug misuse. The group's strength lies in its multidisciplinary approach bringing together expert opinion to ensure the College is able to respond to current issues in sexual health policy, service delivery, care and treatment of patients. SDHIVG identified that RCGP guidance on Abortion would be an important method of increasing good practice in this area. The group consists of appointed GP members of the College and invited representatives from organisations working in the SDHIVG's fields of interest. This includes representatives from FPA, BASHH, MedFASH and RCOG.

FPA was asked to draft the statement on behalf of the group, also referencing a number of other organisations who have researched the topic. The SDHIV group then amended and approved the draft statement, before it went to the RCGP's Ethics Committee, Peer Reviewers and the Council Executive Committee for comment and agreement.

No conflicts of interest were noted, as there are no abortion providers on the SDHVIG.

In reviewing the existing statement by the RCGP[1], an update was deemed necessary so as to provide **a clear position statement on the role of the GP** in enabling women to access abortion services in line with UK law. The intent of the current statement therefore is to show that the RCGP expects all general practitioners to recognise the importance of ensuring that women seeking advice about pregnancy options receive the advice and support they need in a timely manner. It sets out how women should expect to be treated when they approach a general practitioner about an unplanned or unwanted pregnancy.

Abortion Legislation

Abortion is a crucial aspect of sexual health, and is regulated by the 1967 Abortion Act (as amended by the Human Fertilisation and Embryology Act 1990). The law provides that women can access abortion up to 24 weeks if two doctors agree that it is less likely to cause harm to her physical or mental health than continuing with the pregnancy. Abortion may be carried out after 24 weeks if there are exceptional circumstances - for example, if there is a serious risk to the woman's health, or there is a substantial risk of physical or mental disability if the baby was born. **These very late abortions (›24weeks) accounted for 0.1% of the total number of abortions carried out in 2010[2].**

[1] "Conscientious Objection to Abortion" RCGP CEC/35 - 14 December 2000

[2] Department of Health. Abortion statistics, England and Wales: 2010. May 2011.

The Abortion Act 1967 (with some provisions amended by the Human Fertilisation and Embryology Act 1990) defines the grounds upon which an abortion can take place in a lawful manner. The Act covers England, Scotland and Wales, but does not apply to Northern Ireland, where the Offences Against the Person's Act 1861 and case law applies. It is the provisions of the Abortion Act 1967 that make some abortions lawful in certain circumstances in Great Britain. Essentially, authorisation for any abortion can only take place when two registered medical practitioners are of the opinion formed in good faith that one of the grounds for a lawful abortion exists. The Abortion Act 1967 lays out the grounds upon which an abortion can take place. It is a critical element under the Abortion Act that two doctors must agree that one of these grounds exists.

The Role of the General Practitioner

General practice, for many women, will be the first point of contact for unplanned pregnancy advice. It is vital that women are able to access good quality information and advice about all of their options - including abortion - and general practice plays a crucial role in providing this. It is important that women have access to abortion services as soon as possible, as evidence shows that the risk of complications increases the later the gestation.[3]

GPs will have many views on abortion , including some who will have a personal belief against abortion, which could potentially influence their attitude to, and management of, patients requesting an abortion. It is important that GPs recognise their duties and obligations in this area, which can raise personal ethical issues for a practitioner.

The law in relation to abortion is found in statute. GPs must be familiar with the legal requirements of the Abortion Act 1967, as amended in 1990. This guidance will give a brief overview of the main elements of the law - further reading is recommended at the end of the document.

The Abortion Act 1967 provides a right of conscientious objection which allows doctors and nurses to decline to participate in arranging or performing an abortion. This right is limited only to the active participation in an abortion where there is no emergency with regard to the physical or mental health of the pregnant woman. Doctors **cannot** refuse to provide emergency and other medical care for these women.

Women's Rights

All women in England, Wales and Scotland can access an abortion if their circumstances fulfill the terms of the Abortion Act 1967. Abortion services should therefore be easily accessible and allow direct referral, as well as referral from health professionals. Health care providers of abortion services should be committed to ensuring that women can access abortion services as early as possible to reduce the possibility of associated health risks (See RCOG guidelines (www.rcog.org.uk) and MedFASH recommended standards for sexual health services (www.medfash.org.uk)

[3] Gans Epner, J.E., Jonas, H.S., Seckinger, D.L. (1998). Late-term abortion. Journal of the American Medical Association, 280 (8), 724-729.

Statistics show that in 2010 around 189,974 abortions took place in England and Wales. Latest figures (2010) show that progress is being made to increase early access; 77% of NHS funded abortions took place at under 10 weeks, compared with 58% in 2000.

Ethical Values

The GMC's Good Medical Practice guidance[4] states that doctors should make the care of their patients their first concern. The BMA's guidance on the law and ethics of abortion[5] states that doctors with a conscientious objection to abortion may not impose their views on those who do not share them, but they may explain their views to the woman if invited to do so. This document also states that doctors with a conscientious objection to abortion should make their views known to the woman and refer her to another doctor immediately.

A priority goal of the RCGP is to provide leadership at all levels in healthcare by supporting the professional development of general practitioners to maintain standards of excellence and promote patient safety and quality in general practice. RCGP values include "equitable access to, and delivery of, high quality and effective primary healthcare for all". It is important that all women requesting abortion are treated in an equitable way, whatever the personal view of the GP. This position statement aims to promote equity in the clinical area of care for women with unplanned pregnancy who are considering an abortion.

The abortion decision

Unplanned pregnancy may involve complicated and ambivalent feelings. A decision to continue or not with a pregnancy is an important life event that needs careful consideration. Pregnancy brings with it physiological, emotional and psychological changes which can make decision making increasingly difficult, particularly as the pregnancy progresses. It is important to give women the opportunity to consider the issues in a confidential and non-judgemental environment. A wide range of health professionals and organisations currently provide help and support with the decision making process. Systems should be in place to rapidly refer women for pregnancy counselling when this is required.

Whose decision is it?

While the opinion and feelings of others will often form part of the picture for each woman, the decision remains hers. It is important that the woman acknowledges the implications and responsibility of the decision. It is good practice to see the woman on her own (whatever her age or social situation). It may be appropriate for a woman to involve a partner or family member in the decision making process

Given the importance of ensuring that women seeking advice about pregnancy options receive the advice and support they need, it is important that GPs follow the GMC's Good Medical Practice guidance and BMA's guidance on law and ethics on abortion, as stated above.

[4] General Medical Council, *Good Medical Practice* (London: GMC, 2009)

[5] British Medical Association, *The law and ethics of abortion* (London: BMA, 2007)

[6] *Ibid*

Details of doctors with a conscientious objection can be set out in the practice leaflet to enable women to choose which doctor to consult[6]
Good practice guidance from the Royal College of Obstetricians and Gynaecologists (RCOG)[7] states that, as a minimum standard, all women requesting abortion should be
offered an assessment appointment within 5 working days following referral – general practice plays a role in achieving this standard by referring promptly when the woman has made her decision (‹48 hours).

Recommendations:

1. The RCGP expects all general practitioners and their teams to recognise the importance of ensuring that women seeking advice about pregnancy options receive the advice and support they need.

2. All practices should have a clear written statement about how women who wish to discuss this issue can access appropriate practitioners within their practices. Women should be able to look on a practice website or practice leaflet and see if there were some doctors or nurses who would be comfortable with an approach about abortion. Doctors with a conscientious objection would be omitted from the list.

3. Once a woman has chosen abortion, it is important that she has timely access to abortion services (urgent referral by the general practitioner (‹48hrs) and within 5 working days by the abortion service).

4. General Practitioners with a conscientious objection to abortion must not impose their views on those who do not share them, and must arrange to refer a woman requesting abortion to another doctor immediately and without delay. If it is the situation that all of the doctors in a practice have a conscientious objection to abortion, that practice must have a clear pathway for rapid onward referral of women to a service which can provide, and has agreed to provide, abortion advice and treatment. It should also be clear where follow-up care and advice will be available for women if needed or required.

5. Women need to be able to access good quality information and advice about all their options. Women may require advice and information from their General Practitioner on more than one occasion both before and after their decision on abortion.

6. When counselling about abortion, it is good practice for the general practitioner to see the woman on her own (whatever her age or social situation) unless she requires an independent advocate due to capacity issues.

7. Women should be able to access their own General Practice for non-judgemental support and advice after an abortion.

[7] Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7* (London: RCOG Press, 2011)

8. General Practitioners should be aware of local pathways for referring women requesting abortion

9. General Practitioners must be familiar with the legal requirements of The Abortion Act 1967, as amended in 1990.

Summary

Abortion has been legal in England, Scotland and Wales since 1967. The aim of this position statement has been to highlight the importance of having a smooth referral process.

GLOSSARY

Abortion – is the expulsion of a foetus showing no signs of life before the 24th week of pregnancy (although this may be later for an induced abortion)8. Abortion can occur spontaneously, in which case it is usually called a miscarriage, or it can be purposely induced. The term *abortion* most commonly refers to the induced abortion.
FPA - a UK registered charity working to enable people to make informed choices about sex and to enjoy sexual health.
BASHH – British Association for Sexual Health and HIV, the lead professional representative body for those practicing sexual health including the management of STDs and HIV in the UK.
MedFASH – Medical Foundation for AIDS and Sexual Health, a charity dedicated to the pursuit of excellence in the healthcare of people affected by HIV, sexually transmitted infections and related conditions. It undertakes a range of projects to support health professionals and policy-makers.
RCOG – Royal College of Obstetricians and Gynaecologists.
Conscientious objection – *conscience* is the private, constant, ethically attuned part of the human character and not to act in accordance with one's conscience is to betray one's moral integrity. The onus is on the objector to prove that it is due to a matter of conscience – positions that are merely self-protective do not constitute the basis of a genuine claim of conscience. Conscience is a prima-facie value and may need to be overridden in the interest of other moral obligations that outweigh it in a given circumstance.
(American College of Obstetrics and Gynaecology Committee Opinion: *The Limits of Conscientious Refusal in Reproductive Medicine.* Number 385, November 2007)

Appendix Seven: Correspondence on abortion provision and the law

A letter to the Guardian on 29 March 2012, signed by senior clinicians and academics involved in abortion care and research, reads:

We are senior clinicians and researchers who are or have been involved in the management of, or research about, terminations of pregnancy. Some of us also have dealt with a wide variety of presentations, including the types of cases recently described in coverage of so-called "sex selection" abortion, and commented on by persons including the prime minister, and the secretary of state for health among others. We also spend much of our working lives providing abortions to women who need them, or seeking to understand and illuminate more about how to create a policy framework for abortion provision that best meets women's need.

We are deeply concerned about the way the public discussion on abortion provision is currently proceeding (Anti-abortionists grow bold after making friends in high places, *Guardian* 23 March). There appears to be determined effort by some politicians and sections of the media to present a profoundly misleading picture of how abortion provision works, the nature of the law as it stands, and the experiences of women (who we see on a daily basis). Given the speed at which this is all proceeding, carrying with it, for the first time in decades, the genuine prospect of doctors who provide abortions being struck off the medical register, or maybe even subject to prosecution, we are very concerned indeed about how the abortion service will manage to carry on providing what is an already difficult and demanding area of medical practice.

The government should spend its energies addressing the genuine problems that impact on our work as clinicians, and which are the major problems for women requesting abortion: unnecessary restrictions on provision of early medical abortion, and problems with access to second-trimester abortions. In 2007 the Commons science and technology committee performed an extensive inquiry into the workings of the Abortion Act, providing a useful base for reform; we urge the government to review this work.

We also ask members of the public to recognise what is at stake here, and find ways of offering their support to those involved in the provision of abortion.

- Professor Wendy Savage, *Department of Health and Social Science, Middlesex University*
- John Ashton, *Consultant in public health*
- Ed Dorman, *Consultant gynaecologist*
- Colin Francome, *Emeritus professor, Middlesex University*
- Malcolm Griffiths, *Consultant gynaecologist*
- Kate Guthrie, *Consultant gynaecologist*
- Lesley Hoggart, *Principal research fellow, University of Greenwich*
- Emily Jackson, *Professor, law department, London School of Economics*
- Ellie Lee, *Reader in social policy, University of Kent*
- Patricia Lohr, *Consultant gynaecologist*
- Alan Naftalin, *Consultant gynaecologist*
- David Paintin, *Emeritus reader in obstetrics and gynaecology, Imperial College Medical School*
- John Parsons, *Consultant gynaecologist*
- Kate Paterson, *Consultant gynaecologist*
- Sheila Radhakrishnan, *Consultant gynaecologist*
- Sally Sheldon, *Professor, Kent Law School*
- Geetha Subramanian, *Consultant gynaecologist*

In July 2012, a group of eminent legal scholars wrote to the General Medical Council to highlight the errors in this guidance, and to ask the GMC to rectify these for the sake of providing much needed clarity to doctors working within the field. This letter is reproduced here.

Professor Peter Rubin
President
General Medical Council
Regents Place
350 Euston Road
London NW1 3JN

cc. Niall Dickson, Chief Executive, GMC

2 July 2012

Dear Professor Rubin,

We are writing to you as professors with expertise in medical law, who have been extremely concerned by the quality of the advice which the GMC has offered to its members regarding abortion for reason of sex selection. While the revised GMC guidance on this issue is significantly better than the previous version, unfortunately it is still erroneous and misleading in important respects. You will be aware that the CMO has written to doctors to remind them of the law in this area, offering guidance which is both clearer and significantly more accurate than that offered by the GMC. You might also know that the RCOG has recently revised its published statement on this matter to remove some of the fundamental errors which are still present in the GMC's own statement.

Given the undesirability of leaving doctors in any uncertainty regarding their legal obligations and the fact that they will clearly look to the GMC for the highest standards of advice, we would respectfully suggest that the GMC might wish to consider referring doctors to the CMO's guidance rather than issuing its own separate advice. This would have the highly desirable outcome of providing doctors with one clear, consistent, accurate and authoritative account of the relevant law.

We would note three specific problems with the guidance currently given on the GMC's website.

First and most significantly, it is misleading to say either that 'terminating a pregnancy on grounds of the fetus' sex is not covered in the Act and therefore remains illegal' or that 'terminating a pregnancy on the grounds of a fetus' sex is illegal under the 1967 Abortion Act (where this applies) unless specific hereditary diseases are involved'. These statements deny the necessary exercise of clinical discretion, which is central to the operation of the Abortion Act (1967). The correct legal position is rather, as the CMO puts it, that: '[i]t is illegal for a practitioner to carry out an abortion *for that reason [sex selection] alone*, unless the certifying practitioners consider that an abortion was justified in relation to at least one of the section 1(1) grounds. A sex-linked inherited medical condition may be relevant to the practitioner's consideration of whether any of the section 1(1) grounds are met in a specific case' (our italics).

Second, to say that an activity 'is illegal under the 1967 Abortion Act' wrongly suggests that the Abortion Act contains the relevant offence. It does not. As the CMO's guidance more accurately notes: 'unless performed under the conditions set out in the 1967 Act, abortion remains a criminal offence under the Offences Against the Persons Act 1861'. The wrongful activity would thus be illegal under the 1861 Act, which creates the relevant offences. The 1967 Act operates to render lawful conduct which would otherwise be unlawful, provided that certain conditions are met.

Third, the phrase 'where this applies' in the sentence 'terminating a pregnancy on the grounds of a fetus' sex is illegal under the 1967 Abortion Act (where this applies)' is also liable to cause unnecessary confusion, in the absence of further clarification regarding the circumstances in which the 1967 Act might not apply. As professors of law, we remain unclear as to what is envisaged by this phrase (and, as such, we would imagine that doctors will find it equally difficult to interpret).

Again, we would emphasise the important role of the GMC in providing clear and consistent advice to all clinicians, who might reasonably look to you for guidance on this issue.

We look forward to hearing from you.

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