



# Providing abortion under healthcare law

## A British Pregnancy Advisory Service briefing on England and Wales

### Key points

- If consensual abortion were removed from the criminal law up to 24 weeks through repeal or reform of the 1861 Offences Against the Person Act, abortion would be **subject to the same laws and regulations that govern all healthcare procedures**, and would be **regulated in the same way for example as maternity care**.
- The need for 2 doctors' signatures is a legal requirement that is unrelated to either the clinical care or protection of vulnerable women and girls - **procedures for the effective safeguarding of women are contained in entirely separate stand-alone guidance** that all services follow.
- **Abortion would need to be performed in line with professional guidance and by qualified medical professionals**; any service or individual involved in poor practice would face disciplinary and potentially criminal sanctions.
- **The Royal College of Obstetricians and Gynaecologists, British Medical Association, Royal College of Midwives, and the Faculty of Sexual and Reproductive Healthcare all support decriminalisation.**

### Background

There has been significant discussion in the UK regarding the removal of abortion from the criminal law, coinciding with the anniversary of the 1967 Abortion Act – which is no longer regarded as fit for the needs of women in the 21<sup>st</sup> century. **Abortion law in England and Wales is underpinned by the Offences Against the Person Act 1861 which made having - or helping - an abortion a criminal offence, punishable by life in prison.** Any woman who causes her own abortion at any gestation, from Newport to Newcastle, from Bridgend to Brighton, can go to prison.

In October 2018, a bill to remove sections 58 and 59 of the Offences Against the Person Act passed a first parliamentary hurdle. If successful, this bill would have effectively decriminalised abortion up to 24 weeks in England, Wales, and Northern Ireland, making the 1967 Abortion Act redundant before 24 weeks (later abortions would still be covered by the Infant Life Preservation Act and would still need therapeutic exemptions to prosecution provided by the 1967 Act).

**If these sections were removed from the OAPA or reformed, abortion as a medical procedure would be treated as a healthcare matter rather than a criminal one and be subject to the substantial body of law and regulation that govern all healthcare procedures.** It would remain the case that only those qualified to perform a medical procedure would lawfully be able to do perform an abortion - although this could now also include suitably qualified nurses and midwives who are today involved in an ever-expanding range of clinical procedures. Abortions, as today, would need to be performed in line with professional guidance, such as the Care of Women Requesting Induced Abortion (Royal

College of Obstetricians and Gynaecologists, 2011) Termination of Pregnancy: An RCN nursing framework (Royal College of Nursing, 2017) and forthcoming guidelines from NICE to be published in September 2019, and a healthcare professional failing to do so could face sanction. Regulatory bodies such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) play key roles to play in ensuring that professional standards are maintained.

In July 2019, **a bill was passed in Parliament that will decriminalise abortion in Northern Ireland** – repealing s58 and s59 of the Offences Against the Person Act in the region. These laws would, however, still apply in England and Wales.

This briefing explains what frameworks to protect and support women are currently in place – and would remain so – were abortion decriminalised through the removal, or reform, of sections 58 and 59 of the OAPA.

### Safeguarding and the 1967 Act

It has been suggested, primarily by those opposed to women's access to abortion care, that protections for some groups of particularly vulnerable women would be removed if abortion were decriminalised and the 1967 Abortion Act made redundant, and that women would lose the opportunity to discuss their decision, and potentially disclose coercion or abuse. This suggestion reflects a fundamental misunderstanding of the nature of healthcare law and regulation today, as any service providing abortion care in this way would be operating outside existing legislation.

**There is nothing in the 1967 Abortion Act that makes provision for the safeguarding of young or vulnerable women, access to counselling services, or specifies that informed consent must be obtained before an abortion can be lawfully performed. The Act is entirely silent on these issues.** These provisions and safeguards are all contained in entirely separate bodies of regulation, common law and legislation, which would remain firmly in place were abortion decriminalised in England and Wales.

### The regulation of abortion services today

Abortion, alongside other clinical procedures, diagnostic and screening procedures, maternity and midwifery services as well as nursing care, became a regulated activity under the Health and Social Care Act 2008, a piece of legislation designed to improve professional regulation and which created a new regulator, the Care Quality Commission (CQC), for that purpose. The regulator was established with a focus on providing assurance about the safety and quality of care for patients and service users. In Wales, abortion services are inspected by the Healthcare Inspectorate Wales.

These inspectorates use a series of standards which are drawn from legislation, guidance and existing regulation, against which they inspect the quality and safety of a service. They have the power to enforce improvements, suspend services and ultimately pursue criminal prosecutions against providers for failing to provide treatment or care in a safe way. "Safety" in this context refers not just to the clinical standards of the care being offered, but also covers whether the service user is appropriately safeguarded and supported during the process, and their informed consent to any intervention appropriately obtained.

### Obtaining informed consent

All women attending an abortion service will have a discussion about their pregnancy options, their decision about whether to continue or to end the pregnancy, and in the latter case, their understanding of the available procedures and associated risks as part of the process of

gaining informed consent. **Informed consent is entirely separate from - although often confused with - the requirements in the Abortion Act for 2 doctors to certify that a woman meets the grounds for abortion.** This requirement in the act is a legal duty that is unrelated to whether the woman understands and consents to the procedure she is about to undergo.

**The need for consent in healthcare is founded in common law and the principle of bodily autonomy.** For consent to be valid and legal, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These principles apply to all medical procedures, including abortion.

As explained by NHS Choices, these terms mean the following:

- **voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family
- **informed** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment doesn't go ahead
- **capacity** – the person must be capable of giving consent, which means they understand the information given to them and they can use it to make an informed decision

These principles are well-tested in the courts, and are encapsulated within the same universal healthcare requirement for informed consent for any clinical procedure.

**Any suggestion during the consent discussion that a woman is under pressure to make a particular decision regarding the future of the pregnancy will require further exploration,** not least because the woman's consent may not be valid if it is given under pressure or duress from another person – this applies equally whether in the case of abortion or any other clinical procedure. A doctor who undertakes a procedure without the consent of a woman may be guilty of assault.

As part of standards set by the CQC, abortion services must be able to prove they have processes in place to ensure that all women and girls are seeking services voluntarily. Again, these requirements are entirely unrelated to the provisions of the Abortion Act.

### Decision-making support

Although the majority of women who request an abortion have already carefully considered their situation and are sure of their decision when they first present to a provider, some women are undecided about whether to continue with or end the pregnancy and need additional support. **Women seeking abortion must have access to trained staff who can discuss their pregnancy options with them, including continuing the pregnancy and becoming a parent, having the child fostered or adopted, or ending the pregnancy by abortion.** Women who remain undecided will be given all the time they need to arrive at a decision, and offered additional time to discuss their options further with a trained member of staff if they wish. This can be offered in person, or on the phone, if women prefer. Healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process as part of guidance issued by the RCOG.

**Women must be made aware that they can change their minds or delay the procedure at any time. All women attending a service must also have access to post-abortion support or counselling if they need it.** Pathways to further counselling not necessarily

related to the abortion should be available for any woman who may require additional emotional support or whose mental health is perceived to be at risk.

### Safeguarding girls, young women and vulnerable adults

The legal framework to protect children is contained in Working together to safeguard children (2015). This guidance references the intercollegiate document, Safeguarding Children and Young People: Roles and competencies for Health Care Staff, published in 2014.

**Healthcare services have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.**

Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level 3 (the penultimate level) in safeguarding.

**If the service treats women under 18 years of age, staff need to be able to recognise potential cases of child sexual exploitation (CSE), explore them sensitively with the young person, and make prompt referrals.**

Under the Sexual Offences Act 2003 those under the age of 13 are considered of insufficient age to give consent to sexual activity. Most child protection agencies regard pregnancy in a client under 13 as evidence that she is 'at risk' and so expect to be notified by any healthcare provider should she present to that service.

### Domestic violence, including forced marriage and honour-based violence

The cross-government definition of domestic violence and abuse is: 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

**Pregnancy is a time when domestic abuse is more likely to start or to escalate, with 15% of women reporting violence during a pregnancy.** Physical abuse may be one factor in women's decision to end their pregnancy.

Routine enquiry into domestic abuse is carried out in all women's health settings, including women requesting a termination of pregnancy. Abortion services are acutely aware of the risk of domestic abuse and will see all women alone at some point to allow safe disclosure, using guidance NICE 2015 and The Department of Health guidance (2017) which provides relevant information and a practical toolkit for frontline practitioners. Routine inquiry is carried out in a

sensitive way that does not imply or suggest the woman is subject to abuse but includes the following:

- provision of an environment where a woman feels able to discuss her experiences
- a focus on the woman's safety and that of any children
- assess the risk she is at, give information ('signposting'), and refer to specialist agencies
- not judging the woman (for example respecting a decision not to leave the abusive relationship at that point) but provide support and reassurance that help will always be available

**If there is reason to suspect children are at risk, safeguarding and child protection must always take precedence over confidentiality.**

### Female Genital Mutilation (FGM)

In the UK, FGM has been a specific criminal offence since the Prohibition of Female Circumcision Act 1985. The Female Genital Mutilation Act 2003 replaced the 1985 Act in England, Wales and Northern Ireland. Section 1 of the 2003 Act provides that a person is guilty of an offence if he 'excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris'. The definition of FGM includes other harmful procedures to the female genitals, which include pricking, piercing, cutting, scraping and burning the area.

The 2003 Act made it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal.

The Serious Crime Act 2015 further strengthened the law on FGM. It is now also an offence to fail to protect a girl from FGM. Lifelong anonymity for victims of FGM has been guaranteed. FGM protection orders were introduced on 17 July 2015, and the extra-territorial reach of the 2004 Act has been extended to habitual UK residents. **From 2015, there has been a statutory duty to report all girls under 18 who directly disclose FGM, or are identified to have undergone FGM, to the police. All abortion providers must adhere to this legislation.**