ABORTION:
Trusting women to decide, and doctors to practise

Why it’s time to re-think the law

British Pregnancy Advisory Service
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Foreword

As one of those who campaigned in the 1960s for the current Abortion Act, I warmly welcome this forward-looking publication, which presents a well-argued and powerful case for the decriminalisation of abortion. The thorough and wide-ranging analysis of the history of the abortion law, the Parliamentary battles, and the improvements in techniques and services, demonstrates the need to review abortion legislation and remove it from the context of the 1861 Offences Against the Person Act (OAPA).

It is not generally recognised that the 1967 Abortion Act legalises abortion in certain circumstances as exceptions to the provisions of sections 58 and 59 of the 1861 OAPA – already over a century old when the Abortion Act was passed – which make abortion a criminal offence. The 1960s reform, in which I was involved as Secretary of the Abortion Law Reform Association (ALRA) campaigning team, reflected the social mores of that time and has served women and their families well.

But the accumulated experience of nearly half a century points, among other things, to the need for clarification of the role of clinicians, for positive recognition of abortion services as an integral part of healthcare, for giving women autonomy in abortion choice, and for acknowledgement of contemporary social and sexual behaviour in Britain. The underlying nineteenth-century legislation is a block, exercising a ‘chilling effect’ with the threat of criminal proceedings for alleged infringements of the Abortion Act.

Attempts in Parliament from 1969 to the present day aiming to restrict and amend the 1967 Abortion Act have been constant, although Mrs Justice Lane’s Committee on the Working of the Abortion Act sitting from 1971-74 provided a rare reprieve. This publication illustrates the wide variety of Parliamentary attacks, and presents a case study of the most recent and unsuccessful in February 2015: Fiona Bruce MP’s ‘sex selection’ amendment to the Serious Crime Bill.

The late Vera Houghton (Lady Houghton), ALRA chair at the time of the passing of the Abortion Act, said in 1997, ‘I would like the law to be more permissive, but I am not sure how we could achieve it’. She added ‘perhaps in the end scientific developments will place decisions in women’s hands’. While the advent of medical abortion does not give women that power, its availability has significantly transformed the abortion scene both for women and their healthcare providers.

Account needs to be taken of these challenges: is the 1967 Abortion Act ‘fit for purpose’ in this respect? Certainly the 1861 Offences Against the Person Act is not. As the Law Commission stated in a recent scoping exercise, inviting views on whether selected sections of the OAPA should be reformed, ‘The Offences Against the Person Act 1861 is widely recognised as being outdated’. Unfortunately, the Law Commission is not intending to review the sections of this ‘outdated’ law that relate to abortion.

1 Abortion Law Reformers: Pioneers of Change. BPAS 2007
Executive summary

- Britain's abortion law will be 50 years old in 2017. While it has served women well, its provisions are increasingly out of touch with the reality of women's lives, and with best practice in abortion care.

- Abortion in Britain today is a normal fact of life. There are around 200,000 abortions a year. One in three women will have an abortion in her lifetime. Sexual health policy supports the provision of abortion, and 98% of abortions are funded by the National Health Service.

- Developments in services, pregnancy testing, and medical abortion, mean that an increasingly large proportion of abortions take place under 10 weeks' gestation. Early procedures are safer, more straightforward, and better for women. This also creates a significant role for nurses and midwives. First trimester abortions increasingly use the medical method (the abortion pill).

- A small proportion of women (8%) will continue to need access to abortion in the second trimester of pregnancy, for many reasons. These may be very young women who hid their pregnancy, or perimenopausal women who did not suspect they were pregnant. They may be women whose contraception failed without their knowledge. Abortions may be requested when a relationship has broken down, an existing child has become seriously ill, or a fetal anomaly has been detected. Women may need time following a later diagnosis to make the decision that is right for them. It is crucial that the abortion service continues to provide care for these women.

- Less than 0.1% of all abortions take place after 24 weeks' gestation, mainly for reasons of fetal anomaly. This reflects the fact that anomalies cannot always be detected until later in pregnancy, and that women need time to make what is often a very difficult decision to end a much-wanted pregnancy.

- The expectation that safe, legal abortion care can be accessed when needed underpins significant social and cultural changes with regard to women's equality. Without the ability to control their fertility, women would have not achieved the level of educational and workplace equality that younger generations can rightly take for granted. Abortion cannot solve all the problems of inequality; but without the ability to exercise reproductive choice, all problems of inequality are made worse.

- Given the role played by abortion in mainstream healthcare today, the fact that it remains situated within the criminal law is an anomaly. Under the 1861 Offences Against the Person Act (OAPA), having or performing an abortion is a criminal offence that carries a lengthy jail sentence. This Victorian piece of legislation fossilises values well out of step with those cherished today.

- The 1967 Abortion Act provides a therapeutic exemption to the offences under the OAPA, and makes abortion legal provided that women and doctors meet certain requirements. But the 1967 Act is also the product of a very different era to now. The legislation was crafted to regulate different clinical techniques, in a climate where the biggest threat to women's health from abortion came from illegal, backstreet abortions.

- The 1967 Act was also developed in a context where public opinion was far more ambivalent about abortion than it is today. Two thirds of people today say that abortion should be allowed according to a woman's choice, compared to 37% in 1983.

- The very provisions of the Abortion Act that sought to protect women's health are today preventing the provision of modern, evidence-based clinical care. These provisions include:
  - The arcane requirement that two doctors must authorise each abortion;
  - The fact that women are prevented from taking the 'abortion pill' (early medical abortion) at home;
  - The way that nurses and midwives are prevented from playing a full role in the straightforward abortion cases.

- The very provisions of the Abortion Act that sought to protect women's health are today preventing the provision of modern, evidence-based clinical care. These provisions include:
  - One of the aims of the Abortion Act was to protect doctors from prosecution when performing legal abortions. But the discordance between the law and best standards of clinical practice has exposed doctors to the 'chilling effect' of smear campaigns and legal misinterpretations imposed by opponents of abortion.

- Other jurisdictions, in Australia and Canada, have successfully removed abortion from the criminal statute, in order to regulate it with laws more appropriate to a mainstream healthcare procedure. This has not caused an increase in numbers or rates of abortion, and has provided a more constructive platform to consider how abortion can best be provided.

- In addition to the criminal law, abortion in Britain is tightly regulated as a healthcare procedure. Clinics are inspected by the Care Quality Commission (CQC), and healthcare workers are bound by their professional bodies, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). Healthcare teams work to detailed evidence-based guidance produced by the eminent Royal College of Obstetricians and Gynaecologists (RCOG).

- The word 'decriminalisation' immediately implies that there is something wrong with abortion; that maybe it should be criminal. Our aim here is to present a positive case for why we need regulation that meets women's needs. We believe that the time has come to remove abortion from the criminal law, and to regulate the service according to standards of best clinical care.
Introduction

Women in Britain today have access to safe, legal abortion funded by the National Health Service (NHS). Thanks to developments in pregnancy testing, early abortion procedures, and flexible nurse-led services, women can have an abortion almost as soon as they need one. But women are not under pressure to rush their decision: if they don’t immediately realise that they are pregnant, or need time to decide that they don’t want to continue with the pregnancy, they can access abortion up to 24 weeks’ gestation. In cases where the fetus is diagnosed with a serious anomaly, or there is a serious threat to the woman’s life or health, a woman can access abortion at any stage of her pregnancy.

The existence of a sensitive, publicly-funded abortion service in Britain is testament to the commitment of the doctors, nurses, midwives, and others who have dedicated themselves over the past 50 years to meeting women’s need for care. It is also testament to Britain’s abortion law, passed in 1967, which recognised that women needed access to safe abortion in the first and second trimesters of pregnancy, and that women carrying fetuses with serious anomalies needed particular consideration.

The 1967 Abortion Act was crucial to reducing dramatically the mortality and morbidity rates associated with backstreet abortions and forcing women to carry unwanted pregnancies to term. It brought abortion under the auspices of women’s healthcare, and made it possible for doctors to carry out a legitimate, compassionate service. The Act also had a powerful social effect. Abortion became acceptable, and as public funding improved, safe abortion was no longer something that only wealthy women could access. Abortion became an integral part of family planning: a back-up for women when contraception failed, or when life dealt them a harsh blow.

We have a lot to thank the 1967 Abortion Act for, but we also know that it is time to move on. The technology of abortion has changed hugely in the past 50 years, meaning that the Act is now out of step with best clinical practice. Where, in the 1960s, the provisions of the Abortion Act attempted to make procedures safer for women, now they make procedures more risky and difficult than necessary. This is why doctors, nurses, midwives, and others involved in the clinical practice of abortion are so keen to see a change to the law: so that they can provide the best treatment for women, rather than a service that is hampered by archaic legal requirements.

The social context of abortion has also changed dramatically. Abortion is a normal feature of women’s reproductive healthcare, both in Britain and internationally. The Royal College of Obstetricians and Gynaecologists (RCOG) begins its evidence-based guideline with the statement:

Induced abortion is common: over 200,000 procedures are performed each year in Great Britain, and at least one-third of British women will have had an abortion by the time they reach the age of 45 years.¹

Within Britain, several generations of women have grown up with the knowledge that if they experience an unwanted pregnancy, they can consider abortion. They do not think of it as a criminal offence: many are shocked to find that it is still regulated by the criminal law.

While Britain was one of the first countries in the world to make abortion legal, now, most of the developed world has abortion laws that make abortion available on request; particularly at early stages of pregnancy. This makes the way that the law is framed in Britain, where the abortion decision rests with two doctors rather than the woman herself, even more anomalous. In Canada, and some jurisdictions in Australia, abortion has been removed from the criminal statute altogether.

Public opinion in Britain supports women’s access to abortion. British Social Attitudes 30, a major report published in 2013 by the social research company NatCen, looked at how attitudes and values have changed over the previous 30 years. The responses show ‘almost unanimous support for a woman’s right to have an abortion if her own health would be seriously endangered by going ahead with the pregnancy’, with nine in ten people agreeing – and this has barely changed from 1983. When it comes to the question of whether abortion should be allowed according to a woman’s choice, just over six in ten (62%) support this and only a third (34%) oppose it. As the authors state:

[This marks a considerable change since 1983; at that time 37% thought the law should allow this while just over half (55%) thought it should not. In other words, just over half of the public in 1983 opposed abortion being available if a woman does not want a child, while nearly two-thirds support this now.

The question we need to ask, in 2015, is: what justification is there for regulating abortion through the criminal law? There is no question that abortion services need to be regulated: and like every other medical procedure, abortion is subject to a raft of regulations issued by the Department of Health and professional bodies. But unlike any other medical procedure, the law that regulates abortion is grounded not in clinical standards, but in legal requirements that speak to the practices and prejudices of five decades ago.

The aim of this publication is to put the case for abortion regulation that meets the needs of women and standards of best clinical care, and works with the reality of abortion today.

Jennie Bristow,
Editor, BPAS Reproductive Review

Chapter 1. Why women need abortion

Abortion is never a pleasant experience. For women, it is painful, inconvenient, and upsetting. For doctors, nurses and midwives, it involves the destruction of a fetal life – several times a day, and most days of the year. Opponents of abortion frame it as an act of evil; even those who accept that abortion is necessary often avoid talking about it, or make arguments about the need to limit women’s access to abortion, worrying about ‘late’ abortions, ‘repeat’ abortions, or ‘too many’ abortions.

Why do women have abortions – and why do doctors, nurses and midwives perform them? For the simple reason that, for women who need abortions, the alternative is worse. In the discussion surrounding pregnancy, abortion, and birth today, this is what we often forget. We are surrounded by images of beautiful, healthy, wanted babies, where the discomfort of pregnancy, the pain of labour, and the life-changing experience of raising a child is accepted as part of the trade-off for the child that you want.

When the pregnancy is unwanted, all of these things take on a very different meaning. Women are faced with the reality that, in a few months’ time, their lives will change irrevocably with the birth of a new child: a child that they cannot cope with, they cannot afford, or that they simply do not want at this point in their lives, with that partner, under those circumstances. These are not selfish or callous calculations; they result from women knowing, with absolute clarity, what a baby will mean to them.

If a woman decides to terminate the pregnancy, that is not because she doesn’t like babies, or doesn’t ever want a baby, or doesn’t understand that her pregnancy will develop into a baby. It is because she wants to be the best person she can be. For the majority of women who have abortions, who either have children already or who go on to have children in the future, the decision to have an abortion is because she wants to be the best parent she can be.

This does not mean that a pregnancy has to be planned in order to be wanted, nor that wanted pregnancies are happy, healthy, and problem-free. It certainly does not mean that women should have abortions, or that aborting a pregnancy that is initially unwanted is always the right thing to do.

What it means is that a woman should always have the choice to terminate her pregnancy, because it is this choice that gives her autonomy: independence over her body, and control over her life. That is the principle upon which the campaign for abortion rights is built.

Women’s equality

Over the twentieth century, enormous gains were made in the struggle for women’s equality. At the beginning of the century, women in Britain were denied the right to vote, excluded from higher education and many professional jobs, paid less than men for doing the same work, and expected to focus their energy on bearing and raising children. By the end of the century, women were as well qualified as men, paid equally for the same work, and represented in Parliament, not only as voters but also as MPs. While things may not be perfect, it is important to acknowledge just how huge this shift was – and the role played by abortion in bringing it about.
Since the 1970s, access to contraception, with abortion as a back-up when contraception fails, has been central to women’s ability to play an equal role in work and public life. It has affirmed the principle that women should be able to control their fertility and plan their families in accordance with what they want to do and achieve. It is no longer socially acceptable to treat women as second-class citizens, whose destiny is a full-time commitment to motherhood – women are treated as equal citizens, for whom motherhood is a choice.

One important outcome of this is that abortion has become a normal part of life. In 2015, one in three women will have an abortion over her lifetime. This reflects the extent to which abortion has become widely available, publicly funded, and recognised as a public health need.

In 2012, BPAS launched its ‘No More Names’ campaign to recognise the reality of abortion, and the way it has become part of the fabric of women’s everyday lives: for our mothers, daughters, sisters, and friends.

The success of the No More Names campaign indicated how mainstream abortion, and talking about abortion, has become. The idea that, in a world where one in three women will have an abortion, these women could be charged with committing a crime is just anathema to the generations that have grown up with legal abortion as a back-up when their contraception fails. Equally bizarre to women is the idea that the doctor or nurse who helps them with their abortion could find themselves subjected to a criminal prosecution for doing so.

Yet under the law, abortion remains a criminal offence, subject to a jail sentence. The 1967 Abortion Act makes abortion legal only under certain conditions – and this is something that many women, until they access an abortion, do not know. One powerful aspect of the case for decriminalisation is the need to bring the law into line with the reality that women today have rightly grown up to expect: equality with men, and access to abortion when they need it.

Access to contraception and abortion has also underpinned an enormous practical change. The principles of women’s autonomy and equality mean little unless women have the ability to exercise that autonomy and equality, through making choices about their reproductive lives.

One of the most marked changes in over the past 30 years has been the extent to which the age of first motherhood has increased, as women have used their twenties to pursue higher education, begin careers and choose their relationships. This has been possible in part because women are able to use contraception and abortion to enjoy sexual relationships without experiencing pregnancy and childrearing as the immediate result.

Not just about abortion...

Things are not perfect. The struggle for women’s freedom and equality was never reduced to abortion rights alone – and the difficulties of pregnancy and childrearing continue to have an enormous impact once women, and men, become parents.

Childcare is expensive and imperfect, and many careers do not fit easily with the demands of caring for young children. While women and men have equal rights politically, at a cultural level parents are increasingly under pressure to organise their time and energy around an ever-higher set of childrearing standards: orthodoxy that academics have termed ‘intensive parenting’.

The tensions between the demands of work and the demands of home continue to be important issues impacting upon women’s ability to play a full and independent role in society. A woman’s reproductive choices are shaped by the limitations of her circumstances: such as delaying having children because of career demands, or limiting the number of children she has because of a lack of money or time.

These tensions appear in a number of discussions relating to women’s personal choices, and to policy decisions. Fears about the impact of later maternal age on women’s chances of conceiving and bearing a healthy pregnancy have led to headlines and recommendations by medical bodies that often over-state the risks. As BPAS has argued,4 the evidence suggests that women up until the age of 40 still have a relatively high chance of conceiving and having a healthy pregnancy and birth.

As the trend is towards later motherhood, society has a responsibility to meet the needs that come with, for example, slightly more complex births, rather than cajoling women to have their babies at an earlier age.

However, anxieties about the problem of later maternal age tap into a real concern: that there is something not quite right about the way that today’s society often seems to demand that women fulfil their career potential at the peak of their reproductive lives. When Silicone Valley companies Apple and Facebook announced that they would offer cryopreservation (egg freezing) as part of their maternity care packages, the announcement was greeted with disquiet by many, who feared that this apparent attempt to support women’s fertility needs would, in practice, amount to putting them under pressure to put off having babies during their younger and naturally more fertile years.5

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When women do have babies – at whatever age – they tend to be the primary caregivers. This impacts on their careers, and wages. In 2014, it was reported that the ‘gender pay gap’ was at its lowest level ever, at 9.4%, compared with 17.4% in 1997, when figures were first recorded in this form. But as the *Independent* reported, the size of the gap depends largely on whether women have children or not:

It appears that motherhood still causes the biggest disparity in wages. The pay gap has now disappeared for women in their 20s and 30s but it is larger for the over-40s. For workers in their 40s and 60s it is around 14 per cent and amongst over-50s the gap in full-time pay is 18 per cent. The reduction in the pay gap is a good example of the huge contribution that abortion and family planning has made to women’s equality. If women were still in the position where an accidental pregnancy meant they had to have a baby, there would be a very small window in which men and women could compete equally in the labour market, and equal pay would remain as skewed as it ever was.

Yet the fact that the pay gap has diminished so much between childless men and women puts the spotlight on the issues that arise when children come along. Here, some attempts have been made to improve the quality and availability of childcare services, to support employees’ right to request flexible working arrangements, and to bring in changes to maternity leave, so that fathers are able to share leave to care for a new baby with mothers. So far, the effect of these policies has been limited, by a combination of practical and cultural factors.

In practical terms, it remains extremely difficult to combine care of a child under the age of four with full-time work by both parents. Private childcare — whether nursery nurses, childminders, or nannies — remains very expensive, meaning that parents of very young children must often choose between one partner staying at home or juggling some form of part-time work with care by other friends and family members. This period of absence, or stepping back, from the labour market even for a few years tends to have a detrimental effect on career progression and wages.

Yet even where practical solutions to childcare are possible, cultural factors play a role in shaping the career chances and choices of mothers. The expectation that it will be a mother who, following nine months of pregnancy, will stay at home with her newborn is deeply ingrained, and bolstered by campaigns that promote the importance of breastfeeding as a part of a child’s physical and emotional health, and as a part of a mother’s identity. Policies that help to enable mothers to go back to work quickly after birth are welcome for those fathers who want to do that. But couples might also decide that it will be best for them overall if the father progresses his career and focuses on providing financial security for the family.

Then again, there are situations where mothers and fathers do not live together, and childcare issues that involve either formal or informal mechanisms of sharing do not really apply. In such circumstances, single or divorced mothers will often experience a significant financial burden, and find their work options compromised. On the other hand, fathers often find themselves unable to spend the amount of time, or the kind of life, that they want to with their children.

In all of the circumstances described above, it is clear that the greater degree of sexual equality that exists today does not make things perfect. It is also clear that access to contraception and abortion alone have not resolved many of the tensions between society’s need for children and individuals’ desire for children on one hand, and the norms, expectations and demands of the workplace on the other.

But without access to contraception and abortion, we would still be a long way from worrying about gaining a better work-life balance, or pondering the question of when is the right time to have a child. That is what today’s society often seems to be in danger of forgetting.

... But without abortion, all the choices diminish

The magnitude of changes brought about by access to effective, legal and affordable contraception and abortion services is apparent when we look at how this has framed the experience of sex, relationships and parenthood for at least three generations of women. Natsal, the National Survey of Sexual Attitudes and Lifestyles, recently reported on its third survey, with some hugely significant findings.

The most important point to emerge from the study as a whole is the extent to which, as lead authors Kaye Wellings and Anne Johnson explain, ‘sexual activity is not primarily, or even necessarily, about reproduction’. They continue:

In a growing number of contexts globally, the separation of sexual activity from reproduction is well under way as contraception, abortion, and assisted reproduction have weakened the natural link. Sexual behaviours that are not essential to conception have become easier to discuss and have gained greater acceptance; they include masturbation, oral and anal sex, same-sex practices, and sex in groups among whom reproduction may not be possible or might have conventionally been deemed inappropriate. In many cultural contexts, what was once seen as deviance or perversion is increasingly referred to as diversity.

These insights speak to the way that changes in reproductive technology and policy (specifically, improvements in contraception and access to abortion) come together with wider social and cultural changes. Trends in relationship formation, marriage and divorce are all affected by individuals’ ability to control their fertility, and these changes in turn affect the way in which people live their lives.
Of course, these new developments bring tensions of their own. For example, the trend towards later motherhood is often explained primarily in terms of the pressures put on younger women to forge ahead with their careers. Yet, when we look at the graphic overleaf, we can see that things are not so clear-cut. Young people are forming relationships later in life, and taking more time before committing to a partner, and/or a baby.

These changes may bring greater thought and planning into relationships; equally, they may bring the experience of uncertainty and frustration. But at the bottom of it all, there are choices where, for previous generations, life seemed to be mapped out as restrictive ‘next steps’. And these choices are, in a large part, thanks to the availability of safe, legal abortion.

**Planned, unplanned, and ambivalent pregnancy**

Against a background where ‘sex is more often recreational and communicational than procreational, and is increasingly recognised as such’, it is interesting to examine what the Natsal findings reveal about circumstances in which the link between sex and reproduction remains fundamental: people’s experiences of pregnancy.

The researchers’ analysis of data from women of childbearing age between 2010 and 2012 found that one in six pregnancies (16.2%) experienced in the past year were unplanned, 29% were ambivalent, and 55% were planned.

These findings speak to a reality that is often misunderstood, both at a cultural and a policy level. In the twenty-first century, even though it is largely possible to avoid becoming pregnant when you don’t want to, and to plan to have a baby when you do want to, this is not necessarily what happens in real life. Unplanned pregnancy happens because contraception fails, or couples fail to use it. Planned pregnancy happens only when couples set out to become pregnant and then succeed – which, as indicated by the demand for fertility treatment, is an experience that not everyone has.

The category of an ‘ambivalent’ pregnancy encapsulates many people’s reproductive choices, which are neither planned nor unplanned: or indeed, strictly wanted or unwanted. These include the couples that use natural family planning methods rather than more reliable forms of contraception because they don’t want to make a deliberate choice to get pregnant, but they wouldn’t mind too much if it happened by accident. Another example would be the couple that goes without a condom that one time to see what chance brings their way; or the woman who believes she is too old, or infertile, to get pregnant, only to find herself with a pregnancy that she never saw coming.

**Relationship formation**

In this respect, it is interesting to see the way that the gaps between having sex, living with one’s partner, and having one’s first child have increased for both women and men who came of age after the Abortion Act came into force. This reveals how breaking the link between sex and procreation has enabled individuals to have more time – not just to plan when they want to have children, but to work out when they want to ‘settle down’.

Over the past 60 years, the gap between the age people start having sex, the age they first live with a partner, and the age they have their first child has widened – so there is now a longer period in women’s lives where efforts are needed to prevent unplanned pregnancy.

**Median age at first intercourse, first live-in relationship and birth of first child**

The fact that a woman might have been sexually active for about five years before living with a partner, and then spend another five or so years before having a baby, indicates a far greater freedom for both women and men to make choices about who they want to be with and have children with than ever existed in the past. Thanks to contraception, premarital sex is less likely to lead to unintended pregnancy: and if it does, there are more choices. Women can have the baby with their partner, have the baby alone, or abort the pregnancy; and the stigma surrounding any of these choices is far less strong than it ever has been.

Source: *Highlights from Natsal-3*

Visit this [link](http://www.natsal.ac.uk/media/823663/natsal%20infographic.pdf) for more information.
There has long been an assumption in public health policy that if contraceptive provision was better, or if people were more ‘responsible’ about using contraception, the need for abortion would no longer exist. This assumption cannot deal with the couple that begins with a much-wanted pregnancy and splits up, leaving both parties unsure about whether they want to bring a baby into that situation. Nor can it help the woman who falls pregnant without intending to and decides to continue with the pregnancy, only to find out in the second trimester that the fetus has a serious anomaly; or the woman who becomes pregnant and does not immediately know how to feel about it or what to do, and wrestles with her decision for several weeks.

These are all situations where contraception, or planning, are simply not part of the equation; the issue is simply how a woman deals with what life throws at her. In this regard, access to a non-judgemental abortion service beyond the first trimester of pregnancy – as we currently have in Britain – is simply necessary. And this is a reality that girls who have come of age since 1968, when the Abortion Act came into force, have been able to assume.

Reproductive choice does not solve every problem confronting women today. But without reproductive choice, women would not have even the possibility of planning their own life course. And what is striking is that, even after half a century of legal abortion, both the principle and practice of reproductive choice remain constrained.

The abortion law, and women’s autonomy

In Chapter 2, we discuss how Britain’s abortion law has been constructed to allow women access to abortion – but under very particular conditions. Women do not have the right to an abortion: a woman is able to have one only if two doctors agree that it will be better for her physical or mental health to have an abortion than to carry a pregnancy to term.

This means that, under the law, a woman considering an abortion is presented not as a competent citizen who knows what decision she wants to make about her life, but as an unfortunate victim of circumstance. Yet for all the reasons discussed above, a woman’s decision that she doesn’t want to be pregnant at that point in her life is generally based on a rational and responsible assessment of her wishes and circumstances. To assume that she cannot make that decision, but that it needs to be made by doctors on her behalf, treats pregnant women as a different class of citizen as everybody else.

This point was forcefully made by Professor Sally Sheldon, in her evidence to the 2007 House of Commons Science and Technology Select Committee inquiry into ‘Scientific Developments Related to the 1967 Abortion Act’. Sheldon pointed out that the requirement that every abortion is authorised by two doctors runs contrary to the concept of patient autonomy, noting that judges have said that:

[A] medical practitioner must comply with clear instructions given by an adult of sound mind as to the treatment to be given or not given [...] whether those instructions are rational or irrational.11

Pregnant women are not an exception. In the case of George’s Healthcare NHS Trust, v S [1998], the Court of Appeal stated:

6 Sexual attitudes and lifestyles in Britain: Highlights from Natsal-3. http://www.natsal.ac.uk/media/823663/natsal%20infographic.pdf

Pregnancy [...] does not diminish (a woman's) entitlement to decide whether or not to undergo medical treatment [...] Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.13

The presumption that a pregnant woman has a right to bodily autonomy, even if her decision runs contrary to medical opinion about her own health and that of her fetus, remains an important principle in British law. Apart from in exceptional circumstances, a pregnant woman is not forced to undergo blood transfusions or a C-section, even if her refusal to do so is likely to cause death to herself or her fetus. Women are not held criminally liable for harm to their fetus because they have ingested any substances, or undergone any activities, that might harm the pregnancy.

In recent years, there have been some disturbing developments that threaten pregnant women's autonomy. For example, in the 2014 case CP v The Criminal Injuries Compensation Authority; lawyers brought an action on behalf of a seven-year-old girl born with Fetal Alcohol Syndrome (FAS) after her mother drank heavily during pregnancy. Had this claim been successful, it would have had significant implications, establishing the fetus as a person and criminalising women whose behaviour, while pregnant, could be seen to have damaged the fetus.14 Things have already gone a long way in this direction in the United States, where there are continual attempts to create crimes of homicide or harm to the ‘unborn child’.14

In the British case, three judges at the Court of Appeal had to rule on whether or not the girl, CP, was entitled to a payout from the government-funded Criminal Injuries Compensation Scheme as a victim of crime. In rejecting the case, Lord Justice Treacy said an ‘essential ingredient’ for a crime to be committed is the infliction of grievous bodily harm on a person – grievous bodily harm on a fetus will not suffice.

BPAS and the charity Birthrights had intervened in this case. Commenting on the ruling, Ann Furedi, chief executive of BPAS, and Rebecca Schiller, co-chair of Birthrights, said:

This is an extremely important ruling for women everywhere. The UK's highest courts have recognised that women must be able to make their own decisions about their pregnancies. Both the immediate and broader implications of the case were troubling. In seeking to establish that the damage caused to a fetus through heavy drinking was a criminal offence, the case called into question women’s legal status while pregnant, and right to make their own decisions. Any ruling which found that drinking while pregnant constituted a ‘crime of violence’ could have paved the way to the criminalisation of pregnant women's behaviour – an alarming prospect given the ever-expanding list of activities women are warned may pose a risk to the health of their baby.

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmstech/1045/1045v.pdf
13 Intervention On Behalf Of The British Pregnancy Advisory Service And Birthrights, In The Court Of Appeal [Civil Division] On Appeal From The Upper Tribunal Between CP (Appellant) v The Criminal Injuries Compensation Authority (Defendant). Appeal No: CL/2014/0077

As this case underlines, it remains a principle of British law that unless a woman is intending to ‘procure a miscarriage’, her bodily autonomy is paramount. This reflects a particular understanding of the woman as citizen bearing equal rights to others, and the fetus as an entity to which society accords a moral value, but not the legal status of a person.

The status of the fetus

The crux of the abortion debate is the status that is accorded to the fetus. Morally, this status remains hotly disputed. Opponents of abortion believe that a fetus is a person from conception, and that abortion is murder. Those who believe absolutely in a woman’s choice to terminate her pregnancy accord the fetus a different moral status to that of the woman: a fetus is a human life, but it is not a person.

Between these two positions, there are those who believe that a fetus obtains a particular moral status at a certain gestation: ranging from fertilisation to implantation to what was traditionally called ‘quickening’ (when the fetus begins to move), to the stage at which a fetus develops the neural pathways that might potentially allow it to feel pain, to the stage that is misleadingly called ‘viability’: the gestation at which a fetus born prematurely might, with particular clinical interventions and care, survive outside the womb.6

Certain countries – notably, Ireland and some other staunchly Catholic countries – protect the rights of the ‘unborn child’ in their Constitutions: a ban on abortion in all but the most exceptional cases follows. But in Britain, there is no written Constitution, and there are no legal rights afforded to the fetus.

As we explain in Chapter 2, the law implicitly ascribes the fetus protection from abortion: through the Offences Against the Person Act, the Infant Life (Preservation) Act, and the conditions laid down by the 1967 Abortion Act about the circumstances, and gestational limits, in which abortion is legal. The law criminalises a particular act (abortion) on the part of women, as rights-bearing citizens: it does not afford the fetus legal rights.

In this context, it falls to individuals to make their own decisions about the morality of abortion. This is expressed in a number of ways. Women should not be forced or coerced to have abortions because other people (doctors, partners, legislators) think it would be in her best interest or the best interest of the child-to-be: forced abortion is rightly recognised not only as an assault upon women’s bodily autonomy, but also as the imposition of one person’s measurement of a fetus’s worth upon the pregnant woman.

Doctors cannot be forced to perform abortions: the right to hold a conscientious objection is enshrined in the law, and some doctors who perform abortions set personal limits on the gestation at which they will perform an abortion, or the reasons they will accept for doing so. Members of Parliament are not bound by a ‘party line’ on abortion, but allowed a free vote according to their conscience; again, in recognition of the divergence of opinion that people hold about the moral status of the fetus, and the morality of abortion.

Conclusion

We live in a society today that, in many important ways, accepts the need for abortion, the importance of women’s bodily autonomy, the fact that a fetus is not a person that holds legal rights, and that it is crucial to allow people to act according to their own conscience when it comes to having, performing, or legislating for abortion. Yet while the abortion law supports these principles by making abortion legal, it undermines them by presenting women seeking abortion as incapable of making the decision for themselves.

Under the terms of the 1967 Abortion Act, the person given the authority to make the decision about whether a woman should be able to have an abortion is not the woman herself, but two doctors agreeing that this would be better for her health than carrying the pregnancy to term. That is the central problem with the 1967 Act: both in principle, and in practice.
Chapter 2. Abortion in 2015: The law

Abortion in Britain is legal – but it still falls under the criminal law, carrying a lengthy jail sentence for women and those who perform abortions. The 1967 Abortion Act did not decriminalise abortion, but carved out a therapeutic exemption to the offences under the 1861 Offences Against the Person Act (OAPA) (and equivalent common law prohibitions in Scotland) provided that women and doctors meet certain requirements. This has enabled women to access safe, legal abortion, but it has also written into law a number of problematic assumptions and practical barriers to best clinical practice. In this chapter, we look in detail at the legislation, and summarise its history.

History of the abortion law

To understand the basis on which abortion is legal today, we have to look to the various pieces of legislation that make abortion illegal. For while the practice of abortion has existed since ancient times, the laws surrounding it have developed in line with different assumptions and attitudes.6

James Drife, Emeritus Professor of Obstetrics and Gynaecology at the University of Leeds, explains that an Act of Parliament brought in by Lord Ellenborough in 1803 ‘formalised and extended’ the existing common law, to cover medical and surgical abortion before quickening (the point at which a woman feels fetal movements).7

In 1837, section 51 of the Offences Against the Person Act (OAPA) ‘removed the distinction between pre- and post-quickening abortions and replaced the death penalty with life imprisonment for abortion at any stage of pregnancy’. In 1861, the words ‘whether she be or not be with child’ were added to the OAPA, making it clear that a third party abortionist could be charged even if the woman were not actually pregnant.

The 1861 Offences Against the Person Act is still in force today. This seems peculiar, when we consider how different the norms and values of the Victorian era were to those of the present day. Women were unable to vote, let alone to sit in Parliament as MPs; sex outside marriage was condemned, and married women could expect to bear eight or more surviving children. By the 1960s, the gulf between the reality that the OAPA sought to legislate for and the reality of post-war Britain was seen as highly problematic.

By the 1960s, infant mortality had dramatically declined, bringing with it a reduction in the number of children people wanted, and needed, to have. Women had won the right to vote, and the experience of two cataclysmic world wars had thrown into turmoil any remaining consensus about strict sexual morality, the sexual division of labour, and the extent to which the state should dictate people’s private conduct. The Thalidomide tragedy of the early 1960s, in which thousands of children were born with limb deformities after their mothers took a drug to reduce morning sickness in pregnancy, raised concerns about women’s inability to access abortion in cases of fetal anomaly.8

As Madeleine Simms, founding trustee of Birth Control Trust and one of the individuals who was central to bringing about abortion law reform in the 1960s, said back in 1997, reform was ‘in the spirit of the age’:

“We were getting rid of the last bits of Victorian baggage that were surplus to requirements – the 1861 Offences Against the Person Act in our case.9

The 1967 Act did not get rid of the OAPA, but it made safe, legal abortion possible, by bringing it under the control of the medical profession.

The 1861 Offences Against the Person Act

Abortion in England, Wales, and Northern Ireland is made illegal under the 1861 Offences Against the Person Act (OAPA). In Scotland, abortion is a common law offence. The OAPA contains 79 sections 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 sections on abortion. They read 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 misdemeanour, and being convicted thereof shall be liable…to be kept in penal servitude...

The OAPA criminalises equally a woman having an abortion, and a person who provides it. There is no distinction drawn between medical professionals or others; there is no consideration of the reasons why a woman might attempt to ‘procure a miscarriage’.

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Back in 1861, many of the techniques used for abortion were dangerous, and unreliable; particularly because the procedure would often happen illegally, performed by people who were not medically trained. On the other hand, the chances of women suffering death or injury during childbirth were also high. Basic hygiene, straightforward methods of surgical intervention, anaesthesia, pain relief, and many other developments that we take for granted today either did not exist or were rarely used.

In Women’s Bodies: A social history of women’s encounter with health, ill-health, and medicine, the historian Edward Shorter notes that ‘People today have a romanticized and generally false picture of the typical birth in traditional times’, imagining that ‘Nature is left to take her course, and “intervention” is absent’. In fact, the ‘typical mother’ was, at every step, ‘harassed by meddlers and officious interveners’, who ‘felt compelled to take a hand in Nature’s work, except on those occasions when a little “intervention” might have been welcome’.  

These folkloric remedies and interventions included: (c) constantly tugging and hauling at the mother’s birth canal, at the infant’s head, and at the placenta, and sticking hands into the uterus to turn the child, all of which increased the chances of maternal infection and infant death or damage.

Before 1800, writes Shorter, about 1.3 per cent of all births ended in the mother’s death, and:

If we assume that the typical woman who lived to the end of her fertile years gave birth to an average of six children, her lifetime chance of dying in childbirth would be six times 1.3, or 8 per cent.

Shorter estimates the average mother’s ‘lifetime risk’ of contracting a grave puerperal infection at around 25 per cent.

Before Joseph Lister’s discovery of antisepsis in 1867, hospitals were, if anything, more perilous than the home. Indeed, ‘doctors and midwives were equally septic’, and there was no love lost between the two groups:

The doctors have damned the midwives as filthy, ill-kempt slovens. The defenders of the midwives have blasted the doctors for bringing to the mother’s bedside germs contracted on the autopsy table.

The fraught professional ‘boundary wars’ between (male) obstetrics and (female) midwifery continued throughout the twentieth century; but as Shorter makes clear, before the causes of infection were understood and dealt with, ‘The problem was the exploring hand, not the gender of the birth attendant’.

The dangers of childbirth meant that when Victorian women sought out illegal abortions, it was not simply because they could not bear the physical or financial cost of bearing another child, though these were powerful factors. It was also because pregnancy and childbirth themselves were quite dangerous pursuits.

The Infant Life (Preservation) Act 1929

The Infant Life (Preservation) Act (ILPA) made it illegal to kill a child ‘capable of being born alive’, and gave 28 weeks as the age at which a fetus must be presumed to be viable. The text reads:

**Punishment for child destruction**

1. Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life.

2. For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.

Consequently, 28 weeks, as the threshold of viability, was the gestational limit that was read into the 1967 Abortion Act until it was amended by the 1990 Human Fertilisation and Embryology (HFE) Act, as discussed below. The ILPA still applies today.

The 1938 Bourne Decision

The OAPA did not prevent women from having abortions; it only prevented legal abortions. Sometimes abortions were procured through the use of herbal medicines or ‘backstreet abortion’ techniques; sometimes, women would find a doctor willing to perform the procedure. Rich women with connections were proportionately more likely to know somebody who could perform the procedure safely: an inequality that has reverberated through the history of abortion.

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 of having committed an offence under the OAPA.

At the trial, Judge McNaughton reasoned that it was implicit in the offence of ‘unlawful procurement of miscarriage’ that there must be some possibility of lawful procurement of miscarriage. In setting out in what circumstances this might be the case, he borrowed from the ILPA, holding that an abortion might be lawful where it was performed ‘for the purpose of preserving the life of the mother’. 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 for the purpose of preserving the life of the mother.

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The 1967 Abortion Act (as amended)

The 1967 Abortion Act²¹ has been amended by Parliament once, by the 1990 Human Fertilisation and Embryology (HFE) Act. The most significant amendments wrote into law a gestational limit for legal abortion, of 24 weeks except for exceptional health reasons, and gave the Secretary of State for Health the power to approve a ‘class of places’ where abortions could legally be carried out.

The most important, controversial, and widely discussed section of the legislation is Section 1, which lays out the main conditions under which abortion is lawful. Section 1 is headed ‘Medical termination of pregnancy’, and reads:

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.


This judgement became known as the 1938 Bourne decision, and provided an important clarification of the scope of the therapeutic exception to prosecution under the OAPA. In practical terms, it meant that women who could afford to gain a psychiatrist’s agreement that to have an abortion would make her a ‘physical or mental wreck’ could legally obtain the procedure performed in safe conditions. But to do this the woman would need money, connections, and to be prepared to lay herself open to a diagnosis of probable insanity should she continue with the pregnancy.

In Northern Ireland, it is the Bourne decision that still provides the only exemption to offences committed under the OAPA. In practice, this means that women’s access to abortion is extremely limited, and so most women simply travel to England to have the procedure legally, or buy drugs online.

The 1967 Abortion Act provides a therapeutic exemption to the offences under the 1861 OAPA. In other words, it does not replace the OAPA; abortion remains a criminal offence for women or doctors who fail to abide by the conditions set out in the Abortion Act.

The first condition is that the abortion must be performed by a doctor – a ‘registered medical practitioner’. It must not be induced by the woman herself, nor performed by a nurse, midwife, or acquaintance.

Second, the abortion must be authorised by two doctors, and it must be done ‘in good faith’. This means that, other than in an emergency, each abortion requires the approval of a doctor in addition to the doctor that performs the procedure, and that their reasons for authorising the abortion must not be corrupt or negligent. Successful prosecutions brought on the basis of absence of good faith have been extremely rare, indicating how extreme a doctor’s deficiency in this regard has to be.

For example, one rare case of an abortion doctor being successfully prosecuted under the OAPA was the 1974 case of R v Smith. 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 did not ask about her medical history or conduct an internal examination and told her that if she could give him £150 in cash (a little under £3,000 in today’s money) 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.

As Professor Sally Sheldon explains:

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.²²

Third, if the woman is fewer than 24 weeks pregnant, the abortion can be authorised on the grounds that it will pose involve less of a risk to her physical or mental health than would carrying the pregnancy to term. This is a far less extreme judgement than that provided by the 1938 Bourne decision, where the woman would need to be a ‘physical or mental wreck’. Under the 1967 Act, the doctor has to hold a genuine belief that, on balance, it would be worse for a woman to have to continue her pregnancy than to have a termination.

Written into the 1967 Act is a wide discretion given to doctors to judge the relative risk to a woman’s health of having an abortion compared to carrying the pregnancy to term. This point is worth emphasising, as ever since the Act was passed opponents of abortion have claimed that the law is being interpreted more widely than intended. That is not the case: as becomes clear in the next chapter, where we consider the relative health risks of abortion to childbirth.

Section 1(2) of the Act gives a clear statement about the wide discretion afforded to the doctor in determining the risk of abortion to a woman’s mental health, or to that of ‘any existing children of her family’. This states that:

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.

After a great deal of discussion in drafting the law, it was decided against inserting a ‘social clause’ that would have allowed doctors to authorise an abortion where the woman’s ‘capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be’. A clause that allowed abortion where ‘the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape’ was also rejected. Instead, doctors were given the authority to take the pregnant woman’s ‘actual or reasonably foreseeable environment’ into account when weighing up the relative risks of an abortion to their physical or mental health compared with carrying the pregnancy to term.

Where abortions must be carried out

The 1967 Abortion Act stipulated that abortion must be carried out in a hospital, by a doctor. This was because, in the 1960s, abortion was a surgical procedure; and as explained above, one of the key aims of the Abortion Act was to improve the safety of the procedure, by taking it out of the backstreets and placing it under medical control and regulation.

In 1990, when the 1967 Act was last amended, it was recognised that changes in methods of abortion, such as the development of Early Medical Abortion, required that the law make allowance for abortions to be carried out in other settings, such as clinics, licensed for the purpose by the Secretary of State for Health. This section of the legislation now reads:

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.

The impact of the amended Act is that now, for the most part, abortions are carried out in clinics run by independent sector charities – which sometimes operate within community settings. The development of medical abortion (the ‘abortion pill’) has removed the need for many clinics to have surgical facilities, and greatly increased the ability to offer local services.

Unfortunately, however, it is with medical abortion that the practical problems imposed by the Act in delivering best clinical care have become most apparent. Women undergoing medical abortion in early pregnancy take two drugs, mifepristone and misoprostol, usually 24-48 hours apart, to induce a miscarriage. The Department of Health considers both these drugs to form part of the abortion process, and has to date refused to license women’s homes as a ‘class of place’ where terminations may legally be carried out.

This means that women undergoing this procedure are forced to return to the clinic just to take the second drug, meaning that they run the risk of miscarrying on the journey home: a particular consideration for women living far from a clinic, for example in rural areas. As we discuss in Chapter 6, this runs counter to the practice in many other countries, including the USA and Sweden, where ‘home use’ of misoprostol has been shown to be very safe and acceptable, and is now considered best practice.

Notification

The Act states that:

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 I 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.
In December 2014, the UK’s Supreme Court upheld an appeal against a Scottish court ruling which would have enabled healthcare staff to refuse to carry out any duties related to abortion care, however far removed from the procedure itself. The case centred on two midwives from Glasgow, who were at no point asked to participate in an abortion or provide any care for the woman undergoing a procedure, but who believed their right to conscientious objection was breached by being asked to answer telephone calls to book women in for care, and delegate to or supervise staff providing that care to women.

Scotland’s Inner House of the Court of Session ruled in 2013 that they should indeed have legal protection from such tasks. The Royal College of Midwives and BPAS intervened in the case, as that ruling allowed for a widely expanded interpretation of conscientious objection that could have seriously jeopardised women’s care in hospitals around the UK.26

Explaining their decision to uphold the appeal against the 2013 ruling, the Supreme Court judges stated that Parliament in 1967 was likely to have envisaged that right to conscientious objection as being restricted to ‘actually taking part, that is actually performing that tasks involved in the course of treatment.’ Lady Hale, Deputy President of the court, said:

Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital, the caterers who provide the patients with food and the cleaners who provide them with a safe and hygienic environment. Yet all may be said in some way to be facilitating the carrying out of the treatment involved. The managerial and supervisory tasks carried out by the labour ward co-ordinators are closer to these roles than they are to the role of providing the treatment that brings about the termination of the pregnancy. ‘Participate’ in my view means taking part in a ‘hands-on’ capacity.

Ann Furedi, chief executive of the British Pregnancy Advisory Service, said:

We welcome this ruling. BPAS supports the right to refuse to work in abortion care, not least because women deserve better than being treated by those who object to their choice. But the law as it stands already provides healthcare workers with these protections. Extending this protection to tasks not directly related to the abortion would be to the detriment of women needing to end a pregnancy and the healthcare staff committed to providing that care. There are enough barriers in the way of women who need an abortion without further obstacles being thrown in their way.

Northern Ireland

The 1967 Abortion Act does not apply to Northern Ireland. This has been a point of contestation ever since. 27

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The 1967 Abortion Act has helped a new generation of women plan their lives and careers in a way that very few women of my generation were able to. If you are confident that you can control your fertility you can afford to be ambitious and compete with men for the really interesting, worthwhile and powerful jobs. This is beginning to happen now and it is wonderful to witness.

The legal grounds for abortion are:

A) the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated (Abortion Act, 1967 as amended, section 1(1)(a))

B) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(1)(b))

C) 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 (section 1(1)(a))

D) 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 any existing children of the family of the pregnant woman (section 1(1)(a))

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 (section 1(1)(d))

or, in an emergency, certified by the operating practitioner as immediately necessary:

F) to save the life of the pregnant woman (section 1(4))

G) to prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(4)).

Grounds C and D apply to pregnancies before 24 weeks' gestation. Grounds E, F and G apply to pregnancies up to full term, but only in the case of a substantial risk of severe fetal anomaly or to prevent death or grave permanent injury to the woman.

The vast majority (97%, in 2013) of all abortions take place under Ground C: ‘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’. Ground D accounted for 1% of all abortions in 2013, as did Ground E. Grounds A and B together accounted for about a tenth of one per cent of abortions.

Table 7b: Legal abortions: by gestation weeks, residents of England and Wales, 2013

<table>
<thead>
<tr>
<th>Grounds</th>
<th>Gestation weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grounds</td>
<td>Total</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>Grounds</td>
<td>185,331</td>
</tr>
<tr>
<td>A (alone, or with B, C, D) or F or G</td>
<td>57</td>
</tr>
<tr>
<td>B (alone, or with C or D)</td>
<td>136</td>
</tr>
<tr>
<td>C (alone)</td>
<td>180,680</td>
</tr>
<tr>
<td>D (alone, or with C)</td>
<td>1,726</td>
</tr>
<tr>
<td>E (alone, or with A, B, C or D)</td>
<td>2,732</td>
</tr>
</tbody>
</table>

Source: Department of Health (2014).20

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Physical health risks

When the 1967 Act was brought in, a key aim was to reduce the number of complications and deaths from unsafe, illegal abortions. As James Drife explains,32 in the 1930s estimates about the proportion of maternal deaths arising from (illegal) abortion ranged from 14% to 25%. The first report of the Confidential Enquiry into Maternal Deaths, established in 1952, showed abortion to be the third leading cause of maternal mortality, after hypertensive disease and haemorrhage.

By 1966, estimates of the extent of illegal abortion ranged from 87,000 to 100,000 per year. The public health case for bringing abortion under medical control was persuasive. As a result of the 1967 Act, explains Drife, deaths from criminal abortion fell dramatically, as did deaths from ‘spontaneous abortion’, most of which had in fact been due to interference. Whether there were more abortions as a result of legalisation is debatable: as Drife suggests:

'It seems likely that the rapid increase of legal abortions in 1968-72 after the Abortion Act came into force was not due to an increase in abortion but simply the introduction of a system in which abortions were officially counted.'

Table 8: Legal abortions: complication rates by procedure and gestation weeks, residents of England and Wales, 2013

<table>
<thead>
<tr>
<th>Gestation weeks</th>
<th>Total complications (numbers)</th>
<th>Rate, all gestations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surgical</td>
<td>Medical</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
<td>83</td>
</tr>
<tr>
<td>3-9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10-12</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>13-19</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>20 and over</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

1 complications include: haemorrhage, uterine perforation and/or sepsis and are those reported up to the time of discharge from the place of termination.

Source: Department of Health (2014).33

Childbirth has also become much safer in recent decades, due to developments in antenatal care and obstetric technologies. Yet the comparison with abortion is striking, as the RCOG notes:

In the triennium 2006–08, there were 107 direct maternal deaths in the UK and 154 indirect maternal deaths out of 2.29 million mothers who gave birth (overall maternal mortality rate 11.39/100,000 maternities). Of the 107 direct deaths, only two were associated with abortion and both of these were from genital tract sepsis, out of a total number of 628,342 abortions in the same time frame (maternal mortality rate 0.32/100,000 maternities).34

Subsequent developments in the technology used for abortion, such as vacuum aspiration and the medical ‘abortion pill’, have made abortion safer still. Improvements in pregnancy tests and abortion services mean that women are able to access abortion earlier in pregnancy, when the procedure is safest: in 2013, 91% of abortions were carried out at under 13 weeks’ gestation, and 79% at under 10 weeks. Today, as the RCOG notes, ‘estimated complication rates are 1–2 per 1000 abortions’. As we can see from the table below, complication rates in abortions performed at early gestations are very low indeed.
A recent American study confirmed the relative safety of legal induced abortion compared to childbirth, finding that ‘the risk of death associated with childbirth is approximately 14 times higher than that with abortion’ and that ‘the overall morbidity associated with childbirth exceeds that with abortion’.16

The relative safety of abortion compared to childbirth is not an argument for women choosing abortion rather to have a baby. Women do not choose to become pregnant, or have children, for the sake of their health, but for a host of social, cultural and emotional reasons. When a pregnancy is wanted, women will endure all kinds of problems and complications in order to have a baby. But it is a powerful argument as to why, if a pregnancy is not wanted, women should not be misled about the dangers or legality of abortion. Under section (f) of the Abortion Act, the termination of any pregnancy up to 24 weeks’ gestation could be legally authorised on the grounds that abortion is safer than carrying the pregnancy to term.

Mental health risks

The Abortion Act has historically been most controversial in relation to the doctor’s judgement as to whether the risk to a woman’s mental health of having an abortion outweighs that of continuing the pregnancy to term. Again, the discretion afforded to the doctor is widely drawn. The assumption here is that the pregnancy is unwanted, and therefore the experience of having an abortion will be less emotionally damaging to a woman than forcing her to have a pregnancy and baby that she does not want or cannot cope with.

Section 1 (l) of the Act gives a clear statement about the wide discretion afforded to the doctor in determining the risk of abortion to a woman’s mental health, or to that of ‘any existing children of her family’. This states that:

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 (l) of this section, account may be taken of the pregnant woman’s actual or reasonably foreseeable environment.

Here, the law explicitly accepts that the reasons why an unwanted pregnancy can be damaging to a woman’s health, or to her existing family, can involve wider social, personal, and emotional factors. These could include inadequate housing; lack of money; unemployment; relationship breakdown; rape; domestic violence; having more children already than a woman can cope with; needing to care for existing children with a disability; needing to care for ageing parents or other family members; inability to achieve educational qualifications; being too young (or too old) to cope well with the physical and emotional strain of pregnancy, birth, and having a new baby; chronic health conditions suffered by the woman or her partner… There are any number of possible scenarios.

All, or any, of these factors do not necessarily mean that having a baby will damage a woman’s mental health. But they do indicate that the idea of a pregnancy as ‘unwanted’ is not a flippant judgement – a woman’s assessment of her own ability to have a pregnancy and a child is rooted in much deeper issues to do with her personal circumstances. When it comes to balancing the risk to a woman’s mental health of an abortion compared to the risk of continuing the pregnancy to term, it is the wantedness of the pregnancy that emerges as the decisive factor.

In December 2011, a review published by the National Collaborating Centre on Mental Health 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.17 Furthermore, the review supports the finding from other research that a woman is less likely to suffer an adverse mental health response if the resolution of the unwanted pregnancy is of her choosing – that is, if she is able to decide for herself whether to terminate the pregnancy, or continue it to term.

As Dorothy Flower, Partner at the law firm RPC, explains:

Therefore, according 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.17

Over the years, opponents of abortion have made strenuous attempts to claim scientific proof that abortion damages women’s mental health. These studies have been extensively reviewed and rebutted. A major review by the American Psychological Association in 2008 found no causal link between induced abortion and mental health problems.18 What the evidence in fact suggests is that women with previous mental health problems may experience adverse psychological sequelae after abortion or birth, both of which are significant experiences, but abortion itself is not a causal factor in depression or other mental health problems.

It is on this basis that the RCOG’s guidance states:

Women with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby. Women with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy.39

16 National Collaborating Centre for Mental Health (2011) Induced Abortion And Mental Health: A Systematic Review Of The Mental Health Outcomes Of Induced Abortion, Including Their Prevalence And Associated Factors. http://www.nccmh.org.uk/reports/ABORTION_REPORT_WEB%20FINAL.pdf
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 bilateral 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.

Fisher argues:

In the media coverage of the Jepson case and the reporting of ‘abortion for trivial reasons’, 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.

The enduring ‘chilling effect’ of the Jepson case indicates how attempts to hound doctors who are performing perfectly legal procedures can affect women’s ability to access treatment.

Abortions for fetal anomaly

If the woman is more than 24 weeks’ pregnant, an abortion is legal only if a doctor believes that continuing the pregnancy would kill the woman or cause ‘grave permanent injury’ to the physical or mental health, or if two doctors agree that there is a ‘substantial risk’ that the fetus would be born severely disabled.

Again, there are very good reasons for having a different time limit for fetal anomaly cases. Although advances in antenatal screening and testing technologies mean the majority of fetal anomalies are detected before 24 weeks, the major screen for structural anomalies is scheduled between 18 and 20-6 weeks’ gestation, but some anomalies cannot be diagnosed until later in pregnancy.40

The law rightly allows doctors to give women the opportunity to end their pregnancy after 24 weeks if a significant anomaly is found. However, as Jane Fisher of the charity Antenatal Results and Choices (ARC) explains, in reality there has been variation in practice in recent years: for example, some units will offer a termination after 24 weeks’ gestation 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.

Fisher argues that 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’. 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.

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Chapter 4. Legal attempts to amend the 1967 Abortion Act

Since 1967, the Abortion Act has been beset by attempts to restrict and reform it. In the 1970s, these tended to take the form of Parliamentary attempts to overturn, or amend, the Abortion Act. The most significant was John Corrie MP’s Abortion (Amendment) Bill of 1979, which eventually failed.

Since then, Parliamentary and campaigning activity has tended to focus on restricting the scope of the Act. These attempts have rarely called for an explicit ban on abortion; rather, they have focused on attempting to discredit abortion providers and doctors, reducing the gestational limit for abortions, and problematising the reasons why women have abortions.

This shift indicates an implicit acceptance that British society needs to provide access to legal abortion. As such, it is an important and welcome development. However, the attempt to frame attacks on the abortion law in terms of specific, emotive topics (counselling, disability, or ‘sex selection’) can often obscure the motivations behind certain legal changes: which seek to chip away gradually at abortion provision, in a similar way as has happened in the USA.

Here, we briefly review some of the more significant Parliamentary discussions about the Abortion Act since the legislation was passed.41

The Abortion (Amendment) Bill 1969 – Norman St John Stevas MP; Abortion (Amendment) Bill 1970 – Bryant Godwin Irvine MP

St John Stevas’s Ten-Minute Rule Bill intended to restrict the availability of legal abortion by focusing on the proportion of abortions carried out in the private sector. The Bill required that one of the two certifying doctors should be ‘… a consultant gynaecologist in the NHS or a doctor of similar status approved for this purpose by the Minister of State’. It was narrowly defeated. Godwin Irvine’s Private Member’s Bill was ‘… designed to limit the more blatantly commercial exploitation of the new law that is largely carried out in London.’ This Bill was talked out.

The Committee on the Working of the Abortion Act (Lane Committee), 1971-4

In response to concerns about the inadequacy of the original criteria for approving abortion clinics, in 1971 the Secretary of State for Health, Sir Keith Joseph, convened the Committee On the Working of the Abortion Act, chaired by The Hon Mrs Justice Lane. The three-volume report was published in April 1974 and provides a detailed account of abortion provision at that time. The findings were summarised in the statement:

‘… we are unanimous in supporting the Act and its provisions. We have no doubts that the gains facilitated have much outweighed any disadvantages for which it has been criticised.42’

41 Thanks to David Paintin for sharing his papers recording these events. These are published as Abortion Law Reform in Britain 1964-2003: A personal account, by David Paintin. BPAS, 2015

The Committee proposed a reduction in the gestational limit from 28 to 24 weeks; stressed that abortion should be accessed within the first 12 weeks if possible; that day care services should be encouraged and that NHS contraceptive services should be adequate and acceptable.

In February 1975, Dr David Owen, Minister of State for Health, gave the Government’s first response to the Report of the Lane Committee, noting in its conclusion that by facilitating a greatly increased number of abortions, the 1967 Act had relieved a vast amount of individual suffering. Dr Owen also noted that, while there were still problems with private sector provision of abortion care, the private sector had played an important role in compensating for deficiencies in the provision of services by the NHS.

**Abortion (Amendment) Bill 1975 – James White MP**

This Private Member’s Bill intended to remove the wide discretion the Abortion Act allows doctors when assessing whether a woman’s health is at risk because of a pregnancy: essentially, to allow only those terminations necessary because of serious physical or mental illness. The proposed amendments were to:

- increase the threat to the life to ‘grave’ and to health as ‘serious’;
- remove the requirement that the risk of continuing the pregnancy should be ‘greater than if the pregnancy was terminated’;
- specify that the two certifying doctors ‘should not normally be in practice together’ and that one should have ‘a minimum of five years’ experience’;
- require approved nursing homes to have on their staff a consultant medical advisor to superintend clinical procedures, medical staff appointments and the use of the home by doctors;
- require foreign women would have to have been resident in the UK for 20 weeks;
- reduce the gestational limit to 20 weeks;
- prohibit the charging of fees for referring a woman for abortion.

After the second reading of the White Bill was passed, the House of Commons agreed that the Bill should be committed to a Select Committee. The resulting Select Committee report supported the restrictive aims of the original White Bill and recommended some further restrictions. The Government responded by reiterating what had been said about the report of the Lane Committee, noting in its conclusion that by facilitating a greatly increased number of abortions, the 1967 Act had relieved a vast amount of individual suffering. Dr Owen also noted that, while there were still problems with private sector provision of abortion care, the private sector had played an important role in compensating for deficiencies in the provision of services by the NHS.

Abortion (Amendment) Bill 1977 – William Benyon MP

This Private Member’s Bill was introduced because the restrictive recommendations of the subsequent Select Committee had not been adopted by the government. It ultimately failed for lack of Parliamentary time.

Abortion (Amendment) Bill 1977 – Sir Bernard Braine MP

This Ten-Minute Rule Bill called for three changes: 1) The time limit for abortion should be reduced from 28 to 20 weeks; 2) The provisions for conscientious objection to abortion by medical and nursing staff should be strengthened; 3) Pregnancy advisory bureaux should not be allowed to have any financial connection with abortion clinics. The House of Commons voted in favour but no further parliamentary time was allocated and the bill did not progress.

Abortion (Amendment) Bill 1979 – John Corrie MP

This Private Member’s Bill was probably the most significant of all Parliamentary attacks on abortion provision. David Paintin, Emeritus Reader in Obstetrics and Gynaecology at the University of London and one of the doctors who brought the 1967 Abortion Act into being, explains:

John Corrie drew first in the private members’ ballot when Parliament was reconvened after the general election in 1979 when the Conservatives led by Margaret Thatcher replaced Labour led by James Callaghan. The anti-abortion lobby – SPUC, Life and the Roman Catholic Church – had been very active during the election campaign, focusing on the humanity of the fetus and the need to make the grounds for legal abortion more stringent; in particular, to prevent the Act being interpreted by some doctors as allowing abortion on request as always being safer that continuing the pregnancy to term. Mrs Thatcher and several of her ministers were known to support restriction of legal abortion and, of the 60 new Conservative MPs, 59 were to vote in favour of anti-abortion legislation.

John Corrie took two or three weeks to come to a firm decision to make abortion law reform the subject of his bill – he had not been prominent among the anti-abortion MPs in the previous session. He consulted widely not only with SPUC and Life but also with the Department of Health, the BMA, RCOG and Doctors in Defence of the Abortion Act. When the Bill was published, only two or three days before the Second Reading, it had eleven lengthy clauses and was clearly intended to remove all aspects of the Abortion Act that allow doctors to provide the abortions that women had, previously, obtained illegally.

The most important amendments proposed by Corrie were:

- That the risk to life to be ‘grave’, to health ‘serious’ and ‘substantially’ greater than if the pregnancy was terminated, with such opinion having been formed on the basis of individual examination alone [i.e. not only from reading the notes made by the first doctor];
- That the gestational limit be less than 20 weeks – by amending the Infant Life (Preservation) Act (ILPA) 1929;
- That the conscience clause be expanded to include objection on ‘religious, ethical or other grounds’ and to remove the burden of proof from the person claiming the objection;
- The separation of private referral agencies from abortion providing clinics, with more stringent licensing and inspection by the Department of Health.

The Corrie Bill went to the Report Stage, and would have been a major threat to the availability of abortion had it succeeded. Paintin explains that the Bill eventually failed in spite of four days being given to its Report Stage, due to its complexity, divisions of opinion amongst its supporters, and the strength of pro-choice campaigners.
Abortion (Amendment) Bill 1980, and Abortion (Amendment) Bill 1987 – David Alton MP

In a Ten-Minute Rule Bill in 1980, David Alton argued that the gestational limit for abortion should be reduced from 28 to 24 weeks. This was rejected. Mr Alton brought a more successful Private Member’s Bill in 1987, which limited abortion to the first 18 weeks of pregnancy and would have allowed later abortion only when necessary to save the life of the woman, or when immediately necessary to prevent grave permanent injury to her physical health, or if the child was likely to be born dead or with such physical abnormalities so serious that its life cannot be independently sustained.

There was a notable amount of campaigning on both sides of the Alton Bill. It reached Report Stage but fell through lack of time.

Select Committee on the Infant Life (Preservation) Act 1929 – 1987

The Committee, chaired by Lord Brightman, recommended a gestational limit for legal abortion. Its report was published in 1988, and recommended: repeal of sub-section 5(i) of the Abortion Act that defines the gestational limit by reference to the Infant Life (Preservation) Act (ILPA) 1929; the exemption of doctors providing legal abortion from being prosecuted under the ILPA 1929; that a pregnancy should not be terminated after 24 weeks unless two doctors certified that this is essential to the physical or mental health of the woman, and not when there is only a risk to her health or that of any existing children of her family; that if Parliament wished to impose a statutory maximum gestational age this should be by specific provision in the Abortion Act and not be by cross reference to ILPA 1929.

Human Fertilisation and Embryology Act 1990

In 1990 the 1967 Act was amended by the Human Fertilisation and Embryology Act. This enshrined a gestational limit of 24 weeks on the face of the Abortion Act for most abortions. The HFE Act also gave the Secretary of State for Health the power to license a ‘class of places’ for abortions, taking into account developments in Early Medical Abortion that might make it appropriate to provide abortions in premises such as [for example] GPs’ surgeries.

There were some tidying amendments to clarify the situation regarding selective reductions in the case of multiple pregnancies, and the Abortion Act was changed to make it clear that this is essential to the physical or mental health of the woman, and not when there is only a risk to her health or that of any existing children of her family; that if Parliament wished to impose a statutory maximum gestational age this should be by specific provision in the Abortion Act and not be by cross reference to ILPA 1929.

The Partial-Birth Abortion (Prohibition) Bill 1995 – Lord Braine of Wheatley, formerly Sir Bernard Braine MP

An Act with this title had been passed in the US Congress in 1995. The eminent US gynaecologist David Grimes wrote in 2014:

[Partial-birth] abortion is a political, not a medical, neologism designed to inflame. The term is not found in medical texts or coding manuals. It was coined by opponents to describe an uncommon procedure for second-trimester abortion, intact dilation and evacuation. A brilliant public relations ploy, the term conflated two diametrically opposed conclusions of pregnancy, birth and abortion, in a single term. Thanks to politicians, a procedure that has been in obstetric texts for centuries has been made illegal, based aesthetics and not on safety.43

The principal clause in the Braine Bill had similar wording. It sought to capture political and public distaste for later abortions, by focusing on a particular technique used in these rare procedures. However, the technique in question – properly termed ‘intact dilation and extraction’ – has never been routinely used in Britain. The Bill had a second reading, but failed to proceed.

Termination of Pregnancy (Restriction) Bill 1996 – Viscount Brentford, formerly Sir Crispin Joynson-Hicks MP

The intention of this Bill was to prohibit abortion when the fetus had been shown by antenatal testing to have Down’s syndrome. The Bill achieved a second reading but did not proceed.

Human Fertilisation and Embryology Act 2008

During debate on the 2008 HFE Act, MPs rejected a series of options to reduce the upper time limit for abortions, ranging from proposed limits of 12 weeks to 22 weeks. The 24-week gestational limit was retained. Amendments were also proposed to reform the Abortion Act in a positive direction. A cross-party group of MPs proposed allowing women to take the second drug in medical abortion, misoprostol, at home; allowing nurses with relevant qualifications to carry out early stage abortions; increasing the number of places where they could be carried out; and extending the Abortion Act to Northern Ireland.

Most importantly, an amendment was tabled by Evan Harris MP and others to remove the need for two doctors’ signatures to give permission before an abortion could be carried out. Instead, abortion would be provided on the basis of informed patient consent and in their best interests, as with all other medical procedures.

These proposals were the results of a lengthy examination of ‘Scientific Developments since the 1967 Abortion Act’ by the House of Commons Science and Technology Select Committee.44

Had they been accepted, the 1967 Abortion Act would have been brought up to date with clinical developments. Abortion would have remained within the criminal statute, but these changes would have prevented many of the practical problems caused by the abortion law today, which we discuss in Chapter 6. However, the Labour government introduced a motion that effectively blocked Commons discussion of these proposals, and the law remained unchanged.45

Amendment to the Health and Social Care Bill, 2011 – Nadine Dorries MP

In a debate on the Health and Social Care Bill, which brought radical changes to the structure of the health service, Nadine Dorries proposed changing the statutory duties the NHS must provide to include ‘independent information, advice and counselling services for women requesting termination of pregnancy’ – and had said private abortion providers should not be considered ‘independent’. MPs voted on her amendment proposing that women should be offered the option of receiving ‘independent’ counselling and advice. The amendment failed, by 368 votes to 118.

‘Parliamentary Inquiry into Abortion on the Grounds of Fetal Disability’, 2013 – Fiona Bruce MP

Fiona Bruce, a Conservative MP who has brought a number of attempts to restrict abortion, in 2013 chaired a ‘Parliamentary Inquiry into Abortion on the Grounds of Fetal Disability’.46 This recommended changing the law, so that all abortions would take place before 24 weeks; and requiring, in the name of ‘transparency’, that all abortions that take place after 24 weeks’ gestation were subject to post-mortem examination (even where there is no clinical benefit to this). The report made very little impact.


Following the failure of her attempts to reform the law around abortion for fetal anomaly, Bruce introduced a Ten Minute Rule Bill calling for a ‘clarification’ that ‘nothing’ in the Abortion Act ‘allows a pregnancy to be terminated on the grounds of the sex of the unborn child’. Bruce’s Bill was supported by 181 MPs, with only one MP voting against, and received a Second Reading. However, this Bill was dropped in favour of an amendment to the government’s Serious Crime Bill, which had reached Report Stage. Following a vigorous campaign by pro-choice organisations and tense Parliamentary debate on 23 February, Bruce’s amendment was defeated, by 292 votes to 201.47 The Bruce amendment is discussed in more detail in Chapter 7.

Conclusion

As we can see, the Abortion Act has been subject to continual attacks since 1967, many of which have received a hearing in Parliament. Many of the themes of attacks on the Act follow those that have been used by opponents of abortion in the USA, and some have proved more successful than others. While the Act has withstood direct challenges, the chilling effect that has been caused by misinterpretations of the law and attempts to chip away at the legitimacy of the Abortion Act and the practice of doctors should not be underestimated.

Given the heat that is generated by Parliamentary discussions of the Abortion Act, it is not surprising that successive governments and pro-choice MPs have been reluctant to revisit the law. However, this has resulted in a very unsatisfactory situation, where there is a growing gulf between legal requirements and best clinical practice.

47 See the Hansard report on the Parliamentary debate here: http://www.publications.parliament.uk/pa/cm201415/cmhansrd/cm150223/debtext/150223-0004.htm
Chapter 5: Abortion is 2015. The reality

The previous chapters explained the core features of the 1967 Abortion Act, how it is interpreted in practice, attempts to amend and restrict the Act, and some of the ways in which the letter of the law is out of date with the twenty-first century. The next chapters will discuss in more depth the particular elements of the Abortion Act that now pose barriers to best clinical practice, and make some suggestions about the kind of regulation we need today.

First, however, we need to have a brief look at the way that abortion is provided, and used, in Britain today. This indicates that abortion care has been integrated into the fabric of modern society; it is supported by policy, extensively provided and publicly funded, and used by around 200,000 women every year. Even those who wish to turn the clock back on abortion provision would have to admit that to do so would involve unravelling a number of social and cultural changes that have accompanied women’s ability to plan their families.

How many abortions are there?

In the 21st century, around the world, abortion is not a hidden secret but a fact of life. The Guttmacher Institute estimates that more than 40 million abortions are performed worldwide each year.49 There are 24 abortions per 1,000 women aged 15–44 in developed countries, compared with 29 per 1,000 in developing countries. The lowest abortion rate in the world is in Western Europe (12 per 1,000), and the highest is in Eastern Europe (43 per 1,000).

In Britain, abortion is available and publicly-funded: giving women far more access to the procedure than countries in which it is illegal, heavily restricted, or available only in the first 12 weeks of pregnancy. Yet this has not led to a higher number or rate than in other countries. In 2013, the age-standardised abortion rate was 16.6 per 1,000 women residents aged 15–44, and the number of abortions was 181,582. For the past four years, both the number and rate of abortions have declined slightly.

Why do women have abortions?

Research and experience tell us that the reasons why women have abortions are primarily to do with their personal circumstances. These include:


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Figure 1: Age-standardised abortion rate per 1,000 women aged 15 - 44 (2013 ESP), England and Wales, 1969 to 2013

Source: Department of Health (2014).50

The Department of Health (DH) collects statistics for abortions carried out in England and Wales,50 taken from the abortion notification forms (HSA4)51, which all doctors are legally obliged to fill out. These national abortion statistics provide a useful and accurate way of assessing how many legal abortions are carried out in England and Wales in any given year, and how these statistics have changed since 1968. They can also tell us the legal grounds under which abortions were carried out under the 1967 Abortion Act.

However, numbers never tell the whole story, and care should be taken in interpreting them. The national statistics cannot tell us the reasons why women have abortions: they can only tell us the grounds under which doctors decided that an abortion was legal. Some abortion statistics – often those that catch media attention – need to be treated with particular caution, and these are examined below. These include repeat abortions, and teenage pregnancy and abortion rates.

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51 Separate statistics are produced for Scotland, and are available from ISD Scotland.

In recent decades, a great deal of attention has been paid to ‘teenage’ pregnancy and abortion rates. In 2013, the under-16 abortion rate was 2.6 per 1,000 women, and the under-18 abortion rate was 11.7 per 1,000 women. The under-18 conception rate for 2010 is the lowest since 1969, at 35.5 conceptions per 1,000 women aged 15–17.

The decline in young motherhood has been paralleled by a striking rise in older motherhood. In 2012, nearly half (49%) of all live births were to mothers aged 30 and over, and nearly two-thirds (65%) of fathers were aged 30 and over. A more precise account of the figures reveals that about 29% of births are to women aged 30-34, 16% are to women aged 35-39, 4% are to women aged 40-44, and less than 1% are to women over 45. One in 25 babies are now born to the over-40s, a four-fold increase in 30 years.

The percentage of conceptions leading to a legal abortion varies by age group. Over the past decade, this proportion has generally increased for women aged under 20, remained stable for women in their twenties and early thirties, and decreased for women aged 35 and over. In 2010, about 60% of conceptions to women under 16 ended in abortion, as did about 12% of conceptions to women aged 30-34. The most striking decline is in the percentage of conceptions leading to abortion for women aged 40 and over – down from about 43% in 1990 to 29% in 2010.

Age of motherhood and abortion
Most abortions are carried out for women between the ages of 18 and 29. In 2013, the highest abortion rate was to women aged 20-24, at 28.5 per 1,000 women. This reflects the fact that women in their early twenties are at the peak of their fertility; that women tend to be sexually active throughout their twenties; and that women are increasingly having children later in life.

Figure 2: Abortion rate per 1,000 population by single year of age, England and Wales, 2003, 2012 and 2013

Source: ONS, 2012.54
The rise in maternal age is part of an ongoing social trend over the past five decades. It reflects the fact that in the twenty-first century, women have access to effective contraception, and this gives them the scope to construct their lives around choices about partners, careers, and friendships. The magnitude of changes to people’s sexual choices and behaviour was indicated in the third National Survey of Sexual Attitudes and Lifestyles (Natsal)56 published in 2013, discussed in Chapter 1. In this context, having children can be seen less as a ‘natural’ part of life than as a personal act by a couple. There is no right to have a child, and it is not always possible to control whether one becomes pregnant or not. But in twenty-first-century Britain, it is not generally biology that pushes women to have babies, but personal decision-making, which takes place within a wider social context.

The rising age of motherhood has a number of implications for abortion. It means that women are less likely to have children at the peak of their fertile years, leading to a greater need to control their fertility through contraception and abortion. The trend towards delayed motherhood confirms that women are already doing this: it can be assumed that most women are sexually active for some time before starting their families.

Later age of motherhood is also associated with an increased risk of fetal anomaly. This does not mean that women diagnosed with fetal anomalies will necessarily terminate their pregnancies, but a greater proportion of women will face that decision.

There is an enduring stereotype that women who have abortions are single, childless, and do not want children. The annual statistics reveal a more subtle reality: many women have abortions because they don’t want, or cannot manage, any more children. In 2013, over half (53%) of women who had abortions were already mothers — a proportion that has been relatively constant for a decade. In 2013, 67% of women having abortions were either married/in a civil partnership or single, but with a partner.

‘Repeat’ abortion

Figures on ‘repeat abortions’ often provoke shocked headlines in the press. These statistics need to be treated with caution for a number of reasons. The phrase ‘repeat abortion’ implies that women are having serial abortions: this is not the case. The phrase used by the national statistics is ‘previous abortion’, which is a more accurate and less sensational description of the issue.

The statistics show that around 37% who have abortions have had ‘one or more’ previous abortion. The vast majority of these women will have had one previous abortion, not several. When one considers that, in England and Wales, there are an estimated 2 million acts of heterosexual coitus in women per day, it is striking that only one in 1000 acts of sex result in an abortion.58

In modern Britain, women may require more than one abortion because they are exposed to greater risk of unwanted pregnancy than women of previous generations. This is because more women choose not to have children, and those who do choose motherhood tend to delay having children until their late 20s or early 30s. The existence of a longer ‘window’ between women becoming sexually active and starting their families may mean that women are more exposed to unintended pregnancy. It is hardly surprising, then, the proportion of women who have had previous abortions rises with age.

Table B: Percentage of women who had one or more previous abortions, by age England and Wales, 2013

<table>
<thead>
<tr>
<th>Age</th>
<th>% of women who had one or more previous abortions</th>
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<tbody>
<tr>
<td>Under 18</td>
<td>7%</td>
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<tr>
<td>18-19</td>
<td>18%</td>
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<tr>
<td>20-24</td>
<td>34%</td>
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<tr>
<td>25-29</td>
<td>44%</td>
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<tr>
<td>30-34</td>
<td>47%</td>
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<tr>
<td>35 or over</td>
<td>45%</td>
</tr>
<tr>
<td>All women</td>
<td>37%</td>
</tr>
</tbody>
</table>

Source: Department of Health (2014)59

Research on repeat abortion suggests that women who have more than one abortion are no different to those who have one abortion: they are no less likely to use contraception, and are certainly not using abortion as a means of contraception. If they were, we would expect individual women to be having more than one abortion every year – and that is clearly not happening.

Abortion has become more widely available, and less stigmatised. This means that women may well be more likely to report having had a previous abortion than they would in the past. Policymakers’ interest in the number of previous abortions has also encouraged the assiduous collection of these statistics, and flagged ‘repeat abortion’ as an issue of media interest. Because statistics on previous abortions are reported voluntarily by the woman undergoing abortion, we should be aware that the statistics, and flagged ‘repeat abortion’ as an issue of media interest. Because statistics on previous abortions have also encouraged the assiduous collection of these procedures taking place.

 hos, who suspect a pregnancy can confirm this much sooner, while increasing numbers of Clinical Commissioning Groups (CCGs) now allow self-referral, so that a woman can access services without the delays that might be caused by waiting for a referral from her GP. The increasing availability and acceptability of Early Medical Abortion, also known as the ‘abortion pill’, has also played a key role. Early medical abortion now accounts for 61% of all abortions performed nationally up to 9 weeks’ gestation. Medical abortions take place in two stages. First, a single dose of mifepristone is given orally, which blocks the pregnancy hormones so that the pregnancy ceases to be viable and sensitises the uterus to prostaglandins. Typically 24–48 hours later a second drug, misoprostol, which is a synthetic prostaglandin, is administered vaginally. It causes the uterus to contract and to expel the pregnancy much like a miscarriage.

Figure 4: Abortions by gestation, England and Wales, 2003 to 2013

Highly sensitive tests, which can diagnose pregnancy just days after conception, mean that women who suspect a pregnancy can confirm this much sooner, while increasing numbers of Clinical Commissioning Groups (CCGs) now allow self-referral, so that a woman can access services without the delays that might be caused by waiting for a referral from her GP. The increasing availability and acceptability of Early Medical Abortion, also known as the ‘abortion pill’, has also played a key role. Early medical abortion now accounts for 61% of all abortions performed nationally up to 9 weeks’ gestation. Medical abortions take place in two stages. First, a single dose of mifepristone is given orally, which blocks the pregnancy hormones so that the pregnancy ceases to be viable and sensitises the uterus to prostaglandins. Typically 24–48 hours later a second drug, misoprostol, which is a synthetic prostaglandin, is administered vaginally. It causes the uterus to contract and to expel the pregnancy much like a miscarriage.


Table 7b: Legal abortions: grounds by gestation weeks, residents of England and Wales, 2013

<table>
<thead>
<tr>
<th>Number of previous abortions</th>
<th>Total</th>
<th>Under 16</th>
<th>16 and 17</th>
<th>18 and 19</th>
<th>20-24</th>
<th>25-29</th>
<th>30 or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>185,331</td>
<td>2,538</td>
<td>9,141</td>
<td>17,332</td>
<td>43,578</td>
<td>58,704</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>116,811</td>
<td>63</td>
<td>2,470</td>
<td>97</td>
<td>8,421</td>
<td>92</td>
<td>14,248</td>
</tr>
<tr>
<td>1</td>
<td>49,543</td>
<td>27</td>
<td>63</td>
<td>4</td>
<td>667</td>
<td>7</td>
<td>2,718</td>
</tr>
<tr>
<td>2</td>
<td>14,066</td>
<td>8</td>
<td>5</td>
<td>0</td>
<td>51</td>
<td>1</td>
<td>321</td>
</tr>
<tr>
<td>3</td>
<td>3,457</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>4</td>
<td>995</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>264</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>108</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>38</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8 or more</td>
<td>49</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Women are now offered the option of going straight home after taking the second pill, which most do, in order to make themselves comfortable before this process starts. In the UK misoprostol is treated as an abortifacient, and therefore women must visit a clinic to obtain the second pill. In the USA and other European countries, the second stage of a medical abortion is frequently self-administered by the woman in her own home which has been demonstrated in a numbers of studies to be safe, acceptable and preferred by women. The reason why this is not legally permitted in Britain is discussed in Chapter 6.

The increased proportion of ‘early’ abortions funded by the NHS is a reflection of Department of Health policy over the past decade: that women who are legally entitled to an abortion should have access to the procedure as soon as possible. This reflects clinical evidence that the risk of complications from abortion is lower in earlier gestations than in later ones, and a humane understanding that it is best for the woman emotionally to have an abortion once she has decided that she needs one, rather than forcing her to wait.

‘Late’ abortion

The rise in ‘early abortion’ does not reduce women’s need for abortion at later gestations. In 2013, approximately 8% of abortions took place in the second trimester of pregnancy – a similar proportion to previous years. This reflects the variety of reasons that contribute to women’s need to seek ‘later’ abortion, which range from delays in suspecting/confirming a pregnancy to relationship breakdown, diagnoses of fetal anomaly, and difficulty accessing services.

An important study by academics at Southampton University surveyed 883 women who had had second-trimester abortions, to find out what the women considered were the reasons for delay having the procedure. This study found that, as with all women seeking abortion today, women’s decisions and experiences are based on a range of complicated ‘real life’ factors. Just as the decision to have an abortion is rarely made in ideal circumstances, the timing of a woman’s abortion cannot always be tailored to best practice standards.

The study identified no single reason why women have abortions in the second trimester. Indeed, 13 different reasons were selected by at least one fifth of the respondents, ranging from delays in confirming the pregnancy to uncertainty about whether to have an abortion to delays in accessing the abortion services:

- I was not sure about having the abortion, and it took me a while to make my mind up and ask for one (41%)
- I didn’t realise I was pregnant earlier because my periods are irregular (38%)
- I thought the pregnancy was much less advanced than it was when I asked for the abortion (36%)
- I wasn’t sure what I would do if I were pregnant (32%)
- I didn’t realise I was pregnant earlier because I was using contraception (31%)
- I suspected I was pregnant but I didn’t do anything about it until the weeks had gone by (30%)
- I was worried how my parent[s] would react (26%)
- I had to wait more than 5 days before I could get a consultation appointment to get the go-ahead for the abortion (24%)
- My relationship with my partner broke down/changed (23%)
- I was worried about what was involved in having an abortion so it took me a while to ask for one (22%)
- I didn’t realise I was pregnant earlier because I continued having periods (20%)
- I had to wait more than 7 days between the consultation and the appointment for the abortion (20%)
- I had to wait over 48 hours for an appointment at my/a doctor’s surgery to ask for an abortion (20%)

(Women could give more than one reason)

These findings mirror the experience of those who work in abortion services: namely, that every woman is different, and her reasons for seeking abortion – at whatever stage of the pregnancy – are many and varied.

The study also indicated the extent to which individual women can experience a range of factors that, cumulatively, lead to a delay in abortion. For example, they may not realise they are pregnant until relatively late on in the pregnancy – at which point they may struggle for a while with the decision to have an abortion, and then find themselves having to wait for the procedure.

Perhaps the most striking finding of the study by Ingham et al., discussed here, is the extent to which the delay in obtaining an abortion arose, not from factors within the abortion service such as lack of appointments, but from women’s delay in seeking an abortion in the first place. Significantly, half of the women involved in this study were at 13+ weeks’ gestation by the time they first asked for an abortion. The report discussed five ‘stages of delay’ along the pathway to abortion:

• **Suspicion of pregnancy.** A large proportion of the women took several weeks even to suspect they were pregnant – half were over seven and a half weeks’ gestation when they first suspected they were pregnant, whilst one quarter were over 11 weeks 2 days’ gestation. Many did not suspect they were pregnant because they had irregular periods, because their periods continued while they were pregnant, or because they were using contraception. Given that contraception does sometimes fail (and most people assume that it won’t), and that continued periods are usually a sign that a woman is not pregnant, it is not surprising that a number of women find themselves ‘caught out’ by a pregnancy they were fairly certain would not happen.

• **Taking a pregnancy test.** Around a third of respondents took over two weeks between suspecting they were pregnant and taking a pregnancy test. Forty-five percent of these women suspected they were pregnant but ‘didn’t do anything about it until the weeks had gone by’. Others said they were ‘not sure about what they would do if they were pregnant’, or raised fears about the reactions of their parents and partners. Facing up to an unplanned pregnancy involves making one of three tough decisions – to have an abortion, to continue the pregnancy and give the baby up for adoption, or to raise a child whom you hadn’t intended to have at this point in your life, if at all. While it may seem less than rational to policymakers that women might delay confirming their pregnancy, thereby narrowing their choices about what to do about it, one can empathise with this reaction in a real life context.

• **Deciding to have an abortion.** Once their pregnancy was confirmed, around half the respondents took one week or less between taking their test and then making the decision to have an abortion. Among those who took over one week, the most commonly-cited reason was, ‘I was not sure about having the abortion, and it took a while to make up my mind and ask for one’. Reasons for this indecision included concerns about what was involved in having an abortion, and difficulties in agreeing a decision with their partner.

• **First asking for an abortion.** Once women have made up their minds to have an abortion, they are quick to act on that decision. For half of the women the time between making the decision and asking for an abortion was two days or less. This indicates that what women need, once they have decided to have an abortion, is the kind of abortion service that will allow them to act on that decision as quickly as possible.

• **Obtaining an abortion.** A relatively large proportion of respondents (60 percent) perceived a delay between requesting an abortion and having the procedure. Twenty-three percent waited over three weeks — beyond the minimum standard recommended by the Royal College of Obstetricians and Gynaecologists (RCOG).

In 2008, BPAS conducted an anonymised case-study audit of clients who had requested an abortion at gestations of 22 weeks or over: 32 women in total. The age of these women ranged from 14 years to 31 years. Ten of the 32 were teenagers; 11 already had children and were worried about their ability to cope with the needs of their existing family; three were on drug treatment programmes; one had reported her partner to the police for abusing her daughters.

The details of these women’s circumstances indicate just how wrong it is to assume that women seeking abortion at over 20 weeks’ gestation could easily have taken that decision earlier. These are just five of the 32 case studies:

• A 14-year-old girl presenting at 23 weeks and 5 days started her periods a year ago, but they were never regular and it did not register with her that she could be pregnant. She had no idea where she could get help and didn’t feel able to tell her parents. Eventually she ‘plucked up her courage’ to see the school nurse.

• A 15-year-old girl presenting at 23 weeks and 4 days had had sex for the first time to see what it was like: when suspecting her pregnancy she ‘buried [her] head in the sand hoping it would go away’. She started to self-harm: punching herself in the stomach and making herself vomit. Her mother took her to GP suspecting bulimia and the pregnancy was detected.

• A 18-year-old woman presenting at 22 weeks and 4 days had had an early medical abortion 14 weeks previously. A pregnancy test 4 weeks later was negative and she had a contraceptive implant fitted. She had no idea she could be pregnant.

• A 24-year-old mother of two young children presenting at 22 weeks and one day had an unplanned pregnancy. Her current partner had persuaded her to continue; she then found out that he was abusing her children and reported him to the police.

• A 27-year-old woman presenting at 22 weeks and one day already had three children in foster care, as she was a drug user on methadone and unable to cope. She knew that another baby would also be taken away, and while feeling sad about needing the abortion felt that her priority was getting her existing children back.

The national statistics indicate the significant role played by NHS-funded independent sector in providing access to abortion at later gestations. The majority of abortions carried out between 13 and 24 weeks are carried out by the independent sector, which is usually able to offer women a choice of either medical (labour induction) or surgical abortion.

<table>
<thead>
<tr>
<th>Gestation weeks</th>
<th>Total number of abortions</th>
<th>Purchaser (%)</th>
<th>Method (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NHS Funded</td>
<td>Privately Funded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital</td>
<td>Independent Sector</td>
</tr>
<tr>
<td>Total</td>
<td>185,331</td>
<td>34</td>
<td>64</td>
</tr>
<tr>
<td>3-8</td>
<td>131,212</td>
<td>30</td>
<td>67</td>
</tr>
<tr>
<td>9-12</td>
<td>38,403</td>
<td>46</td>
<td>53</td>
</tr>
<tr>
<td>13-19</td>
<td>12,963</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td>20-23</td>
<td>2,563</td>
<td>34</td>
<td>64</td>
</tr>
<tr>
<td>Over 24 weeks</td>
<td>190</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health (2014) 66

For women who can only access abortion within NHS settings – either due to local contracts or medical reasons such as complex health conditions or a high Body Mass Index (BMI) – choice may be restricted, with 79% of NHS hospitals providing abortion offering medical methods only after 13 weeks. This may be due to a lack of surgical skills, conscientious objection among clinicians, or hospital policy.

Research by Kelly et al. carried out in 2010 found that women undergoing second trimester abortions found surgical methods less painful and more acceptable than medical, with more than half of those undergoing medical reporting the experience to be worse than expected. The authors also noted that there was ‘urgent need to introduce novel training strategies’ if women were to be offered the method most suited to them.

Fetal anomaly

Advances in prenatal screening and diagnostic testing, alongside trends in later motherhood, mean that more women are faced with a diagnosis of fetal anomaly in the second trimester of pregnancy. Many women opt for abortion in these circumstances: for example, 90% of pregnancies with a prenatal diagnosis of trisomy 21 (Down’s Syndrome) will be terminated. This indicates the continuing need for the provision of second-trimester abortion services, and the need to offer women a choice between medical induction and surgical methods of abortion.

The focus on the statistics of abortion for fetal anomaly obscures the more subtle and complex reasons why women come to their decisions, which are unique to them and affected by their circumstances. But the statistics do show that abortion for fetal anomaly account for a tiny proportion of all abortions: only 1% are carried out under Ground E (risk of ‘serious handicap’) and less than 0.1% of all abortions take place after 24 weeks’ gestation. In 2013, only 190 abortions were carried out over 24 weeks’ gestation. Despite the ongoing debate about fetal viability and proposals to reduce the ‘time limit’ for abortion, this statistic indicates how rare very late abortions are in Britain.

Yet the fact that post-24 week terminations are rare does not make them any less important than abortions earlier in pregnancy. Opponents of abortion often latch on to these cases, using emotive claims about the extent to which a 24-week fetus looks like a baby, and how children born with particular disabilities can lead a good life, to obscure the emotional anguish and practical difficulties experienced by women who receive a diagnosis of fetal anomaly in an otherwise wanted pregnancy, and cannot see their way to raising a child with a serious disability. This is sometimes because of the emotional, time, and financial costs of raising a disabled child; sometimes because it would limit a woman’s ability to care for her existing children; sometimes because it is felt to be cruel to have a child that will need constant medical intervention and may live in pain – and often, because of all these reasons.

The heartbreaking reasons why a small number of women may need terminations for fetal anomaly are the reasons why it is important that such terminations can continue to be provided. Yet this aspect of the law is frequently subjected to legal challenges, as discussed in the previous chapter; and undermined by the ‘chilling effect’ caused by campaigners attempting to impose a different interpretation of the law. Women can find themselves persuaded against terminating the pregnancy by arguments that do not reflect their needs, or the law; or they may find themselves unable to find doctors willing to perform the procedure.

Women seeking abortion for fetal anomaly before 24 weeks’ gestation are often treated in NHS abortion services, where their only option for abortion is medical induction. Expanding the range of choices of method available to these women is crucial, in attempting to lessen their anguish.

Methods of abortion

The methods of abortion available to women fall into two broad categories – those induced by administration of medications and those conducted by surgical methods. For medical induction, women take a combination of drugs that have the effect of inducing a miscarriage. At early gestations (under 9 weeks of pregnancy), women take the drugs in a clinic, and miscarry at home. After 9 weeks’ gestation, medical induction is more closely supervised, and may sometimes involve an overnight stay in a clinic.

Surgical abortions in early gestations are relatively swift procedures, which are performed by doctors and usually require either general or local anaesthetic. Manual or electric vacuum aspiration (suction) is used in early procedures. At gestations of over 15 weeks, a method called Dilatation and Evacuation (D&E) is used.

The protocols used for medical and surgical methods vary according to the gestation of the pregnancy. These are clearly explained in the Royal College of Obstetricians and Gynaecologists’ (RCOG) evidence-based guideline, The Care of Women Requesting Induced Abortion.
Evidence indicates that, in general, medical and surgical methods are equally safe, effective, and acceptable. Surgical abortions at later gestations require particular training, which may be one reason why they are not widely offered within the NHS. The main reason for offering a choice of method, where possible, is that some women have strong preferences. Some women feel that medical induction is more ‘natural’ and less invasive; other women prefer surgical because it is quicker, or because they prefer to be asleep during the procedure. Both surgical and medical methods are appropriate for abortions at all gestations of pregnancy, and in theory women have a choice of method at all gestations. In practice, choice of method – particularly in later gestations – can vary according to whether abortions are provided by NHS hospitals or by the independent sector under NHS contract, as discussed above.

Abortion policy and provision
Since 2000, the Royal College of Obstetricians and Gynaecologists (RCOG) has produced an evidence-based guideline on induced abortion. This lays out the clinical best practice standards for women having abortions, based on extensive reviews of the current literature. The guidance also underlines the centrality of abortion as a healthcare need today:

In a legal setting where sterile facilities are available, abortion is a safe procedure for which major complications and mortality are rare at all gestations. Abortion accounts for a significant proportion of the workload of many gynaecologists. The RCOG views induced abortion as a healthcare need as well as an important public health intervention, and reiterates the recommendation of the RCOG Working Party on Unplanned Pregnancy (1999) that ‘health authorities should accept responsibility for the abortions needed by women resident in their districts’.72

In England and Wales, the proportion of abortions funded by the National Health Service (NHS) has risen steadily, and in 2013, 98% of abortions were funded by the NHS.73 The availability of abortion in England and Wales has been assisted by the fact that over half (64%) of abortions are carried out in approved independent sector places (such as clinics run by the charities British Pregnancy Advisory Service and Marie Stopes International) but publicly paid for, showing a trend towards giving women increasing access to specialist services outside the general NHS. As noted in Chapter 3, these charities are heavily regulated and unable, by law, to make a profit from abortion services.

Figure 3: Abortions by purchaser / provider, England and Wales, 1981 to 2013

Government policy has also come to recognise abortion as an important part of public health. The New Labour government, in power between 1997 and 2010, produced a National Strategy for Sexual Health and HIV, which stated that ‘Women considering or seeking abortion should:

- have direct access to, or be referred for, an abortion assessment within five working days of initial contact with an abortion provider or other healthcare provider
- receive comprehensive, accurate and unbiased information
- be able to access an abortion ideally within two weeks, but within a maximum of three weeks, of initial contact with healthcare providers
- be offered a choice of abortion methods clinically appropriate for their gestation and individual circumstances
- be offered screening for chlamydial infection, and treatment as necessary, with prophylactic treatment provided when results are not available prior to the procedure
- be able to access screening for other STIs, including HIV
- have individualised support and access to specialist counselling if needed at any time during or after the abortion process.74
The subsequent Conservative/Liberal Democrat Coalition government in 2013 produced *A Framework for Sexual Health Improvement in England*, which clearly recognises the importance of swift access to legal, publicly-funded abortion:

- For those women who request an abortion it is important that they have early access to services, as the earlier in pregnancy an abortion is performed the lower the risk of complications.
- Access to abortion has improved in recent years. In 2011, 96% of abortions carried out on residents of England and Wales were provided free on the NHS; of these, 91% were carried out before the thirteenth week of gestation.
- The Abortion Act 1967 sets out the circumstances in which abortions can be carried out in Great Britain.\(^76\)

**Conclusion**

All the main political parties in Britain are of the view that abortion should be legal, that it should be provided, and that it should be supported by health policy. Public opinion is in favour of a woman being able to choose to end her pregnancy if that is what she decides to do. So there would seem to be few barriers to removing specific criminal offences relating to abortion, in order to find a form of regulation that prioritises women’s health.

On the other hand, the existing law does create numerous barriers to running the kind of service that women need, policymakers claim to want, and doctors consider to be best clinical practice. That is the subject of the next chapter.

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Chapter 6. The problems caused by the 1967 Act in practice

In the decades since the 1967 Abortion Act came into force, abortion providers have worked within the law to ensure that women have the best possible access to services. Abortion care in Britain is extremely safe; the most effective and acceptable methods are used to the extent that they can be within the confines of the law; and the vast majority of women who request an abortion at under 24 weeks of pregnancy are able to access the procedure on the National Health Service. The standard of care offered by Britain’s abortion service is testament to the dedication of clinical staff, abortion providers, and policymakers who have developed this service over the years. However, doctors and nurses working in abortion care experience a growing mismatch between the kind of work they need to do to meet women’s needs, and the legal requirements mandated by the 1967 Abortion Act. This is not surprising, given that the 1967 Act was written at a time when the methods used to provide abortion were very different to those used now.

In 1967, the social and cultural framework surrounding abortion was also quite different. Abortion is legal and available throughout the developed world, in a way that it was not during the 1960s. Consequently, women today expect to be able to control their fertility, and this expectation has enabled them to play a far wider role in public life. While Britain in the 1960s pioneered progressive legislation around abortion, today it is lagging behind.

The political acceptance of abortion in Britain is similar to many other European countries, where abortion is provided on request up to a particular gestation. The combination of political acceptance, public funding, and the motivation of abortion providers to provide the best services they can based on research and best practice internationally has enabled services to change significantly, to move with the times and meet women’s needs.

But these positive shifts have highlighted the ways in which the British law is placing barriers in the way of further service developments that would be good for women. That is why in 2007, ahead of the Parliamentary debate on the Human Fertilisation and Embryology (HFE) Act, the House of Commons Science and Technology Select Committee produced a major report on ‘Scientific Developments Since the Abortion Act 1967’. The government issued its response later that year.

The Committee gathered evidence from professional bodies and experts and reviewed a large body of literature on the clinical developments surrounding abortion. It made recommendations based on this evidence about aspects of the law that should be debated by Parliament, with a view to reform. Yet when it came to debating legal reform in Parliament, the government closed the opportunity off.

The STC noted that the experts whom it consulted gave ‘a range of explanations’ for the introduction into the 1967 Act of the requirement for two doctors’ signatures:

• to appease the pro-life lobby.
• to demonstrate the medico-legal concerns of Parliament, namely that the 1967 Act did not make abortion legal but conferred upon doctors a defence against illegality – the two doctors are expected to police each other.
• to protect doctors from breaking the law.
• to ensure that the provisions in the legislation were being observed
• to protect women
• to ensure that the provisions in the legislation were being observed
• to deportment the medico-legal concerns of Parliament, namely that the 1967 Act did not make abortion legal but conferred upon doctors a defence against illegality – the two doctors are expected to police each other.
• to show the seriousness of the decision to terminate
• to appease the pro-life lobby.

It is widely understood today that the ‘two doctors’ requirement satisfies legal regulations, rather than clinical standards. There are no other clinical procedures in Britain that require the signature of two doctors; and in most other countries where abortion is legal this requirement does not exist.
The STC identified a number of arguments against the requirement for two signatures. Submissions from the medical profession highlighted the issue of two signatures as a barrier to swift access to abortion services: the British Medical Association (BMA), the Royal College of Nursing (RCN), the RCOG, and service providers. This becomes a particular issue when GPs have a conscientious objection to abortion.

Another important point, which was argued by representatives from all sides of the abortion debate, was the lack of a clinical necessity for the requirement of two doctors’ signatures. Anne Weyman of FPA said:

There is absolutely no reason why we should have the two doctors’ signatures, for medical or scientific reasons. It does seem rather odd that in 2007 we are still bound by an Act that was passed in 1861, the Offences Against the Person Act.85

On the other side, Dr Peter Saunders, speaking as a representative of the Alive & Kicking alliance, said:

I think we have to understand this in its historical context. Abortion is quite unique because under the Offences Against the Person Act abortion is still illegal in this country, which means that if you commit an illegal abortion you can go to prison for 14 years. The reason there are two doctors in the Act has nothing to do with medicine or safety but everything to do with legality.86

The fact that the two signatures requirement is clinically superfluous constitutes a major problem with the legislation, both in principle and in practice. As the Science and Technology Committee reported back in 2007, it received many submissions arguing that the need for two doctors signatures was superfluous since one of the grounds (C) was always met, at least in the first trimester. The STC explains:

Most abortions in the UK take place under ground C: that ‘the pregnancy has not exceeded its twenty-fourth week and 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’. Many submissions noted that the earlier an abortion is carried out, the safer it is, and that legal abortions carry lower risks than continued pregnancies. RCOG notes that:

This means that women in the first trimester could be seen as automatically fulfilling the criteria of the Abortion Act. Although this was not the original intention of the Act, in practice it facilitates access to induced abortion within the current law.

There were dissenters to this view, but we found strong evidence that ground C is always met for first trimester abortions.85

The STC concluded:

We were not presented with any good evidence that, at least in the first trimester, the requirement for two doctors’ signatures serves to safeguard women or doctors in any meaningful way, or serves any other useful purpose. We are concerned that the requirement for two signatures may be causing delays in access to abortion services. If a goal of public policy is to encourage early as opposed to later abortion, we believe there is a strong case for removing the requirement for two doctors’ signatures. We would like see the requirement for two doctors’ signatures removed.85

The superfluous character of two doctors’ signatures is not merely irritating, time-consuming and costly for those working in the abortion service – though it is all of these things. It also lays doctors open to spurious allegations of illegal practice, through attempts to find irregularities in paperwork and impose a particular interpretation of the law onto the ways in which abortions must be certified. This problem is discussed below, in relation to the ‘pre-signing’ controversy of 2012.

Involvement of nurses

The 1967 Act requires that an abortion must be conducted by a ‘registered medical practitioner’, which means that only doctors can perform abortions in the UK. When the law was drafted, abortion was exclusively a surgical procedure, and so the role of nurses was relatively restricted.

Today, however, nurses commonly perform interventional procedures and there is evidence that early surgical abortions provided by clinicians other than doctors result in equivalent outcomes.

The development of medical abortion represents the most significant shift in abortion care. Britain, following France, pioneered the medical abortion method. Mifepristone was licensed for use in the UK in 1991. At that time, only 4% of abortions were undertaken using a medical procedure. In 2013, medical abortions accounted for 49% of the total for England and Wales, rising from 17% in 2003. The impact of this method is particularly striking on abortions in early gestations of pregnancy. In 2013, 61% of abortions under nine weeks were medical abortions compared with 21% in 2003.

As the national abortion statistics note:

The choice of early medical abortion as a method of abortion is likely to have contributed to the increase in the overall percentage of abortions performed at under ten weeks’ gestation (58% in 2003 compared with 79% in 2013).87

Most agree that, if a woman is going to have an abortion, it is best if she can have the procedure as soon as she has made the decision to do so, and medical abortion has enabled this to happen. This is partly because the method does not require surgical facilities. This gives much more flexibility to services, enabling abortion clinics to operate in rural areas. Crucially, more flexibility is given by the role that nurses can play in the medical abortion service.

85 Ibid. p34
86 Ibid. p34
In the 1981 case RCN v DHSS, the House of Lords ruled that the medical practitioner is not required to perform personally each and every action needed for an abortion. The STC noted that, in 2007:

Many abortion services rely on nurses to run their medical abortion units, but nurses are not permitted to sign the authorisation forms or prescribe the necessary medication. However, nurses are involved in every other aspect of the procedure and the RCOG notes that ‘Many hospital based abortion services already rely on nurses to run their medical abortion units’. Further, Kathy French from the RCN told us that ‘There is a small group of nurses within abortion services who would like, with appropriate training […] to be able to do the very early medical abortions’.

Surgical abortions are also very different to 1967. Vacuum aspiration, using a hand-operated or electrical suction device, is offered from 4–15 weeks’ gestation under general or local anaesthetic or light conscious sedation as a day-case procedure: as compared to sharp curettage only under general anaesthetic, where women were kept in hospital.

The Science and Technology Committee concluded that there were three key arguments in favour of permitting trained nurses and midwives to carry out medical and surgical abortions with appropriate supervision:

a) Nurses and midwives perform a range of complicated procedures including colposcopies and hysteroscopies, and fitting sub-dermal implants. Nurses also routinely fit contraceptive coils (IUD/ IUS), which require about the same level of skill as manual vacuum aspiration.

b) Nurses are already allowed to prescribe mifepristone for medical needs other than abortion. Mifepristone is listed in the British National Formulary (BNF) for Nurse Independent Prescribing (NIP). Women who have experienced a spontaneous miscarriage self-administer misoprostol at home to ensure the safe expulsion of the miscarried pregnancy.

c) Nurses already carry out medical and sometimes surgical abortions in some US states and in South Africa with good safety profiles. Further, research has been conducted to assess the safety of allowing nurses rather than doctors to perform abortions. For example, complication rates for surgical abortions performed by physician assistants were compared with complication rates for surgical abortions performed by physicians in Vermont and New Hampshire. For physician assistant performed abortions, the complication rate was 22.0 per 1000 compared to 23.3 per 1000 for physician-performed abortions, which is not statistically different.89

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The Science and Technology Committee concluded that there were three key arguments in favour of permitting trained nurses and midwives to carry out medical and surgical abortions with appropriate supervision:

• that such practice would not compromise patient safety or quality of care.
• that subject to usual training and professional standards nurses (and midwives) could be permitted to carry out early surgical abortions; and
• that such practice would not compromise patient safety or quality of care.

In terms of any safety concerns about nurses playing an enhanced role, the STC argued:

‘We are satisfied that there is adequate evidence, particularly in terms of the roles that nurses already play in service provision and in terms of the international experience, to conclude the following:

• that subject to usual training and professional standards nurses (and midwives) could be permitted to sign the HSA1 form, for which they currently obtain consent, and prescribe the necessary drugs, which they currently administer;

• that permitting nurses and midwives to sign the HSA1 form and prescribe the necessary drugs would not alter the rates of failed and incomplete abortions, abdominal pain or uterine cramping, nausea, vomiting, diarrhoea, vaginal bleeding or spotting, or pelvic inflammatory disease that can be associated with EMA;

• that since, as will be discussed below, most women go home after taking the second pill, there is no direct involvement with either nurses or doctors at this point. What is crucial is the ready availability of appropriate care should a complication arise, and clear instructions to women about what to do in the event of complications, something that nurses routinely give;

• that subject to usual training and professional standards nurses (and midwives) could be permitted to carry out early surgical abortions; and

• that such practice would not compromise patient safety or quality of care.

In its 2011 guidance, the RCOG acknowledged the substantial role that nurses now take in the provision of abortion services and recognised the lack of a national standard for training for this role, recommending that the RCN gives thought to developing and implementing specialist training programmes for nurses working in abortion care.

Given the changes in methods used for abortion, the high levels of safety of these methods, and the skill already shown by nurses in prescribing medications and performing routine surgical procedures, it should be uncontroversial to suggest that they should be able to provide abortions. Indeed, if abortion were regulated like other routine medical procedures, it would be bizarre to have them barred from doing so. Doctors could use the time they currently spend signing prescriptions and forms and doing simple procedures on the more complex cases: women presenting at later gestations, or who have particular health conditions.

The existence of a group of nurses willing and able to provide early abortions could also reduce the problems caused by the ongoing shortage of abortion doctors, and reduce tensions arising from conscientious objection. If a larger pool of people were able to carry out abortions, the impact of individual doctors’ conscientious objection upon women would potentially be minimised.

88 Ibid. p37
89 Ibid. pp37-8
90 Ibid. p38
Places where abortions can be carried out

Medical abortion could have revolutionised care for women in rural areas, for whom travelling for an abortion is often logistically difficult, expensive, and emotionally taxing. Yet the law stipulates that, except in an emergency, an abortion must be conducted in an NHS hospital or a place approved by the Secretary of State.

The way that the 1967 Act blocks the ‘home use’ of misoprostol is one of the starkest ways in which the law prevents doctors and nurses from providing women with the best form of clinical care. The STC notes:

When this legislation was put in place, abortion was a surgical procedure. That is why places were specified where abortions could be carried out. However, in the last 10 years, medical abortions have increased in frequency, the requirements of which, from a medical provisions point of view, are markedly different. It is common practice in other countries for the second stage of an early medical abortion to be completed at home.93

The STC report, published seven years ago, noted that ‘outside the UK, research has shown that self-administration of misoprostol at home is safe, effective and acceptable’. The Committee wrote:

For example, in America, where misoprostol is routinely self-administered at home, the estimated case-fatality rate for medical abortion is 0.8 deaths per 100,000 procedures, which is statistically indistinguishable from the risk of death from miscarriage: 0.7 per 100,000 miscarriages; in 1997, the pregnancy related mortality ratio in America was 12.9 deaths per 100,000 live births. From a legal perspective, it is worth noting that in Norway, which has a law similar to the UK, only the mifepristone must be taken in a clinic, as this is regarded as the abortifacient. Misoprostol is viewed as a supporting medication, because it is taken to enable the safe and prompt expulsion of the products of conception. It is noteworthy that in the UK misoprostol is prescribed for home self-administration to women who have experienced a spontaneous miscarriage to ensure the safe expulsion of the miscarried pregnancy.

We were impressed by the evidence that there are no particular safety concerns about early medical abortions on three grounds. First, the studies that have assessed the safety of medical abortion to ensure the safe expulsion of the miscarried pregnancy.

The overwhelming evidence about the safety of the home use of misoprostol, and the success of this approach in other European and North American countries, led the Science and Technology Committee in 2007 to conclude that:

[S]ubject to providers putting in place the appropriate follow up arrangements, there is no evidence relating to safety, effectiveness or patient acceptability that should serve to deter Parliament passing regulations which would enable women who chose to do so taking the second stage of early medical abortion at home, or that should deter Parliament from amending the act to exclude the second stage of early medical abortion from the definition of ‘carrying out a termination’.95

Parliament did not address this question in 2008. Four years later, in 2011, BPAS brought a legal challenge to the Department of Health, arguing that women should be allowed them to take away the misoprostol, so that they could take it at home. The charity’s concern was the extent to which the abortion law, with its insistence on women returning to the clinic for administration of misoprostol, was now putting women at risk of aborting on their journey home.96

BPAS questioned whether the legal definition of ‘treatment’ for abortion covers both the prescription and the administration of medication. But the High Court ruled treatment covered the administration as well, although it said the Health Secretary had the power to amend the rules if advances in medicine justified it.

The Hon Mr Supperstone J. ruled that Section 1(3A) of the Abortion Act as amended in 1990 enables the Secretary of State to react to ‘changes in medical science’ as it gives him ‘the power to approve a wider range of place, including potentially the home, and the conditions on which such approval may be given relating to the particular medicine and the manner of its administration or use.’

In a statement, BPAS said:

The increasing number of women using this form of abortion every year means resolving this issue is now a matter of great urgency. Since we brought our case to court, the Royal College of Obstetricians and Gynaecologists has produced new guidelines noting the weight of evidence in support of home-use of misoprostol for abortions up to nine weeks and the importance of giving women choice of method. This new, evidence-based guidance was supported by the Department of Health. Given Health Secretary Andrew Lansley’s commitment to evidence-based medicine, patient choice and the liberation of clinicians, we assume he will wish to employ the powers the ruling highlights rapidly so that doctors may provide women legally accessing early abortion with the best possible care.

It cannot be morally right to compel a woman to physically take tablets in a clinic and to subject her to the anxiety that symptoms will start on the journey back when her doctor knows it is safe and indeed preferable for her to take these at home. If the law as it stands cannot allow what is safe, right and proper, then it is not fit for purpose and must be changed to reflect modern medical practice. But if the law as it stands allows the Secretary of State to approve a woman’s home as a ‘class of place’ for abortion then this is what he must do.

94 Ibid. pp40-1
95 Ibid. p42
Three years on from the High Court ruling, the Department of Health has made no moves to consider licensing women’s home as a ‘class of place’, and there are no plans to review the abortion law. This resistance to change ignores serious anomalies both in Britain, and internationally. In Britain, women who have a spontaneous miscarriage are often given misoprostol to take home with them, so they do not have to wait for several agonising days before the pregnancy is expelled. This indicates that the problem is not seen as a clinical one, to do with the use of misoprostol; it is a problem about the legal definition of what constitutes an abortion.

Because of the Department of Health’s stubborn refusal to engage with this recent development in abortion care, BPAS remains in the peculiar position where, if a woman comes to the clinic having had an early miscarriage, she can leave with misoprostol tablets in her shoulder bag; if she has come for an abortion, she has to return on another occasion to insert the tablets into her own vagina.

A further development in medical abortion has been through the availability of ‘abortion pills’ online. For countries where abortion is illegal, this has become an alternative to ‘backstreet abortion’ methods. Online abortion services carry risks, particularly where there are unscrupulous suppliers selling drugs that do not work; but there are also some reputable, women-centred services dedicated to helping women have safe ‘DIY abortions’ in countries where abortion is illegal.

In Britain, where early abortion is free and easily accessible, there should be no reason for women to seek the drugs for ‘DIY abortions’ online. But should abortion services become more restricted, or the law continue to make women’s experience of early medical abortion unnecessarily risky and inconvenient, it will hardly be surprising if women decide to take matters into their own hands by seeking the drugs online. From a regulatory, legal, or public health perspective, this cannot be what policymakers want to happen.

Further problems with the notification process

The ‘pre-signing’ controversy of 2012 brought to the fore some of the problems caused by forcing a small group of doctors working in a busy, geographically-extensive abortion service to sign forms that meet legal, rather than clinical, requirements. This controversy arose on the back of a journalistic ‘sting’ operation conducted by the Daily Telegraph newspaper in February 2012, which attempted to find doctors who were prepared to authorise abortions for reason of fetal sex. The resulting newspaper article provoked then Health Secretary Andrew Lansley into mandating a wave of inspections by the Care Quality Commission (CQC) of abortion services across the UK.

The inspection of 249 clinics, found no evidence of sex selective abortions being authorised, nor any evidence of substandard care. But in 14 NHS clinics, it found that doctors had been ‘pre-signing’ the HSA4 form in advance of the patients having been seen.98 Pre-signing HSA4 forms could be seen to contravene Department of Health regulations, and as such resulted in the investigation of the doctors concerned by the professional body, the General Medical Council (GMC). However, it is important to note that this practice did not constitute any danger to women on a clinical level.

In a context where abortion can always be authorised on the grounds of women’s safety up to 24 weeks’ gestation, it is possible to see how the pre-signing of forms became a practice that was adopted to meet the formal requirement for two signatures: particularly in services where a shortage of available doctors would otherwise have delayed women’s access to procedures. Pre-signing did not replace the clinical assessment of the patient, simply the authorisation of the abortion as meeting the legal grounds.

Nonetheless, this controversy has laid doctors open to legalistic attacks by opponents of abortion. One recent example is a parliamentary question asked by Fiona Bruce MP, who is known for bringing a variety of attempts to restrict access to abortion. Bruce asked the Secretary of State for Health what evidence it was going to report about those doctors who had been found not to have filled in abortion notification forms correctly.96

In the furore surrounding the so-called ‘pre-signing’ issue, there was never an argument that illegal, or unsafe, abortions were being carried out. Rather, technicalities to do with paperwork were used to attack the practices of doctors working within the NHS in allegations that could have serious repercussions: if a doctor is found not to be meeting the strict requirements of the Abortion Act, because abortion remains in the criminal statute, he or she could face a jail sentence.

There are further problems with the notification process, through the structure of the HSA4 form. This is the form used by the Department of Health as the basis for the collection of national abortion statistics. However, the collection of statistics is not a neutral process: it skews the ways in which the abortion discussion is framed.

For example, Ground C is often referred to as ‘the mental health clause’, and is perceived as the way in which doctors certify abortion ‘on request’, or ‘social abortions’. It is certainly the case that, despite the lack of a formal right to abortion in England and Wales, the abortion law is interpreted liberally to enable women to access abortion when they need it. Section 1(2) of the Act gives a clear statement about the wide discretion afforded to the doctor in determining the risk of abortion to a woman’s mental health, or to that of ‘any existing children of her family’, and that ‘account may be taken of the pregnant woman’s actual, or reasonably foreseeable environment.’

The structure of the HSA4 form helps to explain why it is that most abortions are authorised on the grounds of risk to women’s mental health. The HSA4 form requires a large amount of personal information about the woman, including: ethnicity, marital status, parity (number of previous pregnancies resulting in live births, stillbirths, miscarriages, ectopic pregnancies, legal terminations).


In terms of information about the procedure, doctors authorising the termination under Ground C are asked to tick whether there was a risk to the woman’s mental health and, if not, to state the ‘main medical condition’ under which the termination is authorised. Yet as we have noted, abortion poses less of a risk to physical health than childbirth: this ground should not require a ‘main medical condition’ to be specified.

For terminations under Ground E (fetal anomaly), the doctor is required to ‘state the abnormality or other reason for termination’, and specify the method of diagnosis. Yet because of the chilling effect of campaigns such as the Jepson case, doctors are understandably nervous about specifying the conditions for which they are authorising a termination: when it would equally true to say that, when a pregnancy is at a gestation of less than 24 weeks and the woman is facing a termination for fetal anomaly, a greater risk is posed to her mental health by continuing the pregnancy when she has decided on a termination, than by ending the pregnancy.

In this way, the reporting requirements both shape and skew official understandings of women’s reasons for having abortions. Because all abortions under 24 weeks’ gestation can be authorised on the grounds of the relative risk posed by the pregnancy to the woman’s mental health, we have ended up in a situation where over 175,000 women a year are presented, by the official statistics, as having a ‘mental health’ reason for not wanting to continue their pregnancies.

The costs of the abortion law

For policymakers and abortion providers alike, providing the best abortion care to women has to be achieved at a reasonable cost to the public purse. When women need abortions, it really matters that they can access them safely, quickly, and without having to pay.

The desire to increase the proportion of publicly-funded abortions relative to privately-funded procedures has been a goal of pro-choice campaigners and the abortion-providing charities since the 1967 Act; and the fact that 98% of abortions are now funded by the NHS is a remarkable achievement. It reduces the inequality between women with money and those without, in their ability to access procedures. It also reduces inequality between women and men, in the sense that it is only women who potentially need abortions, and they need not be dependent on men to fund them.

However, the need to maintain public funding of abortion care does add a pressure to keep the cost as low as possible, without compromising the standard of care. For charities such as BPAS, the best standard of care means ensuring that:

• All women can access procedures when they need them, up to the legal gestational limit;
• The safest and most effective methods are offered;
• Services are provided as locally as possible, reducing women’s need to travel;
• Women are able to take the time they need in discussing and reflecting their decision, even if this means using several appointments;
• Follow-up care is provided around the clock, so that women are not panicked into accessing A&E;
• Women who cannot be treated at BPAS because of particular health conditions are placed in an NHS service that can treat them.

Currently, BPAS is able to meet these goals as much as is possible within the constraints of the law. But it is frustrating that providers are forced to build in, fund, and insist that women take part in processes that are not only unnecessary for their care, but also sometimes potentially damaging to them and to the abortion service.

Demanding that women return to the clinics for the second part of early medical abortion treatment – that they organise childcare, miss work, and run the risk of bleeding on the journey home – sits very uncomfortably with doctors and nurses who want to ensure that their patients are safe, that the procedure is effective, and that women are treated with kindness and compassion.

Similarly, demanding that abortion doctors, who are motivated to do this challenging work because of their concern for women, spend hours on unnecessary paperwork rather than treating their patients, sits badly with a policy framework that explicitly recognises the need for abortion, and insists that all women who need abortions are able to access prompt treatment. Highly skilled and qualified doctors are compelled to spend their time on technicalities, while nurses and midwives are prevented from gaining the training and recognition for roles that they could very effectively play.

Particularly in the current climate, where abortion doctors are continually subject to slurs and investigations about their lawful practice, having the threat of criminal prosecution linked to irregularities in paperwork risks making abortion care into an area of medical practice in which doctors simply refuse to participate – and for understandable reasons. Yet without doctors, there can be no abortion service.

Policymakers do not want this outcome, for all the reasons that they promote the need for women’s access to abortion. But the true cost of this growing gap between the reality of abortion and the role played by an outdated law will be borne by women.
Chapter 7. The campaign against ‘sex-selective abortion’ – a case study in legal misinterpretation, and its consequences

Pro-choice advocates have long argued that the 1967 Abortion Act is problematic, because it puts the abortion decision with doctors, rather than with the pregnant woman. It is fundamentally a paternalistic piece of legislation that presumes that pregnant women cannot decide for themselves to have an abortion, when that is what they feel they need to do.

It is bizarre that in the twenty-first century, we have a law that frames abortion as a crime, which is only legal in circumstances authorised by two doctors. Abortion today is safe, acceptable, and a normal part of life. It would be much better if abortion could be regulated as any other medical procedure, with regulations grounded in patient safety and good clinical practice, rather than attempts to satisfy arcane legal requirements in the criminal statute.

Yet the problem with the Abortion Act does not lie with the doctors themselves. Doctors and their clinical teams are dedicated professionals, who are motivated by a desire to do what is best for their patients within the terms of the law. The most shocking thing about recent attacks on the Abortion Act is the way that these have tried to misinterpret the law in order to create a slur on doctors’ professional practice, creating confusion and a chilling effect around the kind of professional decisions that doctors have been making for years.

One recent example of this was provided by the high-profile anti-abortion campaign to ban ‘sex-selective’ abortion. In November 2014 Fiona Bruce, a Conservative MP and Chair of the All-Party Parliamentary Pro-life Group, who has brought a number of attempts to restrict abortion, introduced a Ten Minute Rule Bill calling for a ‘clarification’ that ‘nothing’ in the Abortion Act ‘allows a pregnancy to be terminated on the grounds of the sex of the unborn child’.99

Bruce’s Ten Minute Rule Bill was supported by 181 MPs, with only one MP voting against; this spurred her on to bring, at the beginning of 2015, an amendment to the government’s Serious Crime Bill, which had reached Report Stage.

The Bruce amendment to the Serious Crime Bill read: ‘Nothing in section 1 of the Abortion Act 1967 is to be interpreted as allowing a pregnancy to be terminated on the grounds of the sex of the unborn child’. A vocal campaign calling itself ‘Stop Gendercide’100 argued vigorously that a ban on sex selective abortion would give a clear message to certain ethnic communities that son preference was wrong.

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99 Hansard, 4 November 2014 http://www.publications.parliament.uk/pa/cm201415/cmhansrd/cm141104/debtext/141104-0001.htm#14110444000001
100 http://www.stopgendercide.org/
In a tense Parliamentary debate on 23 February, Bruce’s amendment was defeated, by 292 votes to 201. Academics, medical bodies such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, charities dedicated to supporting Asian women and campaigning against gender-based violence, and charities dedicated to supporting couples following a diagnosis of fetal anomaly made some powerful arguments about the problems with the Bruce amendment.

These arguments were that the Bruce amendment: a) was unnecessary, as the law already prohibits abortion on the grounds of fetal sex alone; b) would contribute to the difficulties experienced by women who were seeking a termination for reasons that might include the sex of the fetus (for example, a family history of serious sex-linked genetic disorders; c) would not address the deep-rooted causes of son preference in communities where this might exist; and d) was motivated by a well-known opponent of abortion, who was using the language of protecting women from ‘gendercide’ to undermine the abortion law in general, through demanding a greater scrutiny of women’s reasons for seeking terminations.

MPs debating the amendment in the House of Commons took these arguments on board and ultimately recognised that an explicit ban on ‘sex-selective abortion’ would do more harm than good. However, the fact that a challenge of this kind got so far in the first place illustrates some important features of anti-abortion campaigning today, and the way in which misinterpretations of the 1967 Abortion Act can be marshalled to create a chilling effect on doctors’ practice, and restrict women’s reasons for seeking terminations.

The Telegraph is a newspaper known for its antipathy to abortion. In its sting operation of 2012, undercover journalists visited a number of clinics, including those run by British Pregnancy Advisory Service, where they requested an abortion because they believed the fetus to be a boy, or a girl. Most clinics, including those run by BPAS, turned the journalists away. In the end, this major ‘investigation’ was able to find only two doctors, working in private practice, who might be prepared to authorise the abortion — and this was the story that the Telegraph went to town on.

In September 2013, the Director of Public Prosecutions announced that the two doctors would not be prosecuted, because to do so was not in the public interest. When the CPS published the full reasons for its decision not to prosecute, it transpired that the journalist in this investigation, far from demanding a termination based on the sex of the fetus alone, had mixed in other reasons for her request, including concerns about fetal anomaly and late miscarriage.

Yet despite the DPP’s statement that the abortion doctors pilloried by the Telegraph should not be prosecuted, the issue did not go away. If anything, it provoked others into more desperate attempts to find ‘evidence’ to support the concerns about the extent of sex-selective abortions: including the Independent’s claims about sex ratios, the Bruce Bill and amendment, and private prosecutions brought against the two doctors by the Christian Legal Centre. These private prosecutions were eventually stopped by the Crown Prosecution Service.

The Department of Health (DH) in May 2014 published updated annual birth ratio statistics for England and Wales. These continued to find ‘no evidence of sex selection occurring in the UK.’

The DH also published formal ‘Guidance in Relation to Requirements of the Abortion Act 1967’, which confirmed that abortion on the grounds of gender alone is not lawful, and the expectation that two doctors, when certifying that an abortion meets the criteria set out in the Act, must consider the individual circumstances of the woman and be prepared to justify their decision.

In other words: doctors are currently meeting requirements of the 1967 Act by assessing women’s particular circumstances; if fetal sex is mentioned as bound up with these wider circumstances, a doctor may feel that a termination can be authorised. This was the central point made by the 2013 BPAS pamphlet Britain’s Abortion Law: What it says, and why, in which legal scholars explained why the law does not explicitly prohibit abortion for reason of fetal sex.
Fiona Bruce made numerous references to this pamphlet, in her attempts to insinuate that doctors are flouting the law, and that there needed to be more explicit ‘clarification’ that ‘sex-selective abortion’ is illegal. Ultimately, her campaign shone a light onto the reasons why, in fact, such an explicit ban would be deeply problematic for the women that the Abortion Act is designed to protect, and for the doctors who help them.

Turning on doctors

Under the law, a doctor who is confronted with a woman wanting an abortion ‘because it’s a girl’ cannot authorise the abortion for that reason alone. This would be no different if the woman were to demand an abortion ‘because I was raped’, or ‘because I have three children under five already’, or ‘because my partner has been beating me up’, or ‘because I have to take my exams’, or ‘because I’m in my mid-forties and my family was completed years ago’, or any other conceivable, or sympathetic, reason that a woman could give for needing an abortion.

None of these requests are legal grounds for abortion. The 1967 Abortion Act emphatically does not make legal ‘abortion on request’: it is only legal when two doctors agree that the woman meets one or more of the legal grounds. The doctor must make his or her decision based on the relative risk to a woman’s physical or mental health of having an abortion versus carrying the pregnancy to term, and this decision can take into account the woman’s ‘actual or reasonably foreseeable environment’.

So if a doctor believed that a woman with three young children already would struggle, physically, emotionally, or financially, with a fourth baby, and if this woman really did not want a fourth baby and is requesting a termination, how could this doctor, in good conscience, refuse her request for an abortion? If a forty-something mother of teenage children is worried about the impact of pregnancy on her own health, anxious about the risk of having a child with a disability, and really does not want another baby – would it be right to turn her down?

If a woman is being beaten up by her partner and knows that having a baby will destroy her chances of leaving him, thereby compromising her health further – how could the doctor tell her to have the baby? What if the woman does not want to leave her partner, or cannot leave him, but feels that continuing the pregnancy will make the situation worse? The doctor cannot change this woman’s circumstances – but he can permit her to have an abortion, rather than forcing her to carry the pregnancy to term.

These are the kinds of judgements that abortion doctors and their clinical teams have to make every single day. They are often painful, complex, and unhappy. In this context, it is not difficult to see how a woman’s decision to terminate a pregnancy might, in some particular circumstances, be bound up with an anxiety that she cannot have another girl, or another boy.

The abortion would never be authorised for that reason alone – but if that reason formed part of the larger reason why it would be better for a woman’s mental or physical health to terminate the pregnancy, provided this is her decision, then a doctor would be acting quite lawfully in approving her decision.

The discussions that take place between doctor and patient are highly personal, and often involve weighing up a complex set of considerations and circumstances. This is why, when the 1967 Abortion Act was written, there was no list given of particular reasons why an abortion should or should not be authorised. To provide such a list would have undermined the clinical discretion of doctors and their clinical teams to make decisions based on their individual patients – and without that professional integrity, the law would not work at all.

The aim of the campaign against ‘sex-selective abortions’ has been shamelessly to smear abortion doctors, who are acting within the law and for the benefit of their patients. This was revealed by the Telegraph’s partial reporting of its investigation, which omitted the journalist’s claims about fetal anomaly and miscarriage, the speed at which the Health Secretary endorsed this ‘investigation’ to grandstand about the immorality of sex-selective abortions; and the way that Fiona Bruce jumped upon the issue as her latest attempt to undermine access to abortion.

These ongoing attempts to vilify doctors reveal the desperation and tenacity of the anti-abortion movement, who still cannot accept that their tactic of undermining the law through panic-mongering about sex selection has failed. After all, this has been a campaign in the making for some time.

Sex selection: The latest ‘anti’ tactic

In Britain, the campaign to manufacture an opposition to abortion based on sex selection goes back at least as far as 1993, when the Society for the Protection of Unborn Children (SPUC) commissioned a Gallup poll asking whether respondents approved or disapproved of abortion ‘where the couple decide on an abortion after sex selection tests’. Not surprisingly, 86% of people disapproved of abortion in these circumstances; and SPUC’s press release was headlined, ‘Sex Tests: Public Say No to Abortion’.

In 2013, Fiona Bruce, along with Labour MP Jim Dobbin, introduced a private bill to urge the Government to introduce monitoring of the sex of aborted fetuses. This was a ludicrous request, which would not even have been technically possible; but it indicates that Bruce has been attempting to find a way of using this tactic for some time.
As with many campaigns designed to undermine Britain’s abortion law, campaigners have probably obtained their ideas from the USA. Over the past few years, America has experienced an onslaught of state laws designed to restrict access to abortion, on a number of spurious grounds. One of these is an attempt to legislate against ‘sex-selective abortion’ – a campaign that has been exposed as politically motivated, relying on racial stereotypes and a series of ‘myths’ about the practice and prevalence of ‘sex-selective abortion’ in the USA.\(^8\)

An article by Eesha Pandit on the website RH Reality Check reveals how the campaign against sex-selective abortion in the USA is a deliberate tactic designed to undermine abortion rights in general.\(^9\) Pandit cites Steven Mosher, ‘the head of the conservative, anti-choice Population Research Institute’, back in 2008:

I propose that we – the pro-life movement – adopt as our next goal the banning of sex- and race-selective abortion. By formally protecting all female fetuses from abortion on the ground of their sex, we would plant in the law the proposition that the developing child is a being whose claims on us should not depend on their sex.

The anti-abortion movement, said Mosher, should tap into the disquiet that ‘radical feminists, the shock troops of the abortion movement’, may feel ‘at the thought of aborting their unborn sisters’. This, he claimed, opened a space for a campaign to undermine abortion by focusing on claims about sex-selection:

While the pro-aborts are stammering and stuttering, we pro-lifers will be advancing new moral and logical arguments against the exercise of the ‘right’ to an abortion solely on the grounds of sex or race. For those who are immune to moral arguments, we can also use the examples of China and India, where sex-selective abortion is creating enormous societal problems. The debate over sex- and race-selective abortion will also help to focus the public’s attention on how unregulated the abortion industry is. In these and other ways, the debate over this legislation will not subtract from, but add to, the larger goal of reversing Roe v. Wade and, ultimately, passing a Human Life Amendment.

To those of us familiar with the tactics of the anti-abortion movement, the breath-taking cynicism of this quote should not come as a surprise. As Mosher indicates, opponents of abortion have failed to win support for their moral arguments, which rest on the view that all abortion is murder, and therefore wrong. So they have changed their arguments.

In the USA, the cynical motivations behind the recent laws banning sex-selective abortion have been clearly exposed. In 2012, there was an unsuccessful attempt by Republicans to pass the ‘Prenatal Nondiscrimination Act’ (known as PRENDA) in the House of Representatives. If that bill were to become law, Kate Sheppard explained on Mother Jones at the time, ‘a doctor or nurse who suspects that a patient is seeking a sex-selective abortion would be required to report her to authorities. Doctors who perform such a procedure could face jail time, fines, or lawsuits from a patient or her family’.\(^10\)

In a furious riposte to the PRENDA proposals, Miriam Yeung of the National Asian Pacific American Women’s Forum, Jessica González-Rojas of the National Latina Institute for Reproductive Health, and Eleanor Hinton Hoytt of the Black Women’s Health Imperative, wrote:

This bill means that all women – and to be clear, particularly Asian American women – who seek an abortion could face new, intense scrutiny. In particular, given the issue of sex selection in Asian countries, any woman who appears to be Asian American risks intense questioning about the decision she has made to seek an abortion. The bill also targets providers and makes it more difficult to provide reproductive health care including abortion...

No woman should ever be scrutinized or interrogated by her doctor, but this is exactly what would happen if this bill becomes law. Given the risks to providers, even the decision to find out the sex of a child during a wanted pregnancy may become suspect.\(^11\)

PRENDA failed to pass through the House of Representatives. Politicians saw this bill for what it was: as the New York Times reported, ‘Democrats accused Republicans of contriving a vote on legislation to address a problem that does not exist’.\(^12\)

But at a state level, opponents of abortion have succeeded in bringing in a number of laws banning sex-selective abortion: in Arizona, Illinois, Kansas, North Carolina, North Dakota, Oklahoma, Pennsylvania, and South Dakota. In these states, performing a sex-selective abortion (or in some cases attempting to perform such an abortion) carries penalties; in Arizona, Pennsylvania and South Dakota it is classed as a felony.

The intrusive character of these laws is well recognised to be part of a wider attempt by opponents of abortion to restrict women’s access to abortion in general. As the Guttmacher Institute reported in early 2014, more abortion restrictions have been enacted in the USA over 2011-2013 than were in the previous decade.\(^13\) Yet even these highly restrictive, politically motivated laws implicitly recognise that the ‘sex-selective abortion’ issue is difficult to legislate for. Five of the eight legislate for liability only if the sex of the fetus is seen to be the ‘sole factor’ in the woman’s decision-making; and two provide a specific exemption if there is a sex-linked disorder at issue.

These are the grey areas that even punitive anti-abortion laws in the USA have to allow for. And, as we have demonstrated above, they are the grey areas allowed for by the British abortion law.

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\(^{13}\) ‘More State Abortion Restrictions Were Enacted in 2011-2013 Than in the Entire Previous Decade.’ Guttmacher Institute, 2 January 2014 http://www.guttmacher.org/media/inthenews/2014/01/02/index.html
Conclusion

One of the main points to come out of the Parliamentary debate on Fiona Bruce’s sex selection amendment was that this is not the way to reform the law – it is dangerous, incoherent, and politicised. As well as creating a difficult climate for doctors already working in the abortion service, this chilling effect is likely to have a detrimental effect on trainee doctors’ motivation to go on to provide abortions. A shortage of doctors will affect the availability of swift access to care by women, and increase the difficulties experienced by women with complex health conditions, fetal anomalies, or who are presenting for abortion later in pregnancy.

If the Abortion Act is to be amended, this should not be through ill-considered amendments sneaked through the back door at the last minute, but through a thorough, open, and considered reform.
Chapter 8. The kind of regulation we need today

There are two powerful motivations behind the push to reform Britain's abortion law now. First is the need to bring the law into line with the reality of society in 2015. In two years’ time, we will mark the 50th anniversary of the 1967 Abortion Act; a piece of legislation that was progressive for its time and has served women well. But developments both in the methods of abortion – particularly, the development of medical abortion (the ‘abortion pill’) – and social attitudes and experiences have made many aspects of the 1967 Act badly outdated.

The second motivation is the experience undergone by doctors, nurses and midwives over the past two years, where opponents of abortion have seized upon some of the technical provisions of the Act to make the case that abortion providers are somehow twisting the law. While official investigations have subsequently confirmed that doctors are interpreting and implementing the law correctly, a chilling effect has made clinical staff nervous about aspects of their practice, in case official interpretations should suddenly change.

There is no blueprint for a better form of regulation. We can look to the example of many other European countries, which permit abortion on request in the first three months of pregnancy. In France, for example, a new piece of equalities legislation has overturned the requirement that a woman seeking abortion must claim to be in a state of distress. This makes a welcome statement about women’s ability to decide, rationally, that abortion is the best thing for her.

However, laws that allow abortion only in the first trimester, and retain criminal penalties for those contravening them, are still problematic for the small proportion of women who need abortions later on in pregnancy. These women are forced to travel overseas to seek the procedures that they need, or to carry the pregnancy to term at great personal cost.

Fundamentally, such laws rely on the presumption that abortion should be treated as a procedure that is distinct from other aspects of women's healthcare: even though, as European abortion rates indicate, it is an accepted and normal part of life.

More positively, we could look to examples where criminal abortion statutes have been struck down. In France, for example, a new piece of equalities legislation has overturned the requirement that a woman seeking abortion must claim to be in a state of distress. This makes a welcome statement about women’s ability to decide, rationally, that abortion is the best thing for her.

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More positively, we could look to examples where criminal abortion statutes have been struck down. In Canada, abortion has been regulated outside of the criminal code since the 1988 Supreme Court decision in R. v. Morgentaler. This held that the abortion provision in the Criminal Code of Canada was unconstitutional, as it violated a woman’s right to security of person. The consequences of this are discussed below.

In Australia, reform legislation has decriminalised, or partially decriminalised, abortion in four jurisdictions. The barrister Kerry Petersen explains:

> Since the late 1990s, the right to the ‘highest standard of health’ has underpinned four revised legal frameworks regulating abortion in Australian jurisdictions. Although Australia’s abortion laws vary from state to state, there is a trend to classify abortion mainly as a health matter.

The jurisdictions of Western Australia, the Australian Capital Territory (ACT), Victoria, and Tasmania have, explains Petersen, ‘adopted different pathways; however, all of them have struck down criminal laws which make it an offence for a pregnant woman to procure her own abortion at all stages of a pregnancy and abortion is considered mainly as a health matter.’

There are differences between the political frameworks of these countries, and the ways that abortion is provided. In that sense, neither the Canadian nor Australian models provide something that could directly copied by Britain. But they do show that when abortion is decriminalised, the sky does not fall in: numbers and rates remain stable, and abortion care continues to be regulated.

The difference is that care can be regulated according to clinical priorities, rather than legal requirements. And this needs to be the starting point for our discussion.

How the law has evolved, and the problems for today

At a meeting at the House of Commons on 16 October 2014, doctors, lawyers and others working in abortion care began a new campaign for reform of Britain’s antiquated abortion law. The meeting was hosted by Kate Green MP, who stressed the importance of clarifying where advocates for choice want to take the campaign for abortion rights. Too often, campaigns to change the law have been led by those who want more restrictions on abortion; it is rare that we have the opportunity to think about reforms from a pro-choice point of view.

Professor Sally Sheldon explained that abortion is subject to the oldest surviving statutory framework of any specific medical procedure. That a piece of legislation is old is not necessarily a problem; it is a problem, however, when the legislation becomes archaic. Any piece of legislation, explained Sheldon, falsifies the values of the era in which it is passed. The 1861 Offences Against the Person Act does this with regard to the criminal penalty of abortion. The 1967 Abortion Act does it with regard to the kind of requirements that are attached to the therapeutic exemption from prosecution. We need to look for a piece of legislation or regulation that reflects the reality and values of abortion today.

If we got rid of the OAJP tomorrow, that would also remove much of the need for the 1967 Abortion Act. But in the absence of any specific criminal law on abortion, it would still fall under legislation governing other medical procedures. The question, then, is about removing a specific piece of criminal law. In this respect, Sheldon argued, the onus should be on those who wish to justify the retention of the criminal sanction.

There are three arguments that could be made about why abortion should remain in the criminal code. The first is to do with retribution. This, argued Sheldon, is a rather odd justification to invoke in relation to a routine gynaecological procedure that 1 in 3 women will access over the course of their lives. The typical ‘criminal’ under the law today would be a terrified teenager who buys the abortion pill on the internet because she does not want to confide in her doctor, or the doctor who provides care for her or her patient but fails to meet one of the legal requirements – such as signing the authorisation form correctly.

It seems extraordinary that the response to such cases should be framed in terms of retribution. Neither the teenager or doctor in such cases is likely to be prosecuted – but it is a poor justification for a law to say that it will be seldom enforced and that itself indicates that the sanctions are drawn in the wrong place.

The second argument one could make is the prevention or deterrence of harm. We know from the incidence of unsafe or illegal abortion worldwide that repressive abortion laws do not prevent harm to women or protect fetal life, but they do increase maternal mortality.

Sheldon argued that taking abortion out of the criminal statute in Britain would not increase abortion rates, as women have access to the procedure already. It might bring down the number of later abortions, particularly those to women in Northern Ireland, by removing some of the legal barriers to swift access. She drew on the example of the Australian State of Victoria, where abortion was taken out of the criminal code with the express intention of bringing the formal law into line with the reality of practical access to abortion services, without affecting abortion rates.

Third, there is an expressivist argument, where criminal sanctions are seen to express who we are as a society and what we care about. The message sent out by the OAPA is that abortion is seriously morally wrong at all gestations and in all circumstances; this expresses something clear about the values of Victorian society. Today, we have to read the OAPA in conjunction with the Abortion Act, which expresses the acknowledgement that there is a need for abortion, but an insistence that is be done under strict medical control: this was the sentiment of the Sixties.

Both these justifications for legislation are clearly out of step with society today. The 1861 provisions were passed with no debate at all, even at the time; society then had not developed the machinery even for talking about abortion. Today, abortion is accepted, widely provided, and much talked about. The values we would wish our legislation to express today are clearly different to those of both the 1860s and the 1960s.

What happens when abortion is decriminalised? The case of Canada

Joanna Erdman, MacBain Chair in Health Law and Policy at Dalhousie University, Canada, provided the comparative account of Canada, where abortion has been regulated outside of the criminal code since the 1988 Supreme Court decision in R. v. Morgentaler. This held that the abortion provision in the Criminal Code of Canada was unconstitutional, as it violated a woman’s right to security of person.53

In this landmark case, Dr Henry Morgentaler (1923-2013) and two other doctors set up a clinic for the purpose of performing abortions on women who had not received certification from the Therapeutic Abortion Committee, as required under subsection 287(4) of the Criminal Code. They did so to make the case for women having complete control over the decision on whether to have an abortion: highlighting that the existing law, which required abortions to be carried out in hospital, threatened women’s health and wellbeing. Since the 1988 Supreme Court decision, there have been several attempts to introduce a law on abortion but all have failed to reach a consensus, leaving the decriminalisation of abortion as the status quo.

Yet this does not mean, Erdman explained, that Canada has no law on abortion. There is no specific criminal law relating to abortion, but there is plenty of other law. Each provincial government has at some time enacted regulations designed to limit abortion, through restrictions on funding or place of procedure. The courts have often declared such restrictions arbitrary or irrational, and most have been repealed; meaning that most states now treat abortion as a part of healthcare.

But while women have the formal right of access to abortion, this can mean very little when services are not available. Mifepristone, the drug used in medical abortion, has not yet been approved in Canada, meaning that services and procedures are more restricted than they could be.

From this, Erdman argued that the criminalisation of abortion is not just about the criminal law. It is an affect, a social phenomenon, which reaches well beyond letter of law, and impacts on services by discouraging, restricting, and stigmatising provision. The effect of decriminalisation similarly must go beyond the law to make abortion genuinely accepted as a healthcare need.

There are two lessons that campaigners, policymakers and providers in Britain could learn from Canada. The first is that when abortion is taken out of the criminal law, this does not result in more abortions, or more dangerous abortions: indeed, it can make abortion a much safer procedure. But repealing the criminal law alone is not enough to ensure that women can get access to abortion on the basis of need. Sometimes health regulation is needed to protect access: for example, through requirements that health services receiving public funding provide abortions.

To be free and safe is not to be abandoned, Erdman concluded. Decriminalisation should not mean the departure of the state from the provision of abortion, but the incitement of its intervention on progressive terms.

Providing abortions in Britain today

Ann Furedi, chief executive of BPAS, highlighted the gulf between the reality of abortion in Britain today, and the legal framework. We know that women largely have abortions for one reason – they had sex, got pregnant, and don’t want to be pregnant. Abortion today has become an accepted back-up to contraception. Yet the abortion law does not address this reality at all.

Abortion providers, Furedi argued, inhabit two worlds – the world in which we live, and the ‘Alice in Wonderland’ world imagined by the law, where abortion is very rare, risky, and dealt with through surgical procedures performed by doctors in clinics rather than through pills taken by women and administered by nurse-led services.

The 1967 Abortion Act addressed the circumstances in which women sought abortion and became pregnant, but that was a very different climate to the one we live in today. Then Home Secretary Roy Jenkins saw the Abortion Act as part of a raft of liberalising laws. It was not framed in the context of women’s rights but attempted to address some of the particular problems facing society at that time – including the health problems caused by unwanted pregnancies and ‘backstreet’ abortions, and the tragedy for women who were pregnant with fetuses suffering from serious anomalies.

It is not surprising that a law that brought into being nearly 50 years ago, to address these problems, should be out of step with society today. The Abortion Act is not a bad law – the fact that it works as well as it does today perhaps tells us something about the wisdom of politicians in the 1960s. But it is a law that is not fit for purpose today.

The existence of an abortion law has become so taken for granted that even abortion doctors and pro-choice activists, when asked to consider what kind of abortion law would work best, often see the need to build in some limits: a gestational limit; some provision for young people; some kind of counselling; a restriction on the number of abortions women can have. But most of these concerns derive, not from clinical issues, but from the prejudices that people have about the women who are accessing abortion.

Abortion, concluded Furedi, should be subject to no more and less regulation than any other clinical procedure. Law makers are not the best people to decide about abortion: how much better if we can move away from the legislation of the past and trust women and medical professionals to make the decisions for themselves.

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The gulf between the abortion law and the reality is particularly stark in Northern Ireland, where the 1967 Act does not extend. What this means in practice is that women travel to mainland Britain – and now, with the development of medical abortion, women are buying abortion pills over the internet and self-inducing illegally. In a letter signed in 2013, a number of people admitted either taking the pills or helping women to obtain them – and as yet, there have been no legal consequences. Surely, it was suggested, lawmakers must be concerned when a law is being ignored completely.

The example was given of recent developments in Spain, where attempts to overturn a liberal abortion law were met with huge protests and condemnation with Parliament, internationally, and above all among Spanish women and doctors. This indicates that there are limits to how far attempts to roll back abortion provision can go – and that public opinion, when tested, might show itself to be far more in favour of liberalising access to abortion than is often assumed.

Sally Sheldon raised the question of how lawmakers can be encouraged to take this issue on. The Law Commission is currently reviewing the 1861 Offences Against the Person Act, precisely because it is recognised as being badly outdated, yet it is excluding a review of sections 58 to 60, pertaining to abortion and concealment of birth because these sections are said to raise ‘different issues’. In fact, Sheldon argued, they raise the same issues, of the law being out of step with practice and reality. Even when the 1967 Act was passed, doctors were not using vacuum aspiration, or early medical abortion: two developments that have transformed the safety of abortion and the ways it is provided.

The veteran campaigner Dilys Cossey OBE, former secretary to the Abortion Law Reform Association (ALRA), which brought about the 1967 Abortion Act, gave an impassioned description of the events leading up the passage of the 1967 Act. In the 1960s, women were dying from abortion and suffering from ill-health from pregnancy, and had little access to contraception: a very different context to the one we have now. But the abortion debate was about setting the agenda: giving a vision of the kind of society we wanted to live in, in the context of the Wilson government, which was serious about social reform.

ALRA was born in 1936; it took all those years to bring about reform. When it did, the Abortion Act was a compromise, presenting women as victims and medical profession as angels. But in subsequent years, there have been very few positive campaigns around abortion. The years in which the New Labour government held power were lost opportunities, said Cossey, when the pro-choice movement was characterised by timidity and defensiveness. We cannot look to Parliament to lead this debate; it has to come from outside.

Continuum of care, and difficult cases
There was some discussion about the extent to which medical abortion has transformed things, meaning that a woman can access abortion as soon as she needs to, and a doctor does not need to be involved. Given the extent and acceptance of abortion as a part of women’s lives, and the transformative effect of the abortion pill, the logical move is to situate abortion within a continuum of women’s reproductive health care, encompassing contraception, miscarriage care, and childbirth. This would also enable more active involvement of nurses and midwives, whose role in other aspects of women’s reproductive health has increased alongside a growing emphasis on demedicalisation and woman-centred care.
A question was raised about whether the law needed to provide an upper gestational limit, to prevent abortions from being carried out much later in pregnancy. Yet despite abortion being legal in Britain up to 24 weeks’ gestation, the vast majority take place in the first trimester of pregnancy: for the simple reason that women do not want to have abortions later than they need them, and doctors do not want to perform them.

That was the case in Scotland until 1990, where there was no upper time limit: there were no more abortions than elsewhere in Britain. It is currently the case in Canada, where there is no time limit but very few physicians are prepared to perform later abortions, and tend to do so only for reasons of fetal anomaly or maternal health. The doctors’ reluctance to treat is a problem, as often the most compelling cases of women needing abortions are those who end up presenting late in pregnancy; but it does show that the barrier to later abortions is not generally the criminal law.

Sally Sheldon noted that the Australian state of Victoria is interesting, in that abortion has been largely taken out of the criminal law but a distinction has been drawn between earlier and later abortions, with a doctor needing to comply with additional administrative requirements before he or she can perform an abortion after 24 weeks. However, if these requirements are not met, the potential sanction is disciplinary rather than criminal.

A question was raised about terminations for fetal anomaly. The Abortion Act’s insistence that, in such cases beyond 24 weeks’ gestation, two doctors have to agree that the fetus is likely to be seriously disabled does put a burden on doctors deciding which conditions are ‘bad enough’ to warrant an abortion: an issue that has come to the fore through campaigners raising concerns about abortions for such conditions as cleft palate.

On the other hand, the fact that this clause exists within the law implies an obligation to help women when faced with diagnoses of fetal anomaly. Would decriminalisation help in these cases? Joanna Erdman replied that in Canada, these decisions happen informally: doctors want to ensure compassionate care for women, and see themselves as needing to provide patient-centred care as with any other service.

What kind of regulation do we need?

Concluding the House of Commons meeting, Sally Sheldon noted that there are different ways of arriving at a situation of decriminalisation. Unlike Canada, Britain would not have a court striking down our legislation; we would be looking at a managed parliamentary process of reform. Many of the issues that worry people about taking abortion out of the criminal law are already addressed by other legislation, such as that on assault; though it would be important to consider whether there is any conduct in relation to abortion that would warrant a distinct criminal sanction.

Joanna Erdman stressed that discussions around decriminalisation need to take into account the political context in which changes are happening, and address the broader affective aspect of decriminalisation. Maybe we should start asking why the dial has moved in relation to such issues as HIV, or gay marriage, yet seems to be stuck when it comes to abortion. The questions we need to be asking go beyond the provision of services to women who need them, and are more to do with how we as a society want to treat people.

Conclusion

The 1967 Abortion Act was a tremendous achievement for its time, and it has served women well. But as we approach the fiftieth anniversary of this legislation, it is time to move on. We need to bring the law into line with clinical developments, women’s needs, and the social reality of 2015 – where abortion is accepted as a fact of life.

It is time to push away from the idea enshrined in the Abortion Act of women as victims of their circumstances, and instead promote the view that we trust women to make rational decisions, and that we trust doctors’ professional judgement in providing the best standard of care.

The 1967 Abortion Act was a long time in the making. It required dedicated campaigning and intense discussions, both within Parliament and between politicians, health professionals, and advocacy groups. In calling for the decriminalisation of abortion, we do not suppose that this will happen overnight; or that it will be a straightforward process. We do not have a blueprint for how it might happen.

But whatever form of regulation we decide is most appropriate for the 21st century, it should be one based on the central principle of trusting women to decide, and doctors to practise. The aim of this publication is to begin that conversation.
Further reading

The 1967 Abortion Act (as amended by the 1990 Human Fertilisation and Embryology Act)

The 1861 Offences Against the Person Act
http://www.legislation.gov.uk/ukpga/Vict/24-25/100/contents

The 1929 Infant Life (Preservation) Act
http://www.legislation.gov.uk/ukpga/Geo5/19-20/34/section/1

Abortion notification forms for England and Wales

Abortion Statistics, England and Wales: 2013

Abortion Care, by Sam Rowlands (Editor). Cambridge University Press 2014. This comprehensive review of the emotive and often controversial topic of abortion provides clinicians with a multidisciplinary focus on abortion services, discussing clinical topics in their sociological, legal and ethical context. Topics include medical and surgical methods of abortion, ultrasound scanning, pain control, complications, and abortion in women with medical conditions, as well as ethics, stigma, and human rights. Written by leading authorities in their subject areas, Abortion Care is essential reading for medical and nursing specialists and forms a useful resource in the delivery of graduate courses in the fields of obstetrics and gynaecology and sexual and reproductive healthcare. It is also of interest to professionals involved in planning, delivering and managing women's health services, including counsellors, service managers and public health specialists.

Abortion is now recognised as primarily a medical issue, rather than one of political and social importance; its regulation determined by the authority of doctors and other medical professionals. In the first comprehensive historical study of the regulation of abortion, Sally Sheldon examines the causes and effects of the medicalisation of abortion, focusing on the role that law has played in this process. Sheldon traces the history of the modern law on abortion, examining regulation in Britain prior to the 1967 Abortion Act, following with a detailed study of the Act itself and the values that underpin it, and locating the British law in a comparative context. Taking a theoretical approach to the subject, Sheldon draws on the work of Foucault and on feminist theory to challenge common perceptions that the law has evolved to embrace a more permissive stance on abortion and that in so doing Britain, in particular, has now ‘solved’ the ‘abortion problem’.

Abortion, Motherhood and Mental Health: Medicalising Reproduction in the US and Britain, by Ellie Lee. (Second edition) Aldine Transaction, 2004
Whatever reproductive choices women make whether they opt to end a pregnancy through abortion or continue to term and give birth they are considered to be at risk of suffering serious mental health problems. According to opponents of abortion in the USA, potential injury to women is a major reason why people should consider it a problem. On the other hand, becoming a mother can also be considered a big risk. This book is about how people represent the results of reproductive choices. It examines how and why pregnancy and its various outcomes have come to be discussed this way.

Abortion Law Reformed; by Keith Hindell and Madeleine Simms. Peter Owen, 1971
This book is the first fully documented account of the thirty-year campaign to replace Britain's severe and archaic abortion law. Starting with the work of the Abortion Law Reform Association in the thirties, it reaches into the sixties as change begins to become imminent thanks to a new generation of reformers. With an introduction by David Steel.

Abortion Law Reformers: Pioneers of Change. BPAS, 2007
This book presents frank interviews with many of the campaigners, doctors and parliamentarians who brought the 1967 Abortion Act into being, providing an inspiring sense of the spirit in which the Act was conceived and thoughtful reflections on how well the law has worked subsequently.

Britain’s Abortion Law: What it says, and why. BPAS, 2013
This pamphlet, based on papers by legal scholars, explains that 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 to understand the law correctly.